LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
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QUALITY IMPROVEMENT WORK PLAN EVALUATION REPORT CALENDAR YEAR 2018

AND

QUALITY IMPROVEMENT WORK PLAN CALENDAR YEAR 2019

Los Angeles County – Department of Mental Health
Office of Administrative Operations – Quality Improvement Division

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Acronyms and Definitions

AAA	African/African-American
ABA	Applied Behavior Analysis
ABGAR	Annual Medi-Cal Beneficiary and Grievance and Appeal Report
ACA	Affordable Care Act
Access for All	Deaf, hard-of-hearing, and blind communities, and people with physical disabilities
ACS	American Community Survey
ADR	Alternative Dispute Resolution
AI/AN	American Indian/Alaska Native
API	Asian Pacific Islander
ASL	American Sign Language
BIYEP	Black Immigrant Youth Empowerment Project
CCC	Cultural Competency Committee
CCESJC	Cultural Competency, Equity, and Social Justice Committee
CCP	Cultural Competence Plan
CCPR	Cultural Competence Plan Requirements
CCR	Continuum of Care Reform, Code of Regulations
CCU	Cultural Competency Unit
CFR	Code of Federal Regulations
CHIS	California Health Interview Survey
CIOB	Chief Information Office Bureau
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare and Medicaid Services
COD	Co-Occurring Disorders
COP	Change of Provider
Contd.	Continued
CQI	Continuous Quality Improvement
CQM	Continuous Quality Management
CRS	California Relay Service
CSS	Community Services and Supports
CY	Calendar Year
DHCS	Department of Health Care Services
DHS	Department of Health Services
DMH	Department of Mental Health
DO	Directly Operated
DPH	Department of Public Health
EOTD	Emergency Outreach and Triage Division
EQR	External Quality Review
EQRO	External Quality Review Organization
ESM	Ethnic Services Manager
FFS	Fee-For-Service
FOCS	Front Office Customer Service
FPL	Federal Poverty Level
FSP	Full Service Partnership
FY	Fiscal Year
GARE	Government Alliance for Racial Equity
GIS	Geographic Information System
GLAD	Greater Los Angeles Agency on Deafness
HA	Health Agency
HDOFCC	Hospital Discharge Outpatient Follow-up Care Coordination
IBHIS	Integrated Behavioral Information Systems
ICLIR	Institute for Cultural and Linguistic Inclusion and Responsiveness
IHI	Institute for Healthcare Improvement
IMD	Institute of Mental Diseases
INN	Innovations
IS	Integrated System
ISR	Intensive Service Recipient
CY	Calendar Year

Acronyms and Definitions (contd.)

DMH, Department, LACDMH	Los Angeles County – Department of Mental Health
LE	Legal Entities
LGBTQI2-S	Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two-Spirit
LMTC	Labor Management Transformation Council
MEDS	Medi-Cal Eligibility Data System
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MOU	Memorandum of Understanding
NA	Native American
NACT	Network Adequacy Certification Tool
NEO	New Employee Orientation
NOABD	Notice of Adverse Benefit Determination
NOA	Notice of Action
OAO	Office of Administrative Operations
OSB	Outpatient Services Bureau
PEI	Prevention and Early Intervention
PHF	Psychiatric Health Facilities
PIP	Performance Improvement Project
PMRT	Psychiatric Mobile Response Teams
PP	Percentage Points
PRO	Patients' Rights Office
Project ABC	Project About Building Connections
Promotores de Salud	Health Promoters
PSA	Public Service Announcement
PSB	Program Support Bureau
PTSD	Posttraumatic Stress Disorder
QA	Quality Assurance
QI	Quality Improvement
QIC	Quality Improvement Council/Committee
QID	Quality Improvement Division
SA	Service Area
SAAC	Service Area Advisory Committee
SED	Serious Emotional Disturbance
SLT	System Leadership Team
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness
SNF	Skilled Nursing Facilities
SRL	Service Request Log
SRTS	Service Request Tracking System
TAR	Treatment Authorization Request
TAY	Transition Age Youth
TCPI	Transforming Clinical Practice Initiative
TMH	Telemental Health
TV	Television
U.S.	United States
UCLA	University of California, Los Angeles
UREP	Under Represented Ethnic Populations
UsCC	Underserved Cultural Communities
VCC	Virtual Call Center
W&IC	Welfare and Institutions Code
YSS	Youth Services Survey
YSS-F	Youth Services Survey for Families

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Executive Summary

The Los Angeles County – Department of Mental Health (DMH) is the largest county mental health department in the country. The Department directly operates more than 80 programs and contracts with more than 700 providers, including non-governmental agencies and individual practitioners who provide a wide spectrum of behavioral health services to individuals of all ages.

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

Los Angeles County is the most populated county in the nation with an estimated population of 10,272,648 in Calendar Year (CY) 2017. The estimated distribution by race/ethnicity for the six designated categories includes: Latinos representing 48.7%, Whites 26.6 %, Asian Pacific Islanders 14.1%, African Americans 8.1 %, Two or More Races 2.2%, and Native Americans representing 0.18%. During Fiscal Year (FY) 2017-18, a full array of mental health services were provided to approximately 288,744 children and youth with Serious Emotional Disturbance and adults and older adults with Serious Mental Illness in jails, juvenile halls, 24 hour acute psychiatric care or residential facilities, Directly-Operated (DO) and Legal Entities (LE)/Contracted outpatient programs and by Fee-For-Service outpatient network providers. The Work Plan goals focused on the DO and LE/Contracted outpatient programs that served approximately 232,693 persons Countywide.

This QI Work Plan Evaluation report details the progress DMH has made with respect to the CY 2018 annual QI Work Plan goals. For CY 2018, 13 out of 19 of the QI Work Plan goals were met, three were partially met, two were not met, and one goal was not rated. 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 Department's progress towards addressing the mental health service needs of the population. Service Delivery Capacity Work Plan goals are developed and evaluated based on the population living at or below 138% Federal Poverty Level.

The QI Work Plan goals for CY 2019 are set by the Office of Administrative Operations – Quality Improvement Division under the authorization of the Department's executive management team and in collaboration with various Divisions and programs including: ACCESS Center, Chief Information Office Bureau, Emergency Outreach and Triage Division, DO and LE/Contracted outpatient programs, Office of Clinical Operations, Office of the Discipline Chiefs, Office of the Deputy Director, Patients' Rights Office, Prevention and Outcomes Division, Service Area Quality Improvement Committees, the Workforce Development Division, and multidisciplinary PIP teams who have all contributed to this report.

Introduction

In partnering with consumers, families, and communities to provide access to care and resources that are culturally and linguistically competent, the Los Angeles County – Department of Mental Health (DMH) is committed to optimizing the hope, wellbeing, and life trajectory of our most vulnerable residents.

The Department's services to adults and older adults focus on addressing the effects of severe and persistent mental illness and its impact on individuals who are low-income, uninsured, temporarily impaired, or in situational crises. Services to children and youth are focused on those who are emotionally disturbed and diagnosed with a mental health disorder. They include wards or dependents of the juvenile court, children in psychiatric inpatient facilities, seriously emotionally disturbed youth in the community, and special education students referred by educational institutions. Prevention and early intervention services, education, support, and outreach are provided to individuals and families who are at-risk for long-term and negative mental health outcomes. The Department envisions a county unified by shared intention and cross-sector collaboration that helps individuals suffering from serious mental illness heal, grow, and flourish.

The Triple Aim framework, developed by the Institute for Healthcare Improvement (IHI, 2019), has guided the Department's efforts. The Triple Aim[1] refers to the simultaneous pursuit of improving the consumer experience of care (quality and satisfaction), improving the health across our diverse populations, and providing affordable care. Through ongoing innovation, DMH strives for an integrated model of healthcare that encompasses mental health, physical health, and substance use services. The Department 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. The Department embraces and recognizes the highly diverse and interconnected set of communities with unique cultures, strengths, challenges, and behavioral health needs.

The Quality Improvement (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 maintaining a culture of quality improvement.

[1] Retrieved from http://www.ihi.org/

Section 1

Quality Improvement Program Description

Quality Improvement Program Structure

The Office of Administrative Operations (OAO; formerly known as the Program Support Bureau, PSB), Quality Improvement Division (QID) shares responsibility with providers to maintain and improve the quality of mental health services and services delivered. The QID oversees the development of annual Work Plan goals, monitors DMH activities for effectiveness, and facilitates processes for continuous improvement of countywide services.

The QID works to ensure that the quality and appropriateness of care delivered to consumers meet or exceed local, State, and Federal service standards. The QI program is organized and implemented in support of an organizational culture of continuous quality improvement (CQI) that: fosters hope, wellbeing, resilience and recovery; reduces disparities; promotes consumer and family involvement; advances cultural competency; and integrates the treatment of mental health and substance use disorders with physical healthcare. The structure and process of QID are outlined in DMH Policy and Procedure 1100.01, "Quality Improvement Program[2] (Refer to Appendix A)."

The QID is composed of the Cultural Competency Unit (CCU), the Underserved Cultural Communities (UsCC) Unit, and the QI program. The CCU promotes the delivery of mental health services that will meet the diverse needs of Los Angeles County's racial, ethnic, cultural, and linguistic populations. The UsCC Unit has the responsibility for implementing one-time funded projects to build capacity and increase access for underserved cultural communities, within our system of care. The QI program provides QI leadership and coordination, data monitoring and reporting, and technical assistance across DMH and in the execution of the annual QI Work Plan.

[2] Department of Mental Health Policy/Procedure, 1100.01, effective date March 16, 2015.

Quality Improvement Program Processes

The purpose of the design and implementation of the countywide QI program is to ensure an organizational culture of continuous self-monitoring through effective strategies, best practices, and activities at all levels of the system.

The QID and DMH staff collaborate on measurable QI Work Plan goals that aid in the evaluation of annual performance management activities. The annual QI Work Plan goals are categorized into six domains that mirror State and Federal requirements, including: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care, and Provider Appeals. In CY 2019, a seventh domain was created for Departmental Performance Improvement Projects (PIPs). The evaluation of the Work Plan goals is reported annually and made available online at *https://dmh.lacounty.gov/qid/.* Consumer satisfaction activities are also reported annually and made accessible via the QID website.

The QID is responsible for the formal bi-annual reporting of consumer perception of satisfaction data 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 PIPs can also serve as a measure of consumer satisfaction. The Departmental PIPs utilize a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. The PIPs support DMH in addressing countywide clinical and administrative problem areas through CQI science.

The QID collaborates and coordinates related QI activities with multiple DMH Divisions and programs including, but not limited to the: ACCESS Center, Chief Information Office and Bureau (CIOB), Emergency Outreach and Triage Division (EOTD), Directly Operated (DO) and Legal Entities (LE)/Contracted outpatient programs, Office of Clinical Operations, Office of the Discipline Chiefs, Office of the Deputy Director – Strategic Communications, Patients' Rights Office (PRO), Prevention and Outcomes Division, Service Area Quality Improvement Committees (SA QICs), the Workforce Development Division (WDD; formerly known as the Workforce and Education Training Division; WET), and multidisciplinary PIP teams. The QI program 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 Department's QI program acts in coordination with the service delivery system. The Departmental Quality Improvement Council (QIC) meets monthly and includes standing representation from each of the eight SAs as well as multiple DMH Divisions and programs. The Departmental QIC is chaired by the QID Mental Health Clinical Program Manager. All SAs facilitate a local SA QIC. The SA QIC meetings provide a structured forum for the identification of QI opportunities to address challenges and barriers unique to a SA. Each SA QIC has a Chair representing DO providers and most

have a Co-Chair who represents the LE/Contracted providers. The SA QIC Chair and Co-Chair are representative members of the Departmental QIC.

In support of an efficient QIC communication loop, all providers are required to participate in their local/SA QIC. This constitutes a structure that supports effective communication between providers, their SA QICs, the Departmental QIC, and across the system of care. An additional communication loop exists between the SA QIC Chair and/or Co-Chairs, their respective DMH Chiefs, and the Service Area Advisory Committees (SAACs). The SAACs provide valuable information for program planning and grant opportunities for program and service improvement. They include consumers, family members, providers and DMH staff.

Performance Improvement Projects. A PIP is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner[3]." The CMS External Quality Review (EQR) protocol mandates that the assigned External Quality Review Organization (EQRO) validate one clinical and one non-clinical PIP for each Mental Health Plan (MHP).

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

Clinical Performance Improvement Project. In September 2018, the clinical project titled, "Post Discharge Outpatient Follow-up Appointment Scheduling for Hospital Discharges – Impact of Care Coordination and Continuous Quality Management (CQM) Protocols," was submitted for an EQRO review. In July 2017, the EQR team approved this project as a Fiscal Year (FY) 17-18 clinical PIP. The project concluded in September 2018.

During FY 17-18, the following study questions formed the basis of the clinical PIP:

1. Will implementing prolonged stabilization post hospital discharge impact hospital readmission rates?

2. Will Co-Occurring Disorders (COD) group participation contribute to positive perceptions regarding COD groups and self-reported reduction in substance use?

3. Will implementing hospital discharge outpatient follow-up care coordination protocols reduce barriers to scheduling post-hospital discharge, urgent, outpatient appointments for DO and LE/Contracted programs?

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

The purpose of this clinical PIP was to reduce preventable hospital readmissions. The project's interventions were centered around increasing linkages to support DMH consumers approaching hospital discharge. According to the literature, interventions delivered pre- and post- hospital discharge have effectively targeted the clinical and demographic factors that contribute to multiple hospital readmissions. Examples of pre-discharge interventions and bridging strategies include discharge planning and continuity of care between inpatient and outpatient settings. Post-discharge interventions include services provided through integrated outpatient treatment, such as COD support.

In FY 17-18, the clinical PIP included four interventions: (1) the availability of crisis residential treatment services upon discharge from a hospital and facilitated active communication between outpatient providers and hospitals; (2) the delivery of effective outpatient services focused on integrated COD treatment; (3) the implementation of the Hospital Discharge Outpatient Follow-up Care Coordination (HDOFCC) protocol, a system of addressing barriers that hospitals face when scheduling appointments at DMH clinics; and (4) the introduction of the Transforming Clinical Practice Initiative (TCPI) CQM protocols for responding to appointment requests from hospitals at 15 DO clinics. In September 2017, the study's population changed from exclusively Intensive Service Recipients (ISRs) to all adult consumers discharged from Fee-For-Service (FFS) hospitals and in need of immediate outpatient follow-up. The project expanded beyond ISRs due to several barriers with engagement. Hospital readmissions, as a clinical problem, is complex with multiple contributing factors.

There was no notable improvement in the primary indicators and outcomes of this project, specifically: the 7-day outpatient follow-up rates, the 7- and 30-day readmission rates, and the average length of stay in hospitals. There was improvement in the consumers' perception of COD groups as well as evidence of increased participation in outpatient treatment services.

Upon completion of the clinical PIP, DMH DO clinics and hospitals continued the new HDOFCC and TCPI CQM protocols aimed at improving linkages and decreasing hospitalizations.

Non-Clinical Performance Improvement Project. In September 2018, the non-clinical project titled, "The Impact of Training and Psychoeducation to Front Office Staff on Consumer Satisfaction with Front Office Customer Service (FOCS)," was submitted for an EQRO review. In July 2017, the EQR team approved this project as a FY 17-18 non-clinical PIP. The project concluded in September 2018.

During FY 17-18, the following study question formed the basis of the non-clinical PIP:

1. Will implementing front office customer service training and psycho-education on mental health educational materials improve the consumer satisfaction rates related to front office customer service?

The purpose of this non-clinical PIP was to improve customer service of front office staff and thereby improve consumer satisfaction. The Department has administered a variety of consumer satisfaction surveys focusing on access to care and satisfaction with services. Survey data has reflected the feedback of consumers receiving services in general outpatient and specialized programs and across all age groups. Further, based on the feedback received from the consumer focus groups facilitated by the EQR team and Cultural Competency Committee members, DMH recognized the need to implement a consumer satisfaction survey to evaluate front office customer service at DO clinics. The front office experience and customer service was an under-evaluated area of the system; yet it played a role in beneficiary access to initial and ongoing care.

In FY 17-18, DMH implemented two interventions as a part of the non-clinical PIP; front office staff was provided with: (1) customer service training on the consumer experience and (2) psychoeducation on mental health illness. The customer service training was applicable to front office staff at outpatient programs throughout the system of care, including DO and LE/Contracted programs.

The Department's Outpatient Services Bureau (OSB) developed a FOCS satisfaction survey for this project. This brief, five-question satisfaction survey served as a self-report measure designed to assess five aspects of customer service: helpfulness, flexibility, dignity and respect, feeling welcomed, and professionalism. The surveys were administered at 35 DO clinics.

The FOCS satisfaction survey data was gathered prior to the customer service training, between February 12, 2018 and February 26, 2018, and following the training between June 5, 2018 and June 15, 2018.

With the exception of flexibility (i.e., with late arrivals and missed appointments), there was no additional improvement in consumer satisfaction. The question regarding flexibility was found to be the least answered. It is presumed that consumers were either unsure of how to interpret the question or were reluctant to provide a negative rating. While the training did not make an appreciable difference in DMH consumers' satisfaction, front office staff had positive ratings of the customer service training and presumably could use their improved knowledge and skills towards their interactions with consumers. Given that satisfaction was already high, at upwards of 90%, it presented a challenge to further increase these ratings.

This non-clinical PIP provided DMH with confirmation that consumers are generally satisfied with their customer service experience and that "flexibility" warrants further investigation. The EQR team encouraged DMH to identify and present a different project for the next non-clinical PIP.

Cultural Competency Committee

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

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

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

- Facilitate all meetings
- Engage members in Committee discussions
- Collaborate with the CCU in the development of meeting agendas
- Appoint ad-hoc subcommittees as needed
- Communicate the focus of the CCC activities and recommendations made to diverse Departmental entities
- Represent the CCC at the Department's "YourDMH" and UsCC Leadership meetings

The Department's 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 QIC. This structure facilitates communication and collaboration for attaining the goals as set forth in the Department's QI Work Plan and the Cultural Competence Plan (CCP) to reduce disparities, increase capacity, and improve the quality and availability of services. Relevant CCC decisions and activities are reported to the membership at each Departmental QIC meeting.

For CY 2018, the CCC leadership was composed of:

- CCC Co-Chairs (Department and community representatives)
- The Department's ESM

Cultural Competency Committee Membership. The membership of the CCC is culturally and linguistically diverse. For CY 2018, the CCC membership reached 46 members; of which, nine members self-identified as Male and 37 members self-identified as Female. The CCC members described their racial/ethnic identity as follows: African American, Asian, Black, Black American, Caucasian, Filipino, Hispanic, Indigena Latina, Irish and German, Italian, Japanese, Jewish, Latina, Latino, Latino Chinese, Mexican, Mexican American, Native Indian, Spaniard/Latino/American Indian, Spanish, and White. Ten languages were represented in the CCC membership, specifically: American Sign Language (ASL), English, German, Hebrew, Japanese, Korean, Portuguese, Spanish, Swahili, and Tagalog.

Cultural Competency Committee 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. For CY 2018, the CCC opted to schedule presentations on DMH initiatives related to cultural and linguistic competency. The CCC membership identified initiatives of interest to be presented during monthly CCC meetings. At the end of each presentation, the Committee provided feedback and recommendations to ensure the inclusion of cultural competency, in all DMH services. In CY 2018, the CCC welcomed the following presentations and presenters:

- The “Revised Grievance/Appeal/Expedited Appeal form” presentation provided by the PRO
- The “Prevention-Related Services Funded by the Mental Health Services Act (MHSA)” presentation provided by the Prevention Bureau
- The “MHSA Three-Year Program, Expenditure Plan, and Annual Update” presentation provided by the Program Development and Outcomes Bureau
- The “Los Angeles County Health Agency’s Institute for Cultural and Linguistic Inclusion and Responsiveness (ICLIR)” presentation provided by the Department’s ESM
- The “Perspectives about the Deaf Community and its Culture” presentation provided by the Greater Los Angeles Agency on Deafness (GLAD), Inc.
- The “Disaster Preparedness Brochure” presentation provided by the EOTD – Disaster Services
- The “INN 6 Virtual Trainings for Staff Project” presentation provided by the Program Development and Outcomes Bureau
- The Department’s “CCP for FY 15-16” presentation provided by the ESM
- The “Juvenile Justice Initiative: California’s Continuum of Care Reform (CCR)” presentation provided bythe Continuum of Care Reform Division

- The presentation on DMH Policy and Procedure 200.02, "Hearing-Impaired Mental Health Access[4]" provided by the Department's ESM
- Special visit from the Orange County Cultural Competency Advisory Committee
- The "Spirituality in Mental Health Services" presentation provided by a CCC Co-Chair.
- The "YourDMH Vision and Guidelines Concept Paper" presentation provided by the Underserved Cultural Communities Unit
- The "Project About Building Connections (ABC)" presentation provided by the SA 6 Wraparound Program

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

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

[4] Department of Mental Health Policy/Procedure, 200.02, effective date April 7, 2010. This policy was revised. Refer to Appendix B for Policy/Procedure, 200.02 "Interpreter Services for the Deaf and Hard of Hearing Community," effective date July 10, 2019.

Programs and Projects Reviewed by the Cultural Competency Committee in Calendar Year 2018.

The Revised Grievance/Appeal/Expedited Appeal Form. In January 2018, the PRO Director presented the revised "Grievance/Appeal/Expedited Appeal" form that incorporated the CCC's content and formatting recommendations. The committee members reviewed the revised form and provided the following additional feedback:

- Add that forms will be processed "without any retaliation" and assistance will be provided to complete the form
- Make the form available in clinic lobbies
- Provide information to consumers about their rights to file a grievance/appeal/expedited appeal, or State Fair Hearing when they are dissatisfied with mental health services
- Make the PRO contact information visible in all forms, brochures, and documentation
- Employ peers who are trained as advocates at the PRO. Peer advocates could educate and guide the individual filing the grievance
- Consideration should be given to use of "culture-specific advocates" who can guide those who may not trust the system to file grievances by providing reassurance
- Ensure that there is no retaliation towards staff who assist in providing the forms
- Train coalition groups on how to use the "Grievance/Appeal/Expedited Appeal" form

Prevention-related services funded by the Mental Health Services Act. In February 2018, a PowerPoint presentation was delivered to the CCC on countywide prevention-related services funded by the MHSA Prevention and Early Intervention (PEI). The presentation informed the Committee about Prevention services taking a public health approach to address the needs of children, families, and communities who have experienced trauma or are at risk of trauma. The CCC provided these recommendations:

- Promote outreach and engagement to be inclusive of persons with disabilities
- Provide a follow-up presentation on new programs
- Re-examine existing Memorandum of Understanding (MOU) among authorized DMH programs providing services at public schools

The Mental Health Services Act Three-Year Program, Expenditure Plan, and Annual Update. In April 2018, the Program Development and Outcomes Bureau delivered a PowerPoint presentation to the CCC on the MHSA Annual Update Report for FY 18-19. The CCC reviewed detailed program information and data as follows:

- Community Services and Supports (CSS) Client Counts by race/ethnicity, primary languages, and SA; Full Service Partnership (FSP) slot allocations for children, Transition Age Youth (TAY), adults and older adults and outcomes by FSP type
- PEI programs such as Stigma and Discrimination Reduction, Suicide Prevention, Early Intervention, and Prevention; and PEI Client Counts by race/ethnicity and language and outcomes

Los Angeles County Health Agency's Institute for Cultural and Linguistic Inclusion and Responsiveness. In April 2018, the ESM introduced the Institute for Cultural and Linguistic Inclusion and Responsiveness (ICLIR) to the CCC as a Health Agency initiative for cultural and linguistic competence under the Center for Health Equity. The CCC was informed that this Institute was implemented in early April 2018 with representatives from the Department of Health Services (DHS), DMH, and Department of Public Health (DPH). The ICLIR will focus on creating an infrastructure centered on cultural and linguistic responsiveness, training/staff development, communication and stakeholder involvement, and resources for cultural competency, health equity, and disparities. The CCC engaged in a discussion and will provide recommendations to ICLIR as projects and activities are planned and implemented.

Perspectives about the Deaf Community and its Culture. In May 2018, the Greater Los Angeles Agency on Deafness, Inc. delivered a PowerPoint presentation to the CCC regarding the deaf culture and perspectives of the deaf community. The CCC members learned about key definitions related to deaf culture, effective communication strategies, assistive technologies, and community resources for deaf and hard-of-hearing communities. The CCC received this presentation with great interest and as a whole concluded the need for access to mental health services for deaf and hard-of-hearing communities. This presentation was coordinated by the CCU to provide background knowledge to guide the review of DMH Policy and Procedure 200.02, "Hearing-Impaired Mental Health Access[5]."

[5] Department of Mental Health Policy/Procedure, 200.02, effective date April 7, 2010.

The Disaster Preparedness Brochure. In May and June 2018, the EOTD, Disaster Services Unit solicited feedback and recommendations from the CCC on the "Disaster Preparedness" draft brochure. The CCC engaged in a discussion regarding the content of the brochure and provided these recommendations:

- Include information for the deaf and hard-of-hearing community
- Translate the brochure in all threshold languages
- Provide the address and telephone number of the EOTD on the front page of the brochure
- List hotline numbers on the front page of the brochure
- Specify what a Two-Week Emergency Kit contains and ways to prepare for an emergency
- Provide a Family Disaster Plan as an additional handout that can be distributed along with the brochure

Mental Health Services Act Innovations 6 Virtual Trainings for Staff Project. In June 2018, a PowerPoint presentation was delivered to the CCC regarding INN 6 Staff Training project which involved the production of on-line trainings that introduced direct service staff and peer support specialists to various cultural competence scenarios. The CCC membership engaged in a discussion regarding the benefits of these trainings and provided these recommendations:

- Develop avatars that will speak in threshold languages
- Develop trainings that are Applied Behavior Analysis (ABA) compliant
- Consider utilizing human actors instead of the virtual characters

Los Angeles County Health Agency's Institute for Cultural and Linguistic Inclusion and Responsiveness Update. In June 2018, the ESM distributed a handout that explained the adopted model for ICLIR under the Center for Health Equity. The CCC was informed that the mission of the institute is "to create culturally and linguistically appropriate pathways that address gaps in service delivery and advance the Health Agency's ability to meet the needs of Los Angeles County communities." The CCC engaged in a discussion regarding ICLIR's Work Plan for FY 18-19 and the CCC was asked to identify areas where the CCC and ICLIR can work collaboratively in advocating for more appropriate service delivery. The CCC provided the following feedback:

- Consider implementing a staff training on micro-aggressions
- Provide cultural competency trainings to new hires across the three Departments to ensure consumers are being treated with dignity and respect
- Increase the number of approved languages for bilingual bonus

Cultural Competence Plan for Fiscal Year (FY) 15-16. In July 2018, the ESM delivered a PowerPoint presentation to the CCC on the eight criteria composing the the Department's CCP developed in accordance with the Title IX – CCR and CCP requirements from the Department of Health Care Services. The specific topics of the presentation included:

- Criterion I: Commitment to Cultural Competence
  - The Department's mission and vision statements
  - Policies and procedures related to cultural competence
  - Budget for cultural competence initiatives and activities

- Criterion II: Updated Assessment of Service Needs
  - Demographic data for Los Angeles County General Population (race/ethnicity, age group, and gender)
  - Data on identified unserved/underserved target populations with disparities for Medi-Cal, CSS, WET, and PEI populations
  - Departmental strategies to reduce disparities
  - MHSA-funded strategies to reduce disparities

- Criterion III: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
  - Program reports on consumers served, strategies/objectives, status of implementation/progress, monitoring and outcomes
  - Departmental strategies to reduce mental health disparities

- Criterion IV: Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System
  - The Department's CCC mission, membership, structure, and racial/ethnic and linguistic diversity

- Criterion V: Culturally Competent Training Activities
  - Foundational cultural competence trainings
  - Cultural competence trainings for Specialty Mental Health Services (SMHS) providers
  - Language interpreters training and monitoring
  - Requirement for 100% of the Department's workforce to receive annual cultural competence training inclusive of clerical/support, financial, clinical/direct service, and administration/management at DO and LE/Contracted programs

- Criterion VI: County's commitment to growing a multicultural workforce
  - Hiring and retaining culturally and linguistically competent staff

- Criterion VII: Language Capacity
  - Profile of threshold languages by SA
  - Departmental policies and procedures related to language assistance services
  - Departmental protocols to assist persons who have Limited English Proficiency

- Criterion VIII: Adaptation of Services
  - Consumer-driven/operated recovery and wellbeing programs such as Wellness Centers, Drop-in Centers and Client-Run Centers
  - The Department's Contractual Agreements
  - Consumer Perception Survey outcomes
  - PIPs
  - ACCESS Center calls
  - Grievances and complaints data

Juvenile Justice Initiative - California's Continuum of Care Reform. In August 2018, a PowerPoint presentation was delivered to the CCC on Juvenile Justice Initiatives – California's CCR and its framework to ensure access to mental health services and supports to children and youth in the foster care system. The CCC was informed about CCR goals, principles, and programs. The CCC membership engaged in discussion regarding medications given to children and youth. The committee advocated for the following:

- Provide education about CCR services at all schools, including private schools especially when children are enrolled at new schools
- Include the voice and perspective of children in staff trainings
- Create a report addressing how CCR services improve the lives of children and families, and disseminate it to the community

Policy and Procedure 200.02, "Hearing-Impaired Mental Health Access[6]." In August 2018, the ESM presented the CCC with DMH Policy and Procedure 200.02, "Hearing-Impaired Mental Health Access" for review. The CCC recommendations for the revision of this policy included:

- Specify that DMH will be providing access to mental health services for the Deaf and Hard-of-Hearing community
- Delete wording "hearing impairment" and replace with "consumers who are deaf and hard of hearing with mental health needs"
- Identify the contracted agencies that are providing sign language interpretation services for the ACCESS Center
- Update Teletype/Telecommunications Devices to include: Video Phone Technology
- Provide a description of California Relay Service (CRS) or Video Phone for consumers who are deaf and hard-of-hearing

Special Visit From the Orange County Cultural Competency Advisory Committee. In September 2018, the CCC welcomed a visit from the Orange County ESM and members of Cultural Competency Advisory Committee who were interested in learning about the Department's CCC structure, activities, meeting format, and impact on the system of care. The Orange County visitors shared information on their advisory committee demographics, history, leadership, objectives, and projects. The CCC members expressed satisfaction in being held as an example for other Counties.

