LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

PROGRAM SUPPORT BUREAU
QUALITY IMPROVEMENT DIVISION

QUALITY IMPROVEMENT WORK PLAN EVALUATION REPORT CALENDAR YEAR 2016

AND

QUALITY IMPROVEMENT WORK PLAN CALENDAR YEAR 2017

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

July 2017

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

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Executive Summary

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The Los Angeles County Department of Mental Health (LACDMH) Quality Improvement Annual Work Plan is organized into six (6) 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 10,192,376 in Calendar Year (CY) 2015. The estimated distribution by Ethnicity in the major designated ethnic categories includes: Latinos representing 48.4%, Whites 28.3%, Asian Pacific Islanders 14.6%, African Americans 8.5%, and Native Americans representing 0.19%. During Fiscal Year (FY) 15-16, a full array of mental health services were provided to approximately 277,000 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 217,028 persons Countywide.

This Quality Improvement Work Plan Evaluation Report details the progress LACDMH has made with respect to the 2016 Annual Work Plan Goals. Out of the 23 goals for CY 2016, 21 goals were either met or exceeded. Within the six domains for Work Plan goals, each domain had at least one goal that was 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 2017 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 2017 Quality Improvement Work Plan Goals are set by the Program Support Bureau – 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 Bureau, 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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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

QUALITY IMPROVEMENT WORK PLAN EVALUATION
CALENDAR YEAR 2016
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CALENDAR YEAR 2017

INTRODUCTION

In partnering with consumers, families, and communities to provide culturally competent opportunities for Hope, Wellbeing, and Recovery, the Los Angeles 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 Program Support Bureau (PSB), Quality Improvement Division (QID) is under the administration and direction of the PSB Deputy Director. PSB-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 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.

PSB-QID includes the following three (3) Units: the Cultural Competency Unit (CCU), the Underserved Cultural Communities (UsCC)/Innovations (INN) Unit, and the Quality Improvement (QI)/Data-Geographic Information System (GIS) 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 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 Unit also implements the Community-Designed Integrated Care Program (ICP) Model which promotes 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 QI-Data GIS Unit is responsible for the collection, analysis, and reporting of LACDMH demographic and clinical data. The QI-Data GIS Unit conducts assessments of geographic distribution of mental health services within LACDMH.

Quality Improvement Program Processes

The purpose in 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.

PSB-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 (6) 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.

PSB-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 studied 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 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 Outcomes Unit; Emergency Outreach Bureau (EOB); Service Area Quality Improvement Committees (SA QICs) and the multidisciplinary PIP teams. The PSB-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 PSB-QID Mental Health Clinical Program Manager and Co-Chaired by a Regional Medical Director from the Office of the Medical Director (OMD). The PSB-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 eight (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 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. PIPs are conducted to ensure that selected administrative and clinical processes are studied to improve performance outcomes.

Clinical Performance Improvement Projects (PIPs)

Implementation of Family Resource Centers (FRCs) to Improve Access and Continuity of Care: This project was approved as a Clinical PIP for Fiscal Year (FY) 16-17 by the EQRO Review team, in September 2016.

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

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

The Clinical PIP team of stakeholders, that consists of FRC Project Leads from the Children's System of Care Bureau (CSOC) Administration, the QID, as well as managers, supervisors and key staff from FRC programs in SA 2, SA 3, SA 4, and SA 8 addressed program design elements critical to the implementation of FRCs while the budget approval process was in progress. In October 2016, the Clinical PIP team leads made essential steps towards FRC implementation by submitting the duty statements for 38 positions and completing the FRC organizational charts for the DO programs and Request for Service (RFS) to implement FRCs with LE Contracted programs. In December 2016, the PIP team reviewed the YSS, YSS-F, and Adult survey domains and agreed to use the General Satisfaction, Perception of Access, Perception of Cultural Sensitivity/Quality and Appropriateness and Perception of Participation in Treatment Planning subscales of the Mental Health Statistical Improvement Program (MHSIP) domains as outcome measures, within FRC programs. In January and February 2017, the PIP team explored and identified the role of Parent Advocates (Community Workers) at FRCs. In February 2017, the process of developing the FRC workflow was initiated and the potential sources of referrals and the services that FRC programs will provide were discussed. The FRC implementation for DO programs was tentatively scheduled for July 2017 and is now slated to be implemented in October 2017. Following implementation, the PIP team will focus on reviewing referrals to FRCs, enrollment of eligible clients, and outcomes measures data collection.

Commercial Sexual Exploitation of Children and Youth (CSECY): The CSECY Clinical PIP ended in April 2016. The LACDMH CSECY PIP team has continued its efforts to increase CSECY awareness and training within Los Angeles County and an ongoing quarterly CSECY team meeting schedule has been established. During CY 2016, the CSECY team has made notable efforts towards enhancing community outreach and collaborative relationships.

Community Outreach and Collaborative Relationships: The CSECY team has facilitated community outreach activities that include: participation at community events; presentations, trainings, and in-services on CSECY and human trafficking; and consultation and resource-sharing. In addition to the CSECY team's collaborative efforts with other county agencies, such as the Department of Child and Family Services (DCFS), Probation, Law Enforcement, Health Services, and Public Health, Advocacy Groups, and the Department of Public Social Services (DPSS), the team has been directly involved in the development of the Los Angeles CSEC First Responder

Protocol (2014), and has regularly participated in Multidisciplinary Team (MDT) meetings that are hosted by Succeeding Through Achievement and Resilience (STAR) and Dedication to Restoration through Empowerment, Advocacy and Mentoring (DREAM) which are CSEC Specialty Courts that serve Los Angeles County. The CSECY team has joined forces with the Legislative Group (SB 855, WIC 165424.8) to provide ongoing oversight and support. Their aim is to ensure effective collaboration in the identification and provision of services within Los Angeles County. Collaboration with the Interagency Council on Child Abuse and Neglect (ICAN) led to the ICAN CSEC Taskforce, whose goal is to improve the effectiveness of the prevention, identification, investigation, prosecution and provision of services for CSECY. A partnership with LA Regional Human Trafficking Task Force was developed to investigate high-priority trafficking crimes – particularly the sex trafficking of minors – while also bringing together federal, state and local leaders to address the needs of trafficking victims. In support of developing and implementing a Countywide protocol for minors, who testify as witnesses in adult criminal human trafficking cases, the Victim Witness Testimony (VWT) Workgroup partnership was initiated. Additionally, the Mental Health Provider Roundtable was developed to provide support and resources to mental health providers serving victims of CSECY. The roundtable allows for networking, resource-sharing, and discussion of clinical topics that are applicable to the treatment needs of CSECY-identified clients and complex trauma. The CSECY team has facilitated continual efforts to identify and gather data on CSECY victims that may benefit from these community outreach activities and partnerships.

CSECY Identified Client Data and Related Outcomes: Over 500 clinical and non-clinical staff from DO and LE Contracted outpatient programs, juvenile justice camps, and specialized foster care programs participated in the sixteen (16) CSEC 101 or specialty CSECY trainings that were offered between April 2016 and February 2017. Over 400 LACDMH CSECY trained clinicians were granted access to the CSEC SharePoint site. The Quality Improvement Division (QID) has continued to facilitate data collection, technical assistance, and SharePoint site demonstrations. The CSECY team has continued to discuss the purpose and process of gathering client data via the SharePoint site and/or secure client data sharing between QID and clinicians during all CSECY trainings, via email outreach to CSECY-trained clinicians and supervisors, and as announcements during LACDMH Executive Providers' and Quality Improvement Committee (QIC) meetings. To date, 604 CSECY clients have been identified in different settings – Juvenile Halls, Court Linkage Programs, and outpatient programs. Of the CSECY clients identified, 255 clients were from juvenile halls, 77 clients from outpatient programs and 272 individuals from Juvenile Court Mental Health Services and MDT meetings. A total of 286 CSECY clients were identified between April 2016 and February 2017. During FY 15-16, LACDMH participated in the validation of a screening tool developed by West Coast Children's Clinic to further identify CSEC Youth. The screening tool was piloted and normed at Central Juvenile Hall and will be rolled out and used at the remaining juvenile halls.

The CSECY post-training experience survey was developed by the CSECY team in further support of quality improvement and program development. The survey was designed to explore each trainee's experiences with CSECY since participating in CSECY training. The survey will gather information on the clinician's program (location,

setting, and professional role), number of years of direct service experience, the clinician's self-reported awareness and confidence levels, number of potential CSECY-victims that the trainee has identified following training, the types of services that were provided (i.e., assessment, case management, therapy, etc.), and the number of CSECY trainings the clinician received. In CY 2017, the CSECY Post-Training Experience survey will be administered to all CSEC 101 training participants.

Non-Clinical Performance Improvement Projects (PIPs)

ACCESS Center Quality Assurance (QA) Protocol: For FY 16-17, this Non-Clinical PIP was approved by the EQRO review team in July 2016 and involves the Implementation of a Quality Assurance (QA) Protocol within the ACCESS Center.

The ACCESS Center serves as the entry point for mental health services in Los Angeles County by providing referrals and linkages, resources, and crisis intervention to callers seeking these services from the Los Angeles County Local Mental Health Plan (LMHP). A team of multidisciplinary staff members provide referral/crisis services 24-hours, seven days a week, including all holidays. For CY 2016, the ACCESS Center received 147,565 calls. The implementation of the QA Protocol process is non-punitive and designed to improve service delivery, customer service, and training.

The focus of this PIP is: 1) evaluating monthly between 24-32 random calls from the entire consumer population that call the ACCESS Center during the study period; 2) reviewing calls received on the 1 (800) line only; 3) training all agents on the QA Protocol; 4) training all ACCESS Center supervisors on the QA Protocol and validation of the calibration process; and 5) reviewing outcomes on a quarterly basis and through continuous quality improvement, addressing areas identified for improvement during the implementation of this PIP.

PIP team members meet monthly and review/discuss results for the following five (5) outcome indicators: 1) Requesting Caller's Name; 2) Providing Specialty Mental Health Service (SMHS) Referrals; 3) Demonstrating respect/customer service; 4) Documenting the call; and 5) Offering Language Interpreter Services.

Per the outcomes data collected from baseline - Q1 (FY 16-17, July-Sept 2016) through Q2 (FY 16-17, Oct-Dec 2016), there has been improvement in the following areas: 1) Offering language interpreter services (84% to 89%) representing a 5 Percentage Points (PP) increase from baseline; 2) Requesting Caller's Name (88% to 93%) representing a 5 PP increase from baseline; 3) Demonstrating respect to caller (95% to 99%) representing a 4 PP increase from baseline; and 4) Client information was documented (60% to 77%) representing a 17 PP increase from baseline.

Vacancy Adjustment and Notification System (VANS): The Vacancy Adjustment Notification System (VANS) was the Non-Clinical PIP successfully completed in April 2016. The LACDMH VANS PIP team members have continued their efforts to increase the use of the application in additional SAs as well as improve the ability to search for available slots. During CY 2016, the VANS team has made notable efforts towards enhancing the application such as linking it to the Service Request Tracking System (SRTS) for making timely and appropriate appointments.

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

In CY 2016 additional SAs, namely SA 2, SA 3, SA 6 and SA 8 were added to the application. User IDs were created for providers in these SAs and technical webinars were conducted for users as part of training for VANS users. Monthly SA reports, that show utilization patterns of the VANS application by providers, were generated by QID staff and made available to the SA District Chiefs. The outcome variable measuring the number of clients referred for services using the VANS application was replaced with number of Look-Ups of available slots in the VANS application through the SRTS application and number of these Look Ups that led to an actual referral for an appointment. Outcomes data for this new variable is currently in progress in collaboration with the Chief Information Office Bureau (CIOB). In addition, a technical webinar by QID for SRTS users on how to view available program slots in VANS inside the SRTS application was conducted on June 15, 2017.

The VANS team continues to meet every other month to discuss the use of the application and any technical or programmatic issues associated with the use of the application. The remaining two SAs, SA 1 and SA 7 have implemented the VANS application.

Cultural Competency Committee (CCC)
The Cultural Competency Committee serves as an advisory group for the infusion of cultural competency in all LACDMH operations, service planning, delivery and evaluation to improve the quality of services to the consumers we serve. Administratively, the CCC is housed within the PSB-QID - Cultural Competency Unit (CCU). 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 Quality Improvement Council (QIC). This structure facilitates communication and collaboration for attaining the goals as set forth in the Departmental QI Work Plan and the Cultural Competency 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.

Comprised of 101 members, the CCC membership includes the cultural perspectives of consumers, family members, advocates, DO providers, LE Contracted providers, and community-based organizations. In addition to promoting participation of consumers, family members and community members, the CCC considers the expertise from the Service Areas' clinical and administrative programs, front line staff, and management to be essential for the mission of the Committee as well as the impact that it hopes to have in our current system of care.

CCC Mission Statement
"Increase cultural awareness, sensitivity, and responsiveness in the Los Angeles County 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 (2) Co-Chairs elected annually by members of the Committee. The roles and responsibilities of the Co-Chairs include:

- Facilitate all meetings;
- Engagement of 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 to diverse LACDMH entities; and
- Participate as a member of LACDMH System Leadership Team (SLT) meetings and holds an appointed seat for the CCC.

For Calendar Year (CY) 2016, the CCC leadership was composed of:

- CCC Co-Chairs (LACDMH and Community representatives),
- LACDMH PSB Deputy Director, and
- LACDMH Ethnic Services Manager.

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

Membership

The membership of the CCC is culturally and linguistically diverse. Every year, the ESM gathers demographical information on the CCC membership. For CY 2016, the CCC membership reached 101 members, of which 35 were males and 66 were females. The CCC members described their racial/ethnic identity as follows: "African American, American Indian, Armenian, Asian Pacific Islanders (API), Chinese, Eastern European, German, Korean, White, Mexican American, Chinese Latino, Spaniard/Latino/American Indian, and American Indian/Chicano." These descriptors translate into eleven ethnic/racial/biracial/multiracial groups represented within the CCC. Additionally, the following six languages are represented in the CCC membership: English, Cantonese, German, Korean, Spanish, and Swahili.

Key words to guide the CCC in 2016

The CCC engaged in a reflective exercise on what the concept of "cultural competency" means to each member. Out of this exercise, the following four words were chosen by the CCC to frame its activities for 2016:

- Collaboration;
- Community;
- Equity; and
- Inclusion.

CCC Goals and Objectives

At the end of each CY, the CCC 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.

1) For CY 2016, the CCC had three active workgroups. These include the following:
    - Data and Forensic Diversion Workgroup: The goals of this Workgroup were to advance the work products from CY 2015 by: 1) vetting a tool for LACDMH Juvenile Hall and Camp clinicians, which aims at exploring the impact of cultural perspectives on the youth's perceptions of their mental health needs and conditions; and 2) finding a general mechanism to highlight the importance of data collection and utilization at the Service Area level.

    - Outreach and Presentations Workgroup: The goal of this workgroup is to enhance the communication and collaborations among the CCC, Service Area Advisory Committees (SAAC) and the SLT via the SAAC liaisons.

    - The Cultural Competency Research Workgroup: The goal of this workgroup is to find alternative definitions for the term "competency" and to develop a list of cultural tips that the LACDMH workforce can utilize when serving the ethnically diverse populations in Los Angeles County.

Annual Report of CCC

Evaluation of CCC goals and objectives

The CCC conducted an internal mid-year assessment of the 2016 workgroups' goals, objectives and activities. Each workgroup made presentations to the CCC at large. Additionally, each workgroup discussed and made recommendations as to how the CCC will implement the workgroup's products.

1) Data and Forensic Diversion Workgroup

   Accomplishments included:

   - A PowerPoint presentation, "Using Data to Identify Community Cultural Needs" to the CCC, and collection of completed pretests and posttests from the CCC membership to determine acquisition of knowledge.
   - The "Cultural Formulation Index (CFI) Adaptation for Juvenile Justice Mental Health Pilot Project" questionnaire. This questionnaire is being utilized for staff training by the Juvenile Justice Mental Health Program-Camp Assessment Unit.

     Sample questionnaire items included:

     - What are the most important aspects about your self-identity and cultural background?
     - Is there anything about your background or self-identity that can make your situation better or worse?
     - Sometimes people have various ways of coping with personal issues, situations and hardships like yours. What have you done to cope?
     - Often, people look to help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of support, help, advice and/or treatment have you sought to help you cope with personal issues and hardships?

2) The Outreach and Presentations Workgroup

   Accomplishments included:

   - Updated packets containing basic information pertinent to cultural competency for the SAACs to incorporate the Culturally and Linguistically Appropriate Services (CLAS) standards, 2016 SAAC Liaison roster, and LGBTQI2-S glossary.
   - Initiated collaborations with the SAACs to introduce the CCC PowerPoint presentation.
   - Developed a handout containing the CCC membership responses to the following question: What is the benefit of being part of the CCC?
     - Sample CCC responses:
       - Have a voice, share life experience, and represent other Native Americans;
       - Learning to understand the different cultures, not only people's backgrounds;
       - Working on specific workgroup projects that highlight the importance of cultural competency;

- Learn from the CCC and take this learning back to the community; and
- Utilize the guidance from the CCC presenters on the various topics discussed during meetings.

3) Cultural Competency Research Workgroup
   Accomplishments included:
   - Selection of 200 articles and recent publications related to cultural competency;
   - Identification of strengths and weaknesses found in various definitions of cultural competency; and
   - Development of a handout which organizes research findings under the following themes:
     - Cultural competency related terms and definitions;
     - Recent publications relevant to cultural competency; or
     - References and tips for effective cross-cultural engagement.

   This handout will be distributed at various LACDMH venues where CCC presentations are conducted.

Recommendations to County Programs and Services

As an advisory group to LACDMH, 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 CCC 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 diverse 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 CCC meetings. Feedback is either provided by the Committee at large or an ad-hoc workgroup, when the Committee deems that an in-depth project review is necessary. In CY 2016, the CCC reviewed and provided feedback for the following Departmental, county and state level projects:

1) LACDMH Parameter for Assessment and Treatment of Individuals with Co-Occurring Intellectual Disabilities (CID)
   In January 2016, the CCC heard a presentation on Parameter 4.18, which was created to address the challenges of providing culturally competent clinical assessment, treatment, linkage and care to individuals with CID across the lifespan. The Committee's recommendations and feedback about the Parameter include:
   - Intellectual and physical disabilities and abilities are elements of culture;
   - Persons with CID need to be given the opportunity to reach their fullest physical, emotional, psychological, and spiritual potential;
   - Intellectual disabilities and capabilities vary in degree and persons with CID have the same rights as everyone else;
   - The lack of available services and trained staff is still a challenge;

- There is much need for CID training Countywide to increase sensitivity to persons with intellectual and physical disabilities; and
- The CCC also praised the development of parameters for the assessment and treatment of persons with intellectual disabilities.

2) Countywide Community Mental Health Promoters Program

In March 2016, the CCC welcomed the SA 7 District Chief for a presentation on the Countywide Expansion of the Countywide Community Mental Health Promoters Program. This presentation informed the Committee that the expansion will target four additional UsCCs in specific languages selected by the UsCC subcommittees as follows: American Indian/Alaska Native - English; African/African American - Somali; Asian Pacific Islanders - Tagalog; and Eastern European/Middle Easterner - Armenian. The recommendation was made for CCC members to participate in focus groups to provide input on the training curriculum of the Countywide Community Mental Health Promoters.

3) Integrating a Cultural Competency Framework for a Screening, Brief Intervention & Referral to Treatment (SBIRT) Training

In April 2016, The SBIRT project was presented to the CCC as an evidence-based practice for the identification, prevention and reduction of substance use disorders in allied health care settings. The CCC provided the following specific feedback and recommendations:

- Incorporate spirituality and faith into the SBIRT practice;
- Develop a cultural competency framework for the SBIRT training;
- Add definitions for technical terminology; and
- Keep in mind the beliefs and practices regarding substance use in various cultural communities.

4) California Reducing Disparities Report (CRDP) Strategic Plan

In July 2016, the California Reducing Disparities Report (CRDP) Strategic Plan was released a second time by the California Department of Public Health Office of Health Equity (OHE). The CCC agreed to resubmit the detailed feedback and recommendations developed in response to the first release of the CRDP Strategic Plan in 2015.The CCC recommendations covered the following areas:

- CRDP Strategic Plan language revisions;
- Strategic plan rollout and distribution to the community;
- Increasing service accessibility;
- Inclusion of traditional and nontraditional service providers;
- Inclusion of faith-based providers;
- Workforce development; and
- CRDP Proposal evaluation.

5) Cultural Competency in Chaplaincy Programs

In September 2016, the CCC had the opportunity to listen to a presentation from a Chaplain regarding the inclusion of cultural competency in chaplaincy services and training. The guest speaker shared with the Committee the many instances in which cultural diversity comes into play when families are experiencing serious illnesses and deaths within their family circles. The CCC received this presentation with interest and provided the following recommendations:

- Chaplaincy programs should recognize that mental health is deeply connected to spirituality;
- The Chaplaincy curriculum needs to include information on mental health conditions and the history of psychology;
- Chaplains should be mindful of the body, mind and spirit connection, and that culturally competent approaches are needed in working with hospitalized persons and their families; and
- Chaplains should be mindful of terms that may be perceived as stigmatizing, such as "the dominant culture."

6) Three-Year MHSA Program and Expenditure Plan Update

In October 2016, the District Chief from the MHSA Outcomes and Implementation Division provided a presentation on the MHSA Three-Year Program and Expenditure Plan, FYs 2017-2020. The feedback from the CCC included:

- The Community Services and Supports (CSS) Work Plan Consolidation needs to specify the different types of housing covered;
- Employment support services should have their own category with clear strategies and be not be listed as a subcomponent of non-FSP services;
- The CCC's need for information on the various workgroups currently working on the MHSA Three-Year Program and Expenditure Plan in order to further participation and feedback; and
- The need for client informing materials to be generated in order to assist consumers' understanding of the new service classifications.

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, including the status of the CCPR release. During CY 2016, the Committee engaged in discussions regarding updates to the Criterion 4 of the CCPR, "Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System".

In particular, Criterion 4 of the CC Plan will include information on the group affiliations of the CCC membership. A template table was circulated for members to report group affiliations in which they act as cultural competency representatives.

2) The National Standards for Culturally and Linguistically Appropriate Services (CLAS)

In August 2016, the ESM reviewed the 15 CLAS Standards with the CCC and provided several examples on how LACDMH has already implemented the CLAS. Examples of how CLAS standards have been implemented at LACDMH are: Service

Area-based Outreach and Engagement Teams; having a culturally and linguistically diverse stakeholder process; and offering an extensive list of trainings related to cultural competency. The CCC membership was encouraged to assess and evaluate how their programs and agencies are implementing the CLAS Standards.

3) External Quality Review Organization (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 Cultural Competence Plan and mental health disparities. A detailed presentation regarding the CCU's projects and activities was delivered by the ESM during the 2016 EQRO Review. The CCC and UsCC subcommittee Co-Chairs were also present the EQRO session on disparities and answered follow-up questions from the reviewers.

Additionally, in July 2016, the ESM informed the CCC about the EQRO Review results specifying areas of strengths and areas for improvement related to cultural competency. The CCC expressed satisfaction in hearing that the following were areas of strength noted by the reviewers: The inclusion of spirituality in mental health services and trainings; TAY supported employment and support services; expansion of Mobile Outreach Teams for homeless persons; service expansion for Veterans and Older Adults; and the UsCC capacity-building projects.

4) Medi-Cal Systems Review Protocol Training
The QID managers attended a training regarding the 2016 Annual Review Protocol for "Consolidated Specialty Mental Health Services and Other Funded Services." The ESM brought information back to the CCC regarding protocol items pertinent to the Cultural Competence Plan and the Committee's goals and activities.

5) Cultural Competence (CC) Organizational Assessment
The ESM informed the CCC that a revision to the Organizational Assessment Statement of Work (SOW) had been made in order to include the feedback from various stakeholder and focus groups. The CCC will be asked to provide recommendations towards the content of the CC Organizational Assessment once the consultant for this project is hired.

Human Resources Report
In February 2016, the ESM provided an update to the Human Resources Bureau report on the LACDMH bilingual certified employees by threshold language. This information is valuable to the CCC and CCU as inquiries are often received from Programs seeking assistance with language translation and interpretation services. The CCC was impressed to hear that LACDMH's workforce has 562 bilingual certified employees with capability for 22 different languages. The languages most represented in the workforce included: Spanish, Russian, Tagalog, Korean, Farsi and Mandarin.

Additionally, in October 2016, a representative from the Human Resources Bureau made a presentation to the CCC regarding bilingual compensation and current workforce linguistic capacity. The CCC was pleased to hear that in addition to covering the 13 threshold languages of Los Angeles County, 24 additional non-threshold

languages are represented in the LACDMH workforce, inclusive of: Bulgarian, Catalan, Flemish, French, German, Greek, Hakka, Hebrew, Hindi, Italian, Japanese, Korean, Laotian, Nahuatl, Pangasinan, Portuguese, Samoan, Swedish, Taiwanese, Toi Shan, Turkish, Urdu, Visuyan and Yiddish. Suggestions and feedback from the CCC can be summarized in the following:

- Presentation to include the percentages of LACDMH staff who speak the various languages listed in the PowerPoint;
- For LACDMH to consider bilingual bonus differentials for bilingual employees who meet the certification standards on all three aspects of the examination, namely speaking, reading and writing;
- Language representation needs to be expanded to reflect the communities served by LACDMH;
- The list of LACDMH workforce languages lacks representation of prominent communities in Los Angeles County, such as Eastern Africans; and
- Invest in the bilingual certification of employees who are proficient in the languages associated with the UsCC subcommittees.

LACDMH Organizational Assessment

The CCC utilizes the strategic areas identified in the LACDMH Cultural Competence Organizational Assessment in planning its activities. The strategic areas include:

- Cultural Competent System of Care;
- Funding;
- Human Resources;
- Policy;
- Structure;
- Training;
- Treatment Outcome Measurement; and
- MHSA.

Different presentations are scheduled throughout each CY to provide information and updates on various initiatives that fall under the cultural competence organizational assessment strategic areas.

1) To address the strategic areas of *Culturally Competent System of Care, MHSA and Funding*, the CCC has delegate representation at the LACDMH SLT meetings. This allows the CCC to vote on Departmental initiatives that are related to cultural competency. Some examples include: Expansion in services for the homeless and wellness centers; MHSA 3 Year Program and Expenditure Plan; MHSA CSS Plan consolidation; and housing support services and jail diversion services.

