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

Quality Assessment and Performance Improvement Evaluation Report 2022 and Work Plan 2023

Reporting Period: January 1, 2022, to June 30, 2023

Final Draft August 2024

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

Executive Summary

The Los Angeles County Department of Mental Health (LACDMH) is the country's largest county mental health plan (MHP). The Department directly operates more than 187 outpatient sites, has 10 co-located Department of Health Services (DHS) sites, and contracts with close to 1,000 organizations. Approximately 210,005 Los Angeles County residents are under the care of DMH staff, non-governmental agencies (NGA), and individual practitioners who provide various services.

Los Angeles County is the most populated county globally, with an estimated population of 9,944,923 in Calendar Year (CY) 2021. The estimated distribution by race/ethnicity comprises Latinos representing 48.1%, Whites at 25.8%, Asian/Pacific Islanders at 15.0%, African Americans at 7.7%, and Native Americans representing 0.19%. Approximately 47% of our service recipients are in the child and transition age youth groups, 41% are adults, and 12% are older adults. During Fiscal Year (FY) 2021-22, a full array of mental health services was provided to children and youth with Serious Emotional Disturbance (SED) and adults and older adults with Serious Mental Illness (SMI) in jails, juvenile halls, 24-hour acute psychiatric care, or residential facilities, Directly Operated (DO) and Legal Entities (LE)/Contracted outpatient programs, and by Fee-For-Service outpatient network providers. The Department's Work Plan goals focused on the DO and LE/Contracted outpatient programs that served approximately 210,005 individuals countywide.

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

The annual QAPI aims to ensure an organizational culture of continuous self-monitoring through countywide practical strategies, best practices, and activities. The Department's annual QAPI is organized into seven significant domains: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care, Provider Appeals, and Performance Improvement Projects (PIPs). Each domain is designed to address the quality of services provided.

In CY 2022, 9 out of 13 QAPI goals were met and 4 were partially met. The QAPI goals focused on increasing services for individuals from underserved groups by targeting clients and community members from Asian, Black/African American, and Native Hawaiian/Pacific Islander communities, ensuring timely access to care and resources for potential and would-be clients, using client/family feedback and concerns to drive outpatient service priorities, improve tracking and monitoring services for clinical services using HEDIS measures, and improving tracking mechanisms for rehospitalization, beneficiary grievances, and continuous quality improvement for beneficiary services.

In CY 2022, QOTD continued to promote a QI culture through departmental-wide partnerships, including planned collaborative efforts with the Access to Care Leadership Committee, the Office of Clinical Operations, including Pharmacy Services and the Intensive Care Division, the Cultural Competency, Quality Assurance, and Outcomes Units, Outpatient Services, the Homeless Outreach and Mobile Engagement (HOME) team, multidisciplinary PIP committees, and QI stakeholders. In 2022, LACDMH continued to strive for equitable and accessible services by identifying service gaps in the Asian, Black/African American, and Native Hawaiian/Pacific Islander communities and monitoring systemwide timeliness rates and youth HEDIS measures; identifying an adult level of care tool; and using consumer feedback to implement data-driven strategies. Notable CQI efforts included evaluating grievances and appeals and inpatient provider complaints for trends, expanding internally tested peer review and medication monitoring protocols to LEs, and developing a systemwide strategy to reduce hospitalization rates. QAPI activities are reviewed biannually by the Department's QI Council.

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Introduction

The Los Angeles County Department of Mental Health (LACDMH) authorizes inpatient mental health services and provides and contracts for outpatient specialty mental health services (SMHS) for beneficiaries. LACDMH is the country's largest county mental health plan (MHP). The Department directly operates more than 187 outpatient sites, has 10 co-located Department of Health Services (DHS) sites, and contracts with close to 1,000 organizations. Approximately 210,005 Los Angeles County residents are under the care of LACDMH staff, non-governmental agencies (NGA), and individual practitioners who provide various services. With a $2.4 billion budget, LACDMH aims to provide *hope*, *recovery*, *and well-being* to Los Angeles County at large.

MISSION

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

VISION

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

SERVICES

- Mental health services provided include assessments, case management, crisis intervention, medication support, peer support, psychotherapy and other rehabilitative services. Services are provided in a variety of settings including residential facilities, clinics, schools, hospitals, juvenile halls and camps, mental health courts, board and care homes, in the field and in people’s homes. We also provide counseling to victims of natural and man-made disasters, their families and emergency first responders.
- The Director of Mental Health is responsible for protecting patients' rights in all public and private hospitals, programs providing voluntary mental health care and treatment, and all contracted community-based programs. The Director also serves as the public guardian for individuals gravely disabled by mental illness, and is the conservatorship investigation officer for the County.

SERVICE RECIPIENTS

- Our services to adults and older adults are focused on those who are significantly functionally disabled by a mental health disorder or where there is a reasonable probablility of significant deterioration in an important area of life functioning due to a diagnosed mental health disorder or a suspected mental health disorder not yet diagnosed. Criteria for individuals under the age of 21 include:
  - Those who were experiencing a condition placing the individual at high risk for a mental health disorder due to various conditions leading to trauma OR the individual has a significant impairment or a reasonable probability exists that significant deterioration in an important area of life functioning
  - AND the individual has a diagnosed mental health disorder or a suspected mental health disorder that has not yet been diagnosed.

Purpose and Intent

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

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

Structure of Report

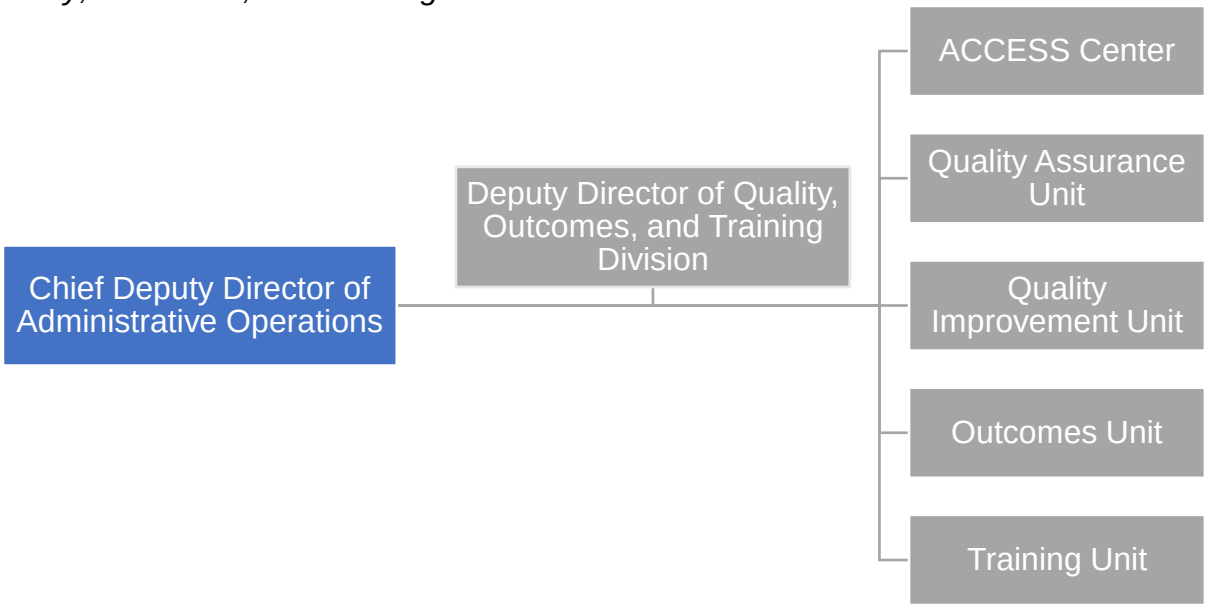
There are four sections in the following report. Section I provides a detailed overview of the QI Unit within the LACDMH Quality, Outcomes, and Training Division. The QI Unit is responsible for reviewing the quality of SMHS provided to LACDMH consumers. This section describes the Unit's organizational structure and elements. Section II provides a demographic profile of Los Angeles County's residents and LACDMH consumers. This section's race/ethnicity, age group, gender, language, and Service Area (SA) represent strategic data categories. Section III contains the Department's annual QAPI WP Evaluation Report. This section details the progress LACDMH has made concerning the calendar year (CY) 2022 WP goals. This report's final section IV presents the QAPI WP for CY 2023.

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

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

Figure

1. *Quality, Outcomes, and Training Division*



Note: QOTD launched in January 2020.

Los Angeles County Department of Mental Health's ACCESS Center

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

Quality Assurance Unit

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

Outcomes Unit

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

Training Unit

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

Quality Improvement Unit

The QI Unit strives to coordinate program development and QI activities that effectively measure, assess, and continuously improve access to, and quality of care provided to LACDMH clients. The QI Unit's vision is to promote a QI culture and increase the professional use of QI practices within the Department by partnering and consulting more closely with departmental improvement efforts where they occur. The QI Unit is client/family-focused and supports the Department's culture of CQI and total organizational involvement. QI and QA collaboration is a priority as QA focuses on testing and implementing State mandates. At LACDMH, the QA and QI Units maintain a collaborative approach to CQI work, including but not limited to efforts to improve access to our services.

Continuous Quality Improvement

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

Most Salient Quality Improvement Collaborations

The QAPI Work Plan fosters opportunities for input and active involvement of clients/families, licensed and paraprofessional LACDMH staff, contracted providers, and stakeholders. The Department's Quality Improvement Council (QI Council) is centralized with countywide representation and QA/QI liaisons who are heavily involved in providing oversight on QI efforts. Active and ongoing data-driven QI partnerships promote CQI efforts countywide through stakeholder engagement, Plan-Do-Study-Act (PDSA) cycles, and lessons learned.

Annual Test Calls Study

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

Access to Care Leadership Committee

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

All Programs of Excellence (APEX)

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

California Advancing and Innovating Medi-Cal (CalAIM) Implementation

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

Chief Information Office Bureau (CIOB)

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

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

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

Cultural Competency Unit (CCU)

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

Performance Improvement Project (PIP) Teams

The Department conducts PIPs to review selected administrative and clinical processes designed to improve performance outcomes. The QI Unit engages and supports QI Council members in QI processes related to the QAPI WP, specific PIP activities, and other QI projects conducted at the SA level. The QI Unit collaborates and coordinates related QI activities with many divisions, programs, and

units within DMH. The QI Unit and the QA Unit, ACCESS Center, Access to Care Leadership committee, APEX, OSD, and the Outcomes Unit contribute to meaningful change in access to care and clinical outcomes for LACDMH beneficiaries. LACDMH strives for PIP teams that are diverse and inclusive. Each committee member participates on a volunteer basis due to special interests.

Quality Assurance

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

Stakeholder Engagement

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

Summary

The QI Unit executes mandated performance outcome studies, evaluations, and research targeting the effectiveness of LACDMH services. In compliance with Federal, State, and local QI requirements, the QI Unit oversees technical reporting related to the annual QAPI WP and Evaluation Report, LACDMH Help Line's Test Calls Study, client/family satisfaction data, PIPs, and collaborative efforts with other programs. The QI Unit also ensures adherence to prescribed site review protocols and timelines, such as those assigned during triennial oversight reviews and CalEQRO visits. QI staff must maintain up-to-date knowledge of QI concepts and provide technical assistance, consultation, and training for Departmental QI Council and SA Quality Improvement Committees (QICs), SALTs, and other community organizations/agencies. Effective communication and collaboration with other LACDMH divisions, programs, and providers support the Department's accelerated use of CQI countywide.

Quality Improvement Council Charter

Statement of Purpose

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

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

The QI Unit is responsible for maintaining and improving mental health service and delivery infrastructure with LACDMH providers.

Council Membership

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

- Compliance, Privacy, and Audit Services;
- Clinical Policy and Standards;
- Cultural Competency Unit;
- Patients' Rights Office;
- LACDMH's Peer Resource Center;
- LACDMH's Help Line;
- Quality Assurance Unit;
- Quality Improvement Unit; and
- DO and LE/Contracted programs.

Authority

A licensed mental health professional supervises the QI Unit and serves as the Departmental QI Council Chair. The QI Council Chair is responsible for chairing and facilitating meetings and ensuring members receive timely and relevant information. Each SA QIC has a Chair representing DO providers, and most have a Co-Chair representing the LE/Contracted providers.

Meetings

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

Responsibilities

The QI Council, QI Unit, and LACDMH staff collaborate on measurable QAPI WP goals to evaluate annual performance management activities. The annual QAPI WP goals mirror State and Federal requirements (Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care, Provider Appeals, and PIPs). The QI Council collaborates and coordinates related QAPI WP activities with multiple DMH Divisions and programs. Besides providing QOTD and CCU updates, the monthly agendas may reflect performance and outcomes management discussions led by various partners and programs across the Department.

Summary

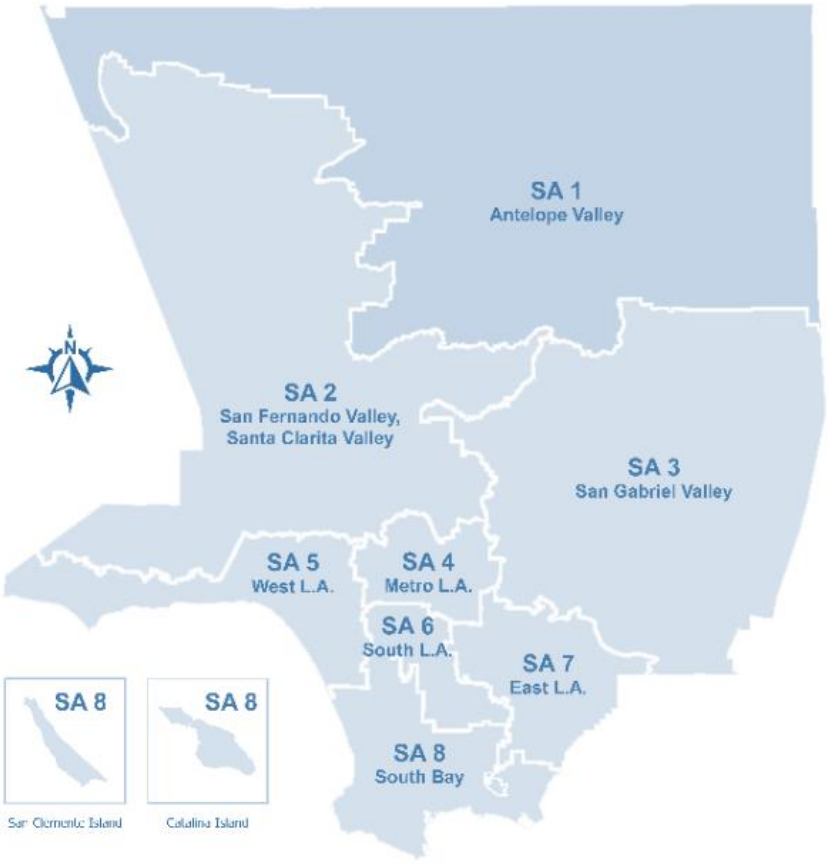
The QI Council charter further supports LACDMH in maintaining a culture of CQI. The QI Council and SA QICs foster the ideal environments to discuss QI activities, identify possible best practices, and maintain performance standards aligned with the Department's mission and DHCS contract. The CCU supervisor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

Geographical Characteristics of Los Angeles County

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

Figure

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



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

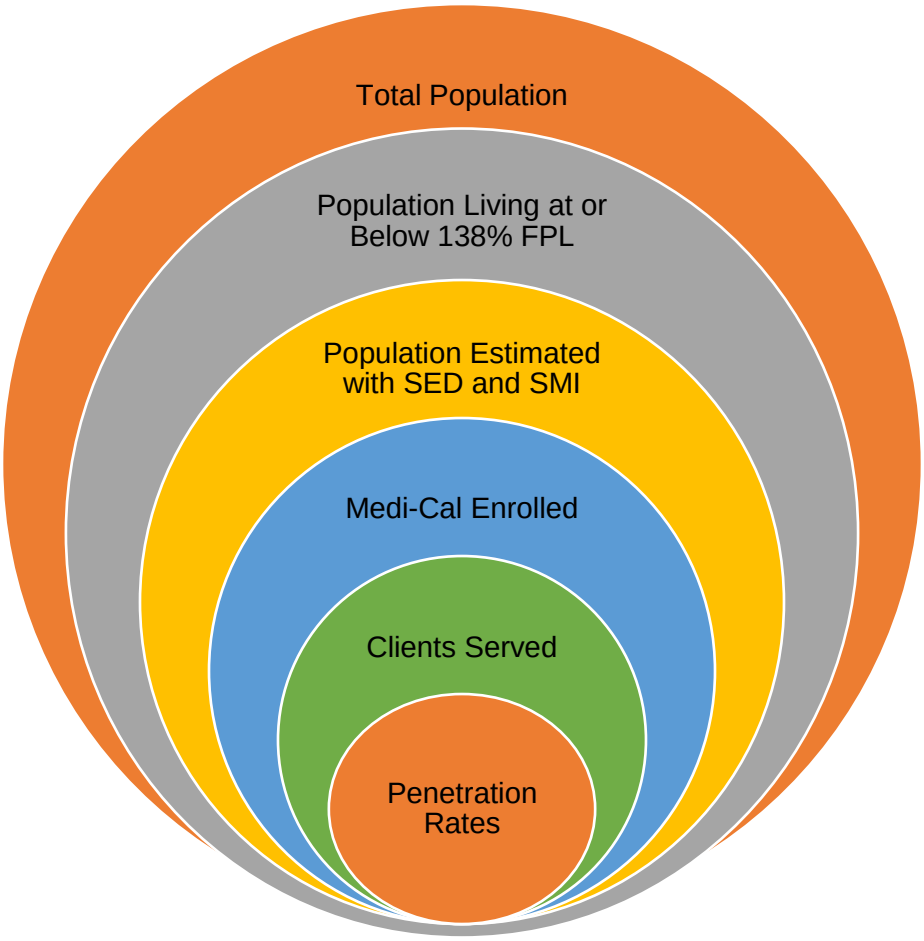
Section II. Population Needs Assessment

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

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

Figure

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



Note: Population and poverty estimates are available by each SA, race/ethnicity, age group, and gender. The distribution of primary language is evaluated for the Medi-Cal Enrolled and Clients Served data. CIOB applies to the population living at or below the 138% FPL when estimating mental illness prevalence among the population eligible for Medi-Cal benefits.

The population and poverty numbers prepared locally and annually by Hedderson Demographic Services accounts for local housing and household income variations.

Methods

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

Estimated prevalence rates for individuals with SED and SMI are derived using the prevalence rates estimated through the California Health Interview Survey (CHIS) Kessler 6 and Impairment Scales, that are conducted every two years by the University of California, Los Angeles (UCLA). This report includes pooled prevalence estimates by CHIS in CY 2021 and CY 2022.

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

Access to services is assessed by calculating Penetration Rates among clients and beneficiaries served in Outpatient facilities in Fiscal Year (FY) 2020-21. The count of clients served does not include those served in 24 Hour/Residential programs such as inpatient hospitals (both County and Fee-For-Service), residential facilities, Institutions of Mental Disease (IMD), Skilled Nursing Facilities (SNF), Psychiatric Health Facilities (PHF), and clients served in Fee-For-Service Outpatient settings. The Office of Clinical Informatics applies a deduplication technique with a Dataflux statistical match to eliminate likely duplicate IDs. This process decreases the likelihood of “false positives”.

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

Total Population

At 48.1%, the Latino group is the most represented among Los Angeles County's residents. In CY 2021, SA 7 had the highest concentration of Latino residents. The smallest group among residents was Native Americans, at 0.2%. Between CY 2019 and CY 2021, the White group declined by 2.6 PP, the most considerable total population shift among all races/ethnicities.

Figure

4. Race/Ethnicity Distribution for Total Population, Calendar Year 2021

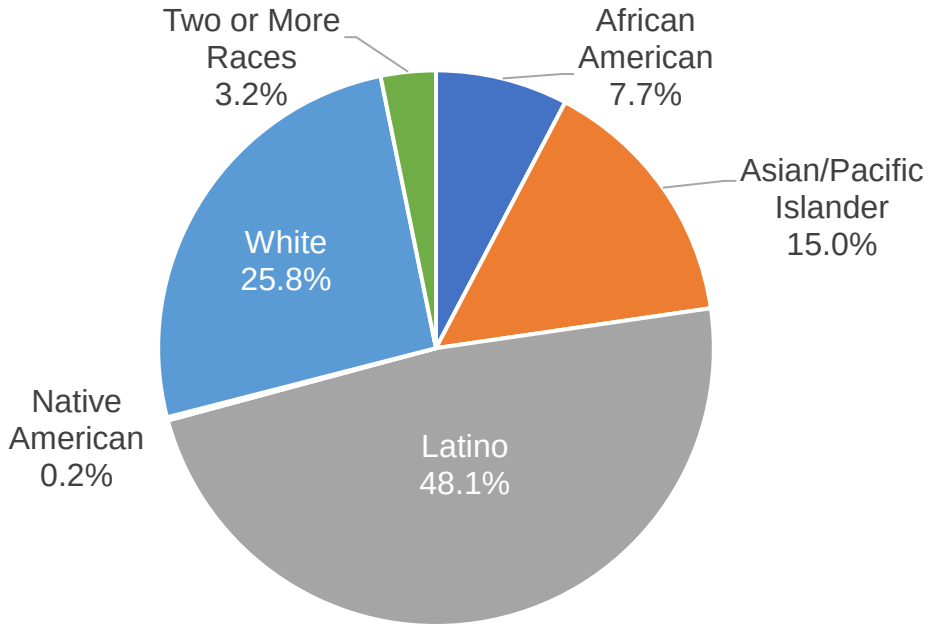


Figure 4 represents the distribution of races/ethnicities among Los Angeles County residents. Latinos are the largest group at 48.1%, Whites at 25.8%, Asian/Pacific Islanders at 15.0%, African Americans at 7.7%, Two or More Races at 3.2%, and Native Americans at 0.2%. The N for the Latino category is 4,787,610. The N for the White category is 2,563,582. The N for the Asian/Pacific Islander category is 1,494,502. The N for the African American category is 764,306. The N for the Two or More Races category is 316,453. The N for the Native American category is 18,470. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by CIOB in May 2023.

Table

1. Total Population by Race/Ethnicity and Service Area, Calendar Year 2021

SA	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	62,170	16,555	218,727	1,446	102,230	15,429	416,557
Percent	14.9%	4.0%	52.5%	**0.35%**	24.5%	3.7%	100.0%
SA 2	79,048	258,577	864,098	3,473	908,431	78,121	2,191,748
Percent	3.6%	11.8%	39.4%	0.16%	41.4%	3.6%	100.0%
SA 3	53,888	543,330	801,531	2,897	301,502	42,174	1,745,322
Percent	3.1%	**31.1%**	45.9%	0.17%	17.3%	2.4%	100.0%
SA 4	61,193	187,659	516,141	2,265	302,874	36,845	1,106,977
Percent	5.5%	17.0%	46.6%	0.20%	27.4%	3.3%	100.0%
SA 5	33,007	91,407	104,392	952	391,061	38,254	659,073
Percent	5.0%	13.9%	**15.8%**	**0.14%**	**59.3%**	**5.8%**	100.0%
SA 6	230,894	24,074	700,784	1,487	32,402	19,038	1,008,679
Percent	**22.9%**	**2.4%**	69.5%	0.15%	**3.2%**	1.9%	100.0%
SA 7	38,494	128,101	948,045	2,775	137,959	20,320	1,275,694
Percent	**3.0%**	10.0%	**74.3%**	0.22%	10.8%	**1.6%**	100.0%
SA 8	205,612	244,799	633,892	3,175	387,123	66,272	1,540,873
Percent	13.3%	15.9%	41.1%	0.21%	25.1%	4.3%	100.0%
Total	764,306	1,494,502	4,787,610	18,470	2,563,582	316,453	9,944,923
Percent	7.7%	15.0%	48.1%	0.19%	25.8%	3.2%	100.0%

Table 1 presents race/ethnicity distribution across Los Angeles's total population by Service Area. Bold values represent the highest and lowest percentages within each racial category and across all SAs. The highest percentage of African Americans was in SA 6 (22.9%) compared to SA 7 (3.0%), with the lowest percentage. The highest percentage of API was in SA 3 (31.1%) compared to SA 6 (2.4%), with the lowest. The highest percentage of Latinos was in SA 7 (74.3%) compared to SA 5 (15.8%), with the lowest. The highest percentage of Native Americans was in SA 1 (0.35%) compared to SA 5 (0.14%), with the lowest. The highest percentage of Whites was in SA 5 (59.3%) compared to SA 6 (3.2%), with the lowest. The highest percentage of Two or more races was in SA 5 (5.8%) compared to SA 7 (1.6%) with the lowest. Some totals/percentages may not total 100% due to rounding. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by CIOB in May 2023.

Figure

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

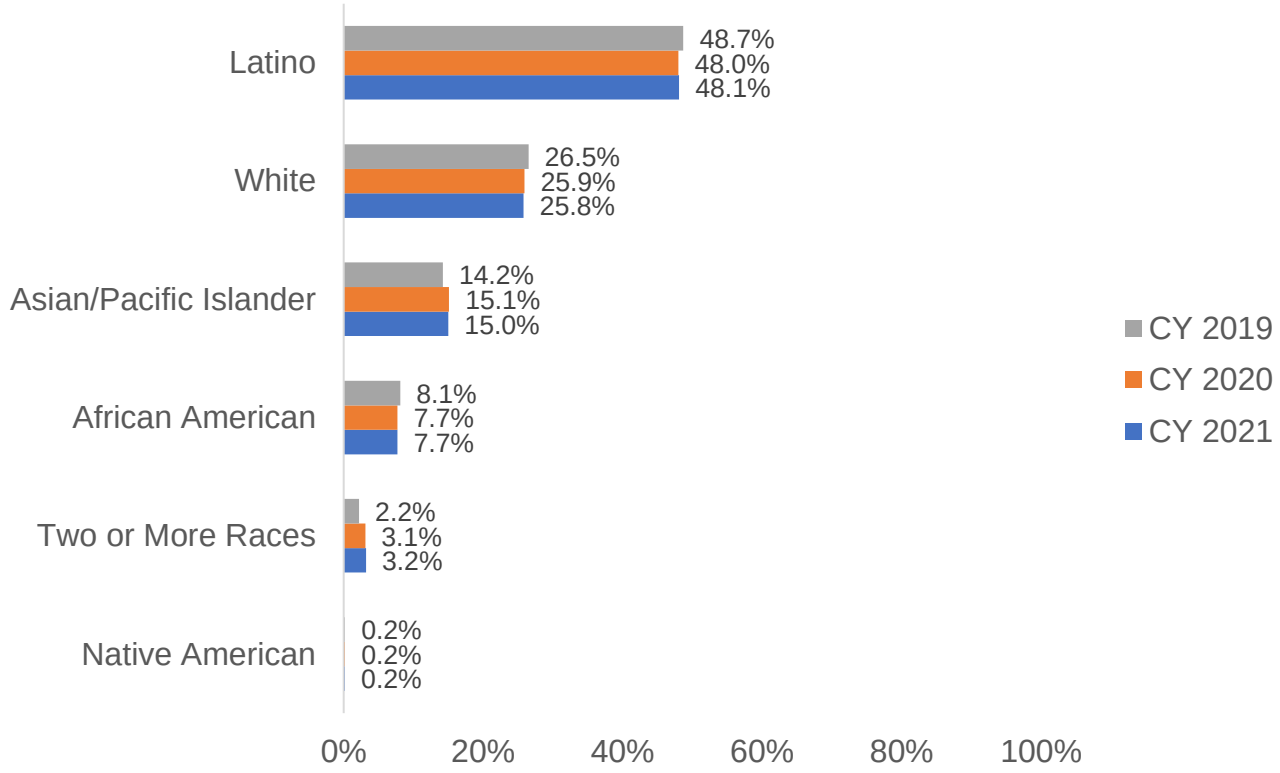


Figure 5 displays the three-year race/ethnicity distribution trends among Los Angeles County's total population. The percentage of Latinos has declined by 0.6 PP between CY 2019 and CY 2021. Whites declined by 0.7 PP during the same three years, API increased by 0.8 PP, and African Americans declined by 0.4 PP. Two or More Races increased by 1.0 PP, and Native Americans remained the same. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, CYs 2019 to 2021, prepared by CIOB in May 2023.

Estimated Population Living at or below 138% FPL

Between CY 2019 and CY 2021, the most notable population shifts concerning poverty estimates were noted for the Asian Pacific Islander (+1.1 PP), Latino (-1.0 PP) and Two or More Races (+0.7 PP) groups. At 59.8%, the Latino group was the most represented among Los Angeles County's estimated population living at or below 138% FPL. In CY 2021, SA 6 had the highest number of Latinos, estimated to be at or below 138% FPL. The Native American group had the lowest number of residents, estimated at or below 138% FPL, with the highest concentration residing in SA 3.

Figure

6. *Race/Ethnicity Distribution for Estimated Population Living at or below 138% Federal Poverty Level, Calendar Year 2021*

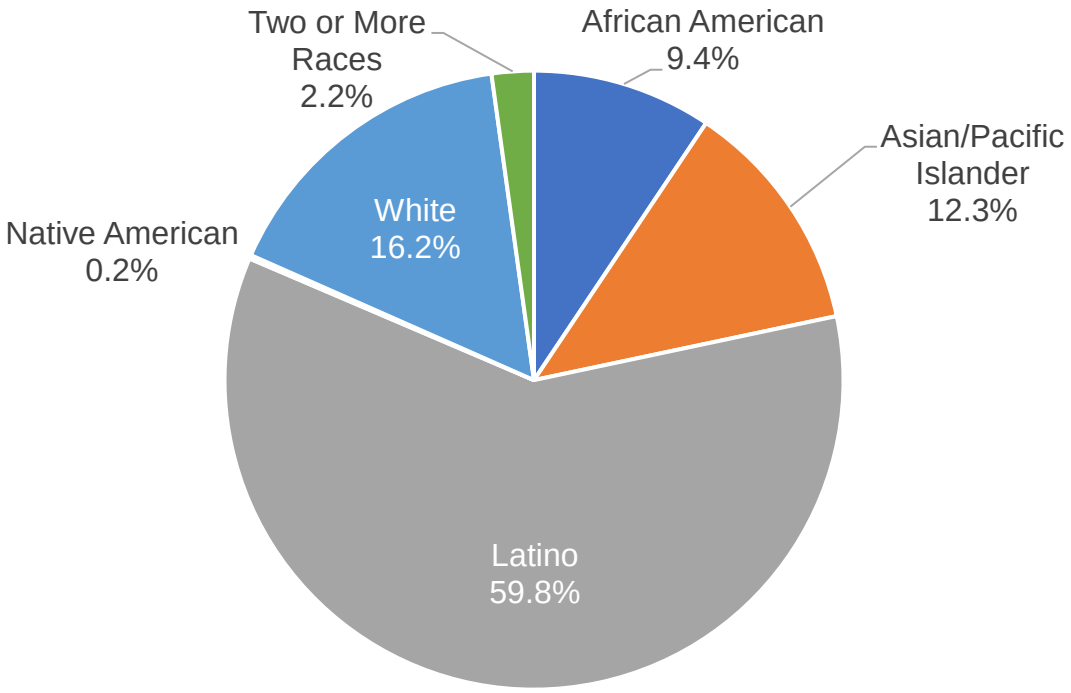


Figure 6 represents the distribution of race/ethnicity among the estimated population living at or below 138% FPL. Latinos are the largest group (59.8%), followed by Whites (16.2%), API (12.3%), African Americans (9.4%), Two or More Races (2.2%), and Native Americans (0.2%). The N for the Latino category is 1,026,863. The N for the White category is 277,710. The N for the Asian/Pacific Islander category is 211,488. The N for the African American category is 160,800. The N for the Two or More Races category is 38,202. The N for the Native American category is 3,228. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by CIOB in May 2023.

Table

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

SA	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	16,701	2,711	54,998	405	17,348	3,462	95,625
Percent	17.5%	2.8%	57.5%	**0.4%**	18.1%	3.6%	100.0%
SA 2	10,918	32,373	162,742	335	103,220	7,626	317,214
Percent	3.4%	10.2%	51.3%	**0.1%**	32.5%	2.4%	100.0%
SA 3	6,248	70,652	131,165	208	26,508	2,900	237,681
Percent	2.6%	**29.7%**	55.2%	**0.1%**	11.2%	1.2%	100.0%
SA 4	13,030	43,046	139,422	729	43,821	6,515	246,563
Percent	5.3%	17.5%	56.5%	0.3%	17.8%	2.6%	100.0%
SA 5	3,472	11,040	13,305	44	37,499	3,542	68,902
Percent	5.0%	16.0%	**19.3%**	**0.1%**	**54.4%**	**5.1%**	100.0%
SA 6	65,138	8,370	219,491	657	5,861	5,639	305,156
Percent	**21.3%**	**2.7%**	71.9%	0.2%	**1.9%**	1.8%	100.0%
SA 7	4,395	11,370.0	174,275	268	10,532	1,026	201,866
Percent	**2.2%**	5.6%	**86.3%**	**0.1%**	5.2%	**0.5%**	100.0%
SA 8	40,898	31,926	131,465	582	32,921	7,492	245,284
Percent	16.7%	13.0%	53.6%	0.2%	13.4%	3.1%	100.0%
Total	160,800	211,488	1,026,863	3,228	277,710	38,202	1,718,291
Percent	9.4%	12.3%	59.8%	0.2%	16.2%	2.2%	100.0%

Table 2 shows the distribution of race/ethnicity among the estimated population living at or below 138% FPL by SA. Bold values represent the highest and lowest percentages within each racial category and across Service Areas. The highest percentage of African Americans were in SA 6 (21.3%) compared to SA 7 (2.2%), with the lowest percentage. The highest percentage of API were in SA 3 (29.7%) compared to SA 6 (2.7%), with the lowest. The highest percentage of Latinos was in SA 7 (86.3%) compared to SA 5 (19.3%), with the lowest. The highest percentage of Native Americans was in SA 1 (0.4%) compared to SAs 2, 3, 5, and 7 (0.1%), with the lowest. The highest percentage of Whites was in SA 5 (54.4%) compared to SA 6 (1.9%), with the lowest. The highest percentage of Two or more Races was in SA 5 (5.1%) compared to SA 7 (0.5%) with the lowest. Data Sources: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by CIOB in May 2023.

Figure

7. *Race/Ethnicity Trends among the Estimated Population Living at or below 138% Federal Poverty Level, Calendar Years 2019 to 2021*

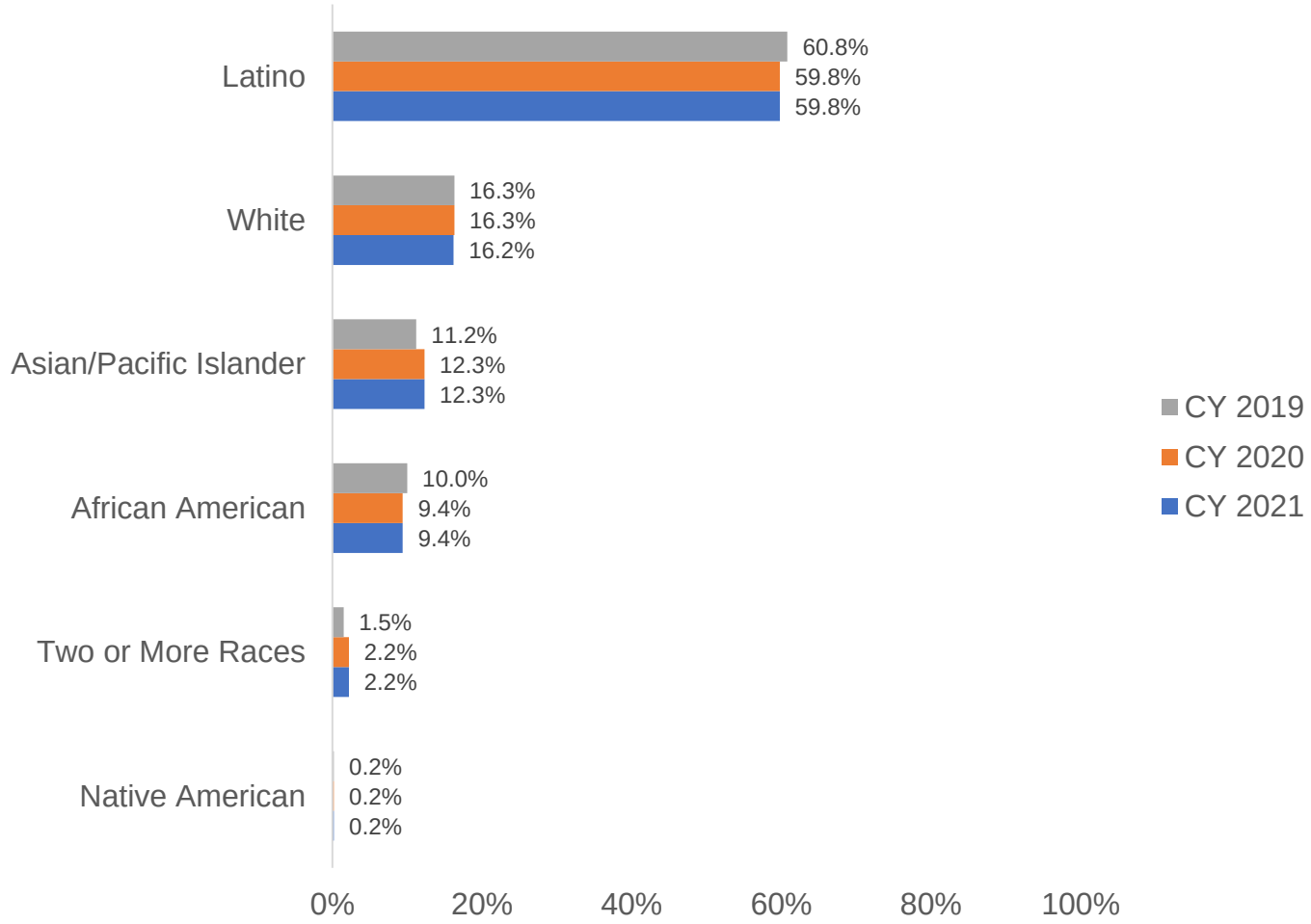


Figure 7 shows a three-year analysis of race/ethnicity for the estimated population at or below 138% FPL. Some totals/percentages may not total 100% due to rounding. The percentage of Latinos has declined by 1.0 PP between CY 2019 and CY 2021. Whites decreased by 0.1 PP; API increased by 1.1 PP, and African Americans decreased by 0.6 PP. Two or More Races increased by 0.7 PP, and Native Americans remained the same. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB in May 2023.