Spirituality in Mental Health Services. In September 2018, the CCC benefited from a brief presentation on Spirituality in Mental Health by one of its co-chairs. The presentation featured spirituality as an element of culture and a healing strategy for several cultural communities.

"YourDMH" Vision and Guidelines Concept Paper. In September and October 2018, the CCC learned of DMH executive management's efforts to reinvigorate the System Leadership Team (SLT) under a new name and structure called "YourDMH." Examples of the feedback provided by the committee members by document section:

General

- Simplify the language used throughout the document
- Post the "YourDMH" Vision and Guidelines on the Department's website and translate it the threshold languages
- Continue gathering input on the name

[6] Department of Mental Health Policy/Procedure, 200.02, effective date April 7, 2010

Vision

- Define “Stakeholder groups”
- Specify the mechanism to be used for DMH follow-up on stakeholder recommendations
- Ensure that culturally competent and linguistically appropriate services are part of the vision
- Define what is meant by “services” by including cultural competence, accessibility, ADA compliance, trauma-informed, and CODs as qualifiers

Purpose

- Define what is meant by stakeholder priorities
- Provide a copy of the departmental action plan along with this document

Values

- Add cultural competence and “acknowledgement and honoring of consumers’ ideas” as core values

Overall Structure

- Open meetings to the community and make everyone feel welcome
- Hold “YourDMH” full group meetings on a monthly basis
- Ensure that the meeting location is accessible by public transportation and ADA compliant
- Provide monetary support/assistance to community members for transportation expenses
- Inform the community about the date/time/location of meetings well in advance, including changes in meeting scheduling
- Develop a communication system to provide meeting information and updates
- Ensure that meetings uphold the Consumers’ Bill of Rights
- Inform the community about budget allocations for various programs and projects

Membership Composition

- Ensure that the “YourDMH” membership is inclusive of all cultural groups, individuals with lived and shared experience, and youth
- Allow the SAs to decide the number of members and to not place any caps on the membership
- Include consumer protections, advocacy, and investigation of issues that may arise during meetings

Membership Eligibility

- Remove quorum specifications and simplify membership eligibility by using a baseline of 50% meeting attendance
- Gather information from prospective members on how they plan to represent the interests of specific stakeholder groups
- Enforce regular attendance of members to the public meetings
- Ensure that voting members miss no more than two consecutive public meetings

Membership Voting

- Simplify the language in this section
- Enforce the requirement for voting privileges to be 50% attendance/participation in meetings
- Allow each SA "YourDMH" committee to make decisions regarding co-chairs

Membership Leadership

- Keep the current leadership roles to one chair position held by a DMH staff and one co-chair held by a community member
- Include the voice of the community and their recommendations in decision-making and shaping of the SA-based "YourDMH" committees

Meetings

- Provide Full group and SA-based "YourDMH" meeting schedule information well in advance via several venues and on the DMH website
- Rotate the meeting location
- Ensure that the meeting location is easily accessible via public transportation
- Provide meeting coordinators to answer questions in a timely manner
- Include an item for "stakeholder priorities" in each meeting agenda
- Exercise an open door policy for meetings to ensure participation from the community
- Track meeting attendance for purposes of establishing voting privileges
- Develop a mechanism to respond to stakeholder priorities and ensure that recommendations presented are taken seriously
- Provide language accessibility in the 13 threshold languages as well as ASL

DMH Responsibilities

- Provide language interpretation and translation services for all meetings
- Translate meeting information in the threshold languages and ASL and meet the needs of persons who are blind or have vision conditions
- Translate website into the threshold languages and ASL
- Allocate DMH support staff to help with meetings and activities at SA-based meetings
- Provide compensation such as gift cards, transportation vouchers, and bus tokens to members attending meetings
- Disseminate "YourDMH" meeting minutes one week prior to the next meeting

"YourDMH" Cultural Communities

- Base all programming and activities on the "Culturally and Linguistically Appropriate Standards" to ensure that services are "effective, equitable, understandable, respectful, and responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs of the communities served."
- Establish close partnerships with the following groups besides the Underserved Cultural Communities subcommittees:
    - CCC
    - Faith-based organizations
    - Age groups
    - Other culture-related groups
- Follow same recommendations as specified on pp. 16-19

Project About Building Connections. In November 2018, a PowerPoint presentation was delivered to the CCC on the Project About Building Connections (Project ABC); a federally funded project aimed to assist Los Angeles County in providing an integrated childhood system of care network that responds to family needs and includes families in planning and service delivery. The CCC learned that the goal of the project is to ensure that children living in Los Angeles County from birth to five years of age have access to a variety of mental health services that are family-driven, strength-based, and culturally competent. The CCC engaged in a dialogue relating to the impacts of early childhood trauma. The CCC was appreciative of this presentation and advocated for prevention and early trauma intervention for children.

Overview of the Office of Administrative Operations – Quality Improvement Division Units

Cultural Competency Unit

The organizational structure of the Cultural Competency Unit (CCU) allows for cultural competency to be integrated into QID roles and responsibilities to systematically improve services and accountability to consumers, family members, and the communities served by the Department. Additionally, this structure places the CCU in a position to collaborate with several Departmental programs such as the UsCC Unit, the PRO, WET Division, MHSA Implementation and Outcomes Division, and the SA QICs.

The supervisor of the CCU serves as the Department's ESM and is a standing member of the Departmental QIC, the Departmental CCC, and the Cultural Competency, Equity, and Social Justice Committee (CCESJC). The ESM facilitates the administrative oversight of the CCC's activities. The ESM reinforces the Departmental framework for cultural responsiveness via the implementation of the CCP requirements and the Culturally and Linguistically Appropriate Services (CLAS) standards. The CCU promotes awareness and utilization of this framework to: reduce disparities and combat stigma; promote hope, wellbeing, recovery and resiliency; and serve Los Angeles County communities with quality care.

Most Salient Activities of the Cultural Competency Unit in Calendar Year 2018.

Implementation of the Health Agency's Institute for Cultural and Linguistic Inclusion and Responsiveness. Implemented in April 2018, the goal of Health Agency's (HA) Institute for Cultural and Linguistic Inclusion and Responsiveness (ICLIR) is to create culturally and linguistically appropriate pathways that address gaps in service delivery and advance the HA's ability to meet the needs of Los Angeles County communities. The framework for ICLIR was developed by the Department's ESM. The CCU provides administrative support for ICLIR's monthly meetings and objectives. Figure 1 is a visual representation of the ICLIR framework, including its four strategic domains:

1. Infrastructure centered on cultural and linguistic competency responsiveness – ensures active collaboration among the three Departments to:
    - Identify and respond to cultural and linguistic service delivery gaps within the HA
    - Establish appropriate goals in accordance with the Department's cultural and linguistic competency reporting requirements and ICLIR's mission statement
    - Assess the functionality of cultural competence-related policies and procedures for ICLIR

2. Training and staff development activities – endows DHS, DMH, and DPH staff with additional skill sets that enhance cross-cultural awareness, sensitivity, and humility, and decrease implicit bias

3. Communication and stakeholder involvement mechanisms – focused on collaborative efforts to:

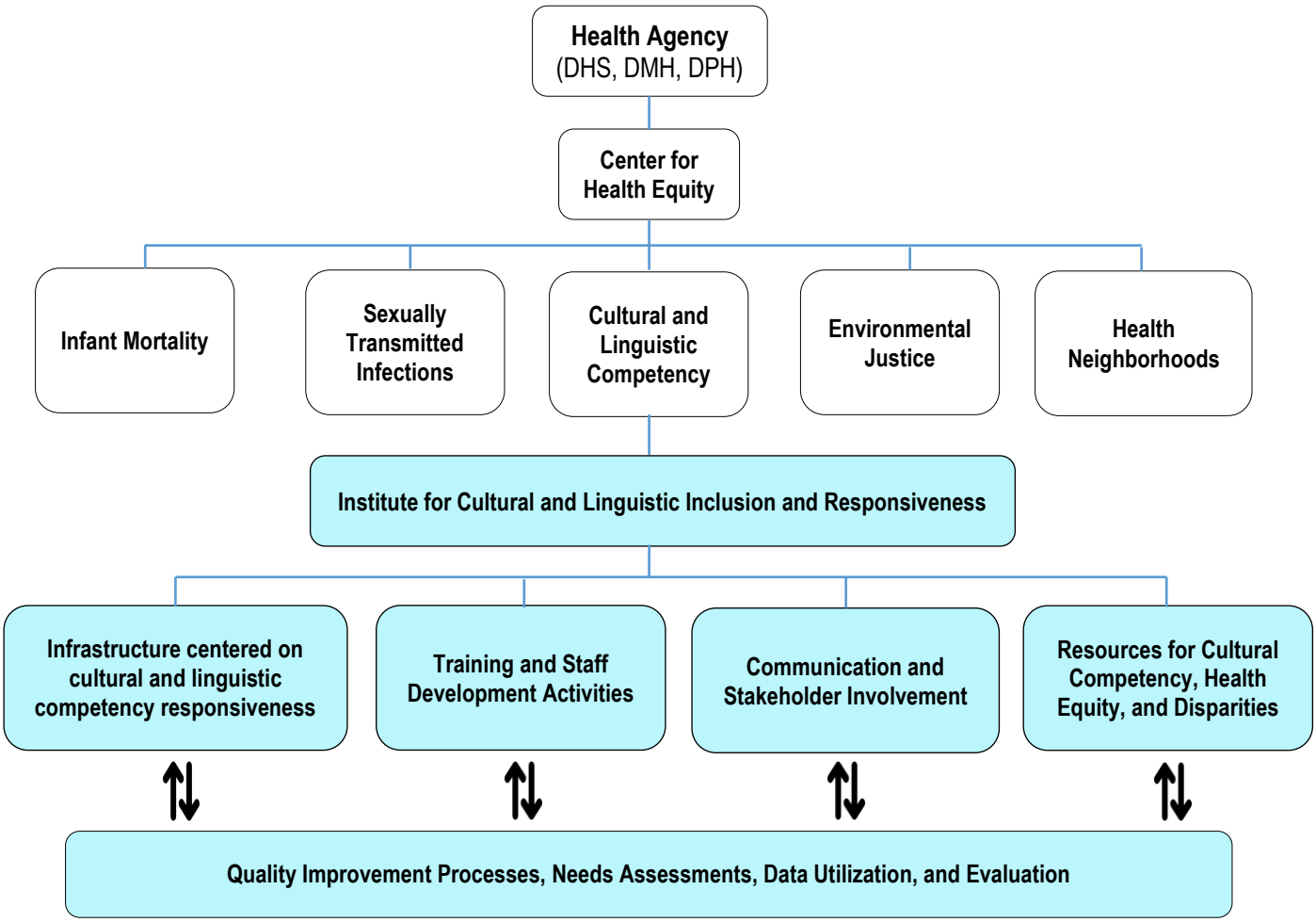
    - Build effective processes for the transmission of information related to CC and linguistic appropriateness within Departments and across the HA
    - Gather and respond to feedback received from stakeholders including consumers, family members, peers, advocates, Promotores de Salud, and staff

4. Resources for cultural competency, health equity and disparities – comprises a virtual repository for useful literature and toolkits pertinent to cultural competence, health equity, and health disparities which inform service planning, delivery, and evaluation

The ICLIR domains are sustained by the following commitments:

- Improve the HA's quality of culturally and linguistically competent services
- Respond to gaps in service delivery
- Fulfill needs assessment follow-up actions
- Utilize data to identify and evaluate the effectiveness of interventions
- Build cross-departmental responsibility to share resources

Figure 1
Institute for Cultural and Linguistic Inclusion and Responsiveness Framework



Data Source: ICLIR, March 2019.

Implementation of the Health Agency's Labor Management Transformation Council's Cultural Intelligence Workgroup. The mission of the Cultural Intelligence Workgroup is to increase cultural sensitivity, understanding and humility within the HA in order to enhance the quality of interpersonal human relationships for all individuals connected to the Los Angeles County system of care. During CY 2018, the workshop reviewed the Consumer Perception Survey data specific to the item "Staff was sensitive to my cultural background." This data was utilized for the planning of a cultural sensitivity campaign for the three HA Departments in CY 2019.

Los Angeles County Department of Mental Health Cultural Competence Organizational Assessment. This project is a system-wide assessment of staff perceptions regarding the Department's responsiveness to the cultural and linguistic needs of the Los Angeles County diverse communities. As the lead for this project, the CCU worked closely with the hired consultant to implement the survey in December 2018. Strategic survey completion reminders were sent to the entire DMH workforce to encourage participation. The survey outcomes and recommendations from the CC Organizational Assessment are expected by Spring 2019. This information will inform future cultural and linguistic competence strategies to reduce mental health disparities. The Department will utilize these recommendations to improve its system of care in the area of cultural and linguistic competency.

Network Adequacy: Annual Completion of Cultural Competency Training. To assist in the implementation of the Network Adequacy requirements pertinent to annual completion of cultural competence training, the CCU developed a "Frequently Asked Questions" handout which was widely utilized to guide clinical and administrative programs seeking technical assistance. It was made available to all DMH programs and providers via the QID webpage. Additionally, the CCU released two departmental memoranda for DO, LE/Contracted providers, and administrative programs to a) clarify the differences between the two provisions under which CC training must be completed: the federal Medicaid Managed Care "Final Rule" Network Adequacy requirements under Title 42 and the State's Medi-Cal regulations under Title 9 – CCP, and b) move the system toward a standardized mechanism to track CC training completion by staff until the Network Adequacy Certification Tool (NACT) became operational.

Tracking of Cultural Competence Training Completed by the Los Angeles County Department of Mental Health Workforce. The CCU developed two levels for tracking the completion of annual cultural competence training. For the first level, the CCU coordinated efforts with the QA Division to access attestations received via Quarterly Reports submitted by DO and LE/Contracted providers. The second level involved the distribution and tracking of completed training attestation forms specifically designed for reporting by executive management, DO and LE/Contracted providers, and administrative programs. After completing an analysis of the collected quarterly reports and attestation forms, the Unit generated SA-specific summary reports which were disseminated to the SA QIC chairs for follow-up on training requirements. Additionally, the CCU collaborated with the QA Division to ensure that the NACT included a field for reporting and tracking of completed annual cultural competence training. Two items were added to the NACT: "Cultural Competence Training (select "yes" or "no") for receiving training in the past 12 months" and "Percentage of workforce members trained in Cultural Competence."

External Quality Review Organization Review. The CCU actively participated in the annual EQRO Review in September 2018. The Unit coordinated the collection of reports from 25 programs regarding strategies to reduce mental health disparities, consumer utilization data, and cultural competence staff trainings. The CCU also provided technical assistance to these programs for the proper completion of these reports. The collective information gathered was utilized for the 2018 DMH CCP Update and EQRO evidentiary documentation. Additionally, the ESM provided a presentation on the CCU's activities in the disparities session of the EQRO Reviews.

Cultural Competence Trainings and Community Presentations. The CCU provides CC-related trainings and presentations throughout the year. Examples for CY 2018 include:

A. New Employee Orientation (NEO)

The CCU participated in NEO by providing bi-monthly one-hour long CC trainings that introduce new employees to the functions of the CCU, the CLAS standards, the Cultural Competence Plan Requirements (CCPR), the Los Angeles County demographics and threshold languages, and the Department's strategies to reduce mental health disparities.

B. Cultural Competence Plan (CCP) presentations at all Service Area Quality Improvement Committees (SA QICs)

The CCU developed and delivered a total of nine presentations on the criteria of the CCP at SAs 1 to 8 and countywide QICs. The presentation covered the following topics:

- What is the CCP?
- Why does the Department develop an annual CCP?
- How is the CCP developed?
- What are the requirements and components of the CCP?
- Sample content for the CCP criteria

C. Service Area 2 Cultural Competency presentations

In the role of the CCU supervisor, the ESM provided a series of three presentations for parents and community members from Morningside, Haddon Avenue Stream Academy and Hubbard Street Elementary Schools in March 2018. Each presentation was conducted in Spanish and had a two-hour duration. The evaluation forms gathered from participants reported high levels of satisfaction with the content relevance and applicability to family life and social relations.

D. Cultural Competency and Cultural Humility presentation for the Health Agency's Labor Management Transformation Council (LMTC)

In May 2018, the ESM delivered this presentation to an audience composed of the HA Directors from the Departments of Mental Health, Health Services and Public Health as well as representatives from Labor Unions. This presentation marked the starting point for the implementation of the LMTC's Cultural Intelligence Workgroup.

E. Cultural Competency and Cultural Humility training for Students of Social Work and Psychology

This training was developed and delivered by the ESM for approximately 20 Master-level students in October 2018. Training topics included:

- Introduction and definitions
- Federal, State and County regulations pertinent to cultural competency
- The CLAS standards
- Departmental strategies to reduce mental health disparities
- Cultural humility
- The client culture and stigma
- Elements of cultural competency in service delivery
- Los Angeles County and the Department's demographics

Los Angeles County Department of Mental Health Integrated Health Multicultural Conference Planning Oversight. Starting in October 2018, the CCU led the planning efforts for the implementation of the Department's first Integrated Health Multicultural Conference, scheduled for June 2019. The conference addresses models of health integration for less-recognized yet well-established underserved populations such as veterans, foster care youth, immigrants and asylum seekers, persons experiencing homelessness, older adults, persons who are incarcerated or recently released from prison, persons with disabilities, and persons who have substance use disorders, among others.

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

Cross-County Department Collaboration in Cultural Competency Initiatives. The CCU collaborated in initiatives that involved a consortium of County Departments with the goal of advancing cultural competence, cultural humility and language justice. Examples include:

- Government Alliance for Racial Equity (GARE)
- 2018 Riverside County CC Summit Planning Committee
- 2019 Countywide Equity Summit Planning Committee

Data Collection, Analysis and Reporting of Preferred Language Requests.
During CY 2018, the CCU continued the collection and analysis of all the preferred language requests reported by the Department's providers via their Initial Request & Referral Logs for Culture Specific Mental Health Services. The Unit produced monthly and annual summaries of the total requests for preferred threshold and non-threshold languages by SA. The data from these reports is utilized to track the language requests from Limited English Proficiency consumers at the time they access mental health services.

Underserved Cultural Communities

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

Each UsCC subcommittee is allotted one-time funding totaling $200,000 per FY to focus on Community Services and Supports (CSS)-based capacity-building projects. This unique opportunity draws on the collective wisdom and experience of community members to determine the greatest needs and priorities in their communities. Project proposals are created and submitted via a participatory and consensus-based approach. An overview of the projects implemented is provided in the following.

Underserved Cultural Communities (UsCC) Subcommittees

African/African-American Underserved Cultural Communities Subcommittee Projects

Black Immigrant Youth Empowerment Project. The Black Immigrant Youth Empowerment Project (BIYEP) project was implemented on July 1, 2018 and is scheduled to be completed on June 30, 2019. This project was developed to engage, empower, and educate the Black immigrant community to seek mental health services as well as reduce stigma and increase the capacity of the public mental health system.

The implementation of this project was divided into two phases:

- Phase one is the recruitment and training of 30 Black Immigrant Youth on basic mental health education and public speaking skills
- Phase two is the facilitation of 50 community mental health presentations countywide

Black Immigrant Youth Empowerment Project Outcomes for Calendar Year 2018.

- Thirty Black Youth were recruited to be a part of this project
- Participants were from eight ethnically diverse racial backgrounds including: African American, Afro-Caribbean, Black, Egyptian, Ethiopian, Jamaican, Mexican American, and Nigerian
- The training curriculum was completed on December 31, 2018
- Thus far, 15 youth have completed the training seminars and an additional 10 will be trained by March 30, 2019
- The community presentations aim to promote mental health services, reduce stigma, and empower community members to access mental health services for themselves and their families. It is projected that a total of 50 community mental health presentations will be conducted by July 1, 2019

The African American Mental Health Radio Campaign. The African American Mental Health Radio Campaign was launched on October 16, 2017 and was completed on January 7, 2018. A local radio station was contracted to produce and broadcast five 30-second and 60-second Public Service Announcements (PSAs) to provide mental health education to the African American community.

The African American Mental Health Radio Campaign Outcomes for Calendar Year 2018:

- The PSA provided culturally sensitive information, education, and resources to the African American community in Los Angeles County. Overall, this radio media campaign successfully helped to reduce stigma, increase mental health awareness, and access among African American community members.
- The PSAs aired on KJLH radio on a weekly basis for a total of three months. In total, 124 PSAs were aired. A total of 342,000 radio impressions were delivered. The digital display banners on the radio station's website delivered approximately 332,934 impressions. A total of 883,000 impressions and audio streaming were delivered under contract; additional impressions were delivered as bonuses, with a grand total of 2,650,800 impressions. The e-blast total was 116,121 impressions.

Life Links: Resource Mapping Project. This project has been implemented for five consecutive years. Funds were allocated to develop a community resource directory called Life Links. Community resources, service providers, and agencies were identified in south Los Angeles County, where there is a large African/African-American (AAA) population. This directory of approximately 300 services and listings of unique interest to specific cultural groups, includes names, addresses, contact information, hotlines, and toll-free numbers.

Life Links: Resource Mapping Project Outcomes for Calendar Year 2018:

- For the fifth reprint, 15,000 booklets were ordered as of December 2018
- To date, there have been over 20,000 Life Links booklets distributed in Los Angeles County

American Indian/Alaska Native Underserved Cultural Communities Subcommittee Projects

American Indian/Alaska Native Bus Advertising Campaign. The American Indian/Alaska Native (AI/AN) Bus Advertising campaign took place in SA 1 for 12 weeks from January to April 2018. It included the following: 15 taillight bus displays, 12 king-size bus posters, five queen-size bus posters, and 80 interior bus cards. It also included an additional 80 interior bus cards for 12 weeks from April to June 2018, at no additional cost. The goal of this advertising campaign was to promote mental health services, increase the capacity of the public mental health system in Los Angeles County, increase awareness of the signs and symptoms of mental illness, and reduce the stigma associated with mental health conditions for the AI/AN community. This 12-week advertising campaign educated and provided linkage and referrals to AI/AN community members.

American Indian/Alaska Native Bus Advertising Campaign Outcomes for Calendar Year (CY) 2018:

- A total of 12,346,100 impressions were delivered
- Advertising took place primarily in the following cities: Lancaster, Palmdale, Littlerock, Lake Los Angeles, and unincorporated areas of Los Angeles County

American Indian/Alaska Native Mental Health Conference. One of the recommendations of the AI/AN UsCC subcommittee was to plan and coordinate the 2017 American Indian/Alaska Native Mental Health Conference: “Bridging the Gaps – Systems, Cultures, and Generations.” The conference took place at the close of FY 17-18 on November 14, 2017.

American Indian/Alaska Native Mental Health Conference Outcomes for Calender Year 2018. The purpose of the conference included the following: to inform participants of mental health issues unique to the AI/AN community, to improve participants' ability to recognize when to refer an AI/AN community member for mental health services, to provide participants with useful information on available mental health resources for AI/AN community members, and to improve participants' ability to provide culturally appropriate mental health treatment to AI/AN consumers. A survey was handed out to all participants at the start of the conference. In total, 265 individuals attended the conference and of those, 119 completed surveys.

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

Asian Pacific Islander Underserved Cultural Communities Subcommittee Projects

Asian Pacific Islander Youth Video Contest: "Go Beyond Stigma!" This project was implemented on January 1, 2018 and is scheduled to be completed on March 30, 2019. The Asian Pacific Islander (API) Youth Video Contest project included the recruitment and training of API Youth on mental health issues and resources as well as technical assistance to support the development of video (maximum of three minutes) on how mental health issues impact their life. The videos were submitted as part of a Video Contest and were showcased at an Awards Ceremony, which was part of a community event. The purpose of this project is to provide API youth (ages 16-25 years) an opportunity to share how mental health issues impact their life, family, and community using video in order to increase awareness and knowledge of the signs and symptoms of mental illness and improved access to mental health services for API Youth in Los Angeles County.

***Asian Pacific Islander Youth Video Contest: "Go Beyond Stigma!" Outcomes for Calendar Year 2018**:*

- Three orientations were held for the youth on mental health issues and the art of storytelling
  - Thirty-nine individuals attended the orientations
  - Their primary languages included Chinese, Cambodian/Khmer, Spanish, Hindi/Urdu, Tagalog and Thai
  - They included a diverse array of API ethnicities including Cambodian, Indian, Latino, Taiwanese and Thai
- Two trainings were held for the youth on how to develop a mental health video
  - Ten individuals attended the trainings
  - Their primary languages included Chinese, Hindi/Urdu, and Thai
  - They included a diverse array of API ethnicities including Indian, Taiwanese and Thai
- Four teams composed of a total of 12 youth, completed the orientation, training, and development of a video
- Four videos were submitted for the Video Contest
- Pre and post-tests were completed by the youth participants in order to measure the impact of the participation on their awareness and knowledge of mental illness. The analysis of these results is still in progress
- Surveys were completed by the community members who attended the Awards Ceremony event at the conclusion of the project. The survey assessed the impact of the event on the attendees' awareness and knowledge of mental illness. The analysis of these results is still in progress

The Samoan Outreach and Engagement Program. In 2018, DMH utilized CSS funds to continue the Samoan Outreach and Engagement (O&E) Program in order to increase awareness of mental illness, knowledge of mental health resources in order to increase referrals, and enrollment into mental health services by the Samoan community. The Department contracted with Special Services for Groups (SSG) who partners with two Samoan community-based agencies to conduct individual and group outreach, engagement, and referral activities with the Samoan community in SA 8, which has the largest concentration of Samoans within the Los Angeles County. This program completed its third year of implementation on June 30, 2018, during which community outreach was conducted at some colleges, churches, Institute of Mental Disease (IMD) facilities, hospitals, jails, and other community gathering sites. Starting July 1, 2017, the focus of the program changed to focus more on referrals. As of 2018, there were a total of 12 referrals made as a direct result of the Samoan O&E Program, which resulted in two enrollments into mental health services.

Asian Pacific Islander Mental Health Awareness Media Campaigns. This project includes seven separate campaigns scheduled to be completed in April 2019. The campaign implementation took place in May 2018. The goal of the API UsCC Mental Health Awareness Media Campaign 2018 was to target various API communities in Los Angeles County and educate them about signs and symptoms of mental illness, mental health resources, reduce mental illness related stigma, and reduce gaps in mental health service delivery in the various API communities by using media to help link the API communities to the public mental health system. The Department targeted the following API communities: Cambodian (Khmer), Chinese (Mandarin and Cantonese), Indian (Hindi and English), Filipino (Tagalog and English), Japanese, and Korean. Each Media company developed and aired at least one PSA to target the respective target community. The Department's banners were developed and posted on their station's website, with a link to the DMH website. Some Media Companies also provided interview segments, outreach events, and community mental health surveys in kind. Social Media was also utilized where possible. All PSAs, segments, etc., are being posted onto the DMH website and used for future outreach purposes. The outcomes are still in progress. All Media Companies will provide a summary of the airing of the PSAs, etc., as well as viewership information. ACCESS Helpline is tracking the number of calls received from various racial/ethnic groups by race/ethnicity and language, so that the community impact can be determined. Project Summary reports will include summaries of the community surveys that were implemented and community feedback that was gathered.

The Deaf, Hard-of-Hearing, Blind, and Physical Disabilities Underserved Cultural Communities Subcommittee Projects

The Deaf, Hard-of-Hearing, Blind, and Physical Disabilities UsCC subcommittee was established January 1, 2018 and held its first UsCC subcommittee meeting on January 30, 2018. The goal of this subcommittee is to reduce disparities and increase mental health access for the deaf, hard-of-hearing, blind, and physically-disabled community. This group works closely with community partners and consumers in order to increase the capacity of the public mental health system, to develop culturally relevant recovery-oriented services specific to the targeted communities, and to develop capacity-building projects. As of June 30, 2018 this subcommittee has identified four capacity-building projects for the next FY, has a membership roster of over 50 individuals, and is actively recruiting new members.

Eastern European/Middle Eastern Underserved Cultural Communities Subcommittee Projects

The Armenian Mental Health Show. A local Armenian television station, ARTN TV Station, was contracted to produce, direct, host, and broadcast a weekly mental health show in the Armenian language. The show consisted of 28 half-hour episodes, where various mental health topics were presented. The Armenian Mental Health Show included episodes on the following topics: depression, anxiety, couple's therapy, trauma, and intergenerational issues. During the third season, the format of the show changed. It included three phases: 1) An introduction that included opening remarks by a mental health professional and a host (three to five minutes); 2) A therapy session reenactment facilitated by a mental health professional and included actors and actresses (10 to 15 minutes); and 3) A TV host and a mental health professional, who explained the therapy session and its process (10 minutes). Each of the actors/actresses were well-known in the community. The show provided an opportunity for the Armenian Community to be educated and informed on the symptoms associated with a variety of different psychological disorders and the psychotherapeutic process. It included current psychological issues that are impacting the Armenian Community in Los Angeles County. The shows were broadcasted in areas in Los Angeles County with the largest concentration of Armenians such as La Cañada, Burbank, North Hollywood, Glendale, Pasadena, Los Angeles, and Montebello.

The Armenian Mental Health Show Outcomes for Calendar Year 2018:

- From August 2018 to November 2018, a total of 28 half hour mental health shows were aired on the local Armenian television station
- The format of the show was unique as it was the first time in the history of the television (TV) station that a show was produced showcasing what the psychotherapy process looks like as a marketing tool to reduce mental health stigma within the Armenian community. Based on the feedback provided by the TV viewers, Armenian Community members felt that the show was interesting, culturally relevant, educational, and expanded their knowledge regarding mental health and how these issues present within the Armenian Community
- The result of the shows surpassed all the expectations. It appeared that there was a shift in the thinking of the Armenian Community about mental health conditions and its treatment approaches
- Since the show began, hundreds and hundreds of ARTN TV viewers have been calling and asking mental health related questions. After the show ended, many community members called ARTN TV requesting for it to continue and even offering new topics for discussion

The Arabic, Farsi, and Russian Public Service Announcement Project. This project was implemented on July 1, 2018 and is expected to be completed on August 31, 2019. The project seeks to increase mental health awareness and education to the Arabic, Farsi, and Russian speaking communities in Los Angeles County, which are significantly underserved by the public mental health system. A consultant will produce, implement, post, and track 42, 90-second PSAs in the Arabic, Farsi and Russian languages. There will be 14 PSAs in each language. The PSAs include celebrities and/or prominent community figures from the three targeted communities. The consultant is responsible for posting/broadcasting the PSAs for a total of eight months via different social media outlets including, but not limited to Twitter, Facebook, and You Tube. The consultant will closely track and monitor the viewership of the PSAs to measure its effectiveness.