2) To address the strategic areas of *Human Resources and Training*, the ESM briefed the CCC on the number and languages of bilingual certified staff as well as the LACDMH Cultural Competence Training Plan, which was disseminated to all the SA QIC's.

3) To address the strategic area of *Structure*, cultural competency updates continue to be provided in all the monthly Service Area QIC meetings. Examples of updates done by ESM and CCC co-chair include 2016 CCC workgroup activities, CCU projects, and statewide initiatives regarding cultural competence.

Training Plans

1) Mental Health and Spirituality Conference

During April and May 2016, the CCC developed a workshop for the Mental Health and Spirituality Conference via an ad-hoc workgroup. The workshop curriculum, presentation materials, and the role of the panel presenters were vetted by the Committee at large. The workshop was titled: "Beyond the Horizon: Shifting Cultural Perspectives" and it covered the following topics:

- Definitions of culture, cultural competency, and shifting cultural perspective;
- The Cultural Competency Committee;
- Research findings on the inclusion of spirituality in healthcare; and
- A Panel presentation based on the following four questions:
  - What does spirituality mean to you and to your culture?
  - In your culture, how is mental health perceived and addressed?
  - How does your spirituality help you cope with the traumatic experiences in your life and support your recovery/healing?
  - How can mental health professionals and clergy be culturally sensitive and support your spirituality in providing services?

Overall, the CCC workshop was very well received. It was attended by consumers, family members, LACDMH staff, and faith-based leaders. The evaluations were positive and supportive of future conference presentations.

2) CCC presentation at the Mental Health Commission and SAAC Committee

In March 2016, the CCC was invited to present before the Mental Health Commission and the SAAC Committee. The presentation was delivered by the CCC Co-Chairs and ESM. The presentation included the CLAS definition of culture, definition of cultural competency, historical background on the CCC, demographical information, 2016 workgroups, and current activities. The presentation was well-received. Among the questions that rose was: "How is the work of the CCC reaching consumers?" The ESM made the recommendation that the Workgroups keep this question in mind when setting and documenting their goals, objectives and activities.

3) 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.

4) Cultural Competence 101 training

The CCC was informed about the Cultural Competency 101 training purpose, content, number of LACDMH staff trained, and recommendations on how to enhance the cultural competency of existing Programs to improve the quality of services, and video links as follows:

- Part 1: Basic definitions, regulations related to cultural competency, LACDMH strategies to reduce mental health disparities, and LACDMH demographical and client utilization data
  [Duration: 37 minutes]
  http://file.lacounty.gov/SDSInter/dmh/1010011_CulturalCompetenceVideov4part1.wmv.wmv

- Part 2: Cultural humility, client culture, stigma, elements of cultural competency in service delivery, and resources
  [Duration: 31 minutes]
  http://file.lacounty.gov/SDSInter/dmh/1009914_CulturalCompetenceVideov3part2.wmv

- Part 3: Cultural competency scenarios and group discussion
  [Duration: 18.5 minutes]
  http://file.lacounty.gov/SDSInter/dmh/1009805_CulturalCompetenceVideov3part3.wmv

PSB-QID UNIT PROGRAM DESCRIPTIONS

The PSB-QID Cultural Competency Unit (CCU)

The Cultural Competency Unit (CCU) is one of three Units of the PSB-QID. This organizational structure allows for cultural competency to be integrated into PSB-QID roles and responsibilities to systematically improve services and accountability to our consumers, their family members, and the communities we serve. This structure also places the CCU in a position to collaborate with several LACDMH Programs such as the Underserved Cultural Communities (UsCC) Unit, the Patients' Rights Office (PRO), the Workforce, Education and Training (WET) Division, Mental Health Services Act (MHSA) Implementation and Outcomes Division and the Service Area Quality Improvement Committees (SA QICs). The supervisor for the CCU is also the LACDMH ESM. This strategy facilitates the administrative oversight of the Cultural Competency Committee (CCC) activities and for the Unit to anchor the Cultural Competence Plan Requirements (CCPR) and the California Reducing Disparities Project (CRDP) reports as our Departmental framework to integrate cultural competency in service planning and delivery. The CCU promotes awareness and utilization of this framework to reduce disparities; combat stigma; promote hope, wellness, recovery and resiliency; and serve our communities with quality care.

Most salient activities of the CCU in CY 2016:

1) <u>Cultural Competency Trainings and Presentations</u>

   A. New Employee Orientation (NEO)

   The CCU participates in the NEO and provides cultural competency presentations to introduce new employees to the functions of the CCU, Los Angeles County Demographics and threshold languages, the National Standards for Culturally and Linguistically Appropriate Services (CLAS), the CCPR, and LACDMH strategies to reduce mental health disparities.

   B. "Cultural Competency 101" Training

   In response to the 2016 EQRO Review recommendation for system-wide training in cultural humility, the ESM developed a two (2)-hour foundational training titled "Cultural Competency 101." Designed as a train-the-trainer tool for the SA QIC members, the content of this training included:

   - 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; and
   - Resources.

The training was made available to the membership of the eight SA QICs and five training sessions were conducted by the ESM in September 2016. Approximately 230 DO and LE Contracted providers were trained, inclusive of Management/Administration, direct service providers, and clerical/support staff. The Cultural Competency 101 training was very well-received. Additionally, training evaluation feedback included requests for "Cultural Competency 101" to become available to all providers.

Furthermore, the pretests and posttests utilized for the "Cultural Competency 101" training allowed the CCU to gather feedback from the participants on how to advance cultural competency in our system of care. There were recurrent themes in the feedback that was collected.

- Continue providing on-going cultural competence training.
- Promote opportunities for staff to engage in cross-cultural dialogue and self-reflection/experiential exercises.
- Partner with consumers and obtain their input on the effectiveness of existing programs.
- Translate all LACDMH forms into the threshold languages.
- Assess and evaluate the effectiveness of programs, interventions, and whether client needs are being properly met.
- Assess and evaluate changes in cultural groups and barriers to service accessibility.
- Gather feedback from staff.
- Provide a safe workplace environment conducive to the exploration of cultural issues.
- Secure professional American Sign Language (ASL) interpreters.
- Continue providing language translation and interpretation services.
- Follow a strength-based model.
- Promote kindness.
- Remove waterproof glass and security guards from lobbies.

The Cultural Competency 101 training was recorded and the hyperlinks were made available to the SA QICs for dissemination to all DO and LE Contracted providers. The total time duration of the online version of the training is approximately 1.5 hours. It was strategically divided into the following three parts, in the event that Providers preferred to show the training video in shorter segments:

Part 1: Basic definitions, regulations related to cultural competency, LACDMH strategies to reduce mental health disparities, and LACDMH demographical and client utilization data [Duration: 37 minutes]
http://file.lacounty.gov/SDSInter/dmh/1010011_CulturalCompetenceVideov4part1.wmv.wmv

Part 2: Cultural humility, client culture, stigma, elements of cultural competency in service delivery, and resources [Duration: 31 minutes]
http://file.lacounty.gov/SDSInter/dmh/1009914_CulturalCompetenceVideov3part2.wmv

Part 3: Cultural competency scenarios and group discussion [Duration: 18.5 minutes] http://file.lacounty.gov/SDSInter/dmh/1009805_CulturalCompetenceVideov3part3.wmv

The SA QICs were informed that this training meets the CCPR for 100% of staff to receive annual cultural competence training, inclusive of clerical/support, direct service providers, and management/administration. Additionally, it was brought to their attention that all Program Directors/Program Managers will be required to attest that 100% of their staff completed an annual cultural competence training in CY 2017. Directly Operated Program Managers will attest in the fourth Quality Assurance Quarterly Monitoring Report and Legal Entities/Contracted Providers will attest in the Annual Quality Assurance Monitoring Report.

2) Health Agency Workgroup: Access to Culturally Competent and Linguistically Appropriate Programs and Services

Cultural competency is one of the Board of Supervisor's Health Agency strategic priorities. From its inception, the ESM was invited to participate in this Workgroup for the implementation of cultural competency across the Departments of Health Services, Mental Health and Public Health. The overarching priority of the Workgroup is to "Ensure access to culturally competent and linguistically appropriate programs and services as a means of improving service quality, enhancing customer experience, and helping to reduce health disparities." Examples of the Health Agency Workgroup's accomplishments for CY 2016 include:

- The standardization of three (3) survey questions that assess the consumers' experience with cultural and linguistic services received in outpatient programs;
- Review of demographic information pertinent to race, ethnicity, language, sexual orientation, and homeless status for standardization in the Health Agency; and
- Identification of community-based programs to be implemented and strategies to cross train existing staff.

3) Cultural Competence Plan Requirements (CCPR)

The ESM developed the LACDMH 2016 Cultural Competence Plan Update. Information was gathered from various LACDMH Programs/Units and organized as evidence that LACDMH met the CCPR in the following areas:

- A 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 LACDMH mental health system;
- Culturally competent training activities;
- Los Angeles County's commitment to growing a multicultural workforce: hiring and retaining culturally and linguistically competent staff;
- Language capacity; and
- Adaptation of services.

4) LACDMH Cultural Competence Training Plan

The ESM, in collaboration with the PSB-QID and PSB-WET Division managers, developed the LACDMH Cultural Competence Training Plan in accordance with the CCPR. The Plan highlights the following information:

- The commitment of LACDMH to provide quality cultural competence trainings to build a multicultural awareness, knowledge, sensitivity, skills and values of its workforce;
- Specialized trainings provided by the PSB-WET Division which address a multiplicity of cultural competency elements such as ethnicity, age, gender, sexual orientation, forensic population, homeless population, hearing-impaired population, spirituality, and client care;
- Guidelines for inclusion of cultural responsiveness in all trainings;
- LACDMH foundational cultural competence trainings;
- Sample cultural competence related specialty mental health trainings;
- Language interpreters training and monitoring; and
- Monitoring of staff skills and skills learned in trainings.

Over 300 trainings are offered during each FY, covering a wide spectrum of culturally relevant issues including lived experience concerns, language interpreter trainings and culture-specific conferences. The majority of these training opportunities are equally available to DO and LE Contracted Providers.

5) Participation in the 2016 Medi-Cal Systems Review

The CCU played an active role in the preparation and presentation of evidentiary documentation for the Access Section of the 2016 Medi-Cal Systems Review, which involved demonstrating that LACDMH has:

- A mechanism to ensure that interpreter services are offered to limited English proficiency individuals;
- Policies and procedures that comply with the prohibition of utilizing family members and minor children as language interpreters;
- Community information and education plans for specialty mental health services;
- Cultural Competence Plan annual updates; and
- A LACDMH Cultural Competence Committee that participates in the planning provides reports to quality assurance/quality improvement programs, and documents its activities in an annual report as required by the CCPR.

6) External Quality Review Organization (EQRO) Review

The CCU actively participated in the annual EQRO Review. The Unit coordinated the collection of reports from fourteen (14) programs regarding their current strategies to reduce mental health disparities, consumer utilization data, staff trainings and workforce development. The CCU also provided technical assistance to the programs for the completion of these reports. The collective information gathered was utilized for the 2016 LACDMH CC Plan Update and EQRO evidentiary documentation. Additionally, the ESM provided an in depth presentation on the CCU's activities in the disparities session of the EQRO Review.

7) Countywide Community Mental Health Promoters Program

The CCU continues to be involved in the implementation of the Countywide Mental Health Promoters program. Cultural and linguistic adaptations will increase mental health accessibility, mental health education, and knowledge of mental health resources to four additional ethnic groups in the specific languages selected by the UsCC subcommittees: For American Indian/Alaska Native - English, African/African American - Somali, Asian Pacific Islanders - Tagalog, and Eastern European/Middle Easterner - Armenian.

In September 2016, the CCU completed a careful review of the 73-page long Request for Services (RFS), "Training for and Services Provided by Community Mental Health Promoters". Detailed recommendations were provided to SA 7 Administration.

- Train Mental Health Promoters to address the LACDMH mental health disparities by SA in terms of ethnicity, age group and gender.
- Develop a backup plan for attrition within the original group of 12 mental health promoters.
- Ensure that the project coordinator/supervisor is clinically trained to assist the Mental Health Promoters with crisis intervention (e.g. community members who are suicidal).

8) CCC Administrative Oversight

The CCU continues to provide on-going technical assistance and administrative oversight conducive to the attainment of the CCC's goals and objectives. The ESM monitors all activities pertaining to the CCC and provides 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 CCC Co-Chairs and the PSB Deputy Director to plan meeting agendas, objectives and activities. The ESM developed the CCC annual report including tracking of committee demographics such as ethnic, gender, cultural expertise, and language expertise of the membership. The report also provides and in-depth summary of the goals and objectives of the committee as well as activities of the committee according to the Cultural Competence Plan Requirements: reviews and recommendations to County programs and services, goals of cultural competence plans, human resources report, County organizational assessment, and training plans.

9) Provision of Technical Assistance for Various LACDMH Programs

- *PSB-WET Division*

  The ESM participated in meetings regarding the implementation of a mechanism to track staff participation in cultural competence trainings offered by the PSB-WET Division. The tracking by staff function (administration/management, direct service, and clerical/support) will satisfy the CCPR related to the provision of cultural competence training to 100% of the workforce.

- *Underserved Cultural Communities (UsCC) subcommittee involvement*
  The ESM continues to participate and collaborate with the UsCC Latino and LGBTQ subcommittees, and other subcommittees upon request.
- *MHSA Implementation and Outcomes Division*
  The ESM participated in the Prevention and Early Intervention (PEI) Regulations Stakeholder Workgroup with representatives from the State. One of the main areas of focus was the culturally appropriate collection of sexual orientation and gender identity data.
- *Three-Year MHSA Program and Expenditure Plan*
  The ESM participated in the Countywide PEI Workgroup for the Three-Year MHSA Program and Expenditure Plan to ensure inclusion of cultural competency in PEI program planning and development. A series of six weekly meetings were attended during which, the ESM advocated for emerging ethnic populations to be included in the PEI Plan. The Workgroup responded positively to the ESM's recommendations and is currently gathering information on Los Angeles County's demographics, risk factors, and protective factors pertinent to the growing refugee population.

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

The CCU continues 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 produces monthly and annual summaries of the total requests for preferred threshold and non-threshold languages by Service Area. These reports are utilized to track the language requests from LEP consumers at the time they access mental health services.

11) Implementation of the PSB-CCU Mailbox for Technical Assistance

In December 2016, the CCU implemented a mailbox to address questions regarding the annual cultural competence training requirements, other Cultural Competence Plan Requirements, and questions related to cultural competence in general. The mailbox address is PSBCC@dmh.lacounty.gov and became operational in February 2017.

The PSB-QID Underserved Cultural Communities (UsCC) / Innovations (INN) Unit
(Formerly known as the Under Represented Ethnic Populations – (UREP)/INN Unit)

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. The UREP Unit has established subcommittees dedicated to working with the various under represented ethnic and cultural populations in order to address their individual needs. These subcommittees are: African/African American; American Indian/Alaska Native; Asian Pacific Islander; Eastern European/Middle Eastern; Latino; and Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two Spirit (LGBTQI2-S).

As of January 2016, UREP was renamed as Underserved Cultural Communities (UsCC) to be inclusive of all cultural communities. Each UsCC subcommittee is allotted one-time funding totaling $100,000 per fiscal year 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

Resource Mapping Project: Funds were allocated to develop a community resource directory titled "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 three times and the fourth reprint was completed on **January 19, 2017**.

Sierra Leone Community Mental Health Training and Education Project:
Community members of Sierra Leonean descent were trained as advocates and facilitated community mental health awareness presentations to the larger community. Additionally, they provided assistance to community members and helped them cope with their losses and concerns related to the Ebola outbreak. This project was implemented on October 1, 2015 and it was completed **on April 30, 2016.**

Outcomes:

- Fifteen (15) community members were trained to become Sierra Leone Community Advocates;
- Forty-eight different community presentations were completed by these Advocates; and
- A total of 480 community members were outreached.

AAA Mental Health Informational Brochures: Brochures will be 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 will be used to educate and inform these

ethnically diverse communities on the benefits of utilizing mental health services and provide referrals and contact information. The informational brochure will be translated into two (2) different African languages: Amharic and Somali. The content, translations, and graphic of the brochures have been completed. The printing of these brochures was completed on **January 19, 2017**.

For FY 16-17 the following projects have been approved and implementation is underway as of 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.

- **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.

- **African Immigrants and Refugees Mental Health Outreach Projects -** This is a mental health outreach project for African immigrants and refugees from Nigeria, Somalia, Ethiopia, Liberia, and Ghana. The purpose of this project is 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.

II. American Indian/Alaska Native (AI/AN) UsCC Subcommittee

AI/AN 2016 National Mental Health Awareness Month Media Outreach Campaign: The media outreach campaign consisted of advertisements that aired on two local television channels (CBC and KCAL) and one radio station (KNX1070) in order to increase awareness of mental health issues faced by the Native American community and to provide community resources. The advertisements aired throughout the month of May 2016, which was National Mental Health Awareness Month. The media campaign also included a digital media campaign on the CBSLA.com website. Additionally, an interview of Mirtala Parada Ward, LCSW, Mental Health Clinical Program Head, was conducted by Tami Heidi of the CBS Radio public service broadcast show, Open line. The interview was approximately 8 minutes long and was broadcast 5 times (one time each on 94.7FM KTWV, 101FM KRTH, 106.7FM KROQ, 97.1FM KAMP, and 93.1FM JACKFM).

Outcomes:

- The television advertisements on CBS and KCAL aired a total of 196 times.

- The radio advertisements on KNX1070 aired a total of 170 times.
- The CBS report shows that 89.3% of the Los Angeles households were reached, with a total of 12,202,000 Impressions (the total number of times households exposed to the commercials). These households saw the TV exposure with a frequency of 2.5 times.
- The advertisements that ran on KNX1070 delivered 4,649,600 impressions and reached 1,539,900 unduplicated adults (age 18+) an average of 3 times during the campaign period.
- The digital media campaign on CBSLA.com provided a total of 153,641 Impressions.
- The Open Line program delivered an estimated 61,000 additional listeners.

For FY 16-17 the following projects have been approved and implementation is underway as of September 1, 2016:

- **Mental Health Clinical Training Project -** Research indicates there is a lack of well-trained mental health professionals who have the skills to effectively treat the unique mental health needs of the American Indian/Alaska Native population. Therefore, the American Indian/Alaska Native Clinical Mental Health Training will 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. These trainings will be conducted once in Service Areas 2, 3, 4, 5, and 6 and twice in Service Areas 1, 7, and 8. A total of 440 mental health clinicians will be trained by the end of this project.

- **The American Indian/Alaska Native Metro Bus Advertisement Campaign –** The goal of this project is to promote mental health services, increase the capacity of the public mental health system, and reduce stigma. This campaign will last for three months and advertisements will be placed inside and outside the Metro buses throughout Los Angeles County.

III. Asian Pacific Islander (API) UsCC Subcommittee

The API Family Member Mental Health Outreach, Education and Engagement Program: This project was implemented on August 17, 2015 and was completed on **August 30, 2016.** The purpose of this project was to increase awareness of mental illness signs and symptoms for API families so that they know when and how to connect family members to mental health services. The ethnic communities being targeted include the following: Chinese community (Cantonese and Mandarin-speaking), Vietnamese community, Korean community, South Asian (Indian/Hindi-speaking) community, Cambodian community, and the Samoan community. There were 12 Outreach, Education and Engagement (OEE) events (two per target population) held; 451 API consumers, family members, and community members were reached, which consisted of the following API subgroups: 80 Chinese, 66 Vietnamese, 84 Korean, 84 South Asian, 57 Cambodian, and 80 Samoan.

The Samoan Outreach and Engagement Program: In 2016, 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 Los Angeles County. This program completed its first year of implementation on June 30, 2016 during which 542 mental health education workshops were conducted and 2,478 individuals were reached. In addition, during the **first quarter of FY 16-17** 152 mental health education activities were conducted that reached 812 individuals. 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 (58%). As of September 2016, activities were held at various community locations including churches (74% of activities), community member homes (14%), Samoan agency offices, community centers, and other community locations (parks, etc.). Attendees continue to be mostly adults (77%), females (59%) and Samoans (88%) who speak English as their primary language (61%).

Outcomes:

- **99%** strongly agree or agree that their knowledge of mental health issues in the community has increased as a result of the activity.
- **99%** strongly agree or agree that their knowledge about mental health services available for the Samoan community has increased as a result of the activity.
- **99%** 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.

For FY 16-17 the following project has been approved and implementation is underway as of August 15, 2016:

- **Multimedia Mental Health Awareness Campaign for the Cambodian and Vietnamese Communities -** The Multimedia Mental Health Awareness Campaigns will target the Cambodian and Vietnamese communities in Los Angeles County. This project will include linguistically and culturally appropriate mental health education and engagement workshops and an ethnic media

campaign, including mental health awareness Advertisements (Ads) on Television and/or Radio.

IV. Eastern European/Middle Eastern (EE/ME) UsCC Subcommittee

The Arabic-Speaking Community Mental Health Project: This project was funded to increase mental health awareness among Arabic-speaking community members in Los Angeles County. This project was implemented on December 1, 2014 and was completed on **May 13, 2016.** This project provided outreach and engagement services by partnering with faith-based and other community-based organizations to conduct mental health presentations targeting Arabic-speaking community members. This project was extremely difficult to implement due to the high level of mental health stigma in this community. As a result of this, the project was extended three times and it took 17 months to be implemented.

Outcomes:

- A total of 28 community presentations and in-home meetings were completed in a period of 17 months.
- Approximately 95% of the community presentations and in-home meetings took place after the San Bernardino shooting.
- There was a stronger than anticipated level of stigma and fear from the Arabic-speaking community and it required multiple attempts for individuals and organizations to agree to participate in the mental health presentations and in the in-home meetings.
- External events such as the San Bernardino shooting created the need for conversations related to the mental health; prior to that it took more than a year to engage this community.
- It was very difficult for the presenters to build positive rapport and engage this community and as a result, presentations were cancelled and instead private meetings took place in people's homes.
- It was recommended that LACDMH develop stronger community relations with small non-profit or for-profit organizations that provide services to the Arabic community in order to increase mental health awareness.

For FY 16-17 the following projects have been approved and implementation is underway as of September 1, 2016:

- **Farsi Peer-Run Outreach Project -** This project will train Farsi speaking volunteers to conduct mental health presentations and provide linkage and referral services. The purpose of the project will be to assist Farsi speaking community members who need mental health services, but are unable or unwilling to access these services due to stigma, lack of education or awareness, and/or language barriers.

- **Mental Health Education & Stigma Reduction for Arabic Speaking College Students -** This project will educate 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.

This project will include presentations that will be 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 the LACDMH. These presentations will be conducted by college students (using a Peer-to-Peer model), who will be trained by a mental health expert.

- **The Armenian Talk Show Project Part II -** Mental health TV talk shows will discuss new topics not covered in the previous project and increase the Armenian community's awareness of mental health issues. This television campaign will be in the Armenian language and will help increase knowledge and awareness about mental health issues by providing information and assistance to community members who may be unaware of mental health services, or avoid utilization due to the stigma.

V. Latino UsCC Subcommittee

Latino 2016 National Mental Health Awareness Month Media Outreach Campaign:
This Media Campaign was aimed at promoting mental health services and increasing the capacity of the public mental health system in Los Angeles County. Univision Communications, Inc. was contracted to launch this Media Campaign that included TV, Radio and Digital elements. In total, 99 commercials, billboards, Public Service Announcements (PSAs), News integrations, and Digital elements (Banners, Takeovers, and Social Media) were delivered. The advertisements were aired 26 times on television (KMEX – Channel 34) and 69 on radio (KLVE-FM). Further, a twenty-five (25) minute PSA pertaining to mental health was recorded and aired on four different local Spanish speaking radio stations (KSCA, KRCD, KTNQ, and KLVE). As an added value to this campaign, a three-minute mental health information segment called, "Una Mente, Una Vida" aired during the local 11 pm Nightly News Broadcast. This project was implemented on March 1, 2016 and was successfully completed by **June 3, 2016**.

Outcomes:

- The KMEX report shows that the television campaign delivered a total of 2,853,000 Impressions (the total number of times households were exposed to the commercials) from viewers ages 18 and above.
- The KLVE-FM report shows that the radio campaign delivered a total of 2,636,400 Impressions from viewers ages 18 and above.
- The online rotating media that includes Homepage Takeover and Social Media Post delivered a total of 60,809 Impressions from viewers 18 and above.
- A gross total of 5,550,209 Impressions were delivered from viewers and listeners ages 18 and above.

For FY 16-17 the following project has been approved and is underway as of March 1, 2017:

- The Latino Metro Bus Advertisement Campaign – The goal of this project is to promote mental health services, increase the capacity of the public mental health system, and reduce stigma. This campaign will last for four months and

advertisements will be placed inside and outside the Metro buses throughout Los Angeles County.

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

Clinical Mental Health Trainings for LGBTQ Youth: Four two-day clinical trainings were conducted to educate and improve the therapeutic skills of licensed mental health clinicians who provide mental health services to LGBTQ youth. This training provided a total of twelve (12) Continuing Education Units for mental health clinicians. The trainings were offered in Service Areas 2, 4, 6, and 8. This project was implemented on October 1, 2015 and was completed on **April 1, 2016**.

Outcomes: A total of 130 licensed mental health clinicians were successfully trained by the end of this project. Pre and post-test surveys were administered at each of the trainings to measure knowledge about LGBTQ concepts, terminology and unique challenges and risks for this population. The results are summarized below:

- 114 pre-test and 105 post-test surveys were collected.
- Post-test results indicated that participants had an improved understanding of what defines sexual orientation. Scores improved from 41% on the pre-test to 60% on the post-test.
- Participants showed improvement on the question related to how to create a LGBTQ-affirming environment, with an increase of 19% from pre to post-test.
- There was an 8% overall increase in knowledge across the four Service Areas (2, 4, 6, and 8) from pre-test to post-test. The highest increase was in SA 8 (17%).