Estimated Prevalence of SED and SMI

Poverty estimates were evaluated for the prevalence of Severe Emotional Disturbance (SED) in Children and TAY and Serious Mental Illness (SMI) in Adults and Older Adults. At 53.3%, Latinos estimated at or below 138% FPL had the highest prevalence of SED and SMI, and Native Americans (0.2%) had the lowest.

Figure

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

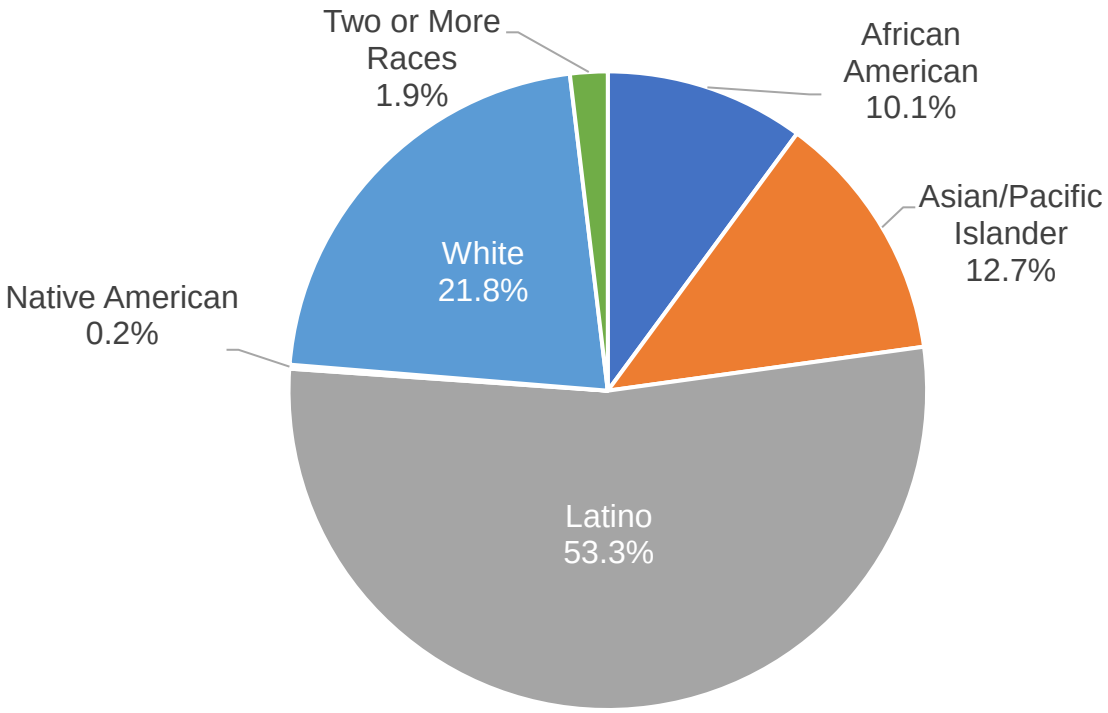


Figure 8 presents the distribution of race/ethnicity among Los Angeles County's population, estimated at or below 138% FPL, and the prevalence of SED or SMI in CY 2021. The Latino group was the largest (53.3%), followed by Whites (21.8%), API (12.7%), African American (10.1%), Two or more Races (1.9%), and Native American (0.2%). The N for the Latino group was 164,298. The N for the White group was 67,206, 39,125 for the Asian/Pacific Islander group, and 31,195 for African Americans. The N for the Two or More Races group was 5,807. The N for the Native American group was 562. Estimated prevalence rates of mental illness by Ethnicity for Los Angeles County are provided by the California Health Interview Survey (CHIS) for the population living at or below 138% FPL.

Table

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

SA	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	3,240	502	8,800	70	4,198	526	17,336
Percent	18.7%	**2.9%**	50.8%	**0.41%**	24.2%	3.0%	100.0%
SA 2	2,118	5,989	26,039	58	24,979	1,159	60,342
Percent	3.5%	9.9%	43.2%	0.10%	41.4%	1.9%	100.0%
SA 3	1,212	13,071	20,986	36	6,415	441	42,161
Percent	2.9%	**31.0%**	49.8%	0.09%	15.2%	1.0%	100.0%
SA 4	2,528	7,964	22,308	127	10,605	990	44,521
Percent	5.7%	17.9%	50.1%	0.28%	23.8%	2.2%	100.0%
SA 5	674	2,042	2,129	8	9,075	538	14,466
Percent	4.7%	14.1%	**14.7%**	**0.05%**	**62.7%**	**3.7%**	100.0%
SA 6	12,637	1,548	35,119	114	1,418	857	51,694
Percent	**24.4%**	3.0%	**67.9%**	0.22%	**2.7%**	1.7%	100.0%
SA 7	853	2,103.5	27,884	47	10,532	156	41,575
Percent	**2.1%**	5.1%	67.1%	0.11%	25.3%	**0.4%**	100.0%
SA 8	7,934	5,906	21,034	101	7,967	1,139	44,082
Percent	18.0%	13.4%	47.7%	0.23%	18.1%	2.6%	100.0%
Total	31,195	39,125	164,298	562	67,206	5,807	308,193
Percent	10.1%	12.7%	53.3%	0.18%	21.8%	1.9%	100.0%

Estimated prevalence rates of mental illness by race/ethnicity for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL. They are pooled estimates for CY 2020 and CY 2021. Note: Bold values represent the highest and lowest percentages across all SAs. The highest SED and SMI prevalence rate among the African American group was in SA 6 (24.4%) compared to SA 7 (2.1%), with the lowest. The highest SED and SMI prevalence rate among the API group was in SA 3 (31.0%) compared to SA 1 (2.9%), with the lowest. The highest SED and SMI prevalence rate among the Latino group was in SA 6 (67.9%) compared to SA 5 (14.7%), with the lowest. The highest SED and SMI rate among the Native American group was in SA 1 (0.41%), whereas SA 5 (0.05%) had the lowest. The highest prevalence rate of SED and SMI among the White group was in SA 5 (67.2%) compared to SA 6 (2.7%) with the lowest. The highest prevalence rate of SED and SMI among the Two or more Races group was in SA 5 (3.7%) compared to SA 7 (0.4%) with the lowest. Due to rounding, some estimated numbers and percentages may not total 100%. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2023.

Figure

9. *Race/Ethnicity Trends among the Prevalence of SED and SMI among the Estimated Population Living at or below 138% Federal Poverty Level, Calendar Years 2020 to 2021*

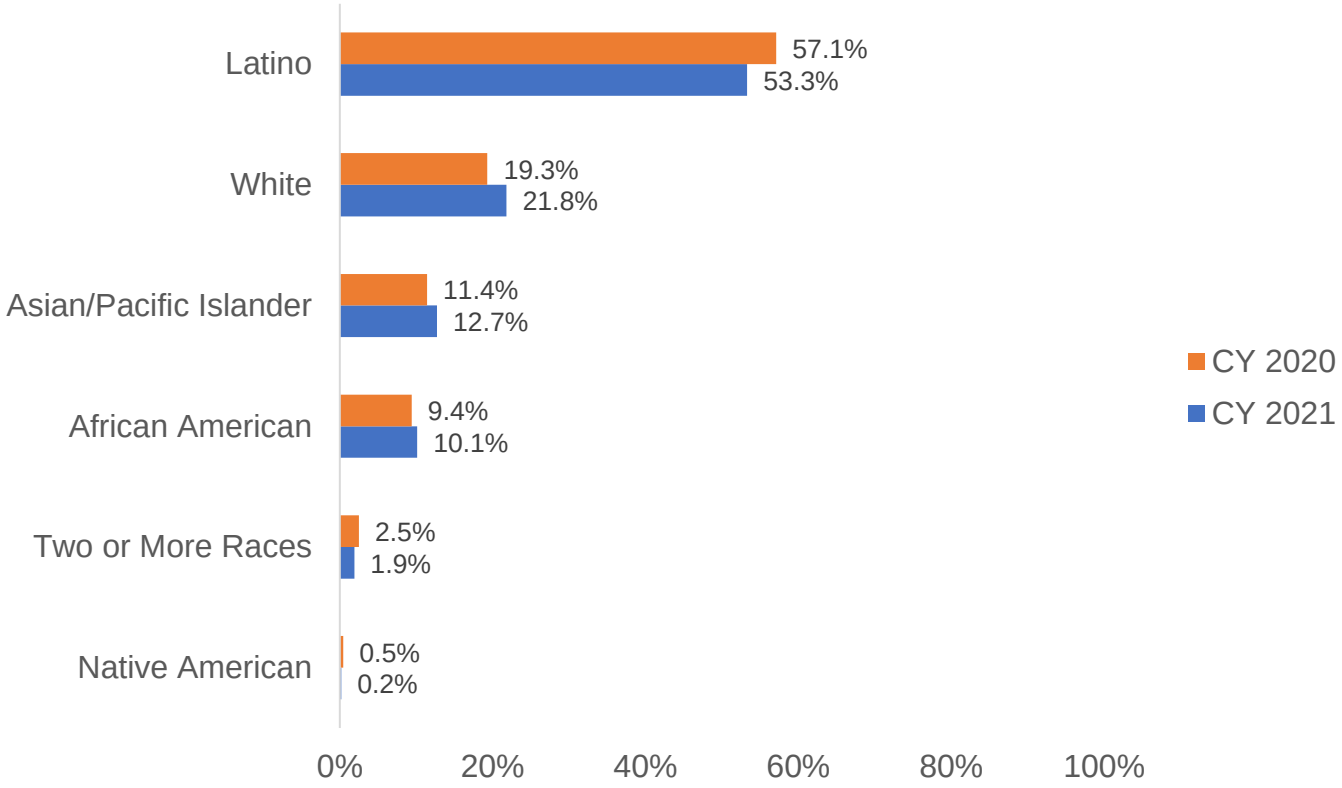


Figure 9 shows a two-year analysis of race/ethnicity among the prevalence of SED and SMI among the estimated population at or below 138% FPL. Some totals/percentages may not total 100% due to rounding. The percentage of Latinos has decreased by 3.8 PP between CY 2020 and CY 2021. Whites increased by 2.5 PP; API increased by 1.3 PP, and African Americans increased by 0.7 PP. Two or More Races decreased by 0.6 PP, and Native Americans decreased by 0.3 PP. Note: SED and SMI were not reported for CY 2019. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB in May 2023.

Population Enrolled in Medi-Cal

The Hispanic group was the race/ethnicity with the highest Medi-Cal enrollment (57.3%). At less than 0.1% of the total population deemed eligible for Medi-Cal benefits, American Indian/Alaska Native was the lowest. The percent of not reported races/ethnicities increased by 1.8 PP between CY 2021 and CY 2022, with little to no shifts in Medi-Cal enrollment across the remaining groups.

Figure

10. Distribution of Race/Ethnicity among Los Angeles County's Medi-Cal Eligibles, Calendar Year 2022

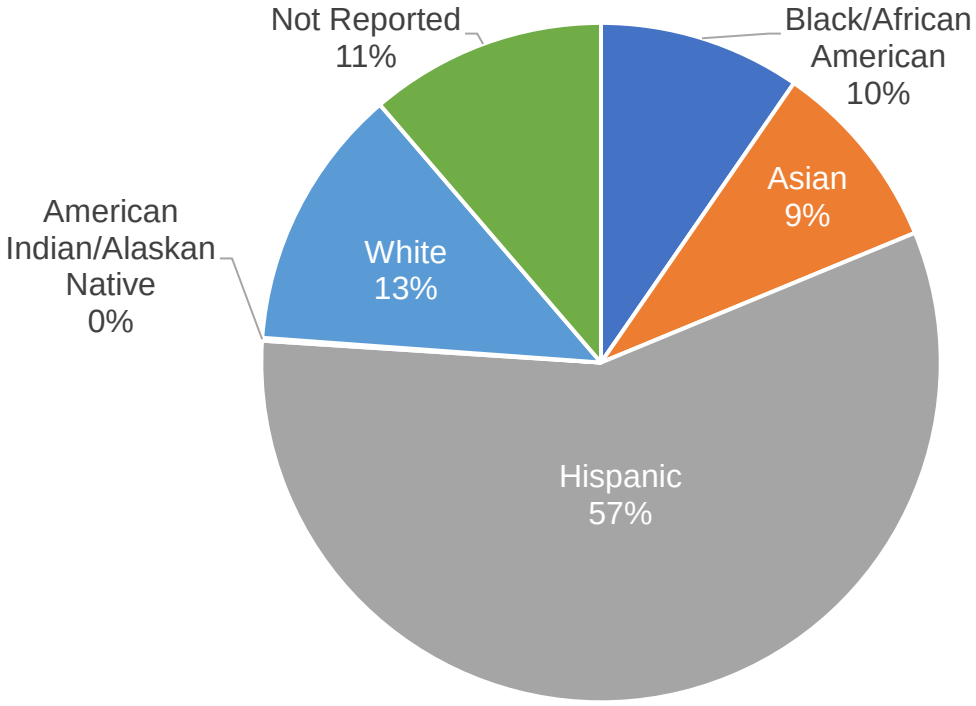


Figure 10 presents the estimated Los Angeles County population deemed eligible for Medi-Cal based on valid eligibility determination by racial categories. Approximately 501,172 Medi-Cal eligible had unreported races/ethnicities. The Hispanic (57.3%) group was the largest, followed by Whites (12.6%), Not Reported ethnicities (11.3%), Black/African American (9.6%), Asian (9.1%), and American Indian/Alaska Native (AI/AN) (0.1%). The N for the White group was 557,995, followed by 427,352 Black/African Americans, 406,389 Asians, and 6,005 AI/ANs. The N for the Hispanic group was 2,544,367. Data was not available by SA. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, downloaded on March 20, 2023. Due to rounding, some estimated totals and percentages may not total 100%.

Figure

11. Three-year Trends for Population Enrolled in Medi-Cal by Race/Ethnicity, Calendar Year 2020 to Calendar Year 2022

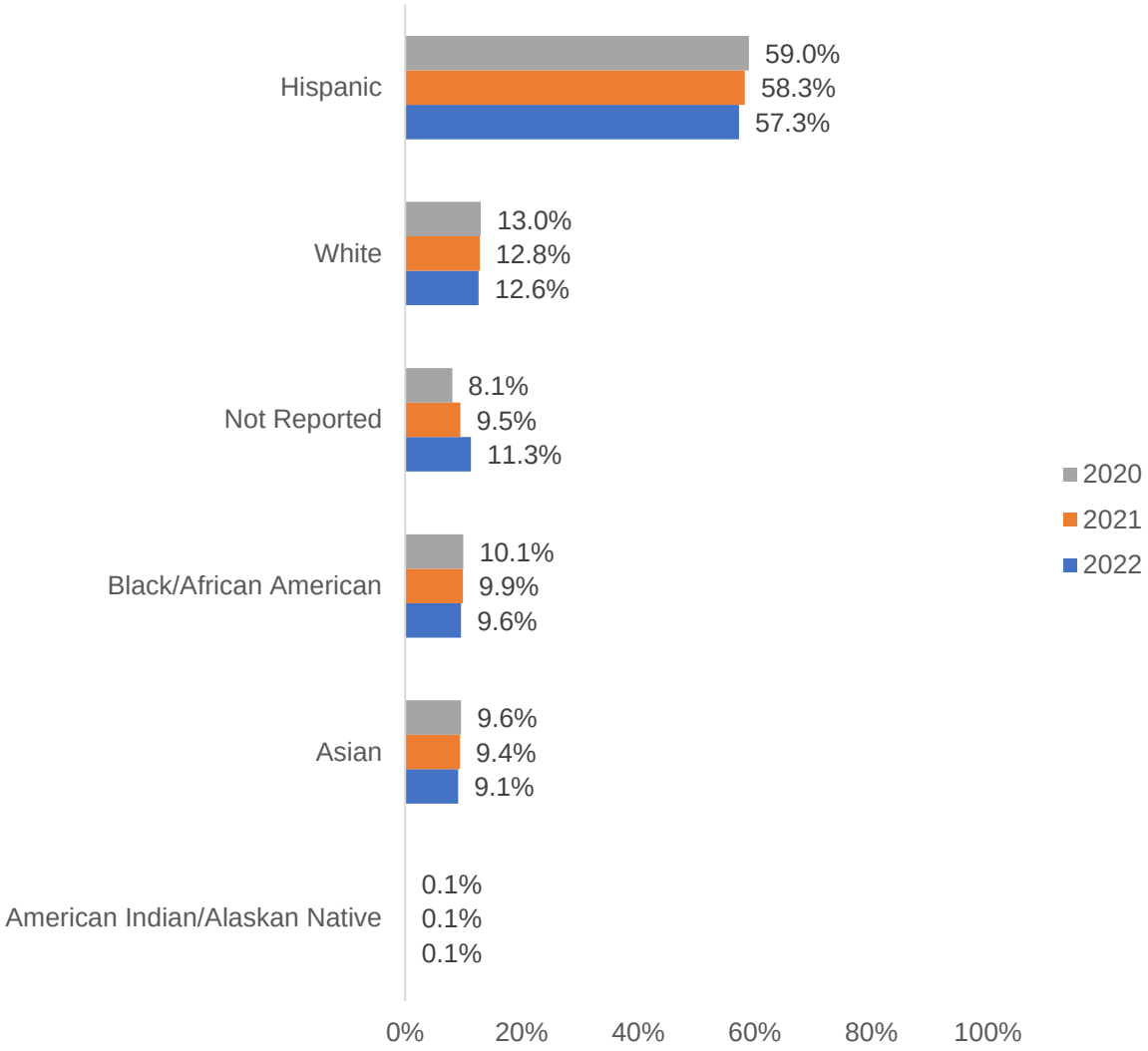


Figure 11 presents Los Angeles County's three-year trends in Medi-Cal Eligibles by race/ethnicity. Between CY 2020 to CY 2022, the Hispanic group declined by 1.7 PP, the White group declined by 0.4 PP, the Black /African American declined by 0.5 PP, Asian group declined by 0.5 PP, and the American Indian/Alaska Native group remained the same. Of note, the Not Reported category increased by 3.2 PP. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, CY 2020 to CY 2022. Due to rounding, some estimated totals and percentages may not total 100%.

Clients Served

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

Figure

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

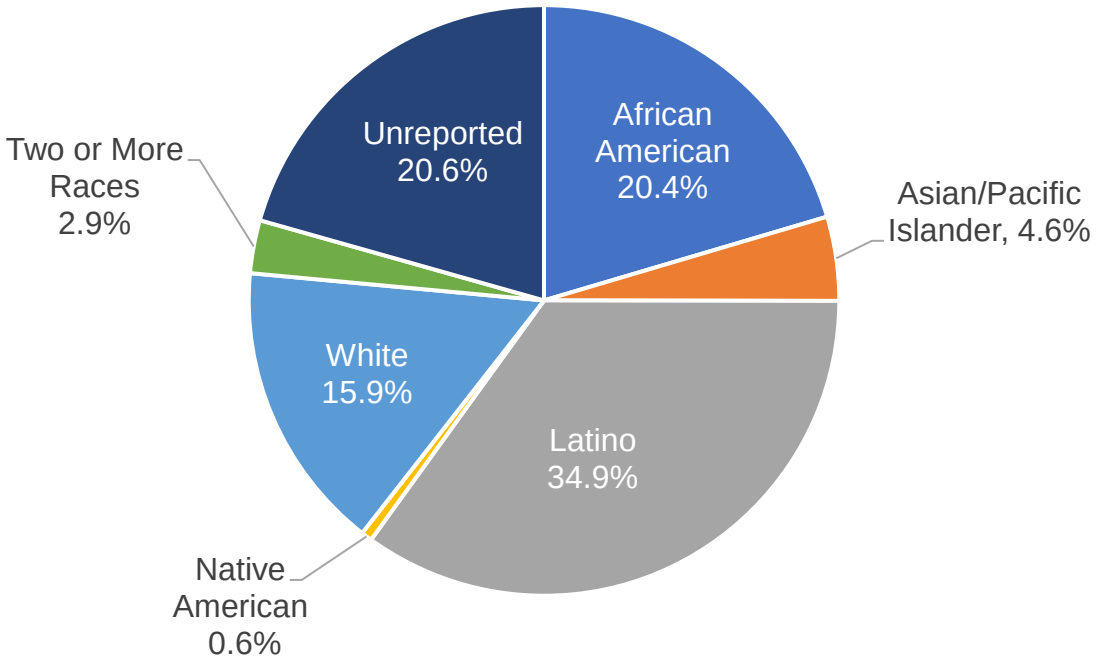


Figure 12 presents the distribution of race/ethnicity for clients served in LACDMH's outpatient clinics. The Latino group is the largest at 34.9%, African American at 20.4%, White at 15.9%, API at 4.6%, Two or more Races at 2.9%, and Native American at 0.6%. Approximately 20.6% of our clients served have unreported races/ethnicities. The N for the Latino group is 45,003. The N for the Unreported category is 26,593. The N for the African American group is 26,386. The N for the White group is 20,503. The N for the Two or more Races group is 3,756. The N for the Native American group is 827. Data Source: LACDMH-IS-IBHIS, June 2023.

Table

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

SA	African American	Asian/ Pacific Islander	Latino	Native American	White	Two or More Races	Unreported	Total
SA 1	3,772	104	2,842	50	2,374	501	1,158	10,801
Percent	34.9%	1.0%	26.3%	0.46%	22.0%	**4.6%**	**10.7%**	100.0%
SA 2	3,575	991	10,930	101	7,379	910	5,851	29,737
Percent	12.0%	3.3%	36.8%	**0.34%**	24.8%	3.1%	19.7%	100.0%
SA 3	2,742	2,606	8,097	114	3,798	1,069	10,766	29,192
Percent	9.4%	**8.9%**	27.7%	0.39%	13.0%	3.7%	**36.9%**	100.0%
SA 4	6,304	1,757	12,231	206	4,708	721	4,992	30,919
Percent	20.4%	5.7%	39.6%	0.67%	15.2%	2.3%	16.1%	100.0%
SA 5	2,097	270	1,894	49	2,733	327	1,708	9,078
Percent	23.1%	3.0%	**20.9%**	0.54%	**30.1%**	3.6%	18.8%	100.0%
SA 6	10,500	205	8,846	254	1,166	448	4,091	25,510
Percent	**41.2%**	**0.8%**	34.7%	**1.00%**	**4.6%**	**1.8%**	16.0%	100.0%
SA 7	1,185	458	9,145	176	1,968	673	5,731	19,336
Percent	**6.1%**	2.4%	**47.3%**	0.91%	10.2%	3.5%	29.6%	100.0%
SA 8	7,949	1,741	10,255	115	4,703	1,087	5,546	31,396
Percent	25.3%	5.5%	32.7%	0.37%	15.0%	3.5%	17.7%	100.0%
Total	26,386	5,994	45,003	827	20,503	3,756	26,593	129,062
Percent	20.4%	4.6%	34.9%	0.64%	15.9%	2.9%	20.6%	100.0%

Table 4 presents race/ethnicity distribution across LACDMH's clients served by Service Area. Bold values represent the highest and lowest percentages within each ethnic group across Service Areas. The highest percentage of African Americans served was in SA 6 (41.2%) compared to SA 7 (6.1%), with the lowest. The highest percentage of API clients served was in SA 3 (8.9%) compared to SA 6 (0.8%), with the lowest. The highest percentage of Latino clients were served in SA 7 (47.3%) compared to SA 5 (20.9%), with the lowest. The highest percentage of Native American clients served was in SA 6 (1.0%) compared to SA 2 (0.3%), with the lowest. The highest percentages of Whites were served in SA 5 (30.1%) compared to SA 6 (4.6%), with the lowest. The highest percentage of clients with Two or more Races was in SA 1 (4.6%) compared to SA 6 (1.8%). Approximately 36.9% of clients served in SA 3 have unreported races/ethnicities, the highest of all SAs. Note: Bold values represent the highest and lowest percentages within each ethnic group across Service Areas. Table excludes Null (N=80,943). Total reflects an unduplicated count of consumers served. Data Source: LACDMH-IS-IBHIS, June 2023.

Figure

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

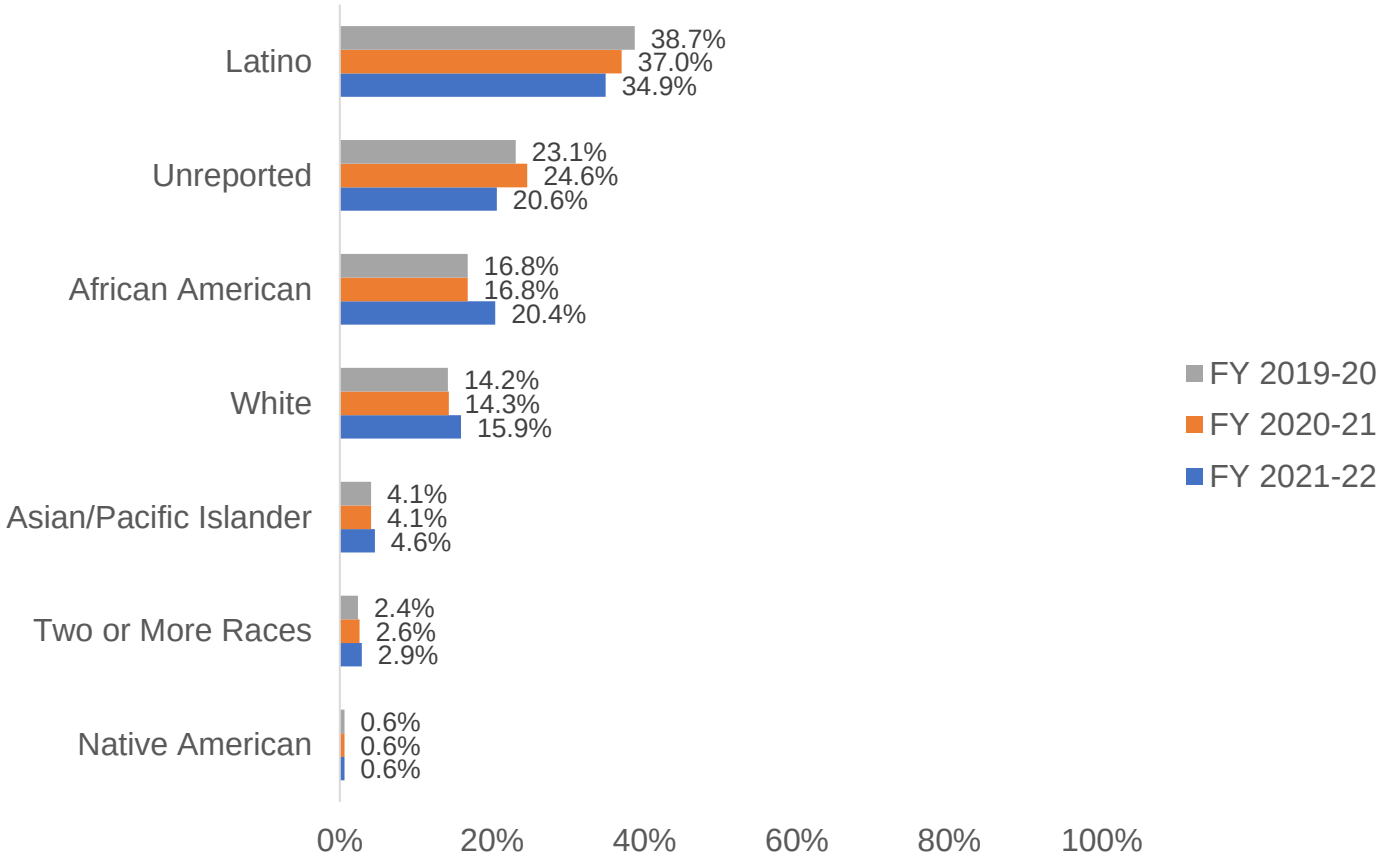


Figure 13 presents the distribution of race/ethnicity among LACDMH clients between FY2019-20 to FY 2021-22. Between FY 2019-20 and FY 2021-22, the Latino group decreased by 3.8 PP, African Americans increased by 3.6 PP, White increased by 1.7 PP, API increased by 0.5 PP, and the Native American group remained the same. QI began evaluating unknown/unreported and Two or more Races as of FY 2019-20. Over the last three years, the Two or more Races category increased by 0.5 PP, and the percentage of LACDMH clients with unknown/unreported ethnicities showed a decrease of 2.5 PP. Data Source: LACDMH-IS-IBHIS, June 2023.

Summary

LA County's total population decreased 1.0 PP from 10,178,592 in CY 2020 to 9,944,923 in CY 2021. The Latino/Hispanic category was Los Angeles County's most common racial group across all demography data sets between CY 2019 and 2021. However, the Latino/Hispanic population is trending downward over the last three years. Conversely, the Native American group has remained the smallest and most stable during the same time frame and across similar data sets.

At 48.1%, the Latino/Hispanic group is the largest community, followed by the White group at 25.8% of all county residents. The racial groups remained relatively stable since CY 2021. Similarly, the Latino/Hispanic and White groups comprised most of the Los Angeles County's population living at or below the 138% Federal Poverty Level (poverty estimates) and eligible for Medi-Cal. CY 2021 showed an increase in poverty estimates among the API and Two or More Races groups and a decline for the Latino/Hispanic and African American groups. Notably, 86.3% of Latinos/Hispanics residing in SA 7 live at or below 138% FPL, the highest rate of all SAs. Trend analysis on the Medi-Cal Eligibles should be interpreted cautiously as all racial groups declined except for the Not Reported category, which increased by 3.2 PP, and AI/AN remained the same. The distribution of race/ethnicity has seen an increase in African American, API, and White clients among LACDMH's clients, with the most significant increase seen for the African American community, 3.0 PP over the last three years. Native Americans in SA 6 seek LACDMH services more often than those in other SAs.

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

Total Population

Approximately 48% of Los Angeles County residents are between 25 and 59 years old, with the largest proportion residing in SA 4. The most noticeable change was the 0-15 years age group decrease by 1.2 PP and the 60+ years age group increase by 1.2 PP between CY 2019 and CY 2021; ages 16-25 years, made up the smallest portion of residents.

Figure

14. MHSA Age Group Distribution for Total Population, Calendar Year 2021

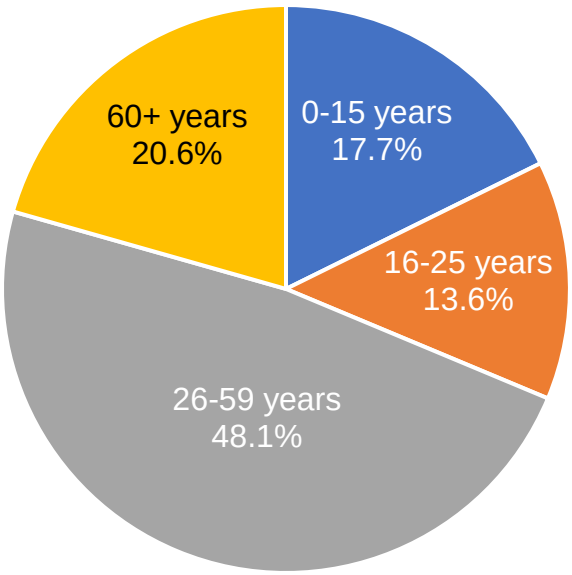


Figure 14 presents the age group distribution for Los Angeles County's total population. Adults (26-59 years) made up the largest age group at 48.1%, followed by Older Adults (60+ years) at 20.6%, Children (0-15 years) at 17.7%, and 16-25 years at 13.6%. The N for the 0-15 years category is 1,763,283. The N for the 16-25 years category is 1,350,477. The N for the 26-59 years category is 4,783,954. The N for the 60+ years category is 2,047,209. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by CIOB in May 2023.

Table

5. Total Population by MHSA Age Group and Service Area, Calendar Year 2021

SA	Age Group				Total
	0-15 years	16-25 years	26-59 years	60+ years	
SA1	95,357	68,395	181,215	71,590	416,557
Percent	**22.9%**	16.4%	**43.5%**	17.2%	100.0%
SA2	379,577	280,797	1,050,856	480,518	2,191,748
Percent	17.3%	12.8%	47.9%	21.9%	100.0%
SA3	295,358	238,430	807,081	404,453	1,745,322
Percent	16.9%	13.7%	46.2%	23.2%	100.0%
SA4	154,617	114,083	618,582	219,695	1,106,977
Percent	14.0%	**10.3%**	**55.9%**	19.8%	100.0%
SA5	84,988	85,632	334,066	154,387	659,073
Percent	**12.9%**	13.0%	50.7%	**23.4%**	100.0%
SA6	224,717	168,612	468,018	147,332	1,008,679
Percent	22.3%	**16.7%**	46.4%	**14.6%**	100.0%
SA7	249,980	189,240	596,961	239,513	1,275,694
Percent	19.6%	14.8%	46.8%	18.8%	100.0%
SA8	278,689	205,288	727,175	329,721	1,540,873
Percent	18.1%	13.3%	47.2%	21.4%	100.0%
Total	1,763,283	1,350,477	4,783,954	2,047,209	9,944,923
Percent	17.7%	13.6%	48.1%	20.6%	100.0%

Table 5 shows age group distribution for LA County residents and by SA. Bold values represent the highest and lowest percentage within each Age Group across Service Areas. The highest percentage of individuals between 0 and 15 years was in SA 1 (22.9%) compared to SA 5 (12.9%), with the lowest. The highest percentage of individuals between 16 and 25 years was in SA 6 (16.7%) compared to SA 4 (10.3%), with the lowest. The highest percentage of individuals between 26 and 59 years was in SA 4 (55.9%) compared to SA 1 (43.5%), with the lowest. The highest percentage of individuals 60 years or more was in SA 5 (23.4%) compared to SA 6 (14.6%), with the lowest. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by CIOB in May 2023.

Figure

15. Three Year Trends for Total Population by MHSA Age Group, Calendar Year 2019 to Calendar Year 2021

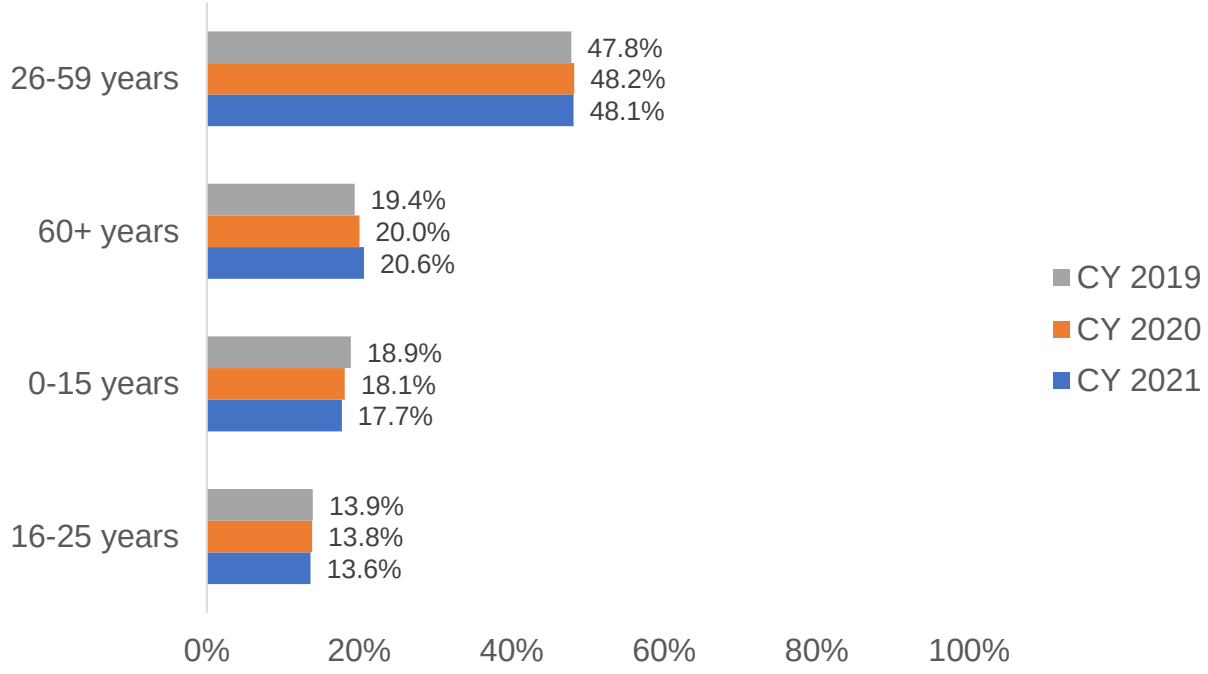


Figure 15 summarizes the three-year trends for age groups. Between CY 2019 and CY 2021, the percentage of 26-59 years increased by 0.3 PP, 0-15 year decreased by 1.2 PP, 60+ years increased by 1.2 PP, and 16-25 years decreased by 0.3 PP. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2019 to 2021, prepared by CIOB in May 2023.