The Arabic, Farsi, and Russian Public Service Announcement Project Outcomes for Calendar Year 2018:

- To date, 10 Arabic, Farsi, and Russian PSAs have been posted on YouTube, Twitter, and Facebook
- Some of the topics include Posttraumatic Stress Disorder (PTSD), domestic violence, child abuse, substance abuse, loss and grief, bullying, etc.
- This project is expected to be completed on August 31, 2019

Latino Underserved Cultural Communities Subcommittee Projects

The Latino Media Campaign. The Latino media campaign was launched on May 1, 2017 and it was completed on July 16, 2018. The commercials were aired on the KMEX television station and KLVE, KRCD, and KTNQ radio stations. KMEX ran a total of 138 television PSAs, a 2-day Homepage takeover, Univision.com geo-LA/Local Los Angeles Rotation – in banner video, and Social Media. KLVE, KRCD, and KTNQ radio stations ran 501 PSAs, a 2-day Homepage takeover, and social media. In addition, three-minute interviews with the Department's ESM were aired weekly on Dr. Eduardo Navarro's program at KTNQ – 1020 Radio Station for nine weeks from May 11, 2017 through July 2, 2017. Another 30-minute interview for a PSA was aired on four radio stations on June 12, 2017 and June 25, 2017.

The Latino Media Campaign Outcomes for Calendar Year 2018:

- The KMEX report shows that the television campaign delivered a total of 14,501,956 impressions
- The KLVE, KRCD, and KTNQ reports showed that the radio campaign delivered a total of 12,200 impressions
- Digital campaign delivered 1,106,234 impressions
- A gross total of 15,620,390 impressions were delivered from viewers and listeners
- The media campaign reached millennials via digital, KLVE Motivational Monday social media posts, and homepage takeovers via Univision.com and at the same time, personally touched the 25-54 age group with their message on KMEX news and novellas
- KTNQ 1020 AM live interviews on Tuesdays with the Department's ESM aired weekly on Dr. Eduardo Navarro's program were considered by Univision Communications, Inc., "jewels for the community" as it offered advice on topics of importance to the functioning of a happy family

The Latino Bus Advertising Campaign. A Bus Advertising Campaign was implemented to promote mental health services, increase the capacity of the public mental health system, and reduce mental health stigma within the Latino community. The campaign began on February 27, 2017 and ended on October 8, 2017. It included the following: 172 taillight bus displays, 56 king-size bus posters, and 4,000 interior bus cards for a total of 32 weeks (including an additional 2,000 interior bus cards for 12 weeks at no additional cost).

The Latino Bus Advertising Campaign Outcomes for Calendar Year 2018:

- Forty-three bus tails for 16 weeks = 3,832,332 impressions
- Fourteen bus kings for 16 weeks = 4,410,672 impressions
- Five hundred interior bus cards for 32 weeks = 13,676,000 impressions
- The campaign delivered a total of 21,919,004 impressions

The Latino Mental Health Stigma Reduction Community Theater Project. The goal of this project is to outreach, educate, and increase knowledge pertaining to mental health services within the Latino community. By utilizing a non-stigmatizing method such as a theatrical play, Latino community members will learn about the signs and symptoms associated with mental health and will become familiar with the services that are available through the Department.

The Latino Mental Health Stigma Reduction Community Theater Project Outcomes for Calendar Year 2018. The Consultant who was awarded this project prematurely ended his Contract with DMH as he was having difficulties complying with the terms and agreements related to this project. As a result, this project is going through the solicitation process once again and will be implemented by May 2019.

Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning, Intersex, Two-Spirit Underserved Cultural Communities Subcommittee Projects

Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning, Intersex Iranian Outreach and Engagement Project. The objective of the Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning, Intersex (LGBTQI) Iranian Outreach and Engagement Project was to engage, empower, enlist, and enlighten the LGBTQI and non-LGBTQI Iranian 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. This would enable this often underserved and marginalized population to access mental health services for themselves and empower other community members to access mental health services. The project involved two phases: Phase 1 included eight health and wellness workshops, which provided outreach to Iranian LGBTQI community members and their families, as well as Iranian Student Clubs at local high schools and colleges; and Phase 2 included a media campaign targeting Iranian LGBTQI and non-LGBTQI community members through local Iranian talk shows, magazines, newspapers, and radio programs.

Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning, Intersex Iranian Outreach and Engagement Project Outcomes for Calendar Year 2018:

- A total of 244 individuals attended the health and wellness workshops. Of those, 213 completed the pre/post tests.
- The results of the pre/post tests showed a significant shift in participant beliefs and knowledge about LGBTQ issues
- Resources were provided at the presentations and included mental health resources, social support resources, and physical health resources.
- Six magazine articles were published in local Iranian magazines: Tehran Magazine and Javanan Magazine
- One article was featured on the cover of Tehran Magazine and it was the first time an article related to the LGBTQ community was on the cover of a mainstream Iranian magazine
- A total of three PSAs were recorded and aired 200 times on local Iranian radio station, KIRN 670am, between the dates of February 19, 2018 thru September 6, 2018
- In addition to the airing of the PSAs, KIRN 670am also broadcast 26, 23-minute radio programs every Sunday between February 25, 2018 thru September 2, 2018. The radio programs featured over 18 Iranian LGBTQ allies, activists, and celebrities.

Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning, Intersex, Two-Spirit Mental Health Conference. One of the recommendations of the LGBTQI2-S UsCC subcommittee was to plan and coordinate the 2018 LGBTQI2-S Mental Health Conference: "Unraveling the Rainbow – Embracing Our Diversity." The conference took place on June 6, 2018.

Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning, Intersex, Two-Spirit Mental Health Conference Outcomes for Calendar Year 2019. The purpose of the conference included the following: to inform participants of mental health issues unique to the LGBTQI2-S community, to improve participants' ability to recognize when to refer an LGBTQI2-S community member for mental health services, to provide participants with useful information on available mental health resources for LGBTQI2-S community members, and to improve participants' ability to provide culturally appropriate mental health treatment to LGBTQI2-S consumers. A survey was handed out to all participants at the start of the conference. The survey was anonymous and voluntary. In total, 303 individuals attended the conference and of those, 168 completed surveys.

- 93% agreed or strongly agreed that the conference made them more aware about the mental health issues unique to the LGBTQI2-S community
- 87% agreed or strongly agreed that the conference improved their ability to recognize when to refer an LGBTQI2-S community member for mental health services
- 91% agreed or strongly agreed that they received useful information on mental health resources for LGBTQI2-S community members
- 92% agreed or strongly agreed that the conference improved their ability to provide culturally-appropriate mental health treatment to LGBTQI2-S consumers

Collaboration with Chief Information Office Bureau (CIOB)

In October 2017, the Data – Geographic Information System (GIS) Unit was assigned to the Department's CIOB. The following QID activities require ongoing coordination and collaboration with CIOB:

1. Compiling system-wide information on consumers served and estimating populations in need of mental health services. The Data GIS Unit under CIOB oversight provides annual calculation on the population estimates for persons with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI), in addition to penetration rates by demographic categories: age group, gender, and race/ethnicity. Trend analysis is conducted on the Penetration Rate to assess fluctuations in service utilization by consumers. The Prevalence and Penetration Rates are also calculated for the eight SAs for dissemination to the respective Service Area Chiefs and QI liaisons for assessing unmet needs and related QI activities to address their needs.

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

3. CIOB will facilitate the process of selecting a random sample for the bi-annual consumer satisfaction survey administration in Day Treatment and outpatient programs. The Bureau is also responsible for conducting data analysis of the seven domains of perception, consumer satisfaction, and preparing a final report. Additionally, CIOB will provide assistance with survey design and implementation and data support to DMH Divisions and programs. In CY 2018, Consumer Perception Surveys were conducted in May and November. A data summary report for the November 2017 Consumer Perception Survey results was completed.

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

Summary

The QI Work Plan Evaluation report that follows provides an assessment of the goals identified in the QI Work Plan for CY 2017. The foundation for this evaluation is presented in the context of population demographics, both Countywide and by SA, as well as beneficiary satisfaction data, including data trends. Evaluation of the QI Work Plan provide a basis for the establishment of goals and objectives for the following calendar year.

Section 2

Population Needs Assessment

Introduction

The County of Los Angeles is the most populated county in the United States (U.S.) with an estimated population of 10,272,648 people in CY 2017. The County consists of 88 incorporated cities and includes 4,058 square miles of land area. Population density in the County, or the average number of people per square mile, is 2,531 as compared to 244 in the State of California.

Population distribution by race/ethnicity in the County of Los Angeles, as shown in Figure 2, is the highest among Latinos at 48.7%, followed by Whites at 26.6%, Asian Pacific Islanders (API) at 14.1%, African Americans (AA) at 8.1%, Two or More Races at 2.2% and Native Americans (NA) at 0.18%. The Two or More Races group was added in CY 2016. In previous years, this group was distributed among other racial/ethnic groups.

Methods

Population and poverty estimates are derived from the American Community Survey (ACS) conducted by the US Census Bureau in CY 2017. Data for the Federal Poverty level (FPL) is reported for population living at or below 138% FPL. The population and poverty numbers were further adjusted locally by Hedderson Demographic Services and standardized to annual data provided by California's Department of Finance to account for local variations in housing and household income in the County of Los Angeles. Data for population living at or below 138% FPL is used to estimate prevalence of mental illness among the population eligible for Medi-Cal benefits under the Affordable Care Act (ACA). Population and poverty data is reported by each SA, race/ethnicity, age group, and gender.

Threshold languages for each SA are identified for the population enrolled in Medi-Cal and consumers served by the Department. Title 9 of the 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 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 FY 17-18. 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, IMD facilities, Skilled Nursing Facilities (SNF), Psychiatric Health Facilities (PHF), and consumers served in FFS outpatient settings.

The data presented in this section includes the following:

- Estimated total population by race/ethnicity, age group, and gender, in CY 2017
- Estimated total population living at or below 138% FPL by race/ethnicity, age group, and gender, in CY 2017
- Estimated prevalence of Serious Emotional Disturbance (SED) in Children and Youth, and Serious Mental Illness (SMI) in Adults and Older Adults for total population and population living at or below 138% FPL
- Population enrolled in Medi-Cal by race/ethnicity, age group, and gender
- Estimated prevalence of SED and SMI among population enrolled in Medi-Cal by race/ethnicity, age group, gender, and threshold language
- DMH threshold languages spoken by population enrolled in Medi-Cal
- Consumers served in outpatient programs by race/ethnicity, age group, and gender
- Primary language of consumers served in outpatient programs by SA and threshold language

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

Estimated prevalence rates for persons with SED and SMI are derived by using Prevalence rates estimated by the California Health Interview Survey (CHIS) that are conducted every two years by the University of California, Los Angeles (UCLA). This report includes pooled prevalence estimates by CHIS in CY 2015 and CY 2016.

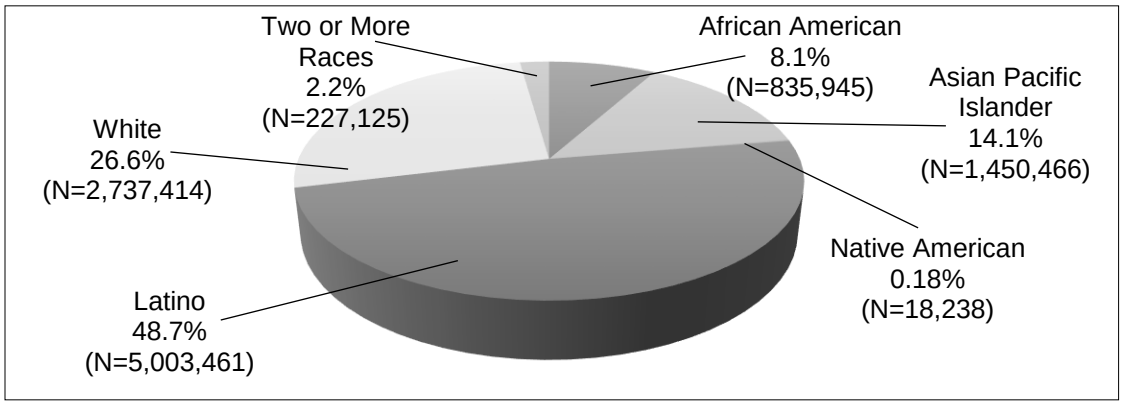
Penetration rates are derived by applying prevalence rates for the racial/ethnic, gender, or age groups to the demographic data for consumers served. These figures are helpful in understanding the needs of the target and underserved populations.

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

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

Total Population
Calendar Year 2017

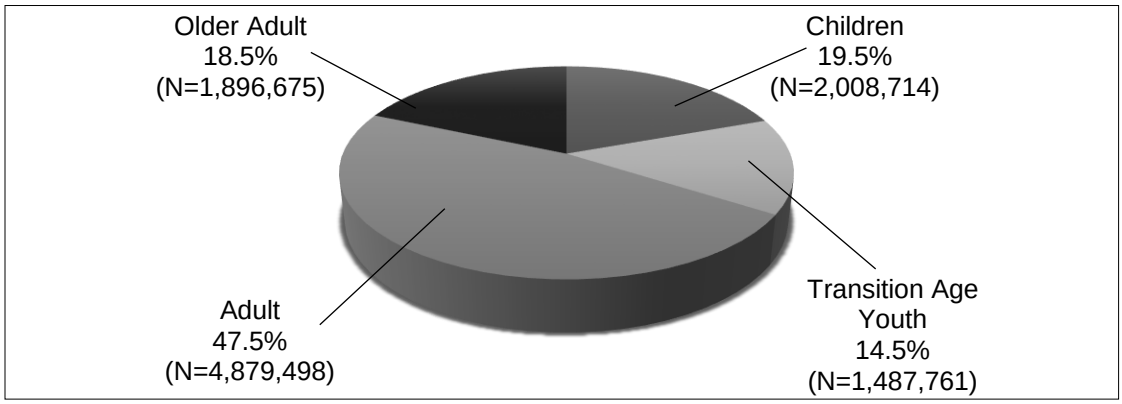
Figure 2
Population by Race/Ethnicity



Note: N=10,272,648. Data Source: ACS, US Census, Bureau and Hedderson Demographic Services, 2018.

Figure 2 shows population by race/ethnicity for CY 2017. Latinos are the largest racial/ethnic group at 48.7%, followed by Whites at 26.6%, Asian Pacific Islanders at 14.1%, African Americans at 8.1%, and Native Americans at 0.18%. The total population with Two or More Races was at 2.2%.

Figure 3
Population by Age Group



Note: N=10,272,648. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Figure 3 shows population by age group for CY 2017. Adults (26-59 years old) made up the largest age group at 47.5%, followed by Children (0-15 years old) at 19.5%, Older Adults (60 years old or greater) at 18.5%, and Transition Age Youth (TAY; 16-25 years old) at 14.5%.

Table 1
Population by Race/Ethnicity and Service Area

SA	African American	Asian/ Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	60,074	15,302	178,838	1,442	125,645	11,164	392,465
Percent	15.3%	3.9%	45.6%	**0.37%**	32.0%	2.8%	100.0%
SA 2	76,613	253,510	916,337	3,597	950,319	58,287	2,258,664
Percent	3.4%	11.2%	40.6%	0.16%	42.1%	2.6%	100.0%
SA 3	63,420	503,804	836,668	2,862	360,440	34,106	1,801,299
Percent	3.5%	**28.0%**	46.4%	0.16%	20.0%	1.9%	100.0%
SA 4	59,505	205,093	618,280	2,002	282,493	21,039	1,188,412
Percent	5.0%	17.3%	52.0%	0.17%	23.8%	1.8%	100.0%
SA 5	37,242	91,422	108,963	945	404,894	28,365	671,830
Percent	5.5%	13.6%	**16.2%**	0.14%	**60.3%**	**4.2%**	100.0%
SA 6	278,788	19,519	731,879	1,420	25,681	11,263	1,068,550
Percent	**26.1%**	**1.8%**	68.5%	**0.13%**	**2.4%**	**1.1%**	100.0%
SA 7	38,652	118,205	969,850	2,541	170,477	15,024	1,314,749
Percent	**2.9%**	9.0%	**73.8%**	0.19%	13.0%	**1.1%**	100.0%
SA 8	221,650	243,611	642,646	3,428	417,466	47,878	1,576,679
Percent	14.1%	15.5%	40.8%	0.22%	26.5%	3.0%	100.0%
Total	835,945	1,450,466	5,003,461	18,238	2,737,414	227,125	10,272,648
Percent	8.1%	14.1%	48.7%	0.18%	26.6%	2.2%	100.0%

Note: Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each racial/ethnic group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Race/Ethnicity

Table 1 presents the total population by race/ethnicity and SA.

The highest percentage of African Americans (AA) was in SA 6 (26.1%) compared to SA 7 (2.9%) with the lowest percentage.

The highest percentage of Asian Pacific Islanders (API) was in SA 3 (28.0%) compared to SA 6 (1.8%) with the lowest percentage.

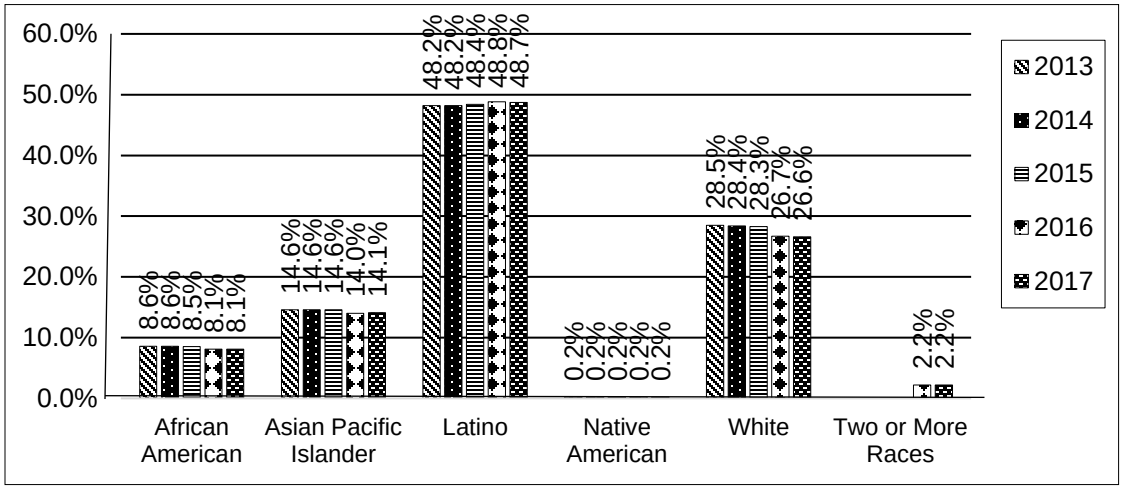
The highest percentage of Latinos was in SA 7 (73.8%) compared to SA 5 (16.2%) with the lowest percentage.

The highest percentage of Native Americans (NA) was in SA 1 (0.37%) compared to SA 6 (0.13%) with the lowest percentage.

The highest percentage of Whites was in SA 5 (60.3%) compared to SA 6 (2.4%) with the lowest percentage.

The highest percentage of the Two or More Races ethnic group was in SA 5 (4.2%) compared to SA 6 and SA 7 (1.1%) with the lowest percentage.

Figure 4
Population Percent Change by Race/Ethnicity
Calendar Year (CY) 2013 to CY 2017



Note: The "Two or More Races" ethnic group was added in CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

The percentage of African Americans in Los Angeles County has decreased by 0.5 Percentage Points (PP) over the past five years. African Americans represented 8.6% of the total population in CY 2013 and represented 8.1% of the population in CY 2017.

The percentage of Asian Pacific Islanders in Los Angeles County has decreased by 0.5 PP over the past five years. Asian Pacific Islanders represented 14.6% of the total population in CY 2013 and represented 14.1% in CY 2017.

The percentage of Latinos in Los Angeles County has increased by 0.5 PP over the past five years. Latinos represented 48.2% of the total population in CY 2013 and represented 48.7% in CY 2017.

The percentage of Native Americans in Los Angeles County has remained the same over the past five years. Native Americans represented 0.2% of the total population in CY 2013 and CY 2017.

The percentage of Whites in Los Angeles County has decreased by 1.9 PP over the past five years. Whites represented 28.5% of the total population in CY 2013 and represented 26.6% in CY 2017.

The percentage of the Two or More Races ethnic group in Los Angeles County did not change between CY 2016 and CY 2017. Two or More Races has represented 2.2% of the total population over the past two years.

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Table 2
Population by Age Group and Service Area

SA	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	107,823	13,667	35,620	172,624	21,722	41,009	392,465
Percent	27.5%	3.5%	**9.1%**	**44.0%**	5.5%	10.4%	100.0%
SA 2	509,543	62,196	159,969	1,087,572	137,854	301,530	2,258,664
Percent	22.6%	2.8%	7.1%	48.2%	6.1%	13.3%	100.0%
SA 3	403,888	55,508	136,382	825,869	112,813	266,839	1,801,299
Percent	22.4%	3.1%	7.6%	45.8%	**6.3%**	14.8%	100.0%
SA 4	244,409	27,224	73,845	638,090	61,286	143,558	1,188,412
Percent	20.6%	**2.3%**	**6.2%**	**53.7%**	5.2%	12.1%	100.0%
SA 5	120,204	22,971	41,549	340,661	40,633	105,812	671,830
Percent	**17.9%**	3.4%	**6.2%**	50.7%	6.0%	**15.7%**	100.0%
SA 6	316,275	40,075	97,022	476,381	46,518	92,279	1,068,550
Percent	**29.6%**	**3.8%**	**9.1%**	44.6%	**4.4%**	**8.6%**	100.0%
SA 7	342,561	41,852	107,360	597,266	68,134	157,576	1,314,749
Percent	26.1%	3.2%	8.2%	45.4%	5.2%	12.0%	100.0%
SA 8	377,894	44,413	114,225	741,035	91,717	207,395	1,576,679
Percent	24.0%	2.8%	7.2%	47.0%	5.8%	13.2%	100.0%
Total	2,422,597	307,906	765,972	4,879,498	580,677	1,315,998	10,272,648
Percent	23.6%	3.0%	7.5%	47.5%	5.7%	12.8%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Age Group

Table 2 shows the total population by age group and SA.

The highest percentage of individuals between 0 and 18 years old was in SA 6 (29.6%) compared to SA 5 (17.9%) with the lowest percentage.

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

The highest percentage of individuals between 21 and 25 years old was in SA 1 and SA 6 (9.1%) compared to SA 4 and SA 5 (6.2%) with the lowest percentage.

The highest percentage of individuals between 26 and 59 years old was in SA 4 (53.7%) compared to SA 1 (44.0%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old was in SA 3 (6.3%) compared to SA 6 (4.4%) with the lowest percentage.

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

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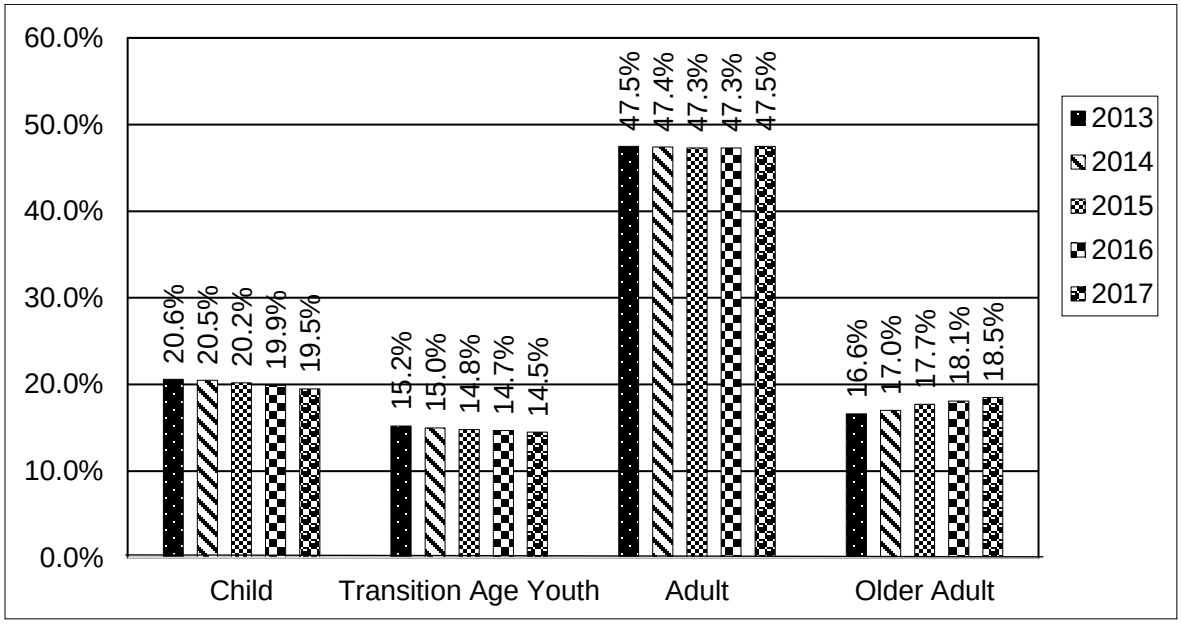
Figure 5
Population Percent Change by Age Group
Calendar Year (CY) 2013 to CY 2017



Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

The percentage of children in Los Angeles County has decreased by 1.1 PP over the past five years. Children represented 20.6% of the total population in CY 2013 and represented 19.5% in CY 2017.

The percentage of TAY in Los Angeles County has decreased by 0.7 PP over the past five years. TAY represented 15.2% of the total population in CY 2013 and represented 14.5% in CY 2017.

The percentage of adults in Los Angeles County has remained stable over the past five years. Adults represented 47.5% of the total population in CY 2013 and CY 2017.

The percentage of older adults in Los Angeles County has increased by 1.9 PP over the past five years. Older Adults represented 16.6% of the total population in CY 2013 and represented 18.5% in CY 2017.

Table 3
Population by Gender and Service Area

SA	Males	Females	Total
SA 1	194,913	197,552	392,465
Percent	49.7%	50.3%	100.0%
SA 2	1,117,894	1,140,770	2,258,664
Percent	49.5%	50.5%	100.0%
SA 3	879,280	922,019	1,801,299
Percent	48.8%	51.2%	100.0%
SA 4	610,270	578,142	1,188,412
Percent	**51.4%**	**48.6%**	100.0%
SA 5	325,718	346,112	671,830
Percent	**48.5%**	**51.5%**	100.0%
SA 6	521,324	547,226	1,068,550
Percent	48.8%	51.2%	100.0%
SA 7	646,209	668,540	1,314,749
Percent	49.2%	50.8%	100.0%
SA 8	771,433	805,246	1,576,679
Percent	48.9%	51.1%	100.0%
Total	5,067,041	5,205,607	10,272,648
Percent	49.3%	50.7%	100.0%

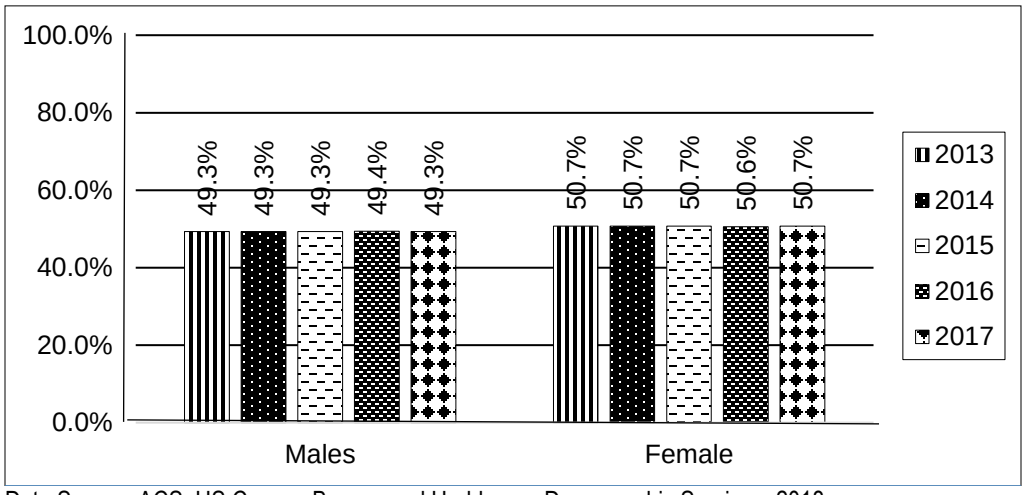
Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Gender

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

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

Figure 6
Estimated Percent Change Among Total Population by Gender
Calendar Year (CY) 2013 to CY 2017



Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

The percentage of Males in Los Angeles County has remained stable over the past five years. Males represented 49.3% of the total population in CY 2013 and CY 2017.

The percentage of Females in Los Angeles County has also remained stable over the past five years. Females represented 50.7% of the total population in CY 2013 and CY 2017.