For FY 16-17 the following project has been approved and implementation is underway as of August 15, 2016:

- **Youth Speak Your Mind Academy Mental Health Outreach Project –** This is a two component project, which will train 50 LGBTQI2-S Youth Advocates (ages 18-25) from all eight (8) Service Areas served by LACDMH and once trained, the Advocates will conduct two community mental health presentations each. The objective of the LGBTQI2-S Youth Speak Your Mind Academy Mental Health Outreach Project is 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.

VII. The Countywide Community Mental Health Promoters (CCMHP) Program

In 2010, to address the unmet mental health needs of the Latino community, LACDMH embarked upon a path to strategically reduce access disparities and decrease cultural stigma surrounding mental health services within the Latino UREP (Under-represented Ethnic Populations) group. This innovative and unique program created by DMH to combat disparities is identified as the Promotores Comunitarios De Salud Mental (Community Mental Health Promoters) training program. Due to the overwhelming

success of the outreach and educational services offered to Latino residents in SA 7 and SA 8, LACDMH is prepared to launch an expanded, Countywide, multi-cultural, community-based mental health education program which includes the following four chosen ethnic communities: Eastern European/Middle Eastern (EE/ME), African/African American (AAA), Asian Pacific Islander (API), and the American Indian/Alaska Native (AI/AN) ethnic groups. This program will replicate in many ways the Promotores program within these four other ethnic groups.

In the initial phase of creating the new Countywide, multi-cultural training program, LACDMH conducted a series of informational presentations at the planned UsCC monthly meetings and announced the intent to release a Countywide Community Mental Health Promoters Training Program. To obtain appropriate input regarding cultural and linguistic priorities, LACDMH offered focused discussions to four UsCC groups. Due to their low utilization of mental health services and unique linguistic needs, the following ethnic communities were selected as the target groups for the CCMHP Programs:

- AAA Ethnic Group: Somalian Community, Somali
- AI/AN Ethnic Group: AI/AN Community, English
- EE/ME Ethnic Group: Armenian Community, Armenian
- API Ethnic Group: Filipino Community, Tagalog

The QI-Data-GIS Unit

The QI-Data-GIS Unit is responsible for compiling system-wide information on consumers served and estimating populations in need of mental health services. The QI-Data GIS Unit annually calculates 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 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 for dissemination to the respective District Chiefs and Quality Improvement Liaisons for use in Quality and Performance Improvement Projects.

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. The QI-Data-GIS Unit provides mapping support to all Divisions in the Department and conducts 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, Senate and Congressional boundaries. This year the Data-GIS Unit continued to provide mapping support to the Health Neighborhood Project, EOB and the Legislative Analyst Office for maps showing providers and consumers served by various jurisdictional boundaries.

The Data GIS Unit maintains and updates 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 Service Area (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.

The QI-Data-GIS Unit is responsible for selecting a random sample for the bi-annual consumer satisfaction survey administration in Outpatient and Day Treatment Programs. The Unit is also responsible for conducting data analysis of the seven (7) domains of perception, consumer satisfaction, and preparing a final report. Additionally, the QI-Data-GIS unit provides assistance with survey design and implementation and data support to LACDMH Divisions and Bureaus. Some examples include assisting the

Office of Consumer and Family Affairs with the annual Peer Survey, the Office of Medical Director with the Seclusions and Restraints Report, and the UsCC/INN/CCU with data on disparities for UsCC groups. In CY 2016, Consumer Perception Surveys were conducted in May and November 2016. A data report for the May 2016 Consumer Perception Survey results was completed.

Summary

The QI Work Plan Evaluation report that follows assesses the goals identified in the LACDMH Quality Improvement Work Plan for CY 2016. 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 2017.

SECTION 2

POPULATION NEEDS ASSESSMENT

Los Angeles County is the most populated county in the United States (US) with an estimated population of 10,192,376 people in Calendar Year (CY) 2015. The County consists of 88 incorporated cities and includes 4,058 square miles of land area.

Population density in Los Angeles 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 Ethnicity in Los Angeles County, as shown in Figure 1, is the highest among Latinos at 48.4%, followed by Whites at 28.3%, Asian Pacific Islanders (API) at 14.6%, African Americans (AA) at 8.5%, and Native Americans (NA) at 0.19%.

Methods

Population and poverty estimates are derived from the American Community Survey (ACS) conducted by the US Census Bureau in CY 2015. Data for the Federal Poverty level (FPL) is reported for the 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 Los Angeles County. Data for the 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), 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) 15-16. 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 presented data in this section includes the following:

- Estimated Total Population by Ethnicity, Age Group, and Gender, in CY 2015;
- Estimated Total Population living at or below 138% Federal Poverty Level (FPL) by Ethnicity, Age Group, and Gender, in CY 2015;
- 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 the Population living at or below 138% FPL;
- Population enrolled in Medi-Cal by Ethnicity, Age Group and Gender;
- Estimated Prevalence of SED and SMI among population enrolled in Medi-Cal by Ethnicity, Age Group, Gender, and Threshold Language;
- LACDMH Threshold Languages spoken by Population enrolled in Medi-Cal;
- Consumers served in outpatient programs by Ethnicity, Age Group, and Gender; and
- 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 2013 and CY 2014.

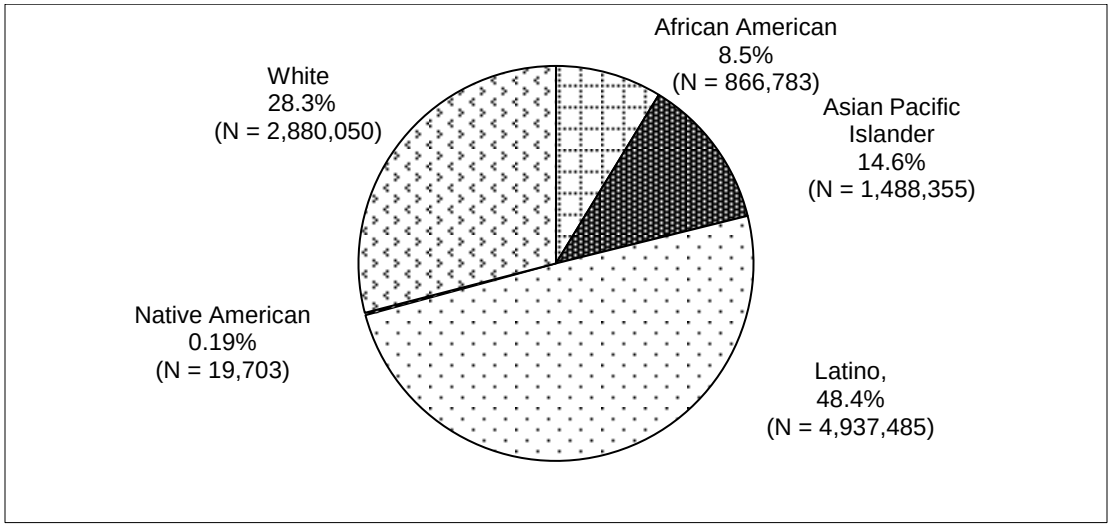
Penetration Rates are derived by applying Prevalence Rates for the Ethnicity, Gender, or Age Groups to the demographic data for consumers served. These figures are helpful in understanding the needs of the target and underserved populations.

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 the population living at or below 138% FPL to account for expansion of services under the Affordable Care Act (ACA).

Total Population

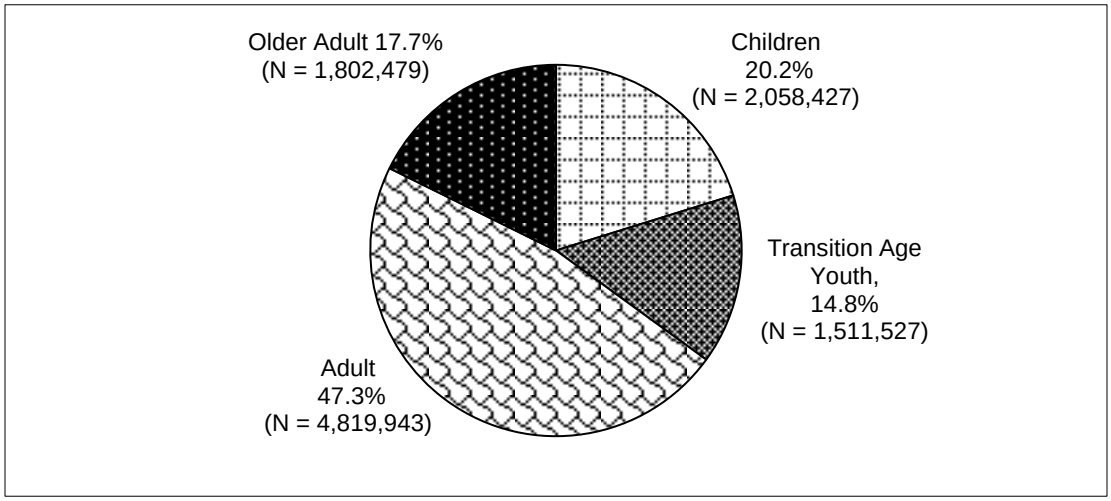
FIGURE 1: POPULATION BY ETHNICITY
CY 2015 (N = 10,192,376)



Data Source: American Community Survey (ACS), US Census, Bureau and Hedderson Demographic Services, 2016.

Figure 1 shows population by Ethnicity for CY 2015. Latinos are the largest group at 48.4%, followed by Whites at 28.3%, Asian Pacific Islanders (API) at 14.6%, African Americans (AA) at 8.5%, and Native Americans (NA) at 0.19%.

FIGURE 2: POPULATION BY AGE GROUP
CY 2015 (N = 10,192,376)



Data Source: American Community Survey (ACS), US Census Bureau, and Hedderson Demographic Services, 2016.

Figure 2 shows population by Age Group for CY 2015. Adults (26-59 years) make up the largest group at 47.3%, followed by Children (0-15 years) at 20.2%, Older Adults (60+ years) at 17.7%, and Transition Age Youth (TAY; 16-25 years) at 14.8%.

TABLE 1: POPULATION BY ETHNICITY AND SERVICE AREA
CY 2015

Service Area (SA)	African American	Asian Pacific Islander	Latino	Native American	White	Total
SA1	64,282	15,636	177,649	1,599	137,191	396,357
Percent	16.2%	3.9%	44.8%	**0.40%**	34.6%	100.0%
SA2	78,630	257,326	895,281	4,035	993,549	2,228,821
Percent	3.5%	11.5%	40.2%	0.18%	44.6%	100.0%
SA3	66,228	515,594	833,066	3,038	381,278	1,799,204
Percent	3.7%	**28.7%**	46.3%	0.17%	21.2%	100.0%
SA4	61,229	209,958	605,023	2,146	288,930	1,167,286
Percent	5.2%	18.0%	51.8%	0.18%	24.8%	100.0%
SA5	37,612	93,530	105,740	995	422,204	660,081
Percent	5.7%	14.2%	**16.0%**	**0.15%**	**64.0%**	100.0%
SA6	286,857	19,543	715,381	1,525	25,428	1,048,734
Percent	**27.4%**	**1.9%**	68.2%	**0.15%**	**2.4%**	100.0%
SA7	40,321	122,293	972,046	2,733	185,550	1,322,943
Percent	**3.0%**	9.2%	**73.5%**	0.21%	14.0%	100.0%
SA8	231,624	254,475	633,299	3,632	445,920	1,568,950
Percent	14.8%	16.2%	40.4%	0.23%	28.4%	100.0%
Total	866,783	1,488,355	4,937,485	19,703	2,880,050	10,192,376
Percent	8.5%	14.6%	48.4%	0.19%	28.3%	100.0%

Note: Bold values represent the highest and lowest percentage within each Ethnic Group across Service Areas.
Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

Differences by Ethnicity

The highest percentage of African Americans (AA) was in SA 6 (27.4%) compared to SA 7 (3.0%) with the lowest percentage.

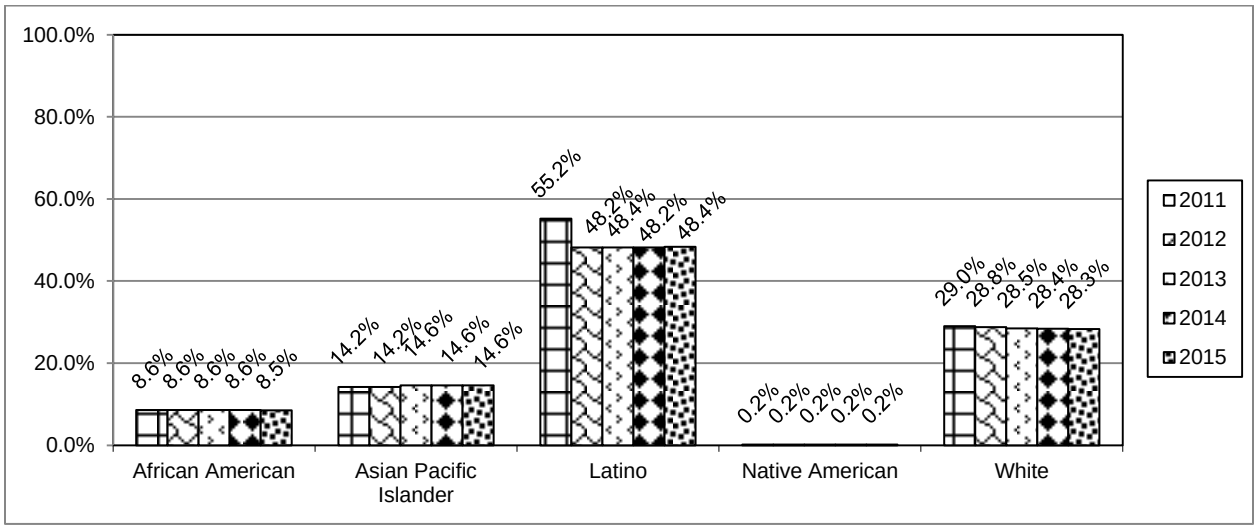
The highest percentage of Asian Pacific Islanders (API) was in SA 3 (28.7%) compared to SA 6 (1.9%) with the lowest percentage.

The highest percentage of Latinos was in SA 7 (73.5%) compared to SA 5 (16.0%) with the lowest percentage.

The highest percentage of Native Americans (NA) was in SA 1 (0.40%) compared to SA 5 and SA 6 (0.15%) with the lowest percentage.

The highest percentage of Whites was in SA 5 (64.0%) compared to SA 6 (2.4%) with the lowest percentage.

FIGURE 3: POPULATION PERCENT CHANGE BY ETHNICITY
CY 2011–2015



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

The percentage of African Americans (AA) in Los Angeles County has decreased by 0.1 Percentage Points (PP) over the past five years. AA represented 8.6% of the total population in CY 2011 and represented 8.5% of the population in CY 2015.

The percentage of Asian Pacific Islanders (API) in Los Angeles County has increased by 0.4 PP over the past five years. API represented 14.2% of the total population in CY 2011 and represented 14.6% in CY 2015.

The percentage of Latinos in Los Angeles County has decreased by 6.8 PP over the past five years. Latinos represented 55.2% of the total population in CY 2011 and represented 48.4% in CY 2015.

The percentage of Native Americans (NA) in Los Angeles County has remained the same over the past five years. NA represented 0.2% of the total population in CY 2011 and in CY 2015.

The percentage of Whites in Los Angeles County has decreased by 0.7 PP over the past five years. Whites represented 29.0% of the total population in CY 2011 and represented 28.3% in CY 2015.

TABLE 2: POPULATION BY AGE GROUP AND SERVICE AREA
CY 2015

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	113,478	14,524	36,641	172,652	19,754	39,308	396,357
Percent	28.6%	3.7%	**9.2%**	**43.6%**	5.0%	9.9%	100.0%
SA2	518,831	62,652	161,505	1,071,750	125,891	288,192	2,228,821
Percent	23.3%	2.8%	7.2%	48.1%	5.6%	12.9%	100.0%
SA3	417,958	56,940	137,653	823,464	105,994	257,195	1,799,204
Percent	23.2%	3.2%	7.7%	45.8%	**5.9%**	14.3%	100.0%
SA4	244,509	27,602	77,241	623,088	56,535	138,311	1,167,286
Percent	20.9%	**2.4%**	6.6%	**53.4%**	4.8%	11.8%	100.0%
SA5	117,073	22,635	42,942	337,341	38,044	102,046	660,081
Percent	**17.7%**	3.4%	**6.5%**	51.1%	5.8%	**15.5%**	100.0%
SA6	321,073	40,721	96,899	460,516	41,781	87,744	1,048,734
Percent	**30.6%**	**3.9%**	**9.2%**	43.9%	**4.0%**	**8.4%**	100.0%
SA7	358,354	44,130	110,066	593,512	63,643	153,238	1,322,943
Percent	27.1%	3.3%	8.3%	44.9%	4.8%	11.6%	100.0%
SA8	386,870	45,372	114,285	737,620	84,153	200,650	1,568,950
Percent	24.7%	2.9%	7.3%	47.0%	5.4%	12.8%	100.0%
Total	2,478,146	314,576	777,232	4,819,943	535,795	1,266,684	10,192,376
Percent	24.3%	3.1%	7.6%	47.3%	5.3%	12.4%	100.0%

Note: Bold values represent the highest and lowest percentage within each Age Group across Service Areas. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

Differences by Age Group

The highest percentage of 0-18 year olds was in SA 6 (30.6%) compared to SA 5 (17.7%) with the lowest percentage.

The highest percentage of 19-20 year olds was in SA 6 (3.9%) compared to SA 4 (2.4%) with the lowest percentage.

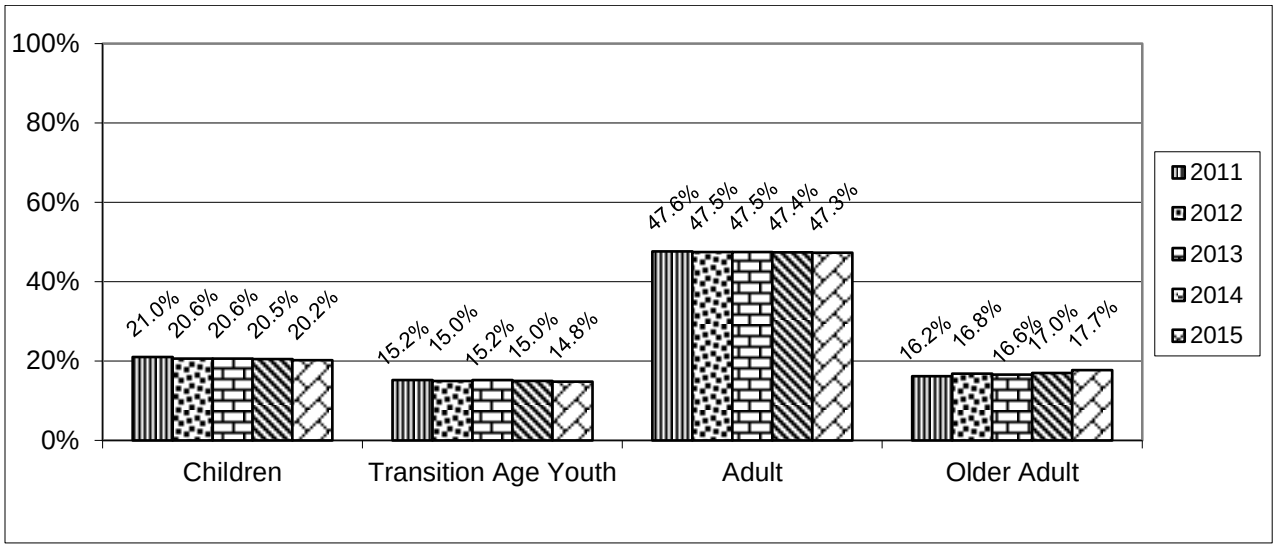
The highest percentage of 21-25 year olds was in SA 1 and SA 6 (9.2%) compared to SA 5 (6.5%) with the lowest percentage.

The highest percentage of 26-59 year olds was in SA 4 (53.4%) compared to SA 1 (43.6%) with the lowest percentage.

The highest percentage of 60-64 year olds was in SA 3 (5.9%) compared to SA 6 (4.0%) with the lowest percentage.

The highest percentage of 65+ year olds was in SA 5 (15.5%) compared to SA 6 (8.4%) with the lowest percentage.

FIGURE 4: POPULATION PERCENT CHANGE BY AGE GROUP
CY 2011–2015



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

The percentage of Children in Los Angeles County has decreased by 0.8 Percentage Points (PP) over the past five years. Children represented 21.0% of the total population in CY 2011 and represented 20.2% in CY 2015.

The percentage of Transition Age Youth (TAY) in Los Angeles County has decreased by 0.4 PP over the past five years. TAY represented 15.2% of the total population in CY 2011 and represented 14.8% in CY 2015.

The percentage of Adults in Los Angeles County has decreased by 0.3 PP over the past five years. Adults represented 47.6% of the total population in CY 2011 and represented 47.3% in CY 2015.

The percentage of Older Adults in Los Angeles County has increased by 1.5 PP over the past five years. Older Adults represented 16.2% of the total population in CY 2011 and represented 17.7% in CY 2015.

TABLE 3: POPULATION BY GENDER AND SERVICE AREA
CY 2015

Service Area (SA)	Male	Female	Total
SA1	197,050	199,307	396,357
Percent	49.7%	50.3%	100.0%
SA2	1,103,786	1,125,035	2,228,821
Percent	49.5%	50.5%	100.0%
SA3	879,016	920,188	1,799,204
Percent	48.9%	51.1%	100.0%
SA4	599,006	568,280	1,167,286
Percent	**51.3%**	**48.7%**	100.0%
SA5	320,080	340,001	660,081
Percent	**48.5%**	**51.5%**	100.0%
SA6	511,475	537,259	1,048,734
Percent	48.8%	51.2%	100.0%
SA7	650,539	672,404	1,322,943
Percent	49.2%	50.8%	100.0%
SA8	767,992	800,958	1,568,950
Percent	48.9%	51.1%	100.0%
Total	5,028,944	5,163,432	10,192,376
Percent	49.3%	50.7%	100.0%

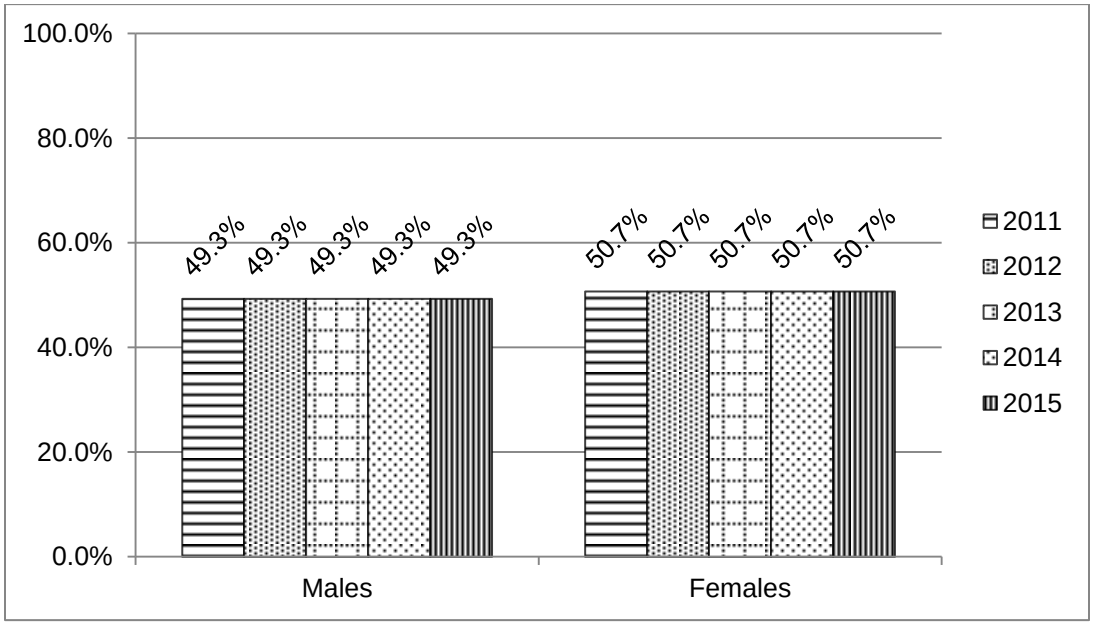
Note: Bold values represent highest and lowest percentage within each Gender across Service Areas. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

Differences by Gender

The highest percentage of Males was in SA 4 (51.3%) 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 (48.7%) with the lowest percentage.

FIGURE 5: ESTIMATED PERCENT CHANGE AMONG TOTAL POPULATION BY GENDER CY 2011–2015



Data Source: American Community Survey (ACS) US Census Bureau and Hedderson Demographic Services, 2016

The percentage of Males and Females among the Total Population remained the same at 49.3% and 50.7% respectively between CY 2011 and CY 2015.

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

TABLE 4: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY AND SERVICE AREA CY 2015

Service Area (SA)	African American	Asian Pacific Islander	Latino	Native American	White	Total
SA1	21,384	2,556	61,927	465	26,023	112,355
Percent	19.0%	2.3%	55.1%	**0.41%**	23.2%	100.0%
SA2	17,427	36,899	286,116	805	146,775	488,022
Percent	3.6%	7.6%	58.6%	0.16%	30.1%	100.0%
SA3	12,944	88,974	226,146	569	50,084	378,717
Percent	3.4%	**23.5%**	59.7%	0.15%	13.2%	100.0%
SA4	17,548	56,538	264,774	843	63,047	402,750
Percent	4.4%	14.0%	65.7%	0.21%	15.7%	100.0%
SA5	6,860	16,371	23,991	138	56,077	103,437
Percent	6.6%	15.8%	**23.2%**	**0.13%**	**54.2%**	100.0%
SA 6	113,891	8,164	378,223	880	9,140	510,298
Percent	**22.3%**	**1.6%**	74.1%	0.17%	**1.8%**	100.0%
SA7	8,740	15,393	304,134	641	26,023	354,931
Percent	**2.5%**	4.3%	**85.7%**	0.18%	7.3%	100.0%
SA8	70,182	40,089	236,214	952	49,143	396,580
Percent	17.7%	10.1%	59.6%	0.24%	12.4%	100.0%
Total	268,976	264,984	1,781,525	5,293	426,312	2,747,090
Percent	9.8%	9.6%	64.9%	0.2%	15.5%	100.0%

Note: Bold values represent the highest and lowest percentage within each Ethnic Group across Service Areas. Multi-race (N= 35,098) and Unknown or Other Ethnicity (N=7,274) are not included in this table. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

Differences by Ethnicity

The highest percentage of African Americans (AA) living at or below 138% FPL was in SA 6 (22.3%) compared to SA 7 (2.5%) with the lowest percentage.