Estimated Population living at or below 138% FPL

Much of Los Angeles County's estimated population at or below 138% FPL are between 26 and 59 years old (42.3%) or 0 and 15 years old (26.4%).

Figure

16. Age Group Distribution for the Estimated Population Living at or below 138% FPL, Calendar Year 2021

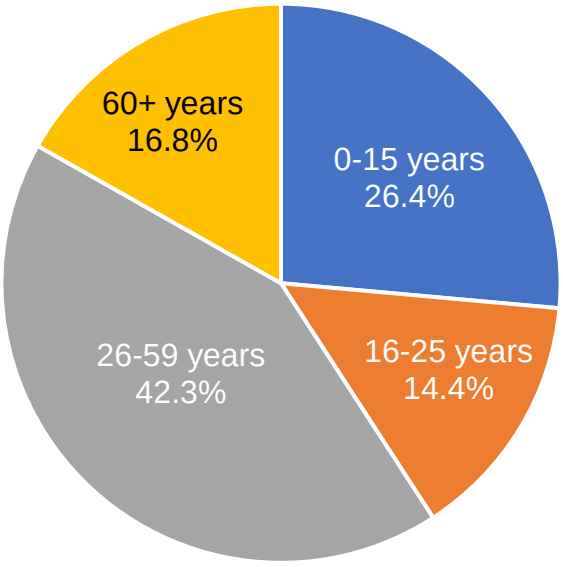


Figure 16 presents the age group distribution for Los Angeles County's total population. Adults (26-59 years) made up the largest group at 42.3%, followed by Children (0-15 years) at 26.4%, Older Adults (60+ years) at 16.8%, and TAY (16-25 years) at 14.4%. The N for the 0-15 years category is 454,412. The N for the 16-25 years category is 247,358. The N for the 26-59 years category is 727,303. The N for the 60+ years category is 289,218. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by CIOB in May 2023.

Table

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

SA	Age Group 0-15 years	16-25 years	26-59 years	60+ years	Total
SA1	31,331	15,537	35,305	13,452	95,625
Percent	**32.8%**	16.2%	**36.9%**	14.1%	100.0%
SA2	76,000	42,705	139,735	58,774	317,214
Percent	24.0%	13.5%	44.1%	18.5%	100.0%
SA3	56,901	33,646	97,960	49,174	237,681
Percent	23.9%	14.2%	41.2%	**20.7%**	100.0%
SA4	52,800	27,816	118,949	46,998	246,563
Percent	21.4%	**11.3%**	48.2%	19.1%	100.0%
SA5	9,578	11,184	34,444	13,696	68,902
Percent	**13.9%**	16.2%	**50.0%**	19.9%	100.0%
SA6	100,022	50,867	117,977	36,290	305,156
Percent	32.8%	**16.7%**	38.7%	**11.9%**	100.0%
SA7	61,300	30,563	80,214	29,789	201,866
Percent	30.4%	15.1%	39.7%	14.8%	100.0%
SA8	66,480	35,040	102,719	41,045	245,284
Percent	27.1%	14.3%	41.9%	16.7%	100.0%
Total	454,412	247,358	727,303	289,218	1,718,291
Percent	26.4%	14.4%	42.3%	16.8%	100.0%

Table 6 outlines the SA distribution of age groups for the estimated population living at or below 138% FPL. Bold values represent the highest and lowest percentages within each Age Group across Service Areas. The highest percentage of individuals between 0-15 years was in SA 1 (32.8%) compared to SA 5 (13.9%), with the lowest. The highest percentage of individuals between 16 and 25 years was in SA 6 (16.7%) compared to SA 4 (11.3%), with the lowest. The highest percentage of individuals between 26 and 59 years was in SA 5 (50.0%) compared to SA 1 (36.9%), with the lowest. The highest percentage of individuals 60 years or more was in SA 3 (20.7%) compared to SA 6 (11.9%), with the lowest. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by CIOB in May 2023.

Figure

17. Three Year Trends for Estimated Population Living at or below 138% FPL by MHSA Age Groups, Calendar Year 2019 to Calendar Year 2021

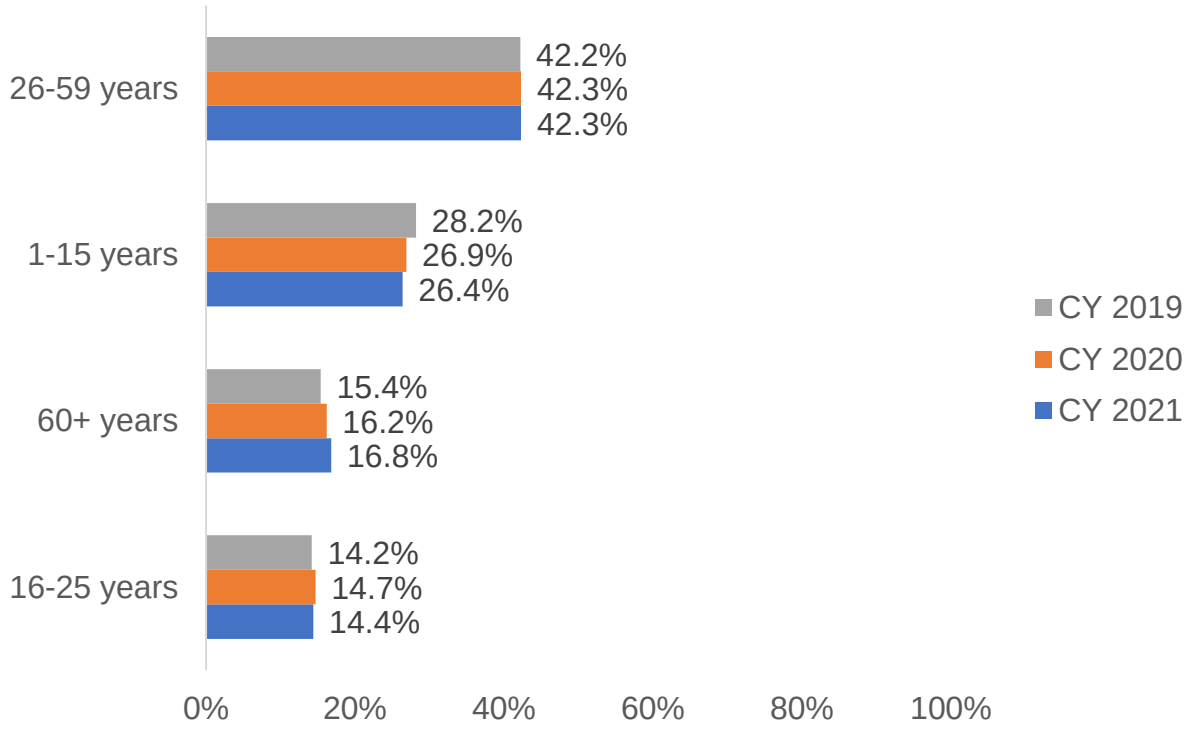


Figure 17 displays a trend analysis for the past three years. Between CY 2019 and CY 2021, adults estimated at or below 138% FPL increased by 0.1 PP, children decreased by 1.8 PP, older adults increased by 1.4 PP, and TAY increased by .2 PP. Data source: ACS, US Census Bureau, and Hedderson Demographic Services, CY 2019 to CY 2021, last revised by CIOB in May 2023.

Estimated Prevalence of SED or SMI

At 47.2%, residents between 26 and 59 years old and estimated at or below 138% FPL had the highest prevalence of SED and SMI, with the higher majority residing in SA 4. Residents ages 60+ years (6.8%) had the lowest prevalence rates when applied to poverty estimates.

Figure

18. Estimated Prevalence of SED or SMI by Age Group

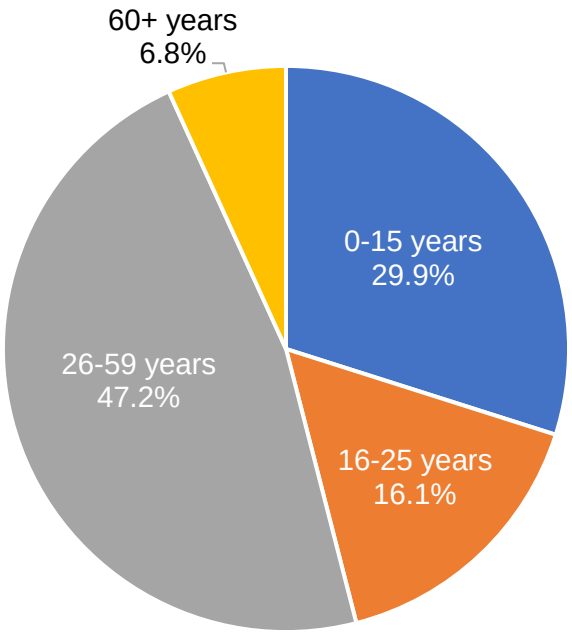


Figure 18 presents the estimated population at or below 138% FPL with SED or SMI prevalence and by MHSA age categories. Adults comprised the largest group at 47.2%, followed by children at 29.9%, TAY at 16.1%, and older adults at 6.8%. The N for the 0-15 years was 126,781. The N for the 16-25 years group was 68,023 and 200,008 for the 26-59 years group. The N for the 60+ years group was 28,922.

Table

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

SA	Age Group				
	0-15 years	16-25 years	26-59 years	60+ years	Total
SA1	8,741	4,273	9,709	1,345	24,068
Percent	**36.3%**	17.8%	**40.3%**	5.6%	100.0%
SA2	21,204	11,744	38,427	5,877	77,252
Percent	27.4%	15.2%	49.7%	7.6%	100.0%
SA3	15,875	9,253	26,939	4,917	56,984
Percent	27.9%	16.2%	47.3%	**8.6%**	100.0%
SA4	14,731	7,649	32,711	4,700	59,791
Percent	24.6%	**12.8%**	54.7%	7.9%	100.0%
SA5	2,672	3,076	9,472	1,370	16,590
Percent	**16.1%**	**18.5%**	**57.1%**	8.3%	100.0%
SA6	27,906	13,988	32,444	3,629	77,967
Percent	35.8%	17.9%	41.6%	**4.7%**	100.0%
SA7	17,103	8,405	22,059	2,979	50,545
Percent	33.8%	16.6%	43.6%	5.9%	100.0%
SA8	18,548	9,636	28,248	4,105	60,536
Percent	30.6%	15.9%	46.7%	6.8%	100.0%
Total	126,781	68,023	200,008	28,922	423,735
Percent	29.9%	16.1%	47.2%	6.8%	100.0%

Table 7 shows the SA distribution of age groups. Bold values represent the highest and lowest percentages. The highest percentage of individuals between 0 and 15 years was in SA 1 (36.3%) compared to SA 5(16.1%), with the lowest. The highest percentage of individuals between 16 and 25 years was in SA 5 (18.5%) compared to SA 4 (12.8%), with the lowest. The highest percentage of individuals between 26 and 59 years was in SA 5 (57.1%) compared to SA 1 (40.3%), with the lowest. The highest percentage of individuals 60 years or more was in SA 3 (8.6%) compared to SA 6 (4.7%), with the lowest. Trending data was not included as QI did not examine prevalence rates for CY 2019 and CY 2020. Due to rounding, some estimated numbers and percentages may not total 100%. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by CIOB in May 2022.

Population Enrolled in Medi-Cal

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

Figure

19. Age Group Distribution among Medi-Cal Eligibles, Calendar Year 2022

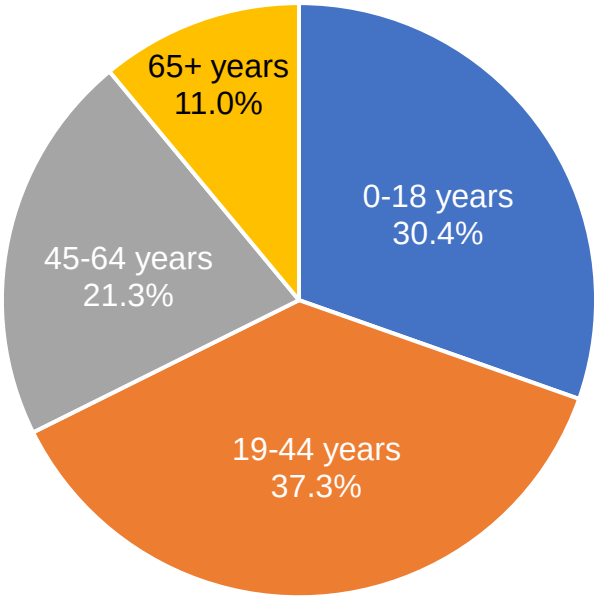


Figure 19 presents the Medi-Cal enrolled population by age group. Individuals between 19 and 44 years were the largest group (37.3%), followed by individuals between 0 and 18 years (30.4%), individuals between 45 and 64 years (21.3%), and individuals 65 years or more (11.0%). The N for the 19-44 years group was 1,655,495. The N for the 0-18 years group was 1,350,605. The N for the 45-64 years group was 947,825, and the N for the 65+ group was 489,354. Note: Race/ethnicity categories as defined by State. Due to rounding, some estimated totals and percentages may not total 100%. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, downloaded on March 20, 2023.

Figure

20. Three-year trends for Population Enrolled in Medi-Cal by Age Categories, Calendar Year 2020 to Calendar Year 2022

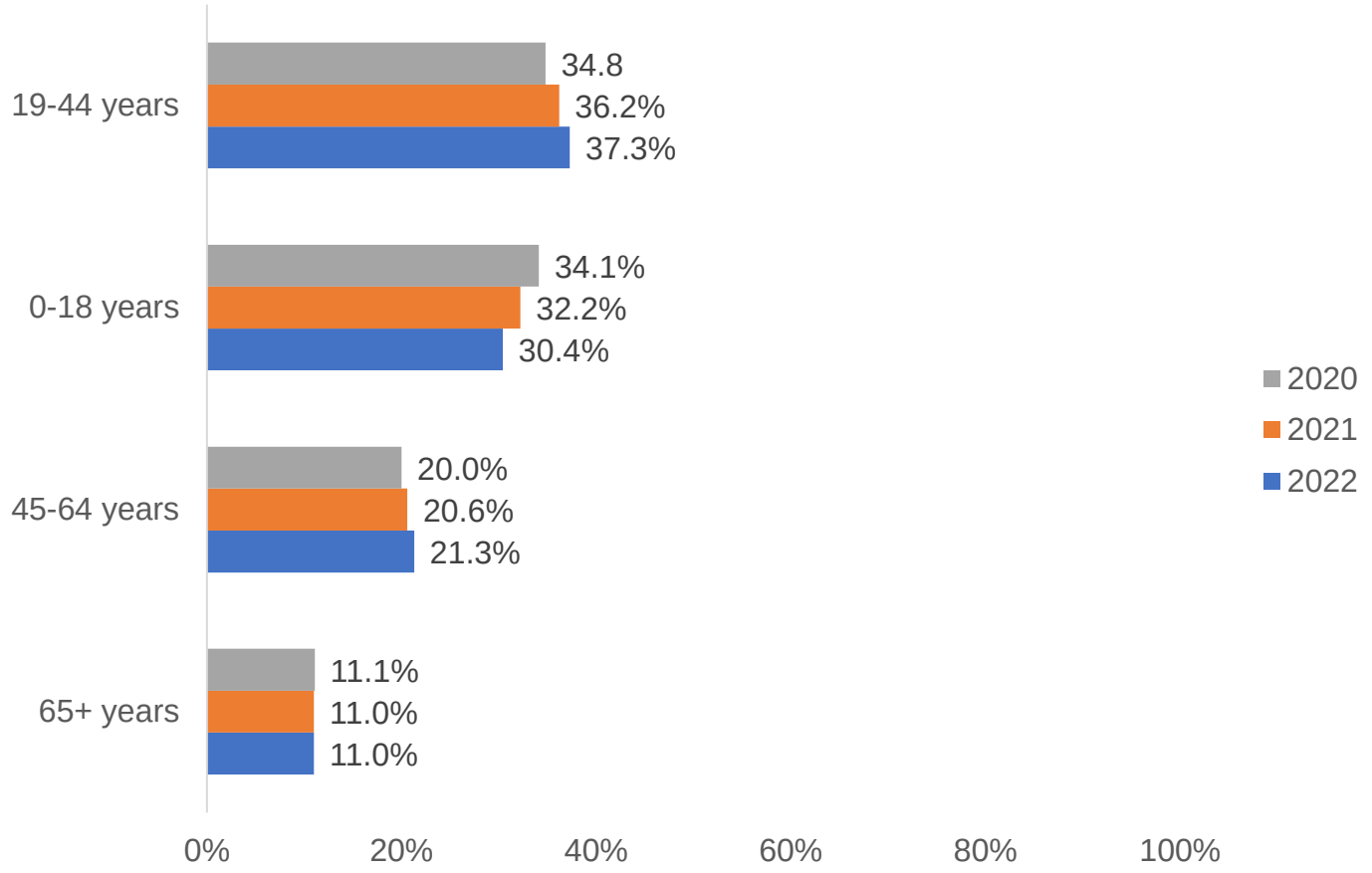


Figure 20 breaks down the three-year trend for age categories among Medi-Cal enrollees. Most notably, the 0-18 years category declined by 3.6 PP. Due to rounding, some estimated totals and percentages may not total 100%. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, downloaded on March 20, 2023.

Clients Served

At 41.3%, clients between ages 26 and 59 comprised the highest percentage of clients served in LACDMH outpatient services. Despite demonstrating the most considerable client population growth in the past three years, older adults were the smallest age group served in FY 2021-22.

Figure

21. MHSA Age Group Distribution for Clients Served in Outpatient LACDMH Clinics

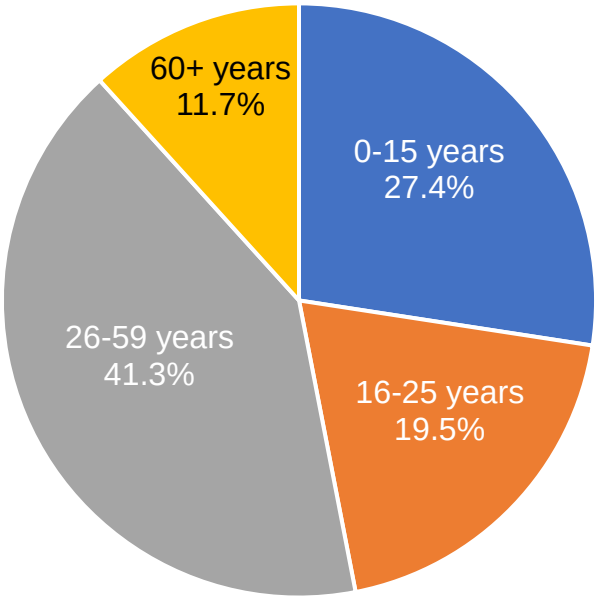


Figure 21 introduces the FY 2021-22 distribution of clients served by age group. Most clients are Adults ages 26-59 years at 41.3%, Children ages 0-15 years at 27.4%, TAY ages 16-25 years at 19.5%, and Older Adults ages 60 and above at 11.7%. The N for Children is 57,623. The N for TAY is 40,996. The N for Adults is 86,714. The N for Older Adults is 24,672. Data Source: LACDMH IS-IBHIS, June 2023.

Table

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

SA	Age Group				
	0-15	16-25	26-59	60+	Total
SA 1	6,065	3,283	7,046	1,355	17,749
Percent	34.2%	18.5%	39.7%	7.6%	100.0%
SA 2	12,105	10,118	21,246	5,264	48,733
Percent	24.8%	20.8%	43.6%	10.8%	100.0%
SA 3	15,627	12,172	15,739	3,885	47,423
Percent	33.0%	**25.7%**	33.2%	8.2%	100.0%
SA 4	12,958	8,959	20,514	6,038	48,469
Percent	26.7%	18.5%	42.3%	12.5%	100.0%
SA 5	2,769	2,253	6,701	2,222	13,945
Percent	**19.9%**	**16.2%**	**48.1%**	**15.9%**	100.0%
SA 6	13,531	7,919	14,867	3,712	40,029
Percent	33.8%	19.8%	37.1%	9.3%	100.0%
SA 7	11,537	7,841	10,284	2,155	31,817
Percent	**36.3%**	24.6%	**32.3%**	**6.8%**	100.0%
SA 8	14,995	10,332	20,181	4,833	50,341
Percent	29.8%	20.5%	40.1%	9.6%	100.0%
Total	57,623	40,996	86,714	24,672	210,005
Percent	27.4%	19.5%	41.3%	11.7%	100.0%

Table 8 presents the SA distribution of age groups for LACDMH clients. Bold values represent the highest and lowest percentages for each age group. The highest percentage of children LACDMH served was in SA 7 (36.3%) compared to SA 5 (19.9%), with the lowest. The highest percentage of TAY served by LACDMH was in SA 3 (25.7%) compared to SA 5 (16.2%), with the lowest. The highest percentage of Adults served by LACDMH was in SA 5 (48.1%) compared to SA 7 (32.3%), with the lowest. The highest percentage of older adults served by LACDMH was in SA 5 (15.9%) compared to SA 7 (6.8%), with the lowest. Data Source: LACDMH IS-IBHIS, June 2023.

Figure

22. Three-Year Trend in Clients Served by MHSA Age Group

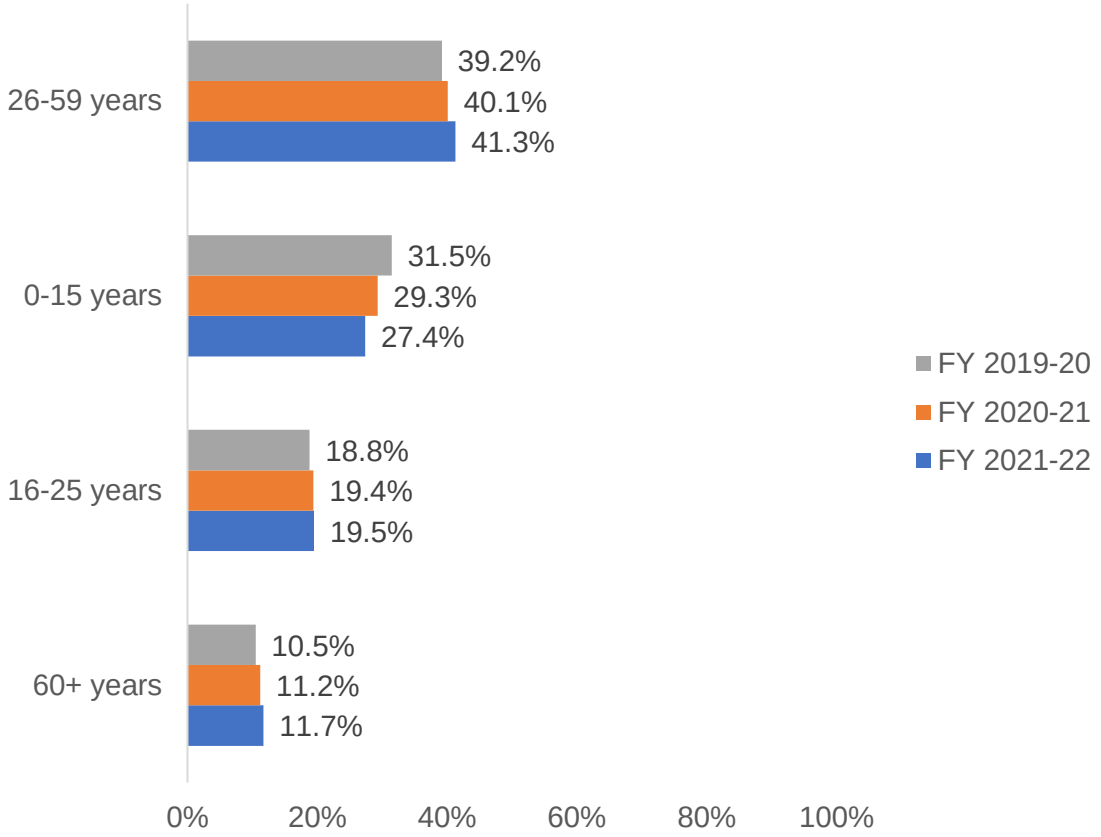


Figure 22 presents the distribution of age groups for clients served over the prior three fiscal years. All age groups increased except for the 0-15 years group, which decreased by 4.1 PP. 26-59 years increased by 2.1 PP, 60+ years by 1.2 PP, and 16-25 years by 0.7 PP. Data Source: LACDMH IS-IBHIS, June 2023.

Summary

At 48.1%, the highest percentage of Los Angeles residents fell in the 26 to 59 age group. Poverty estimates show ages 0-15 years and 26-59 years as the largest age groups likely meeting the Medi-Cal eligibility criterion, and similar rates were observed among the clients served. According to California DHCS, an estimated 67.7% of LA County's Med-Cal eligibles are between 0 and 44 years old. Children had the second highest rate of living at 138% FPL and rate SED and SMI prevalence.

Most LACDMH outpatient clinics primarily serve adults. SA 5 serves primarily adults; however, in SAs 3 and 7, children are the most represented age group served. The Child LACDMH client population is the only age group trending downwards.

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

Total Population

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

Figure

23. Gender Distribution for Total Population, Calendar Year 2021

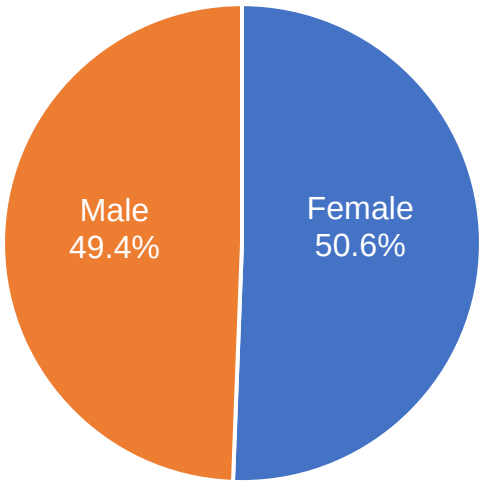


Figure 23 presents the ratio of Males and Females among LA County residents. The N for the Male group is 4,909,145. The N for the Female group is 5,035,778. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2023.

Table

9. Total Population by Gender and Service Area, Calendar Year 2021

SA	Male	Female	Total
SA1	205,882	210,675	416,557
Percent	49.4%	50.6%	100.0%
SA2	1,085,478	1,106,270	2,191,748
Percent	49.5%	50.5%	100.0%
SA3	850,645	894,677	1,745,322
Percent	48.7%	51.3%	100.0%
SA4	572,730	534,247	1,106,977
Percent	**51.7%**	**48.3%**	100.0%
SA5	319,252	339,821	659,073
Percent	**48.4%**	**51.6%**	100.0%
SA6	493,940	514,739	1,008,679
Percent	49.0%	51.0%	100.0%
SA7	627,055	648,639	1,275,694
Percent	49.2%	50.8%	100.0%
SA8	754,163	786,710	1,540,873
Percent	48.9%	51.1%	100.0%
Total	4,909,145	5,035,778	9,944,923
Percent	49.4%	50.6%	100.0%

Table 9 presents the SA distribution of Male and Female LA County residents. Bold values represent the highest and lowest percentage within each gender group across Service Areas. The highest percentage of Males reside in SA 4 (51.7%) compared to SA 5 (48.4%), with the lowest. Contrarily, the highest percentage of Females reside in SA 5 (51.6%) compared to SA 4 (48.3%) with the lowest. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2023.

Figure

24. Three Year Gender Trends for Total Population, Calendar Year 2019 to Calendar Year 2021

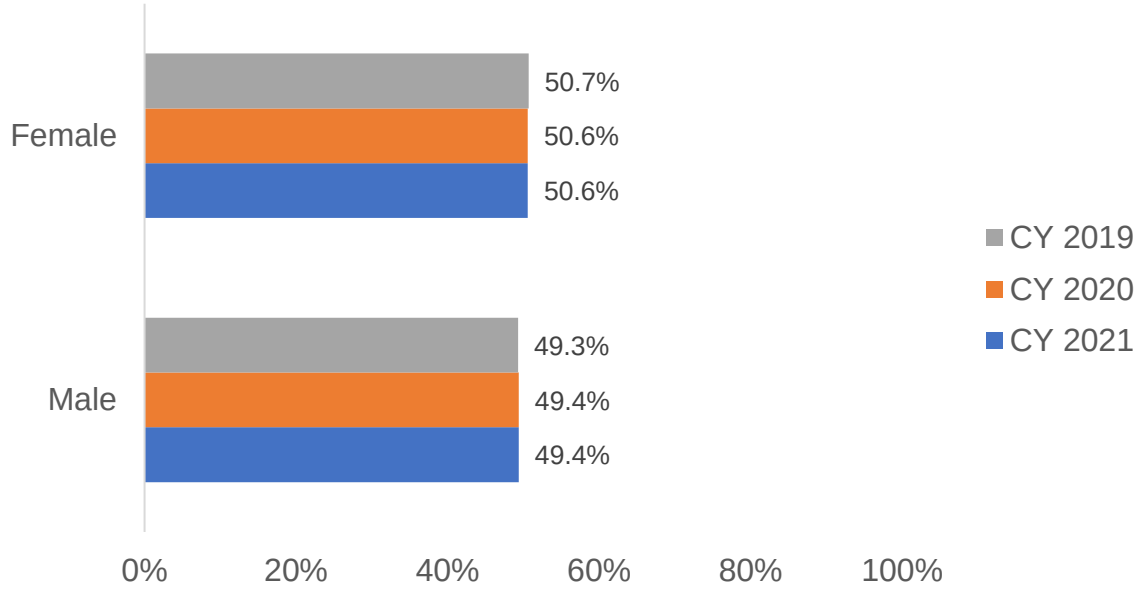


Figure 24 displays the three-year trends for gender distribution among LA County residents, and no major population shifts were observed. Across these three years, Females remained slightly more represented than Males. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2023.

Estimated Population at or Below 138% Federal Poverty Level

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

Figure

25. Gender Distribution for the Estimated Population Living at or below 138% FPL, Calendar Year 2021

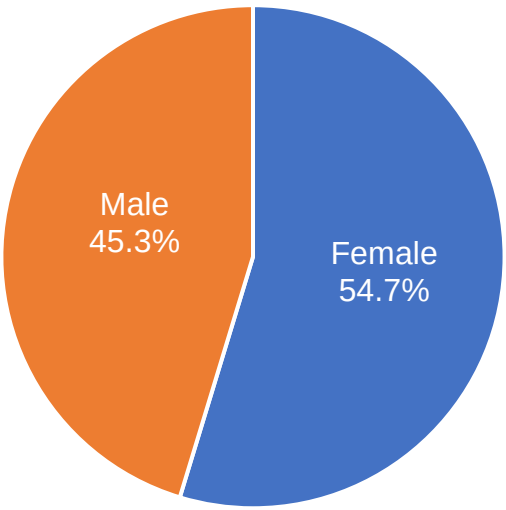


Figure 25 shows the gender distribution for the estimated population living at or below 138% FPL. Females were the largest at 54.7%. The N for the Female category was 940,586. Males were at 45.3%. The N for the Male category was 777,705. Data Source: Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, 2022.

Table

10. Estimated Population Living at or below 138% FPL by Gender and Service Area, Calendar Year 2021

SA	Male	Female	Total
SA1	43,353	52,272	95,625
Percent	45.3%	54.7%	100.0%
SA2	143,783	173,431	317,214
Percent	45.3%	54.7%	100.0%
SA3	106,171	131,510	237,681
Percent	44.7%	55.3%	100.0%
SA4	115,475	131,088	246,563
Percent	**46.8%**	**53.2%**	100.0%
SA5	30,602	38,300	68,902
Percent	**44.4%**	**55.6%**	100.0%
SA6	138,192	166,964	305,156
Percent	45.3%	54.7%	100.0%
SA7	89,958	111,908	201,866
Percent	44.6%	55.4%	100.0%
SA8	110,171	135,113	245,284
Percent	44.9%	55.1%	100.0%
Total	777,705	940,586	1,718,291
Percent	45.3%	54.7%	100.0%

Table 10 shows the gender distribution by SA for the estimated population living at or below the 138% FPL. The highest percentage of Males was in SA 4 (46.8%) compared to SA 5 (44.4%) with the lowest. Contrarily, the highest percentage of Females was in SA 5 (55.6%) compared to SA 4 (53.2%) with the lowest. Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each gender and across all SAs. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB in May 2023.

Figure

26. Three Year Gender Trends for Estimated Population Living at or below 138% FPL, Calendar Years 2019 to 2021

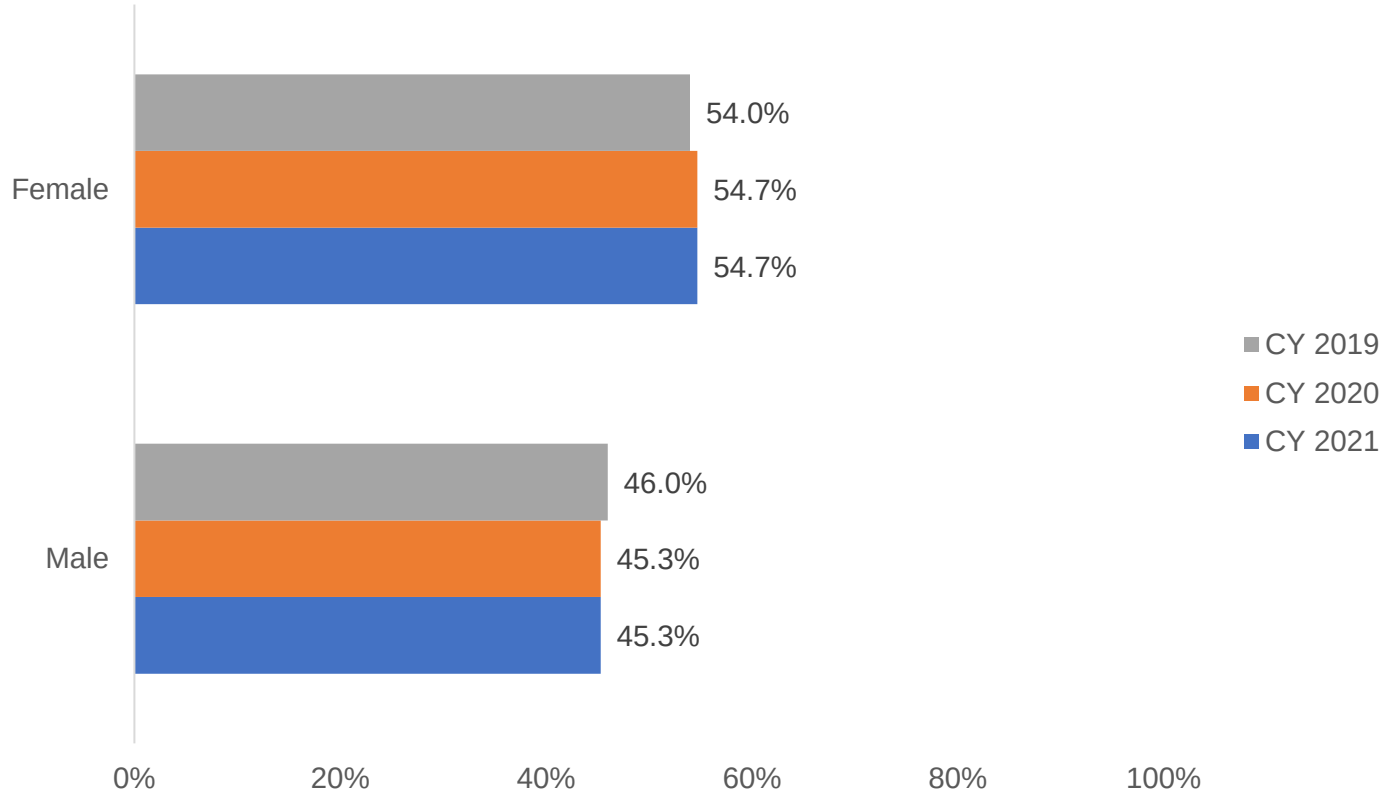


Figure 26 evaluates trends for gender between CY 2019 and 2021. The percentage of Females within the estimated population at or below 138% FPL increased by 0.7 PP, and there was a 0.7 PP decline in the percentage of Males. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB in May 2023.

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

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

Figure

27. Estimated Prevalence of SED or SMI by Gender

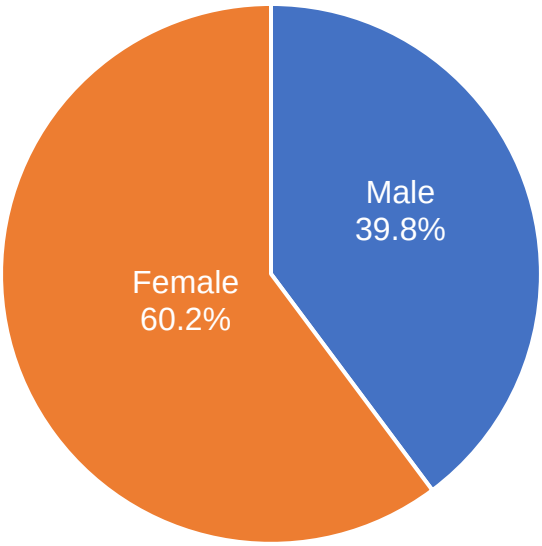


Figure 27 presents the estimated prevalence of SED and SMI among LA county's population, estimated at or below 138% FPL. At 60.2%, the majority are Female. Males are at 39.8%. The N for the Female category is 178,711, and the N for the Male category is 118,211. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB on May 2023.