Estimated Population Living at or Below Federal Poverty Level
Calendar Year 2017

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

SA	African American	Asian/ Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	18,141	2,830	56,357	443	25,299	2,930	105,999
Percent	17.1%	2.7%	53.2%	**0.40%**	23.9%	2.7%	100.0%
SA 2	15,231	40,099	251,339	674	134,142	9,806	451,292
Percent	3.4%	8.9%	55.7%	0.15%	29.7%	2.2%	100.0%
SA 3	11,353	89,638	193,954	528	46,052	5,102	346,627
Percent	3.3%	**25.9%**	56.0%	0.15%	13.3%	1.5%	100.0%
SA 4	14,537	56,873	219,483	743	53,363	5,029	350,028
Percent	4.2%	16.2%	62.7%	0.20%	15.2%	1.5%	100.0%
SA 5	5,130	15,470	17,328	122	48,538	3,879	90,466
Percent	5.7%	17.0%	**19.2%**	**0.13%**	**53.7%**	**4.3%**	100.0%
SA 6	95,821	8,784	325,720	719	8,974	4,123	444,141
Percent	**21.6%**	**2.0%**	73.3%	0.16%	**2.0%**	0.9%	100.0%
SA 7	7,326	16,209	274,318	567	23,376	2,143	323,939
Percent	**2.3%**	5.0%	**84.7%**	0.18%	7.1%	**0.7%**	100.0%
SA 8	63,013	44,312	210,444	840	47,087	8,791	374,488
Percent	16.8%	11.8%	56.2%	0.22%	12.6%	2.4%	100.0%
Total	230,552	274,213	1,548,943	4,637	386,832	41,803	2,486,980
Percent	9.3%	11.0%	62.2%	0.19%	15.6%	1.7%	100.0%

Note: Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each racial/ethnic group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Race/Ethnicity

Table 4 presents the estimated population living at or below 138% FPL by race/ethnicity and SA.

The highest percentage of African Americans living at or below 138% FPL was in SA 6 (21.6%) compared to SA 7 (2.3%) with the lowest percentage.

The highest percentage of Asian Pacific Islanders living at or below 138% FPL was in SA 3 (25.9%) compared to SA 6 (2.0%) with the lowest percentage.

The highest percentage of Latinos living at or below 138% FPL was in SA 7 (84.7%) compared to SA 5 (19.2%) with the lowest percentage.

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

The highest percentage of Whites living at or below 138% FPL was in SA 5 (53.7%) compared to SA 6 (2.0%) with the lowest percentage.

The highest percentage of Two or More Races living at or below 138% FPL was in SA 5 (4.3%) compared to SA 7 (0.7%) with the lowest percentage.

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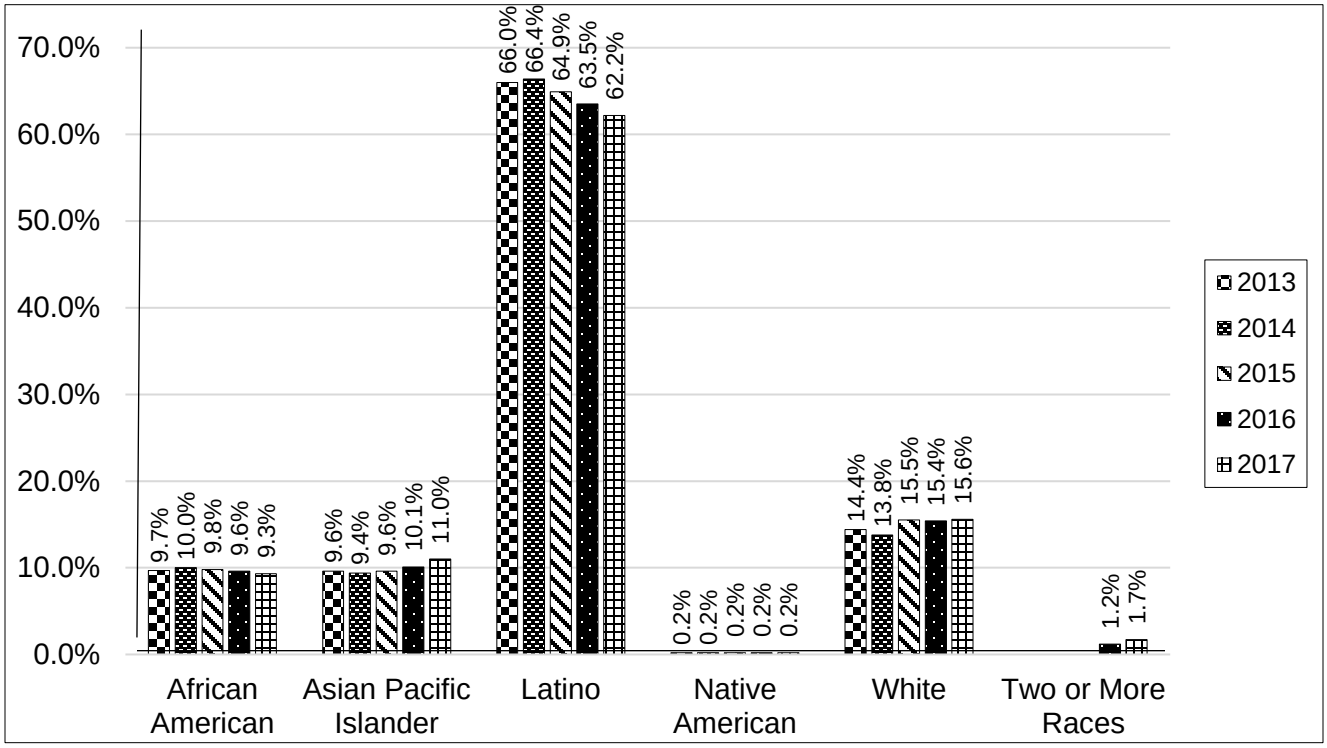
Figure 7
Estimated Percent Change Among Population Living at or Below 138% FPL by Race/Ethnicity
Calendar Year (CY) 2013 to CY 2017



Note: The "Two or More Races" category was added in CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

The percentage of African Americans living at or below 138% FPL has decreased by 0.4 PP from 9.7% in CY 2013 to 9.3% in CY 2017.

The percentage of Asian Pacific Islanders living at or below 138% FPL has increased by 1.4 PP from 9.6% in CY 2013 to 11.0% in CY 2017.

The percentage of Latinos living at or below 138% FPL has decreased by 3.8 PP from 66.0% in CY 2013 to 62.2% in CY 2017.

The percentage of Native Americans living at or below 138% FPL has remained the same at 0.2% from CY 2013 to CY 2017.

The percentage of Whites living at or below 138% FPL has increased by 1.2 PP from 14.4% in CY 2013 to 15.6% in CY 2017.

The percentage of Two or More Races living at or below 138% FPL increased by 0.5 PP from CY 2016 to CY 2017.

Table 5
Estimated Population Living at or Below 138% FPL by Age Group and Service Area

SA	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	40,481	3,692	9,599	40,136	4,216	7,875	105,999
Percent	38.2%	3.5%	9.1%	37.8%	4.0%	7.4%	100.0%
SA 2	143,180	12,910	34,711	198,719	19,383	42,389	451,292
Percent	31.7%	2.9%	7.7%	44.0%	4.3%	9.4%	100.0%
SA 3	108,569	10,370	27,661	144,053	15,700	40,274	346,627
Percent	31.3%	3.0%	8.0%	41.6%	**4.5%**	**11.6%**	100.0%
SA 4	104,794	8,332	23,908	164,368	13,822	34,804	350,028
Percent	29.9%	**2.4%**	**6.8%**	47.1%	3.9%	9.9%	100.0%
SA 5	15,388	3,417	11,279	46,268	3,974	10,140	90,466
Percent	**17.0%**	**3.8%**	**12.5%**	**51.1%**	4.4%	11.2%	100.0%
SA 6	184,698	15,225	40,606	165,774	14,231	23,607	444,141
Percent	**41.6%**	3.4%	9.1%	**37.3%**	**3.3%**	**5.3%**	100.0%
SA 7	125,757	9,751	25,608	125,036	11,873	25,914	323,939
Percent	38.8%	3.0%	7.9%	38.6%	3.7%	8.0%	100.0%
SA 8	133,270	11,242	29,699	154,593	14,742	30,942	374,488
Percent	35.6%	3.0%	7.9%	41.3%	3.9%	8.3%	100.0%
Total	856,137	74,939	203,071	1,038,947	97,941	215,945	2,486,980
Percent	34.4%	3.0%	8.2%	41.8%	3.9%	8.7%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs.
Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Age Group

Table 5 shows the estimated population living at or below 138% FPL by age group and SA.

The highest percentage of individuals between 0 and 18 years old and estimated to be living at or below 138% FPL was in SA 6 (41.6%) compared to SA 5 (17.0%) with the lowest percentage.

The highest percentage of individuals between 19 and 20 years old and estimated to be living at or below 138% FPL was in SA 5 (3.8%) compared to SA 4 (2.4%) with the lowest percentage.

The highest percentage of individuals between 21 and 25 years old and estimated to be living at or below 138% FPL was in SA 5 (12.5%) compared to SA 4 (6.8%) with the lowest percentage.

The highest percentage of individuals between 26 and 59 years old and estimated to be living at or below 138% FPL was in SA 5 (51.1%) compared to SA 6 (37.3%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old and estimated to be living at or below 138% FPL was in SA 3 (4.5%) compared to SA 6 (3.3%) with the lowest percentage.

The highest percentage of individuals age 65 years and older and estimated to be living at or below 138% FPL was in SA 3 (11.6%) compared to SA 6 (5.3%) with the lowest percentage.

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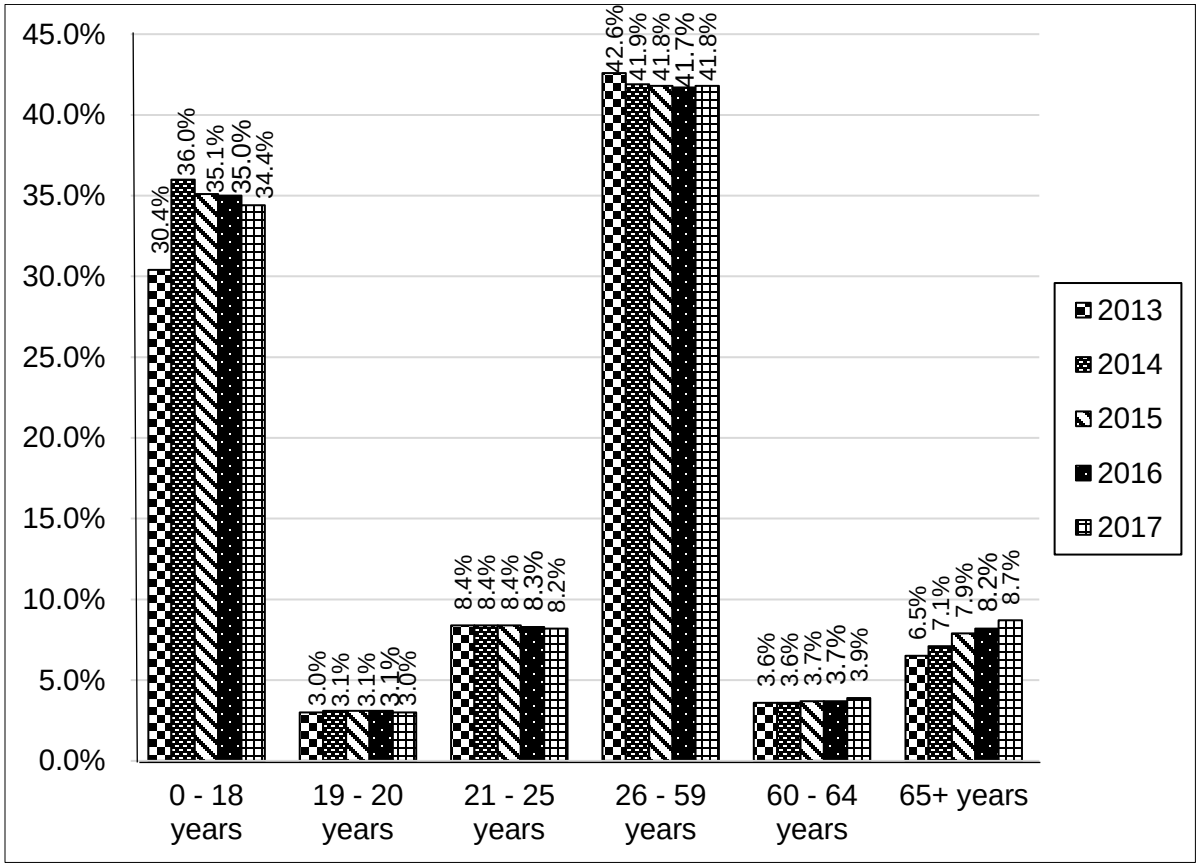
Figure 8

Estimated Percent Change among Population Living at or Below 138% by Age Group Calendar Year (CY) 2013 TO CY 2017



Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

The percentage of individuals between 0 and 18 years old and estimated to be living at or below 138% FPL increased by 4 PP from 30.4% in CY 2013 to 34.4% in CY 2017.

The percentage of individuals between 19 and 20 years old and estimated to be living at or below 138% FPL remained the same at 3.0% in CY 2013 and CY 2017.

The percentage of individuals between 21 and 25 years old and estimated to be living at or below 138% FPL decreased by 0.2 PP from 8.4% in CY 2013 to 8.2% in CY 2017.

The percentage of individuals between 26 and 59 years old and estimated to be living at or below 138% FPL decreased by 0.8 PP from 42.6% in CY 2013 to 41.8% in CY 2017.

The percentage of individuals between 60 and 64 years old and estimated to be living at or below 138% FPL increased by 0.3 PP from 3.6% in CY 2013 to 3.9% in CY 2017.

The percentage of individuals age 65 years and older and estimated to be living at or below 138% FPL increased by 2.2 PP from 6.5% in CY 2013 to 8.7% in CY 2017.

Table 6
Estimated Population Living at or Below 138% FPL by Gender and Service Area
Calendar Year 2017

SA	Males	Females	Total
SA 1	49,941	56,058	105,999
Percent	**47.1%**	**52.9%**	100.0%
SA 2	215,567	235,725	451,292
Percent	47.8%	52.2%	100.0%
SA 3	163,522	183,105	346,627
Percent	47.2%	52.8%	100.0%
SA 4	170,399	179,629	350,028
Percent	**48.7%**	**51.3%**	100.0%
SA 5	42,646	47,820	90,466
Percent	**47.1%**	**52.9%**	100.0%
SA 6	210,119	234,022	444,141
Percent	47.3%	52.7%	100.0%
SA 7	152,833	171,106	323,939
Percent	47.2%	52.8%	100.0%
SA 8	176,600	197,888	374,488
Percent	47.2%	52.8%	100.0%
Total	1,181,627	1,305,353	2,486,980
Percent	47.5%	52.5%	100.0%

Note: Bold values represent highest and lowest percentages within each gender and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

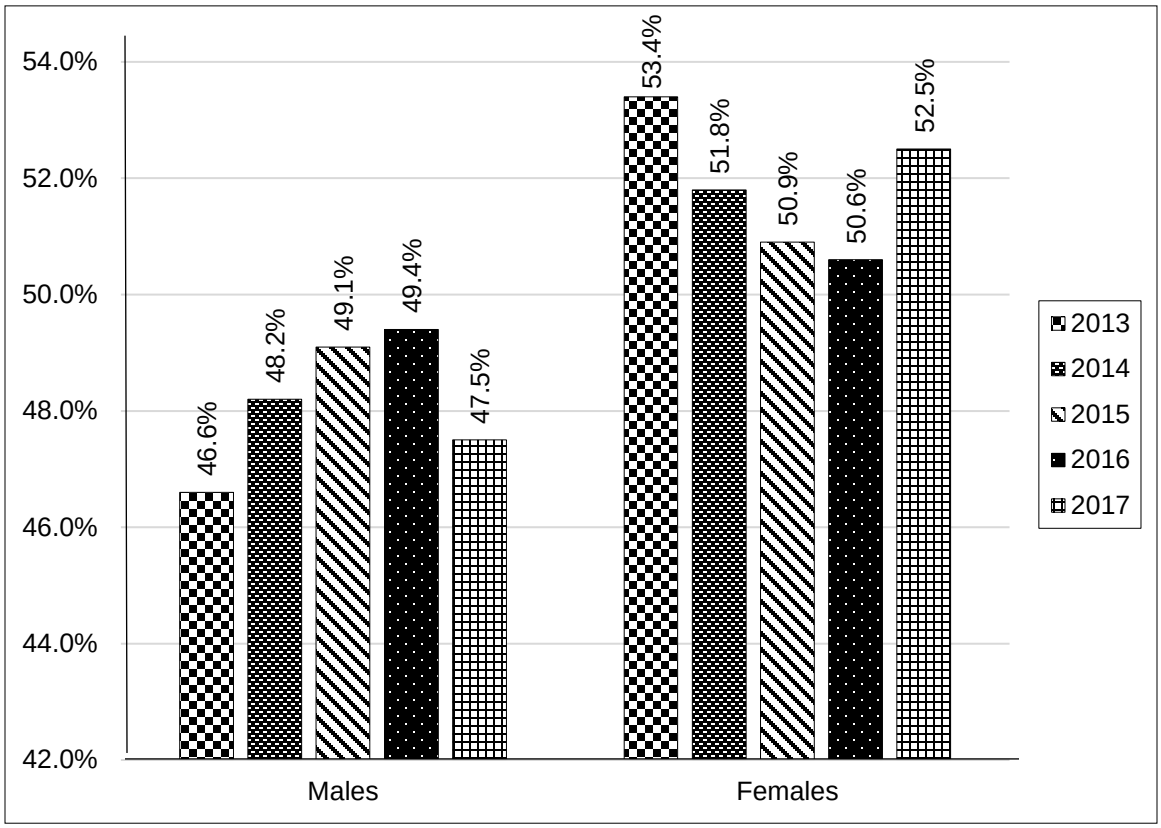
Differences by Gender

Table 6 presents the estimated population living at or below 138% FPL by gender and SA.

The highest percentage of Males estimated to be living at or below 138% FPL was in SA 4 (48.7%) compared to SA 1 and SA 5 (47.1%) with the lowest percentage.

The highest percentage of Females estimated to be living at or below 138% FPL was in SA 1 and SA 5 (52.9%) compared to SA 4 (51.3%) with the lowest percentage.

Figure 9
Estimated Percent Change Among Population Living at or Below 138% FPL by Gender Calendar Year (CY) 2013 to CY 2017



Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

The percentage of Males in Los Angeles estimated to be living at or below 138% FPL increased by 0.9 PP from 46.6% in CY 2013 to 47.5% in CY 2017.

The percentage of Females in Los Angeles estimated to be living at or below 138% FPL decreased by 0.9 PP from 53.4% in CY 2013 to 52.5% in CY 2017.

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

SA	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	557	301	96	117	60,124	154	171	119	76	53	35,436	513	313	98,030
Percent	0.57%	0.31%	0.10%	0.12%	**61.33%**	0.16%	0.17%	0.12%	0.08%	0.05%	**36.15%**	0.52%	0.32%	100.00%
SA 2	5,718	37,513	187	308	129,680	7,415	4,872	504	2,841	5,809	219,604	7,235	2,608	424,294
Percent	**1.35%**	**8.84%**	0.04%	0.07%	**30.56%**	**1.75%**	**1.15%**	0.12%	0.67%	**1.37%**	**51.76%**	**1.71%**	0.61%	100.00%
SA 3	2,437	1,906	1,037	13,815	95,477	529	3,060	20,081	22,378	215	151,779	3,905	10,303	326,922
Percent	0.75%	0.58%	0.32%	**4.23%**	**29.20%**	0.16%	**0.94%**	**6.14%**	**6.85%**	0.07%	**46.43%**	**1.19%**	**3.15**%	100.00%
SA 4	1,442	5,318	718	2,558	76,196	1,429	20,811	931	7,425	4,114	202,419	5,581	1,688	330,630
Percent	0.44%	**1.61**%	0.22%	0.77%	**23.05%**	0.43%	**6.29%**	0.28%	**2.25%**	**1.24%**	**61.22%**	**1.69%**	0.51%	100.00%
SA 5	1,553	478	96	877	48,483	5,644	1,561	1,895	2,325	1,149	15,835	566	529	80,991
Percent	1.92%	0.59%	0.12%	1.08%	**59.86%**	**6.97%**	1.93%	2.34%	2.87%	1.42%	**19.55**%	0.70%	0.65%	100.00%
SA 6	411	130	183	318	107,845	423	1,881	706	3,153	93	312,518	316	416	428,393
Percent	0.10%	0.03%	0.04%	0.07%	**25.17%**	0.10%	0.44%	0.16%	**0.74%**	0.02%	**72.95%**	0.07%	0.10%	100.00%
SA 7	1,516	818	572	376	62,169	182	2,908	1,130	1,887	153	240,946	2,242	924	315,823
Percent	0.48%	0.26%	0.18%	0.12%	**19.68%**	0.06%	0.92%	0.36%	0.60%	0.05%	**76.29%**	0.71%	0.29%	100.00%
SA 8	2,635	449	5,675	222	138,993	871	4,527	613	3,065	353	186,648	5,022	2,879	351,952
Percent	0.75%	0.13%	**1.61%**	0.06%	**39.49%**	0.25%	**1.29%**	0.17%	**0.87%**	0.10%	**53.03%**	**1.43%**	0.82%	100.00%
Total	16,269	46,913	8,564	18,591	718,967	16,647	39,791	25,979	43,150	11,939	1,365,185	25,380	19,660	2,357,035
Percent	0.69%	1.99%	0.36%	0.79%	30.50%	0.71%	1.69%	1.10%	1.83%	0.51%	57.92%	1.08%	0.83%	100.00%

Note: The data reported in this table only represents the Department's 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 State MEDS File, 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. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

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

A total of 95% (N = 2,357,035) of the estimated population living at or below 138% FPL (N = 2,486,980) spoke one of the Department's threshold languages. Among these, 30.5% (N = 718,967) were English speaking, 57.9% were Spanish speaking (N = 1,365,185) and 11.5% spoke the Department's remaining threshold languages.

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

SA 1 reported two SA threshold languages as primary languages: English (61.3%) and Spanish (36.2%).

SA 2 reported eight SA threshold languages as primary languages: Arabic (1.4%), Armenian (8.8%), English (30.6%), Farsi (1.8%), Korean (1.2%), Russian (1.4%), Spanish (51.8%), and Tagalog (1.7%).

SA 3 reported eight SA threshold languages as primary languages: Cantonese (4.2%), English (29.2%), Korean (0.94%), Mandarin (6.1%), Other Chinese (6.9%), Spanish (46.4%), Tagalog (1.2%), and Vietnamese (3.2%).

SA 4 reported seven SA threshold languages as primary languages: Armenian (1.6%), English (23.1%), Korean (6.3%), Other Chinese (2.3%), Russian (1.2%), Spanish (61.2%), and Tagalog (1.7%).

SA 5 reported three SA threshold languages as primary languages: English (59.9%), Farsi (7.0%), and Spanish (19.6%).

SA 6 reported three SA threshold languages as primary languages: English (25.2%), Other Chinese (0.7%), and Spanish (73.0%).

SA 7 reported two SA threshold languages as primary languages: English (19.7%) and Spanish (76.3%).

SA 8 reported six SA threshold languages as primary languages: Cambodian (1.6%), English (39.5%), Korean (1.3%), Other Chinese (0.87%), Spanish (53.0%), and Tagalog (1.4%).

Estimated Prevalence of Serious Emotional Disturbance and Serious Mental Illness Among Population Living at or Below 138% Federal Poverty Level Calendar Year 2017

Table 8
Estimated Prevalence of Serious Emotional Disturbance and Serious Mental Illness Among the Population Living at or Below 138% FPL by Race/Ethnicity and Service Area

SA	African American	Asian/ Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	4,191	192	5,974	77	3,921	440	14,795
Percent	28.3%	1.3%	40.4%	**0.52%**	26.5%	3.0%	100.0%
SA 2	3,518	2,727	26,642	118	20,792	1,471	55,268
Percent	6.4%	4.9%	48.2%	0.21%	37.6%	2.7%	100.0%
SA 3	2,623	6,095	20,559	92	7,138	765	37,273
Percent	7.0%	**16.4%**	55.2%	0.25%	19.1%	2.1%	100.0%
SA 4	3,358	3,867	23,265	130	8,271	754	39,646
Percent	8.5%	9.8%	58.7%	0.33%	20.9%	1.8%	100.0%
SA 5	1,185	1,052	1,837	21	7,523	582	12,200
Percent	9.7%	8.6%	**15.0%**	**0.17%**	**61.7%**	**4.8%**	100.0%
SA 6	22,135	597	34,526	126	1,391	618	59,394
Percent	**37.3%**	**1.0%**	58.2%	0.21%	**2.3%**	1.0%	100.0%
SA 7	1,692	1,102	29,078	99	3,623	321	35,916
Percent	**4.7%**	3.1%	**81.0%**	0.28%	10.1%	**0.8%**	100.0%
SA 8	14,556	3,013	22,307	147	7,298	1,319	48,641
Percent	29.9%	6.2%	45.9%	0.30%	15.0%	2.7%	100.0%
Total	53,258	18,647	164,188	811	59,959	6,270	303,133
Percent	17.6%	6.2%	54.2%	0.27%	19.8%	2.1%	100.0%

Note: Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each ethnic group and across all SAs. Estimated prevalence rates of mental illness by race/ethnicity for Los Angeles County are provided by the CHIS for the population living at or below 138% FPL, CY 2015 and CY 2016.
Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Race/Ethnicity

Table 8 shows the estimated prevalence of SED and SMI among the population living at or below 138% FPL by race/ethnicity and SA.

The highest rate of estimated prevalence of SED and SMI among the African American group was in SA 6 (37.3%) compared to SA 7 (4.7%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among the Asian Pacific Islander group was in SA 3 (16.4%) compared to SA 6 (1.0%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among the Latino group was in SA 7 (81.0%) compared to SA 5 (15.0%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among the Native American group was in SA 1 (0.52%) compared to SA 5 (0.17%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among the White group was in SA 5 (61.7%) compared to SA 6 (2.3%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among the Two or More Races group was in SA 5 (4.8%) compared to SA 7 (0.8%) with the lowest rate.

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Table 9
Estimated Prevalence of Serious Emotional Disturbance and Serious Mental Illness Among the Population Living at Below 138% FPL by Age Group and Service Area

SA	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	7,044	746	1,190	4,816	447	638	14,881
Percent	47.3%	5.0%	8.0%	32.4%	3.0%	4.3%	100.0%
SA 2	24,913	2,608	4,304	23,846	2,055	3,434	61,160
Percent	40.7%	4.3%	7.0%	39.0%	3.4%	5.6%	100.0%
SA 3	18,891	2,095	3,430	17,286	1,664	3,262	46,628
Percent	40.5%	4.5%	7.4%	37.0%	**3.6%**	7.0%	100.0%
SA 4	18,234	1,683	2,965	19,724	1,465	2,819	46,890
Percent	38.9%	**3.6%**	**6.3%**	42.1%	3.1%	6.0%	100.0%
SA 5	2,678	690	1,399	5,552	421	821	11,561
Percent	**23.2%**	**6.0%**	**12.1%**	**48.0%**	**3.6%**	**7.1%**	100.0%
SA 6	32,137	3,075	5,035	19,893	1,508	1,912	63,562
Percent	**50.6%**	4.8%	7.9%	**31.3%**	**2.4%**	**3.0%**	100.0%
SA 7	21,882	1,970	3,175	15,004	1,259	2,099	45,389
Percent	48.2%	4.3%	7.0%	33.1%	2.8%	4.6%	100.0%
SA 8	23,189	2,271	3,683	18,551	1,563	2,506	51,763
Percent	44.8%	4.4%	7.2%	35.8%	3.0%	4.8%	100.0%
Total	148,968	15,138	25,181	124,674	10,382	17,492	341,833
Percent	43.6%	4.4%	7.4%	36.5%	3.0%	5.1%	100.0%

Note: Bold values represent the highest and lowest percentage within each age group and across all SAs. Estimated prevalence rates of mental illness for Los Angeles County are provided by the CHIS for the population living at or below 138% FPL, CY 2015 and 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Age Group

Table 9 presents the estimated prevalence of SED and SMI among population living at or below 138% FPL by age group and SA.

The highest rate of estimated prevalence of SED and SMI among individuals between 0 and 18 years old was in SA 6 (50.6%) compared to SA 5 (23.2%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among individuals between 19 and 20 years old was in SA 5 (6.0%) compared to SA 4 (3.6%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among individuals between 21 and 25 years old was in SA 5 (12.1%) compared to SA 4 (6.3%) the lowest rate.

The highest rate of estimated prevalence of SED and SMI among individuals between 26 and 59 years old was in SA 5 (48.0%) compared to SA 6 (31.3%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among individuals between 60 and 64 years old was in SA 3 and SA 5 (3.6%) compared to SA 6 (2.4%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among individuals age 65 years and older was in SA 5 (7.1%) compared to SA 6 (3.0%) with the lowest rate.

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Table 10
Estimated Prevalence of Serious Emotional Disturbance and Serious Mental Illness Among Population Living at or Below 138% FPL by Gender and Service Area

SA	Males	Females	Total
SA 1	6,143	6,615	12,758
Percent	**48.1%**	**51.9%**	100.0%
SA 2	26,515	27,816	54,331
Percent	48.8%	51.2%	100.0%
SA 3	20,113	21,606	41,720
Percent	48.2%	51.8%	100.0%
SA 4	20,959	21,196	42,155
Percent	**49.7%**	**50.3%**	100.0%
SA 5	5,245	5,643	10,888
Percent	48.2%	51.8%	100.0%
SA 6	25,845	27,615	53,459
Percent	48.3%	51.7%	100.0%
SA 7	18,798	20,191	38,989
Percent	48.2%	51.8%	100.0%
SA 8	21,722	23,351	45,073
Percent	48.2%	51.8%	100.0%
Total	145,340	154,032	299,372
Percent	48.5%	51.5%	100.0%

Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Estimated prevalence rates of mental illness for Los Angeles County are provided by the CHIS for the population living at or below 138% FPL, CY 2015 and CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Gender

Table 10 presents the estimated prevalence of SED and SMI among the population living at or below 138% FPL by gender and SA.

The highest rate of estimated prevalence of SED and SMI among Males living at or below 138% FPL was in SA 4 (49.7%) compared to SA 1 (48.1%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among Females living at or below 138% FPL was in SA 1 (51.9%) compared to SA 4 (50.3%) with the lowest rate.