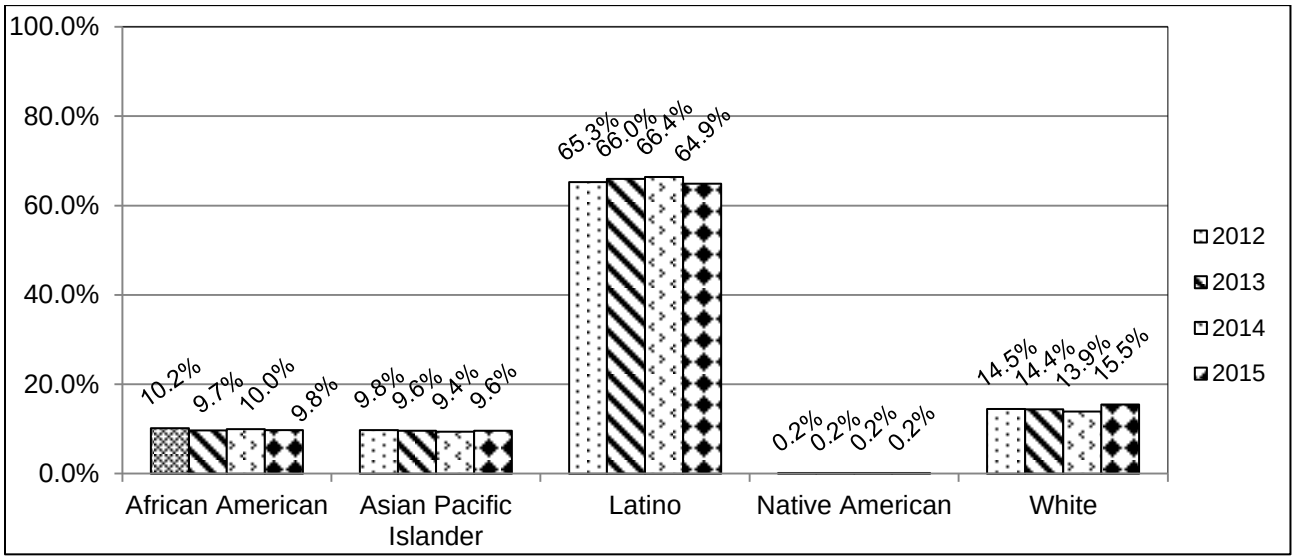
The highest percentage of Asian Pacific Islanders (API) living at or below 138% FPL was in SA 3 (23.5%) compared to SA 6 (1.6%) with the lowest percentage.

The highest percentage of Latinos living at or below 138% FPL was in SA 7 (85.7%) compared to SA 5 (23.2%) with the lowest percentage.

The highest percentage of Native Americans (NA) living at or below 138% FPL was in SA 1 (0.41%) 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.

FIGURE 6: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY CY 2012–2015



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

The percent of African Americans (AA) living at or below 138% FPL has decreased by 0.4 Percentage Points (PP), from 10.2% in CY 2012 to 9.8% in CY 2015.

The percent of Asian Pacific Islanders (API) living at or below 138% FPL has decreased by 0.2 PP, from 9.8% in CY 2012 to 9.6% in CY 2015.

The percent of Latinos living at or below 138% FPL has decreased by 0.4 PP, from 65.3% in CY 2012 to 64.9% in CY 2015.

The percent of Native Americans (NA) living at or below 138% FPL has remained the same at 0.2% from CY 2012 to CY 2015.

The percent of Whites living at or below 138% FPL has increased by 1.0 PP, from 14.5% in CY 2012 to 15.5% in CY 2015.

TABLE 5: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP AND SERVICE AREA CY 2015

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	45,539	4,271	10,549	43,085	4,042	7,528	115,014
Percent	39.6%	**3.7%**	9.2%	37.5%	3.5%	6.5%	100.0%
SA2	161,324	14,448	39,791	218,836	19,963	43,469	497,831
Percent	32.4%	2.9%	8.0%	44.0%	4.0%	8.7%	100.0%
SA3	125,484	11,900	31,049	158,882	16,470	39,572	383,357
Percent	32.7%	3.1%	8.1%	41.4%	**4.3%**	**10.3%**	100.0%
SA4	123,761	10,121	30,218	191,665	15,372	37,472	408,609
Percent	30.3%	**2.5%**	**7.4%**	46.9%	3.8%	9.2%	100.0%
SA5	17,946	3,879	13,819	55,936	4,495	11,051	107,126
Percent	**16.8%**	3.6%	**12.9%**	**52.2%**	4.2%	**10.3%**	100.0%
SA6	216,622	18,032	46,794	192,637	15,344	26,349	515,778
Percent	**42.0%**	3.5%	9.1%	**37.3%**	**3.0%**	**5.1%**	100.0%
SA7	141,912	11,302	28,478	136,683	12,242	26,550	357,167
Percent	39.7%	3.2%	8.0%	38.3%	3.4%	7.4%	100.0%
SA8	147,403	12,783	33,240	167,525	14,667	28,962	404,580
Percent	36.4%	3.2%	8.2%	41.4%	3.6%	7.2%	100.0%
Total	979,991	86,736	233,938	1,165,249	102,595	220,953	2,789,462
Percent	35.1%	3.1%	8.4%	41.8%	3.7%	7.9%	100.0%

Note: Bold values represent the highest and lowest percentage within each Age Group across Service Areas. Age Groups relevant to the Affordable Care Act (ACA) are used in the 138% FPL table by contrast with other Age Group tables. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

Differences by Age Group

The highest percentage of 0-18 year olds estimated to be living at or below 138% FPL was in SA 6 (42.0%) compared to SA 5 (16.8%) with the lowest percentage.

The highest percentage of 19-20 year olds estimated to be living at or below 138% FPL was in SA 1 (3.7%) compared to SA 4 (2.5%) with the lowest percentage.

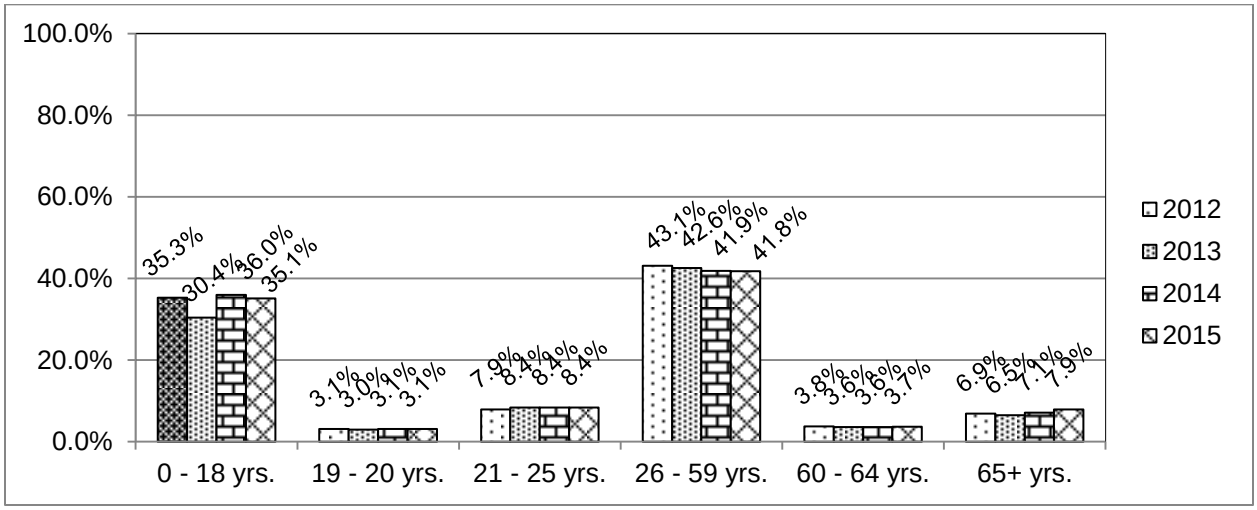
The highest percentage of 21-25 year olds estimated to be living at or below 138% FPL was in SA 5 (12.9%) compared to SA 4 (7.4%) with the lowest percentage.

The highest percentage of 26-59 year olds estimated to be living at or below 138% FPL was in SA 5 (52.2%) compared to SA 6 (37.3%) with the lowest percentage.

The highest percentage of 60-64 year olds estimated to be living at or below 138% FPL was in SA 3 (4.3%) compared to SA 6 (3.0%) with the lowest percentage.

The highest percentage of 65+ year olds estimated to be living at or below 138% FPL was in SA 3 and SA 5 (10.3%) compared to SA 6 (5.1%) with the lowest percentage.

FIGURE 7: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP CY 2012–2015



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

The percentage of 0-18 year olds living at or below 138% FPL decreased by 0.2 Percentage Points (PP), from 35.3% in CY 2012 to 35.1% in CY 2015.

The percentage of 19-20 year olds living at or below 138% FPL remained the same at 3.1% in CY 2012 and CY 2015.

The percentage of 21-25 year olds living at or below 138% FPL increased by 0.5 PP, from 7.9% in CY 2012 to 8.4% in CY 2015.

The percentage of 26-59 year olds living at or below 138% FPL decreased by 1.3 PP, from 43.1% in CY 2012 to 41.8% in CY 2015.

The percentage of 60-64 year olds living at or below 138% FPL decreased by 0.1 PP, from 3.8% in CY 2012 to 3.7% in CY 2015.

The percentage of 65+ year olds living at or below 138% FPL increased by 1.0 PP, from 6.9% in CY 2012 to 7.9% in CY 2015.

TABLE 6: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA CY 2015

Service Area (SA)	Male	Female	Total
SA1	55,621	59,393	115,014
Percent	48.4%	51.6%	100.0%
SA2	245,418	252,413	497,831
Percent	49.3%	50.7%	100.0%
SA3	187,091	196,266	383,357
Percent	48.8%	51.2%	100.0%
SA4	205,957	202,652	408,609
Percent	**50.4%**	**49.6%**	100.0%
SA5	51,704	55,422	107,126
Percent	**48.3%**	**51.7%**	100.0%
SA6	251,403	264,375	515,778
Percent	48.7%	51.3%	100.0%
SA7	175,019	182,148	357,167
Percent	49.0%	51.0%	100.0%
SA8	196,430	208,150	404,580
Percent	48.6%	51.4%	100.0%
Total	1,368,643	1,420,819	2,789,462
Percent	49.1%	50.9%	100.0%

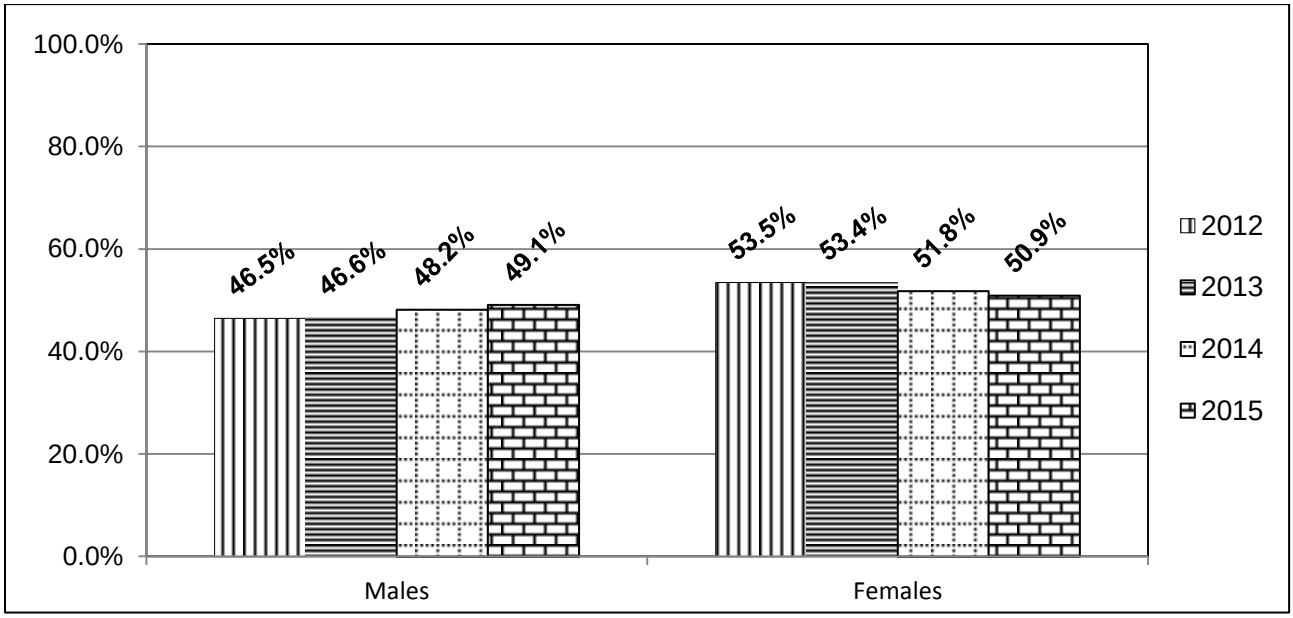
Note: Bold values represent the highest and lowest percentage within each Gender across Service Areas. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

Differences by Gender

The highest percentage of Males estimated to be living at or below 138% FPL was in SA 4 (50.4%) compared to SA 5 (48.3%) with the lowest percentage.

The highest percentage of Females estimated to be living at or below 138% FPL was in SA 5 (51.7%) compared to SA 4 (49.6%) with the lowest percentage.

FIGURE 8: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER CY 2012–2015



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

The percentage of Males living at or below 138% FPL increased by 2.6 Percentage Points (PP) from 46.5% in CY 2012 to 49.1% in CY 2015. Conversely, the percentage of Females living at or below 138% FPL decreased by 2.6 PP, from 53.5% in CY 2012 to 50.9% in CY 2015.

TABLE 7: PRIMARY LANGUAGES[1] OF ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY SERVICE AREA AND THRESHOLD LANGUAGE CY 2015

Service Area (SA)	Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese	Total
SA1	589	472	16	351	61,506	111	121	61	36,666	485	295	100,673
Percent	0.6%	0.5%	0.0%	0.3%	**61.1%**	0.1%	0.1%	0.1%	**36.4%**	0.5%	0.3%	100.0%
SA2	5,158	42,129	252	4,236	136,133	7,094	5,740	6,034	230,798	6,699	2,748	447,021
Percent	1.2%	**9.4%**	0.1%	0.9%	**30.5%**	**1.6%**	**1.3%**	**1.3%**	**51.6%**	**1.5%**	**0.6%**	100.0%
SA3	2,264	1,935	1,156	26,632	110,456	634	4,254	274	175,412	4,015	14,059	341,091
Percent	0.7%	0.6%	0.3%	7.8%	**32.4**%	0.2%	**1.2%**	0.1%	**51.4%**	1.2%	**4.1%**	100.0%
SA4	1,256	6,278	854	7,947	87,546	1,248	23,751	4,836	230,863	5,612	2,208	372,399
Percent	0.3%	**1.7%**	0.2%	2.1%	**23.5%**	0.3%	**6.4%**	**1.3%**	**62.0%**	**1.5%**	0.6%	100.0%
SA5	1,423	440	107	3,409	56,116	5,521	1,743	1,210	19,382	523	706	90,580
Percent	1.6%	0.5%	0.1%	3.8%	**62.0%**	**6.1%**	1.9%	1.3%	**21.4%**	0.6%	0.8%	100.0%
SA6	509	99	207	2,487	126,532	318	1,960	78	348,008	303	307	480,808
Percent	0.1%	0.02%	0.04%	0.5%	**26.3%**	0.1%	0.4%	0.02%	**72.4%**	0.1%	0.1%	100.0%
SA7	1,521	767	536	2,429	68,517	141	3,470	147	258,174	1,991	872	338,565
Percent	0.4%	0.2%	0.2%	0.7%	**20.2%**	0.04%	**1.0%**	0.04%	**76.3%**	0.6%	0.3%	100.0%
SA8	1,952	278	6,009	3,294	145,789	689	4,005	404	193,921	4,160	2,903	363,404
Percent	0.5%	0.1%	**1.7%**	0.9%	**40.1%**	0.2%	**1.1%**	0.1%	**53.4%**	1.1%	**0.8%**	100.0%
Total	14,672	52,398	9,137	50,785	792,595	15,756	45,044	13,044	1,493,224	23,788	24,098	2,534,541
Percent	0.6%	2.1%	0.4%	2.0%	31.3%	0.6%	1.8%	0.5%	58.9%	0.9%	1.0%	100.0%

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016. [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 and therefore not reported in the above table.

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

A total of 91% (N = 2,534,541) of the population (N = 2,789,462) living at or below 138% FPL spoke a LACDMH threshold language. Among these, 31.3% (N = 792,595) were English speaking, 58.9% were Spanish speaking (N = 1,493,224) and the remaining 9.8% 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) threshold languages as their primary languages: English (61.1%) and Spanish (36.4%).

SA 2 reported eight (8) threshold languages as their primary languages: Armenian (9.4%), English (30.5%), Farsi (1.6%), Korean (1.3%), Russian (1.3%), Spanish (51.6%), Tagalog (1.5%), and Vietnamese (0.6%).

SA 3 reported four (4) threshold languages as their primary languages: English (32.4%), Korean (1.2%), Spanish (51.4%), and Vietnamese (4.1%).

SA 4 reported six (6) threshold languages as their primary languages: Armenian (1.7%), English (23.5%), Korean (6.4%), Russian (1.3%), Spanish (62.0%), and Tagalog (1.5%).

SA 5 reported three (3) threshold languages as their primary languages: English (62.0%), Farsi (6.1%), and Spanish (21.4%).

SA 6 reported two (2) threshold languages as their primary languages: English (26.3%) and Spanish (72.4%).

SA 7 reported three (3) threshold languages as their primary languages: English (20.2%), Korean (1.0%), and Spanish (76.3%).

SA 8 reported five (5) threshold languages as their primary languages: Cambodian (1.7%), English (40.1%), Korean (1.1%), Spanish (53.4%), and Vietnamese (0.8%).

TABLE 8: ESTIMATED PREVALENCE OF SERIOUS EMOTIONAL DISTURBANCE (SED) AND SERIOUS MENTAL ILLNESS (SMI) AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY AND SERVICE AREA CY 2015

Service Area (SA)	African American	Asian Pacific Islander	Latino	Native American	White	Total
SA1	2,481	253	6,936	293	6,532	16,495
Percent	15.0%	1.5%	42.0%	**1.8%**	39.6%	100.0%
SA2	2,022	3,653	32,045	508	36,841	75,068
Percent	2.7%	4.9%	42.7%	0.7%	49.1%	100.0%
SA3	1,502	8,808	25,328	359	12,571	48,568
Percent	3.1%	**18.1%**	52.1%	0.7%	25.9%	100.0%
SA4	2,036	5,597	29,655	532	15,825	53,644
Percent	3.8%	10.4%	55.3%	1.0%	29.5%	100.0%
SA5	796	1,621	2,687	87	14,075	19,266
Percent	4.1%	8.4%	**13.9%**	**0.5%**	**73.1%**	100.0%
SA6	13,211	808	42,361	555	2,294	59,230
Percent	**22.3%**	**1.4%**	71.5%	0.9%	**3.9%**	100.0%
SA7	1,014	1,524	34,063	404	6,532	43,537
Percent	**2.3%**	3.5%	**78.2%**	0.9%	15.0%	100.0%
SA8	8,141	3,969	26,456	601	12,335	51,501
Percent	15.8%	7.7%	51.4%	1.2%	24.0%	100.0%
Total	31,201	26,233	199,531	3,340	107,004	367,309
Percent	8.5%	7.1%	54.3%	0.91%	29.1%	100.0%

Note**:** Bold values represent the highest and lowest percentages within each Ethnic Group and across the Service Areas. Estimated prevalence rates of mental illness by Ethnicity for Los Angeles County are provided by the California Health Interview Survey (CHIS) for the population living at or below 138% FPL, CY 2013 and CY 2014. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

Differences by Ethnicity

The highest rate of prevalence of SED and SMI among the African American (AA) ethnic group was in SA 6 (22.3%) compared to SA 7 (2.3%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Asian Pacific Islander (API) ethnic group was in SA 3 (18.1%) compared to SA 6 (1.4%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Latino ethnic group was in SA 7 (78.2%) compared to SA 5 (13.9%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Native American (NA) ethnic group was in SA 1 (1.8%) compared to SA 5 (0.5%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the White ethnic group was in SA 5 (73.1%) compared to SA 6 (3.9%) with the lowest percentage.

TABLE 9: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL BY AGE GROUP AND SERVICE AREA CY 2015

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	3,643	491	1,867	5,687	182	662	12,533
Percent	29.1%	**3.9%**	14.9%	45.4%	1.5%	5.3%	100.0%
SA2	12,906	1,662	7,043	28,886	898	3,825	55,220
Percent	23.4%	3.0%	12.8%	52.3%	1.6%	6.9%	100.0%
SA3	10,039	1,369	5,496	20,972	741	3,482	42,099
Percent	23.8%	3.3%	13.1%	49.8%	**1.8%**	**8.3%**	100.0%
SA4	9,901	1,164	5,349	25,300	692	3,298	45,702
Percent	21.7%	**2.5%**	**11.7%**	55.4%	1.5%	7.2%	100.0%
SA5	1,436	446	2,446	7,384	202	972	12,886
Percent	**11.1%**	3.5%	**19.0%**	**57.3%**	1.6%	7.5%	100.0%
SA6	17,330	2,074	8,283	25,428	690	2,319	56,123
Percent	27.8%	3.3%	13.3%	**40.8%**	**1.2%**	**3.7%**	100.0%
SA7	11,353	1,300	5,041	18,042	551	2,336	38,623
Percent	**29.4%**	3.4%	13.1%	46.7%	1.4%	6.0%	100.0%
SA8	11,792	1,470	5,883	22,113	660	2,549	44,468
Percent	26.5%	3.3%	13.2%	49.7%	1.5%	5.7%	100.0%
Total	78,399	9,975	41,407	153,813	10,831	19,444	313,869
Percent	25.5%	3.2%	13.5%	50.0%	1.5%	6.3%	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 California Health Interview Survey (CHIS) for the population living at or below 138% FPL, CY 2013 and 2014. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

Differences by Age Group

The highest rate of prevalence of SED and SMI among age 0-18 years was in SA 7 (29.4%) compared to SA 5 (11.1%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among age 19-20 years was in SA 1 (3.9%) compared to SA 4 (2.5%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among age 21-25 years was in SA 5 (19.0%) compared to SA 4 (11.7%) the lowest percentage.

The highest rate of prevalence of SED and SMI among age 26-59 years was in SA 5 (57.3%) compared to SA 6 (40.8%) with the lowest percentage.
The highest rate of prevalence of SED and SMI among age 60-64 years was in SA 3 (1.8%) compared to SA 6 (1.2%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among age 65+ years and older was in SA 3 (8.3%) compared to SA 6 (3.7%) with the lowest percentage.

TABLE 10: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA CY 2015

Service Area (SA)	Male	Female	Total
SA1	4,950	9,325	14,275
Percent	34.7%	65.3%	100.0%
SA2	21,842	39,629	61,471
Percent	35.5%	64.5%	100.0%
SA3	16,651	30,814	47,465
Percent	35.1%	64.9%	100.0%
SA4	18,330	31,816	50,147
Percent	**36.6%**	**63.4%**	100.0%
SA5	4,602	8,701	13,303
Percent	**34.6%**	**65.4%**	100.0%
SA6	22,375	41,507	63,882
Percent	35.0%	65.0%	100.0%
SA7	15,577	28,597	44,174
Percent	35.3%	64.7%	100.0%
SA8	17,482	32,680	50,162
Percent	34.9%	65.1%	100.0%
Total	121,809	223,069	344,878
Percent	35.3%	64.7%	100.0%

Note: Bold values represent the highest and lowest percentage within each Gender across Service Areas. Estimated prevalence rates of mental illness for Los Angeles County are provided by the California Health Interview Survey (CHIS) for the population living at or below 138% FPL, CY 2013 and CY 2014. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016.

Differences by Gender

The highest rate of prevalence of SED and SMI among Males was in SA 4 (36.6%) compared to SA 5 (34.6%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among Females was in SA 5 (65.4%) compared to SA 4 (63.4%) with the lowest percentage.

Population Enrolled in Medi-Cal

TABLE 11: POPULATION ENROLLED IN MEDI-CAL BY ETHNICITY AND SERVICE AREA MARCH 2016

Service Area (SA)	African American	Asian Pacific Islander	Latino	Native American	White	Total
SA 1	38,352	4,234	91,682	367	32,750	167,385
Percent	22.9%	2.5%	54.8%	0.22%	19.6%	100.0%
SA 2	26,368	53,190	389,256	833	216,986	686,633
Percent	3.8%	7.7%	56.7%	0.12%	31.6%	100.0%
SA 3	21,315	161,043	334,616	729	56,848	574,551
Percent	3.7%	**28.0%**	58.2%	0.13%	9.9%	100.0%
SA 4	26,150	62,900	291,227	614	59,910	440,801
Percent	5.9%	14.3%	66.1%	0.14%	13.6%	100.0%
SA 5	10,815	7,968	30,246	238	40,987	90,254
Percent	12.0%	8.8%	**33.5%**	**0.30%**	**45.4%**	100.0%
SA 6	136,625	5,826	418,597	447	13,101	574,596
Percent	**23.8%**	**1.0%**	72.9%	**0.08%**	**2.3%**	100.0%
SA 7	13,107	27,813	412,045	691	32,115	485,771
Percent	**2.7%**	5.7%	**84.8%**	0.14%	6.6%	100.0%
SA 8	85,319	54,453	265,174	858	54,488	460,292
Percent	18.5%	11.8%	57.6%	0.19%	11.8%	100.0%
Total	358,051	377,427	2,232,843	4,777	507,185	3,480,283
Percent	10.3%	10.8%	64.2%	0.14%	14.6%	100.0%

Note: Bold values represent the highest and lowest percentage within each Ethnic Group across Service Areas. Unknown Service Area (N=165,797), Unknown Ethnicity (N=374,359), and "Other" Ethnicity (N= 69,398) were not included in the Ethnicity table. Data Source: State Medi-Cal Eligibility Data System (MEDS) File, March 2016.