Table

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

SA	Male	Female	Total
SA1	6,590	9,932	16,521
Percent	39.9%	60.1%	100.0%
SA2	21,855	32,952	54,807
Percent	39.9%	60.1%	100.0%
SA3	16,138	24,987	41,125
Percent	39.2%	60.8%	100.0%
SA4	17,552	24,907	42,459
Percent	**41.3%**	**58.7%**	100.0%
SA5	4,652	7277	11,929
Percent	**39.0%**	**61.0%**	100.0%
SA6	21,005	31,723	52,728
Percent	39.8%	60.2%	100.0%
SA7	13,674	21,263	34,936
Percent	39.1%	60.9%	100.0%
SA8	16,746	25,671	42,417
Percent	39.5%	60.5%	100.0%
Total	118,211	178,711	296,923
Percent	39.8%	60.2%	100.0%

Table 11 presents the estimated prevalence of SED and SMI for LA County's estimated population living at or below 138% FPL by gender and SA. Bold values represent the highest and lowest percentages. SA 4 (41.3%) had the highest population of Males, estimated at or below 138% FPL and prevalence of SED or SMI, compared to SA 5 (39.0%) with the lowest. Contrarily, SA 5 (61.0%) had the highest population of Females estimated at or below 138% FPL and prevalence of SED or SMI compared to SA 4 (58.7%) with the lowest. Data Source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH CIOB on May 2023.

Population Enrolled in Medi-Cal

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

Figure

28. Distribution of Gender for Population Enrolled in Medi-Cal, Calendar Year 2022

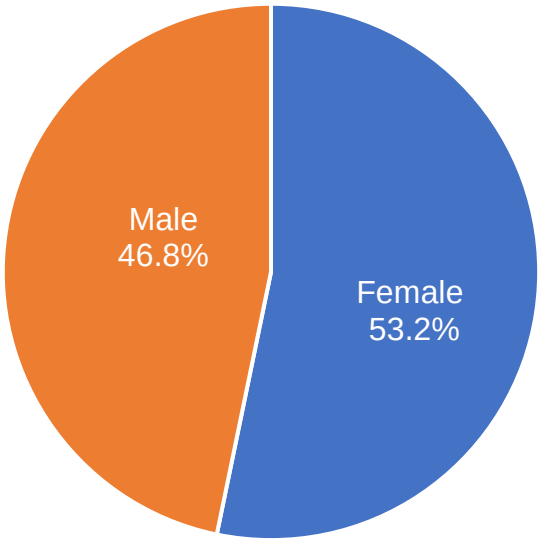


Figure 28 shows the distribution of Male and Female Medi-Cal eligibles in CY 2022. The majority of Medi-Cal eligibles are Female at 53.2%. Males are at 46.8%. The N for the Male category is 2,077,547. The N for the Female category is 2,365,732. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, downloaded on March 20, 2023.

Figure

29. Three Year Trend in Population Enrolled in Medi-Cal by Gender, Calendar Years 2020 to 2022

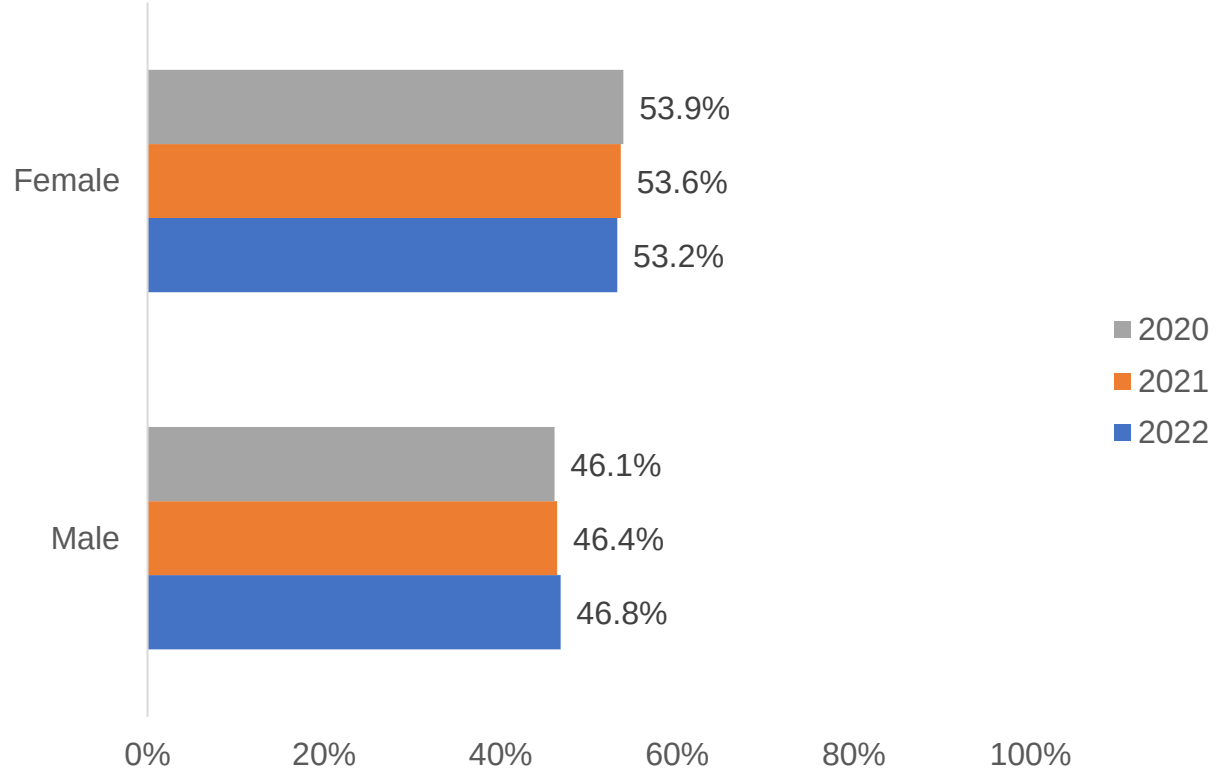


Figure 29 presents the three-year trend in Medi-Cal eligibles by gender, and there were no notable shifts.

Clients Served

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

Figure

30. Clients Served in Outpatient LACDMH Programs by Gender

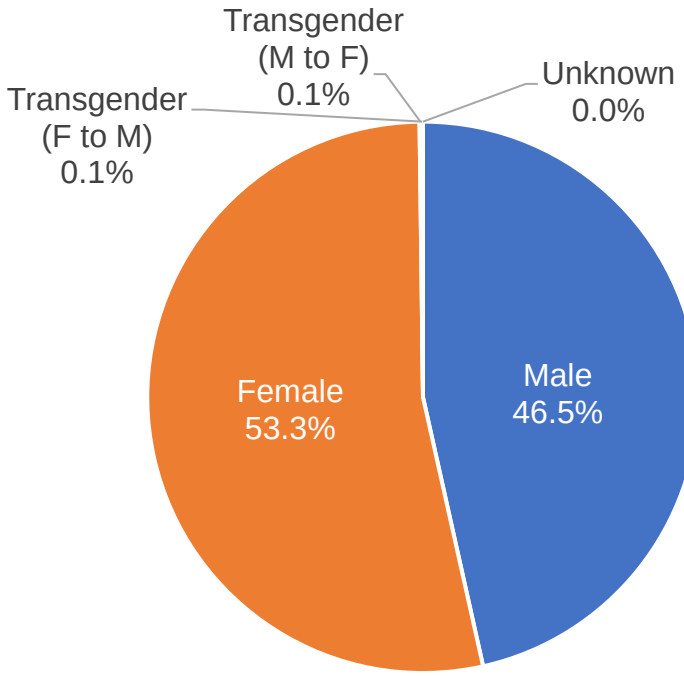


Figure 30 presents the distribution of gender among clients served in LACDMH outpatient clinics. At 53.3%, most clients are categorized as Female, Male at 46.5%, and Transgender or Unknown at less than 5%.

Table

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

SA	Gender					
	Male	Female	Transgender (M to F)	Transgender (F to M)	Unknown	Total
SA 1	7,863	9,844	22	15	5	17,749
Percent	**44.3%**	**55.5%**	0.12%	**0.08%**	0.03%	100.0%
SA 2	23,278	25,367	37	39	12	48,733
Percent	47.8%	52.1%	0.08%	**0.08%**	0.02%	100.0%
SA 3	22,146	25,210	22	38	7	47,423
Percent	46.7%	53.2%	0.05%	**0.08%**	**0.01%**	100.0%
SA 4	24,510	23,815	82	49	13	48,469
Percent	**50.6%**	**49.1%**	**0.17%**	0.10%	0.03%	100.0%
SA 5	6,833	7,075	11	20	6	13,945
Percent	49.0%	50.7%	0.08%	0.14%	**0.04%**	100.0%
SA 6	18,461	21,505	16	36	11	40,029
Percent	46.1%	53.7%	0.04%	0.09%	0.03%	100.0%
SA 7	14,317	17,458	8	30	4	31,817
Percent	45.0%	54.9%	**0.03%**	0.09%	**0.01%**	100.0%
SA 8	23,130	27,050	58	85	18	50,341
Percent	45.9%	53.7%	0.12%	**0.17%**	**0.04%**	100.0%
Total	97,554	112,014	183	201	53	210,005
Percent	46.5%	53.3%	0.09%	0.10%	0.03%	100.0%

Table 12 shows the gender distribution of clients served by SA. Bold values represent the highest and lowest percentages for each gender. The highest percentage of Males was in SA 4 (50.6%) compared to SA 1 (44.3%) with the lowest. The highest percentage of Females was in SA 1 (55.5%) compared to SA 4 (49.1%) with the lowest. With 82 clients, SA 4 had the highest number of clients identifying as Transgender (M to F); with 85 clients, SA 8 had the highest number of clients identifying as Transgender (F to M). Data Source: DMH IS/IBHIS, June 2023.

Summary

Females were the larger majority across all data sets.

Estimated Population at or Below 138% Federal Poverty Level

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

Table

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

SA	SA 1	Percent	SA 2	Percent	SA 3	Percent	SA 4	Percent
Arabic	406	0.42%	3,131	0.99%	1,089	0.46%	805	0.33%
Armenian	360	0.38%	26,737	8.43%	1,235	0.52%	3,565	1.45%
Cambodian	63	0.07%	121	**0.04%**	502	0.21%	308	**0.12%**
Cantonese	74	0.08%	482	0.15%	11,607	4.88%	2,700	1.10%
English	55,140	**57.66%**	111,830	35.25%	73,737	31.02%	71,134	28.85%
Farsi	97	0.10%	4,175	1.32%	281	0.12%	697	0.28%
Korean	224	0.23%	3,776	1.19%	2,359	0.99%	16,200	6.57%
Mandarin	58	0.06%	1,160	0.37%	15,803	6.65%	1,387	0.56%
Other Chinese	144	0.15%	2,244	0.71%	19,406	8.16%	5,668	2.30%
Russian	50	**0.05%**	4,373	1.38%	163	**0.07%**	2,422	0.98%
Spanish	34,541	36.12%	139,655	**44.03%**	93,792	**39.46%**	128,561	**52.14%**
Tagalog	404	0.42%	5,536	1.75%	2,928	1.23%	4,252	1.72%
Vietnamese	212	0.22%	3,452	1.09%	9,199	3.87%	1,548	0.63%
Others	3,852	4.03%	10,542	3.32%	5,580	2.35%	7,316	2.97%
Total	95,625	100.0%	317,214	100.0%	237,681	100.0%	246,563	100.0%

Table 13 shows Service Areas 1 through 4's estimated population living at or below 138% FPL whose primary language met the criteria of a threshold language for LACDMH. Bold values represent the highest and lowest language percentages for each SA. In SA 1, 93.8% of the estimated population at or below 138% FPL spoke English (57.66%) or Spanish (36.12%). The remaining 5% were spread among the other languages at a rate of 4.03% of the population or lower. In SA 2, 87.7% of the estimated population's primary language was Spanish (44.03%), English (35.25%), or Armenian (8.43%). In SA 3, 94.04% of the estimated population's primary language was Spanish (39.46%), English (31.02%), Other Chinese (8.16%), Mandarin (6.65%), Cantonese (4.88%), or Vietnamese (3.87%). In SA 4, 87.6% of the estimated population's primary language was Spanish (52.14%), English (28.85%) or Korean (6.57%).

Table

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

SA	SA 5	Percent	SA 6	Percent	SA 7	Percent	SA 8	Percent	Total	Percent
Arabic	700	1.02%	202	0.07%	1,243	0.62%	1,684	0.69%	9,260	0.54%
Armenian	376	0.55%	46	**0.02%**	479	0.24%	263	0.11%	33,061	1.92%
Cambodian	48	**0.07%**	83	0.03%	281	0.14%	2,945	1.20%	4,351	**0.25%**
Cantonese	603	0.88%	187	0.06%	406	0.20%	302	0.12%	16,361	0.95%
English	42,624	**61.86%**	83,054	27.22%	47,032	23.30%	102,124	41.64%	586,675	34.14%
Farsi	3,317	4.81%	203	0.07%	93	**0.05%**	441	0.18%	9,304	0.54%
Korean	990	1.44%	1,367	0.45%	1,482	0.73%	3,310	1.35%	29,708	1.73%
Mandarin	2,004	2.91%	762	0.25%	674	0.33%	790	0.32%	22,638	1.32%
Other Chinese	2,284	3.31%	1,993	0.65%	1,390	0.69%	1,670	0.68%	34,799	2.03%
Russian	850	1.23%	66	0.02%	107	0.05%	254	**0.10%**	8,285	0.48%
Spanish	10,974	15.93%	209,418	**68.63%**	141,323	**70.01%**	116,562	**47.52%**	874,826	**50.91%**
Tagalog	306	0.44%	411	0.13%	1,726	0.86%	4,080	1.66%	19,643	1.14%
Vietnamese	597	0.87%	468	0.15%	895	0.44%	2,533	1.03%	18,904	1.10%
Others	3,229	4.69%	6,896	2.26%	4,735	2.35%	8,326	3.39%	50,476	2.94%
Total	68,902	100.0%	305,156	100.0%	201,866	100.0%	245,284	100.0%	1,718,291	100.00%

Table 14 shows the grand totals and Service Areas 5 through 8's estimated population living at or below 138% FPL whose primary language met the criteria of a threshold language for LACDMH. Bold values represent the highest and lowest language percentages for each SA. In SA 5, 88.8% of the estimated population living at or below 138% FPL had English (61.86%), Spanish (15.93%), Farsi (4.81%), Other Chinese (3.31%) and Mandarin (2.91%) as their primary languages. In SA 6, 95.9% of the population's primary language was Spanish (68.63%) or English (27.22%). In SA 7, 93.3% of the estimated population's primary language was Spanish (70.01%) or English (23.30%). In SA 8, 89.2% of the estimated population Spanish (47.52%) or English (41.64%) was the primary language. Across all eight Service Areas, much of the estimated population had Spanish (50.91%) or English (34.14%) as their primary language.

Similarly, Spanish (52.45%) is the most common language among the estimated population living at or below 138% FPL estimated with SED or SMI, followed by English (35.18%).

Table

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

Service Area	SA 1	Percent	SA 2	Percent	SA 3	Percent	SA 4	Percent
Arabic	71	0.44%	545	1.02%	189	0.47%	140	0.34%
Armenian	63	0.39%	4,652	8.72%	215	0.53%	620	1.49%
Cambodian	11	0.07%	21	**0.04%**	87	0.22%	54	**0.13%**
Cantonese	13	0.08%	84	0.16%	2,020	5.00%	470	1.13%
English	9,594	**60.08%**	19,458	36.47%	12,830	31.77%	12,377	29.73%
Farsi	17	0.11%	726	1.36%	49	0.12%	121	0.29%
Korean	39	0.24%	657	1.23%	410	1.02%	2,819	6.77%
Mandarin	10	0.06%	202	0.38%	2,750	6.81%	241	0.58%
Other Chinese	25	0.16%	390	0.73%	3,377	8.36%	986	2.37%
Russian	9	**0.05%**	761	1.43%	28	**0.07%**	421	1.01%
Spanish	6,010	37.64%	24,300	**45.54%**	16,320	**40.41%**	22,370	**53.74%**
Tagalog	70	0.44%	963	1.81%	509	1.26%	740	1.78%
Vietnamese	37	0.23%	601	1.13%	1,601	3.96%	269	0.65%
Total	15,969	100.00%	53,361	100.00%	40,386	100.00%	41,629	100.00%

Table 15 presents SED and SMI prevalence for poverty estimates in Service Areas 1 through 4. Bold values represent the highest and lowest language percentages for each SA. In SA 1, prevalence and poverty estimates were the highest among those whose primary language was English (60.08%) and Spanish (37.64%). In SA 2, prevalence and poverty estimates were highest among those whose primary language was Spanish (45.54%), English (36.47%), and Armenian (8.72%). In SA 3, prevalence and poverty rates were highest for those whose primary language was Spanish (40.41%), English (31.77%), Cantonese (5.00%), Mandarin (6.81%), Vietnamese (3.96%), and Other Chinese (8.36%). In SA 4, prevalence and poverty estimates were the highest among those whose primary language was Spanish (53.74%), English (29.73%), Korean (6.77%), and Cantonese (1.13%).

Table

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

Service Area	SA 5	Percent	SA 6	Percent	SA 7	Percent	SA 8	Percent	Total	Percent
Arabic	122	1.07%	35	0.07%	216	0.63%	293	0.71%	1,611	0.56%
Armenian	65	0.57%	8	**0.02%**	83	0.24%	46	**0.11%**	5,753	1.98%
Cambodian	8	**0.07%**	14	0.03%	49	0.14%	512	1.24%	757	**0.26%**
Cantonese	105	0.92%	33	0.06%	71	0.21%	53	0.13%	2,847	0.98%
English	7,417	**64.90%**	14,451	27.85%	8,184	23.86%	17,770	43.10%	102,081	35.18%
Farsi	577	5.05%	35	0.07%	16	**0.05%**	77	0.19%	1,619	0.56%
Korean	172	1.51%	238	0.46%	258	0.75%	576	1.40%	5,169	1.78%
Mandarin	349	3.05%	133	0.26%	117	0.34%	137	0.33%	3,939	1.36%
Other Chinese	397	3.48%	347	0.67%	242	0.71%	291	0.70%	6,055	2.09%
Russian	148	1.29%	11	**0.02%**	19	**0.05%**	44	**0.11%**	1,442	0.50%
Spanish	1,909	16.71%	36,439	**70.21%**	24,590	**71.69%**	20,282	**49.19%**	152,220	**52.45%**
Tagalog	53	0.47%	72	0.14%	300	0.88%	710	1.72%	3,418	1.18%
Vietnamese	104	0.91%	81	0.16%	156	0.45%	441	1.07%	3,289	1.13%
Total	11,427	100.00%	51,897	100.00%	34,301	100.00%	41,231	100.00%	290,200	100.00%

Table 16 presents SED and SMI prevalence for poverty estimates in Service Areas 5 through 8. Bold values represent the highest and lowest language percentages for each SA. In SA 5, prevalence and poverty rates were the highest among those whose primary language was English (64.90%), Spanish (16.71%), Farsi (5.05%), Other Chinese (3.48%), and Mandarin (3.05%). In SA 6, prevalence and poverty rates were the highest among those whose primary language was Spanish (70.21%) and English (27.85%). In SA 7, prevalence and poverty rates were the highest among those whose primary language was Spanish (71.69%) and English (23.86%). In SA 8, prevalence and poverty rates were the highest among those whose primary language was Spanish (49.19%) and English (43.10%). Across all eight Service Areas, prevalence and poverty rates were the highest among those whose primary language was Spanish (52.45%), English (35.18%), and Other Chinese (2.09%).

Population Enrolled in Medi-Cal

In CY 2022, the majority of Medi-Cal eligible's primary language was English (57.8%) and Spanish (32.7%).

Figure

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

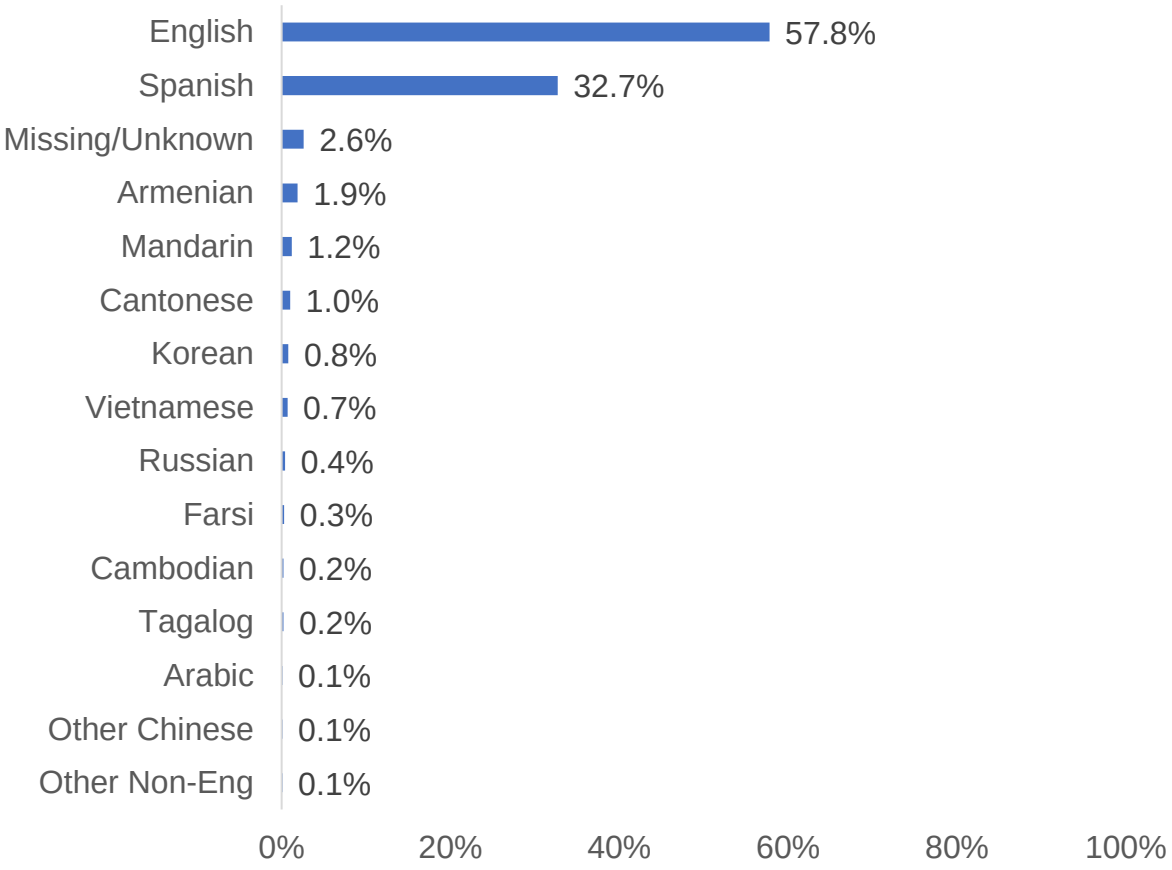


Figure 31 presents the distribution of languages by 5% or 3,000 Medical Eligibles. At 57.8%, most common language was English.

Table

17. Primary Languages of Clients Served in Outpatient LACDMH clinics in Service Areas 1 through 4, Fiscal Year 2021- 22

Language	SA 1	Percent	SA 2	Percent	SA 3	Percent	SA 4	Percent
Arabic	7	0.04%	68	0.1%	30	0.1%	26	0.1%
Armenian	13	0.08%	951	2.1%	73	0.2%	345	0.7%
Cambodian		0.00%	30	0.1%	129	0.3%	53	0.1%
Cantonese		0.00%	16	0.0%	662	1.5%	108	0.2%
English	16,040	93.20%	38,724	84.0%	36,544	81.3%	37,077	80.2%
Farsi	12	0.07%	572	1.2%	17	0.0%	51	0.1%
Korean		0.00%	82	0.2%	79	0.2%	649	1.4%
Mandarin	2	0.01%	18	0.0%	693	1.5%	84	0.2%
Other Chinese		0.00%	16	0.0%	80	0.2%	16	0.0%
Other Non-English	3	0.02%	17	0.0%	14	0.0%	8	0.0%
Russian	4	0.02%	100	0.2%	7	0.0%	216	0.5%
Spanish	1,124	6.53%	5,379	11.7%	6,131	13.6%	7,495	16.2%
Tagalog	6	0.03%	75	0.2%	36	0.1%	68	0.1%
Vietnamese		0.00%	56	0.1%	463	1.0%	42	0.1%
Total	17,211	100.00%	46,104	100.0%	44,958	100.0%	46,238	100.0%

Table 17 shows the distribution of primary languages for clients served in Service Areas 1 through 4. In SA 1, 93.2% of clients' primary language was English, 6.53% Spanish, and less than 4% Armenian, Arabic, Farsi, Russian, Tagalog, and Other Non-English languages. In SA 2, 84.0% of clients' primary language was English, 11.7% Spanish, 2.1% Armenian, 1.2% Farsi, and Other Non-English languages were at less than 1%. In SA 3, 81.3% of clients' primary language was English, 13.6% Spanish, 1.5% Cantonese or Mandarin, 1.0% Vietnamese, and Other Non-English languages were at less than 1%. In SA 4, 80.2% of clients' primary language was English, 16.2% Spanish, 1.4% Korean, 0.1% Vietnamese, and Other Non-English languages were at less than 1%. Note: "Threshold Language" means a language that has been identified as a primary language, as indicated on the MEDS file, from the 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. The table excludes Unknown address (N = 7,328). A total of consumers served in Outpatient Programs specified another non-threshold primary language shown in in Table 19. Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. Data Source: LACDMH-IS-IBHIS, June 2023.

Table

18. Primary Languages of Clients Served in Outpatient LACDMH Clinics in Services Areas 5 through 8 and Overall, Fiscal Year 2021-22

Language	SA 5	Percent	SA 6	Percent	SA 7	Percent	SA 8	Percent	Total	Percent
Arabic	13	0.1%	3	0.01%	16	0.05%	23	0.05%	155	0.1%
Armenian	14	0.1%	23	0.06%	3	0.01%	40	0.08%	1,196	0.6%
Cambodian	2	0.0%		0.00%	25	0.08%	572	1.19%	746	0.4%
Cantonese	7	0.1%	6	0.02%	7	0.02%	22	0.05%	535	0.3%
English	12,051	91.4%	32,641	84.13%	24,810	79.30%	41,217	85.73%	163,835	82.3%
Farsi	139	1.1%	9	0.02%	2	0.01%	21	0.04%	693	0.3%
Korean	10	0.1%	20	0.05%	45	0.14%	87	0.18%	780	0.4%
Mandarin	7	0.1%	4	0.01%	31	0.10%	36	0.07%	562	0.3%
Other Chinese	2	0.0%	1	0.00%	11	0.04%	12	0.02%	103	0.1%
Other Non-English	2	0.0%	1	0.00%	2	0.01%	9	0.02%	40	0.0%
Russian	41	0.3%	5	0.01%		0.00%	17	0.04%	332	0.2%
Spanish	881	6.7%	6,065	15.63%	6,301	20.14%	5,813	12.09%	29,229	14.7%
Tagalog	8	0.1%	9	0.02%	24	0.08%	76	0.16%	245	0.1%
Vietnamese	7	0.1%	10	0.03%	10	0.03%	130	0.27%	543	0.3%
Total	13,184	100.0%	38,797	100.00%	31,287	100.00%	48,075	100.00%	198,994	100.0%

Table 18 shows the distribution of primary languages for clients served in Service Areas 5 to 8. In SA 5, 91.4% of clients' primary language was English, 6.7% Spanish, and 1.1% Farsi languages. In SA 6, 84.1% English, and 15.6% Spanish. In SA 7, 79.3% of clients' primary language was English, and 20.1% Spanish. In SA 8, 85.7% identified English, 12.1% Spanish, and 1.2% Cambodian languages. Overall, English was primary language at 82.3%, and Spanish was at 14.7%. The remaining 3.0% identified other Non-English languages. Note: "Threshold Language" means a language that has been identified as a primary language, as indicated on the MEDS file, from the 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. Table excludes Unknown address (N = 7,328). A total of consumers served in Outpatient Programs specified another non-threshold primary language show in in Table 19. Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. Data Source: LACDMH-IS-IBHIS, June 2023.

Table

19. Other Non-English Languages for Clients Served in LACDMH Outpatient Clinics, Fiscal Year 2021-22

Languages	SA 1	SA 2	SA 3	SA 4	SA 5	SA 6	SA 7	SA 8	Total
Afghan, Pashto, Pusho		18		1				1	19
Percent	0.00%	0.12%	0.00%	0.01%	0.00%	0.00%	0.00%	0.01%	0.02%
American Sign Language	9	9	15	11	6	7	7	17	70
Percent	0.90%	0.06%	0.07%	0.07%	0.14%	0.28%	0.16%	0.12%	0.09%
Burmese		2	12	2		1		3	13
Percent	0.00%	0.01%	0.06%	0.01%	0.00%	0.04%	0.00%	0.02%	0.02%
Ethiopian		2	4	30	4	4	5	11	33
Percent	0.00%	0.01%	0.02%	0.19%	0.10%	0.16%	0.12%	0.08%	0.04%
French		7	2	7	3	1		2	20
Percent	0.00%	0.05%	0.01%	0.04%	0.07%	0.04%	0.00%	0.01%	0.03%
Hebrew		13	1	3	5	2	2	1	17
Percent	0.00%	0.09%	0.00%	0.02%	0.12%	0.08%	0.05%	0.01%	0.02%
Hindi	1	5	3	1	2	1	4	7	22
Percent	0.10%	0.03%	0.01%	0.01%	0.05%	0.04%	0.09%	0.05%	0.03%
Japanese		6	4	38	6	1	2	39	78
Percent	0.00%	0.04%	0.02%	0.24%	0.14%	0.04%	0.05%	0.28%	0.10%
Lao			28	3				12	43
Percent	0.00%	0.00%	0.14%	0.02%	0.00%	0.00%	0.00%	0.09%	0.06%
Portuguese		11	3	8	8	4	2	9	32
Percent	0.00%	0.07%	0.01%	0.05%	0.19%	0.16%	0.05%	0.07%	0.04%
Punjabi		6		1		2	4	1	10
Percent	0.00%	0.04%	0.00%	0.01%	0.00%	0.08%	0.09%	0.01%	0.01%
Romanian		2	1	3			1		6
Percent	0.00%	0.01%	0.00%	0.02%	0.00%	0.00%	0.02%	0.00%	0.01%
Thai		24	19	22			3	7	63
Percent	0.00%	0.16%	0.09%	0.14%	0.00%	0.00%	0.07%	0.05%	0.085
Toisan		1	17	2					14
Percent	0.00%	0.01%	0.08%	0.01%	0.00%	0.00%	0.00%	0.00%	0.02%
Urdu		12	3	2	4			7	22
Percent	0.00%	0.08%	0.01%	0.01%	0.10%	0.00%	0.00%	0.05%	0.03%
Other Chinese		16	80	16	2	1	11	12	103
Percent	0.00%	10.60%	38.83%	10.13%	4.76%	4.00%	25.58%	8.70%	13.32%
Other Non - English		17	14	8	2	1	2	9	40
Percent	0.00%	11.26%	6.80%	5.06%	4.76%	4.00%	4.65%	6.52%	5.17%
Total	10	151	206	158	42	25	43	138	773
Percent	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table 19 shows the percentage of clients served whose primary language was “Other non-English” by Service Area. American Sign Language (ASL) was the preferred language of clients in SA 1 (0.90%) the most, followed by SA 6 (0.28%) and SA7 (0.16%). Data Source: LACDMH-IS-IBHIS, 2023. Row total is for unduplicated count of Consumers Non - Threshold language.

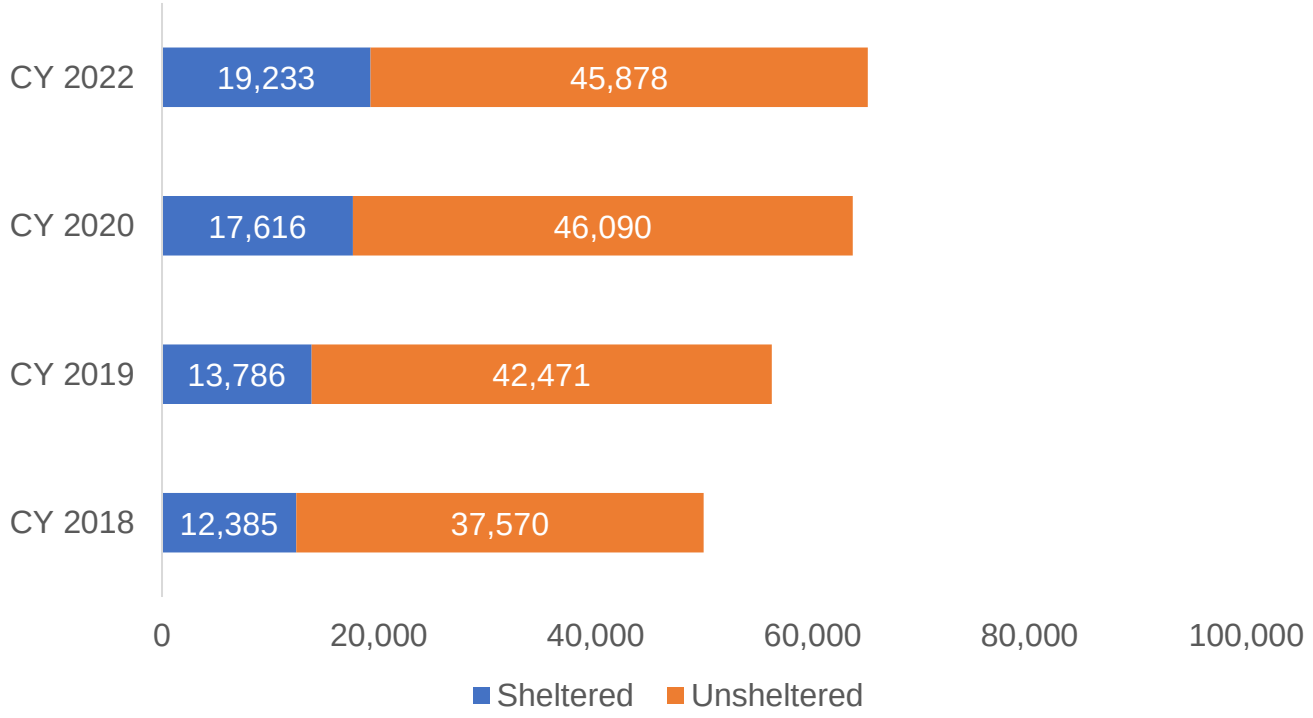
Los Angeles Homeless Services Authority's 2022 Greater Los Angeles Homeless Counts

The Los Angeles Homeless Services Authority's (LAHSA) results of the 2022 Greater Los Angeles Homeless Count showed 69,144 individuals in Los Angeles County were experiencing homelessness reflecting a 4% increase from 2020-2022.

Los Angeles County data includes the Los Angeles Continuum of Care, and the cities of Pasadena, Glendale, and Long Beach. Data from the 2022 Greater Los Angeles Point-In-Time Count estimate the number and demographic characteristics of the homeless population on a single night in February 2022. Due to the impact of the COVID-19 pandemic, a homeless count was not conducted in 2021.

Figure

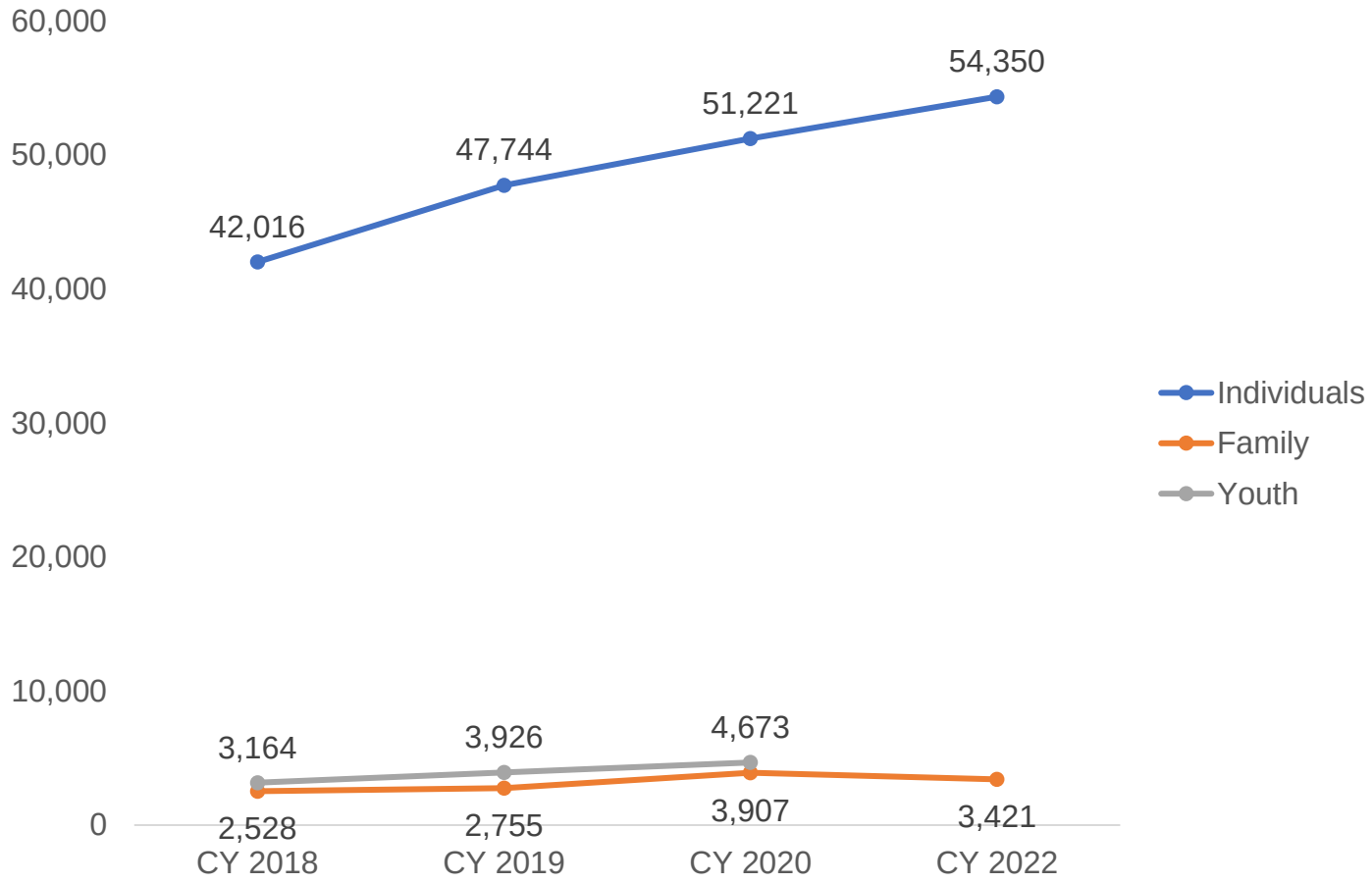
32. Five-year Trend for Sheltered versus Unsheltered Individuals Experiencing Homelessness



Note: Data reflects individuals ages 18 years and older and households with no adults over age18 years (unaccompanied minors). The Homeless Count was not conducted in CY 2021 due to the COVID-19 pandemic. Data source: Los Angeles Homeless Services Authority (LAHSA) Homeless Count by Service Planning Area 2015-2022 Dashboard. Retrieved from https://www.lahsa.org/data?id=51-homeless-count-by-service-planning-area-2015-2022 in May 2024.