Population Enrolled in Medi-Cal
March 2018

Table 11
Population Enrolled in Medi-Cal by Race/Ethnicity and Service Area

SA	African American	Asian/ Pacific Islander	Latino	Native American	White	Total
SA 1	40,268	4,072	97,299	322	29,608	171,569
Percent	**23.5%**	2.4%	56.7%	0.19%	17.3%	100.0%
SA 2	25,380	49,583	377,517	711	209,101	662,292
Percent	3.83%	7.49%	57.0%	0.11%	31.6%	100.0%
SA 3	19,929	154,105	318,141	557	52,147	544,879
Percent	3.7%	**28.3%**	58.4%	0.10%	9.6%	100.0%
SA 4	26,389	58,902	278,731	1005	58,433	423,460
Percent	6.2%	13.9%	65.8%	**0.24%**	13.8%	100.0%
SA 5	11,194	7,137	28,676	200	35,904	83,111
Percent	13.5%	8.6%	**34.5%**	**0.24%**	**43.2%**	100.0%
SA 6	133,616	5,614	421,443	511	13,390	574,574
Percent	23.3%	**1.0%**	73.3%	**0.09%**	**2.3%**	100.0%
SA 7	12,477	25,916	395,991	518	30,933	465,835
Percent	**2.7%**	5.6%	**85.0%**	0.11%	6.6%	100.0%
SA 8	86,052	50,532	263,987	791	50,477	451,839
Percent	19.0%	11.2%	58.4%	0.18%	11.2%	100.0%
Total	355,305	355,861	2,181,785	4,615	479,993	3,377,559
Percent	10.5%	10.5%	64.6%	0.14%	14.2%	100.0%

Note: Bold values represent the highest and lowest percentages within each ethnic group and across all SAs. Unknown SA (N= 456,423), Unknown Race/Ethnicity (N= 572), and "Other" race/ethnicity (N= 64,978) were not included in the race/ethnicity table. Due to rounding, some estimated totals and percentages may not total 100%.
Data Source: State MEDS File, March 2018.

Differences by Race/Ethnicity

Table 11 presents the Medi-Cal enrolled population by race/ethnicity and SA.

The highest percentage of African Americans enrolled in Medi-Cal was in SA 1 (23.5%) compared to SA 7 (2.7%) with the lowest percentage.

The highest percentage of Asian Pacific Islanders enrolled in Medi-Cal was in SA 3 (28.3%) compared to SA 6 (1.0%) with the lowest percentage.

The highest percentage of Latinos enrolled in Medi-Cal was in SA 7 (85.0%) compared to SA 5 (34.5%) with the lowest percentage.

The highest percentage of Native Americans enrolled in Medi-Cal was in SA 4 and SA 5 (0.24%) compared to SA 6 (0.09%) with the lowest percentage.

The highest percentage of Whites enrolled in Medi-Cal was in SA 5 (43.2%) compared to SA 6 (2.3%) with the lowest percentage.

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Table 12
Population Enrolled in Medi-Cal by Age Group and Service Area

SA	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	76,885	6,625	15,061	67,700	6,490	11,490	184,251
Percent	**41.7%**	**3.6%**	**8.2%**	36.7%	**3.5%**	**6.2%**	100.0%
SA 2	236,145	20,707	49,797	284,006	35,322	94,132	720,109
Percent	32.8%	2.9%	**6.9%**	39.4%	4.9%	13.1%	100.0%
SA 3	206,056	18,381	43,211	226,187	29,080	78,986	601,901
Percent	34.2%	3.1%	7.2%	37.6%	4.8%	13.1%	100.0%
SA 4	135,138	12,315	32,156	195,513	23,471	63,705	462,298
Percent	29.2%	2.7%	7.0%	42.3%	5.1%	13.8%	100.0%
SA 5	23,568	2,374	6,989	46,531	5,382	14,597	99,441
Percent	**23.7%**	**2.4%**	7.0%	**46.8%**	**5.6%**	**14.7%**	100.0%
SA 6	249,741	20,671	47,596	229,915	23,644	43,804	615,371
Percent	40.6%	3.4%	7.7%	37.4%	3.8%	7.1%	100.0%
SA 7	195,960	16,743	37,852	181,123	19,917	50,127	501,722
Percent	39.1%	3.3%	7.5%	**36.1%**	4.0%	10.0%	100.0%
SA 8	183,249	16,016	39,273	198,481	22,175	47,510	506,704
Percent	36.2%	3.2%	7.8%	39.2%	4.4%	9.4%	100.0%
Total	1,306,742	113,832	271,935	1,429,456	165,481	404,351	3,691,797
Percent	35.4%	3.1%	7.4%	38.7%	4.5%	11.0%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Unknown SA (N=142,185). Due to rounding, some estimated totals and percentages may not add up correctly. Data Source: State MEDS File, March 2018.

Differences by Age Group

Table 12 shows the Medi-Cal enrolled population by age group and SA.

The highest percentage of individuals between 0 and 18 years old enrolled in Medi-Cal was in SA 1 (41.7%) compared to SA 5 (23.7%) with the lowest percentage.

The highest percentages of individuals between 19 and 20 years old enrolled in Medi-Cal were in SA 1 (3.6%) compared to SA 5 (2.4%) with the lowest percentage.

The highest percentage of individuals between 21 and 25 years old enrolled in Medi-Cal was in SA 1 (8.2%) compared to SA 2 (6.9%) with the lowest percentage.

The highest percentage of individuals between 26 and 59 years old enrolled in Medi-Cal was in SA 5 (46.8%) compared to SA 7 (36.1%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old enrolled in Medi-Cal was in SA 5 (5.6%) compared to SA 1 (3.5%) with the lowest percentage.

The highest percentage of individuals age 65 years and older enrolled in Medi-Cal was in SA 5 (14.7%) compared to SA 1 (6.2%) with the lowest percentage.

Table 13
Population Enrolled in Medi-Cal by Gender and Service Area

SA	Males	Females	Total
SA 1	85,130	100,348	185,478
Percent	45.9%	54.1%	100.0%
SA 2	332,242	391,945	724,187
Percent	45.9%	54.1%	100.0%
SA 3	276,876	328,703	605,579
Percent	45.7%	54.3%	100.0%
SA 4	219,141	245,635	464,776
Percent	47.1%	52.9%	100.0%
SA 5	47,444	52,388	99,832
Percent	**47.5%**	**52.5%**	100.0%
SA 6	282,901	337,093	619,994
Percent	45.6%	54.4%	100.0%
SA 7	226,802	278,255	505,057
Percent	**44.9%**	**55.1%**	100.0%
SA 8	233,711	276,237	509,948
Percent	45.8%	54.2%	100.0%
Total	1,704,247	2,010,604	3,714,851
Percent	45.9%	54.1%	100.0%

Note: Due to rounding, some estimated totals and percentages may not add up correctly. Bold values represent the highest and lowest percentages within each gender and across all SAs. Unknown SA (N=119,131). Data Source: State MEDS File, March 2018.

Differences by Gender

Table 12 presents the Medi-Cal enrolled population by gender and SA.

The highest percentage of Males enrolled in Medi-Cal was in SA 5 (47.5%) as compared with the lowest in SA 7 (44.9%).

The highest percentage of Females enrolled in Medi-Cal was in SA 7 (55.1%) compared to SA 5 (52.5%) with the lowest percentage.

Estimated Prevalence of Serious Emotional Disturbance and Serious Mental Illness Among the Population Enrolled in Medi-Cal March 2018

Table 14
Estimated Prevalence of Serious Emotional Disturbance and Serious Mental Illness Among Medi-Cal Enrolled Population by Race/Ethnicity and Service Area

SA	African American	Asian/ Pacific Islander	Latino	Native American	White	Total
SA 1	11,476	330	10,800	114	4,708	27,428
Percent	41.8%	1.2%	39.4%	0.4%	17.2%	100.0%
SA 2	7,233	4,016	41,904	251	33,247	86,652
Percent	8.3%	4.6%	48.4%	0.29%	38.4%	100.0%
SA 3	5,680	12,483	35,314	197	8,291	61,964
Percent	9.2%	**20.1%**	57.0%	0.32%	13.4%	100.0%
SA 4	7,521	4,771	30,939	355	9,291	52,877
Percent	14.2%	9.0%	58.5%	**0.67%**	17.6%	100.0%
SA 5	3,190	578	3,183	71	5,709	12,731
Percent	25.1%	4.5%	**25.0%**	0.55%	**44.8%**	100.0%
SA 6	38,081	455	46,780	180	2,129	87,625
Percent	**43.5%**	**0.5%**	53.4%	**0.21%**	**2.4%**	100.0%
SA 7	3,556	2,099	43,955	183	4,918	54,711
Percent	**6.5%**	3.8%	**80.3%**	0.33%	9.0%	100.0%
SA 8	24,525	4,093	29,303	279	8,026	66,226
Percent	37.0%	6.2%	44.2%	0.42%	12.1%	100.0%
Total	101,262	28,825	242,178	1,629	76,319	450,213
Percent	22.5%	6.4%	53.8%	0.36%	17.0%	100.0%

Note: Bold values represent the highest and lowest percentages within each ethnic group and across all SAs. Estimated prevalence rates of mental illness by race/ethnicity for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2015 and CY 2016. Due to rounding, some estimated numbers and percentages may not add up correctly. Data source: State MEDS File, March 2018.

Differences by Race/Ethnicity

Table 14 reports the estimated prevalence of SED and SMI among the population enrolled in Medi-Cal by race/ethnicity and SA.

The highest rate of estimated prevalence of SED and SMI among the African American group was in SA 6 (43.5%) compared to SA 7 (6.5%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among the Asian Pacific Islander group was in SA 3 (20.1%) compared to SA 6 (0.5%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among the Latino group was in SA 7 (80.3%) compared to SA 5 (25.0%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among the Native American group was in SA 4 (0.67%) compared to SA 6 (0.21%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among the White group was in SA 5 (44.8%) compared to SA 6 (2.4%) with the lowest rate.

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Table 15
Estimated Prevalence of Serious Emotional Disturbance and Serious Mental Illness Among Medi-Cal Enrolled Population by Age Group and Service Area

SA	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	14,685	1,458	1,807	9,072	896	873	28,791
Percent	**51.0%**	**5.1%**	**6.3%**	**31.5%**	**3.1%**	**3.0%**	100.0%
SA 2	45,104	4,556	5,976	38,057	4,874	7,154	105,720
Percent	42.7%	4.3%	**5.7%**	36.0%	4.6%	6.8%	100.0%
SA 3	39,357	4,044	5,185	30,309	4,013	6,003	88,911
Percent	44.3%	4.5%	5.8%	34.1%	4.5%	6.8%	100.0%
SA 4	25,811	2,709	3,859	26,199	3,239	4,842	66,659
Percent	38.7%	4.1%	5.8%	39.3%	4.9%	7.3%	100.0%
SA 5	4,501	522	839	6,235	743	1,109	13,950
Percent	**32.3%**	**3.7%**	6.0%	**44.7%**	**5.3%**	**8.0%**	100.0%
SA 6	47,701	4,548	5,712	30,809	3,263	3,329	95,360
Percent	50.0%	4.8%	6.0%	32.3%	3.4%	3.5%	100.0%
SA 7	37,428	3,683	4,542	24,270	2,749	3,810	76,483
Percent	48.9%	4.8%	5.9%	31.7%	3.6%	5.0%	100.0%
SA 8	35,001	3,524	4,713	26,596	3,060	3,611	76,504
Percent	45.7%	4.6%	6.2%	34.8%	4.0%	4.7%	100.0%
Total	249,588	25,043	32,632	191,547	22,836	30,731	552,377
Percent	45.2%	4.5%	5.9%	34.7%	4.1%	5.6%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Estimated prevalence rates of mental illness by age group for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2015 and CY 2016. Due to rounding, some estimated totals and percentages may not total 100%. Data Source: State MEDS File, March 2018.

Differences by Age Group

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

The highest rate of estimated prevalence of SED and SMI among individuals between 0 and 18 years old enrolled in Medi-Cal was in SA 1 (51.0%) compared to SA 5 (32.3%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among individuals between 19 and 20 years old enrolled in Medi-Cal was in SA 1 (5.1%) compared to SA 5 (3.7%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among individuals between 21 and 25 years old enrolled in Medi-Cal was in SA 1 (6.3%) compared to SA 2 (5.7%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among individuals between 26 and 59 years old enrolled in Medi-Cal was in SA 5 (44.7%) compared to SA 1 (31.5%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among individuals between 60 and 64 years old enrolled in Medi-Cal was in SA 5 (5.3%) compared to SA 1 (3.1%) with the lowest rate.

The highest rate of estimated prevalence of SED and SMI among individuals 65 years and older enrolled in Medi-Cal was in SA 5 (8.0%) compared to SA 1 (3.0%) with the lowest rate.

Table 16
Estimated Prevalence of Serious Emotional Disturbance and Serious Mental Illness Among the Medi-Cal Enrolled Population by Gender and Service Area

SA	Males	Females	Total
SA 1	12,599	11,941	24,541
Percent	51.3%	48.7%	100.0%
SA 2	49,172	46,641	95,813
Percent	51.3%	48.7%	100.0%
SA 3	40,978	39,116	80,093
Percent	51.2%	48.8%	100.0%
SA 4	32,433	29,231	61,663
Percent	52.6%	47.4%	100.0%
SA 5	7,022	6,234	13,256
Percent	**53.0%**	**47.0%**	100.0%
SA 6	41,869	40,114	81,983
Percent	51.1%	48.9%	100.0%
SA 7	33,567	33,112	66,679
Percent	**50.3%**	**49.7%**	100.0%
SA 8	34,589	32,872	67,461
Percent	51.3%	48.7%	100.0%
Total	252,229	239,262	491,490
Percent	51.3%	48.7%	100.0%

Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Estimated prevalence rates of mental illness by gender for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2015 and CY 2016. Due to rounding, some estimated numbers and percentages may not total 100%. Data Source: State MEDS File, March 2018.

Differences by Gender

Table 16 compares the estimated prevalence of SED and SMI among the Medi-Cal enrolled population for each age group and SA.

The highest rate of estimated prevalence of SED and SMI among Males was in SA 5 (53.0%) compared to SA 7 (50.3%) with the lowest rate among the Medi-Cal enrolled population.

The highest rate of estimated prevalence of SED and SMI among Females was in SA 7 (49.7%) compared to SA 5 (47.0%) with the lowest rate among the Medi-Cal enrolled population.

Table 17
Primary Language of Population Enrolled In Medi-Cal by Service Area and Threshold Language

SA	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	256	222	41	33	136,576	65	146	79	13	25	46,077	154	177	183,864
Percent	0.14%	0.12%	0.02%	0.02%	**74.28%**	0.04%	0.08%	0.04%	0.01%	0.01%	**25.06%**	0.08%	0.10%	100.00%
SA 2	2,688	65,076	188	283	373,424	10,156	4,876	593	122	6,099	245,178	3,158	3,695	715,536
Percent	0.38%	**9.09%**	0.03%	0.04%	**52.19%**	**1.42%**	**0.68%**	0.08%	0.02%	**0.85%**	**34.26%**	**0.44%**	**0.52%**	100.00%
SA 3	1,205	2,022	1,073	34,712	324,210	381	3,252	44,096	3,790	132	159,238	1,664	21,090	596,865
Percent	0.20%	0.34%	0.18%	**5.82%**	**54.32%**	0.06%	**0.54%**	**7.39%**	**0.63%**	0.02%	**26.68%**	0.28%	**3.53%**	100.00%
SA 4	256	6,597	622	7,703	214,816	641	18,814	1,291	449	5,195	196,549	2,904	1,584	457,421
Percent	0.06%	**1.44%**	0.14%	**1.68%**	**46.96%**	0.14%	**4.11%**	0.28%	0.10%	**1.14%**	**42.97%**	0.63%	0.35%	100.00%
SA 5	322	79	14	113	73,587	3,917	520	331	63	1,490	16,852	104	106	97,498
Percent	0.33%	0.08%	0.01%	0.12%	**75.48%**	**4.02%**	0.53%	0.34%	0.06%	1.53%	**17.28%**	0.11%	0.11%	100.00%
SA 6	78	15	106	113	313,730	37	1,646	77	16	49	298,664	123	90	614,744
Percent	0.01%	0.00%	0.02%	0.02%	**51.03%**	0.01%	0.27%	0.01%	0.00%	0.01%	**48.58%**	0.02%	0.01%	100.00%
SA 7	669	553	1,069	1,054	265,217	57	3,013	1,554	215	73	223,708	997	876	499,055
Percent	0.13%	0.11%	0.21%	0.21%	**53.14%**	0.01%	**0.60%**	0.31%	0.04%	0.01%	**44.83%**	0.20%	0.18%	100.00%
SA 8	669	109	5,643	437	326,773	479	3,588	793	146	256	158,965	1,976	3,046	502,880
Percent	0.13%	0.02%	**1.12%**	0.09%	**64.98%**	0.10%	**0.71%**	0.16%	0.03%	0.05%	**31.61%**	0.39%	**0.61%**	100.00%
Total	6,143	74,673	8,756	44,448	2,028,333	15,733	35,855	48,814	4,814	13,319	1,345,231	11,080	30,664	3,667,863
Percent	0.17%	2.04%	0.24%	1.21%	55.30%	0.43%	0.98%	1.33%	0.13%	0.36%	36.68%	0.30%	0.84%	100.00%

Note: "Threshold Language" means a language that has been identified as the primary language, as indicated on the State MEDS File, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. SA Threshold Languages are in bold. Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. A total of 6,143 (0.2%) individuals enrolled in Medi-Cal reported Arabic as their primary language in March 2018. Unknown SA is (N = 119,131). A total of 7,843 (0.2%) individuals enrolled in Medi-Cal reported "Other" as a primary language. Data Source: State MEDS File, March 2018.

Table 17 shows the Department's 13 threshold languages for the Med-Cal enrolled population and by SA.

Countywide, 55.3% (N=2,028,333) of the Medi-Cal enrolled population spoke English. The SA with the highest percentage of Medi-Cal enrolled population with English as the primary language was SA 5 (75.5%) and the lowest percentage was SA 4 (47.0%).

Of the 12 non-English threshold languages spoken among the population enrolled in Medi-Cal, Spanish (36.7%) had the highest percentage, followed by Armenian (2.0%), Mandarin (1.3%), Cantonese (1.2%), and Korean (1.0%). The remaining languages were spoken by less than 1.0% of the Medi-Cal enrolled population. All other threshold languages range between 0.13% (Arabic, Cambodian, and Other Chinese) and 1.21% (Armenian).

The following identifies the Department's threshold languages for Medi-Cal enrollees in each SA:

SA 1 has two threshold languages: English (74.3%) and Spanish (25.1%).

SA 2 has eight threshold languages: Armenian (9.1%), English (52.2%), Farsi (1.4%), Korean (0.7%), Russian (0.9%), Spanish (34.3%), Tagalog (0.4%), and Vietnamese (0.5%).

SA 3 has seven threshold languages: Cantonese (5.8%), English (54.3%), Korean (0.5%), Mandarin (7.4%), Other Chinese (0.6%), Spanish (26.7%), and Vietnamese (3.5%).

SA 4 has six threshold languages: Armenian (1.4%), Cantonese (1.7%), English (47.0%), Korean (4.1%), Russian (1.1%), and Spanish (43.0%).

SA 5 has three threshold languages: English (75.5%), Farsi (4.0%), and Spanish (17.3%).

SA 6 has two threshold languages. English (51.0%) and Spanish (48.6%).

SA 7 has three threshold languages: English (53.1%), Korean (0.6%), and Spanish (44.8%).

SA 8 has five threshold languages: Cambodian (1.1%), English (65.0%), Korean (0.7%), Spanish (31.6%), and Vietnamese (0.6%).

Table 18
Distribution of "Other" Languages Spoken by Population Enrolled In Medi-Cal by Service Area

SA	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	Total
ASL	76	200	130	129	15	80	118	56	804
Percent	**9.5%**	24.9%	16.2%	16.0%	1.9%	10.0%	14.7%	7.0%	100.0%
French	5	44	6	30	36	46	4	31	202
Percent	2.5%	21.8%	3.0%	14.9%	**17.8%**	22.8%	2.0%	15.3%	100.0%
Hebrew	0	248	6	43	31	0	1	2	331
Percent	**0.0%**	**74.9%**	**1.8%**	13.0%	9.4%	**0.0%**	0.3%	0.6%	100.0%
Hmong	0	3	5	0	0	1	0	11	20
Percent	**0.0%**	15.0%	25.0%	**0.0%**	**0.0%**	5.0%	**0.0%**	**55.0%**	100.0%
Italian	1	23	10	5	2	0	3	13	57
Percent	1.8%	40.4%	17.5%	8.8%	3.5%	**0.0%**	5.3%	22.8%	100.0%
Japanese	1	78	89	196	91	12	25	275	767
Percent	0.1%	10.2%	11.6%	25.6%	11.9%	1.6%	3.3%	35.9%	100.0%
Lao	1	14	70	31	1	3	22	47	189
Percent	0.5%	**7.4%**	37.0%	16.4%	0.5%	1.6%	11.6%	24.9%	100.0%
Mien	0	1	2	0	0	0	0	0	3
Percent	**0.0%**	33.3%	**66.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	100.0%
Other Sign Language	8	37	24	12	7	10	9	20	127
Percent	6.3%	29.1%	18.9%	9.4%	5.5%	7.9%	7.1%	15.7%	100.0%
Polish	2	23	7	11	6	0	3	6	58
Percent	3.4%	39.7%	12.1%	19.0%	10.3%	**0.0%**	5.2%	10.3%	100.0%
Portuguese	4	39	13	25	27	1	22	65	196
Percent	2.0%	19.9%	6.6%	12.8%	13.8%	0.5%	11.2%	33.2%	100.0%
Samoan	9	16	18	11	0	48	29	55	186
Percent	4.8%	8.6%	9.7%	5.9%	**0.0%**	**25.8%**	**15.6%**	29.6%	100.0%
Thai	6	614	284	513	27	16	116	91	1,667
Percent	0.4%	36.8%	17.0%	**30.8%**	1.6%	1.0%	7.0%	5.5%	100.0%
Turkish	2	33	10	20	9	3	10	10	97
Percent	2.1%	34.0%	10.3%	20.6%	9.3%	3.1%	10.3%	10.3%	100.0%
Ilocano	2	13	8	4	2	0	7	13	49
Percent	4.1%	26.5%	16.3%	8.2%	4.1%	**0.0%**	14.3%	26.5%	100.0%
Total	117	1,386	682	1,030	254	220	369	695	4,753
Percent	2.5%	29.2%	14.3%	21.7%	5.3%	4.6%	7.8%	14.6%	100.0%

Note: Bold percentages represent the highest and lowest language among the SAs. Data Source: State MEDS File, March 2018

Table 18 reports the distribution of “Other” non-threshold languages spoken in each SA by population enrolled in Medi-Cal for March 2018.

The language with the highest number of Medi-Cal enrollees that spoke “Other” non-threshold languages was Thai (N = 1,667) with the highest percentage residing in SA 2 at 36.8%, followed by ASL (N = 804) with the highest percentage also residing in SA 2 at 24.9%.

The remaining languages spoken by Medi-Cal enrollees were:

Japanese (N = 767) with the highest percentage residing in SA 8 at 35.9%; Hebrew (N = 331) with the highest percentage residing in SA 2 at 74.9%, French (N = 202) with the highest percentage residing in SA 6 at 22.8%, Portuguese (N = 196) with the highest percentage residing in SA 8 at 33.2%, Lao (N = 189) with the highest percentage residing in SA 3 at 37.0%, Samoan (N = 186) with the highest percentage residing in SA 8 at 29.6%, and Other Sign Language (N = 127) with the highest percentage residing in SA 2 at 29.1%.

Hmong, Ilocano, Italian, Mien, Polish, and Turkish were spoken by less than 100 Medi-Cal enrollees.

Consumers Served in Outpatient Programs
Fiscal Year 17-18

In FY 17-18, DMH served approximately 288,744 consumers. The majority were served in outpatient programs (N=232,693). Approximately, 27,373 were served by Fee-For-Service outpatient network providers, another 4,491 were served in jails and juvenile halls and 24,187 were served in 24-Hour acute psychiatric care or residential facilities.

In previous years, unique Client ID counts were used when reporting on the number of consumers served Countywide. The Office of Clinical Informatics has now implemented the deduplication technique with a Dataflux statistical match to eliminate likely duplicate IDs. This process decreases the likelihood of "false positives."

Table 19
Consumers Served In Outpatient Programs by Race/Ethnicity and Service Area

SA	African American	Asian/ Pacific Islander	Latino	Native American	White	Total
SA 1	8,579	377	7,676	235	5,411	22,278
Percent	38.5%	1.7%	34.5%	**1.05%**	24.3%	100.0%
SA 2	3,996	1,821	21,080	191	12,018	39,106
Percent	10.2%	4.7%	53.9%	0.49%	30.7%	100.0%
SA 3	3,675	2,943	19,452	237	5,202	31,509
Percent	11.7%	**9.3%**	61.7%	0.75%	16.5%	100.0%
SA 4	7,326	2,820	19,868	232	5,686	35,932
Percent	20.4%	7.8%	55.3%	0.65%	15.8%	100.0%
SA 5	1,884	389	1,869	81	3,647	7,870
Percent	23.9%	4.9%	**23.7%**	1.03%	**46.3%**	100.0%
SA 6	21,294	569	20,763	165	2,166	44,957
Percent	**47.4%**	**1.3%**	46.2%	**0.37%**	**4.8%**	100.0%
SA 7	2,074	921	23,807	288	2,972	30,062
Percent	**6.9%**	3.1%	**79.2%**	0.96%	9.9%	100.0%
SA 8	11,283	2,488	14,308	294	6,795	35,168
Percent	32.1%	7.1%	40.7%	0.84%	19.3%	100.0%
Total	41,896	9,699	82,064	1,276	32,625	167,560
Percent	25.0%	5.8%	49.0%	0.76%	19.5%	100.0%

Note: Bold values represent the highest and lowest percentages within each ethnic group and across all SAs. Unique client counts. The table excludes consumers served outside the SA (N=4,848), those whose race/ethnicity is unknown (N = 8,125) and "Other" (N =5,728). Total reflects an unduplicated count of consumers served. Data Source: Los Angeles County - Department of Mental Health (DMH) Integrated System (IS)-Integrated Behavioral Information Systems (IBHIS), December 2018.

Differences by Race/Ethnicity

Table 19 presents the unduplicated count of consumers served in outpatient programs by race/ethnicity and SA.

The highest percentage of African American consumers served in outpatient programs was in SA 6 (47.4%) as compared to SA 7 (6.9%) with the lowest percentage.

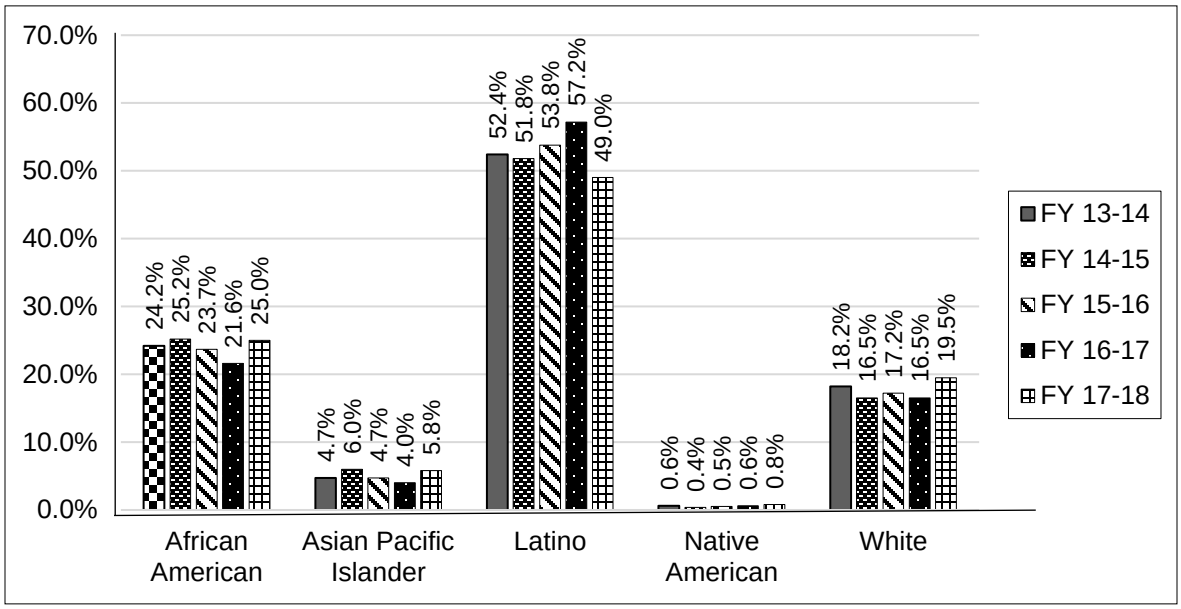
The highest percentage of Asian Pacific Islander consumers served in outpatient programs was in SA 3 (9.3%) as compared to SA 6 (1.3%) with the lowest percentage.

The highest percentage of Latino consumers served in outpatient programs was in SA 7 (79.2%) as compared to SA 5 (23.7%) with the lowest percentage.

The highest percentage of Native American consumers served in outpatient programs was in SA 1 (1.05%) as compared to SA 6 (0.37%) with the lowest percentage.

The highest percentage of White consumers served in outpatient programs was in SA 5 (46.3%) as compared to SA 6 (4.8%) with the lowest percentage.

Figure 10
Percent Change in Consumers Served in Outpatient Programs by Race/Ethnicity Fiscal Year (FY) 13-14 to FY 17-18



Data Source: DMH, IS-IBHIS, December 2018.

The percentage of African Americans served in outpatient programs increased by 0.8 PP from 24.2% to 25.0% between FY 13-14 and FY 17-18.

The percentage of Asian Pacific Islanders served in outpatient programs increased by 1.1 PP from 4.7% to 5.8% between FY 13-14 and FY 17-18.

The percentage of Latinos served in outpatient programs decreased by 3.4 PP from 52.4% to 49.0% between FY 13-14 and FY 17-18.

The percentage of Native Americans served in outpatient programs increased by 0.2 PP from 0.6% to 0.8% between FY 13-14 and FY 17-18.

The percentage of Whites served in outpatient programs increased by 1.3 PP from 18.2% to 19.5% between FY 13-14 and FY 17-18.