Differences by Ethnicity

The highest percentage of African Americans (AA) enrolled in Medi-Cal was in SA 6 (23.8%) compared to SA 7 (2.7%) with the lowest percentage.

The highest percentage of Asian Pacific Islanders (API) enrolled in Medi-Cal was in SA 3 (28.0%) 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 (33.5%) with the lowest percentage.

The highest percentage of Native Americans (NA) enrolled in Medi-Cal was in SA 5 (0.30%) compared to SA 6 (0.08%) with the lowest percentage.

The highest percentage of Whites enrolled in Medi-Cal was in SA 5 (45.4%) compared to SA 6 (2.3%) with the lowest percentage.

TABLE 12: POPULATION ENROLLED IN MEDI-CAL BY AGE GROUP AND SERVICE AREA MARCH 2016

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	73,370	7,063	15,431	67,964	6,316	11,957	182,101
Percent	**40.3%**	**3.9%**	**8.5%**	37.3%	**3.5%**	**6.6%**	100.0%
SA2	245,064	24,401	55,791	308,169	36,714	100,210	770,349
Percent	31.8%	3.2%	7.2%	40.0%	4.8%	13.0%	100.0%
SA3	214,085	22,506	48,931	247,400	30,287	86,440	649,649
Percent	33.0%	3.5%	7.5%	38.1%	4.7%	13.3%	100.0%
SA4	141,686	14,349	34,790	205,494	24,157	69,114	489,590
Percent	28.9%	2.9%	7.1%	42.0%	4.9%	14.1%	100.0%
SA5	25,285	2,653	7,254	51,809	5,893	16,651	109,545
Percent	**23.1%**	**2.4%**	**6.6%**	**47.3%**	**5.4%**	**15.2%**	100.0%
SA6	250,328	22,924	51,569	235,949	23,361	46,618	630,749
Percent	39.7%	3.6%	8.2%	37.4%	3.7%	7.4%	100.0%
SA7	204,787	19,603	42,896	192,417	21,122	54,461	535,286
Percent	38.3%	3.7%	8.0%	**35.9%**	3.9%	10.2%	100.0%
SA8	188,734	18,248	42,321	208,149	23,054	51,916	532,422
Percent	35.4%	3.4%	7.9%	39.1%	4.3%	9.8%	100.0%
Total	1,343,339	131,747	298,983	1,517,351	170,904	437,367	3,899,691
Percent	34.4%	3.4%	7.7%	38.9%	4.4%	11.2%	100.0%

Note: Bold values represent the highest and lowest percentage within each Age Group across Service Areas. Unknown Service Area (N=164,881). Data Source: State Medi-Cal Eligibility Data System (MEDS) File, March 2016.

Differences by Age Group

The highest percentage of 0-18 year olds enrolled in Medi-Cal was in SA 1 (40.3%) compared to SA 5 (23.1%) with the lowest percentage.

The highest percentages of 19-20 year olds enrolled in Medi-Cal were in SA 1 (3.9%) compared to SA 5 (2.4%) with the lowest percentage.

The highest percentage of 21-25 year olds enrolled in Medi-Cal was in SA 1 (8.5%) compared to SA 5 (6.6%) with the lowest percentage.

The highest percentage of 26-59 year olds enrolled in Medi-Cal was in SA 5 (47.3%) compared to SA 7 (35.9%) with the lowest percentage.

The highest percentage of 60-64 year olds enrolled in Medi-Cal was in SA 5 (5.4%) compared to SA 1 (3.5%) with the lowest percentage.

The highest percentage of 65+ year olds enrolled in Medi-Cal was in SA 5 (15.2%) compared to SA 1 (6.6%) with the lowest percentage.

TABLE 13: POPULATION ENROLLED IN MEDI-CAL BY GENDER AND SERVICE AREA MARCH 2016

Service Area (SA)	Male	Female	Total
SA1	83,499	98,601	182,100
Percent	45.9%	54.1%	100.0%
SA2	353,335	417,014	770,349
Percent	45.9%	54.1%	100.0%
SA3	297,290	352,359	649,649
Percent	45.8%	54.2%	100.0%
SA4	228,865	260,725	489,590
Percent	46.7%	53.3%	100.0%
SA5	51,804	57,741	109,545
Percent	**47.3%**	**52.7%**	100.0%
SA6	285,949	344,800	630,749
Percent	**45.3%**	54.7%	100.0%
SA7	240,459	294,827	535,286
Percent	44.9%	**55.1%**	100.0%
SA8	241,762	290,660	532,422
Percent	45.4%	54.6%	100.0%
Total	1,782,963	2,116,727	3,899,690
Percent	45.7%	54.3%	100.0%

Note: Bold values represent the highest and lowest percentage within each Gender across Service Areas. One Unknown Gender reported in SA 1. Unknown Service Area (N=164,881). Data Source: State Medi-Cal Eligibility Data System (MEDS) File, March 2016.

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 6 (45.3%).

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 2016

Service Area (SA)	African American	Asian Pacific Islander	Latino	Native American	White	Total
SA 1	5,638	347	12,010	232	10,382	28,609
Percent	19.7%	1.2%	42.0%	**0.81%**	36.3%	100.0%
SA 2	3,876	4,362	50,993	526	68,785	128,540
Percent	3.0%	3.4%	39.7%	0.41%	53.5%	100.0%
SA 3	3,133	13,206	43,835	460	18,021	78,654
Percent	4.0%	**16.8%**	55.7%	0.58%	22.9%	100.0%
SA 4	3,844	5,158	38,151	387	18,991	66,531
Percent	5.8%	7.8%	57.3%	0.58%	28.5%	100.0%
SA 5	1,590	653	3,962	150	12,993	19,348
Percent	8.2%	3.4%	**20.5%**	0.78%	**67.2%**	100.0%
SA 6	20,084	478	54,836	282	4,153	79,833
Percent	**25.2%**	**0.6%**	68.7%	**0.35%**	**5.2%**	100.0%
SA 7	1,927	2,281	53,978	436	10,180	68,802
Percent	**2.8%**	3.3%	**78.5%**	0.63%	14.8%	100.0%
SA 8	12,542	4,465	34,738	541	17,273	69,559
Percent	18.0%	6.4%	49.9%	0.8%	24.8%	100.0%
Total	52,633	30,949	292,502	3,014	160,778	539,877
Percent	9.7%	5.7%	54.2%	0.56%	29.8%	100.0%

Note: Bold values represent the highest and lowest percentage within each Ethnic Group across Service Areas. Estimated prevalence rates of mental illness by Ethnicity for Los Angeles County are provided by the California Health Interview Survey (CHIS) for the population living at or below 100% FPL, CY 2013 and CY 2014.

Differences by Ethnicity

The highest prevalence of SED and SMI among the African American (AA) ethnic group was in SA 6 (25.2%) compared to SA 7 (2.8%) with the lowest percentage.

The highest prevalence of SED and SMI among the Asian Pacific Islander (API) ethnic group was in SA 3 (16.8%) compared to SA 6 (0.6%) with the lowest percentage.

The highest prevalence of SED and SMI among the Latino ethnic group was in SA 7 (78.5%) compared to SA 5 (20.5%) with the lowest percentage.

The highest prevalence of SED and SMI among the Native American (NA) ethnic group was in SA 1 (0.81%) compared to SA 6 (0.35%) with the lowest percentage.

The highest prevalence of SED and SMI among the White ethnic group was in SA 5 (67.2%) compared to SA 6 (5.2%) with the lowest percentage.

TABLE 15: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY AGE GROUP AND SERVICE AREA MARCH 2016

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	10,712	600	1,852	8,767	790	873	23,594
Percent	**45.4%**	**2.5**%	**7.8**%	37.2%	**3.3%**	**3.7%**	100.0%
SA2	35,779	2,074	6,695	39,754	4,589	7,315	96,207
Percent	37.2%	2.2%	7.0%	41.3%	4.8%	7.6%	100.0%
SA3	31,256	1,913	5,872	31,915	3,786	6,310	81,052
Percent	38.6%	2.4%	7.2%	39.4%	4.7%	7.8%	100.0%
SA4	20,686	1,220	4,175	26,509	3,020	5,045	60,654
Percent	34.1%	2.0%	6.9%	43.7%	5.0%	8.3%	100.0%
SA5	3,692	226	870	6,683	737	1,216	13,423
Percent	**27.5%**	**1.7%**	**6.5%**	**49.8%**	**5.5%**	**9.1%**	100.0%
SA6	36,548	1,949	6,188	30,437	2,920	3,403	81,445
Percent	44.9%	2.4%	7.6%	37.4%	3.6%	4.2%	100.0%
SA7	29,899	1,666	5,148	24,822	2,640	3,976	68,150
Percent	43.9%	2.4%	7.6%	**36.4%**	3.9%	5.8%	100.0%
SA8	27,555	1,551	5,079	26,851	2,882	3,790	67,708
Percent	40.7%	2.3%	7.5%	39.7%	4.3%	5.6%	100.0%
Total	196,127	11,198	35,878	195,738	21,363	31,928	492,233
Percent	39.8%	2.3%	7.3%	39.8%	4.3%	6.5%	100.0%

Note: Bold values represent the highest and lowest percentage within each Age Group across Service Areas. Estimated prevalence rates of mental illness by Age Group for Los Angeles County are provided by the California Health Interview Survey (CHIS) for the population living at or below 100% FPL. Rates from CHIS for CY 2011 and CY 2012 were used due to statistically unreliable pooled estimates for CY 2013 and CY 2014.

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 (45.4%) compared to SA 5 (27.5%) with the lowest percentage.

The highest prevalence of SED and SMI among the Age Group 19-20 years was in SA 1 (2.5%) compared to SA 5 (1.7%) with the lowest percentage.

The highest prevalence of SED and SMI among the Age Group 21-25 years was in SA 1 (7.8%) compared to SA 5 (6.5%) with the lowest percentage.

The highest prevalence of SED and SMI among the Age Group 26-59 years was in SA 5 (49.8%) compared to SA 7 (36.4%) 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 (9.1%) compared to SA 1 (3.7%) with the lowest percentage.

TABLE 16: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY GENDER AND SERVICE AREA MARCH 2016

Service Area (SA)	Male	Female	Total
SA1	8,266	18,143	26,409
Percent	31.3%	68.7%	100.0%
SA2	34,980	76,731	111,711
Percent	31.3%	68.7%	100.0%
SA3	29,432	64,834	94,266
Percent	31.2%	68.8%	100.0%
SA4	22,658	47,973	70,631
Percent	32.1%	67.9%	100.0%
SA5	5,129	10,624	15,753
Percent	**32.6%**	**67.4%**	100.0%
SA6	28,309	63,443	91,752
Percent	30.9%	69.1%	100.0%
SA7	23,805	54,248	78,054
Percent	**30.5%**	**69.5%**	100.0%
SA8	23,934	53,481	77,416
Percent	30.9%	69.1%	100.0%
Total	176,513	389,478	565,991
Percent	31.2%	68.8%	100.0%

Note: Bold values represent the highest and lowest percentage within each Gender across Service Areas. Estimated prevalence rates of mental illness by Gender for Los Angeles County are provided by the California Health Interview Survey (CHIS) for the population living at or below 100% FPL, CY 2013 and CY 2014.

Differences by Gender

The highest prevalence of SED and SMI among Males was in SA 5 (32.6%) compared to SA 7 (30.5%) with the lowest percentage among the Medi-Cal enrolled population.

The highest prevalence of SED and SMI among Females was in SA 7 (69.5%) compared to SA 5 (67.4%) 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 2016

Service Area (SA)	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	177	31	44	134,191	47	166	86	26	16	49,997	179	169	185,129
Percent	0.10%	0.02%	0.02%	**72.49%**	0.03%	0.09%	0.05%	0.01%	0.01%	**27.01%**	0.10%	0.09%	100.00%
SA 2	59,917	189	482	407,933	9,939	6,088	729	180	5,426	258,859	3,689	3,661	757,092
Percent	**7.91%**	0.02%	0.06%	**53.88%**	**1.31%**	**0.80%**	0.10%	0.02%	**0.72**%	**34.19%**	**0.49%**	**0.48%**	100.00%
SA 3	2,212	1,068	33,352	348,887	376	4,011	45,670	6,285	139	172,474	2,017	20,891	637,382
Percent	0.35%	0.17%	**5.23%**	**54.74%**	0.06%	**0.63%**	**7.17%**	**0.99%**	0.02%	**27.06%**	0.32%	**3.28%**	100.00%
SA 4	6,990	649	8,116	224,278	602	20,582	1,432	724	5,070	206,841	3,438	1,666	480,388
Percent	**1.46%**	0.14%	**1.69%**	**46.69%**	0.13%	**4.28%**	0.30%	0.15%	**1.06%**	**43.06**%	**0.72%**	0.35%	100.00%
SA 5	75	14	104	81,131	4,051	645	377	108	1,455	18,274	125	132	106,491
Percent	0.07%	0.01%	0.10%	**76.19%**	**3.80%**	0.61%	0.35%	0.10%	1.37%	**17.16%**	0.12%	0.12%	100.00%
SA 6	19	106	185	316,115	30	1,505	80	21	35	305,976	169	65	624,306
Percent	0.003%	0.02%	0.03%	**50.63%**	0.005%	0.24%	0.01%	0.003%	0.01%	**49.01%**	0.03%	0.01%	100.00%
SA 7	634	1,035	1,091	279,128	61	3,633	1,637	305	89	237,725	1,141	880	527,359
Percent	0.12%	0.20%	0.21%	**52.93%**	0.01%	**0.69%**	0.31%	0.06%	0.02%	**45.08%**	0.22%	0.17%	100.00%
SA 8	90	5,719	505	339,624	408	4,216	849	251	226	166,220	2,149	3,022	523,279
Percent	0.02%	**1.09%**	0.10%	**64.90%**	0.08%	**0.81%**	0.16%	0.05%	0.04%	**31.77%**	0.41%	**0.58%**	100.00%
Total	70,114	8,811	43,879	2,131,287	15,514	40,846	50,860	7,900	12,456	1,416,366	12,907	30,486	3,841,426
Percent	1.83%	0.23%	1.14%	55.48%	0.40%	1.06%	1.32%	0.21%	0.32%	36.87%	0.34%	0.79%	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 and therefore not reported in the above table. A total of 6,524 (0.2%) individuals enrolled in Medi-Cal reported Arabic as their primary language in March 2016. Unknown Service Area is (164,530). A total of 9,835 (0.2%) individuals enrolled in Medi-Cal reported "Other" as a primary language. Data Source: State Medi-Cal Eligibility Data System (MEDS) File, March 2016.

Table 17 shows the thirteen (13) LACDMH threshold languages by Service Area (SA). Of the twelve Non-English threshold languages spoken among the population enrolled in Medi-Cal, Spanish had the highest percentage within the eight SAs.

The SA with the highest percentage of Medi-Cal enrolled population with English as the primary language was SA 5 (76.2%) and the lowest percentage was SA 4 (46.7%).

The Service Area with the highest percentage of Medi-Cal enrolled population with Spanish as the primary language was SA 6 (49.0%) and the lowest percentage was SA 5 (17.2%).

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

SA 1 has two (2) threshold languages: English (72.5%) and Spanish (27.0%).

SA 2 has eight (8) threshold languages: Armenian (7.9%), English (53.9%), Farsi (1.3%), Korean (0.8%), Russian (0.7%), Spanish (34.2%), Tagalog (0.5%), and Vietnamese (0.5%).

SA 3 has seven (7) threshold languages: Cantonese (5.2%), English (54.7%), Korean (0.6%), Mandarin (7.2%), Other Chinese (1.0%), Spanish (27.1%), and Vietnamese (3.3%).

SA 4 has seven (7) threshold languages: Armenian (1.5%), Cantonese (1.7%), English (46.7%), Korean (4.3%), Russian (1.1%), Spanish (43.1%), and Tagalog (0.7%).

SA 5 has three (3) threshold languages: English (76.2%), Farsi (3.8%), and Spanish (17.2%).

SA 6 has two (2) threshold languages: English (50.6%), and Spanish (49.0%).

SA 7 has three (3) threshold languages: English (52.9%), Korean (0.7%), and Spanish (45.1%).

SA 8 has five (5) threshold languages: Cambodian (1.1%), English (64.9%), Korean (0.8%), Spanish (31.8%), and Vietnamese (0.6%).

Countywide, the highest percentage of Medi-Cal Enrolled persons reported English as the primary language (55.5%) and the second highest percentage reported was Spanish (36.9%). All other threshold languages range between 0.2% (Cambodian, Other Chinese) and 1.8% (Armenian).

TABLE 18: DISTRIBUTION OF "OTHER" LANGUAGES SPOKEN BY POPULATION ENROLLED IN MEDI-CAL BY SERVICE AREA MARCH 2016

Service Area (SA)	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	Total
American Sign Language (ASL)	77	250	136	133	11	70	130	46	853
Percent	9.0%	29.3%	15.9%	15.6%	1.3%	8.2%	15.2%	5.4%	100.0%
French	8	34	12	38	26	31	8	32	189
Percent	4.2%	18.0%	6.3%	20.1%	13.8%	16.4%	4.2%	16.9%	100.0%
Hebrew		220	13	64	33	4	1	2	337
Percent	0.0%	65.3%	3.9%	19.0%	9.8%	1.2%	0.3%	0.6%	100.0%
Hmong		2	8	1	2	1	2	19	**32**
Percent	0.0%	6.3%	25.0%	3.1%	6.3%	3.1%	6.3%	59.4%	100.0%
Italian	1	23	12	10	3	1	3	15	68
Percent	1.5%	33.8%	17.6%	14.7%	4.4%	1.5%	4.4%	22.1%	100.0%
Japanese		88	125	196	81	29	36	155	710
Percent	0.0%	12.4%	17.6%	27.6%	11.4%	4.1%	5.1%	21.8%	100.0%
Lao	1	13	55	20	4	5	21	33	152
Percent	0.7%	8.6%	36.2%	13.2%	2.6%	3.3%	13.8%	21.7%	100.0%
Mien		1	2		1				4
Percent	0.0%	25.0%	50.0%	0.0%	25.0%	0.0%	0.0%	0.0%	100.0%
Other Sign Language	8	88	32	11	8	7	22	20	196
Percent	4.1%	44.9%	16.3%	5.6%	4.1%	3.6%	11.2%	10.2%	100.0%
Polish	2	27	6	18	7	1	3	2	66
Percent	3.0%	40.9%	9.1%	27.3%	10.6%	1.5%	4.5%	3.0%	100.0%
Portuguese	2	33	14	14	17	2	17	5	102
Percent	2.0%	32.4%	13.7%	13.7%	16.7%	2.0%	16.7%	4.9%	100.0%
Thai	5	658	327	509	30	27	124	44	1,724
Percent	0.3%	38.2%	19.0%	29.5%	1.7%	1.6%	7.2%	2.6%	100.0%
Turkish	4	37	15	10	7	3	15	1	92
Percent	4.3%	40.2%	16.3%	10.9%	7.6%	3.3%	16.3%	1.1%	100.0%
Ilocano	3	15	19	7	1	1	10	17	73
Percent	4.1%	20.5%	26.0%	9.6%	1.4%	1.4%	13.7%	23.3%	100.0%
Total	111	1,489	776	1,031	231	182	392	391	4,603
Percent	2.4%	32.3%	16.8%	22.4%	5.0%	3.9%	8.5%	8.5%	100.0%

Data Source: State Medi-Cal Eligibility Data System (MEDS) File, March 2016.

Table 18 shows the distribution of “Other” non-threshold languages spoken by population enrolled in Medi-Cal in March 2016 by Service Area (SA). The highest number of Medi-Cal enrollees that spoke “Other” non-threshold languages was Thai (N = 1,724) with the highest percent residing in SA 2 at 38.2%. The next highest number of Medi-Cal enrollees spoke American Sign Language (ASL; N = 853) with the highest percent also residing in SA 2 at 29.3%. Remaining languages spoken by Medi-Cal enrollees were Japanese (N = 710) with the highest percent residing in SA 4 at 27.6%, Hebrew (N = 337) with the highest percent residing in SA 2 at 65.3%, Other Sign Language (N = 196) with the highest percent residing in SA 2 at 44.9%, French (N = 189) with the highest percent residing in SA 4 at 20.1% and Lao (N = 152) with the highest percent residing in SA 3 at 36.2%.

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

Consumers Served in Outpatient Programs

In FY 15-16, LACDMH served approximately 277,000 consumers (unduplicated). A majority were served in outpatient programs (N = 217,028). Approximately 10,000 were served by Fee-For-Service (FFS) Outpatient network providers, another 39,000 were served in jails and juvenile halls and 20,000 were served in 24 Hour acute psychiatric care or residential facilities.

TABLE 19: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY ETHNICITY AND SERVICE AREA FY 2015–2016

Service Area (SA)	African American	Asian Pacific Islander	Latino	Native American	White	Total
SA1	5,160	129	5,245	96	3,065	13,695
Percent	37.7%	**0.9%**	38.3%	0.7%	22.4%	100.0%
SA2	3,614	1,037	16,326	131	8,970	30,078
Percent	12.0%	3.4%	54.3%	0.4%	29.8%	100.0%
SA3	3,173	2,312	16,334	144	4,194	26,157
Percent	12.1%	**8.8%**	62.4%	0.6%	16.0%	100.0%
SA4	10,227	2,628	21,055	394	6,265	40,569
Percent	25.2%	6.5%	51.9%	1.0%	15.4%	100.0%
SA5	2,348	257	2,638	52	3,420	8,715
Percent	26.9%	2.9%	**30.3%**	0.6%	**39.2%**	100.0%
SA6	15,774	292	15,465	55	1,168	32,754
Percent	**48.2%**	**0.9%**	47.2%	**0.2%**	**3.6%**	100.0%
SA7	2,223	556	18,108	335	2,352	23,574
Percent	**9.4%**	2.4%	**76.8%**	**1.4%**	10.0%	100.0%
SA8	9,640	1,588	14,769	160	6,131	32,288
Percent	29.9%	4.9%	45.7%	0.5%	19.0%	100.0%
Total	46,800	9,340	106,094	1,065	33,982	197,281
Percent	23.7%	4.7%	53.8%	0.5%	17.2%	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 = 13,249), Multi-race (N = 2,191) and "Other" (N = 4,307). Total reflects an unduplicated count of consumers served. Data Source: LACDMH-IS-IBHIS, December 2016.

Differences by Ethnicity

The highest percentage of African American (AA) consumers served in outpatient programs was in SA 6 (48.2%) as compared to SA 7 (9.4%) with the lowest percentage.

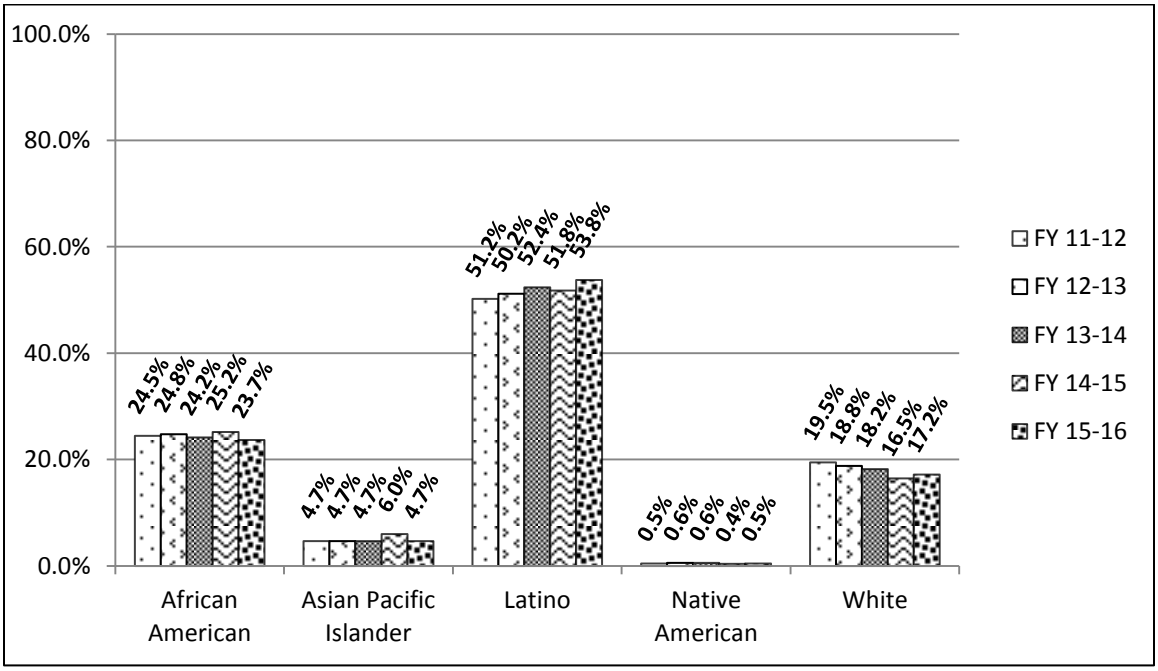
The highest percentage of Asian Pacific Islander (API) consumers served in outpatient programs was in SA 3 (8.8%) as compared to SAs 1 and 6 (0.9%) with the lowest percentage.

The highest percentage of Latino consumers served in outpatient programs was in SA 7 (76.8%) as compared to SA 5 (30.3%) with the lowest percentage.

The highest percentage of Native American (NA) consumers served in outpatient programs was in SA 7 (1.4%) as compared to SA 6 (0.2%) with the lowest percentage.

The highest percentage of White consumers served in outpatient programs was in SA 5 (39.2%) as compared to SA 6 (3.6%) with the lowest percentage.

FIGURE 9: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY ETHNICITY FY 2011–2012 TO FY 2015–2016



Data Source: LACDMH-IS-IBHIS, December 2016.

As a percentage of consumers served, African Americans (AA) served in outpatient programs decreased by 0.8 Percentage Points (PP), from 24.5% to 23.7% between FY 11–12 and FY 15–16.

As a percentage of consumers served, Asian Pacific Islanders (API) served in outpatient programs has remained unchanged at 4.7% between FY 11–12 and FY 15–16.

As a percentage of consumers served, Latinos served in outpatient programs increased by 2.6 PP, from 51.2% to 53.8% between FY 11–12 and FY 15–16.