Figure

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



Note: There was no homeless count during CY 2021. Youth data was not available for CY 2022. Data source: Individual and Family Homeless Count by Service Planning Area 2015-2022 Dashboard. Retrieved from https://www.lahsa.org/data?id=51-homeless-count-by-service-planning-area-2015-2022 in May 2024. Youth Count by Supervisorial District (SD) Dashboard. Retrieved from https://www.lahsa.org/data?id=36-youth-count-by-supervisorial-district-sd- in May 2024.

The number of individuals and youth experiencing homelessness trends upward from 2018-2022. For family members there is an upward trend from 2018-2020, with a decline from 2020-2022. Over the past five years, the number of individuals experiencing homelessness showed the most significant increase between 2020 and 2022. Youth has shown a steady increase from 2018 to 2020.

Penetration Rates, Fiscal Year 2021-22

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

Differences by Ethnicity

Table

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

Ethnicity and SA	Number of Clients Served[1]	Total Population Estimated with SED and SMI[3]	Penetration Rates for Total Population[2]	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3]	Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2]
SA 1					
African American	3,772	9,388	40.2%	3,240	116.4%
Asian/Pacific Islander	104	2,384	4.4%	502	20.7%
Latino	2,842	35,653	8.0%	8,800	32.3%
Native American	50	233	21.5%	70	71.0%
White	2,374	2,608	91.0%	4,198	56.5%
Two or more races	501	23,002	2.2%	526	95.2%
Total	9,643	73,266	13.2%	17,336	55.6%
SA 2					
African American	3,575	11,936	30.0%	2,118	168.8%
Asian/Pacific Islander	991	37,235	2.7%	5,989	16.5%
Latino	10,930	140,848	7.8%	26,039	42.0%
Native American	101	559	18.1%	58	173.3%
White	7,379	13,202	55.9%	24,979	29.5%
Two or more races	910	204,397	0.4%	1,159	78.5%
Total	23,886	408,178	5.9%	60,342	39.6%
SA 3					
African American	2,742	8,137	33.7%	1,212	226.2%
Asian/Pacific Islander	2,606	78,240	3.3%	13,071	19.9%
Latino	8,097	130,650	6.2%	20,986	38.6%
Native American	114	466	24.4%	36	315.0%
White	3,798	7,127	53.3%	6,415	59.2%
Two or more races	1,069	67,838	1.6%	441	242.5%
Total	18,426	292,458	6.3%	42,161	43.7%

[1]Number of Clients Served represents clients served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include clients served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps, and Inpatient-Fee-For Service and County Hospitals. [2]Penetration Rate = Number of Consumers Served / Number of

People Estimated with SED & SMI. * Duplicated clients by ethnicity/unduplicated consumers by ethnicity (13,122/26,386 = 46.5% for African Americans). [3]SED and SMI = Severe Emotional Disturbance and Severe Mental Illness. Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2020-2021 pooled.

Table

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

Ethnicity and SA	Number of Clients Served[1]	Total Population Estimated with SED and SMI[3]	Penetration Rates for Total Population[2]	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3]	Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2]
SA 4					
African American	6,304	9,240	68.2%	2,528	249.4%
Asian/Pacific Islander	1,757	27,023	6.5%	7,964	22.1%
Latino	12,231	84,131	14.5%	22,308	54.8%
Native American	206	365	56.5%	127	162.4%
White	4,708	6,227	75.6%	10,605	44.4%
Two or more races	721	68,147	1.1%	990	72.8%
Total	25,927	195,132	13.3%	44,521	58.2%
SA 5					
African American	2,097	4,984	42.1%	674	311.3%
Asian/Pacific Islander	270	13,163	2.1%	2,042	13.2%
Latino	1,894	17,016	11.1%	2,129	89.0%
Native American	49	153	32.0%	8	640.0%
White	2,733	6,465	42.3%	9,075	30.1%
Two or more races	327	87,989	0.4%	538	60.7%
Total	7,370	129,769	5.7%	14,466	50.9%
SA 6					
African American	10,500	34,865	30.1%	12,637	83.1%
Asian/Pacific Islander	205	3,467	5.9%	1,548	13.2%
Latino	8,846	114,228	7.7%	35,119	25.2%
Native American	254	239	106.1%	114	222.2%
White	1,166	3,217	36.2%	1,418	82.2%
Two or more races	448	7,290	6.1%	857	52.3%
Total	21,419	163,307	13.1%	51,694	41.4%

[1]Number of Clients Served represents clients served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include clients served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps, and Inpatient-Fee-For Service and County Hospitals. [2]Penetration Rate = Number of Consumers Served / Number of People Estimated with SED & SMI. * Duplicated clients by ethnicity/unduplicated consumers by ethnicity (13,122/26,386 = 46.5% for African Americans). [3]SED and SMI = Severe Emotional Disturbance and Severe Mental Illness. Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2020-2021 pooled.

Table

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

Ethnicity and SA	Number of Clients Served[1]	Total Population Estimated with SED and SMI[3]	Penetration Rates for Total Population[2]	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3]	Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2]
SA 7					
African American	1,185	5,813	20.4%	853	139.0%
Asian/Pacific Islander	458	18,447	2.5%	2,103	21.8%
Latino	9,145	154,531	5.9%	27,884	32.8%
Native American	176	447	39.4%	47	377.4%
White	1,968	3,434	57.3%	10,532	18.7%
Two or more races	673	31,041	2.2%	156	431.5%
Total	13,605	213,712	6.4%	41,575	32.7%
SA 8					
African American	7,949	31,047	25.6%	7,934	100.2%
Asian/Pacific Islander	1,741	35,251	4.9%	5,906	29.5%
Latino	10,255	103,324	9.9%	21,034	48.8%
Native American	115	511	22.5%	101	113.6%
White	4,703	11,200	42.0%	7,967	59.0%
Two or more races	1,087	87,103	1.2%	1,139	95.5%
Total	25,850	268,437	9.6%	44,082	58.6%
Unduplicated Clients Served in at least 1 Service Area.					
African American	26,386	115,410	22.9%	31,195	84.6%
Asian/Pacific Islander	5,994	215,208	2.8%	39,125	15.3%
Latino	45,003	780,380	5.8%	164,298	27.4%
Native American	827	2,974	27.8%	562	147.2%
White	20,503	53,481	38.3%	67,206	30.5%
Two or more races	3,756	576,806	0.7%	5,807	64.7%
Total	**102,469**	**1,744,259**	**5.9%**	**308,193**	**33.2%**

Duplicated Countywide Clients Served in More Than One Service Area*		
	Total Clients Served	**Percent Clients Served**
African American	13,122	49.7%
Asian/Pacific Islander	2,297	38.3%
Latino	20,515	45.6%
Native American	264	31.9%
White	9,333	45.5%
Two or more races	2,109	56.2%
Total	47,640	46.5%

[1]Number of Clients Served represents clients served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include clients served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps, and Inpatient-Fee-For Service and County Hospitals. [2]Penetration Rate = Number of Consumers Served / Number of People Estimated with SED & SMI. * Duplicated clients by ethnicity/unduplicated consumers by ethnicity (13,122/26,386 = 46.5% for African Americans). [3]SED and SMI = Severe Emotional Disturbance and Severe Mental Illness. Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2020-2021 pooled.

Differences by Age

Table

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

Age Group (Years) and SA	Number of Clients Served[1]	Total Population Estimated with SED and SMI[3]	Penetration Rates for Total Population[2]	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3]	Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2]
SA 1					
0-18	7,772	42,090	18.5%	9,878	78.7%
19-20	554	3,769	14.7%	615	90.1%
21-25	1,022	9,744	10.5%	2,195	46.6%
26-59	7,046	26,820	26.3%	5,613	125.5%
60-64	795	2,030	39.2%	515	154.5%
65 and above	560	2,327	24.1%	824	68.0%
Total	17,749	86,779	20.5%	19,639	90.4%
SA 2					
0-18	17,114	168,848	10.1%	24,119	71.0%
19-20	1,851	15,728	11.8%	1,775	104.3%
21-25	3,258	39,461	8.3%	6,277	51.9%
26-59	21,246	155,527	13.7%	2,643	803.8%
60-64	2,794	12,001	23.3%	1,945	143.6%
65 and above	2,470	16,618	14.9%	3,836	64.4%
Total	48,733	408,183	11.9%	40,595	120.0%
SA 3					
0-18	22,234	132,325	16.8%	18,164	122.4%
19-20	2,361	14,217	16.6%	1,417	166.6%
21-25	3,204	33,594	9.5%	4,967	64.5%
26-59	15,739	119,448	13.2%	1,902	827.5%
60-64	1,944	9,446	20.6%	1,400	138.9%
65 and above	1,941	14,392	13.5%	3,386	57.3%
Total	47,423	323,422	14.7%	31,236	151.8%

[1]Number of Clients Served represents clients served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include clients served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps, Inpatient Fee-For-Service, and County Hospitals. [2]Penetration Rate = Number of Clients Served / Number of People Estimated with SED & SMI. * Duplicated clients by age/unduplicated clients by age (For example, 46,060/78,055 = 59.0% for ages 0-18). [3]SED and SMI = Severe Emotional Disturbance and Severe Mental Illness. Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2020-2021 pooled.

Table

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

Age Group (Years) and SA	Number of Clients Served[1]	Total Population Estimated with SED and SMI[3]	Penetration Rates for Total Population[2]	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3]	Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2]
SA 4					
0-18	17,350	67,025	25.9%	16,481	105.3%
19-20	1,600	6,887	23.2%	1,180	135.5%
21-25	2,967	16,856	17.6%	4,183	70.9%
26-59	20,514	91,550	22.4%	1,841	1114.1%
60-64	2,873	5,201	55.2%	1,355	212.0%
65 and above	3,165	7,774	40.7%	3,223	98.2%
Total	48,469	195,294	24.8%	28,264	171.5%
SA 5					
0-18	3,832	38,288	10.0%	3,014	127.1%
19-20	430	7,092	6.1%	496	86.7%
21-25	760	11,319	6.7%	2,204	34.5%
26-59	6,701	49,442	13.6%	5,477	122.4%
60-64	1,103	3,372	32.7%	392	281.1%
65 and above	1,119	5,638	19.8%	941	118.9%
Total	13,945	115,151	12.1%	12,524	111.3%
SA 6					
0-18	17,964	98,562	18.2%	31,332	57.3%
19-20	1,420	10,577	13.4%	2,168	65.5%
21-25	2,066	23,858	8.7%	7,340	28.1%
26-59	14,867	69,267	21.5%	18,758	79.3%
60-64	2,023	4,041	50.1%	1,404	144.0%
65 and above	1,689	4,872	1.0%	2,210	76.4%
Total	40,029	211,177	19.0%	63,213	63.3%

[1]Number of Clients Served represents clients served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include clients served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps, Inpatient Fee-For-Service, and County Hospitals. [2]Penetration Rate = Number of Clients Served / Number of People Estimated with SED & SMI. * Duplicated clients by age/unduplicated clients by age (For example, 46,060/78,055 = 59.0% for ages 0-18). [3]SED and SMI = Severe Emotional Disturbance and Severe Mental Illness. Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2020-2021 pooled.

Table

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

Age Group (Years) and SA	Number of Clients Served[1]	Total Population Estimated with SED and SMI[3]	Penetration Rates for Total Population[2]	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3]	Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2]
SA 7					
0-18	15,936	110,590	14.4%	19,371	82.3%
19-20	1,456	10,870	13.4%	1,229	118.5%
21-25	1,986	27,147	7.3%	4,258	46.6%
26-59	10,284	88,350	11.6%	12,754	80.6%
60-64	1,011	5,774	17.5%	988	102.3%
65 and above	1,144	8,411	13.6%	1,942	58.9%
Total	31,817	251,143	12.7%	40,542	78.5%
SA 8					
0-18	20,684	110,590	18.7%	20,993	98.5%
19-20	1,813	10,870	16.7%	1,457	124.4%
21-25	2,830	27,147	10.4%	5,039	56.2%
26-59	20,181	88,350	22.8%	16,332	123.6%
60-64	2,562	5,774	44.4%	1,406	182.2%
65 and above	2,271	8,411	27.0%	2,641	86.0%
Total	50,341	251,143	20.0%	47,869	105.2%
Unduplicated Clients Served in At least 1 Service Area					
0-18	78,055	780,980	10.0%	143,351	54.5%
19-20	7,834	81,002	9.7%	10,338	75.8%
21-25	12,730	190,951	6.7%	36,462	34.9%
26-59	86,714	708,025	12.2%	115,641	75.0%
60-64	12,501	50,076	25.0%	9,406	132.9%
65 and above	12,171	71,449	17.0%	19,003	64.0%
Total	210,005	1,882,484	11.2%	334,201	62.8%

Duplicated Countywide Clients Served in More Than One Service Area*		
	Total Clients Served	Percent Clients Served
0-18	46,060	59.0%
19-20	3,925	50.1%
21-25	5,767	45.3%
26-59	34,658	40.0%
60-64	3,560	28.5%
65 and above	2,632	21.6%
Total	96,602	46.0%

[1]Number of Clients Served represents clients served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include clients served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps, Inpatient Fee-For-Service, and County Hospitals. [2]Penetration Rate = Number of Clients Served / Number of People Estimated with SED & SMI. * Duplicated clients by age/unduplicated clients by age (For example, 46,060/78,055 = 59.0% for ages 0-18). [3]SED and SMI = Severe Emotional Disturbance and Severe Mental Illness. Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2020-2021 pooled.

Differences by Gender

Table

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

Gender Group and Service Area	Number of Clients Served[1]	Total Population Estimated with SED and SMI[3]	Penetration Rates for Total Population[2]	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3]	Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2]
SA 1					
Male	7,863	28,206	27.9%	6,590	119.3%
Female	9,844	38,975	25.3%	9,932	99.1%
Total	17,707	67,181	26.4%	16,521	107.2%
SA 2					
Male	23,278	148,710	15.7%	21,855	106.5%
Female	25,367	204,660	12.4%	32,952	77.0%
Total	48,645	353,370	13.8%	54,807	88.8%
SA 3					
Male	22,146	116,538	19.0%	16,138	137.2%
Female	25,210	165,515	15.2%	24,987	100.9%
Total	47,356	251,773	18.8%	41,125	115.2%
SA 4					
Male	24,510	78,464	31.2%	17,552	139.6%
Female	23,815	98,836	24.1%	24,907	95.6%
Total	48,325	177,300	27.3%	42,459	113.8%
SA 5					
Male	6,833	43,738	15.6%	4,652	146.9%
Female	7,075	62,867	11.3%	7,277	97.2%
Total	13,908	106,604	13.0%	11,929	116.6%

[1]Number of Clients Served represents clients served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include clients served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps, Inpatient Fee-For-Service, and County Hospitals. [2]Penetration Rate = Number of Clients Served / Number of People Estimated with SED & SMI. * Duplicated clients by age/unduplicated clients by age (For example, 47,922/97,554 = 49.1% for ages Male). [3]SED and SMI = Severe Emotional Disturbance and Severe Mental Illness. Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2020-2021 pooled.

Table

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

Gender Group and Service Area	Number of Clients Served[1]	Total Population Estimated with SED and SMI[3]	Penetration Rates for Total Population[2]	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI[3]	Penetration Rates for Population Living at or Below 138% Federal Poverty Level[2]
SA 6					
Male	18,461	67,670	27.3%	21,005	87.9%
Female	21,505	95,227	22.6%	31,723	67.8%
Total	39,966	145,820	27.4%	52,728	75.8%
SA 7					
Male	14,317	85,907	16.7%	13,674	104.7%
Female	17,458	119,998	14.5%	21,263	82.1%
Total	31,775	205,905	15.4%	34,936	91.0%
SA 8					
Male	23,130	103,320	22.4%	16,746	138.1%
Female	27,050	145,541	18.6%	25,671	105.4%
Total	50,180	248,862	20.2%	42,417	118.3%
Unduplicated Clients Served in At least 1 Service Area					
Male	97,554	672,553	14.5%	118,211	82.5%
Female	112,014	931,619	12.0%	178,711	62.7%
Total	209,568	1,604,172	13.1%	296,923	70.6%

Duplicated Countywide Clients Served in More Than One Service Area*		
	Total Clients Served	**Percent Clients Served**
Male	47,922	49.1%
Female	48,456	43.3%
Total	96,378	46.0%

[1]Number of Clients Served represents clients served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include clients served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps, Inpatient Fee-For-Service, and County Hospitals. [2]Penetration Rate = Number of Clients Served / Number of People Estimated with SED & SMI. * Duplicated clients by age/unduplicated clients by age (For example, 47,922/97,554 = 49.1% for ages Male). [3]SED and SMI = Severe Emotional Disturbance and Severe Mental Illness. Data Source for Prevalence Rate: California Health Interview Survey (CHIS) 2020-2021 pooled.

Penetration Rate Changes for Medi-Cal Beneficiaries

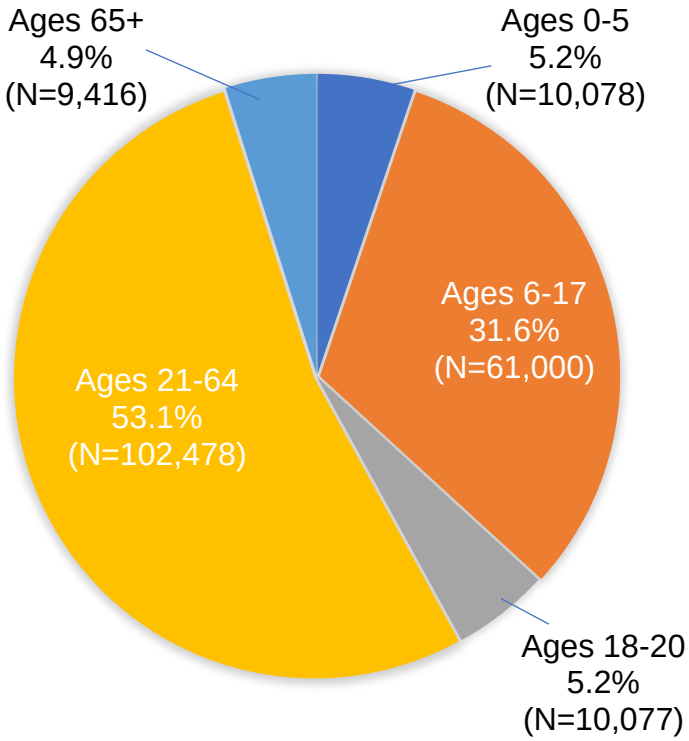
The Mental Health Services Division at DHCS contracts with Behavioral Health Concepts, Inc. (BHC) to provide CalEQRO services for California's MHPs. Information on Medi-Cal beneficiaries served, and penetration rates represent two of the seven performance measures summarized in their annual BHC CalEQRO Validation of Performance Measures (PM) Report. Reports are made public and accessible via their CalEQRO for Medi-Cal Specialty Mental Health Services website.

The Department refers to the BHC reports for penetration rate changes and trends by age group and race/ethnicity. Of note, the penetration rates that follow are limited to the Medi-Cal enrolled population of clients served. BHC calculates penetration rate by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The County's total number of yearly unduplicated Medi-Cal eligibles for CY 2021 is 4,156,251 and includes the population eligible through Affordable Care Act (ACA) Expansion. Los Angeles County has consistently had a higher PR during the last three years than other large counties and the statewide rate.

Differences by Age Group

Figure

34. Age Group Distribution for Medi-Cal Beneficiaries Served, Calendar Year 2021

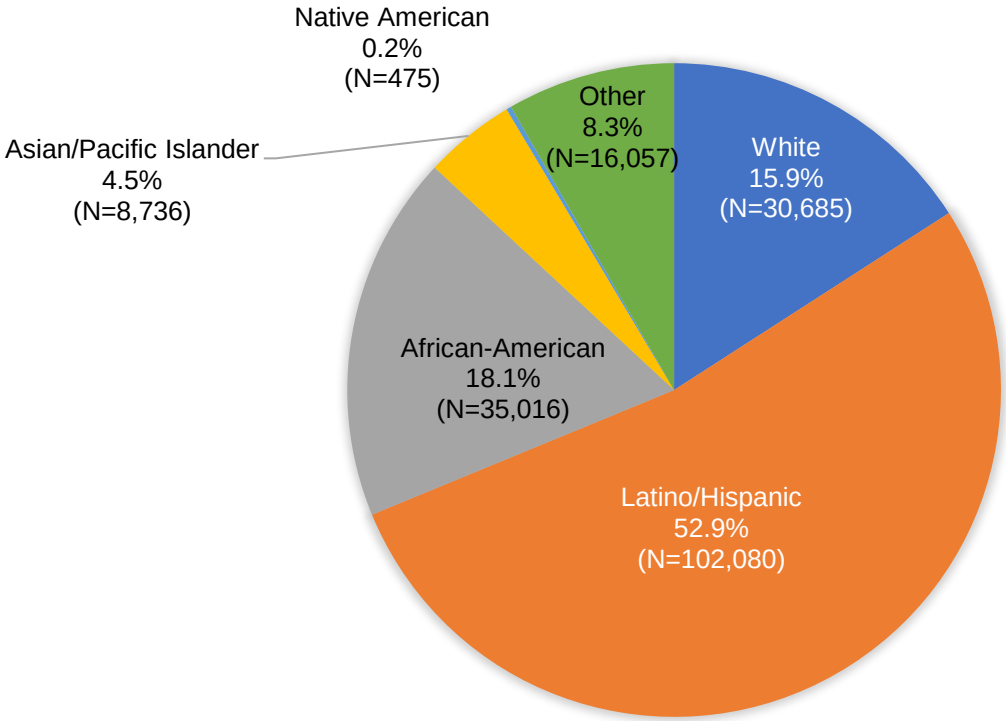


Note: Trend data is not available as age group data was not reported for Medi-Cal beneficiaries in the FY 2020-21 and FY 2021-22 reports. Data source: FY 2022-23 Medi-Cal Specialty Mental Health External Quality Review Los Angeles Mental Health Plan (MHP) Final Report.

Differences by Race Ethnicity

Figure

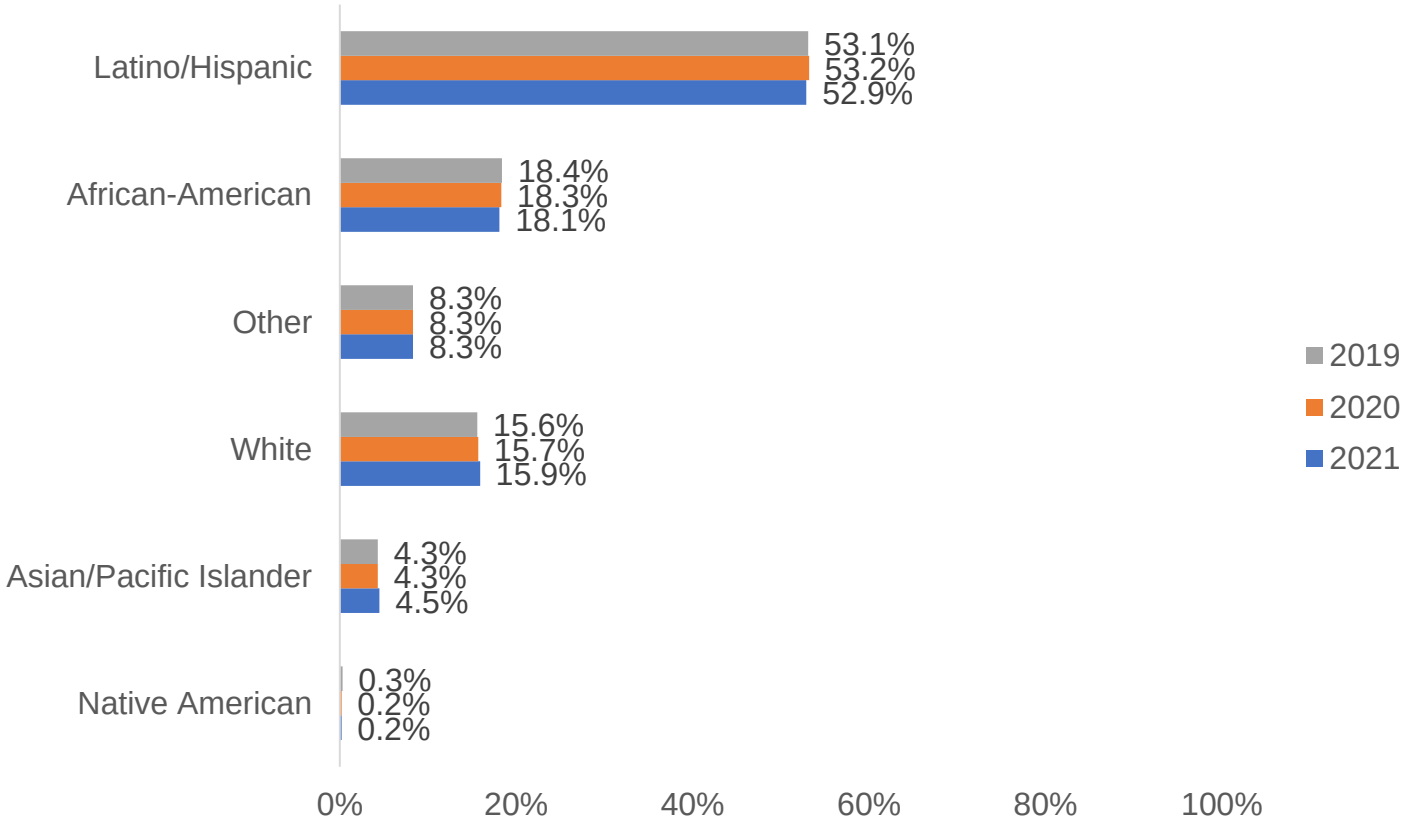
35. Race/Ethnicity Distribution for Medi-Cal Beneficiaries Served, Calendar Year 2021



Data source: FY 2022-23 Medi-Cal Specialty Mental Health External Quality Review Los Angeles Mental Health Plan (MHP) Final Report.

Figure

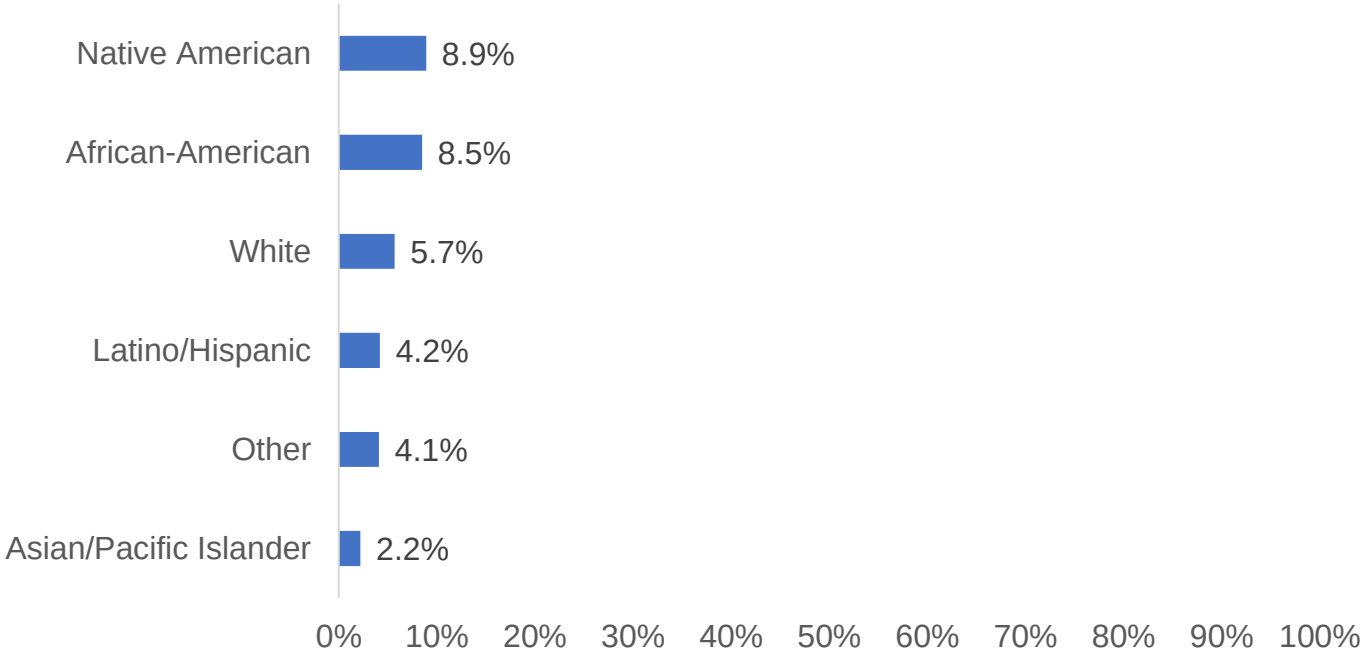
36. Three-Year Trend in Medi-Cal Beneficiaries Served by Race/Ethnicity, Calendar Years 2019-2021



Note: Data for Medi-Cal beneficiaries served was reported a year behind in the EQR reports. Data source: FY 2020-21, FY 2021-22, and FY 2022-23 Medi-Cal Specialty Mental Health External Quality Review Los Angeles Mental Health Plan (MHP) Final Reports.

Figure

37. Penetration Rates by Race/Ethnicity, Calendar Year 2021



Note: Trend data is not available as penetration rates by race/ethnicity was not reported for Medi-Cal beneficiaries in the FY 2020-21 and FY 2021-22 reports. Data source: FY 2022-23 Medi-Cal Specialty Mental Health External Quality Review Los Angeles Mental Health Plan (MHP) Final Report.

Summary

For CY 2021, ages 21 - 64 years make up the largest portion of Medi-Cal beneficiaries served in LA County. Ages 65+ are the smallest group served. Hispanics/Latinos comprised 52.9% of the beneficiaries served by LACDMH, followed by African Americans and Whites. Rates of Medi-Cal beneficiaries served are trending downward for Latino/Hispanic and African American communities from 2019-2021. The White community appears to be trending upward over the last three years. Native American and African American communities had the highest penetration rates. Asian/Pacific Islander and Other communities had the lowest penetration rates.

Section III. Quality Assessment and Performance Improvement Work Plan Evaluation Report

Quality Assessment and Performance Improvement Work Plan Evaluations, Calendar Year 2022

QAPI Work Plan goals are set to monitor and evaluate the service delivery system's access, timeliness, and quality. Under the MHP's reporting requirements of the CCR Title 9, Chapter 11, Section 1810.440, concerning QI, the Department's evaluation of QAPI activities is structured and organized according to the following domains:

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

The QAPI Work Plan Evaluation report assesses the 13 goals and 28 objectives identified in the QAPI Work Plan for CY 2022. These goals were established, monitored, and evaluated by the QI Unit. The CY 2022 QAPI Work Plan goals focused on increasing services for individuals from underserved groups by targeting clients and community members from Asian, Black/African American, and Native Hawaiian/Pacific Islander communities, ensuring timely access to care and resources for potential and would-be clients, using client/family feedback and concerns to drive outpatient service priorities, improve tracking and monitoring services for clinical services using HEDIS measures, and improving tracking mechanisms for rehospitalization, beneficiary grievances, and continuous quality improvement for beneficiary services. The QI Unit partnered with the Department's Cultural Competency Unit, Chief Information Office Bureau, Intensive Care Division, Outpatient Services Division, Psychiatry, and Pharmacy Services, Patients' Rights Office, Quality, Outcomes, and Training Division, QI Council, SA QICs, and the multidisciplinary PIP teams to accomplish meaningful change. The evaluation of the QAPI Work Plan provides a basis for establishing goals and objectives for CY 2023.

Table

28. Quality Assessment and Performance Improvement Work Plan Goals and Year to Date Status, Calendar Year 2022

Domain	No.	Goal	Status Year-to-Date (Per Objective)
SERVICE DELIVERY CAPACITY	Ia.	Analyze root causes in the underrepresentation of self-identified Asian, Black/African Americans, and Native Hawaiian/Pacific Islanders receiving DMH services.	**MET**
	Ib.	Share findings on the Department's capacity to deliver culture-specific services.	**MET**
	Ic.	Maintain the number of clients receiving telehealth services.	**MET**
ACCESSIBILITY OF SERVICES	II.	DMH will meet 80% of initial requests for outpatient SMHS with a timely appointment.	**PARTIALLY MET**
BENEFICIARY SATISFACTION	IIIa.	Evaluate findings and develop data-driven improvement strategies at the Service-Area level.	**PARTIALLY MET**
	IIIb.	Monitor grievances, appeals, and requests for a Change of Provider.	**MET**
CLINICAL CARE	IVa.	Rollout Child and Adolescent Needs and Strengths – 50 (CANS-50) and Pediatric Symptom Checklist-35 (PSC-35) aggregate reporting to support children and youth program operations.	**PARTIALLY MET**
	IVb.	Develop and refine processes to enhance provider knowledge surrounding documentation and claiming-related requirements associated with the provision of Medi-Cal SMHS.	**PARTIALLY MET**
	IVc.	Develop a mechanism to measure and track HEDIS Measures for children and youth.	**MET**

	IVd.	Review common clinical tools and identify modifications that would best meet the needs of LACDMH's adult population.	**MET**
CONTINUITY OF CARE	V.	Develop a systemwide strategy to reduce 7 and 30-day rehospitalization rates.	**MET**
PROVIDER APPEALS	VI.	Monitor Provider Appeals.	**MET**
PERFORMANCE IMPROVEMENT PROJECTS	VII.	Develop and implement two (clinical, administrative) data-driven performance improvement projects to improve client access, service quality, timely access to care, or information systems with direct beneficiary impact.	**MET**

Note: Goals and objectives above cover the Fiscal Year 2021-22 and Calendar Year 2022 reporting periods.