Table 20
Consumers Served in Outpatient Programs by Age Group and Service Area

SA	Age Group				
	0-15	16-25	26-59	60+	Total
SA 1	8,015	4,283	9,968	1,429	23,695
Percent	33.8%	18.1%	42.1%	**6.0%**	100.0%
SA 2	14,430	10,404	17,188	4,159	46,181
Percent	31.2%	**22.5%**	37.2%	9.0%	100.0%
SA 3	15,985	10,087	12,413	2,717	41,202
Percent	38.8%	24.5%	**30.1%**	6.6%	100.0%
SA 4	11,173	7,856	18,232	4,513	41,774
Percent	26.7%	18.8%	43.6%	10.8%	100.0%
SA 5	1,563	1,504	4,892	1,403	9,362
Percent	**16.7%**	**16.1%**	**52.3%**	**15.0%**	100.0%
SA 6	17,905	10,661	20,171	4,098	52,835
Percent	33.9%	20.2%	38.2%	7.8%	100.0%
SA 7	14,571	8,077	11,869	2,475	36,992
Percent	**39.4%**	21.8%	32.1%	6.7%	100.0%
SA 8	12,278	7,378	17,148	4,124	40,928
Percent	30.0%	18.0%	41.9%	10.1%	100.0%
Total	69,623	40,653	85,114	20,411	215,801
Percent	32.3%	18.8%	39.4%	9.5%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Unique client counts. Unknown/not reported and consumers outside the SA (N=33,603) were excluded from this table. Total reflects unduplicated count of consumers served. Data Source: DMH IS-IBHIS, December 2018.

Differences by Age Group

Table 20 shows the unduplicated count of consumers served in outpatient programs by age group and SA.

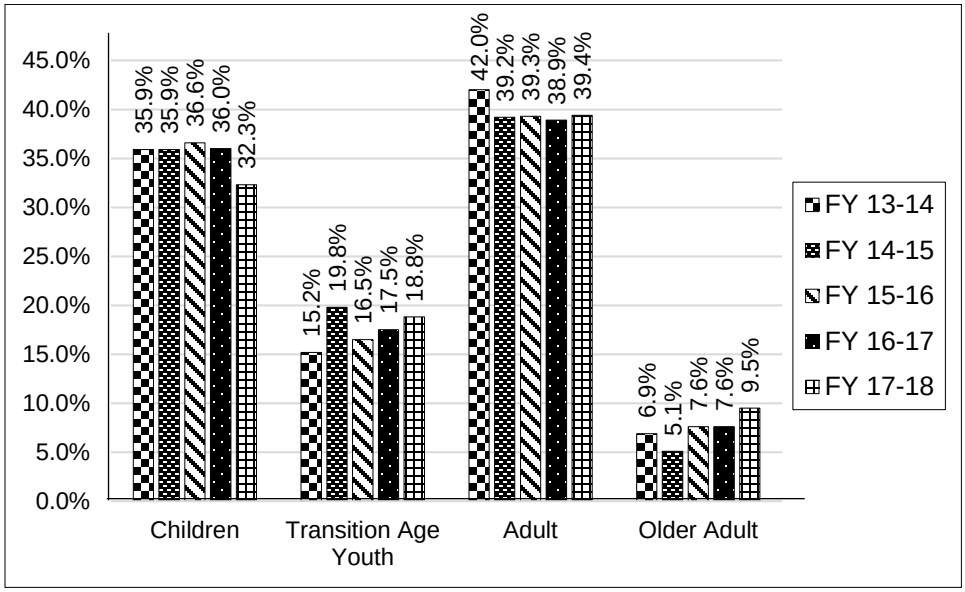
The highest percentage of Children (0-15 years old) served was in SA 7 (39.4%) compared to SA 5 (16.7%) with the lowest percentage.

The highest percentage of TAY (16-25 years old) served was in SA 2 (22.5%) when compared to SA 5 (16.1%) with the lowest percentage.

The highest percentage of Adults (26-59 years old) served was in SA 5 (52.3%) compared to SA 3 (30.1%) with the lowest percentage.

The highest percentage of Older Adults (60+ years old) was in SA 5 (15.0%) compared to SA 1 (6.0%) with the lowest percentage.

Figure 11
Percent Change in Consumers Served in Outpatient Programs by Age Group
Fiscal Year (FY) 13-14 to FY 17-18



Data Source: DMH, IS-IBHIS, December 2018.

The percentage of Children served in outpatient programs decreased by 3.6 PP from 35.9% to 32.3% between FY 13-14 and FY 17-18

The percentage of TAY served in outpatient programs increased by 3.6 PP from 15.2% to 18.8% between FY 13-14 and FY 17-18.

The percentage of Adults served in outpatient programs decreased by 2.6 PP from 42.0% to 39.4% between FY 13-14 and FY 17-18.

The percentage of Older Adults served in outpatient programs increased by 2.6 PP from 6.9% to 9.5% between FY 13-14 and FY 17-18.

Table 21
Consumers Served in Outpatient Programs by Gender and Service Area

SA	Males	Females	Total
SA 1	11,613	12,060	23,673
Percent	**49.1%**	**50.9%**	100.0%
SA 2	23,434	22,705	46,139
Percent	50.8%	49.2%	100.0%
SA 3	20,751	20,417	41,168
Percent	50.4%	49.6%	100.0%
SA 4	22,768	18,920	41,688
Percent	**54.6%**	**45.4%**	100.0%
SA 5	4,830	4,509	9,339
Percent	51.7%	48.3%	100.0%
SA 6	26,926	25,852	52,778
Percent	51.0%	49.0%	100.0%
SA 7	18,753	18,205	36,958
Percent	50.7%	49.3%	100.0%
SA 8	20,512	20,363	40,875
Percent	50.2%	49.8%	100.0%
Total	108,249	107,301	215,550
Percent	50.2%	49.8%	100.0%

Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Unique client counts. Table excludes consumers outside SA (N=4,848); Transgender Female to Male (N=107); and Male to Female (N=90); and Unknown/Not reported gender (N= 60). Data Source: DMH-IS-IBHIS, December 2018.

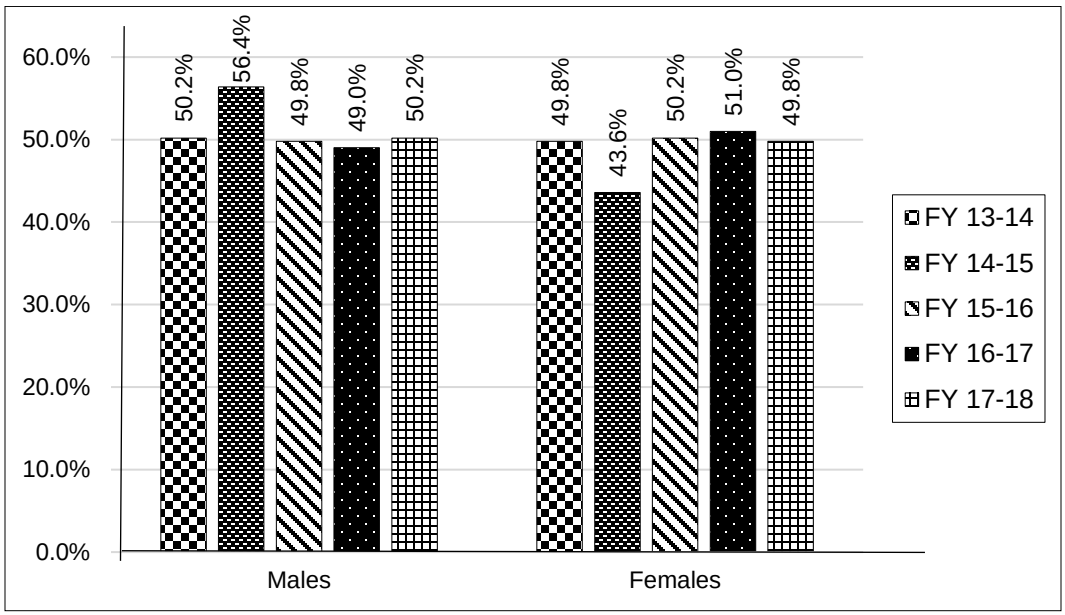
Differences by Gender

Table 21 presents the unduplicated count of consumers served in outpatient programs by gender and SA.

The highest percentage of Males served in outpatient programs was in SA 4 (54.6%) compared to SA 1 (49.1%) with the lowest percentage.

The highest percentage of Females served in outpatient programs was in SA 1 (50.9%) compared to SA 4 (45.4%) with the lowest percentage.

Figure 12
Percent Change in Consumers Served in Outpatient Programs by Gender
Fiscal Year (FY) 13-14 to FY 17-18



Data Source: DMH – IS-IBHIS Database, December 2018.

As a percentage of consumers served, Males served in outpatient programs remained at 50.2% between FY 13-14 and FY 17-18.

As a percentage of consumers served, Females served in outpatient programs remained at 49.8% between FY 13-14 and FY 17-18.

Table 22
Primary Language of Consumers Served in Outpatient Programs by Service Area and Threshold Language

SA	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	8	14	3	0	21,785	9	2	5	0	5	1,448	9	3	23,291
Percent	0.03%	0.06%	0.01%	0.00%	**93.53%**	0.04%	0.01%	0.02%	0.00%	0.02%	**6.22%**	0.04%	0.01%	100.00%
SA 2	106	1,311	19	8	35,638	501	118	12	9	142	6,913	108	53	44,938
Percent	0.24%	**2.92%**	0.04%	0.02%	**79.3%**	**1.11%**	**0.26%**	0.03%	0.02%	**0.32%**	**15.4%**	**0.24%**	**0.12%**	100.0%
SA 3	25	42	65	529	31,648	10	79	501	96	6	6,704	37	341	40,083
Percent	0.06%	0.10%	0.16%	**1.32%**	**79.0%**	0.02%	**0.20%**	**1.25%**	**0.24%**	0.01%	**16.7%**	0.09%	**0.85%**	100.0%
SA 4	14	166	67	147	30,221	47	813	47	21	104	7,919	86	70	39,722
Percent	0.04%	**0.42%**	0.17%	**0.37%**	**76.1%**	0.12%	**2.05%**	0.12%	0.05%	**0.26%**	**19.9%**	**0.22%**	0.18%	100.0%
SA 5	9	4	0	3	8,087	145	19	9	0	21	566	4	5	8,872
Percent	0.10%	0.05%	0.00%	0.03%	**91.2%**	**1.63%**	0.21%	0.10%	0.00%	0.24%	**6.38%**	0.05%	0.06%	100.0%
SA 6	6	5	21	21	41,570	10	107	20	4	17	9,465	8	10	51,264
Percent	0.01%	0.01%	0.04%	0.04%	**81.09%**	0.02%	0.21%	0.04%	0.01%	0.03%	**18.46%**	0.02%	0.02%	100.00%
SA 7	23	9	92	20	27,003	2	63	27	9	2	8,747	25	35	36,057
Percent	0.06%	0.02%	0.26%	0.06%	**74.89%**	0.01%	**0.17%**	0.07%	0.02%	0.01%	**24.26%**	0.07%	0.10%	100.00%
SA 8	27	3	625	11	32,577	13	105	23	12	4	5,953	82	128	39,563
Percent	0.07%	0.01%	**1.58%**	0.03%	**82.34%**	0.03%	0.27%	0.06%	0.03%	0.01%	**15.05%**	0.21%	0.32%	100.00%
Total	185	1,446	860	617	164,492	638	98	561	131	261	37,582	298	603	207,772
Percent	0.09%	0.70%	0.4%	0.30%	79.2%	0.31%	0.05%	0.27%	0.06%	0.13%	18.1%	0.14%	0.29%	100.0%

Note: "Threshold Language" means a language that has been identified as a primary language, as indicated on the State MEDS File, from the 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. Primary languages for Medi-Cal enrollees (see Table 17) are in bold. A total of 8,035 consumers served in outpatient programs specified another non-threshold primary language show in Table 23. Another 1,316 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. A total of 185 Arabic speaking consumers were served in FY 17-18. Data Source: DMH-IS-IBHIS, December 2018.

Table 22 compares the outpatient programs of consumers served by SA and threshold language.

English was the highest reported primary language among consumers served in outpatient programs, in all SAs. A total of 164,492 (79.2%) English-speaking consumers were served followed by 37,582 (18.1%) Spanish-speaking consumers. The remaining 5,698 (2.7%) consumers served spoke the Department's other threshold languages. A total of 43,280 (20.8%) of the consumers served reported a primary language other than English.

SA 1 (93.5%) had the highest percentage of English speaking consumers, as compared to SA 7 (74.9%) 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 (24.3%) and the lowest percentage was in SA 1 (6.2%).

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

- SA 1: Spanish (6.2%)
- SA 2: Armenian (2.9%), Farsi (1.1%), Korean (0.3%), Russian (0.3%), Spanish (15.4%), Tagalog (0.2%), and Vietnamese (0.1%)
- SA 3: Cantonese (1.3%), Korean (0.2%), Mandarin (1.2%), Other Chinese (0.2%), Spanish (16.7%), and Vietnamese (0.9%)
- SA 4: Armenian (0.4%), Cantonese (0.4%), Korean (2.0%), Russian (0.3%), and Spanish (19.9%)
- SA 5: Farsi (1.6%) and Spanish (6.4%)
- SA 6: Spanish (18.5%)
- SA 7: Korean (0.2%) and Spanish (24.3%)
- SA 8: Cambodian (1.6%), Korean (0.3%), Spanish (15.1%), and Vietnamese (0.32%)

Table 23
"Other" non-Threshold Languages Spoken by Consumers Served in Outpatient Programs by Service Area

Languages	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	Total
Afghan, Pashto, Pusho	1	23	1	5	0	0	0	3	33
Percent	3.0%	69.7%	3.0%	15.2%	0.0%	0.0%	0.0%	9.1%	100.0%
ASL	11	10	10	12	6	16	11	8	84
Percent	13.1%	11.9%	11.9%	14.3%	7.1%	19.0%	13.1%	9.5%	100.0%
Burmese	0	5	7	3	0	0	1	1	17
Percent	0.0%	29.4%	41.2%	17.6%	0.0%	0.0%	5.9%	5.9%	100.0%
Ethiopian	0	12	3	18	1	15	4	10	63
Percent	0.0%	19.0%	4.8%	28.6%	1.6%	23.8%	6.3%	15.9%	100.0%
French	7	10	8	14	6	3	0	2	50
Percent	14.0%	20.0%	16.0%	28.0%	12.0%	6.0%	0.0%	4.0%	100.0%
Hebrew	0	12	2	2	3	4	1	0	24
Percent	0.0%	50.0%	8.3%	8.3%	12.5%	16.7%	4.2%	0.0%	100.0%
Hindi	2	9	4	4	7	1	5	9	41
Percent	4.9%	22.0%	9.8%	9.8%	17.1%	2.4%	12.2%	22.0%	100.0%
Japanese	3	5	9	39	8	6	1	39	110
Percent	2.7%	4.5%	8.2%	35.5%	7.3%	5.5%	0.9%	35.5%	100.0%
Lao	0	5	12	16	0	5	3	27	68
Percent	0.0%	7.4%	17.6%	23.5%	0.0%	7.4%	4.4%	39.7%	100.0%
Portuguese	1	5	4	12	11	0	1	7	41
Percent	2.4%	12.2%	9.8%	29.3%	26.8%	0.0%	2.4%	17.1%	100.0%
Punjabi	0	12	1	1	0	0	1	0	15
Percent	0.0%	80.0%	6.7%	6.7%	0.0%	0.0%	6.7%	0.0%	100.0%
Romanian	0	11	1	9	1	2	2	0	26
Percent	0.0%	42.3%	3.8%	34.6%	3.8%	7.7%	7.7%	0.0%	100.0%
Thai	2	25	8	30	1	1	4	9	80
Percent	2.5%	31.3%	10.0%	37.5%	1.3%	1.3%	5.0%	11.3%	100.0%
Toisan	0	2	15	6	0	3	1	0	27
Percent	0.0%	7.4%	55.6%	22.2%	0.0%	11.1%	3.7%	0.0%	100.0%
Urdu	4	10	1	1	2	2	5	12	37
Percent	10.8%	27.0%	2.7%	2.7%	5.4%	5.4%	13.5%	32.4%	100.0%
Other Non-English	4	12	11	11	2	7	4	4	55
Percent	7.3%	21.8%	20.0%	20.0%	3.6%	12.7%	7.3%	7.3%	100.0%
Total	35	168	97	183	48	65	44	131	771
Percent	4.5%	21.8%	12.6%	23.7%	6.2%	8.4%	5.7%	17.0%	100.0%

Data Source: DMH-IS-IBHIS, December 2018

Table 23 reports the distribution of “Other” non-threshold languages spoken by consumers served in FY 17-18. The highest number of consumers who spoke “Other” non-threshold languages was in SA 4 (N = 183), followed by SA 2 (N = 168).

The language with the highest number of speakers was Japanese (N=110). SA 4 (N=39) and SA 8 (N=39) served the highest number of consumers who spoke Japanese, followed by SA 3 (N=9) and SA 5 (N=8).

The language with the second highest number of speakers was ASL (N=84), followed by 80 consumers who preferred Thai, and 63 consumers who preferred Ethiopian.

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Section 3

Quality Improvement Work Plan Evaluation Report for Calendar Year 2018

The Department provides a full array of treatment services as required under the 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 MHP's reporting requirements of the CCR Title 9, Chapter 11, Section 1810.440, concerning QI, the Department's evaluation of QI activities are structured and organized according to the following domains:

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

The QI Work Plan goals for CY 2018 were designed to address: access to services for consumers, service delivery capacity for underserved populations, the timeliness of DMH services provided, beneficiary satisfaction with the services received, the quality of services provided, and other areas of quality improvement as identified by the Department.

Section 3 provides an evaluation summary on the progress made by DMH in reaching each QI Work Plan goal.

Los Angeles County Department of Mental Health (LACDMH)
Quality Improvement Work Plan Evaluation Summary for Calendar Year 2018

I. Monitoring Service Delivery Capacity

1. Between 52.9% and 53.5% of Latinos estimated with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH outpatient programs in Fiscal Year (FY) 17-18. **Not Met.**
2. Between 34.8% and 36.4% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% FPL will be served in LACDMH outpatient programs in FY 17-18. **Met.**
3. Develop and implement a Community Mental Health Needs Assessment in order to assess the mental health needs of the deaf, hard-of-hearing, and blind communities as well as people who have physical disabilities and identify gaps in service delivery for CY 2018. **Partially Met**.
4. Provide Telemental Health (TMH) services to at least 500 clients in CY 2018. **Met.**

II. Monitoring Accessibility of Services

1. Maintain the percentage of after-hours Psychiatric Mobile Response Teams (PMRT) responses with a response time of one hour or less at 60% for CY 2018. **Not Met.**

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

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

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

III. Monitoring Beneficiary Satisfaction

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

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

3b. Resolve all standard appeals within 30 calendar days and all expedited appeals within 72 hours of receipt of appeal by Patients' Rights Office (PRO) for FY 17-18. **Not rated.**

3. Resolve all grievances within 90 calendar days from the date the grievance was logged on the Problem Resolution Log for FY 17-18. **Met.**
4. Monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their Change of Provider requests. **Met.**

IV. Monitoring Clinical Care

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

V. Monitoring Continuity of Care

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

VI. Monitoring Provider Appeals

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

Monitoring Service Delivery Capacity

Prevalence and Penetration Rates for Fiscal Year 17-18

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

The penetration rates were derived by calculating the number of unduplicated consumers served in DMH outpatient programs during FY 17-18 from the total Los Angeles County population living at or below 138% FPL estimated with SED and SMI (by racial/ethnic group). Table 24 shows the penetration rates for FY 15-16, FY 16-17, and FY 17-18 using prevalence estimates from CHIS survey data.

Goal I.1.

Between 52.9% and 53.5% of Latinos estimated with SED and SMI at or below the 138% FPL will be served in LACDMH outpatient programs in FY 17-18.

Evaluation. This goal was not met. A total of 50.0% of Latinos estimated with SED and SMI, and at or below 138% FPL were served in FY 17-18.

Goal I.2.

Between 34.8% and 36.4% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% FPL will be served in LACDMH outpatient programs in FY 17-18.

Evaluation. This goal was met. A total of 52.0% of API estimated with SED and SMI, and at or below 138% FPL were served in FY 17-18.

Table 24

Three-Year Trend in Penetration Rates by Race/Ethnicity for Population Living at or Below 138% Federal Poverty Level Based on Prevalence Rates From the California Health Interview Survey Fiscal Year (FY) 15-16 to FY 17-18

Race/Ethnicity	FY 15-16	FY 16-17	FY 17-18
African American	150.0%	68.8%	78.7%
Consumers Served	46,800	38,984	41,896
Estimated population with SED/SMI	31,201	56,701	53,258
Asian Pacific Islander	35.6%	41.0%	52.0%
Consumers Served	9,340	7,252	9,699
Estimated population with SED/SMI	26,233	17,709	18,647
Latino	53.2%	59.7%	50.0%
Consumers Served	106,094	103,172	82,064
Estimated population with SED/SMI	199,531	172,795	164,188
Native American	31.9%	116.2%	157.3%
Consumers Served	1,065	989	1,276
Estimated population with SED/SMI	3,340	851	811
White	31.8%	48.2%	54.4%
Consumers Served	33,982	29,844	32,625
Estimated population with SED/SMI	107,004	61,956	59,959

Note: The CHIS's ethnic-specific prevalence rates of SED and SMI were applied to calculate penetration rates. Data Source: DMH-IS Database, December 2018.

Three-Year Trend in Penetration Rates by Race/Ethnicity

Table 24 presents the penetration rates by race/ethnicity for FY 15-16, FY 16-17, and FY 17-18.

The penetration rates for the African American group decreased from 150% in FY 15-16 to 78.7% in FY 17-18.

The penetration rates for the Asian Pacific Islander group increased from 35.6% in FY 15-16 to 52.0% in FY 17-18.

The penetration rates for the Latino group decreased from 53.2% FY 15-16 to 50.0% in FY 17-18.

The penetration rates for the White group increased from 31.9% in FY 15-16 to 157.3% in FY 17-18.

Penetration Rates by Race/Ethnicity and Service Area

Table 25 presents penetration rates for the total population estimated with SED and SMI and the population living at or below 138% FPL by race/ethnicity and SA.

Table 25
Penetration Rate Among Total Population and Population Living at or Below 138% Federal Poverty Level by Race/Ethnicity and Service Area
Fiscal Year 17-18

Race/Ethnicity and SA	[1]Number of Consumers Served	Total Population Estimated With SED and SMI	[2]Penetration Rates for Total Population	Population Living at or Below 138% FPL and Estimated With SED and SMI	Penetration Rates for Population Living at or Below 138% FPL
SA 1					
African American	8,579	8,350	102.7%	4,191	204.7%
Asian/Pacific Islander	377	1,148	32.8%	192	196.4%
Latino	7,676	15,559	49.3%	5,974	128.5%
Native American	235	186	126.3%	77	305.2%
White	5,411	10,303	52.5%	3,921	138.0%
Total	22,278	35,546	62.7%	14,355	155.2%
SA 2					
African American	3,996	10,649	37.5%	3,518	113.6%
Asian/Pacific Islander	1,821	19,013	9.6%	2,727	66.8%
Latino	21,080	79,721	26.4%	26,642	79.1%
Native American	191	464	41.2%	118	161.9%
White	12,018	77,926	15.4%	20,792	57.8%
Total	39,106	187,773	20.8%	53,797	72.7%
SA 3					
African American	3,675	8,815	41.7%	2,623	140.1%
Asian/Pacific Islander	2,943	37,785	7.8%	6,095	48.3%
Latino	19,452	72,790	26.7%	20,559	94.6%
Native American	237	369	64.2%	92	257.6%
White	5,202	29,556	17.6%	7,138	72.9%
Total	31,509	149,315	21.1%	36,507	86.3%
SA 4					
African American	7,326	8,271	88.6%	3,358	218.2%
Asian/Pacific Islander	2,820	15,382	18.3%	3,867	72.9%
Latino	19,868	53,790	36.9%	23,265	85.4%
Native American	232	258	89.9%	130	178.5%
White	5,686	23,164	24.5%	8,271	68.7%
Total	35,932	100,865	35.6%	38,891	92.4%

Note: [1]Number of Consumers Served by DMH outpatient programs. This count does not include consumers served by outpatient FFS providers; inpatient FFS providers and hospitals; Institutional facilities, such as jails and probation camps.
[2]Penetration Rate = Number of Consumers Served / Number of individuals estimated with SED and SMI.
Data Source: CHIS, 2015-2016 (pooled estimates).

Table 25 (contd.):
Penetration Rate Among Total Population and Population Living at or Below 138% Federal Poverty Level by Race/Ethnicity and Service Area
Fiscal Year 17-18

Race/Ethnicity and SA	[1]Number of Consumers Served	Total Population Estimated with SED and SMI	[2]Penetration Rates for Total Population	Population Living at or Below 138% FPL and Estimated with SED and SMI	Penetration Rates for Population Living at or Below 138% FPL
SA 5					
African American	1,884	5,177	36.4%	1,185	159.0%
Asian/Pacific Islander	389	6,857	5.7%	1,052	37.0%
Latino	1,869	9,480	19.7%	1,837	101.7%
Native American	81	122	66.4%	21	385.7%
White	3,647	33,201	11.0%	7,523	48.5%
Total	7,870	54,837	14.4%	11,618	67.7%
SA 6					
African American	21,294	38,572	55.2%	22,135	96.2%
Asian/Pacific Islander	569	1,464	38.9%	597	95.3%
Latino	20,763	63,673	32.6%	34,526	60.1%
Native American	165	183	90.2%	126	131.0%
White	2,166	2,106	102.8%	1,391	155.7%
Total	44,957	105,998	42.4%	58,775	76.5%
SA 7					
African American	2,074	5,373	38.6%	1,692	122.6%
Asian/Pacific Islander	921	8,865	10.4%	1,102	83.6%
Latino	23,807	84,377	28.2%	29,078	81.9%
Native American	288	328	87.8%	99	290.9%
White	2,972	13,979	21.3%	3,623	82.0%
Total	30,062	112,922	26.6%	35,594	84.5%
SA 8					
African American	11,283	30,809	36.6%	13,973	80.7%
Asian/Pacific Islander	2,488	18,271	13.6%	2,627	94.7%
Latino	14,308	55,910	25.6%	21,629	66.2%
Native American	294	442	66.5%	151	194.7%
White	6,795	34,232	19.8%	7,072	96.1%
Total	35,168	139,664	25.2%	45,452	77.4%

Note: [1]Number of Consumers Served by DMH outpatient programs. This count does not include consumers served by outpatient FFS providers; inpatient FFS providers and hospitals; Institutional facilities, such as jails and probation camps.
[2]Penetration Rate = Number of Consumers Served / Number of individuals estimated with SED and SMI.
Data Source: CHIS, 2015-2016 (pooled estimates).

Table 25 (contd.):
Penetration Rate Among Total Population and Population Living at or Below 138% Federal Poverty Level by Race/Ethnicity and Service Area
Fiscal Year 17-18

Unduplicated Consumers Served in at least one SA					
African American	41,896	116,196	36.1%	53,258	78.7%
Asian/Pacific Islander	9,699	108,785	8.9%	18,647	52.0%
Latino	82,064	435,301	18.9%	164,188	50.0%
Native American	1,276	2,353	54.2%	811	157.3%
White	32,625	224,468	14.5%	59,959	54.4%
Total	167,560	887,103	18.9%	296,863	56.4%
[3]Duplicated Countywide Consumers Served in More than one SA					
African American	18,215	43.5%			
Asian/Pacific Islander	2,629	27.1%			
Latino	46,759	57.0%			
Native American	447	35.0%			
White	11,272	34.6%			
Total	79,322	47.3%			

Note: [1]Number of Consumers Served by DMH outpatient programs. This count does not include consumers served by outpatient FFS providers; inpatient FFS providers and hospitals; Institutional facilities, such as jails and probation camps.
[2]Penetration Rate = Number of Consumers Served / Number of individuals estimated with SED and SMI.
[3]Duplicated consumers by ethnicity (number of consumers whom received services in more than one SA) = Duplicated Count of Consumers by ethnicity – Unduplicated Count of Consumers by ethnicity
[3]Percent of Consumers served in more than one Service Area = Duplicated consumers by ethnicity/Unduplicated Count of Consumers by ethnicity. Data Source: CHIS, 2015-2016 (pooled estimates).

Estimated Prevalence Rates With Confidence Intervals

Table 26 presents the estimated prevalence rates and confidence intervals by race/ethnicity for the 2013-2014, 2014-2015, and 2015-2016 CHIS cycles.

Table 26
Estimated Prevalence Rates for SED and SMI by CHIS With Confidence Intervals: 2013-2014 to 2015-2016

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

Note: *Data represents a wide confidence interval and is statistically unstable. The CHIS rates for 2015-16 were applied when calculating prevalence rates based on FY 17-18 data. Data Source: CHIS, 2015 and 2016.

Goal I. 3.

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

Evaluation. This goal was partially met. The Community Mental Health Needs Assessment was designed to assess the mental health needs of the deaf, hard-of-hearing, blind, and physically disabled communities; however, it has not yet been sent out for solicitation. The supporting documentation was submitted in May 2018. It was determined that this Community Mental Health Needs Assessment would not be a duplication, and this goal will be included in the QI Work Plan for CY 2019. The project has moved through Procurement and the assessment is expected to be completed in CY 2019.

Goal I. 4.

Provide Telemental Health (TMH) services to at least 500 clients in CY 2018.

Evaluation. This goal was met. In CY 2019, there were 510 consumers whom received DMH TMH services.

Monitoring Accessibility of Services

Goal II.1.

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

Evaluation. This goal was not met. Table 27 presents PMRT responsiveness for CY 2014 through CY 2018. In CY 2018, PMRT was dispatched and on scene within one hour or less, from acknowledgement of receipt of the call, for 55% of PMRT after-hours calls. This represents a 5 PP decline in ACCESS Center PMRT responsiveness when compared to CY 2017 and an 18 PP decline from 73% in CY 2014.