As a percentage of consumers served, Native Americans (NA) served in outpatient programs has remained unchanged at 0.5% between FY 11–12 and FY 15–16.

As a percentage of consumers served, Whites served in outpatient programs decreased by 2.3 PP, from 19.5% to 17.2% between FY 11–12 and FY 15–16.

TABLE 20: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP AND SERVICE AREA FY 2015–2016

Service Area (SA)	Children (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)	Total
SA1	5,716	3,551	5,648	631	15,546
Percent	36.8%	**22.8%**	36.3%	**4.1%**	100.0%
SA2	11,455	7,061	14,382	2,703	35,601
Percent	32.2%	19.8%	40.4%	7.6%	100.0%
SA3	13,693	5,663	9,912	1,753	31,021
Percent	**44.1%**	18.3%	32.0%	5.7%	100.0%
SA4	14,584	7,874	17,572	4,019	44,049
Percent	33.1%	17.9%	39.9%	9.1%	100.0%
SA5	2,316	1,423	5,200	1,213	10,152
Percent	**22.8%**	**14.0%**	**51.2%**	**11.9%**	100.0%
SA6	13,434	5,184	14,970	2,227	35,815
Percent	37.5%	14.5%	41.8%	6.2%	100.0%
SA7	11,537	5,811	8,093	1,407	26,848
Percent	43.0%	21.6%	**30.1%**	5.2%	100.0%
SA8	12,734	5,555	16,588	2,890	37,767
Percent	33.7%	14.7%	43.9%	7.7%	100.0%
Total	77,212	34,911	82,962	16,067	211,152
Percent	36.6%	16.5%	39.3%	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, December 2016.

Differences by Age Group

Table 20 shows the number of consumers served in outpatient programs by Age Group and Service Area (SA).

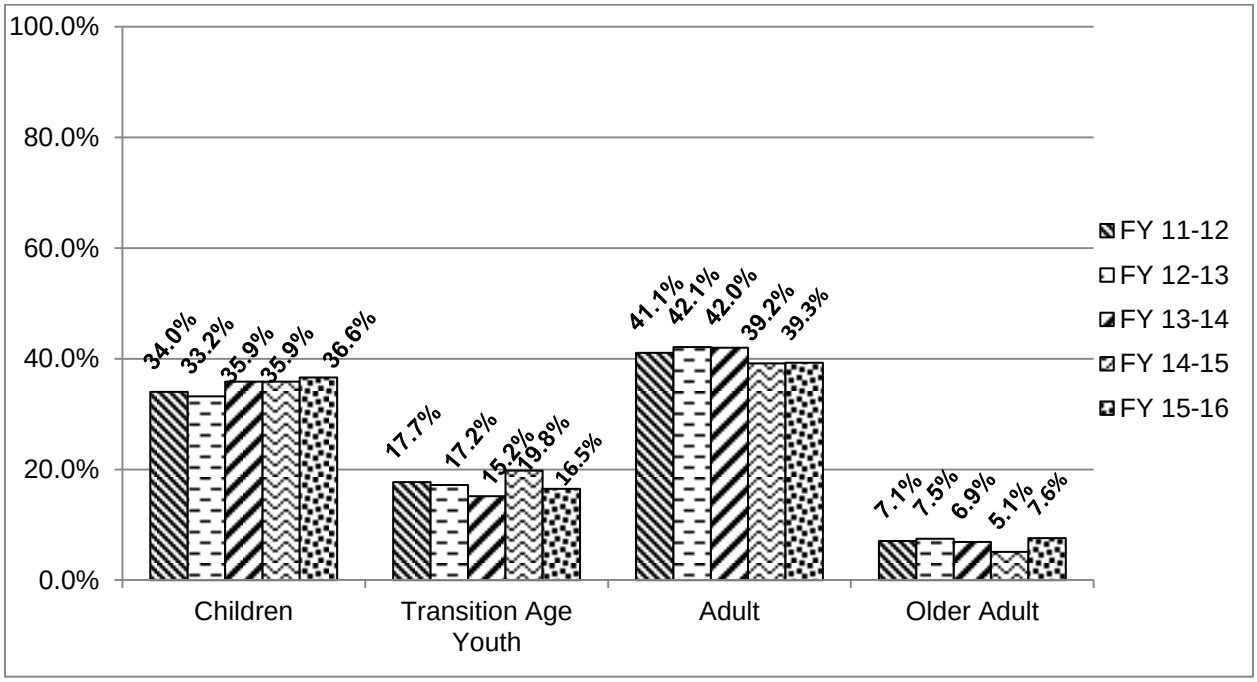
The highest percentage of Children (0-15 years old) served was in SA 3 (44.1**%)** compared to SA 5 (22.8%) with the lowest percentage.

The highest percentage of Transition Age Youth (TAY; 16-25 years old) was in SA 1 (22.8%) when compared to SA 5 (14.0%) with the lowest percentage.

The highest percentage of Adults (26-59 years old) served was in SA 5 (51.2%) compared to SA 7 (30.1%) with the lowest percentage.

The highest percentage of Older Adults (60+ years old) was in SA 5 (11.9%) compared to SA 1 (4.1%) with the lowest percentage.

FIGURE 10: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP FY 2011–2012 TO FY 2015–2016



Data Source: LACDMH-IS-IBHIS, December 2016.

As a percentage of consumers served, Children served in outpatient programs increased by 2.6 Percentage Points (PP), from 34.0% to 36.6% between FY 11–12 and FY 15–16.

As a percentage of consumers served, TAY served in outpatient programs decreased by 1.2 PP from 17.7% to 16.5% between FY 11–12 and FY 15–16.

As a percentage of consumers served, Adults served in outpatient programs decreased by 1.8 PP, from 41.1% to 39.3% between FY 11–12 and FY 15–16

As a percentage of consumers served, Older Adults served in outpatient programs increased by 0.5 PP, from 7.1% to 7.6% between FY 11–12 and FY 15–16.

TABLE 21: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER AND SERVICE AREA FY 2015–2016

Service Area (SA)	Male	Female	Total
SA1	7,998	7,528	15,526
Percent	51.5%	48.5%	100.0%
SA2	17,992	17,595	35,587
Percent	50.6%	49.4%	100.0%
SA3	15,992	15,025	31,017
Percent	51.6%	48.4%	100.0%
SA4	23,557	20,444	44,001
Percent	**53.5%**	**46.5%**	100.0%
SA5	5,134	5,014	10,148
Percent	50.6%	49.4%	100.0%
SA6	17,719	18,084	35,803
Percent	49.5%	50.5%	100.0%
SA7	13,750	13,091	26,841
Percent	51.2%	48.8%	100.0%
SA8	18,561	19,187	37,748
Percent	**49.2%**	**50.8%**	100.0%
Total	105,203	105,832	211,035
Percent	49.8%	50.2%	100.0%

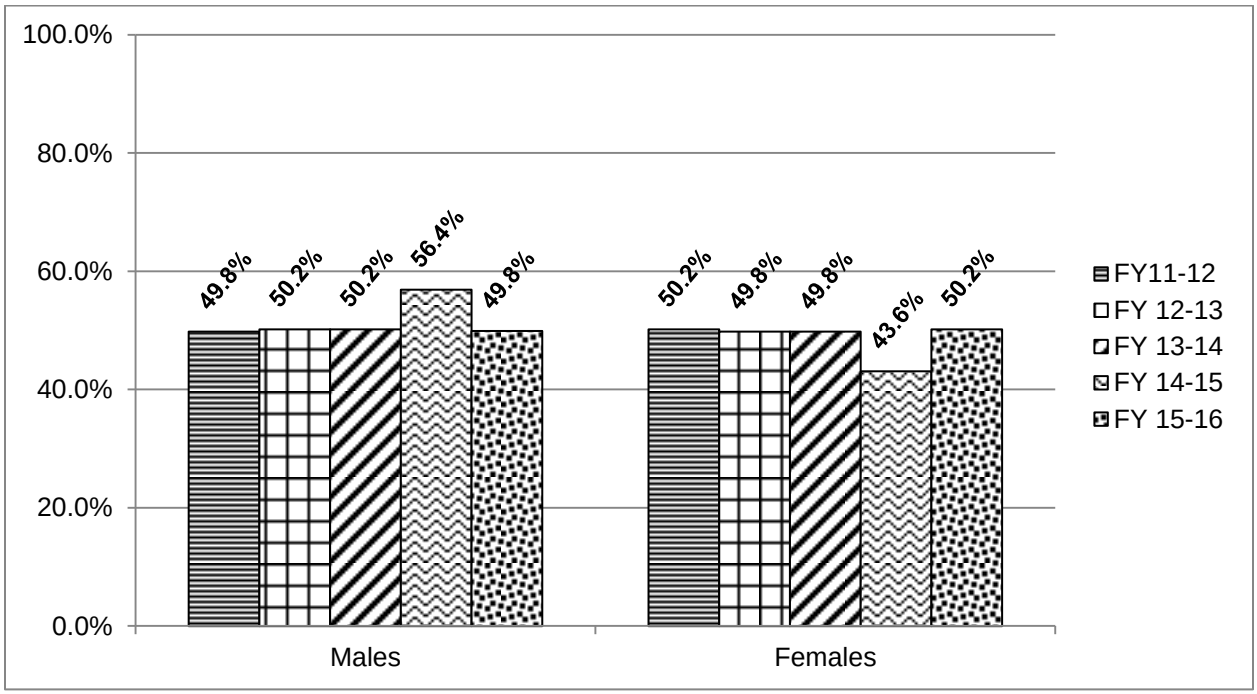
Note: Bold values represent the highest and lowest percentages within each Gender and across Service Areas. Unknown/Not reported Gender (N=130) were not included in this table. Data Source: LACDMH-IS-IBHIS, December 2016.

Differences by Gender

The highest percentage of Males served in outpatient programs was in SA 4 (53.5%) compared to SA 8 (49.2%).

The highest percentage of Females served in outpatient programs was in SA 8 (50.8%) compared to SA 4 (46.5%) with the lowest percentage.

FIGURE 11: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER FY 2011–2012 TO FY 2015–2016



Data Source: LACDMH-IS-IBHIS Database, December 2016

As a percentage of consumers served, Males served in outpatient programs remained at 49.8% between FY 11–12 and FY 15–16.

As a percentage of consumers served, Females served in outpatient programs remained at 50.2% between FY 11–12 and FY 15–16.

TABLE 22: PRIMARY LANGUAGE OF CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY SERVICE AREA AND THRESHOLD LANGUAGE FY 2015–2016

Service Area (SA)	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	3	0	1	9,936	5	1	9	0	0	1,015	5	2	10,977
Percent	0.02%	0.0%	0.01%	**74.6%**	0.04%	0.01%	0.07%	0.00%	0.0%	**7.6%**	0.04%	0.02%	100.0%
SA 2	1,001	19	10	20,370	326	60	13	16	81	5,408	92	41	27,437
Percent	**3.1%**	0.1%	0.03%	**63.9%**	**1.0%**	**0.19%**	0.04%	0.05%	**0.3%**	**17.0%**	**0.29%**	**0.1%**	100.0%
SA 3	65	19	413	16,937	5	26	290	82	2	4,076	30	213	22,158
Percent	0.2%	0.1%	**0.20%**	**61.2%**	0.02%	**0.09%**	**1.10%**	**0.30%**	0.01%	**14.7%**	0.11%	**0.4%**	100.0%
SA 4	205	123	137	24,033	93	686	120	35	85	7,544	99	132	33,292
Percent	**0.5%**	0.3%	**0.34%**	**60.1%**	0.2%	**1.71%**	0.30%	0.09%	**0.2%**	**18.9%**	**0.25%**	0.3%	100.0%
SA 5	5	0	2	6,921	64	7	4	2	14	682	5	0	7,706
Percent	0.1%	0.0%	0.02%	**76.3%**	**0.7%**	0.08%	0.78%	0.02%	0.2%	**7.5%**	0.06%	0.00%	100.0%
SA 6	1	2	11	22,224	6	37	16	3	3	6,280	7	10	28,600
Percent	0.00%	0.01%	0.03%	**69.4%**	0.02%	0.12%	0.05%	0.01%	0.01%	**19.6%**	0.02%	0.03%	100.0%
SA 7	9	41	8	14,219	2	50	38	3	1	5,151	29	6	19,557
Percent	0.04%	0.2%	0.03%	**59.3**%	0.01%	**0.21%**	0.16%	0.01%	0.0%	**21.5%**	0.12%	1.0%	100.0%
SA 8	7	691	7	21,267	6	94	26	15	1	5,385	89	176	27,764
Percent	0.02%	**2.1%**	0.02%	**64.1%**	0.02%	**0.28%**	0.08%	0.05%	0.0%	**16.2%**	0.27%	**0.5%**	100.0%
Total	1,296	895	589	135,907	507	961	516	156	187	35,541	356	580	177,491
Percent	0.7%	0.5%	0.3%	76.6%	0.3%	0.5%	0.3%	0.1%	0.1%	20.0%	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. 802 consumers served in Outpatient Programs specified another non-threshold primary language show in in Table 23. Another 31,845 consumers had primary languages that were "Unknown" or "Missing". Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level and is not reported in the above table. A total of 146 Arabic speaking consumers were served in FY 15-16. Data Source: LACDMH-IS-IBHIS, December 2016.

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

English was the highest primary language among consumers served in outpatient programs, in all SAs. A total of 135,907 (76.6%) English speaking consumers were served, followed by 35,541 (20.0%) Spanish speaking consumers and the remaining 6,043 (3.4%) consumers served spoke other LACDMH threshold languages. A total of 41,584 (23.4%) of the consumers served reported a primary language other than English.

SA 5 (76.3%) had the highest percentage of English speaking consumers, as compared to SA 7 (59.3%) which had the lowest percentage.

Spanish was the highest reported non-English threshold language for consumers served in all SAs. The SA with the highest percentage of consumers served reporting Spanish as their primary language was in SA 7 (21.5%) and the lowest percentage was in SA 5 (7.5%).

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

- SA 1: Spanish (7.6%);
- SA 2: Armenian (3.1%), Farsi (1.0%), Korean (0.2%), Russian (0.3%), Spanish (17.0%), Tagalog (0.3%), and Vietnamese (0.1%);
- SA 3: Cantonese (0.2%), Korean (0.1%), Mandarin (1.1%), Other Chinese (0.3%), Spanish (14.7%), and Vietnamese (0.4%);
- SA 4: Armenian (0.5%), Cantonese (0.3%), Korean (1.7%), Russian (0.2%), Spanish (18.9%), and Tagalog (0.3%);
- SA 5: Farsi (0.7%) and Spanish (7.5%);
- SA 6: Spanish (19.6%);
- SA 7: Korean (0.2%) and Spanish (21.5%); and
- SA 8: Cambodian (2.1%), Korean (0.3%), Spanish (16.2%), and Vietnamese (0.5%).

TABLE 23: "OTHER" NON-THRESHOLD LANGUAGES SPOKEN BY CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY SERVICE AREA FY 2015–2016

Languages	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	Total
Afghan, Pashto, Pusho		25							25
Percent		100.0%							100.0%
American Sign Language		11	59	22	5		12	10	119
Percent		9.2%	49.6%	18.5%	4.2%		10.1%	8.4%	100.0%
Burmese			8						8
Percent			100.0%						100.0%
Ethiopian				19					19
Percent				100.0%					100.0%
French			7	10				5	22
Percent			31.8%	45.5%				22.7%	100.0%
Hebrew		16						5	21
Percent		76.2%						23.8%	100.0%
Hindi				7					7
Percent				100.0%					100.0%
Japanese			8	30	7	6		45	96
Percent			8.3%	31.3%	7.3%	6.3%		46.9%	100.0%
Lao				45				18	63
Percent				71.4%				28.6%	100.0%
Portuguese		6							6
Percent		100.0%							100.0%
Punjabi		8							8
Percent		100.0%							100.0%
Romanian				7					7
Percent				100.0%					100.0%
Thai		13	8	37				7	65
Percent		20.0%	12.3%	56.9%				10.8%	100.0%
Toisan			19	8					27
Percent			70.4%	29.6%					100.0%
Urdu		7						10	17
Percent		41.2%						58.8%	100.0%
Other Non-English		70	24	84	27	15	16	41	277
Percent		25.3%	8.7%	30.3%	9.7%	5.4%	5.8%	14.8%	100.0%
Total	0	160	136	275	39	21	28	143	802
Percent	0.0%	20.0%	16.9%	34.2%	4.9%	2.6%	3.5%	17.8%	100.0%

Data Source: LACDMH-IS-IBHIS, December 2016.

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 4 (N = 275), followed by SA 2 (N = 160).

There were a total of 119 consumers whose primary language was American Sign Language (ASL). SA 3 served the highest number of ASL consumers (59), followed by SA 4 (22). The lowest number of ASL consumers served was in SA 5 (5).

Nearly 96 consumers spoke Japanese, followed by 65 consumers who spoke Thai and 63 consumers who spoke Lao.

SECTION 3

QI WORK PLAN EVALUATION REPORT FOR CY 2016

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 Quality Improvement, the LACDMH evaluation of Quality Improvement 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 2016 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 the LACDMH.

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

QUALITY IMPROVEMENT WORK PLAN EVALUATION SUMMARY – CY 2016

I. MONITORING SERVICE DELIVERY CAPACITY

1. *Between 49% and 55% of Latinos estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Outpatient facilities in FY 15-16.* ***This goal was met.***
2. *Between 41.6% and 43.6% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Outpatient facilities in FY 15-16.* ***This goal was not met.***
3. *Maintain the number of clients served by tele-psychiatry in CY 2016 at a minimum of 650.* ***This goal was 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 contracted and/or directly operated agencies to improve their skills for assessment and treatment of this population.* ***This goal was met.***

II. MONITORING ACCESSIBILITY OF SERVICES

1. *Maintain the percentage of after-hours PMRT responses with a response time of one hour or less at 71%.* ***This goal was met.***

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

2b. *Sixty-five percent of daytime calls to the toll free hotline are answered by a live agent within 1 minute from when they present to the VCC of the toll free hotline.* ***This goal was met.***

3. *Maintain the percentage of completed test calls to the toll free hotline in CY 2016 at a minimum of 95%.* ***This goal was met.***
4. *Monitor the number of assigned appointments for hearing impaired interpreter services coordinated by the toll free hotline for FY 15-16.* ***This goal was met.***
5. *Maintain the percentage of consumers/families reporting that they are able to receive services at convenient locations between 83% and 85% for the May 2016 survey period.* ***This goal was met.***
6. *Maintain the percentage of consumers/families reporting that they are able to receive services at convenient times between 88% and 90% for the May 2016 survey period.* ***This goal was met.***

III. MONITORING BENEFICIARY SATISFACTION

1. *Maintain the percentage of consumers/families reporting that staff was sensitive to their cultural/ethnic background between 86% and 88% for the May 2016 survey period.* ***This goal was met.***
2. *Maintain the percentage of consumers/families reporting overall satisfaction with services provided between 84% and 86% for the May 2016 survey period and continue year-to-year trending of the data.* ***This goal was met.***

3a. *Monitor the grievances, appeals and requests for State Fair Hearings for FY 15-16.* ***This goal was met.***

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

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

4. *Monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their change of provider requests.* ***This goal was met.***

IV. MONITORING CLINICAL CARE

1. *Address evolving standards and requirements associated with the use of medication in mental health programs through systematic 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.* ***This goal was met.***
2. *Continue to improve Clinical Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders (COD) through on-site and online trainings and Annual State Wide Integrated Care Conference targeting LACDMH Directly Operated and LE Contracted programs.* ***This goal was met.***
3. *Continue to improve Clinical Care for Older Adult consumers with mental illness with or at risk for involvement in the Criminal Justice System through providing a series of trainings to staff of both LE contracted and/or DO agencies.* ***This goal was met.***

V. MONITORING CONTINUITY OF CARE

1. *At least 90% 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.* ***This goal was not met.***
2. *Improve Continuity of Care for Older Adult consumers with mental illness with or at risk for involvement in the Criminal Justice System through providing consultation on complex cases to enhance treatment planning and intervention process.* ***This goal was met.***

VI. MONITORING OF PROVIDER APPEALS

1. *The MHP will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal.* ***This goal was met.***

I. MONITORING SERVICE DELIVERY CAPACITY

Goal I.1.

Between 49% and 55% of Latinos estimated with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) at or below 138% Federal Poverty Level (FPL) will be served in LACDMH Outpatient facilities in Fiscal Year (FY) 15–16.

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 2013 and CY 2014). 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 Service Area (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. Approximately 53.2% of Latinos estimated with SED and SMI at or below 138% FPL were served in FY 15–16. Table 24A shows the penetration rates for FY 13–14, FY 14–15 and FY 15–16 using prevalence estimates from CHIS survey data.

Goal I.2.

Between 41.6% and 43.6% of Asian Pacific Islanders (API) estimated with SED and SMI at or below 138% FPL will be served in LACDMH Outpatient facilities in FY 15–16.

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.

Prevalence rates utilized to estimate SED and SMI were derived from the California Health Interview Survey (CHIS; CY 2013 and CY 2014). 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 population of Los Angeles County 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 not met. A total of 35.6% API estimated with SED and SMI and living at or below 138% FPL were served in FY 15-16. Table 24A shows the penetration rates for FY 13–14, FY 14–15 and FY 15–16 using prevalence estimates from CHIS survey data.

Although the Penetration Rate for API declined, the number of API consumers served actually increased from 9,171 in FY 14–15 to 9,340 in FY 15–16. Due to an increase in the prevalence rate from the CHIS survey for the API population from 7.3% in CY 11–12 to 9.9% in CY 13–14, the Penetration Rate was lower for the API in FY 15–16 despite the decrease in percent of API population living at or below 138% FPL from 9.8% in CY 2012 to 9.6% in CY 2015.

A similar increase in the API prevalence rate was also observed by the CHIS survey in CY 12–13 at 10.6%. Due to the non-availability of this data from CHIS at the time of completing the CY 2015 QI Evaluation Report, this rate for the API population was not applied to the Penetration Rate for FY 14–15 and the rate of 7.3% from CY 11-12 was applied instead.

TABLE 24A: THREE YEAR TREND IN PENETRATION RATE BY ETHNICITY FOR POPULATION LIVING AT OR BELOW 138% FPL BASED ON PREVALENCE RATE FROM CHIS[1] FY 2013-2014 TO FY 2015-2016

Ethnicity	FY 13-14	FY 14-15	FY 15-16
African American	112.9%	129.0%	150.0%
Consumers Served	47,343	56,011	46,800
Estimated population with SED/SMI	41,939	43,419	31,201
Asian Pacific Islander	47.5%	48.5%	35.6%
Consumers Served	9,117	9,171	9,340
Estimated population with SED/SMI	19,208	18,918	26,233
Latino	50.0%	51.5%	53.2%
Consumers Served	102,640	106,891	106,094
Estimated population with SED/SMI	205,131	207,651	199,531
Native American	103.6%	95.9%	31.9%
Consumers Served	1,192	1,184	1,065
Estimated population with SED/SMI	1,151	1,235	3,340
White	82.4%	97.0%	31.8%
Consumers Served	35,710	40,810	33,982
Estimated population with SED/SMI	43,337	42,052	107,004

Note: Ethnic specific Prevalence Rate for SED for Youth and SMI for Adults from CY 2013 and CY 2014 California Health Interview Survey (CHIS) [1] were applied to calculate Penetration Rate. Data Source: LACDMH-IS Database, December 2016.

TABLE 24B: PENETRATION RATE AMONG TOTAL POPULATION AND POPULATION LIVING AT OR BELOW 138% FPL BY ETHNICITY AND SERVICE AREA

Ethnicity and Service Area	[1]Number of Consumers Served[1]	Total Population Estimated with SED and SMI	Penetration Rates for Total Population[2]	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI	Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2]
SA 1					
African American	5,160	4,950	104.2%	2,481	208.0%
Asian Pacific Islander	129	860	15.0%	253	51.0%
Latino	5,245	17,765	29.5%	6,936	75.6%
Native American	96	1,167	8.2%	293	32.8%
White	3,065	12,759	24.0%	6,532	46.9%
Total	13,695	37,501	36.5%	16,495	83.0%
SA 2					
African American	3,614	6,055	59.7%	2,022	178.7%
Asian Pacific Islander	1,037	14,153	7.3%	3,653	28.4%
Latino	16,326	89,528	18.2%	32,045	50.9%
Native American	131	2,946	4.4%	508	25.8%
White	8,970	92,400	9.7%	36,841	24.3%
Total	30,078	205,082	14.7%	75,069	40.1%
SA 3					
African American	3,173	5,100	62.2%	1,502	211.3%
Asian Pacific Islander	2,312	28,358	8.2%	8,808	26.2%
Latino	16,334	83,307	19.6%	25,328	64.5%
Native American	144	2,218	6.5%	359	40.1%
White	4,194	35,459	11.8%	12,571	33.4%
Total	26,157	154,442	16.9%	48,568	53.9%
SA 4					
African American	10,227	4,715	216.9%	2,036	502.3%
Asian Pacific Islander	2,628	11,548	22.8%	5,597	47.0%
Latino	21,055	60,502	34.8%	29,655	71.0%
Native American	394	1,567	25.1%	532	74.1%
White	6,265	26,870	23.3%	15,825	39.6%
Total	40,569	105,202	38.6%	53,644	75.6%
SA 5					
African American	2,348	2,896	81.1%	796	295.0%
Asian Pacific Islander	257	5,144	5.0%	1,621	15.9%
Latino	2,638	10,574	24.9%	2,687	98.2%
Native American	52	726	7.2%	87	59.8%
White	3,420	39,265	8.7%	14,075	24.3%
Total	8,715	58,605	14.9%	19,266	45.2%

TABLE 24B (CONTD.): PENETRATION RATE AMONG TOTAL POPULATION AND POPULATION LIVING AT OR BELOW 138% FPL BY ETHNICITY AND SERVICE AREA FY 2015–2016

Ethnicity and Service Area	[1]Number of Consumers Served[1]	Total Population Estimated with SED and SMI	Penetration Rates for Total Population[2]	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI	Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2]
SA 6					
African American	15,774	22,088	71.4%	13,211	119.4%
Asian Pacific Islander	292	1,075	27.2%	808	36.1%
Latino	15,465	71,538	21.6%	42,361	36.5%
Native American	55	1,113	4.9%	555	9.9%
White	1,168	2,365	49.4%	2,294	50.9%
Total	32,754	98,179	33.4%	59,229	55.3%
SA 7					
African American	2,223	3,105	71.6%	1,014	219.2%
Asian Pacific Islander	556	6,726	8.3%	1,524	36.5%
Latino	18,108	97,205	18.6%	34,063	53.2%
Native American	335	1,995	16.8%	404	82.9%
White	2,352	17,256	13.6%	6,532	36.0%
Total	23,574	126,287	18.7%	43,537	54.1%
SA 8					
African American	9,640	17,835	54.1%	8,141	118.4%
Asian Pacific Islander	1,588	13,996	11.3%	3,969	40.0%
Latino	14,769	63,330	23.3%	26,456	55.8%
Native American	160	2,651	6.0%	601	26.6%
White	6,131	41,471	14.8%	12,335	49.7%
Total	32,288	139,283	23.2%	51,502	62.7%
Unduplicated Consumers Served in At least 1 Service Area					
African American	46,800	66,742	70.1%	31,201	150.0%
Asian Pacific Islander	9,340	81,860	11.4%	26,233	35.6%
Latino	106,094	493,749	21.5%	199,531	53.2%
Native American	1,065	14,383	7.4%	3,340	31.9%
White	33,982	267,845	12.7%	107,004	31.8%
Total	197,281	924,579	21.3%	367,309	53.7%

Data Source: Prevalence Rate by Ethnicity from 2013–2014 California Health Interview Survey (CHIS). Note: [1]Number of Consumers Served represents consumers served by LACDMH in outpatient programs and Day Treatment Facilities. The count does not include consumers served by 24 Hour/Residential Facilities such as Acute Care Inpatient Hospitals etc. [2]Penetration Rate = Number of Consumers Served / Number of People Estimated with SED and SMI. In some Service Areas, Penetration Rates for some ethnic groups exceed 100% because of small distribution of that population in that Service Area.