Monitoring Service Delivery Capacity, Calendar Year 2022

Service Equity

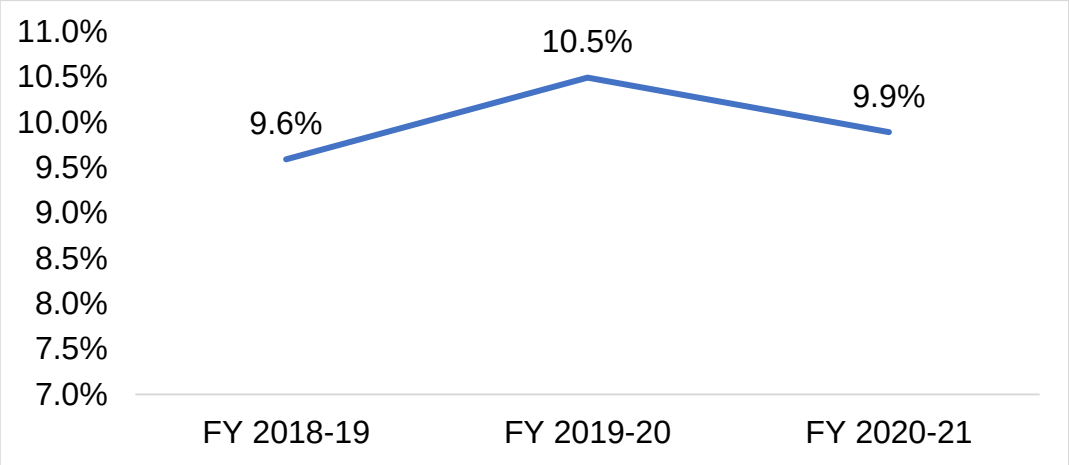
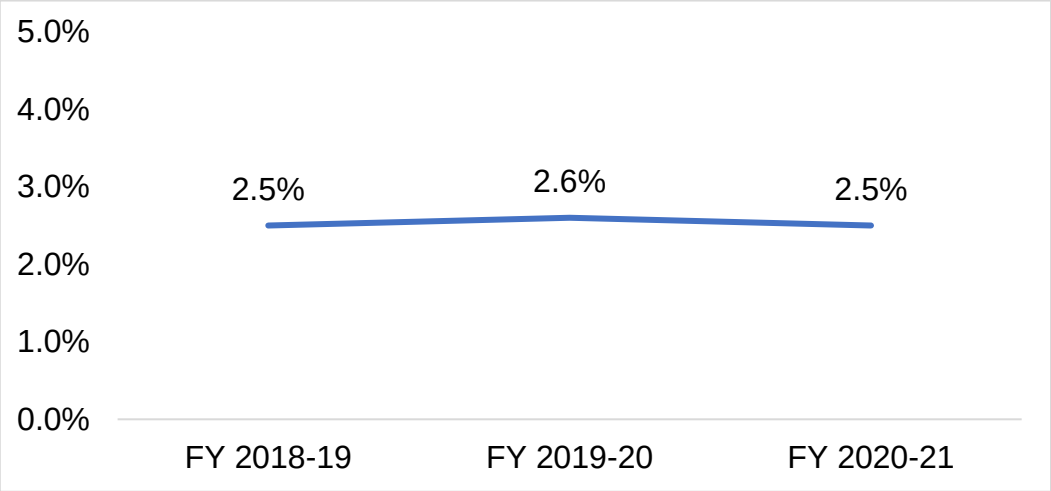
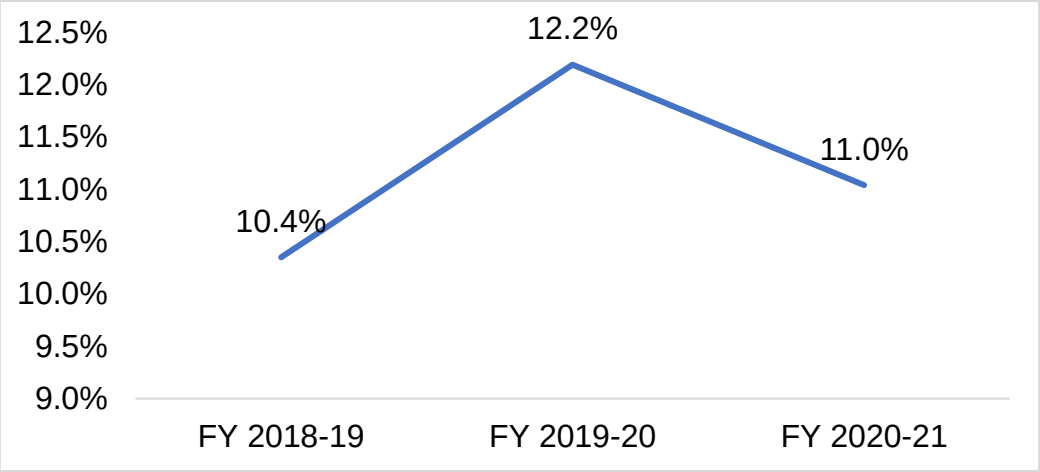
Goal Ia.	**Analyze root causes in the underrepresentation of self-identified Asian, Black/African Americans, and Native Hawaiian/Pacific Islanders receiving DMH services.**
Objective(s)	1. Work collaboratively with LACDMH stakeholders to develop a United Mental Health Promoters (UMHPs) program curriculum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

Figure 39. Penetration Rates for Medi-Cal Beneficiaries in the Asian Pacific Islander Group



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

Figure 40. Penetration Rate Changes for Medi-Cal Beneficiaries in the Native American Group



Note: The Ns for Medi-Cal Beneficiaries from the Native American group served in FY 2018-19 was 522, 581 in FY 2019-20, and 530 in FY 2020-21. Uninsured/indigent clients are not reflected in this data. Data Source: Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2019 to CY 2021, prepared by BHC/CalEQRO in July 2019, July 2020, and July 2021.

Frequency of Collection	Annually
Responsible Entity	Quality, Outcomes, and Training Division – QA and QI Units

The goal was met.

Objective 1: Work collaboratively with LACDMH stakeholders to develop a United Mental Health Promoters (UMHPs) program curriculum for the Black/African American and Asian Pacific Islander (API) communities.

Approximately four years ago, Mental Health Program Manager III, Ana Suarez, led work groups with the API and Black African Heritage (BAH) UsCC subcommittees to develop and implement cultural adaptations for the UMHPs program curriculum. Feedback from the BAH included a need to train staff that looked like the BAH communities to deliver information that could be trusted by the community. Feedback from the API workgroup included the need for information to be translated into the top four API languages, including Chinese, Korean, Khmer, and Tagalog. A total of thirteen translations of the UMHPs program curriculums have been made into Korean, Chinese, and Khmer languages with Tagalog still pending. Currently, the UMHPs include 10 Korean, four Chinese, and two Khmer staff who are providing presentations in their associated language. Eighteen African American UMHPs are providing services in SAs 4, 5, 6, and 8. The 10 Korean UMHPs are providing services in SAs 3, 4, 7, and 8. Two Khmer UMHPs are providing services in SA 8. Two Native American UMHPs are also providing services in SAs 3 and 8.

LACDMH has been working with stakeholders to develop a UMHP program curriculum for Black/African American and API communities. All 13 modules have been completed and translated into Korean and Chinese but are in need of updates. Nine modules are in Khmer. Nine are also in English but are delivered in API languages using verbal cultural adaptations for the target groups.

In addition to the work done in house, the Antiracism, Diversity, and Inclusion (ARDI) Division leveraged the Innovations (INN) 2 project, to expand our work with the community by setting up a Community Ambassadors Network (CAN) to address community needs particularly related to COVID-19. The concept of the CAN leverages existing networks of trusted community-based providers and organizations to have the right people in the right place at the right time to provide necessary resources to those in need. By the end of FY 2021-22, 209 individuals were active Community Ambassadors. The majority of CAN (45.5%) identify as Latino/Latinx, Hispanic or Mexican; 15.3% identify as Black and/or African American; 9.6% Asian, Cambodian, Filipino, East Indian, or Tongan (Asian/Pacific Islander); 5.1% as Multiracial; and 3.8 % as White. The ARDI Division purposefully emphasized the hiring of CAN to represent the communities in which they were working.

During Fiscal Year 2021-2022, INN 2 providers recorded a total of 13,841 outreach and engagement events. Through these innovative outreach and engagement events, partnerships reached hundreds of thousands of community members. General community outreach, meetings, trainings, and community events represented the other top outreach and engagement activities. Trainings in the community have remained consistently high and have been an integral way for partnerships to help build capacity within their communities. As expected with partnerships in the sustainability phase of the project, there were less trainings for partners and staff over the past year as compared to previous years.

Related to meeting the needs of the community, during FY 2021-2022, the CAN made a total of 71,635 referrals to specific resources and/or support services to enable or empower participants to obtain support independently. Ninety-three percent of the referrals were noted as successful linkages, meaning that the CAN provided a warm handoff or followed up with the participant to confirm that they had connected with the referred support. The most common referrals during the initiative were for basic needs including food and housing, education and mental health services and

supports. Linkages with food resources included vouchers or gift cards for local markets, support applying for Cal-Fresh, and distribution of food boxes or groceries through curbside pick-up or delivery services accounted for 34% of the linkages during COVID-19. Prior to the pandemic, food resources only accounted for 5% of the referrals made, which highlights how the pandemic exacerbated the already pressing issue of food insecurity for many individuals within LA County. Referrals for basic needs includes providing backpacks and sleeping bags for TAY, clothes, diapers and wipes for families, and hygiene and household cleaning products.

Next steps include working with UCLA to map the CAN and UMHP platforms and cross train for more comprehensive UMHP support to the community.

Objective 2: Utilize the Speakers Bureau for ongoing outreach and engagement.

Table 29 shows the number of Speakers Bureau activities completed in CY 2022 that supported the African American community. Activities supporting the African American, Older Adult community were the most frequent (2 activities total) and Presentation/Training - Standalone Workshops were the most frequent type of activity (2 activities total).

Table

29. Number of Speakers Bureau Activities by Type and Black/African American Cultural Groups, Calendar Year 2022

Speakers Bureau Activity Type	African American	African American, Diverse, Latino, White (Not Eastern European, Latino, Middle Eastern)	African American, Older Adult	African, African American, Latino, Youth	Total
Media Interview – Social Media	0	0	1	0	**1**
Presentation/Training – Community Event Speaker	1	0	0	0	**1**
Presentation/Training - Conference/Seminar Panelist	0	0	1	0	**1**
Presentation/Training - Standalone Workshop	0	1	0	1	**2**
Total	**1**	**1**	**2**	**1**	**5**

Note: The African American Speakers Bureau activities occasionally included individuals from other cultural groups when listed. Data source: ARDI, July 2023.

Table 30 displays the number of Speakers Bureau activities completed in CY 2022 that supported the API community. Activities supporting the Korean-speaking community were the most frequent (80 activities). The most frequent activity was Consultation (111 activities), which included, but were not limited to, activities such as proving resources, mental health information, and information on LACDMH services.

Table

30. Number of Speakers Bureau Activities by Type and API Languages, Calendar Year 2022

Speakers Bureau Activity Type	Cantonese	Korean	Korean, English*	Korean, Spanish*	Mandarin	Total
Clinical - Group	8	0	0	0	0	**8**
Consultation	1	69	41	0	0	**111**

Information on Mental Health Resources	1	0	0	0	0	**1**
Interpretation	0	0	0	0	1	**1**
Media Interview - Print	0	0	2	0	0	**2**
Media Interview - Radio	0	1	1	0	3	**5**
Outreach - Group	0	0	0	0	1	**1**
Presentation/Training – Community Event Speaker	0	2	0	0	0	**2**
Presentation/Training - Conference/Seminar Keynote	0	0	0	1	2	**3**
Presentation/Training - Conference/Seminar Panelist	0	0	0	0	1	**1**
Presentation/Training - Conference/Seminar Workshop	0	1	1	0	2	**4**
Presentation/Training - Standalone Workshop	0	0	0	0	10	**10**
Translation - Reviewed Translations	1	7	0	0	4	**12**
Translation - Translated materials	1	0	0	0	0	**1**
Total	**12**	**80**	**45**	**1**	**24**	**162**

Note: * The Korean-focused cultural and language activities were also presented in English and Spanish during an activity in order to support English and Spanish-speakers in attendance. Data source: ARDI, July 2023.

Additional activities to support underrepresented communities include LACDMH multi-disciplinary participation in the Solano County/University of California-Davis Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) Learning Collaborative targeting community research and the integration of Culturally and Linguistically Appropriate Service (CLAS) standards. At the September 2022 kickoff meeting, LACDMH identified the API and Persons with Disabilities communities as Communities of Focus for intervention. Additionally, systemwide and workforce related QI Action Plans were developed from a Rapid Data Analysis (RDA) based on feedback from the UsCCs and the Faith-based Advisory Council (FBAC). An ICCTM Advisory Committee consisting of representatives of the UsCCs, FBAC, and the eight Service Area Leadership Teams (SALTs) reviewed the QI Action Plans and additional feedback on their structure.

Delivering Culture-Specific Services

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

This goal was met. In May 2022, the Anti-Racism, Diversity, and Inclusion - Cultural Competency Unit (ARDI-CCU) began scheduling ASL appointments during the business hours of 8:00 AM to 5:00 PM. An email box was established to submit requests, ARDIaccessibility@dmh.lacounty.gov. The ACCESS Center will continue to take requests that come in after business hours, on weekends, and on holidays. ARDI-CCU also worked with the ACCESS Center to update Policy 200.02 Interpreter Services for the Dead and Hard of Hearing Community.

Furthermore, the ARDI-CCU developed an online American Sign Language Service Satisfaction Survey (ASL SSS) in collaboration with representatives of the deaf and hard-of-hearing community, the Cultural Competency Committee (CCC), and the Access for All Underserved Cultural Communities (UsCC) subcommittee. The survey was implemented in January 2023 with the goal of gathering feedback from the clinic-based requestors of ASL services such as clinicians, case managers, support staff, and the deaf and hard of hearing individuals utilizing ASL services provided by hired vendors.

In addition to information on the vendor rendering ASL services, the survey covered several key points of feedback. For example:

1. How satisfied are you with the ASL interpreter services you received?
2. Did you have any problems with your ASL interpreter services?
   a. Tell us about the problem you experienced with your ASL interpreter services.
3. Was Interpreter able to meet your language needs?
4. Was the ASL interpretation accurate?
5. Did the ASL interpreter provide adequate uninterrupted service during the meeting?
6. Did the interpreter join the session in-person or via a virtual platform?
   a. If virtual, which platform?
   b. How likely are you to recommend ASL video conferencing interpreting to others?
   c. Were there any technical issues?
7. Open comments

An analysis of the 80 ASL SSS gathered from January to May 2023 revealed the following outcomes:

1) Received survey submissions
   - 78 surveys were submitted by service providers (e.g., clinicians, case managers, psychiatrists, etc.)
   - One submitted by reception
   - One submitted by a consumer

2) Mode of ASL interpreter service delivery:
   - 78% or 62 services were delivered via a virtual platform
   - 21% or 17 services were delivered in-person

3) Breakdown of Virtual Platforms most widely used:
   - Zoom – 24
   - VSee – 18
   - Microsoft Teams – 13
   - Other/Unknown – 8

4) Average satisfaction scores for ASL interpreter services by item and rating scale:
   - "If the interpreter(s) joined via a virtual platform, how likely are you to recommend ASL videoconferencing interpreting to others?" *(Rating scale: 1 = not at all, 3 = maybe, and 5 = definitely*) **4.8**

   - "How satisfied are you with the ASL interpreter services you received?" *(Rating scale: 0 = not at all satisfied, 10 = completely satisfied):* **9.55**
     - Negative feedback included technology issues such as freezing and lag time, interpreter not showing up, and interpreter arriving late.

   - "Did you have any problems with your ASL interpreter services?" *(Rating scale: yes or no)*
     - **93% or 74 out of 80 reported no problems, 7.5% or six out of 80 reported issues, and 1% or one survey had no answer for this item.**

   - "Was the interpreter(s) able to meet your language needs?" *(Rating scale: yes or no)*
     - **95% or 76 out of 80 answered "yes" and 1% or one out of 80 answered "no". Finally, 4% or three surveys did not include answers to this item.**

   - "Did the ASL interpreter(s) provide adequate uninterrupted service during the meeting?" *(Rating scale: 1 = not at all, 3 = some, and 5 = nearly all meeting)* **4.8**

   - "How satisfied are you with the ASL interpreter services you received?" *(Rating scale: 0 = not at all satisfied, 10 = completely satisfied):* **9.55**
     - Negative feedback included technology issues such as freezing and lag time, client not showing up, and interpreter arriving late.

   - "Did you have any problems with your ASL interpreter services?" *(Rating scale: yes or no)*
     - **93% or 74 out of 80 reported no problems, 7.5% or six out of 80 reported issues, and 1% or one survey had no answer for this item.**

- "Was the interpreter(s) able to meet your language needs?" *(Rating scale: yes or no)*
  - **95% or 76 out of 80 answered "yes" and 1% or one out of 80 answered "no". Finally, 4% or three surveys did not include answers to this item.**

- "Did the ASL interpreter(s) provide adequate uninterrupted service during the meeting?" *(Rating scale: 1 = not at all, 3 = some, and 5 = nearly all meeting)*
  - **4.8**

Additionally, inclusion of an open comment section facilitated the collection of "Additional Comments" regarding satisfaction with ASL interpreter services. The feedback gathered reflects direct comments about the ASL services and the customer-oriented service provided by the ARDI-CCU. Comments written in *BOLD* indicate unfavorable feedback.

1) Direct feedback regarding satisfaction with ASL interpreter services.

- Interpreter was very good, and I felt fortunate that she was available for that date.
- My client is deaf and blind and requires tactile ASL which interpreter is more than capable of communicating for us.
- The interpreter was very accommodating even stayed on longer as the interview lasted longer than expected.
- Our interpreter was phenomenal!
- I appreciate the interpreters' patience with technical difficulties related to the VSee platform. I also appreciate their recommendation for me at the end of session about finding a certified deaf interpreter.
- This was a wonderful service and clients face light up with having someone they could properly communicate with.
- ASL was on Time & was able to help client set up a new appointment after her session was over.
- She was very patient and professional.
- She was great and very patient with us.
- Thank you for the services.
- **ASL interpreter did not show for the scheduled appointment.**
- Interpreter was great.
- Interpreter was very helpful.
- Interpreter was amazing and very helpful.
- **Interpreter got lost trying to find our clinic (Augustus Hawkins) and was about 35 mins late. She however is an excellent interpreter and offered valued insight on the ASL community.**

2) Satisfaction with ARDI-CCU services

- Great team and a pleasure to work with.
- Thank you for checking in!
- The services are greatly appreciated.
- Thank you for this much needed service.
- Thank you for the service.
- Thank you.

The next steps for the project include the ARDI-CCU's presentation of the feedback received from the ASL SSS at the June 2023 departmental Quality Improvement Council meeting.

Telemental Health

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

This goal was met.

Objective 1: Explore and resolve barriers to telehealth services including but not limited to the client and staff-related issues with video or telehealth platforms.

In CY 2022, the Outpatient Services Division (OSD) led several efforts to explore and resolve barriers to the use of telehealth services. OSD regularly maintained an internal Share Point site to distribute training resources, including how-to guides and videos highlighting strategies to educate providers and enhance treatment using telehealth delivery methods. Telehealth data was monitored regularly by OSD, Clinical Informatics, and CIOB through a strategic dashboard in Power BI and at the provider level for DO clinics during the monthly All Programs of Excellence Forum (APEX) meetings. APEX is an interactive process consisting of LACDMH managers, supervisors, and staff from directly operated outpatient clinics, Clinical Informatics, OSD, CIOB, Quality Improvement and Outcomes Divisions where data trends and program operations are reviewed to improve service delivery effectiveness. During the APEX meetings, a variety of data are reviewed and evaluated which include the Mental Health Sessions over time and telehealth utilization. Directly operated (DO) providers chosen for the monthly APEX meetings are given the opportunity to discuss, address and resolve any barriers to telehealth services both at the consumer and provider level.

Objective 2: Survey client/family telehealth service delivery preference.

Telehealth by video and telephone continued to be service delivery options within DO and LE clinics in CY 2022. DO clinics utilized the telehealth platform VSee a HIPAA-compliant telehealth application. While a formal survey for service delivery preference was not conducted in CY 2022 due to not wanting to add additional burden to treatment staff, the number of service encounters by session delivery type including face-to-face, telehealth via video and telephone are reported through a strategic dashboard in Power BI. Face-to-face encounters are in person sessions with consumers that include the face-to-face service as well as documentation and travel time as needed. As reported

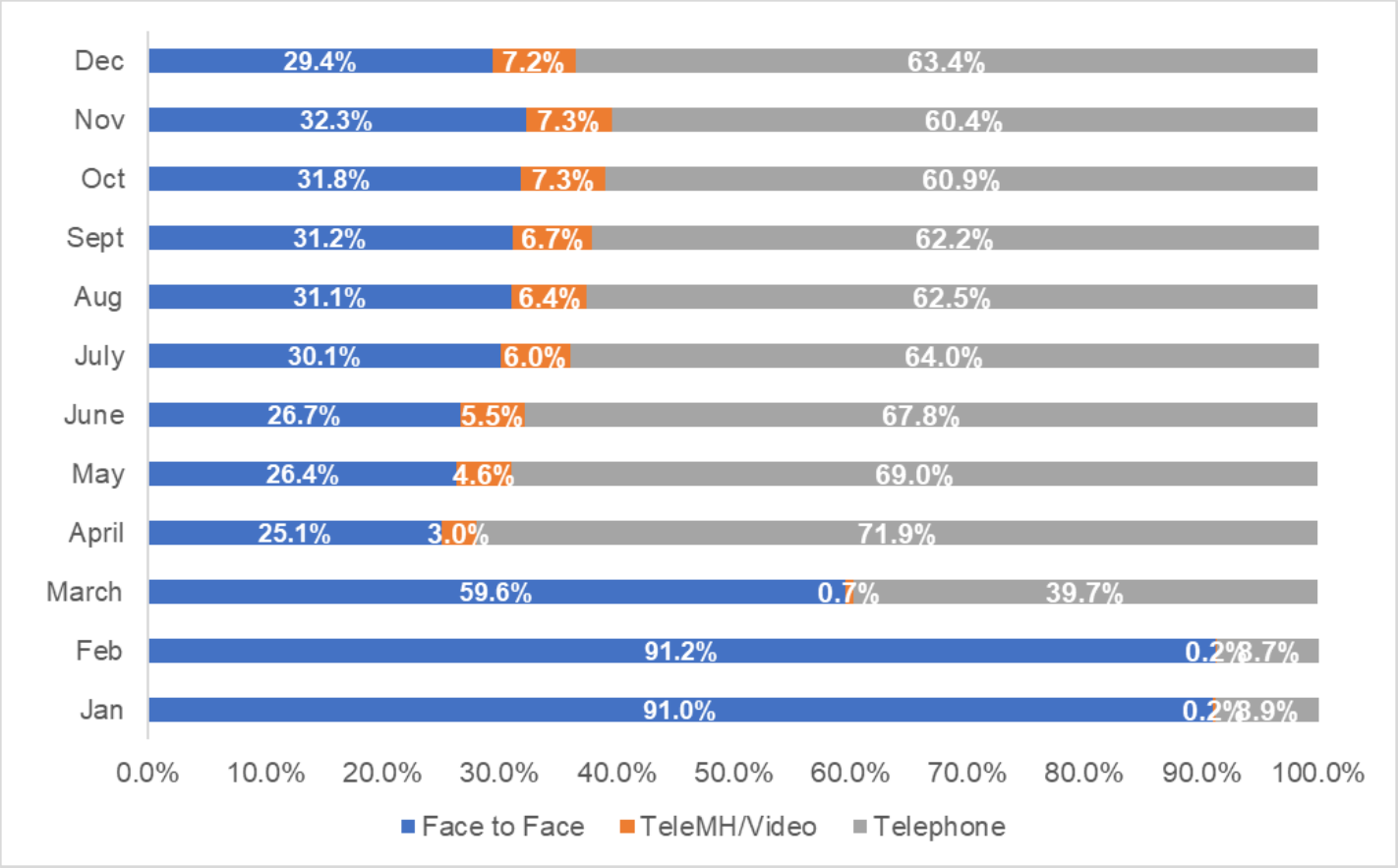
in the dashboard, the percentage of telehealth via video services in DO and LE clinics were typically lower than telephone and face-to-face services from CY 2020-CY 2022.

From CY 2020-CY 2022, the percentage of services using telehealth via video in DO clinics peaked in March 2021 with 9.6% of all sessions delivered via video. The lowest percentage of telehealth services via video were reported in January and February 2020 with 0.2% of all services delivered, reflective of the service delivery preference for face-to-face sessions prior to the COVID-19 pandemic.

In CY 2020, for DO clinics, the highest percentage of telehealth via video encounters were reported in October and November with 7.3% of all services. The lowest percentages were seen in January and February prior to the pandemic, with 0.2% of all services delivered via video. By telephone was the highest percentage reported was in April with 71.9% of all service encounters. This percentage was reflective of the transition and time necessary to onboard onto a telehealth via video platform during the COVID-19 pandemic.

Figure

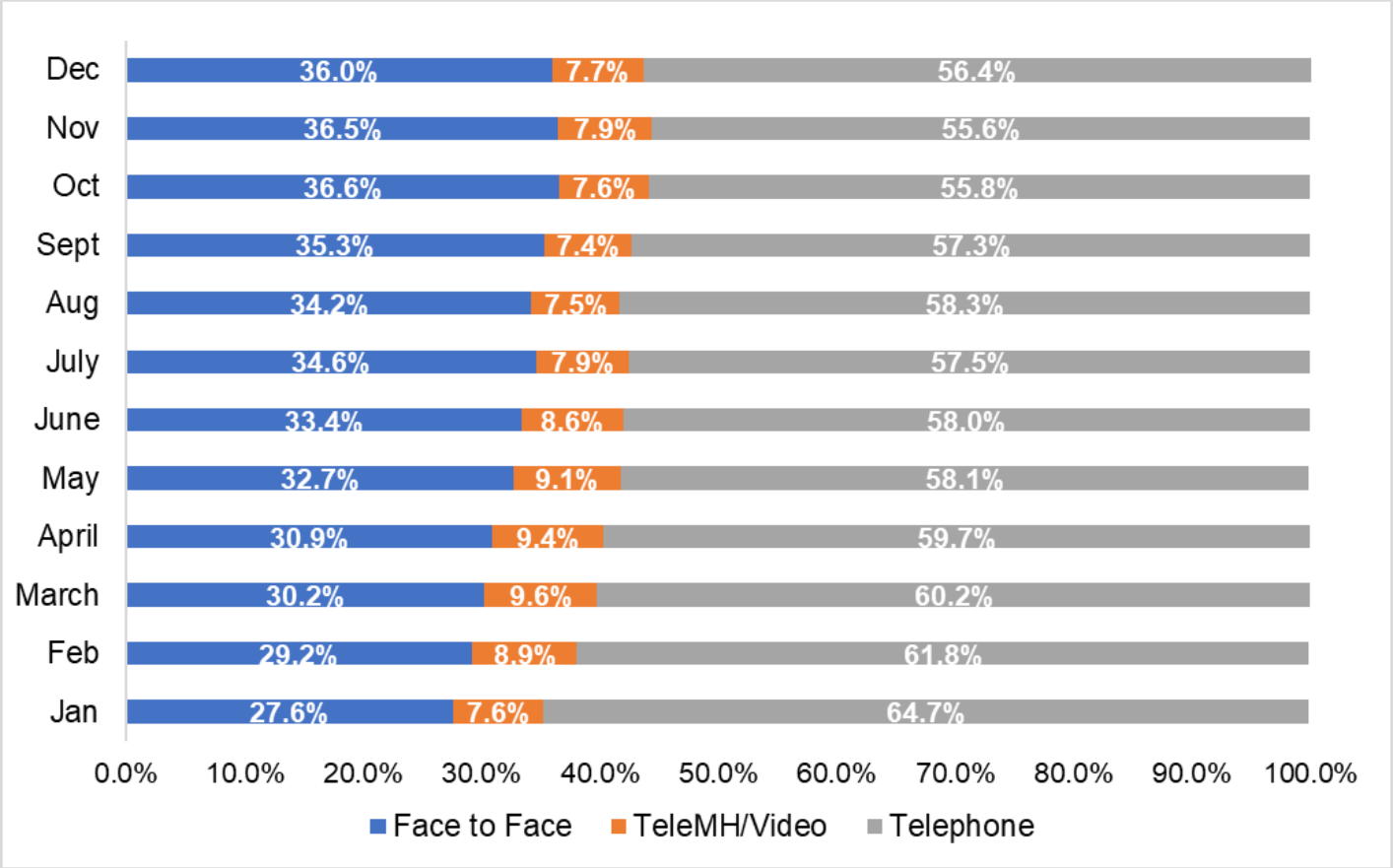
42. Percent by Service Delivery Type by Month in Directly Operated Clinics, Calendar Year 2020



In CY 2021, for DO clinics, the highest percentage of telehealth via video service encounters was reported in March with 9.6% of all services delivered. The lowest percentage was seen in September with 7.4% of all services delivered via telehealth video. By telephone, the highest percentage was reported in January with 64.7% of all services. The lowest percentage of services delivered by telephone was seen in November with 55.6% of all service encounters.

Figure

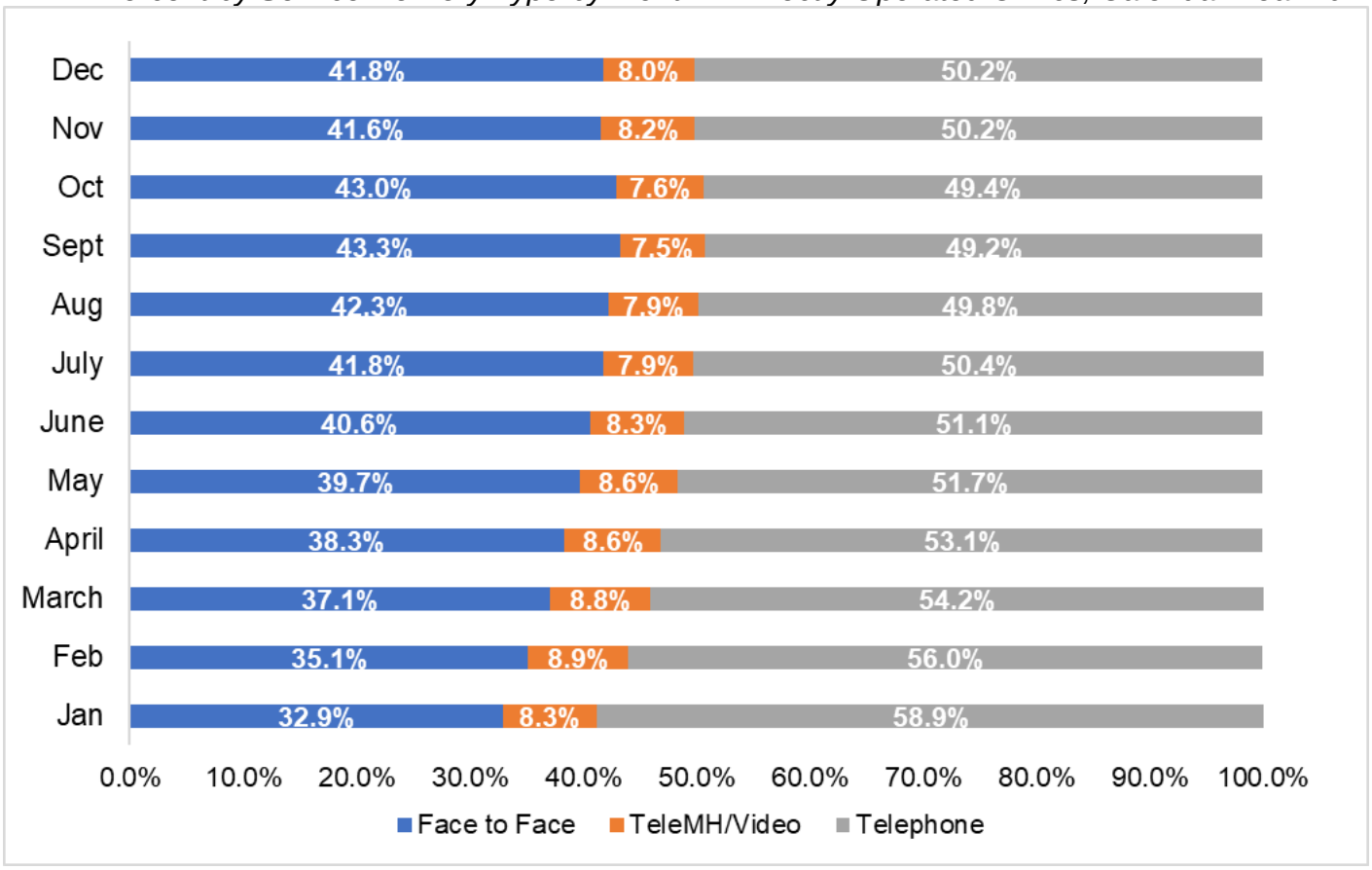
43. Percent by Service Delivery Type by Month in Directly Operated Clinics, Calendar Year 2021



In CY 2022, for DO clinics, the highest percentage of telehealth encounters via video were reported in February with 8.9% of services delivered and the lowest percentage was reported in September with 7.5% of services delivered. For telephone services, the highest percentage was seen in January with 58.9% of all services and the lowest was reported in September with 49.2% of all services provided. While telehealth services via video remained within a 1.4PP range during CY 2022, there was an 8.9PP increase in face-to-face encounters and an 8.7PP decrease in telephone encounters from January to December demonstrating a positive trend of return to in person services.

Figure

44. Percent by Service Delivery Type by Month in Directly Operated Clinics, Calendar Year 2022

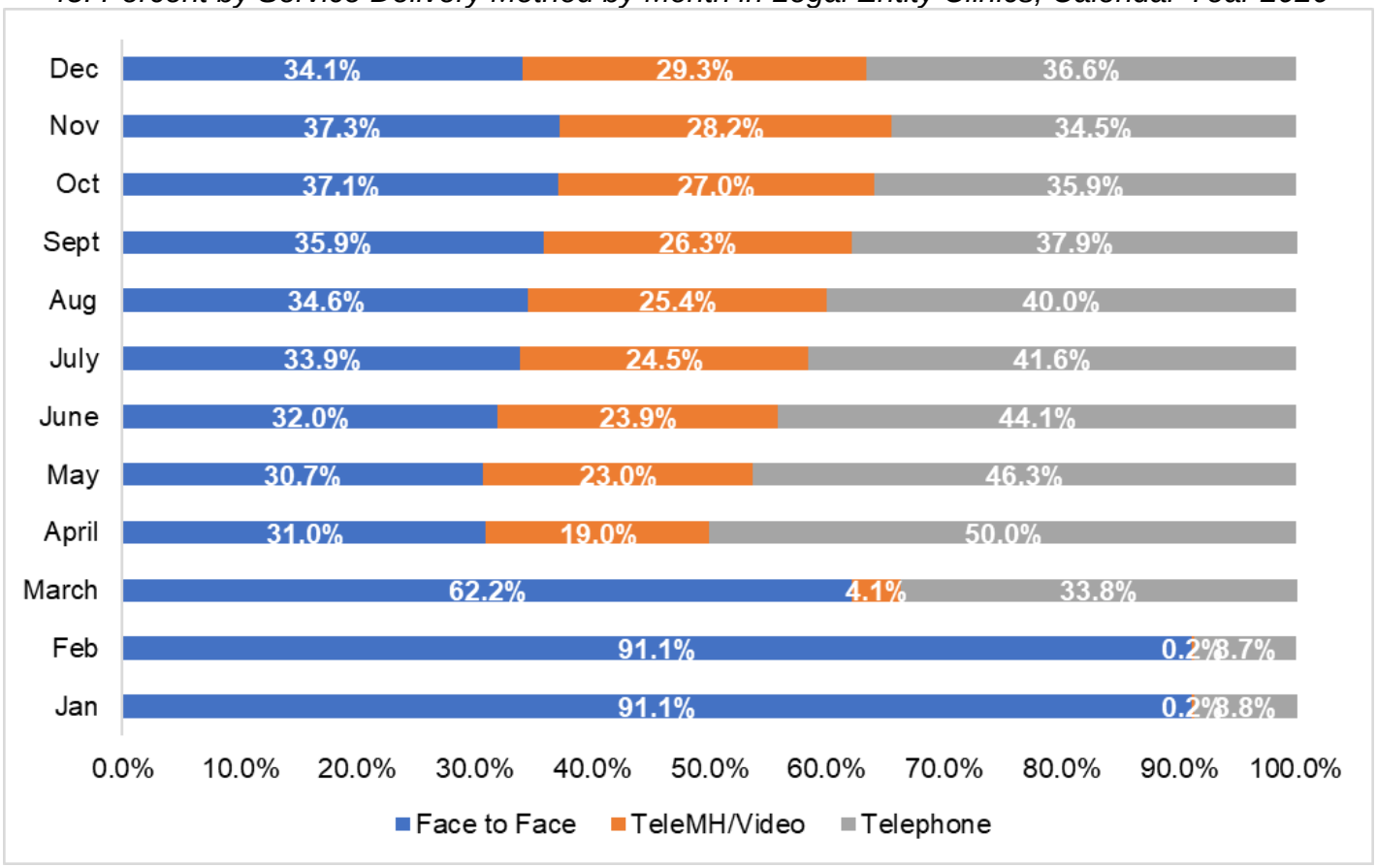


Like DO clinics, for LE clinics, percentage rates of services delivered via telehealth video were consistently lower than telephone and face to face services from CY 2020-CY 2022. Through the COVID-19 pandemic, there was also an overall rise in the percentage of telehealth services via video for LE clinics from April 2020–December 2022. The percentage of services via telehealth video in LE clinics fell within the range of 18.7%-31.9% range, peaking in February 2021.

In CY 2020, for LE clinics, the highest percentage of telehealth services via video was reported in December with 29.3% of all services delivered. The lowest percentages were reported in January and February with 0.2% of services delivered via video reflective of service delivery preferences prior to the COVID-19 pandemic. By telephone, the highest percentage was reported in April with 50% of services delivered. The lowest percentage was reported in February with 8.7% of all services delivered by telephone.