In CY 2018, the increase in Los Angeles County's traffic during after-hours negatively impacted PMRT responsiveness. The majority of PMRT dispatched during after-hours were noted to occur on weekdays and between 5:00 PM and 7:00 PM; these were the County's peak traffic hours. The Department's after-hours field response teams are assigned to each SA. However, after-hours PMRT is often dispatched to other SAs to meet the demand. This contributed to delays in arrival and an overall decline in PMRT responsiveness from CY 2017 to CY 2018. Table 27 presents the five-year trend in PMRT response rates of one hour or less.

Table 27
Psychiatric Mobile Response Team After-Hours Response Rates of One Hour or Less
Calendar Year (CY) 2014 to CY 2018

Month	2014	2015	2016	2017	2018
January	75%	72%	70%	63%	54%
February	73%	70%	74%	61%	63%
March	73%	69%	74%	62%	58%
April	72%	68%	73%	63%	56%
May	71%	70%	73%	62%	57%
June	73%	73%	73%	59%	53%
July	74%	75%	74%	59%	52%
August	76%	72%	75%	58%	55%
September	73%	69%	70%	59%	54%
October	74%	71%	66%	58%	52%
November	67%	70%	63%	58%	52%
December	73%	71%	71%	56%	52%
Annual Total	**5,824**	**3,670**	**3,904**	**4,825**	**4,612**
Annual Average %	**73%**	**71%**	**71%**	**60%**	**55%**

Note: The data presented in this table is exclusive to calls received during after-hours and dispatched within one hour or less. Data Source: DMH EOTD, ACCESS Center, CY 2014 to CY 2018.

ACCESS Center's 24/7 Toll-Free Line

The Department's 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 providers and services that are conveniently located and appropriate to their cultural and behavioral health needs. Table 28 presents the total calls answered within one minute by number, percent, and month.

Goal II.2a.

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

Evaluation. This goal was met. The ACCESS Center achieved an annual average of 84% of after-hours calls to the toll-free hotline being answered by a live agent within 1 minute.

Goal II.2b.

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

Evaluation. This goal was met. The ACCESS Center achieved an annual average of 83% of business-hours calls to the toll-free hotline being answered by a live agent within 1 minute.

Table 28
Calls Answered Within 1 Minute by Number and Percent
Calendar Year 2018

Month	Total Calls by Shift	Calls Answered Within 1 Minute by Shift	Percentage of Calls Answered Within 1 Minute
January			
Business-Hours	5,373	4,807	89%
After-Hours	5,709	4,868	85%
February			
Business-Hours	5,391	4,296	80%
After-Hours	5,706	4,402	77%
March			
Business-Hours	6,003	5,114	85%
After-Hours	6,503	5,186	80%
April			
Business-Hours	5,871	4,860	83%
After-Hours	5,814	4,648	80%
May*			
Business-Hours	5,960	5,020	84%
After-Hours	6,287	5,207	83%
June			
Business-Hours	5,637	4,773	85%
After-Hours	6,258	5,331	85%
July			
Business-Hours	5,364	4,773	89%
After-Hours	6,324	5,263	83%
August			
Business-Hours	6,196	5,221	84%
After-Hours	6,249	5,441	87%
September**			
Business-Hours	5,594	4,032	72%
After-Hours	6,522	5,646	87%
October			
Business-Hours	6,305	5,227	83%
After-Hours	6,629	5,699	86%
November			
Business-Hours	5,159	4,397	85%
After-Hours	6,025	5,152	86%
December			
Business-Hours	4,750	3,844	81%
After-Hours	5,831	5,125	88%
Year-to-Date			
Business-Hours	*67,603*	*56,364*	*83%*
After-Hours	*73,857*	*61,968*	*84%*
Total (Overall)	*141,460*	*118,332*	*84%*

Note: Business-hours are 8:00 AM to 5:00 PM, Monday through Friday, excluding holidays. After-hours are outside of business-hours and include weekends and holidays. *VCC was down from Saturday, May 12 through Monday, May 14, 2018. No information was available for Sunday, May 13, 2018. **Higher rates of agent absenteeism, agents in training and VCC system technical issues during business-hours in September 2018 may have contributed to the decline in the percent of calls answered within one minute.
Data Source: DMH ACCESS Center, CY 2018.

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

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

Goal II. 3

Monitor the number of assigned appointments for hearing-impaired interpreter services coordinated by the toll free hotline for FY 17-18.

Evaluation. This goal was met. A total of 1,140 requests for sign language interpreter services were coordinated by the toll free hotline in FY 17-18. Table 29 shows the number of assigned sign language interpreter services appointments for the five prior fiscal years.

Table 29
Summary of Appointments for Hearing-Impaired Services by Fiscal Year (FY)
FY 13-14 to FY 17-18

FY	Number of Assigned Appointments
13-14	937
14-15	1,137
15-16	1,058
16-17	1,242
17-18	1,140
Total	5,514

Note: Data includes only interpreter services requests assigned to ASL interpreters available to provide service on a given date. Data Source: DMH, EOTD, ACCESS Center, FY 13-14 to FY 17-18.

Table 30
Five-Year Trend non-English Language Calls Received by ACCESS Center Calendar Year (CY) 2014 to CY 2018

*Language	CY				
	2014	2015	2016	2017	2018
Amharic	1	0	0	1	0
*Arabic	24	6	16	8	18
*Armenian	225	80	130	128	65
Bahasa	0	0	1	0	0
Bengali	0	0	1	0	2
Bosnian	1	0	0	0	0
Bulgarian	0	0	0	0	0
Burmese	0	0	0	0	2
Cambodian	0	0	7	10	26
*Cantonese	60	46	40	46	73
Cebuano	1	0	0	0	0
*Farsi	81	58	56	178	59
French	2	2	2	1	1
German	0	1	0	0	0
Greek	0	1	0	0	0
Hebrew	2	1	0	0	0
Hindi	1	0	0	0	1
Hungarian	0	3	0	0	0
Italian	0	0	0	0	0
Japanese	2	2	4	2	6
Khmer	5	3	1	0	0
*Korean	132	108	116	140	224
Kurdish-Behdini	1	0	0	0	0
Laotian	2	0	0	0	0
Luganda	0	0	0	0	1
*Mandarin	30	62	86	82	166
Mongolian	0	0	0	0	0
Nepali	2	0	0	0	0
Pashto	0	0	0	0	0
Persian	0	0	1	5	4
Polish	0	0	1	0	1
Portuguese	1	0	1	1	1
Punjabi	0	1	0	2	1

Note: *DMH Threshold Languages excludes Other Chinese in CY 2016 and CY 2017. Data Source: DMH ACCESS Center, CY 2014 to CY 2018.

Table 30 (contd.)
Five-Year Trend non-English Language Calls Received by Access Center
Calendar Year (CY) 2014 to CY 2018

*Language	CY				
	2014	2015	2016	2017	2018
Romanian	0	0	1	0	0
***Russian**	11	12	16	37	13
Samoan	0	0	0	0	0
Serbian	0	0	2	0	0
Slovak	0	0	1	0	0
[1]Spanish (LISMA)	1,402	1,089	1,474	2,303	1,370
[2]Spanish ACCESS Center	6,135	6,159	6,040	6,150	6,612
Spanish Subtotal	7,537	7,248	7,514	8,453	7,982
***Tagalog**	18	7	10	9	16
Thai	2	1	0	7	0
Turkish	0	0	0	0	0
Urdu	1	0	0	0	1
***Vietnamese**	24	**17**	**28**	195	34
Total	**8,166**	**7,659**	**8,035**	**9,305**	**8,697**

Note: *DMH Threshold Languages excludes Other Chinese in CY 2016 and CY 2017. [1]LISMA or Language Interpretation Services Master Agreement. [2]Telephone Interpreter Line Calls. Data Source: DMH ACCESS Center, CY 2014 to CY 2018.

Table 30 summarizes the total number of non-English language calls received by the ACCESS Center, from CY 2014 through CY 2018. Over the past five years, the majority of the requests for non-English language calls were for Spanish, followed Armenian and Korean.

In CY 2018, the ACCESS Center staff provided language interpreter services, in the Spanish language, for 6,612 calls. An additional 1,370 Spanish language calls were interpreted through a language interpreter service vendor. Approximately, 92% of the non-English calls received by ACCESS Center staff were in Spanish (N=7,982), followed by Korean (N=224) at 2.5% and Mandarin (N=166) at 2.0%. The remaining languages received less than 100 calls in CY 2018 and accounted for 3.5% of all non-English calls.

Consumer Satisfaction Survey Goals

The Consumer Perception Surveys (CPS) were distributed at randomly selected outpatient and Day Treatment programs between May 14, 2018 and May 18, 2018. Survey data was gathered from youth (ages 13-17) using the Youth Services Survey (YSS), from adults (ages 18–59) using the Adult Survey, and from older adults (ages 60 and older) using the Older Adult Survey. The families of Youth (ages 0-17) completed surveys for services received by their children using the Youth Services Survey for Families (YSS-F).

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

Goal II.4.

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

Evaluation. This goal was met. Approximately, 86.9% of the consumers/families who participated in the May 2018 survey period reported they agreed or strongly agreed with the statement, “Location of services was convenient.” This represents a 0.1 PP decline from May 2017 and a 0.3 PP decrease from May 2016.

Table 31

Percent of Consumers / Families by Age Group who Strongly Agree or Agree With the "Location of Services was Convenient" Item
Calendar Year 2016 to May 2018

Age Group	CY 2016		CY 2017		CY 2018
	May	November	May	November	May
YSS-F					
Number	2,622	2,684	2,209	4,158	4,213
Percent	92.4%	91.2%	92.8%	91.7%	92.8%
YSS					
Number	1,223	1,263	1,107	1,944	1,979
Percent	80.8%	83.7%	84.3%	82.5%	84.3%
Adult					
Number	3,346	3,620	3,299	5,119	5,422
Percent	84.2%	83.9%	83.7%	82.5%	83.7%
Older Adult					
Number	427	514	432	499	609
Percent	91.5%	88.7%	89.5%	88.4%	86.6%
Total					
Number	7,618	8,081	7,047	11,720	12,223
Percent	87.2%	86.9%	87.0%	86.0%	86.9%

Note: The "Number" represents the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from one to five. The denominator is the sum of all survey responses for that item.
Data Source: CPS forms completed by consumers/families served in DMH outpatient programs between CY 2016 and May 2018.

Table 31 reports the percentage of consumers and families in CY 2016, CY 2017, and May 2018 that agreed or strongly agreed with the statement, "Location of services was convenient." There were no change in percentages for the YSS-F (92.8%), YSS (84.3%), and Adult (83.7%) from May 2017 to May 2018. Among Older Adult surveys, there was a 2.9 PP decline from 89.5% in May 2017 to 86.6% in May 2018.

Goal II.5.

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

Evaluation. This goal was met. A total of 90.6% of the consumers and families that participated in the May 2018 survey period reported they agreed to strongly agreed with the statement, "Services were available at times that were convenient." There was a 0.2 PP decline from 90.8% in May 2017.

Table 32
Percent of Consumers / Families by Age Group who Strongly Agree or Agree With the "Services Were Available at Times That Were Convenient" Item
Calendar Year 2016 to May 2018

Age Group	CY 2016		CY 2017		CY 2018
	May	November	May	November	May
YSS-F					
Number	2,622	2,684	2,209	4,158	4,213
Percent	94.0%	92.3%	93.4%	92.7%	93.5%
YSS					
Number	1,223	1,263	1,107	1,944	1,979
Percent	82.3%	83.3%	86.3%	83.1%	84.5%
Adult					
Number	3,346	3,620	3,299	5,119	5,422
Percent	90.6%	89.3%	90.3%	90.2%	90.5%
Older Adult					
Number	427	514	432	499	609
Percent	95.1%	93.3%	94.0%	95.2%	93.8%
Total					
Number	7,618	8,081	7,047	11,720	12,223
Percent	90.5%	89.6%	90.8%	90.0%	90.6%

Note: The "Number" represents the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from one to five. The denominator is the sum of all survey responses on the five point Likert scale. Data Source: CPS forms completed by consumers/families served in DMH outpatient programs between CY 2016 and May 2018.

Table 32 reports the percentage of consumers and families in families in CY 2016, CY 2017, and May 2018 that agreed to strongly agreed with the statement, “Services were available at times that were convenient.” Among YSS-F surveys, there was a 0.1 PP increase from 93.4% in May 2017 to 93.5% in May 2018. Among YSS surveys, there was a 1.8 PP decrease from 86.3% in May 2017 to 84.5% in May 2018. Among Adult surveys, there was a 0.2 PP increase from 90.3% in May 2017 to 90.5% in May 2018 in reported satisfaction. Among Older Adult surveys, there was a 0.2 PP decline from 94.0% in May 2017 to 93.8% in May 2018.

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Monitoring Beneficiary Satisfaction

Goal III.1.

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

Evaluation. This goal was met. A total of 88.3% of the consumers and families who participated in the May 2018 survey period reported they strongly agreed or agreed that staff were sensitive to their cultural/ethnic background. There was a 0.1 PP increase in reported satisfaction from May 2017 to May 2018.

Table 33
Percent of Consumers / Families by Age Group who Strongly Agree or Agree With the "Staff Were Sensitive to My Cultural/Ethnic Background" Item
Calendar Year 2016 to May 2018

Age Group	CY 2016		CY 2017		CY 2018
	May	November	May	November	May
YSS-F					
Number	2,622	2,684	2,209	4,158	4,213
Percent	94.9%	94.7%	95.4%	94.7%	94.9%
YSS					
Number	1,223	1,263	1,107	1,944	1,979
Percent	81.5%	84.7%	86.0%	82.6%	82.4%
Adult					
Number	3,346	3,620	3,299	5,119	5,422
Percent	86.0%	84.1%	84.5%	85.2%	86.1%
Older Adult					
Number	427	514	432	499	609
Percent	91.2%	92.0%	86.4%	91.0%	89.6%
Total					
Number	7,618	8,081	7,047	11,720	12,223
Percent	88.4%	88.9%	88.2%	88.3%	88.3%

Note: The "Number" represents the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from one to five. The denominator is the sum of all survey responses for that item. Data Source: CPS forms completed by consumers/families served in DMH outpatient programs between CY 2016 and May 2018.

Table 33 reports the percentage of consumers and families in families in CY 2016, CY 2017, and May 2018 that agreed to strongly agreed with the statement, "Staff were sensitive to my cultural/ethnic background." Among YSS-F surveys, there was a 0.5 PP decrease from 95.4% in May 2017 to 94.9% in May 2018. Among YSS surveys, there was a 3.6 PP decrease from 86.0% in May 2017 to 82.6% in May 2018. Among Adult surveys, there was a 1.6 PP increase from 84.5% in May 2017 to 86.1% in May 2018. Among Older Adult surveys, there was a 3.2 PP decline from 86.4% in May 2017 to 89.6% in May 2018.

Goal III.2.

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

Evaluation. During the May 2018 survey period, this goal was met for two of the four age groups/CPS forms. When comparing the overall satisfaction reported by consumers/families completing one of the four CPS forms, the goal was not met by ratings of overall satisfaction on the Adult survey (87.0%) or the YSS (86.7%). The goal was met and exceeded by families who completed the YSS-F (93.1%) and consumers who completed the Older Adult survey (90.3%). Table 34 presents the three-year trends in overall satisfaction for the May 2016, May 2017, and May 2018 survey periods by age group.

Table 34
Three-Year Trend in Overall Satisfaction for May Survey Periods by Age Group Calendar Year (CY) 2016 to CY 2018

Age Group	May 2016	May 2017	May 2018
YSS-F			
Percent	88.5%	94.2%	93.1%
YSS			
Percent	93.3%	88.3%	86.7%
Adult			
Percent	86.5%	87.3%	87.0%
Older Adult			
Percent	92.0%	89.7%	90.3%

Data Source: CPS forms completed by consumers/families served in DMH outpatient programs between CY 2016 and May 2018.

Beneficiary Problem Resolution

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

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

Goal III.3a

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

Evaluation. This goal has been met. In FY 17-18, grievances and appeals were collected and reviewed by the PRO and recorded on the Annual Medi-Cal Beneficiary and Grievance and Appeal Report (ABGAR) form. The ABGAR form is required by California's DHCS for Medi-Cal beneficiaries only.

The Department's PRO is finalizing a new and electronic process for filing grievances and appeals. The PRO is proposing a "Grievance and Appeal Reporting" feature through YourDMH, the Department's online patient portal. Grievances could still be submitted via paper format. However, electronic grievances and appeals data would support PRO with: capturing grievances even when they are resolved at the local level/internally, addressing the low numbers of grievances received by increasing accessibility to the process for consumers, and contribute to enhanced trending of DMH's beneficiary problems/complaints data. The implementation date will be announced in CY 2019.

Table 35
Inpatient and Outpatient Grievances and Appeals
Fiscal Year 17-18

Category	Process			
	Grievance	Exempt Grievances	Appeal	Expedited Appeal
Access				
Service not Available	0	0		
Service not Accessible	0	0		
Timeliness of Services	0	0		
24/7 Toll-Free ACCESS Line	0	0		
Linguistic Services	0	0		
Other Access Issues	0	0		
Access – Total by Category	**0**	**0**	**N/A**	**N/A**
Percent	**0%**	**0%**	**N/A**	**N/A**
Quality of Care				
Staff Behavior Concerns	**24**	**0**		
Treatment Issues or Concerns	**15**	**0**		
Medication Concern	**5**	**0**		
Cultural Appropriateness	**0**	**0**		
Other Quality of Care Issues	**8**	**0**		
Quality of Care – Total by Category	**52**	**0**	**N/A**	**N/A**
Percent	**53.1%**	**0%**		
Change of Provider – Total by Category	**0**	**0**	**N/A**	**N/A**
Percent	**0%**	**0%**		
Confidentiality Concern – Total by Category	**0**	**0**	**N/A**	**N/A**
Percent	**0%**	**0%**	**N/A**	**N/A**
Other				
Financial	0	0		
Lost Property	0	0		
Operational	3	0		
Patients' Rights	18	0		
Peer Behaviors	2	0		
Physical Environment	0	0		
Other Grievance not Listed Above	23	0		
Other – Total by Category	**46**	**0**	**N/A**	**N/A**
Percent	**47.0%**	**0%**	**N/A**	**N/A**
Grand Totals	**98**	**0**	**N/A**	**N/A**

Note: Grievances and Appeals Data is limited to Medi-Cal beneficiaries. Data Source: DMH PRO – ABGAR Form FY 17-18, October 2018

Table 35 shows the total number of inpatient and outpatient beneficiary grievances and appeals by category, for FY 17-18. Ninety-eight grievances were received in FY 17-18. Of the beneficiary grievances received, 53% were related to Quality of Care and the remaining 47% were categorized as Other. In FY 17-18, there were no inpatient and outpatient grievances related to Access, Change of Provider, or Confidentiality Concern. There were 12 State Fair Hearings for FY 17-18 that were closed/dismissed or redirected.

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Table 36
Inpatient and Outpatient Appeals' Disposition and Total Notice of Adverse Benefit Determination/Notice of Action Issued
Fiscal Year 17-18

Category	APPEAL DISPOSITION			EXPEDITED APPEAL DISPOSITION			NOABD/NOA
	Appeals Pending as of June 30	Decision Upheld	Decision Overturned	Expedited Appeals Pending as of June 30	Decision Upheld	Decision Overturned	Total Number of NOABD/NOAs Issued
[1]Appeals Resulting From NOABD NOA							
Denial Notice (Formerly NOA A)	0	0	0	0	0	0	2,440
Payment Denial Notice (Formerly NOA C)	0	0	0	0	0	0	1,784
Delivery System Notice	0	0	0	0	0	0	0
Modification Notice	0	0	0	0	0	0	0
Termination Notice	0	0	0	0	0	0	0
Authorization Delay Notice	0	0	0	0	0	0	0
Timely Access Notice (Formerly NOA E)	0	0	0	0	0	0	5,935
Financial Liability Notice	0	0	0	0	0	0	0
Grievance and Appeal Timely Resolution Notice (Formerly NOA D)	0	0	0	0	0	0	0
Notice Of Action - B (NOA B)	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**10,159**

Note: [1]Prior to implementation of the Final Rule, (Title 42, Code of Federal Regulations, part 438, Subpart F), five types of Notice of Actions, referred to as NOA-A, NOA-B, NOA-C, NOA-D, and NOA-E, were the responsibility of the Network Providers to issue to beneficiaries. However, since the implementation of the Final Rule, these NOAs are obsolete and are replaced by Notices of Adverse Benefit Determination (NOABD) letters developed by the DHCS and under the authority of the MHP for determinations on SMHS. Data Source: DMH PRO – ABGAR Form FY 17-18, October 2018

Table 36 reports the total number of Notice of Adverse Benefit Determination (NOABDs), formerly known as Notice of Action (NOAs), as well as the dispositions for appeals and expedited appeals. There were 10,162 NOABDs or NOAs issued in FY 17-18. Fifty-eight percent of the NOABDs or NOAs determined were Timely Access Notices (N=5,935), followed by Denial Notices (N=2,440) at 24%, and Payment Denial Notices (N=1,784) at 18%. There were no beneficiary appeals resulting from a NOABD or NOA in FY 17-18.

Goal III. 3b

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

Evaluation. There were no standard or expedited appeals in FY 17-18. This goal could not be evaluated**.**

Table 37
Inpatient and Outpatient Grievances' Disposition
Fiscal Year 17-18

Category	Grievance Disposition		
	Grievances Pending as of June 30	Resolved	Referred
Access			
Service not Available	0	0	0
Service not Accessible	0	0	0
Timeliness of Services	0	0	0
24/7 Toll-Free Line	0	0	0
Linguistic Services	0	0	0
Other Access Issues	0	0	0
Access – Total by Category	0	0	0
Percent	**0%**	**0%**	**0%**
Quality Of Care			
Staff Behavior Concerns	0	12	12
Treatment Issues or Concerns	0	13	2
Medication Concern	0	3	2
Cultural Appropriateness	0	0	0
Other Quality of Care Issues	0	7	1
Quality of Care – Total by Category	**0**	**35**	**17**
Percent	**0%**	**81.4%**	**31.0%**
Change of Provider – Total by Category	**0**	**0**	**0**
Percent	**0%**	**0%**	**0%**
Confidentiality Concern – Total by Category	**0**	**0**	**0**
Percent	**0%**	**0%**	**0%**
Other			
Financial	0	0	0
Lost Property	0	0	0
Operational	0	0	3
Patients' Rights	0	6	12
Peer Behaviors	0	2	0
Physical Environment	0	0	0
Other Grievance not Listed Above	0	0	23
Other – Total by Category	**0**	**8**	**38**
Percent	**0%**	**18.6%**	**69.0%**
Grand Totals	**0**	**43**	**55**

Data Source: DMH PRO – ABGAR Form FY 17-18, October 2018

Table 37 shows the disposition of 98 grievances in FY 17-18. Out of the 43 grievances that were resolved, 81.4% pertained to Quality of Care (N=35) and the remaining 18.6% were categorized as Other (N=55). Out of the 55 grievances that were referred, 69.0% were categorized as Other (N=38) and the remaining 31.0% pertained to Quality of Care (N=17). There were no grievances pending as of June 30, 2018.

Goal III. 3c

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

Evaluation. This goal was met. In FY 17-18, 100% of grievances were resolved within 90 days.

Goal III.4.

Monitor beneficiary requests for Change of Provider (COP) including reasons given by consumers for their COP requests in FY 17-18.

Evaluation. This goal was met. The QID monitored the reporting of COP requests by providers. The number of COP requests increased from 4,192 requests during FY 16-17 to 5,269 requests in FY 17-18. The percent of COP requests that were approved declined by 2.6 PP from 91.7% in FY 16-17 to 89.1% in FY 17-18.

In July 2018, an online application for COP submissions was introduced at DO clinics. The system will be unveiled at LE/Contracted providers in CY 2019. The LE/Contracted providers will submit their monthly COP logs via email until instructed otherwise.

Table 38
Request for Change of Provider by Reasons and Percent Approved
Fiscal Year (FY) 15-16 to FY 17-18

[1]Reason	FY 15-16		FY 16-17		FY 17-18	
	Number of Requests	Percent Approved	Number of Requests	Percent Approved	Number of Requests	Percent Approved
A – Time/Schedule	160	93.8%	148	90.8%	235	87.2%
B – Language	116	93.1%	128	96.2%	144	88.9%
C – Age	58	91.4%	76	87.4%	85	89.4%
D – Gender	188	95.7%	172	91.5%	246	94.3%
E – Treating Family Member	33	93.9%	25	92.6%	32	93.8%
F – Treatment Concerns	361	91.7%	330	92.7%	430	89.8%
G – Medication Concerns	230	90.9%	222	91.0%	276	87.0%
H – Lack of Assistance	331	91.5%	332	91.2%	427	85.9%
I – Want Previous Provider	94	95.7%	84	92.3%	89	83.1%
J – Want 2nd Option	116	89.7%	98	89.9%	155	89.0%
K – Uncomfortable	529	92.4%	553	92.0%	613	89.6%
L – Insensitive/Unsympathetic	347	90.5%	330	92.2%	398	89.7%
M – Not Professional	246	91.9%	240	91.6%	309	90.9%
N – Does Not Understand Me	382	92.4%	424	91.2%	509	88.8%
O – Not a Good Match	658	92.9%	555	91.7%	693	90.3%
P – Other	349	94.8%	373	92.6%	509	87.2%
R – No Reason Given	107	93.3%	102	86.4%	109	91.7%
Total	4,305	92.7%	4,192	91.7%	5,259	89.1%

Note: [1]Multiple reasons may be given by a consumer. Data Source: DMH, PRO, October 2018

Table 38 shows the number of request for COP by reasons and percent approved for FY 15-16, FY 16-17, and FY 17-18. Data on the requests for COP is based on monthly COP logs submitted to PRO. According to the FY 17-18 data, the most frequent reason for a COP request was “Not a Good Match (N=693),” and the least frequent reason for a COP request was “Treating a Family Member (N=32).”

Monitoring Clinical Care

Goal IV.1.

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

Evaluation. This goal was met. During FY 17-18, QID monitored the number of approved, denied, and returned Prescription Drug PA requests.

Table 39
Approved and Denied Prescription Drug Prior Authorization Requests by Month Fiscal Year 17-18

Month	Prescription Drug PA Requests APPROVED	Prescription Drug PA Requests DENIED	Total Prescription Drug PA Requests by Month
July 2017	19	1	20
August 2017	29	9	38
September 2017	20	19	39
October 2017	23	26	49
November 2017	14	11	25
December 2017	12	18	30
January 2018	17	10	27
February 2018	19	28	47
March 2018	23	13	36
April 2018	34	25	59
May 2018	23	25	48
June 2018	13	22	35
Total	246	207	453
Percent	54.3%	45.7%	100%

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

Table 39 presents a monthly breakdown of the 453 Prescription Drug PA requests that were approved or denied during FY 17-18. A total of 54.3% of Prescription Drug PA requests were approved. The highest number of approved Prescription Drug PA requests occurred in April 2018 with a monthly total of 34. The lowest number of approved Prescription Drug PA requests occurred in December 2017 with a monthly total of 12. A total of 45.7% Prescription Drug PA requests were denied. The highest number of denied Prescription Drug PA requests occurred in February 2018 with a

monthly total of 18. The lowest number of Prescription Drug PA requests denied occurred in July 2017 with a monthly total of one.

The three most common reasons for denied Prescription Drug PA requests included: no documentation of trial/failure of two formulary antipsychotic agents; no medication history submitted; and submission of an incomplete Prescription Drug PA form or submission of the old form. Additional reasons for denied Prescription Drug PA requests included: the Prescription Drug PA request did not originate from a prescriber and official clinic fax number; justification by the use of free or sample medication; the Prescription Drug PA form had already been denied; missing or not matching physician signatures; requests for non-psychiatric medications; and consumer ineligibility.

There were a total of 24 returned Prescription Drug PA requests for FY 17-18. The three most common reasons for returned Prescription Drug PA requests included: alternative coverage or no Magellan coverage; submission of an incomplete Prescription Drug PA form or old form; and no attachments or information received in the faxed request. Additional reasons for a Prescription Drug PA request return were having no need for the request; submission of another health plan's Prescription Drug PA form; and inability to locate the consumer in the database due to having no IBHIS number or an error in the number provided.

In order to increase consumer access to pharmacy services, DMH has a goal of hiring 14 new pharmacists by the end of FY 18-19.

Monitoring Continuity of Care

Goal V.1.

At least 94% of the consumers referred to the Urgent Appointment Line at the ACCESS Center for CY 2018 will receive urgent appointments for a SMHS assessment within five business days.

Evaluation. This goal was partially met. The Department's data on urgent appointments is obtained from two sources of information: the Service Request Log form in IBHIS and the Service Request Tracking System, (SRTS). The SRL records met one of four conditions defined by referral source (DMH Collaboration Program; Department of Health Services, eConsult; Medi-Cal Managed Care Plans; or Psychiatric Emergency Services) and an "Urgent" field on the SRL form. The SRTS records were selected based on location; specifically, "ACCESS Center – 855 Appointment Line," and were categorized as "Urgent."

This goal was not met per the SRL records in CY 2018. Approximately 91% of the urgent appointments received (offered) and recorded in the SRL were within five business days. For the 353 offered appointments recorded in the SRL, the average (mean) business days to appointments was 4.11 days. The median number of business days to appointment was four days.

This goal was exceeded per the SRTS records in CY 2018. Approximately 95% of the urgent appointments received (offered) and recorded in the SRTS were within five business days. For the 704 offered appointments recorded in the SRTS, the average (mean) business days to appointments was 3.65 days. The median number of business days to appointment was three days.

Monitoring Provider Appeals

All FFS Medi-Cal acute psychiatric inpatient providers/hospitals submit inpatient Treatment Authorization Requests (TARs) to the Department. A TAR is a State Form (18-3), each with a unique number, used statewide for authorization of inpatient psychiatric hospital days. A hospital TAR is submitted in the process of an Alternative Dispute Resolution (ADR) to resolve a fiscal appeal. Appeals are submitted by network providers or billing agents in order to resolve disputed processing or payment of claims.

Goal VI.1.

The MHP will respond in writing to 100% of all appeals from providers in CY 2018 within 60 calendar days from the date of receipt of the appeal.