TABLE 25: ESTIMATED PREVALANCE RATES FOR SED AND SMI BY CALIFORNIA HEALTH INTERVIEW SURVEY (CHIS) WITH CONFIDENCE INTERVALS: 2011–2012 TO 2013–2014

Total Population						
	2011-12	Confidence Interval	2012-13	Confidence Interval	2013-14	Confidence Interval
Total	8.0%	(7.1-8.9)	8.3%	(7.4 - 9.3)	9.1%	(8.0 - 10.1)
African American	7.8%	(5.0-10.6)	9.6%	(6.2 - 13.1)	7.7%	(4.1 - 11.2)
API	6.9%	(4.4-9.4)	5.6%	(3.7 - 7.4)	5.5%	(3.1 - 7.9)
Latino	8.6%	(7.2-10.0)	9.0%	(7.4 - 10.6)	10.0%	(8.2 - 11.9)
Native American	19.4%*	(1.6-37.2)	-	-	73.0%*	(46.3 - 99.6)
White	7.7%	(6.2-9.3)	7.9%	(6.1 - 9.8)	9.3%	(7.1 - 11.6)
Two or More Races	6.9%*	(0.7-13.1)	17.2%*	(3.1 - 31.4)	13.7%*	(1.0 - 26.4)
Population at or Below 138% FPL						
	2011-12	Confidence Interval	2012-13	Confidence Interval	2013-14	Confidence Interval
Total	11.4%	(9.5 - 13.3)	12.4%	(10.1 - 14.6)	12.5%	(10.2 - 14.9)
African American	15.8%	(9.0 - 22.6)	18.9%	(9.7 - 28.1)	11.6%*	(3.6 - 19.6)
API	7.3%	(3.1 - 11.5)	10.6%*	(3.6 - 17.6)	9.9%*	(3.0 - 16.9)
Latino	11.4%	(9.0 - 13.8)	11.4%	(8.9 - 13.9)	11.2%	(8.5 - 13.8)
Native American	24.0%*	(0.0 - 63.2)	-	-	63.1%*	(41.9 - 84.3)
White	11.0%	(5.8 - 16.2)	14.5%*	(4.1 - 24.9)	25.1%	(13.5 - 36.7)
Two or More Races	14.8%*	(0.0 - 37.7)	23.5%*	(0 - 51.4)	16.8%*	(0 - 36.6)
Population at or Below 200% FPL						
	2011-12	Confidence Interval	2012-13	Confidence Interval	2013-14	Confidence Interval
Total	10.7%	(9.1-12.3)	10.9%	(9.2 - 12.7)	11.7%	(9.5 - 13.8)
African American	14.0%	(8.6-19.5)	15.4%	(8.8 - 22.0)	10.2%	(4.4 - 16.0)
API	5.3%	(2.4-8.2)	7.6%	(3.4 - 11.9)	7.3%*	(3.0 - 11.5)
Latino	10.6%	(8.6-12.6)	9.9%	(7.9 - 11.8)	10.3%	(8.0 - 12.7)
Native American	19%*	(0.0-40.7)	-	-	62.8%*	(41.7 - 84.0)
White	13.0%	(8.1-7.8)	15.1%	(7.4 - 22.8)	23.5%	(14.6 - 32.3)
Two or More Races	14.1%*	(0.0-32.1)	30.7%*	(0.3 - 61.0)	24.2%*	(0 - 49.6)

* = Statistically Unreliable. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 and California Health Interview Survey (CHIS), CY 2013 & CY 2014.

Goal I.3.

Maintain the number of clients served by tele-psychiatry in CY 2016 at a minimum of 650.

EVALUATION

This goal has been met. In CY 2016, 1,338 consumers were served through tele-psychiatry appointments. This represents a 42% increase over the 941 consumers served by tele-psychiatry in CY 2015. Stability in tele-psychiatry staffing for CY 2016 led to an expansion of services to Service Area (SA) 1. This expansion assisted with the shortage of psychiatrists for SA 1 and contributed to the 42% increase in CY 2016. It is difficult to recruit staff to this remote part of the county. The tele-psychiatry expansion contributed an increase in services for CY 2016.

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 LE Contracted and/or DO agencies to improve their skills for assessment and treatment of this population.

EVALUATION

This goal has been met. The Lesbian, Gay, Bisexual, Transgender, Queer and Questioning, Intersex, and Two-Spirit (LGBTQI2-S) Youth FY 14–15 Capacity Building Project was managed by the Underserved Cultural Communities (UsCC)/Innovations (INN) Unit of the Quality Improvement Division at LACDMH. This project was created in support of reducing disparities and increasing mental health access for the LGBTQI2-S community within Los Angeles County. The UsCC/INN Unit contracted with Stars Inc. and the Los Angeles LGBT Center who were responsible for facilitating and developing a curriculum that was based on current research and best practices for working with LGBTQ youth. Four (4) 12-hour, two-day trainings were conducted for a total of 8 training days and were held in Los Angeles County Service Area (SA) 2, SA 4, SA 6, and SA 8. A total of 130 individuals attended from 27 LE Contracted and DO agencies.

Pre and post tests were developed for this training in order to measure knowledge about LGBTQ concepts, terminology, and challenges and risks that are unique to this population. Training participants were instructed to complete a pre-test at the start of Day 1 of the training series, and a post-test at the end of Day 2. Based on the 105 post-tests and the 114 pre-tests, the overall LGBTQ knowledge (i.e.: LGBTQ terminology, coming out process, engaging LGBTQ youth, assessing risk factors for suicide/bullying, religion/spirituality, and relationship/intimacy) increased by 8.0 Percentage Points (PP) across all SAs. Participants showed the most improvement on the question related to how to create an LGBTQ-supportive environment, with an increase of 19 PP from pre to post-test (62% and 81% respectively). Post-test results indicated that participants had an improved understanding of what defines sexual orientation; scores improved from 41% correct on the pre-test to 60% correct on the post-test. The majority of participants

across all SAs rated the usefulness, content, and delivery of the training curriculum highly in the evaluation and comments section.

Ninety-eight percent of the training's participants 'strongly agreed' or 'agreed' with evaluation question #1: "This training helped me understand how to support and provide Mental Health services to LGBTQ youth." Ninety-nine percent of the training's participants 'strongly agreed' or 'agreed' with evaluation question #2: "The training was easy to understand." Ninety-one percent of participants reported the pace of the training as "just right." In regards to question # 4: "Which areas did you find most helpful to you as a Mental Health Service Provider," the majority of participants (approximately 89%) checked the boxes: The "Coming Out" Process, Bias, Engaging LGBTQ Youth and Assessing Risk-Suicide and bullying.

II. MONITORING ACCESSIBILITY OF SERVICES

Goal II.1.

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

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 has been fully met. The annual average percent of after-hours PMRT response time of one hour or less was maintained at 71% in CY 2016.

TABLE 26: PSYCHIATRIC MOBILE RESPONSE TEAM (PMRT) AFTER HOURS RESPONSE RATES OF ONE HOUR OR LESS CY 2012–2016

Month	2012	2013	2014	2015	2016
January	69%	75%	75%	72%	70%
February	64%	68%	73%	70%	74%
March	66%	68%	73%	69%	74%
April	61%	72%	72%	68%	73%
May	66%	71%	71%	70%	73%
June	65%	71%	73%	73%	73%
July	70%	71%	74%	75%	74%
August	70%	71%	76%	72%	75%
September	65%	74%	73%	69%	70%
October	67%	75%	74%	71%	66%
November	70%	73%	67%	70%	63%
December	N/A[1]	74%	73%	71%	71%
Annual Total	**3,984**	**4,859**	**5,824**	**3,670**	**3,904**
Annual Average %	**67%**	**72%**	**73%**	**71%**	**71%**

Note: [1]December 2012 data was not available due to transition to the new phone monitoring system on November 27, 2012. Data Source: LACDMH ACCESS Center, CY 2012 – CY 2016.

LACDMH utilizes the ACCESS Center 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.

Table 26 shows that in CY 2016, an average of 71% of PMRT after hours calls resulted in mobile teams being present at the scene within one hour or less from acknowledgement of receipt of the call. When compared to CY 2015, the percentage of PMRT after-hours mobile team response times remained the same in CY 2016.

In January 2016, the former Emergency Outreach Bureau (EOB) implemented a large scale recruitment effort for after-hours responders in the PMRT program. This project was undertaken to: 1) Increase the pool of after-hours clinicians available for service calls throughout the county; 2) Decrease stress and burn out amongst PMRT staff while improving morale; and 3) Stabilize the after-hours staffing pattern allowing for more efficient mobilization/deployment, faster arrival times, and overall, improved quality of care. The initial goal to recruit 30 licensed or licensed waivered staff to work overtime in the PMRT program was met and exceeded. In March 2016, a total of 69 clinicians (more than double the projected number) were recruited. They participated in a 1-day orientation session followed by assignment to an appropriate PMRT unit, received individual training/shadowing, and ultimately were scheduled on the after-hours calendar to work no less than two (2) after-hours shifts per month.

The long term plan to stabilize PMRT after-hours operations was also initiated in CY 2016. In March 2016, the EOB Deputy and Program Manager identified 5 EOB vacancies (1 Senior Mental Health Counselor RN-Supervisor; 2 Psychiatric Social Workers and 2 Psychiatric Technicians) that could be re-allocated to start a dedicated after-hours program. The hiring process began in June 2016 for the clinicians with the final offer of employment for the Supervisory position occurring in late 2016. The establishment of the two dedicated after-hours teams and Supervisor, coupled with the expansion of available after-hours clinicians has improved the quality of after-hours operations in that we are able to dispatch teams in the afternoon in an expeditious fashion, thus better able to meet response arrival times expectations. While they have had one dedicated team working after-hours since July 2016, full implementation of the after-hours unit (i.e. 4 clinical staff and the supervisor) will commence March 13, 2017. Continued improvement in both the quality and efficiency of program operations is expected once a full-time compliment of PMRT after-hours staff (ideally with 2 regional catchment areas 1–4 & 5–8) are fully integrated and expanded to meet the needs of the community.

Trend analysis during a five (5) year period from CY 2012 to CY 2016 shows the annual average percentage of after-hours PMRT responses with the response time of one hour of less increased overall from 67% in CY 2012 to 71% in CY 2016. There was fluctuation in these rates between CY 2012 and CY 2016 from 67% in CY 2012 to 72% in CY 2013, 73% in CY 2014 and 71% in CY 2015 and CY 2016.

ACCESS Center Response Time

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 are answered by a live agent within one 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

The ACCESS Center successfully met this Work Plan goal, achieving an annual average of 77% of after-hours calls to the toll-free hotline being answered by a live agent within 1 minute.

Goal II.2b.

Sixty-five percent of daytime-hours calls to the toll free hotline are answered by a live agent within one minute from when they present to the Virtual Call Center (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

The ACCESS Center successfully met this Work Plan goal, achieving an annual average of 79% of daytime-hours calls to the toll-free hotline being answered by a live agent within 1 minute.

The annual average in CY 2016 for after-hours calls to the toll free hotline answered by a live agent within one minute was at 77%. This represents a 1.0 Percentage Point (PP) increase over CY 2015, when the annual average of after-hours calls to the toll free hotline and answered by a live agent within the one minute criteria was at 76%.

The annual average of daytime calls to the toll free hotline answered by a live agent within one minute was 79%. This represents a 22.0 PP increase over CY 2015, when the annual average of daytime calls to the toll free hotline and answered by a live agent within the one minute criteria was 57%.

These improvements were the result of multiple changes, including an increase in hiring to fill vacancies, working with QID closely in reviewing monthly data related to these measures, developing strategies such as altering agent work schedules to better match anticipated call volume and improve performance, as well as increased familiarity with new IBHIS/AVATAR procedures. As a result, addressing agent turnover has improved performance for after-hours and daytime percentage of calls answered within one minute.

ACCESS Center management will continue in their efforts towards monthly data monitoring, collaboration with QID in implementing operational strategies and changes aimed at continuing to meet these performance goals.

TABLE 27: CALLS ANSWERED WITHIN 1 MINUTE BY NUMBER AND PERCENT CY 2016

Month	Total Number of Calls	Total # of Calls Answered Within 1 Minute	Percentage of Calls Answered Within 1 Minute
January			
Daytime	5,463	4,045	74%
After Hours	6,469	5,194	80%
February			
Daytime	6,270	4,951	79%
After Hours	6,152	4,598	75%
March			
Daytime	6,670	4,889	73%
After Hours	6,276	4,678	75%
April			
Daytime	6,668	4,377	66%
After Hours	6,273	4,520	72%
May			
Daytime	6,508	4,280	66%
After Hours	6,741	4,766	71%
June			
Daytime	5,742	5,130	89%
After Hours	6,352	4,862	77%
July			
Daytime	4,924	4,456	90%
After Hours	6,108	5,186	85%
August			
Daytime	5,945	5,208	88%
After Hours	6,216	5,021	81%
September			
Daytime	6,360	5,093	80%
After Hours	6,391	4,987	78%
October			
Daytime	5,660	4,599	81%
After Hours	7,074	5,380	76%
November			
Daytime	5,395	4,091	76%
After Hours	6,533	5,151	79%
December			
Daytime	5,136	4,413	86%
After Hours	6,239	4,950	79%
Year-to-Date			
Daytime	*70,741*	*55,532*	*79%*
After Hours	*76,824*	*59,293*	*77%*
Grand Total	***147,565***	***114,825***	***78%***

Note: Daytime hours are 8:00 AM – 5:00 PM, Monday through Friday; this excludes holidays. After hours are outside of Daytime hours and include weekends and holidays. Data Source: LACDMH ACCESS Center, CY 2016.

Goal II.3.

Maintain percent of completed test calls to the toll free hotline in CY 2016 at a minimum of 95%.

EVALUATION

This goal has been met, with the percent of completed calls at 100% in CY 2016. The Test Calls Report is available via this link: http://psbqi.dmh.lacounty.gov/QI.htm

ACCESS Center Calls Received in Non-English Languages

Non-English speaking and Limited English Proficiency beneficiaries have a right to receive services in their primary or preferred language. LACDMH has 13 threshold languages including: Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog, and Vietnamese. When ACCESS Center staff is unable to assist callers due to a language barrier, they are able to immediately contact the Language Line for assistance with language interpretation services.

The ACCESS Center also provides equitable language assistance services to deaf/hearing impaired consumers and providers requesting American Sign Language (ASL) interpretation services for their consumers.

Goal II.4.

Monitor the number of assigned appointments for hearing impaired interpreter services coordinated by the toll free hotline for FY 2015–2016.

EVALUATION

Table 28 presents the summary of appointments for hearing impaired services at the ACCESS Center for the last five years. There was an increase in total hearing impaired service appointments from FY 11–12 to FY 12–13 and from FY 13–14 to FY 14–15. In FY 15–16, the number of assigned appointments decreased by 79 appointments from the FY 14–15 period.

TABLE 28: SUMMARY OF APPOINTMENTS FOR HEARING IMPAIRED SERVICES BY FISCAL YEAR FY 2011–2012 TO FY 2015–2016

Fiscal Year (FY)	Number of Assigned Appointments
FY 11-12	963
FY 12-13	1,025
FY 13-14	937
FY 14-15	1,137
FY 15-16	1,058
TOTAL	**5,120**

Data Source: LACDMH ACCESS Center, FY 15-16

TABLE 29: NON-ENGLISH LANGUAGE CALLS RECEIVED BY THE ACCESS CENTER FIVE YEAR TREND CY 2012–2016

*Language	2012	2013	2014	2015	2016
AMHARIC	2	0	1	0	0
*ARABIC	4	21	24	6	16
*ARMENIAN	61	48	225	80	130
BAHASA	0	0	0	0	1
BENGALI	2	1	0	0	1
BOSNIAN	0	0	1	0	0
BULGARIAN	0	0	0	0	0
BURMESE	0	0	0	0	0
*CANTONESE	7	46	60	46	40
CAMBODIAN	0	0	0	0	7
CEBUANO	0	0	1	0	0
*FARSI	59	70	81	58	56
FRENCH	1	1	2	2	2
GERMAN	0	0	0	1	0
GREEK	0	0	0	1	0
HEBREW	0	1	2	1	0
HINDI	5	0	1	0	0
HUNGARIAN	0	0	0	3	0
ITALIAN	0	0	0	0	0
JAPANESE	5	3	2	2	4

TABLE 29 (CONTD.): NON-ENGLISH LANGUAGE CALLS RECEIVED BY THE ACCESS CENTER FIVE YEAR TREND CY 2012–2016

*Language	2012	2013	2014	2015	2016
KHMER	35	10	5	3	1
*KOREAN	83	109	132	108	116
KURDISH-BEHDINI	0	0	1	0	0
LAOTIAN	0	0	2	0	0
*MANDARIN	40	57	30	62	86
MONGOLIAN	0	1	0	0	0
NEPALI	0	1	2	0	0
PASHTO	0	0	0	0	0
PERSIAN	0	0	0	0	1
POLISH	0	0	0	0	1
PORTUGUESE	0	0	1	0	1
PUNJABI	0	0	0	1	0
ROMANIAN	1	0	0	0	1
*RUSSIAN	26	15	11	12	16
SAMOAN	0	5	0	0	0
SERBIAN	0	0	0	0	2
SLOVAK	0	0	0	0	1
*SPANISH ([2]AVAZA Language Services Corporation)	4,552	2,509	1,402	1,089	1,474
SPANISH ACCESS CTR	4,043	11,240	6,135	6,159	6,040
SPANISH SUBTOTAL	8,595	13,749	7,537	7,248	7,514
*TAGALOG	14	16	18	7	10
THAI	1	1	2	1	0
TURKISH	1	0	0	0	0
URDU	3	2	1	0	0
*VIETNAMESE	23	24	24	**17**	**28**
TOTAL	**8,968**	**14,186**	**8,169**	**7,659**	**8,035**

*LACDMH Threshold Languages excluding Other Chinese and English in CY 2016. [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. [2]Telephone Interpreter Line Calls. Data Source: LACDMH ACCESS Center, CY 2012 - CY 2016.

Table 29 summarizes the total number of non-English language calls received by the ACCESS Center for CY 2012 through CY 2016. The trend over the past five years

indicates that the majority of non-English language callers have requested Spanish language interpretation services, followed by Armenian and Korean language services.

In CY 2016, ACCESS Center staff provided interpreter services for 6,040 calls in Spanish; a telephone interpreter line was used for 1,474 Spanish calls. Among the total of all non-English language calls, a total of 93.5% were Spanish language calls, followed by Armenian (130 calls) at 1.6 % of all non-English calls and Korean (116 calls) at 1.4% of all non-English calls.

There was an increase in non-English Language calls from CY 2015 to CY 2016. For the top three non-English language calls to the ACCESS Center, there was an increase in Spanish language calls from 7,248 to 7,514; Armenian language calls from 80 to 130; and Korean language calls from 108 to 116.

Languages in which at least 10 or more callers requested interpretation services in CY 2016 included: Arabic, Armenian, Cantonese, Farsi, Korean, Mandarin, Russian, Tagalog, and Vietnamese.

Consumer Satisfaction Survey Goals

Goal II.5.

Maintain the percent of consumers/families reporting that they are able to receive services at convenient locations between 83% and 85% for the May 2016 survey period.

EVALUATION

This goal has been met. The May 2016 Consumer Perception Survey forms were collected between May 16, 2016 and May 20, 2016. A total of 86.7% of the consumers/families that participated in the May 2016 survey period reported that they strongly agreed or agreed that the location of services were convenient for them. This represents a 2.6 Percentage Points (PP) increase from May 2015 (84.1%), and a 0.8 PP increase from Spring (April) 2014 (85.9%).

TABLE 30: PERCENT OF CONSUMERS / FAMILIES BY AGE GROUP WHO STRONGLY AGREE OR AGREE WITH "LOCATION OF SERVICES WAS CONVENIENT FOR ME"

Age Group	FY 13-14 (CY 2014) April	FY 14-15 (CY 2014) November	FY 14-15 (CY 2015) May	FY 14-15 (CY 2015) November	FY 15-16 (CY 2016) May
YSS-F					
Number	2,797	1,977	2,622	2,340	2,392
Percent	90.9%	89.0%	91.0%	92.0%	92.4%
YSS					
Number	1,166	894	1,223	1,159	1,206
Percent	82.9%	79.5%	78.3%	82.9%	80.8%
Adult					
Number	2,907	2,743	3,346	3,201	3,194
Percent	82.6%	83.7%	82.5%	84.4%	84.2%
Older Adult					
Number	268	235	427	423	377
Percent	88.4%	90.5%	84.5%	87.5%	91.5%
Total					
Number	7,138	5,849	7,658	7,123	7,169
Percent	85.9%	85.7%	84.1%	86.9%	86.7%

Note: YSS-F = Survey for Families of Children 0-17 years old; YSS = Survey for Youth 13-17 years old. Number is the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from 1 to 5. The denominator was all survey responses on the 5 point Likert scale.

Table 30 compares the percentage of consumers and families in May 2016 that strongly agreed or agreed that they had received services at convenient locations with four previous survey periods in FY 13-14 to FY 14-15. Among YSS-F, there was an increase of 1.5 Percentage Points (PP), from 90.9% in April 2014 to 92.4% in May 2016. Among YSS, there was a 2.1 PP decline from 82.9% in April 2014 to 80.8% in May 2016.

Among Adults, there was a 1.6 PP increase from 82.6% in April 2014 to 84.2% in May 2016. Among Older Adults there was a 3.1 PP increase from 88.4% in April 2014 to 91.5% in May 2016.

Goal II.6.

Maintain the percent of consumers/families reporting that they are able to receive services at convenient times between 88% and 90% for the May 2016 survey period.

EVALUATION

This goal has been met. A total of 90.6% of the consumers and families that participated during the May 2016 survey period reported that they strongly agreed or agreed that services were offered at times that were convenient. This represents a 1.3 Percentage Points (PP) increase from May 2015 at 89.3% and a 1.4 PP increase from April 2014 at 89.2%.

TABLE 31: PERCENT OF CONSUMERS / FAMILIES BY AGE GROUP WHO STRONGLY AGREE OR AGREE WITH "SERVICES WERE AVAILABLE AT TIMES THAT WERE GOOD FOR ME"

Age Group	FY 13-14 (CY 2014) April	FY 14-15 (CY 2014) November	FY 14-15 (CY 2015) May	FY 14-15 (CY 2015) November	FY 15-16 (CY 2016) May
YSS-F					
Number	2,843	1,977	2,622	2,334	2,381
Percent	92.2%	91.4%	92.0%	93.4%	94.0%
YSS					
Number	1,241	899	1,226	1,158	1,195
Percent	81.0%	83.1%	81.1%	84.3%	82.3%
Adult					
Number	3,158	2,743	3,346	3,212	3,196
Percent	88.8%	91.0%	90.0%	89.8%	90.6%
Older Adult					
Number	261	427	427	424	388
Percent	94.9%	96.1%	94.1%	92.5%	95.1%
Total					
Number	7,503	6,046	7,621	7,128	7,160
Percent	89.2%	90.4%	89.3%	90.3%	90.6%

Note: YSS-F = Survey for Families of Children 0-17 years old; YSS = Survey for Youth 13-17 years old. Number is the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from 1 to 5. The denominator was all survey responses on the 5 point Likert scale.

Table 31 compares the percentage of consumers and families in May 2016 that strongly agreed or agreed that services were available at times that were convenient with four previous survey periods in FY 13–14 to FY 14–15. Among YSS-F, there was an increase of 1.8 Percentage Points (PP), from 92.2% in April 2014 to 92.4% in May 2016. Among YSS, there was a 1.3 PP increase from 81.0% in April 2014 to 82.3% in May

2016. Among Adults, there was a 1.8 PP increase from 88.8% in April 2014 to 90.6% in May 2016. Among Older Adults there was a .2 PP increase from 94.9% in April 2014 to 95.1% in May 2016.

III. MONITORING BENEFICIARY SATISFACTION

Goal III.1.

Maintain the percent of consumers/families reporting that staff was sensitive to their cultural/ethnic background between 86% and 88% for the May 2016 survey period.

EVALUATION

This goal has been met. A total of 88.0% of consumers/families that participated in the May 2016 survey period reported that they strongly agreed or agreed that staff were sensitive to their cultural/ethnic background.