Figure

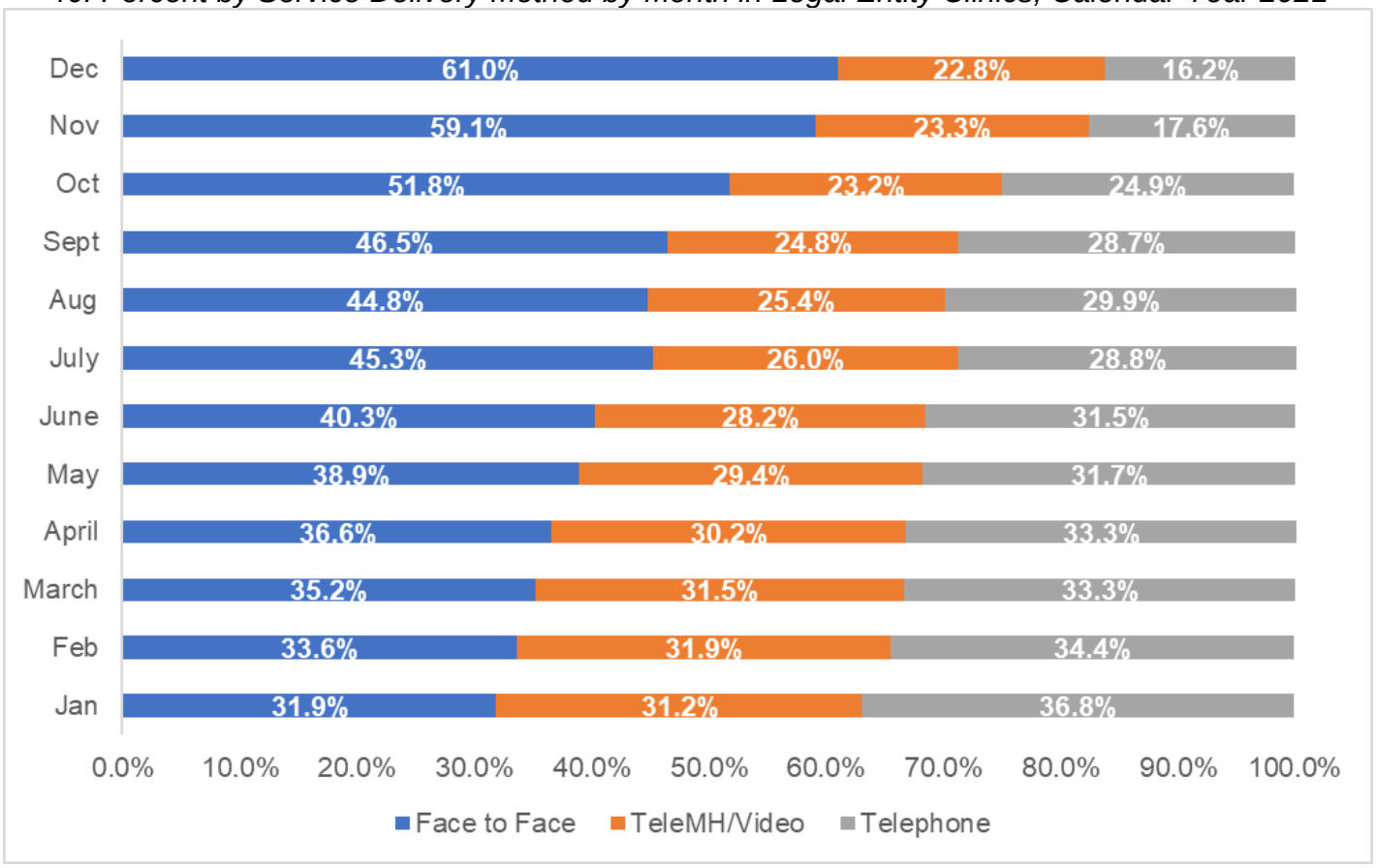
45. Percent by Service Delivery Method by Month in Legal Entity Clinics, Calendar Year 2020



In CY 2021, for LE clinics, the highest percentage of telehealth services was reported in February with 31.9% of all services delivered via video. The lowest percentage was reported in December with 22.8% of services delivered via video. By telephone, January reported the highest percentage with 36.8% and the lowest was December with 16.2% of all service encounters. Overall trends for service delivery encounters in CY 2021 from January through December demonstrated an increase in face-to-face sessions (29.1PP) and a decrease in telehealth encounters via video (8.4PP) and by telephone (20.6PP).

Figure

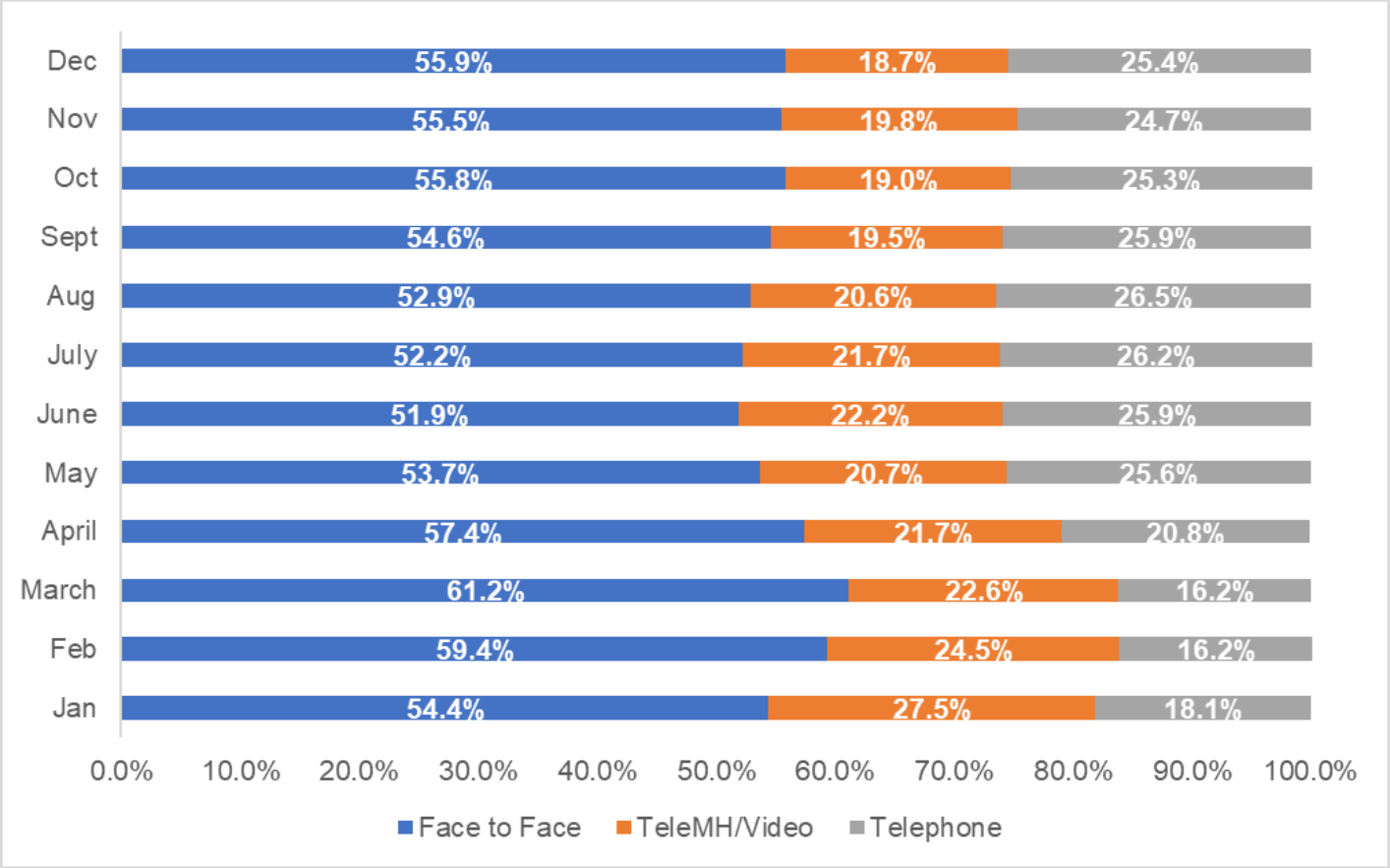
46. Percent by Service Delivery Method by Month in Legal Entity Clinics, Calendar Year 2021



In CY 2022, for LE clinics, the highest percent of telehealth sessions were reported in January with 27.5% of all services provided via video and the lowest percentage was in December with 18.7% of all services by video. By telephone, the highest percentage of service encounters reported was in August with 26.5% and the lowest were reported in February and March with 16.2%. In CY 2022, for all 12 months, the largest percentage of service encounters in LE clinics were delivered face-to-face.

Figure

47. Percent by Service Delivery Method by Month in Legal Entity Clinics, Calendar Year 2022



Monitoring Accessibility of Services, Calendar Year 2022

Timely Access to Services

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

This goal was partially met.

Objective 1: Monitor time to first offered appointment.

The QA Unit reviewed the percent of untimely versus timely appointments for all providers across quarterly initial requests for routine, urgent, and hospital discharge services. For routine appointments, the 80% goal was met in quarter one and almost met in quarters 2, 3 and 4. For urgent requests, the goal was not met in any quarter and review of the problem leading to such low percentage was initiated. For hospital discharge services, the 80% goal was met in all quarters.

Objective 2: Monitor wait times to initial medication evaluation appointments.

For initial medication evaluation appointments, the QA Unit began reviewing psychiatry data for Directly Operated (DO) providers that Clinical Informatics started pulling during this time. QA Unit also began working with our Chief Information Systems Analyst to begin pulling in psychiatry data for our Contracted providers through the WebService.

The information below (Table 30) reflects data from multiple sources, including Contractor Service Request Log (SRL) web services, Integrated Behavioral Health Information System (IBHIS) (DO) SRL, Katie A. Enterprise Monitoring System (KAEMS), Service Request Tracking System (SRTS), and SRTS v2.0.

Table

31. Timely Access Data by Quarter and Referral Type for Fiscal Year 2022-23

Quarter 2022	Type of Referral	# of Referrals	# of Timely Appt/Ref Declined	% of Timely Appt/Ref Declined
Q1	Routine	22,037	19,004	86%
Q1	Urgent	168	78	46%
Q1	Inpatient/Jail Discharge	2,138	2,001	94%

Quarter 2022	Type of Referral	# of Referrals	# of Timely Appt/Ref Declined	% of Timely Appt/Ref Declined
Q2	Routine	21,450	16,633	78%
Q2	Urgent	485	175	36%
Q2	Inpatient/Jail Discharge	2,427	2,157	89%

Quarter 2023	Type of Referral	# of Referrals	# of Timely Appt/Ref Declined	% of Timely Appt/Ref Declined
Q3	Routine	20,877	15,688	75%
Q3	Urgent	520	164	32%
Q3	Inpatient/Jail Discharge	2,500	2,180	87%

Quarter 2023	Type of Referral	# of Referrals	# of Timely Appt/Ref Declined	% of Timely Appt/Ref Declined
Q4	Routine	21,280	16,491	77%
Q4	Urgent	543	208	38%
Q4	Inpatient/Jail Discharge	2,422	2,075	86%

Monitoring Beneficiary Satisfaction, Calendar Year 2022

Client/Family Satisfaction

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

This goal was partially met.

Objective 1: Review methodology concerning sample size and participants.

The QI Unit currently asks that 100% of outpatient providers who provide more than linkage or one-time assessment services participate in the CPS periods. This request was also made by the State of LACDMH due to participation decline as a result of the COVID-19 pandemic.

Objective 2: Gather Sexual Orientation and Gender Identity (SOGI) related demographics and assess the quality and delivery of affirming care.

During the CY 2022 Consumer Perception Survey period, LACDMH developed and included SOGI related demographic questions into the LACDMH electronic portal survey methods for Directly Operated (DO) and Legal Entity (LE) providers. SOGI questions were included in all age group LACDMH electronic portal surveys (Youth, Family, Adult and Older Adult). The SOGI questions were developed during FY 2020-2021 with stakeholder feedback prioritized and under the guidance of the DMH LGBTQIA2-S Specialty Care Workgroup, the LGBTQIA2-S UsCC Subcommittee, and the Cultural Competency Committee.

SOGI demographic questions included gender identity, sex designated at birth and sexual orientation. Consumers were given the opportunity to respond voluntarily to the questions asked. Listed on the Youth, Family, Adult and Older Adult Surveys were the following questions and response options:

What is your gender identity?

- Man
- Woman
- Transgender man / Transmasculine

- Transgender woman / Transfeminine
- Non-binary (e.g., genderqueer or gender-expansive)
- Another category (e.g., Two-Spirit)
- Undecided/unknown at this time
- Not sure what this question means
- Prefer not to answer

What was your sex designated or listed at birth?

- Male
- Female
- X
- Another category (e.g., Intersex)
- Prefer not to answer

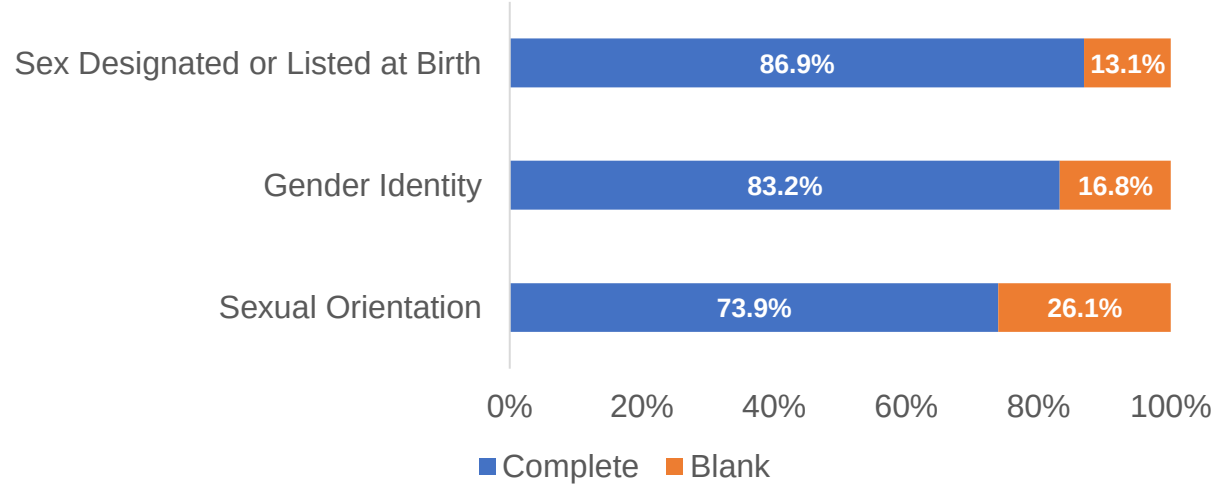
Do you think of yourself as:

- Heterosexual/straight
- Gay or lesbian
- Bisexual or pansexual
- Something else (e.g., queer, asexual)
- Undecided/unknown at this time
- Not sure what this question means
- Prefer not to answer/prefer no labels

For Adults, 801 (73.9%) respondents provided completed responses on the sexual orientation question, 837 (86.9%) responded to the sex designated or listed at birth question, and 712 (83.2%) provided a response on the sexual orientation question. Figure 48 shows the percentage of completed and blank SOGI questions for Adults.

Figure

48. Percentage of Completed and Blank SOGI questions for Adults, Calendar Year 2022

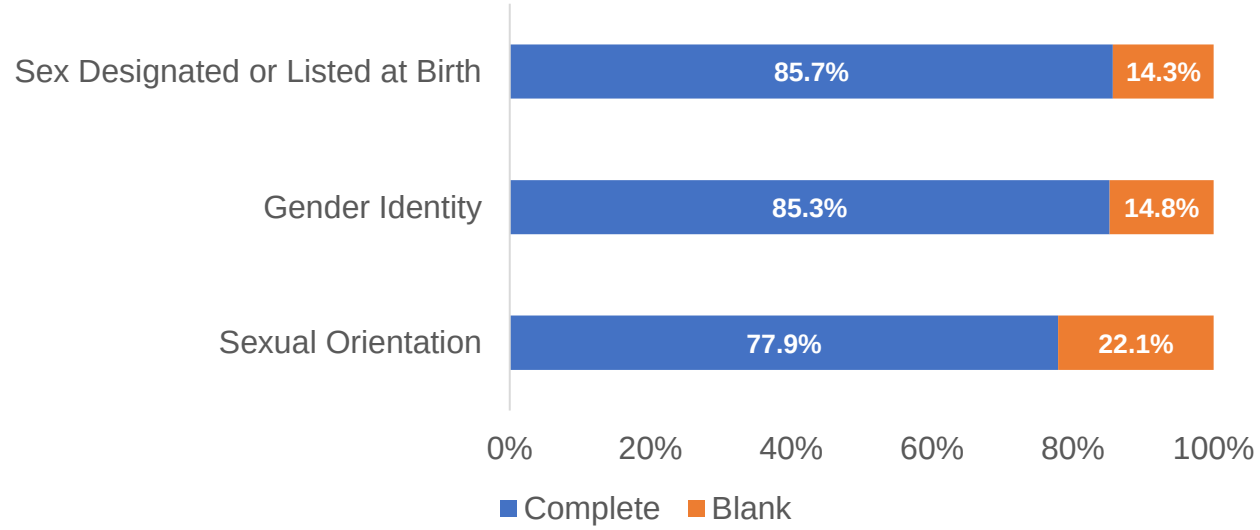


Data Source: Consumer Perception Survey data, May 2022.

For Older Adults, 169 (77.9%) respondents provided completed responses on the sexual orientation question, 186 (85.7%) responded to the sex designated or listed at birth question, and 185 (85.3%) provided a response on the sexual orientation question. Figure 49 shows the percentage of completed and blank SOGI questions for Older Adults.

Figure

49. Percentage of Complete and Blank SOGI questions for Older Adults, Calendar Year 2022

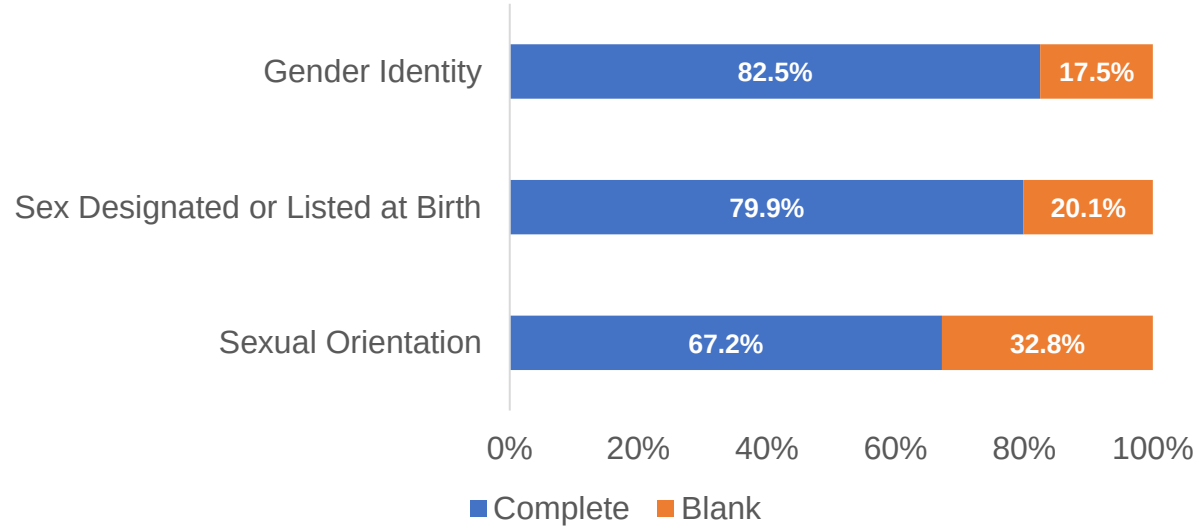


Data Source: Consumer Perception Survey data, May 2022.

For Youth, 283 (67.2%) respondents provided complete responses on the sexual orientation question, 283 (79.9%) responded to the sex designated or listed at birth question, and 292 (82.5%) provided a response on the sexual orientation question. Figure 50 shows the percentage of completed and blank SOGI questions for Youth.

Figure

50. Percentage of Completed and Blank SOGI questions for Youth, Calendar Year 2022

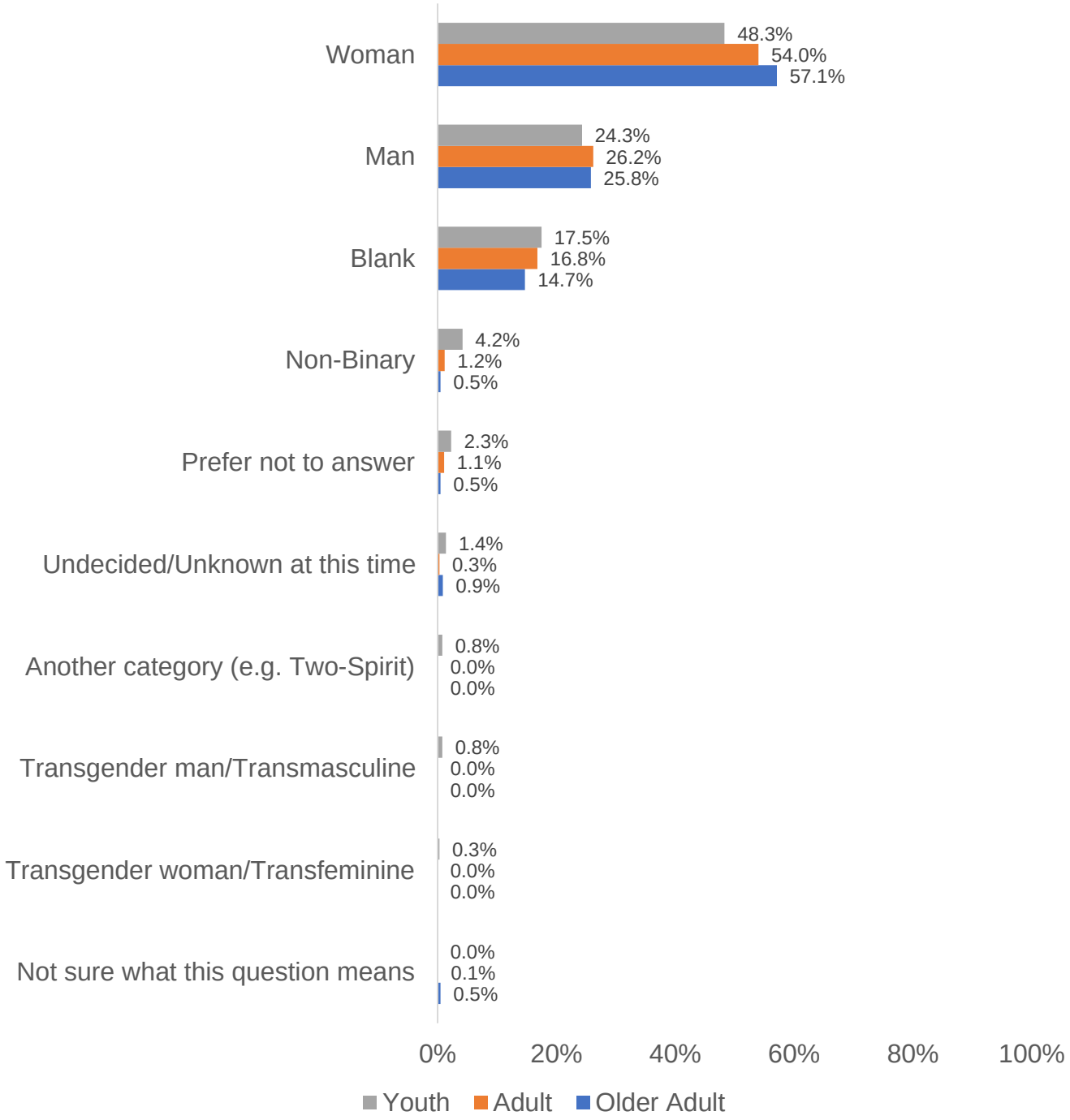


Data Source: Consumer Perception Survey data, May 2022

Of those that responded to the gender identity question, the majority of responses from Youth (48.3%), Adults (54.0%) and Older Adults (57.1%), endorsed Woman as their gender identity. Man was the second most frequently endorsed response with 24.3% from Youth, 26.2% from Adult, and 25.8% from Older Adults. Figure 51 shows the percentages of responses to gender identify from Youth, Adult and Older Adult age groups.

Figure

51. Percent of Responses to Gender Identity by Age Group, Calendar Year 2022

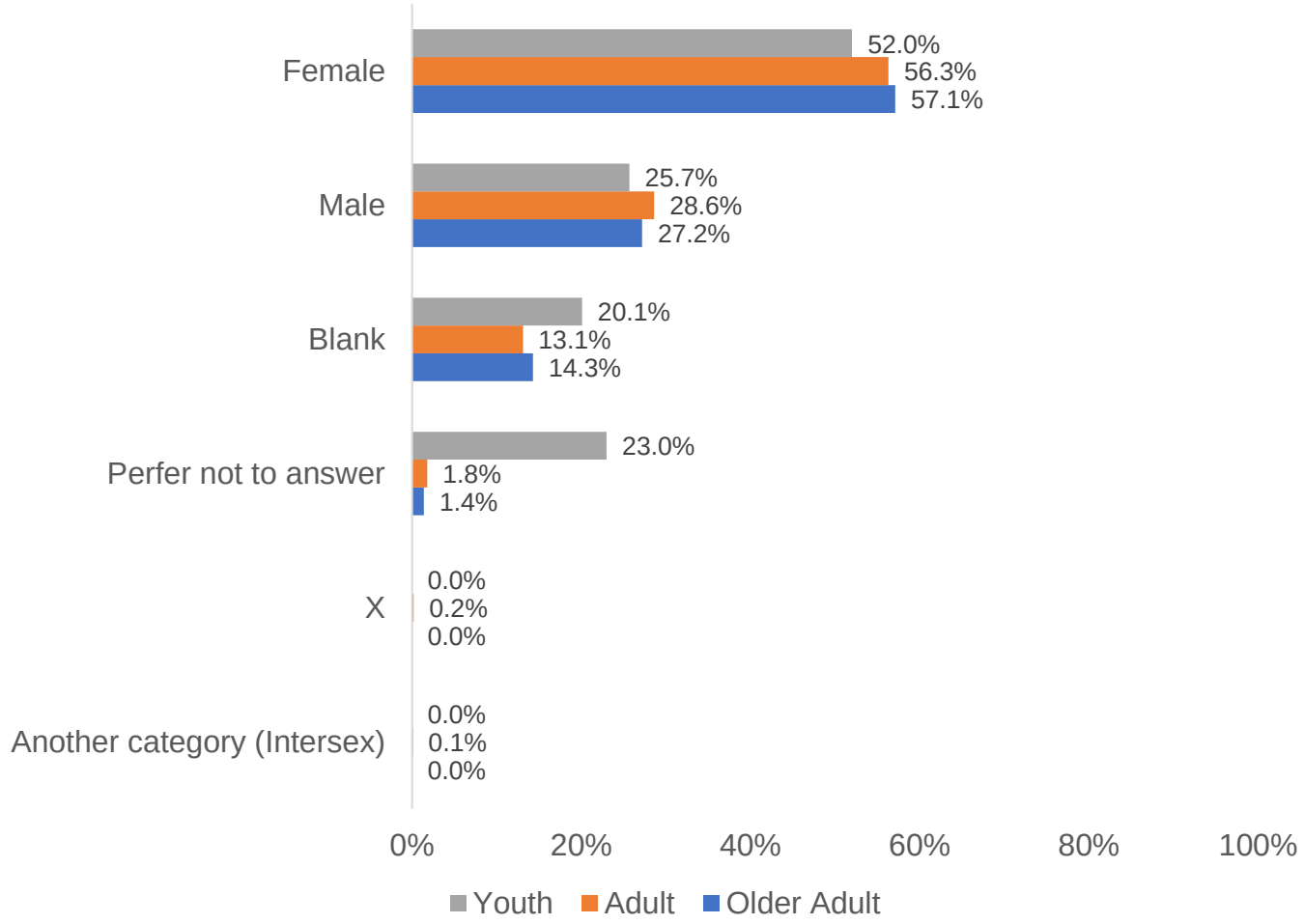


Data Source: Consumer Perception Survey data, May 2022

Of those that responded to the sex designated at birth question, the majority of responses from Youth (52.0%), Adults (56.3%) and Older Adults (57.1%), endorsed Female as their sex designated at birth. Male was the second most frequently endorsed response with 25.7% from Youth, 28.6% from Adult, and 27.2% from Older Adults. Figure 52 shows the percentage of responses to sex designated at birth from Youth, Adult and Older Adult age groups.

Figure

52. Percent of Responses to Sex Designated at Birth by Age Group, Calendar Year 2022

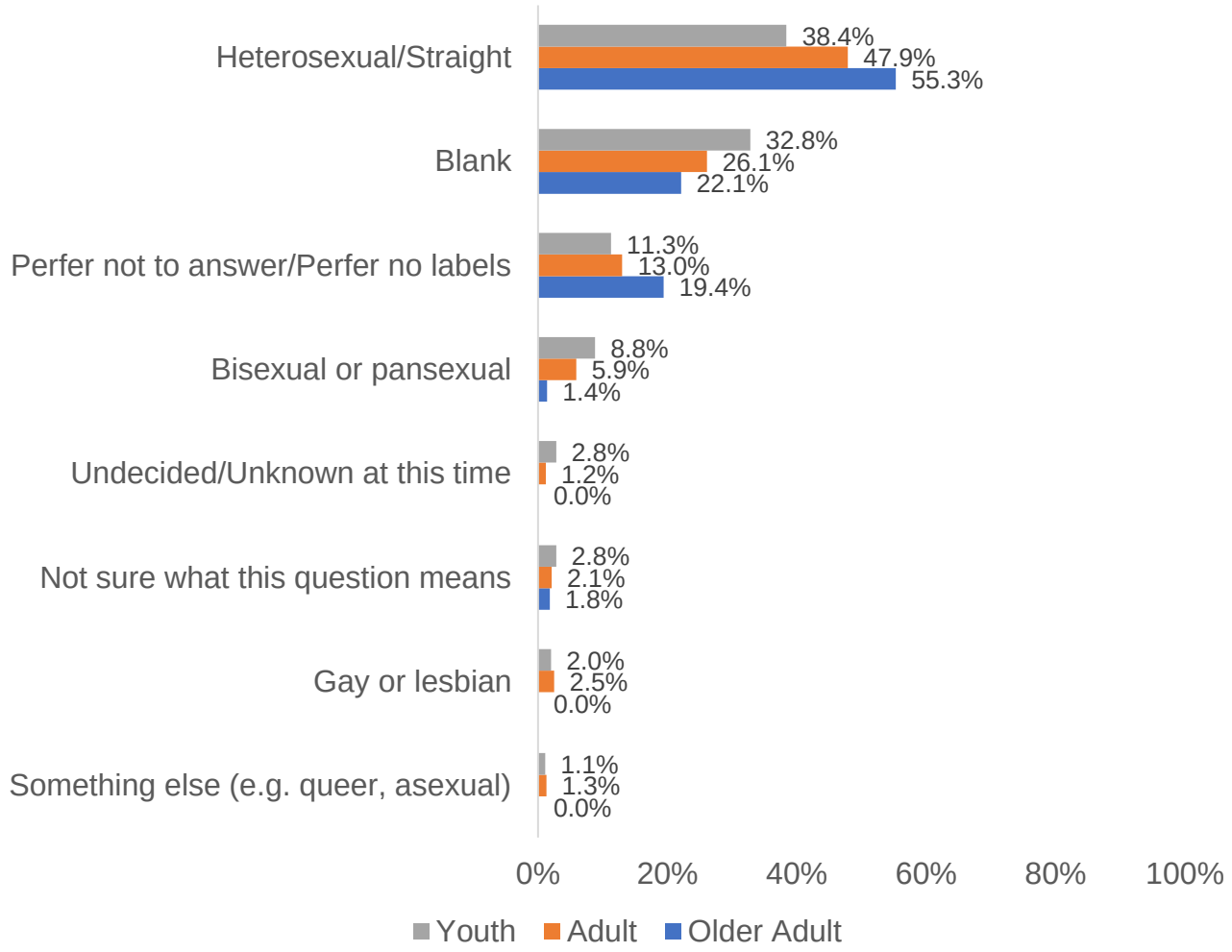


Data Source: Consumer Perception Survey data, May 2022

Figure 53 shows the percentage of respondents to the question, “Do you think of yourself as/Which best describes your sexual orientation”. Heterosexual/Straight had the highest percentage of responses from Youth (38.4%), Adults (47.9%) and Older Adults (55.3%). The question left Blank was the next highest percentage for Youth (32.8%), Adult (26.1%) and Older Adult (22.1%) age groups, followed by Prefer not to answer/Prefer no labels and Bisexual or pansexual.

Figure

53. Percent of Responses to Sexual Orientation by Age Group, Calendar Year 2022



Data Source: Consumer Perception Survey data, May 2022.

While SOGI questions were included in the LACDMH CPS electronic Family Surveys, analysis and report of responses was not initiated and is not included here due to lack of formal reporting regulations from local, state, and federal guidelines regarding caregiver report of SOGI responses on behalf of minors. Data will be held until further guidance and regulations are implemented. The Family Survey SOGI questions are listed below as reference.

The Family Survey contained the following questions and responses:
What is your child's gender identity?

- Man
- Woman
- Transgender man / Transmasculine

- Transgender woman / Transfeminine
- Non-binary (e.g., genderqueer or gender-expansive)
- Another category (e.g., Two-Spirit)
- Undecided/unknown at this time
- Not sure what this question means
- Prefer not to answer

What was your child's sex designated or listed at birth?

- Male
- Female
- X
- Another category (e.g., Intersex)
- Prefer not to answer

Do you think of yourself as:

- Heterosexual/straight
- Gay or lesbian
- Bisexual or pansexual
- Something else (e.g., queer, asexual)
- Undecided/unknown at this time
- Not sure what this question means
- Prefer not to answer/prefer no labels

Objective 3: Roll out a Power BI portal to evaluate provider-level performance trends.

In CY 2022 a Power BI dashboard was in development to provide Directly Operated (DO) and Legal Entity (LE)/Contracted providers the ability to access provider-level satisfaction and domain specific data. In FY 2022-23, the Quality Improvement (QI) Unit management transitioned to new leadership and the QI Unit began to receive support from the Outcomes Team on data analysis and organization including Consumer Perception Survey (CPS). After a brief pause due to low QI Unit staffing, work has reinitiated on development of a Power BI dashboard to display both Directly Operated (DO) and Legal Entity (LE)/Contracted provider-level overall satisfaction data, domain-specific data, and data trends over multiple survey periods. The QI and Outcomes Units' collaborative efforts will create opportunities for new strategies to increase the utility of the consumer satisfaction data for providers and the Department.

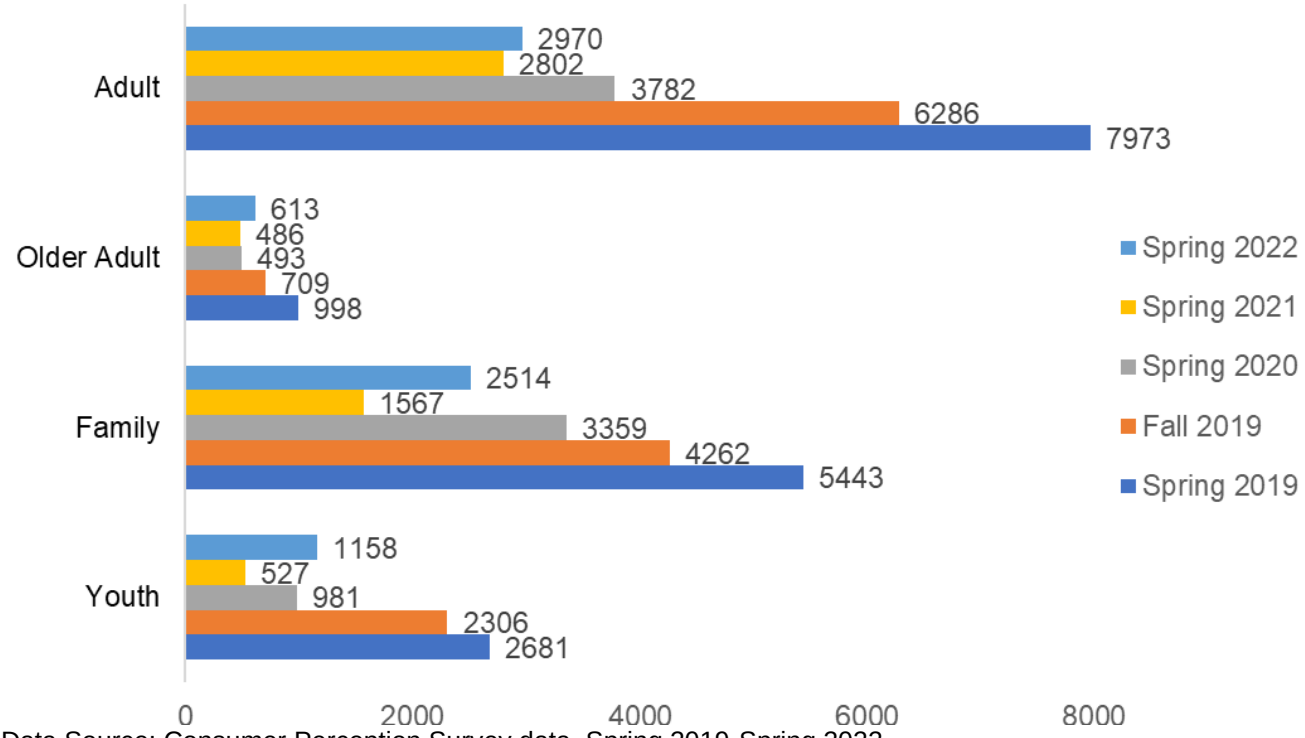
Objective 4: Monitor response rates and review the mechanism for tracking participation history and program types.

The QI Unit tracks and logs all providers who participate in CPS by provider reporting number. In CY 2022 all Directly Operated (DO) and Legal Entity (LE)/Contracted outpatient providers were required to participate. Lists of participating providers are categorized by Service Area (SA). The QI Unit also requires that participating providers complete and turn in tracking logs for number of completed paper surveys and sent UCLA electronic survey links to track participation. LACDMH electronic survey numbers and provider participation are recorded and logged by CIOB and the QI Unit. Data regarding provider and consumer participation during the survey period are reported to the SAs in subsequent SA Quality Improvement Committee meetings.

The QI Unit also tracks and logs number of received and completed surveys via age group, survey delivery method, and service area. These include the LACDMH and UCLA electronic surveys and paper surveys. Figure 54 shows the number of completed surveys by age group for the past 5 survey periods. There is a notable decline in number of received surveys from all age groups between Spring 2019 to Spring 2021 with an increase in number of surveys completed from Spring 2021 to Spring 2022.