Evaluation. This goal has been met. In CY 2018, 100% of appeals from providers were responded to within 60 calendar days.

Table 40
Provider Appeals
Calendar Year 2018

Appeals	Day Treatment	Network Inpatient	Network Outpatient
Approved	0	Total TARs: 1,157 Total Approved Appeal Days: 2,653	0
Denied	0	Total Denied Appeal Days: 4,862	0
Total	0	Total Days: 7,515	0

Note: Due to COGNOS no longer providing the number of TARs categorized as approved versus denied, only the total number of TARs and approved and denied days are included in this table. Data Source: DMH Intensive Care Division, CY 2018

Table 40 presents the number of provider appeals received from Day Treatment, Network Inpatient, or Network Outpatient providers, in CY 2018. There were 1,157 hospital TARs processed in CY 2018.

A total of 7,515 appeal days were requested by Network Inpatient providers. Thirty-five percent of the requested appeal days were approved (N=2,653) and the remaining 65% (N=4,862) were denied. No TARs were received from Day Treatment or Network Outpatient providers.

Quality Improvement Work Plan for Calendar Year 2019

The QI Work Plan functions as the foundation of DMH's efforts to improve the quality of services delivered to consumers. The CY 2019 QI Work Plan activities will serve to reinforce an organizational culture of continuous self-monitoring through effective strategies, best practices, and activities at all levels of the system.

The CY 2019 QI Work Plan goals are structured and organized according to the following domains:

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

Los Angeles County – Department of Mental Health (DMH)
Quality Improvement Work Plan Goals Summary for Calendar Year 2019

I. MONITORING SERVICE DELIVERY CAPACITY

1. By June 30, 2019, between 78.2% and 79.2% of the total Los Angeles County African American population estimated with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) and at or below the 138% Federal Poverty Level (FPL) will be served in DMH outpatient programs.
2. By June 30, 2019, between 49.7% and 50.3% of the total Los Angeles County Latino population estimated with SED and SMI and at or below the 138% FPL will be served in DMH outpatient programs.
3. By December 31, 2019, a Community Mental Health Needs Assessment that identifies gaps in service delivery for the deaf, hard-of-hearing, and blind communities as well as people with physical disabilities will be implemented.
4. By December 31, 2019, at least 500 DMH consumers will receive Telemental Health (TMH) services.
5. By December 31, 2019, Promotores de Salud (Health Promoters) trained in delivering community-designed, peer-based engagement and education will serve the Latino population in all eight Service Areas (SAs) of Los Angeles County.

II. MONITORING ACCESSIBILITY OF SERVICES

1. Maintain the percentage of after-hours Psychiatric Mobile Response Teams (PMRT) responses with a response time of one hour or less at 60% for Calendar Year (CY) 2019.
2. By December 31, 2019, 80% of the calls to the toll-free hotline received during after-hours will be answered by a live agent within one minute from when they present to the Virtual Contact Center (VCC).
3. By December 31, 2019, 80% of the calls to the toll-free hotline received during business-hours will be answered by a live agent within one minute from when they present to the VCC.
4. By June 30, 2019, a report on the number of sign language interpreter services appointments coordinated by the toll-free hotline will be evaluated for trends.
5. In May 2019, between 86.5% and 87.7% of DMH consumers/families will report satisfaction with location of their outpatient programs.
6. In May 2019, between 90.2% and 91.2% of DMH consumers/families will report satisfaction with the times of their outpatient services.

III. MONITORING BENEFICIARY SATISFACTION

1. In May 2019, between 88.0% and 89.2% of DMH consumers/families will report satisfaction with their outpatient program staff's sensitivity to their cultural/ethnic background.
2. In May 2019, between 88.5% and 89.6% of DMH consumers/families will report overall satisfaction with their outpatient program.
3. By June 30, 2019, a report on the number of grievances, appeals (standard and expedited), and State Fair Hearings will be categorized by type and disposition and evaluated.
4. By June 30, 2019, a report on the number of beneficiary requests for a Change of Provider (COP) including reasons given by consumers for their requests as well as changes to the providers' COP submission process will be monitored and evaluated.

IV. MONITORING CLINICAL CARE

1. By June 30, 2019, the number and reasons for approved, denied, and returned Prescription Drug Prior Authorization (PA) Requests will be evaluated for trends.

V. MONITORING CONTINUITY OF CARE

1. By December 31, 2019, at least 93% of the consumers referred to DMH Directly-Operated (DO) programs by the toll-free line will be offered priority appointments for Specialty Mental Health Services (SMHS) assessments within five business days.
2. By December 31, 2019, at least 96% of the consumers referred to DMH LE/Contracted programs by the toll-free line will be offered priority appointments for SMHS assessments within five business days.

VI. MONITORING PROVIDER APPEALS

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

VII. MONITORING PERFORMANCE IMPROVEMENT PROJECTS

1. By December 31, 2019, one non-clinical Performance Improvement Project (PIP) will be developed and implemented.
2. By December 31, 2019, one clinical PIP will be developed and implemented.

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain I: Monitoring Service Delivery Capacity

Goal 1:	By June 30, 2019, between 78.2% and 79.2% of the total Los Angeles County African American population estimated with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) at or below the 138% Federal Poverty Level (FPL) will be served by the Los Angeles County – Department of Mental Health (DMH)
Population:	African American population estimated with SED and SMI and living at or below 138% FPL
Indicator:	African American consumers receiving mental health treatment services in DMH outpatient programs
Measure:	Numerator = unduplicated number of African American consumers served in DMH outpatient programs Denominator = African American population estimated with SED and SMI and living at or below 138% FPL
Source of Information:	1. Prevalence: California Health Interview Survey (CHIS) 2. Consumers Served: DMH Integrated System (IS) and Integrated Behavioral Health Information Systems (IBHIS) approved claims data 3. Population Estimates: American Community Survey (ACS), U.S. Census Bureau and Hedderson Demographic Services.
Responsible Entity:	Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain I:	Monitoring Service Delivery Capacity
Goal 2:	By June 30, 2019, between 49.7% and 50.3% of the total Los Angeles County Latino population estimated with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) at or below the 138% Federal Poverty Level (FPL) will be served by the Los Angeles County – Department of Mental Health (DMH)
Population:	Latino population estimated with SED and SMI and living at or below 138% FPL
Indicator:	Latino consumers receiving mental health services in DMH outpatient programs
Measure:	Numerator = unduplicated number of Latino consumers served in DMH outpatient programs Denominator = Latino population estimated with SED and SMI and living at or below 138% FPL
Source of Information:	1. Prevalence: California Health Interview Survey (CHIS) 2. Consumers Served: DMH Integrated System (IS) and Integrated Behavioral Health Information Systems (IBHIS) approved claims data 3. Population Estimates: American Community Survey (ACS), U.S. Census Bureau and Hedderson Demographic Services.
Responsible Entity:	Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain I:	Monitoring Service Delivery Capacity
Goal 3:	By December 31, 2019, a Community Mental Health Needs Assessment that identifies gaps in service delivery for the deaf, hard-of-hearing, and blind communities as well as people with physical disabilities will be implemented
Population:	Deaf, hard-of-hearing, and blind communities as well as people with physical disabilities
Indicator:	Community Mental Health Needs
Measure:	Unmet needs of the deaf, hard-of-hearing, and blind communities and people with physical disabilities as identified by the Community Mental Health Needs Assessment
Source of Information:	Office of the Deputy Director of Strategic Communications – Underserved Cultural Communities (UsCC), Access for All (deaf, hard-of-hearing, and blind communities and people with physical disabilities) subcommittee
Responsible Entity:	Office of the Deputy Director of Strategic Communications – UsCC, Access for All subcommittee and Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain I: Monitoring Service Delivery Capacity

Goal 4:	By December 31, 2019, at least 500 Los Angeles County – Department of Mental Health (DMH) consumers will receive Telemental Health (TMH) services
Population:	Consumers receiving TMH services at various end-points in DMH Directly-Operated (DO) Clinics
Indicator:	Service delivery capacity for psychiatry appointments via the TMH program
Measure:	Number of consumers receiving mental health services through the TMH program in CY 2019
Source of Information:	1. DMH Integrated System (IS) 2. Integrated Behavioral Health Information Systems (IBHIS) approved claims data
Responsible Entity:	Office of Clinical Operations, Chief Information Office Bureau and Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain I:	Monitoring Service Delivery Capacity
Goal 5:	By December 31, 2019, Promotores de Salud (Health Promoters) trained in delivering community-designed, peer-based engagement and education will serve the Latino population in all eight Service Areas (SAs) of Los Angeles County
Population:	Los Angeles County residents living in Latino/Spanish-speaking communities
Indicator:	Promotion of behavioral health awareness, education, and available resources for Los Angeles County's Latino population
Measure:	Total number of Los Angeles County – Department of Mental Health (DMH) Promotores de Salud trained in Calendar Year (CY) 2019
Source of Information:	Promotores de Salud program training reports
Responsible Entity:	DMH Promotores de Salud program and Office of Administrative Operations – Quality Improvement Division (OAO – QID)

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain II: Monitoring Accessibility of Services

Goal 1:	Maintain the percentage of after-hours Psychiatric Mobile Response Teams (PMRT) responses with a response time of one hour or less at 60% for Calendar Year (CY) 2019
Population:	Consumers receiving urgent after-hours care from PMRT of Los Angeles County – Department of Mental Health's (DMH) Emergency Outreach and Triage Division (EOTD)
Indicator:	Timeliness of after-hours care
Measure:	Numerator = number of after-hours PMRT responses with response times of one hour or less Denominator = total number of after-hours PMRT responses in Calendar Year 2019
Source of Information:	1. EOTD data reports 2. DMH Integrated System (IS) 3. Integrated Behavioral Health Information Systems (IBHIS) approved claims data
Responsible Entity:	EOTD and Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain II: Monitoring Accessibility of Services

Goal 2:	By December 31, 2019, 80% of the calls to the toll-free hotline received during after-hours will be answered by a live agent within one minute from when they present to the Virtual Contact Center (VCC)
Population:	Callers using the ACCESS 24/7 toll-free number: 1-800-854-7771
Indicator:	Timeliness of the Los Angeles County – Department of Mental Health's ACCESS 24/7 toll free hotline during after-hours
Measure:	Numerator = Number of after-hours calls in CY 2019 that are answered within one minute from when they present at the VCC Denominator = Total number of after-hours calls in CY 2019 extended to the VCC
Source of Information:	ACCESS Center data
Responsible Entity:	ACCESS Center, Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain II:	Monitoring Accessibility of Services
Goal 3:	By December 31, 2019, 80% of the calls to the toll-free hotline received during business-hours will be answered by a live agent within one minute from when they present to the Virtual Contact Center (VCC)
Population:	Callers using the ACCESS 24/7 toll-free number: 1-800-854-7771
Indicator:	Timeliness of the Los Angeles County – Department of Mental Health's ACCESS 24/7 toll free hotline during business-hours
Measure:	Numerator = Number of business-hours calls in CY 2019 that are answered within one minute from when they present at the VCC Denominator = Total number of business-hours calls in CY 2019 extended to the VCC
Source of Information:	ACCESS Center data
Responsible Entity:	ACCESS Center and Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain II: Monitoring Accessibility of Services

Goal 4:	By June 30, 2019, a report on the number of sign language interpreter services appointments coordinated by the toll-free hotline will be evaluated for trends
Population:	Consumers who need sign language interpreter services
Indicator:	Cultural and linguistic access to care
Measure:	Number of assigned appointments for hearing-impaired interpreter services coordinated by the toll free hotline in Fiscal Year 18-19
Source of Information:	ACCESS Center sign language interpreter services appointment schedules
Responsible Entity:	ACCESS Center and Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain II: Monitoring Accessibility of Services

Goal 5:	In May 2019, between 86.5% and 87.7% of the Los Angeles County Department of Mental Health (DMH) consumers/families will report satisfaction with location of their outpatient programs
Population:	Consumers served in DMH outpatient clinics
Indicator:	Convenience of service locations
Measure	Consumer Perception Survey (CPS) Forms: Numerator = number of consumers/families that agree or strongly with the "location of services was convenient" item in May 2019 Denominator = number of responses received for the "location of services was convenient" item in May 2019
Source of Information:	May 2019 CPS data
Responsible Entity:	Office of Administrative Operations – Quality Improvement Division and DMH outpatient programs

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain II:	Monitoring Accessibility of Services
Goal 6:	In May 2019, between 90.2% and 91.2% of Los Angeles County – Department of Mental Health's (DMH) consumers/families will report satisfaction with the times of their outpatient services
Population:	Consumers served in DMH outpatient clinics
Indicator:	Convenience of appointment times
Measure:	Consumer Perception Survey (CPS) Forms: Numerator = number of consumers/families that agree or strongly with the "services were available at times that were good for me" item in May 2019 Denominator = number of responses received for the "services were available at times that were good for me" item in May 2019
Source of Information:	May 2019 CPS data
Responsible Entity:	Office of Administrative Operations – Quality Improvement Division and DMH outpatient programs

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain III:	Monitoring Beneficiary Satisfaction
Goal 1:	In May 2019, between 88.0% and 89.2% of Los Angeles County – Department of Mental Health's (DMH) consumers/families will report satisfaction with their outpatient program staff's sensitivity to their cultural/ethnic background
Population:	Consumers served in DMH outpatient clinics
Indicator:	Sensitivity of staff to consumers' cultural/ethnic backgrounds
Measure:	Consumer Perception Survey (CPS) Forms: Numerator = number of consumers/families that agree or strongly with the "staff were sensitive to my cultural/ethnic background" item in May 2019 Denominator = number of responses received for the "staff were sensitive to my cultural/ethnic background" item in May 2019
Source of Information:	May 2019 CPS data
Responsible Entity:	Office of Administrative Operations – Quality Improvement Division and DMH outpatient programs

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain III:	Monitoring Beneficiary Satisfaction
Goal 2:	In May 2019, between 88.5% and 89.6% of Los Angeles County Department of Mental Health's (DMH) consumers/families will report overall satisfaction with their outpatient program
Population:	Consumers served in DMH outpatient clinics
Indicator:	Overall satisfaction with services provided
Measure:	Consumer Perception Survey (CPS) Forms: Numerator = number of consumers/families that agree or strongly agree they are satisfied overall with the services they have received Denominator = total number of responses received in May 2019
Source of Information:	May 2019 CPS data
Responsible Entity:	Office of Administrative Operations – Quality Improvement Division and DMH outpatient programs

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain III:	Monitoring Beneficiary Satisfaction
Goal 3:	By June 30, 2019, a report on the number of grievances, appeals (standard and expedited), and State Fair Hearings will be categorized by type and disposition and evaluated
Population:	Consumers/families served by DMH
Measure:	Resolution of beneficiary grievances, appeals, and requested State Fair Hearings
Indicator:	Number and type of the beneficiary grievances, appeals, and State Fair Hearings resolved and referred out, and pending in Fiscal Year 18-19
Source of Information:	Patients' Rights Office (PRO) data reports
Responsible Entity:	PRO and Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain III:	Monitoring Beneficiary Satisfaction
Goal 4:	By June 30, 2019, a report on the number of beneficiary requests for a Change of Provider (COP) including reasons given by consumers for their requests as well as changes to the providers' COP submission process will be monitored and evaluated
Population:	Consumers/families served by DMH
Indicator:	Number and type of Requests for COP
Measure:	Number of providers reporting consumer requests for COP in Fiscal Year 18-19
Source of Information:	Patients' Rights Office (PRO) data reports
Responsible Entity:	PRO and Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain IV: Monitoring Clinical Care

Goal 1:	By June 30, 2019, the number and reasons for approved, denied, and returned Prescription Drug Prior Authorization (PA) Requests will be evaluated for trends
Population:	Consumers receiving Pharmacy Benefits Management (PBM) services
Indicator:	Prescribing standards and parameters
Measure:	Monthly PA data reports
Source of Information:	Office of the Discipline Chiefs – Pharmacy Services data reports
Responsible Entity:	Office of the Discipline Chiefs – Pharmacy Services and Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain V: Monitoring Continuity of Care

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

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

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

Measure: Numerator = number of priority appointments referred to DO programs offered SMHS assessment appointments within five business days from the date referred by the DMH Collaboration programs, DHS eConsult, Medi-Cal Managed Care Plans, and PES to the Priority Appointment Line in Calendar Year (CY) 2019

Denominator = total number of priority appointment referrals received from DMH Collaboration programs, DHS eConsult, Medi-Cal Managed Care Plans, and PES to the Priority Appointment Line in CY 2019

Source of Information:
1. ACCESS Center
2. Integrated Behavioral Health Information Systems (IBHIS)
3. Service Request Tracking System (SRTS)

Responsible Entity: ACCESS Center, Chief Information Office Bureau – Clinical Informatics, and Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain V:	Monitoring Continuity of Care
Goal 2:	By December 31, 2019, at least 93% of the consumers referred to Los Angeles County Department of Mental Health's (DMH) Legal Entities (LE)/Contracted programs by the toll-free line will be offered priority appointments for Specialty Mental Health Services (SMHS) assessments within five business days
Population:	Consumers referred for urgent appointments by DMH Collaboration programs, Department of Health Services (DHS) eConsult, Medi-Cal Managed Care Plans, and Psychiatric Emergency Services (PES)
Indicator:	Continuity of Care for consumers referred for SMHS by primary care providers and behavioral health network providers of the DMH Collaboration programs, DHS eConsult, Medi-Cal Managed Care Plans, and PES
Measure:	Numerator = number of priority appointments referred to LE/Contracted programs offered SMHS assessment appointments within five business days from the date referred by the DMH Collaboration programs, DHS eConsult, Medi-Cal Managed Care Plans, and PES to the Priority Appointment Line in Calendar Year (CY) 2019 Denominator = total number of priority appointment referrals received from DMH Collaboration programs, DHS eConsult, Medi-Cal Managed Care Plans, and PES to the Priority Appointment Line in CY 2019
Source of Information:	1. ACCESS Center 2. Integrated Behavioral Health Information Systems (IBHIS) 3. Service Request Log (SRL)
Responsible Entity:	ACCESS Center, Chief Information Office Bureau – Clinical Informatics, and Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain VI	Monitoring Provider Appeals
Goal 1:	By December 31, 2019, the total number of Treatment Authorization Requests (TARs) appeals will be evaluated for trends.
Population:	Legal Entity (LE)/Contracted Providers
Indicator:	Timeliness of DMH's responses to Provider Appeals
Measure:	Total number of TARs in CY 2019
Source of Information:	DMH COGNOS report
Responsible Entity:	Office of Clinical Operations and Office of Administrative Operations – Quality Improvement Division

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain VII:	Monitoring Performance Improvement Projects
Goal 1:	By December 31, 2019, one non-clinical Performance Improvement Project (PIP) will be developed and implemented
Population:	Medi-Cal beneficiaries receiving outpatient Specialty Mental Health Services (SMHS) from Los Angeles County – Department of Mental Health (DMH)
Indicator:	Non-clinical PIP-related interventions and outcomes targeting a problem identified following a review of system-level facts and data
Measure:	1. Non-clinical PIP committee meeting sign-in sheets, agendas, and minutes 2. "PIP Development Outline Fiscal Year 2019-20" 3. Data collection tool(s), performance indicators, and outcomes
Source of Information:	Committee members/stakeholders, relevant Los Angeles Department of Mental Health (DMH) Divisions and programs, and Office of Administrative Operations – Quality Improvement Division (OAO-QID)
Responsible Entity:	DMH Divisions and programs and OAO-QID

Los Angeles County – Department of Mental Health

Quality Improvement Work Plan

Calendar Year 2019

Domain VII:	Monitoring Performance Improvement Projects
Goal 2:	By December 31, 2019, one clinical Performance Improvement Project (PIP) will be developed and implemented
Population:	Medi-Cal beneficiaries receiving outpatient Specialty Mental Health Services (SMHS) from Los Angeles County – Department of Mental Health (DMH)
Indicator:	Clinical PIP-related interventions and outcomes targeting a problem identified following a review of system-level facts and data
Measure:	1. Clinical PIP committee meeting sign-in sheets, agendas, and minutes 2. "PIP Development Outline Fiscal Year 2019-20" 3. Data collection tool(s), performance indicators, and outcomes
Source of Information:	Committee members/stakeholders, relevant Los Angeles Department of Mental Health (DMH) Divisions and programs, and Office of Administrative Operations – Quality Improvement Division (OAO-QID)
Responsible Entity:	DMH Divisions and programs and OAO-QID

Appendix A
Quality Improvement Program

Retrieved from: http://file.lacounty.gov/SDSInter/dmh/1041432_1100_01.pdf.

DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE

SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
QUALITY IMPROVEMENT PROGRAM	**1100.01**	**03/16/2015**	**1 of 6**
APPROVED BY: Director	SUPERSEDES **105.01**	ORIGINAL ISSUE DATE **02/15/2006**	DISTRIBUTION LEVEL(S) **1, 2**

PURPOSE

1.1 To ensure the quality and appropriateness of care delivered to consumers of the mental health system meet or exceed the established local, State, and federal service standards.

1.2 To define the structure and process of the Quality Improvement (QI) Program within the Los Angeles County Department of Mental Health (LACDMH).

1.3 To comply with standards set by the Department of Health Care Services (DHCS) through the Medi-Cal Performance Contract.

BACKGROUND

2.1 The LACDMH QI Program has a shared responsibility with its contract providers. It has a commitment to maintain and improve the quality of its service and delivery infrastructure. The QI Program shall support this commitment by establishing processes for continuous improvement of services. This includes processes for resolving service and system issues through systematic evaluation and implementation of feedback loops matched to available resources.

DEFINITION

3.1 **Quality Improvement Program:** A consumer-focused program involving leadership, management, and clinic staff to create and sustain a culture of continuous improvement and total involvement.

POLICY

4.1 Management Responsibilities

4.1.1 The QI Program shall be accountable to the Director of the LACDMH.

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4.1.2 The QI Program shall be under the general auspices of the Deputy Director of the Program Support Bureau, who shall direct program responsibility and ensure compliance with Departmental QI practices. This includes, but is not limited to, compliance with all mandated QI programs as well as Departmental policies and procedures which impact the quality of care.

PROCEDURE

5.1 The Departmental QI Program shall:

5.1.1 Be administered by a licensed mental health professional.

5.1.2 Coordinate with the Bureaus/Units which conduct performance monitoring activities throughout the Department including, but not limited to, client and system outcomes, fair hearings, resolution of beneficiary grievances, clinical issues, provider appeals, assessment of beneficiary and provider satisfaction, and clinical record review.

5.1.3 Include the Compliance, Privacy, and Audit Services Bureau on the LACDMH Quality Improvement Council (QIC) monthly meeting agenda for purposes of reporting and discussing policy updates.

5.1.4 Develop an annual QI Work Plan and Evaluation Report that includes the following:

5.1.4.1 An evaluation of the overall effectiveness of the QI Program demonstrating that QI activities have contributed to meaningful improvement in clinical care and client services;

5.1.4.2 A description of completed and in-process QI activities including performance improvement projects;

5.1.4.3 Monitoring of previously identified issues;

5.1.4.4 Planning and initiating activities for sustaining improvement; and

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POLICY/PROCEDURE

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5.1.4.5 Developing goals and monitoring plans for activities in the following six (6) areas:

- Service delivery capacity and organization;
- Service accessibility;
- Beneficiary satisfaction;
- Service delivery system and meaningful clinical issues affecting beneficiaries;
- Continuity and coordination with other human service agencies; and
- Provider appeals.

5.1.5 Identify and implement at least two (2) performance improvement projects annually, one clinical and one non-clinical, in accordance with Title 42, Code of Federal Regulations (CFR), Section 438.240(a)(2).

5.1.6 Support local Service Area/Countywide QIC structure

5.1.6.1 Participate in the local Service Area and Countywide QIC meetings;

5.1.6.2 Review and respond to issues and/or recommendations raised by the local Service Area QICs;

5.1.6.3 Assist the local Service Area QICs in determining and developing performance improvement projects relevant to local issues; and

5.1.6.4 Provide information and support to the local Service Area and Countywide QIC Chairs on problem/issue resolutions.

5.1.7 Disseminate information that will enable service providers throughout the system to be in compliance with quality of care requirements.

5.1.8 Distribute the QI Work Plan to all Short-Doyle/Medi-Cal Organizational Providers (directly operated and contractors).

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5.1.8.1 All inpatient programs shall develop their own quality improvement plan which must comply with relevant California State and local requirements.

5.1.9 Provide quarterly updates and appropriate recommendations to the LACDMH Executive Management Team on QI related projects and activities, External Quality Review Organization review items, and DHCS mandates.

5.2 The LACDMH QIC shall consist of practitioners, consumers, and family members who will have an active role in the planning, design, and execution of QI activities. The LACDMH QIC shall:

- Oversee and be involved in QI activities including performance improvement projects;
- Recommend policies;
- Review and evaluate results of QI activities including performance improvement projects;
- Institute needed QI actions;
- Ensure follow-up on QI processes;
- Review the Department's QI Work Plan; and
- Meet at least quarterly. Minutes of these meetings shall be taken. The signed and dated meeting minutes shall reflect all decisions and actions. The minutes shall be maintained for a minimum of three (3) years.

5.3 Local Service Area/Countywide Quality Improvement Committees (SA QICs)

5.3.1 Local Service Area QICs shall be composed of at least one (1) staff from every organizational provider within the Service Area, as well as family members and clients. Since the Countywide QICs represent specific groups such as children, the composition shall be appropriate to the represented group.

5.3.2 Local Service Area QICs and Countywide QICs shall:

- Meet at least quarterly;
- Select a Chair/Co-chair member;

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- Discuss pertinent issues related to areas identified in Section 5.1.4;
- Develop and implement feedback loops to organizational provider staff regarding quality of care issues and problem resolutions discussed at the QIC meeting; and
- Minutes of these meetings shall be taken. The signed and dated meeting minutes shall reflect all decisions and actions. The minutes shall be in the same format as used for LACDMH QIC meeting minutes. Minutes shall be maintained for a minimum of three (3) years.

5.4 Organizational Provider QIC

5.4.1 All organizational providers, directly operated and contracted, shall have a QIC.

5.4.2 The QIC shall meet at least quarterly or more frequently based on agency's needs.

5.4.3 The QIC shall maintain meeting minutes that reflect all decisions and actions. The minutes shall be signed and dated and be maintained for a minimum of three (3) years.

5.4.4 The QIC shall monitor the following areas to ensure quality of care of:

- Service accessibility;
- Beneficiary satisfaction;
- Service delivery system and meaningful clinical issues affecting beneficiaries;
- Coordination of care with other human service agencies; and
- Beneficiary grievances.

5.5 Utilization Review (UR)

5.5.1 Each organizational provider shall establish a UR process within the agency.

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5.5.2 UR shall be part of the Organizational Provider's QI program and under the umbrella of the QIC.

AUTHORITY

1. Title 9 CCR § 1810.440

REFERENCE

1. Title 42 CFR § 438.240(a)(2)

RESPONSIBLE PARTY

LACDMH Program Support Bureau, Quality Improvement Division

Appendix B
Interpreter Services for the Deaf and Hard of Hearing Community

Retrieved from: http://file.lacounty.gov/SDSInter/dmh/1041173_200_02.pdf.

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

Policy Title: **Interpreter Services for the Deaf and Hard of Hearing Community**
Policy Number: 200.02
Policy Category: Administrative
Distribution Level: Directly-Operated Programs and Contracted Agencies
Responsible Party: ACCESS Center and Cultural Competence Unit

I. POLICY STATEMENT

This policy defines Los Angeles County Department of Mental Health (DMH) standards and procedures regarding interpreter services for the Deaf and Hard of Hearing community seeking mental health services.

II. DEFINITIONS

Sign Language: A system of communication using visual gestures and signs. With signing, the brain processes linguistic information through the eyes. The shape, placement, and movement of the hands, as well as facial expressions and body movements, all play important parts in conveying information. It is not a universal language – each country has its own sign language, and regions have dialects, much like the many languages spoken all over the world.

- ***American Sign Language (ASL)***: The sign language used in the USA and Canada.

Interpreter: A person who interprets, especially one who translates speech orally or into sign language.

Telecommunication Device for the Deaf (TDD): A telecommunications device for the deaf is a teleprinter, an electronic device for text communication over a telephone line that is designed for use by persons with hearing or speech difficulties

Tele Type Writer (TTY): is a device like a typewriter that has a small readout. It is a special device that lets people who are deaf, hard of hearing, or speech-impaired use the telephone to communicate by allowing them to type text messages. A TTY is required at both ends of the conversation in order to communicate and can be used with both land lines and cell phones. Unlike text messaging, it is designed for synchronous conversation, like a text version of a phone call. A modern digital cell phone must support a special digital TTY mode in order to be compatible with a TTY device.

III. POLICY

In accordance with applicable Federal, State, and County policies and agreements, DMH shall provide equal access to services for the Deaf and Hard of Hearing community seeking mental health services at all Directly-Operated (DO) and contracted provider sites.

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

Policy Title: **Interpreter Services for the Deaf and Hard of Hearing Community**
Policy Number: 200.02

Live telephone contact to schedule sign language interpreter services for clients from the deaf and hard of hearing community seeking mental health services at DO and contracted provider sites shall be available 24 hours a day, seven (7) days a week at the DMH ACCESS Center via the DMH contract agreement.

Sign language interpreter services coordinated by DMH shall be available at no cost to clients who are deaf and hard of hearing.

IV. PROCEDURES

Click here to view procedures.

V. AUTHORITIES

U.S. Department of Justice, Civil Rights Division, Disability Rights Section, Americans With Disabilities Act (ADA) Title II Requirements
California Code of Regulations Title 9 Section 1810.410, Cultural and Linguistic Requirements
Los Angeles County Board of Supervisors Policy 3.060, Non-Discrimination On The Basis Of Disability

VI. EFFECTIVE DATES

This policy was effective September 1, 1993.

Review Dates: January 1, 2001 Reviewed with Revisions
February 15, 2006 Reviewed with Revisions
April 7, 2010 Reviewed with Revisions
June 28, 2019 Reviewed with Revisions

VII. SIGNATURE, TITLE, and DATE OF APPROVAL

Name/Title

7-10-19
Date