TABLE 32: PERCENT OF CONSUMERS / FAMILIES WHO STRONGLY AGREE OR AGREE WITH "STAFF WERE SENSITIVE TO MY CULTURAL BACKGROUND" BY AGE GROUP

Age Group	FY 13-14 (CY 2014) April	FY 14-15 (CY 2014) November	FY 14-15 (CY 2015) May	FY 14-15 (CY 2015) November	FY 15-16 (CY 2016) May
YSS-F					
Number	2,843	1,977	2,622	2,132	2,173
Percent	93.7%	94.3%	94.9%	95.2%	94.9%
YSS					
Number	1,241	899	1,226	1,082	1,111
Percent	83.8%	84.5%	81.5%	84.0%	81.5%
Adult					
Number	3,158	2,743	3,346	3,036	3,067
Percent	84.1%	86.7%	85.1%	85.1%	85.0%
Older Adult					
Number	261	427	427	405	365
Percent	89.2%	91.8%	87.6%	88.9%	91.2%
Total					
Number	7,503	6,046	7,621	6,655	6,716
Percent	87.7%	89.3%	87.3%	88.4%	88.0%

Note: YSS-F = Survey for Families of Children 0-17 years old; YSS = Survey for Youth 13-17 years old. Number is the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from 1 to 5. The denominator was all survey responses on the 5 point Likert scale.

Table 32 compares the percentage of consumers and families in May 2016 who strongly agreed or agreed that staff were sensitive to their cultural background with four previous survey periods in FY 13–14 and FY 14–15. Among YSS-F, there was an increase of 1.2

Percentage Points (PP), from 93.7% in April 2014 to 94.9% in May 2016. Among YSS, there was a 2.3 PP decline from 83.8% in April 2014 to 81.5% in May 2016. Among Adults, there was a .9 PP increase from 84.1% in April 2014 to 85.0% in May 2016. Among Older Adults there was a 2 PP increase from 89.2% in April 2014 to 91.2% in May 2016.

Goal. III.2.

Maintain the percent of consumers/families reporting overall satisfaction with services provided between 84% and 86% for the May 2016 survey period and continue year to year trending of data.

EVALUATION

This goal was exceeded. In May 2016, 90.1% of consumers/families who participated in the YSS (93.3%), YSS-F (88.5%), Adult (86.5%), and Older Adult (92.0%) consumer surveys positively endorsed an overall satisfaction in services.

Goal. III.3a.

Monitor the grievances, appeals and requests for State Fair Hearings for FY 2015-2016.

EVALUATION

This goal has been met. A new Annual Medi-Cal Beneficiary and Grievance and Appeal Report (ABGAR) form became effective FY 15-16 and finalized in June 2016. All counties within the state of California were instructed to utilize the new ABGAR form. The new form captures more Access categories and subcategories, including field services; comprehensive instructions, definitions, and explanations were added. Notices of Actions (NOAs) are also being tracked as the State Department of Health Care Services (DHCS) holds LACDMH increasingly more accountable to timeliness. All grievances and appeals are collected and reviewed by PRO; however, only Medi-Cal beneficiaries are required in the end of fiscal year report.

The Quality Improvement Division (QID) is responsible for conducting the annual evaluation of beneficiary grievances, appeals, and fair hearings (DHCS, Program Oversight and Compliance, 2012–2013).

The MHP shall insure that a procedure is included by which 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, Program Oversight and Compliance, 2012–2013).

TABLE 33A: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS FY 2015–2016

CATEGORY	PROCESS			
	GRIEVANCE	APPEAL	EXPEDITED APPEAL	State Fair Hearing
ACTIONS				
NOTICE OF ACTION - A		1		
NOTICE OF ACTION - B				
NOTICE OF ACTION - C				
NOTICE OF ACTION - D				
NOTICE OF ACTION - E		1		
ALL OTHER ACTIONS				
ACTIONS – TOTAL BY CATEGORY	N/A	2	0	5
PERCENT	N/A	100.0%	0.0%	41.7%
ACCESS				
SERVICE NOT AVAILABLE	2			
SERVICE NOT ACCESSIBLE	6			
TIMELINESS OF SERVICES	2			
24/7 TOLL-FREE ACCESS LINE				
LINGUISTIC SERVICES				
OTHER ACCESS ISSUES	1			
ACCESS - TOTAL BY CATEGORY	11	N/A	N/A	1
PERCENT	4.1%			8.3%
QUALITY OF CARE				
STAFF BEHAVIOR CONCERNS	67			
TREATMENT ISSUES OR CONCERNS	56			
MEDICATION CONCERN	27			
CULTURAL APPROPRIATENESS	9			
OTHER QUALITY OF CARE ISSUES	24			
QUALITY OF CARE - TOTAL BY CATEGORY	183	N/A	N/A	2
PERCENT	68.5%			16.7%
CHANGE OF PROVIDER	3	N/A	N/A	
CHANGE OF PROVIDER - TOTAL BY CATEGORY	3			1
PERCENT	1.1%			8.3%
CONFIDENTIALITY CONCERN	7	N/A	N/A	
CONFIDENTIALITY CONCERN - TOTAL BY CATEGORY	7			
PERCENT	2.6%			

TABLE 33A (CONTD.): INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS FY 2015–2016

CATEGORY	PROCESS			
	GRIEVANCE	APPEAL	EXPEDITED APPEAL	State Fair Hearing
OTHER				
FINANCIAL	7			
LOST PROPERTY	9			
OPERATIONAL	9			
PATIENTS' RIGHTS	9			
PEER BEHAVIORS	2			
PHYSICAL ENVIRONMENT	6			
OTHER GRIEVANCE NOT LISTED ABOVE	21			
OTHER – TOTAL BY CATEGORY	63	N/A	N/A	3
PERCENT	23.6%			25.0%
GRAND TOTALS	267	2	0	12
PERCENT	99.3%	0.7%	0.0%	100.0%

Note: Grievances and appeals data is limited to Medi-Cal beneficiaries. Data Source: LACDMH Patients' Rights Office (PRO), October 2016.

Table 33A shows the total number of inpatient and outpatient grievances and appeals by category in FY 15–16. The majority of inpatient and outpatient grievances were related to Quality of Care (68.5%), followed by Other (23.6%), Access (4.1%), Confidentiality Concern (2.6%), and Change of Provider (1.1%). Table 33A also shows that among the inpatient and outpatient grievances and appeals in FY 15–16, there were 267 grievances, two appeals, and 12 requests for State Fair Hearings.

TABLE 33B: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS' DISPOSITION FY 2015–2016

CATEGORY	DISPOSITION		
	COMPLETED	REFERRED OUT	PENDING as of June 30
ACTIONS			
NOTICE OF ACTION - A	1		
NOTICE OF ACTION - B			
NOTICE OF ACTION - C			
NOTICE OF ACTION - D			
NOTICE OF ACTION - E	1		
ALL OTHER ACTIONS			
ALL OTHER ACTIONS - TOTAL BY CATEGORY	2	0	0
PERCENT	0.9%	0.00%	0.00%
ACCESS			
SERVICE NOT AVAILABLE	2		
SERVICE NOT ACCESSIBLE	5		1
TIMELINESS OF SERVICES	2		
24/7 TOLL-FREE ACCESS LINE			
LINGUISTIC SERVICES			
OTHER ACCESS ISSUES	1		
ACCESS - TOTAL BY CATEGORY	10	0	1
PERCENT	4.4%		2.4%
QUALITY OF CARE			
STAFF BEHAVIOR CONCERNS	61		6
TREATMENT ISSUES OR CONCERNS	43		13
MEDICATION CONCERN	20		7
CULTURAL APPROPRIATENESS	9		
OTHER QUALITY OF CARE ISSUES	16		8
QUALITY OF CARE - TOTAL BY CATEGORY	149	0	34
PERCENT	65.6%	0.0%	81.0%
CHANGE OF PROVIDER	3		
CHANGE OF PROVIDER - TOTAL BY CATEGORY	3		
PERCENT	1.3%		
CONFIDENTIALITY CONCERN	5		2
CONFIDENTIALITY CONCERN - TOTAL BY CATEGORY	5	0	2
PERCENT	2.2%	0.00%	4.8%
OTHER			
FINANCIAL	7		
LOST PROPERTY	9		

TABLE 33B (CONTD.): INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS' DISPOSITION FY 2015–2016

CATEGORY	DISPOSITION		
	COMPLETED	REFERRED OUT	PENDING as of June 30
OPERATIONAL	9		
PATIENTS' RIGHTS	6		3
PEER BEHAVIORS	2		
PHYSICAL ENVIRONMENT	6		
OTHER GRIEVANCE NOT LISTED ABOVE	19		2
OTHER - TOTAL BY CATEGORY	58	0	5
PERCENT	25.6%	0.00%	11.9%
GRAND TOTALS	227	0	42
PERCENT	84.4%	0.0%	15.6%

Note: Grievances and appeals data is limited to Medi-Cal beneficiaries. Data Source: LACDMH Patients' Rights Office (PRO), October 2016.

Table 33B shows the disposition of the 269 grievances and appeals in FY 15–16, of which 227 (84.4%) were resolved and 42 (15.6%) were reported as still pending.

Goal III.3b.

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

EVALUATION

This goal has been met. 100% of standard appeals were resolved within 45 calendar days.

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. 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 has been met.

The electronic format of the COP log was introduced in March 2016. The DMHCOP@dmh.lacounty.gov email account was implemented during CY 2016 for the purpose of collecting monthly logs in a centralized location. The electronic submission of COP logs has proven beneficial towards tracking COP log submissions and eliminating barriers that were associated with sending or receiving faxes. In September 2016, the Patients' Rights Office (PRO) announced that there would be an increased presence of PRO team members during SA Quality Improvement Committee (QIC) meetings to monitor the COP reports. The QID has monitored the consistent reporting of COP requests from the providers to PRO. The number of COP decreased from 4,610 requests during FY 14–15 to 4,305 requests in FY 15–16. The percent of COP that were approved increased by 11.7 Percentage Points (PP) between FY 13–14 (81.8%) and FY 15–16 (92.7%).

TABLE 34: REQUEST FOR CHANGE OF PROVIDER BY REASONS AND PERCENT APPROVED FY 2013–2014 TO FY 2015–2016

	FY 2013 - 2014		FY 2014 - 2015		FY 2015 - 2016	
Reason[1]	**Number of Requests**	**Percent Approved**	**Number of Requests**	**Percent Approved**	**Number of Requests**	**Percent Approved**
Age	57	77.2%	62	75.8%	58	91.4%
Does Not Understand Me	254	76.4%	408	77.2%	382	92.4%
Gender	114	89.5%	184	84.8%	188	95.7%
Insensitive/unsympathetic	225	76.0%	323	78.6%	347	90.5%
Lack of Assistance	238	80.7%	385	80.5%	331	91.5%
Language	89	85.4%	199	82.9%	116	93.1%
Medication Concerns	191	80.1%	270	74.8%	230	90.9%
No Reason Given	183	82.5%	155	82.6%	107	93.3%
Not a Good Match	452	83.6%	642	82.2%	658	92.9%
Not Professional	111	82.0%	237	82.7%	246	91.9%
Other	278	82.4%	378	84.7%	349	94.8%
Time/Schedule	88	76.1%	317	92.7%	160	93.8%
Treating Family Member	21	85.7%	23	74.0%	33	93.9%
Treatment Concerns	251	82.5%	356	77.2%	361	91.7%
Uncomfortable	371	80.3%	507	80.1%	529	92.4%
Want 2nd Option	77	80.5%	98	77.6%	116	89.7%
Want Previous Provider	101	89.1%	66	72.7%	94	95.7%
Total	**3,101**	**81.8%**	**4,610**	**81.1%**	**4,305**	**92.7%**

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

Table 34 compares the number of Requests for Change of Provider (COP) by reasons and percent approved for FY 13–14, FY 14–15, and FY 15–16. Data for the requests for Change of Provider are based on information from COP logs that agencies are required to submit on a monthly basis, to the Patients' Rights Office (PRO). The data for FY 15-16 shows that the most frequent reason for a COP request was "Not a Good Match (N=658)" and the least frequent reason for a COP request was Age (N=58).

IV. MONITORING CLINICAL CARE

Goal IV.1.

Address evolving standards and requirements associated with the use of medication in mental health programs through systematic 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 has been met. During CY 2016, 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 302.15 Administration of Intranasal Naloxone (NEW). Submitted for signature on 1/23/17.

2. Revised:

    a. DMH Policy 302.07 Access to Care –Revised May 2016. This policy is an integration of the previous DMH Policy 202.45 for Scheduling of Initial Medication Services.
    b. DMH Policy 306.03 Storing, Administering and Accountability of Medications, Signed October 2016.
    c. DMH Policy 303.05 Reporting Clinical Events Concerning Active Clients - Revised September 2016. This policy includes requirements for reporting Medication Errors and Adverse Medication Events.

B. DMH Parameters:

1. Revised:

    a. Parameter 3.3 Use of Anti-Psychotic Medications- Revised May 2016.
    b. Parameter 3.7 Parameters for General Health Monitoring-Revised February 2017 to include Consultation and Interventions.
    c. Parameter 3.8 Use of Psychotropic Medication in Children and Adolescents – Revised September 2016.

C. CME Trainings re: Medication Practices:

During CY 2016, four (4) trainings, which included medication practices, were sponsored by the Department, for which a total of 174 physicians attended.

Goal IV.2.

Continue to improve Clinical Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders (COD) through on-site and online trainings and Annual State Wide Integrated Care Conference targeting LACDMH Directly Operated and LE Contracted programs.

EVALUATION

This goal has been met. In CY 2016, a total of 2,260 individuals participated in trainings aimed at improving clinical care for Consumers with Co-Occurring Mental Health and Substance Use Disorders (COD). Fifty-five trainings were conducted on-site at various LACDMH DO and LE Contracted Adult System of Care (ASOC) programs. A breakout session was scheduled and conducted during the Annual Statewide Integrated Care Conference that took place on October 19, 2016 and a total of 12 online courses were offered between January and June of 2016.

COD training and conference participants were asked to complete evaluation summaries at the close of their trainings. It should be noted that evaluation summaries were not collected at all trainings and some participants may have opted out of the evaluation process. Of the evaluation summaries collected, a majority of the participants rated their satisfaction with the COD training course, material, and instructor highly.

On question three of the evaluation summary, when participants were asked to rate the statement, “the course expanded my knowledge by using experiential or active learning techniques” or “the course expanded my knowledge of this topic,” on a scale from Absolutely (5), Somewhat (4), Uncertain (3), Probably Not (2), and Absolutely Not (1), the average response was 4.9. For question 10 of the evaluation summary, when participants were asked to rate the overall value of their training, on the same Absolutely (5) to Absolutely Not (1) scale, the average response was 4.9.

Goal IV.3.

Continue to improve Clinical Care for Older Adult consumers with mental illness with or at risk for involvement in the Criminal Justice System through providing a series of trainings to staff of both LE Contracted and/or Directly Operated (DO) agencies.

EVALUATION

This goal has been met. During FY 15–16, the Older Adult System of Care (OASOC) Bureau launched a series of five (5) trainings that were aimed at strengthening the workforces' ability to provide clinical and case management interventions to Older Adults that are exiting or at risk for involvement, in the criminal justice system. This was a foundational training series aimed at establishing a framework upon which advanced training could serve as a supplement. The results of these trainings indicated that staff were able to meet the training objectives and enhance their knowledge and skills in working with Older Adults with/or at risk of involvement, in the criminal justice system.

A total of 398 individuals from 41 programs participated in this training series. A high percentage of attendees were both licensed/licensed waivered and interns who either had a Master's degree, a California Consortium of Addiction Programs and Professionals certificate (CCAPP) as a Substance Abuse Counselor, or a Doctoral degree. A total of 42% of participants indicated that they attended the training for Professional Development/Growth, and 32% reported that the training was important to their job.

At the close of each training, participants were asked to rate the training's effectiveness at reaching the training's objectives. An estimated 322 training participants completed an evaluation summary for their training. Participants were asked to rate the overall value of the program, on a scale from Absolutely (5), Somewhat (4), Uncertain (3), Probably Not (2), and Absolutely Not (1). The overall average score for the five trainings was 3.99. This indicated training participants found the training effective at improving their ability to provide clinical and case management services to Older Adults that are exiting or at risk for involvement, in the criminal justice system.

V. MONITORING CONTINUITY OF CARE

Goal V.1.

At least 90% 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.

EVALUATION

This goal has not been met. An average of 85.1% of the consumers referred for urgent appointments by the Medi-Cal Managed Care Plans to the Urgent Appointment Line at the ACCESS Center received an appointment within 5 business days. There was an increase in the number of urgent appointment requests from a total of 1,253 in CY 2015, to a total of 2,082 in CY 2016 that contributed to the decrease in the percentage of urgent appointments given within 5 business days.

Goal V.2.

Improve Continuity of Care for Older Adult consumers with mental illness with or at risk for involvement in the Criminal Justice System through providing consultation on complex cases to enhance treatment planning and intervention process.

EVALUATION

This goal has been met. The Community Diversion and Re-entry Program for Seniors (CDRPS) developed the Justice Involved Consultation Team in order to provide an expert venue for treatment teams to present complex cases and obtain feedback. This team was comprised of experts across several disciplines that provided relevant and culturally sensitive interventions that were applicable to mental health treatment with justice involved Older Adults. The team meeting participants were granted opportunities to consult with professionals in Geriatric Medicine, Gero-Psychiatry, Substance Use, Psychological Screening/Testing, and community resources. The team was also prepared to explore treatment planning and engagement, access to legal services, and conservatorship matters.

During CY 2016, six (6) meetings were facilitated between February and November. Presentations were welcomed from one or several treatment team members, including therapists and case managers, from DO and LE Contracted programs. A total of 13 cases were presented (two to three per meeting) with 9-20 participants in attendance per meeting. The outcomes to recommendations were monitored via follow-up phone calls that were conducted four to six weeks after each presentation.

There were positive outcomes from the Justice Involved Consultation Team meetings. Treatment team members were encouraged to seek specialty assessments, such as comprehensive mental health evaluations, neuropsychological assessments, cognitive

impairment screenings, and medication re-evaluations (psychiatric and medical). Treatment team members were encouraged to obtain releases and concurrently seek collateral information from Primary Care Providers (PCP), Probation Officers, and/or via a review of the client's prison records.

As a result of the implementation of these recommendations, the following positive outcomes were noted among the different clients – increased frequency of clinician visits and suicidality assessment, reduction in suicidality, referral to IMD Stepdown, medications reviewed and changed resulting in client's self-report of doing "much better", abstinence from substance use, approval for low income housing, outstanding warrant resolved, transitional housing for client, benefits establishment and Section 8 vouchers in progress, participation in 12 Step programs, and follow up with Primary Care Provider regarding medication concerns. Client refusals were reported during follow-ups regarding specialized assessments and the team continued to engage and follow up with the clients in such cases. The importance of consultation and collaboration with pertinent individuals within the clients' lives were also addressed.

VI. MONITORING OF PROVIDER APPEALS

Goal. VI.1.

The MHP will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal.

EVALUATION

This goal has been met. For CY 2016, 100% of provider appeals were responded to within 60 calendar days.

TABLE 35: PROVIDER APPEALS
CY 2016

Appeals	Day Treatment	Network Inpatient	Network Outpatient
Total	0	Total TARs: 1,778 Total Days: 10,143	2
Approved	0	TARs Approved: 425 Total Approved Days: 2,249	0
Denied	0	TARs Denied: 1,353 Total Denied Days: 7,894	2
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.

Out of a total of 1,778 Treatment Authorization Requests (TARs) that were appealed, 425 were approved for Network Inpatient, and two (2) appeals were denied for Network Outpatient. There were no TARs appealed from Day Treatment providers for CY 2016.

QUALITY IMPROVEMENT WORK PLAN GOALS 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.*
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.*
3. *Provide tele-psychiatry services to at least 1,000 clients in Calendar Year (CY) 2017.*
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, aging for the LGBTQ community and generational differences, and issues specific to transgender consumers and their families.*
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.*

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.*

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.

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.

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

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.*
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.*

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

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.

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

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.*

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.*

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.*

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

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) at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH outpatient programs in Fiscal Year (FY) 16–17.

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: Program Support Bureau – Quality Improvement Division (PSB-QID)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 2: Between 34.6% and 36.6% of Asian Pacific Islanders (API) 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.

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: Program Support Bureau – Quality Improvement Division (PSB-QID)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 3: Provide tele-psychiatry services to at least 1,000 clients in Calendar Year (CY) 2017.

Population: Consumers receiving mental health services through tele-psychiatry at various end points in LACDMH Directly Operated (DO) Clinics

Indicator: Service delivery capacity for psychiatry appointments via tele-psychiatry

Measure: Number of consumers receiving mental health services through tele-psychiatry appointments in CY 2017

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 (OMD), Program Support Bureau – Quality Improvement Division (PSB-QID)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 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, aging for the LGBTQ community and generational differences, and issues specific to transgender consumers and their families.**

Population: LGBTQ youth with mental illness

Indicator: Training Protocols and Procedures to improve assessment and treatment for LGBTQ youth

Measure: Review, provision, and evaluation of Service Area LGBTQ trainings; total number of staff who completed these trainings in CY 2017, and training evaluation summaries completed for these trainings

.

Source(s) of Information: Program Support Bureau – Quality Improvement Division (PSB-QID), Underserved Cultural Communities (UsCC)

Responsible Entity: PSB-QID, Workforce Education and Training (WET) Division

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 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 Directly Operated (DO) and/or Legal Entity (LE) Contracted agencies to improve their skills for effective screening, engagement, treatment and best practices for this population.

Population: AI/AN with mental illness

Indicator: Training Protocols and Procedures to improve screening, engagement, treatment and best practice for AI/AN

Measure: Review, provision, and evaluation of Service Area AI/AN trainings; total number of staff that completed these trainings in CY 2017, and training evaluation summaries completed for these trainings

Source(s) of Information: Program Support Bureau-Quality Improvement Division (PSB-QID), Underserved Cultural Communities (UsCC)

Responsible Entity: PSB-QID

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

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 71% for Calendar Year (CY) 2017.

Population: Consumers receiving urgent after-hours care from PMRT of LACDMH – Emergency Outreach Bureau (EOB)

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 2017 multiplied by 100

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

Responsible Entity: EOB, Program Support Bureau – Quality Improvement Division (PSB-QID)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 2a: Seventy-five percent of after-hours calls to the toll-free hotline for Calendar Year (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 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.

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 2017 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 2017 multiplied by 100.

2b. The number of daytime calls for the CY 2017 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 2017 multiplied by 100.

Source(s) of Information: ACCESS Center Data

Responsible Entity: ACCESS Center, Program Support Bureau – Quality Improvement Division (PSB-QID)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

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) 16–17.

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 16–17

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

Responsible Entity: ACCESS Center, Program Support Bureau – Quality Improvement Division (PSB-QID)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

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 87% for the May 2017 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 form 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 2016 response rate of 86.7%. At 95% Confidence Level, the confidence interval for 86.7% response rate is a plus or minus .63, i.e., between 86.07% and 87.33%.

Source(s) of Information: Consumer Perception Surveys

Responsible Entity: Program Support Bureau – Quality Improvement Division (PSB-QID), LACDMH outpatient programs

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

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 2017 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 form 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 2016 response rate of 90.6%. At 95% Confidence Level, the confidence interval for 90.6% response rate is a plus or minus .54, i.e., between 90.06% and 91.14%.

Source(s) of Information: Consumer Perception Surveys

Responsible Entity: Program Support Bureau – Quality Improvement Division (PSB-QID), LACDMH outpatient programs

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

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 2017 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 form / 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 2016 response rate of 88.0%. At 95% Confidence Level, the confidence interval for 88.0% response rate is a plus or minus .60, i.e., between 87.4% and 88.6%.

Source(s) of Information: Consumer Perception Surveys

Responsible Entity: Program Support Bureau – Quality Improvement Division (PSB-QID), LACDMH outpatient programs

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 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.

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 form / 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 2016 response rate of 90.05%. At 95% Confidence Level, the confidence interval for 87.3% response rate is a plus or minus .56, i.e., between 89.49% and 90.61%.

Source(s) of Information: Consumer Perception Surveys

Responsible Entity: Program Support Bureau – Quality Improvement Division (PSB-QID), LACDMH outpatient programs

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 3: **a. Monitor the grievances, appeals and requests for State Fair Hearings for Fiscal Year (FY) 16–17.**

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

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

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 16–17

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

Responsible Entity: PRO, Program Support Bureau – Quality Improvement Division (PSB-QID)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

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.

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 Calendar Year (CY) 2017

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

Responsible Entity: PRO, Program Support Bureau – Quality Improvement Division (PSB-QID)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

DOMAIN IV: MONITORING CLINICAL CARE

GOAL 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.

Population: Consumers receiving medication support services

Indicator: Prescribing standards and parameters

Measure: Review and update of medication parameters, medication-related trainings, and supervisory structure of Mental Health Practitioners and Nurse Practitioners

Source(s) of Information: Office of the Medical Director (OMD) Reports

Responsible Entity: OMD, Program Support Bureau – Quality Improvement Division (PSB-QID)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

DOMAIN V: MONITORING CONTINUITY OF CARE

GOAL 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.

Population: Consumers referred for urgent appointments by the Medi-Cal Managed Care Plans

Indicator: Continuity of Care for consumers referred for specialty mental health services by primary care providers and behavioral health network providers of the Medi-Cal Managed Care Plans

Measure: Number of Urgent Appointments received within five (5) business days from the date referred by the Medi-Cal Managed Care Plans to the Urgent Appointment Line for Calendar Year (CY) 2017 divided by the Total Number of Urgent Appointment Referrals received from the Medi-Cal Managed Care Plans to the Urgent Appointment Line for the CY 2017 multiplied by 100

Source(s) of Information: ACCESS Center, Integrated Behavioral Health Information Systems (IBHIS)

Responsible Entity: ACCESS Center, IBHIS, Program Support Bureau – Quality Improvement Division (PSB-QID)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY IMPROVEMENT DIVISION

QI WORK PLAN GOALS FOR CALENDAR YEAR 2017

DOMAIN VI: MONITORING PROVIDER APPEALS

GOAL 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.

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 Calendar Year (CY) 2017 / the total number of provider appeals for CY 2017 multiplied by 100

Source(s) of Information: Office of the Medical Director (OMD) - Managed Care Division.

Responsible Entity: OMD - Managed Care Division, Program Support Bureau – Quality Improvement Division (PSB-QID)