Figure

54. Number of Surveys Completed by Age Group, Spring 2019-Spring 2022

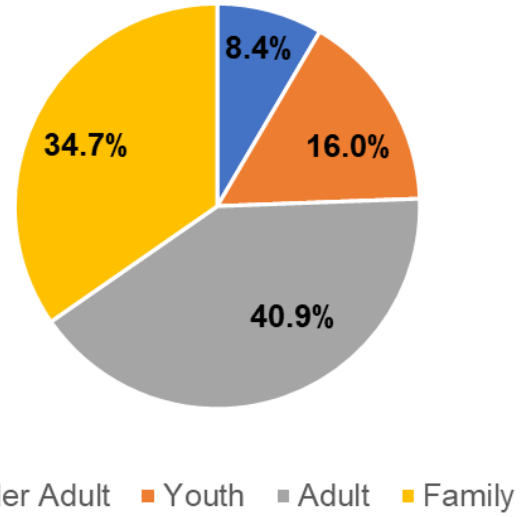


Data Source: Consumer Perception Survey data, Spring 2019-Spring 2022.

In CY 2022, there was an increase in surveys completed during the survey period. The majority of surveys were completed by Adults (40.9%), followed by Families (34.7%), Youth (16.0%) and Older Adults (8.4%). Surveys were collected from 12.2% of the consumers who received services from outpatient and day treatment programs during the one-week survey period. SA 2 had the highest amount of completed surveys (18.0%) and SA 1 (3.2%) had the lowest amount of completed surveys. Figure 55 shows the percent of surveys completed by age group in CY 2022.

Figure

55. Percent of Surveys Completed by Age Group, Calendar Year 2022

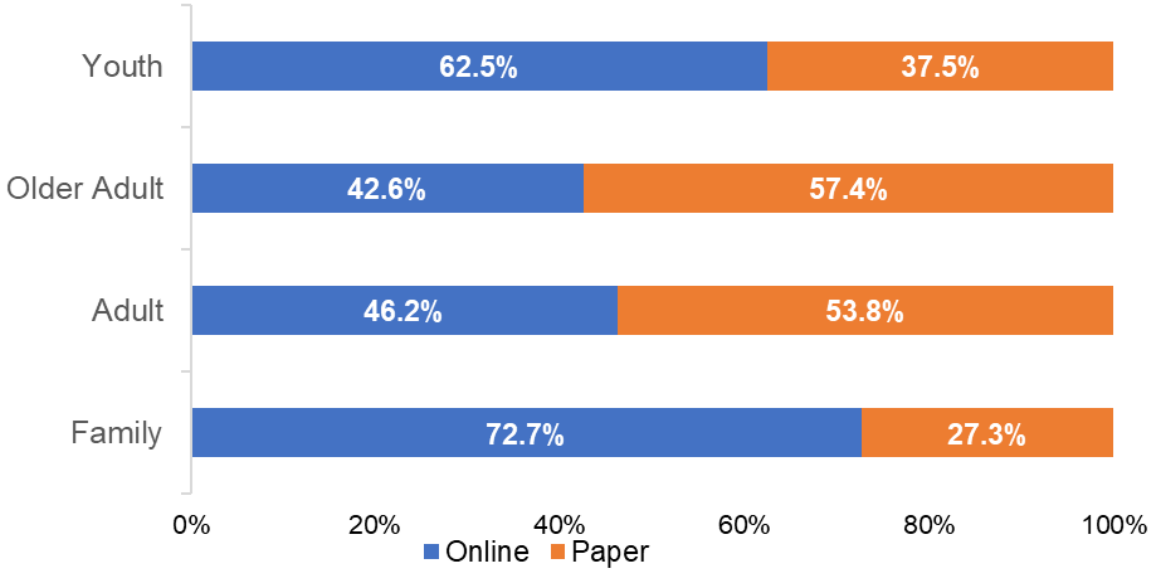


Data Source: Consumer Perception Survey data, May 2022.

In CY 2022, it was noted that the four age groups showed preferences for completing surveys in different formats. Families and Youth completed most surveys using the online format (Families,72.7%; Youth, 62.5%). Adults completed the majority of surveys using the paper format (53.8%). Older Adult respondents also completed the majority of the surveys using the paper format (57.4%). The QI Unit will continue to make available multiple survey delivery methods and monitor and share consumer preferences with providers in order to increase response rates among the various age groups in future survey periods.

Figure

56. Percent of Surveys Completed by Format by Age Group, Calendar Year 2022

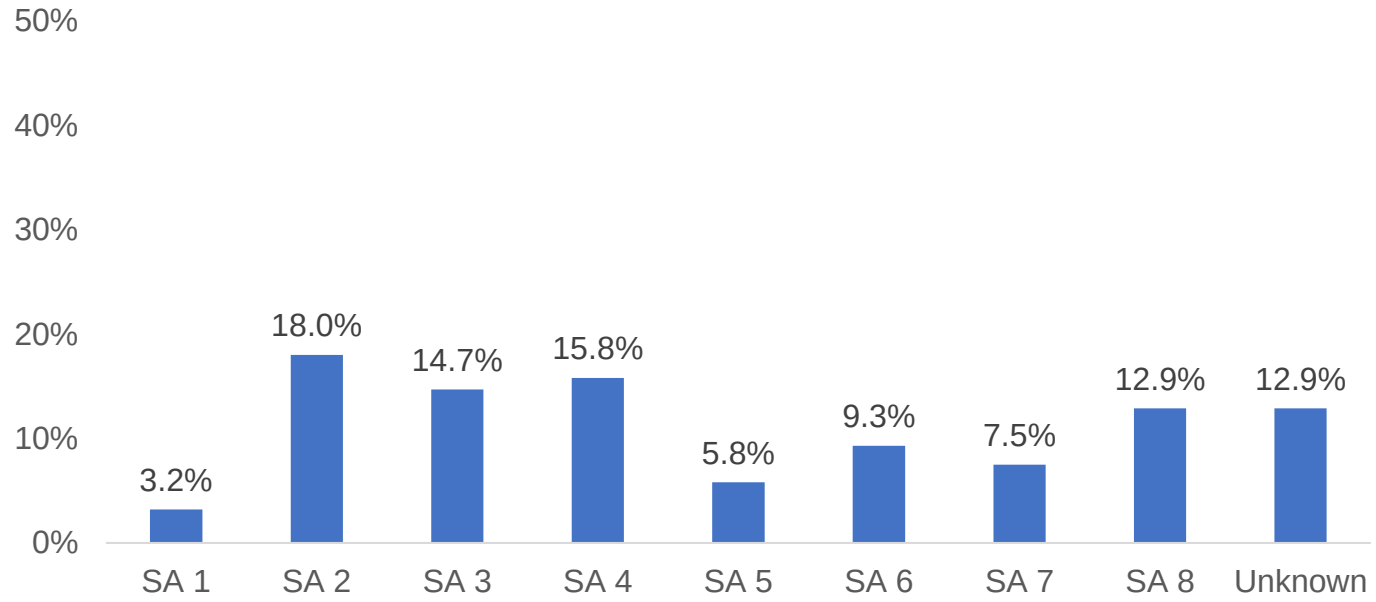


Data Source: Consumer Perception Survey data, May 2022.

The QI Unit also monitors and reports the number of completed surveys and method of returned surveys by SA. The QI Unit informs providers during SA QIC meetings of participation rates to encourage and highlight provider participation. In CY 2022, SA 2 had the highest number of surveys returned from all 8 SAs with 18.0% of total surveys returned. SA 1 had the lowest number of surveys returned with 3.2% of total surveys returned. It is of note that 12.9% of surveys were returned as Unknown in which SA and reporting unit were not identified nor included in SA totals. Figure 57 shows the percent of surveys returned by SA.

Figure

57. Percent of Surveys Returned by Service Area

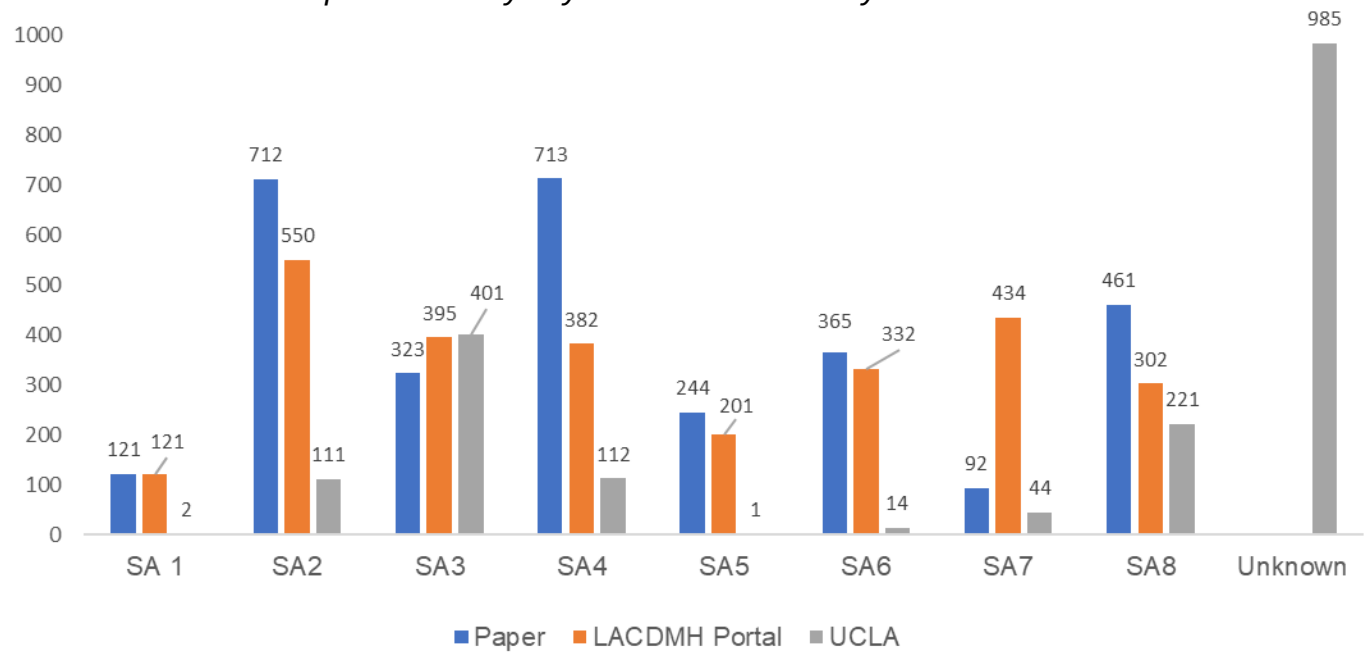


Data Source: Consumer Perception Survey data, May 2022.

Additionally, in CY 2022, SA2 had the highest number of completed surveys by LACDMH portal and a similar number of completed paper surveys as SA4. The majority of surveys completed by UCLA link were returned as Unknown. The majority of those with reporting unit identified were from SA3. Figure 58 shows the number of completed surveys returned by service delivery method returned by SA during the Spring 2022 survey period.

Figure

58. Number of Completed Surveys by Method Returned by Service Area



Data Source: Consumer Perception Survey data, May 2022.

Client Grievances, Appeals, and Change of Provider Requests

Goal IIIb.	Monitor grievances, appeals, and requests for a Change of Provider (COP).
Objective(s)	1. Automate data collection processes to eliminate waste and improve the availability of real-time data. • Implement a public-facing portal to receive client grievances and complaints. • Develop a provider application to track monthly submissions of COP requests. 2. Review the nature of complaints, resolutions, and COP requests for significant trends that may warrant policy recommendations or system-level improvement strategies.
Population	Los Angeles County residents engaging in DMH services (outpatient, inpatient, FFS)
Performance Indicator(s)	1. Total beneficiary complaints and resolutions by type in FY 2021-22 2. COP requests by type in FY 2021-22
Frequency of Collection	Annually
Responsible Entity	Patient's Rights Office

This goal was partially met. As of March 2022, the Patient's Rights Office (PRO) worked to increase staff and transitioned to support the changing requirements for reporting to the State. Regular meetings with the Clinical Risk Unit resumed in April 2022 to review trends and data.

Objective 1: Automate data collection processes to eliminate waste and improve the availability of real-time data.

Forms for grievances are now available for beneficiaries online. The public facing Grievance portal is still in progress, and PRO meets weekly with CIOB for continued development of the portal. Tables 20 and 21 describe the grievances received and their disposition in FY 2021-22.

Table

32. Inpatient and Outpatient Grievances for LACDMH Medi-Cal Beneficiaries by Category, Fiscal Year 2021-22

Category	Grievance	Exempt Grievances
ACCESS		
Service not Available	0	0
Service not Accessible	0	0
Timeliness of Services	8	0
24/7 Toll-Free ACCESS Line	0	0
Linguistic Services	1	0
Other Access Issues	10	0
ACCESS – Total by Category	**19**	**0**
Percent	**5.6%**	**0%**
QUALITY OF CARE		
Staff Behavior Concerns	72	0
Treatment Issues or Concerns	35	0
Medication Concern	22	0
Cultural Appropriateness	2	3
Other Quality of Care Issues	24	0
QUALITY OF CARE – Total by Category	**155**	3
Percent	**45.5%**	**50.0%**
CHANGE OF PROVIDER – Total by Category	**0**	**0**
Percent	**0%**	**0%**
CONFIDENTIALITY CONCERN – Total by Category	**0**	**0**
Percent	**0%**	**0%**
OTHER		
Financial	0	0
Lost Property	14	1
Operational	4	0
Patients' Rights	31	0
Peer Behaviors	18	2
Physical Environment	9	0
County (Plan) Communication	0	0
Payment/Billing Issues	0	0
Suspected Fraud	0	0
Abuse, Neglect, or Exploitation	4	0
Other Grievance not Listed Above	87	0
Other – Total by Category	**167**	**3**
Percent	**49.0%**	**50.0%**
Grand Totals	**341**	**6**

Note: Data above reflects the grievances for/by Medi-Cal beneficiaries. Data Source: DMH, ABGAR Form FY 2021-22, prepared by PRO in July 2023.

Table

33. Inpatient and Outpatient Grievance Dispositions for DMH Medi-Cal Beneficiaries, Fiscal Year 2021-22

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	8	0
24/7 Toll-Free Line	0	0	0
Linguistic Services	0	1	0
Other Access Issues	0	10	0
ACCESS – Total by Category	**0**	**19**	**0**
QUALITY OF CARE			
Staff Behavior Concerns	1	71	0
Treatment Issues or Concerns	3	30	2
Medication Concern	0	22	0
Cultural Appropriateness	1	4	0
Other Quality of Care Issues	2	22	0
QUALITY OF CARE – Total by Category	**7**	**149**	**2**
OTHER			
Financial	0	0	0
Lost Property	0	14	1
Operational	0	4	0
Patients' Rights	5	26	0
Peer Behaviors	0	20	0
Physical Environment	0	9	0
County (Plan) Communication	0	0	0
Payment/Billing Issues	0	0	0
Suspected Fraud	0	0	0
Abuse, Neglect, or Exploitation	0	4	0
Other Grievances not Listed Above	0	87	0
OTHER – Total by Category	**5**	**164**	**1**
Grand Totals	**10**	**332**	**3**

Data Source: DMH ABGAR Form FY 2021-22, prepared by PRO in July 2023.

Objective 2: Review the nature of complaints, resolutions, and COP requests for significant trends that may warrant policy recommendations or system-level improvement strategies.

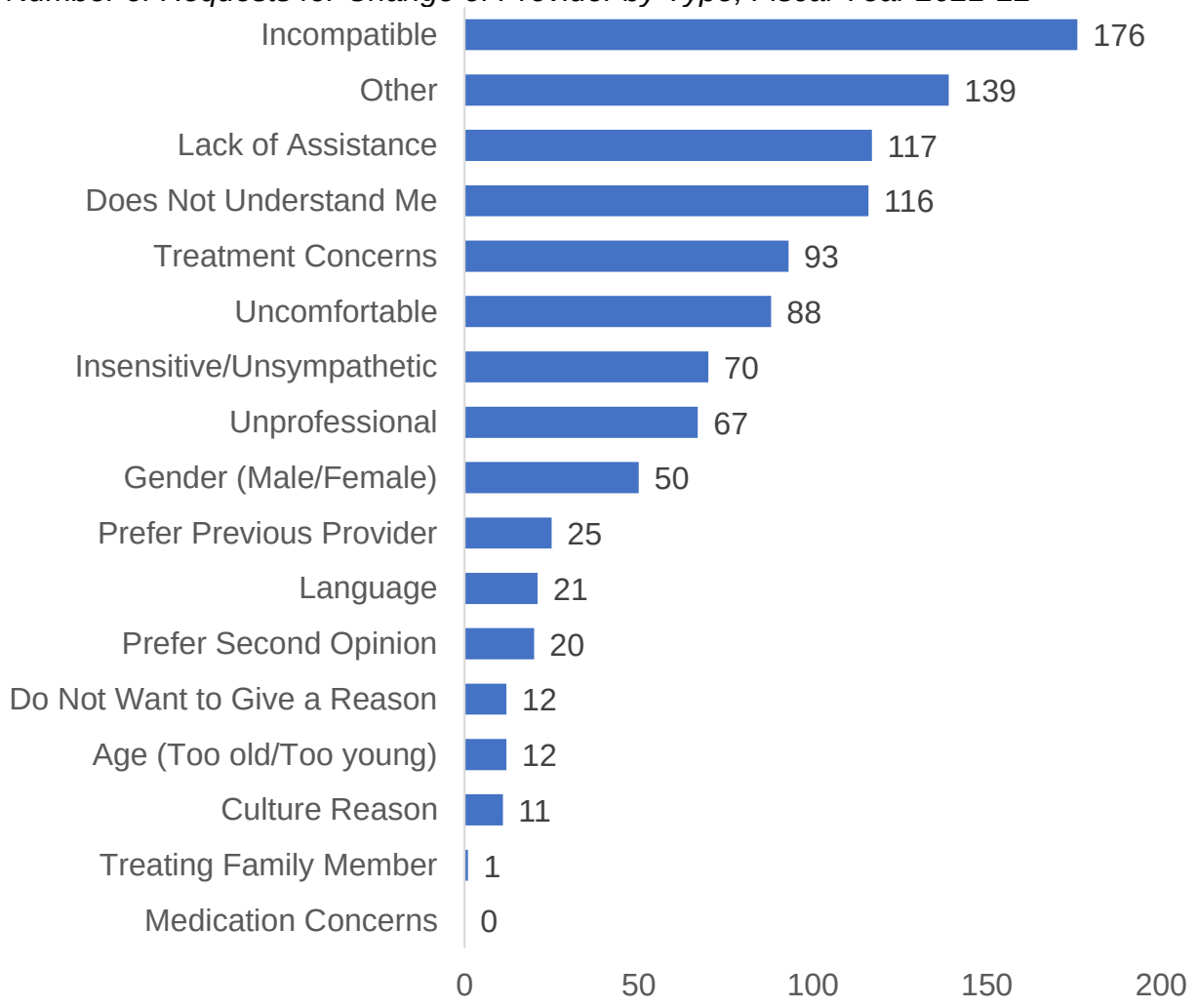
For FY 2021-22, 475 COP requests were received by the PRO office from DO and LE/Contracted providers. Of the 475 requests, 234 were granted and 241 were not granted. Reasons COP requests were not granted included the following categories:

- Staff are available to assist with interpretation
- Unable to contact client to discuss request
- Unable to meet client's need in providing the specific medication - denied by Medi-Cal multiple times
- A requested provider was unable to take client due to a full caseload
- Request was resolved
- Client agreed to talk with provider about their concerns
- Request was against medical staff recommendation
- Unable to accommodate request due to insufficient practitioners
- Client decided to stay with current therapist/provider
- Client agreed to seeing a therapist on VSee instead of making changes
- Client requested their case be closed and a referral was provided for another mental health clinic

The reason categories for COP requests were revised and are displayed in Figure 59 as number of COP requests by type for FY 2021-22. The highest number of requests were for Incompatibility at 176, Other category at 139, Lack of Assistance at 117, and Does Not Understand Me at 116. The lowest number of requests were for Do Not Want to Give Reason and Age at 12, Cultural Reason at 11, Treating a Family Member at 1, and Medication Concerns at 0.

Figure

59. Number of Requests for Change of Provider by Type, Fiscal Year 2021-22



Note: Clients were able to indicate more than one reason for their Change of Provider request. Data source: PRO Change of Provider Logs, July 2023.

Clinical Reporting

Goal IVa.	Rollout Child and Adolescent Needs and Strengths – 50 (CANS-50) and Pediatric Symptom Checklist-35 (PSC-35) aggregate reporting to support children and youth program operations.
Objective(s)	1. Providers will have access to client-level aggregate reports. 2. Identify and develop the mechanism for generating program-level reports. 3. Run tests with a sample of providers. 4. Develop and implement training for DO staff and supervisors (Year One). 5. Research and explore relevant and user-friendly reporting elements to include on an LACDMH public-facing dashboard.
Population	DMH Directly Operated (DO) and LE/Contracted programs providing SMHS to children and youth between ages 3 and 21 years.
Performance Indicator(s)	1. One client-level report 2. One provider-level report 3. Clinical utility training with supporting materials
Frequency of Collection	Annually
Responsible Entity	Outcomes Unit

This goal was partially met.

Objective 1: Providers will have access to client-level aggregate reports.

In CY 2022, the LACDMH Outcomes Unit developed a Child and Adolescent Needs and Strengths (CANS) Client Level Report in Power BI that provides data aggregated by each consumer. From the report, directly operated (DO) and legal entity (LE) providers will be able to view all CANS assessments completed for an individual consumer across the LACDMH system. Providers will also be able to compare consumers' CANS scores across assessments over time.

Following development of the CANS Client Level Report, the Outcomes Unit implemented multiple steps to ensure that the report would be ready for production. The report was tested internally to identify and address issues. The Outcomes Unit also granted access to a selected group of supervisors from LACDMH DO children's programs to test the report to provide feedback. Additionally, the Outcomes Unit worked with the LACDMH Chief Information Office Bureau (CIOB) to fix database issues identified and verified that corrections were made. In collaboration with CIOB, the Outcomes Unit explored options regarding where to house the final CANS Client Level report so that both DO and LE providers can easily access the report. In CY 2023, the Outcomes Unit continues to identify potential final report locations, resolve problem areas with the CANS Client Level Report and will finalize the report when all issues are addressed.

In CY 2022, the Outcomes Unit initiated development of a Pediatric Symptom Checklist (PSC) Client Level Report in Power BI. The PSC Client Level Report continues to be in development and validation tests will be run with a sample of LACDMH providers.

Objective 2: Identify and develop the mechanism for generating program-level reports.

Following the CANS Client Level Report in Power BI, in CY 2022 the Outcomes Unit worked on developing a CANS Provider Level Report. The report development team gathered requirements for the provider level report based on provider feedback to determine report elements that best fit the needs of LACDMH DO and LE providers. In CY2023, the CANS Provider Level Report continues to be in development. The Outcomes Unit plans to run validation tests internally and with a sample of LACDMH providers to identify and resolve any potential issues following development of the report.

Objective 3: Run tests with a sample of providers.

The Outcomes Unit provided access to a sample of LACDMH DO supervisors at selected children's provider sites to run validation tests on the CANS Client Level Report following development. Supervisors were asked to provide feedback and recommendations regarding the CANS Client Level Report following testing. Recommendations included requests for increased capability to filter domains, items, and timeframes for specific content viewing and suggestions on where to house the report to allow for increased provider accessibility. Feedback also stated that the CANS Client Level Report is helpful for staff training purposes to guide treatment and determine appropriate level of care for consumers. The Outcomes Unit utilized feedback from provider testing and addressed requests for increased filter options. Based on provider feedback, the Outcomes Unit continues to explore with CIOB options for final location of the report to ensure both DO and LE providers can easily access the report. The Outcomes Unit plans to utilize the same sample of providers to run validation tests with the PSC Client Level Report when ready.

Objective 4: Develop and implement training for DO staff and supervisors (Year One).

In CY 2022, the Outcomes Unit collaborated with the Quality Assurance Unit to develop the Clinical Utility of the CANS for Supervisors Training for LACDMH Directly Operated (DO) Providers. The intended participants for the training are supervisors and program managers of LACDMH DO programs who administer the CANS and PSC-35. The material covered the clinical utility of the CANS and discussed ways of improving the clinical use of the CANS and how to incorporate the review of the CANS in supervision.

The training included the following objectives:

- Identify at least 3 powerful aspects of the CANS that can augment clinical work,
- Identify the 4 scoring levels of the CANS and describe the therapeutic implications and meaning of each,
- Discuss how to organize the needs from the CANS to develop a care plan,
- Discuss how to organize the strengths from the CANS to develop a care plan,
- Discuss how to track CANS and PSC-35 data in IBHIS.

The first Clinical Utility of the CANS for Supervisors Training was conducted on October 4, 2022. The training was attended by 22 participants. Participants were provided 3 continuing education units (CEUs). In an evaluation of the training, the majority of training participants rated that they Agreed or

Strongly Agreed that the training fulfilled training objectives, addressed cultural competency and diversity and the content was useful for clinical practice.

In CY 2023, the Outcomes Unit plans to conduct the Clinical Utility of the CANS for Supervisors Training with CEUs to LACDMH DO providers twice more, conduct the training for LE providers, and record the training to be made available on the LACDMH EPSDT Outcomes page on the LACDMH website.

Objective 5: Research and explore relevant and user-friendly reporting elements to include on an LACDMH public-facing dashboard.

LACDMH engages in ongoing research to explore and identify relevant and user-friendly reporting elements to include on public-facing dashboards. With stakeholder involvement, LACDMH developed a Dashboards committee with team members across LACDMH programs. Committee members participate in monthly meetings to review, identify appropriate and useful elements to include and address issues related to development and publishing of public facing dashboards. Committee members include members of LACDMH Clinical Informatics, Chief Information Office Bureau, Prevention and MHSA Services, Outcomes, and Quality Improvement Units. Dashboard committee members are committed to ongoing review and development of user-friendly, public-facing dashboards to provide consumers with access to necessary LACDMH information and data.

Provider-Level Improvement

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

This goal was partially met. As of March 2022, Training and Operations was a standing agenda item in the Service Area (SA) Quality Improvement Committee (QIC) Meetings. This gave an opportunity to share information and help facilitate discussion around QA Knowledge Assessment surveys. Feedback was collected on available training resources or training needs. Preplanned topics were provided by QA Leads at each meeting. QA Leads focused on Knowledge Assessment Survey process and results, reviewing QA related questions, i.e., questions from the QA email box or providers (regarding Medi-Cal, Specialty Mental Health Services requirements), sharing chart review trends as well as facilitating an exchange of ideas and perspectives from providers.

Due to the implementation of CalAIM's Documentation Redesign Policy which became effective as of July 1, 2022, QA Knowledge Assessments were suspended, allowing providers time to adjust and clearly understand the related requirement changes. Only one Knowledge Assessment was conducted in 2022, in May prior to the July 1 Go-Live date. The subsequent Knowledge Assessment Survey was recently conducted in June 2023. For this reason, the projected goals for this QAPI cycle

should not be considered as valid. The goals for 2023 will be based on Knowledge Assessments administered in June 2023, September 2023, and December 2023.

Healthcare Effectiveness Data and Information Set (HEDIS) Elements

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

This goal was met.

Objective: Identify and pilot a data collection process for dependent foster Child/Youth HEDIS data.

In CY 2022, LACDMH identified and implemented a data collection process for dependent foster Child/Youth HEDIS data. Annually, LACDMH notifies directly operated (DO) and contracted providers regarding SB 1291. Providers are given a data collection workbook, technical guidance documents for each quality assurance (QA) measure, and a timeline for submission. LACDMH further supplements these resources with weekly workgroup meetings (from April through August) and ad hoc individual consultations to support providers through their individual data collection processes. Each provider sources data from their own electronic health record (EHR), medication prescribing system, and laboratory result tracking system. No later than August, each provider submits their completed data collection workbook to LACDMH via a secure electronic file transfer (EFT) process mediated by information technology (IT) staff. Once the workbooks and reports are received by LACDMH, the data is compiled, reviewed, and findings are summarized.

Level of Care

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

This goal was met. As of September 2022, the Access to Care Leadership and Action workgroups, as well as executive management, reviewed several options for an adult Level of Care tool:

1. Determinants of Care, supported by the Milestones of Recovery
2. Reaching Recovery
3. Needs Evaluation Tool (NET) currently used for Targeted Case Management purposes
4. Level of Care Utilization Scale (LOCUS)
5. Adults Needs and Strengths Assessment (ANSA)

Deputy Director Dr. Debbie Innes-Gomberg is leading this implementation effort, and the Outpatient Services Division will support the pilot project when a tool is chosen.

In June 2023, it was recommended and presented to executive management that LACDMH implement the LOCUS tool. DMH is meeting with the American Academy of Community Psychiatry and Deerfield Solutions to obtain pricing and further outline a proposal.

Monitoring Continuity of Care, Calendar Year 2022

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

This goal was met.

Objective 1: Establish a committee to review data monthly.

In FY 2021-2022 Q3 the Intensive Care Division-Treatment Authorization Requests Unit (ICD) initiated a 30-day hospital Re-Admission Reduction Project to reduce rehospitalization rates among Los Angeles County consumers. Two LACDMH hospitals were chosen to participate in the pilot project, Southern California Hospital at Van Nuys, and Los Angeles Downtown Medical Center. The Re-Admission Pilot project is predicated on the implementation of concurrent authorization. The population focus is on those consumers who had 4 hospitalizations within the year or had been hospitalized twice within 30 days. The overall re-hospitalization goal was to reduce rates to no more than 19%. The aim of the pilot was to reduce those factors that may lead to repetitive hospitalizations by increasing the support of the LACDMH teams and programs to aid the hospitals as part of the discharge planning process.

A pilot committee was established to oversee the project. Led by the ICD-TAR Unit, the committee consists of hospital and emergency room clinicians and staff, Los Angeles County Public Health (Substance Abuse Prevention and Control), Managed Care Plans, Department of Mental Health (DMH) Clinical Pharmacy, DMH Navigation (hospital liaisons), ICD (Treatment Authorization Unit, 24 Hour Residential Program), DMH Full-Service Partnership, and DMH Enhanced Care Management (ECM). The committee continues to meet monthly to review data, share progress and status of the Re-Admission Reduction Pilot, identify and problem-solve barriers, and determine steps for expansion of the pilot project.

Each committee member and division has stated expectations and tasks as listed:

Hospital clinicians and staff:

- Review the Treatment Authorization Status (TAS) Forms received via email which will contain information relative to discharge planning.
- Meet with LACDMH team representatives.
- Identify a hospital contact person for the pilot.
- Identify hospital processes and procedures that may need to be added or changed to meet the pilot goals.

TAR Unit:

- Identify the patients that meet the pilot criteria.
- Identify patients' last mental health program.
- Identify if the patient is in a FSP program.
- Identify potential next level of care (with help of InterQual)
- Identify the TAR Unit contact person for the pilot- point of contact.
- Attend weekly meetings with the hospitals.

Clinical Pharmacy:

- Provide additional information concerning prior medications.
- Consult on psychotropic medications.
- Consult on need for non-psychotropic medications.
- Address issues or concerns with prescriptions at pharmacies.
- Follow up with the patients after discharge.
- Follow up with the next level of care physician.
- Attend the weekly meeting with the hospitals.

Enhanced Care Management:

- Identify an ECM liaison at each of our FFS Hospitals to assist hospital social workers and discharge planners with discharge planning and accessing the next level of care (assistance could come in the form of accessing transportation to initial clinic assessment; accessing housing resources; assisting with motivational interviewing; assisting with connections to the next level of care.
- Attend weekly meetings with the hospitals.

Service Area Hospital Navigation Teams:

- Assist with applications for FSP services.
- Assist with applications for AOT services.
- Assist with accessing DMH resources.
- Attend weekly meetings with the hospitals.

Department of Public Health/SAPC:

- Provide the hospitals with direct access to residential substance abuse treatment post discharge without the need of going through the SASH hotline.
- Problem-solve challenges of accessing substance abuse treatment.
- Attend the weekly meetings with the hospitals.

Managed Care Plans:

- Assist with managed care plan resources.
- Assist with enhanced care managed authorizations.

Objective 2: Identify and implement at least one intervention targeting systemwide re-admission rates.

The Re-Admission Pilot goal focuses on early identification of individuals at risk for 30-day re-admission to reduce re-hospitalization rates. The pilot project was initiated with a sample of two contracted hospitals, Southern California Hospital at Van Nuys (SCHVN) and Los Angeles Downtown Medical Center (LADMC), to ensure availability and capacity of program implementation and staff participation with the goal of expanding systemwide. Interventions identified and implemented include concurrent recommendations for transition of care and post discharge services, provision of in-reach, education and support to consumers, multidisciplinary consultation, care planning and utilization of a health information data exchange to improve care coordination.

During FY 2021-22 Q3 through FY 2022-23 Q3, the Re-Admission Pilot identified 495 consumers at risk with 3,700 treatment authorization status forms sent, resulting in 774 recommendations made for LACDMH services. These recommendations included 234 recommendations for Full-Service Partnership services, 22 recommendations for Enhanced Care Management services, and 433 recommendations for Enhanced Care Management and Full-Service Partnership combined services.

Of those 774 recommendations to services, 75 referrals were made to the ICD Unit. Table 34 shows the disposition of referrals made from Southern California Hospital at Van Nuys and Table 35 shows the disposition of referrals from Los Angeles Downtown Medical Center. At Southern California Hospital in Van Nuys a total of 50 out of 59 referrals were approved with the majority for crisis stabilization. At Los Angeles Downtown Medical Center 10 out of 16 referrals were approved, with 10 for crisis stabilization.

Table

34. Southern California Hospital at Van Nuys (SCHVN)

	Crisis Stabilization	Step Down	Subacute	Acute Inpatient	Total
Approved	47	1	1	1	50
No Longer Referred	8	1	0	0	9
Total	55	2	1	1	59

Data source: Mental Health Resource Locator and Navigator (MHRLN).

Table

35. Los Angeles Downtown Medical Center (LADMC)

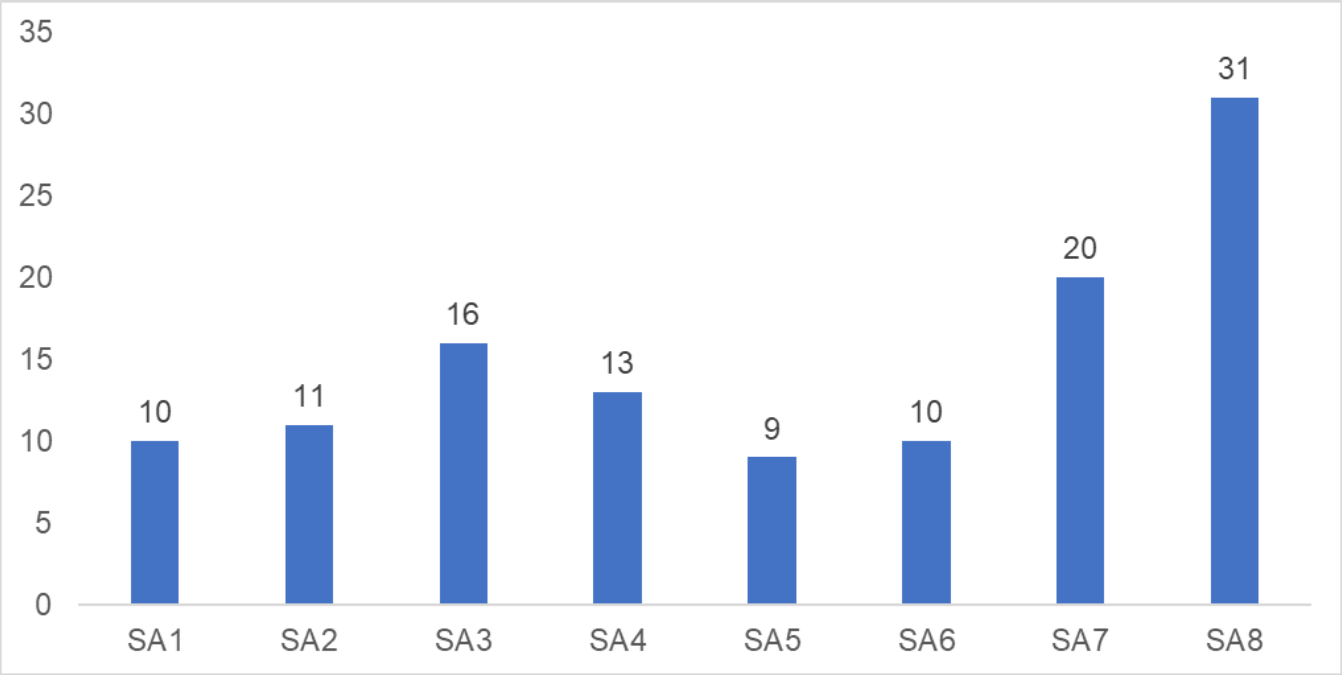
	Crisis Stabilization	Step Down	Subacute	Acute Inpatient	Total
Approved	10	0	0	0	10
No Longer Referred	5	0	0	0	5
Denied	1	0	0	0	1
Total	16	0	0	0	16

Data Source: Mental Health Resource Locator and Navigator (MHLRN).

In addition, 37 referrals were made to pharmacy in-reach services where 13 consumers agreed to in-reach services and 5 agreed to clinical pharmacy recommendations including Narcan exploration and medication tool kits. Forty-three consumers received Long-Acting Injection (LAI) treatment with 238 consumers evaluated and 122 identified as potential candidates for LAI. Referrals made to ECM services were from all 8 Service Areas totaling 120 referrals. Service Area 8 had the most authorized and closed referrals with 31 referrals. Figure 60 shows the total referrals both authorized and closed by Service Area. Consumers also received consultation services from SAPC. Their health plans, presentations and in-reach were provided by the ICD-Crisis Residential Treatment Program (CRTP) and the Homeless Outreach and Mobile Engagement (HOME) teams regarding LAC DMH available services and resources.

Figure

60. Total Enhanced Care Management Referrals Authorized and Closed by Service Area

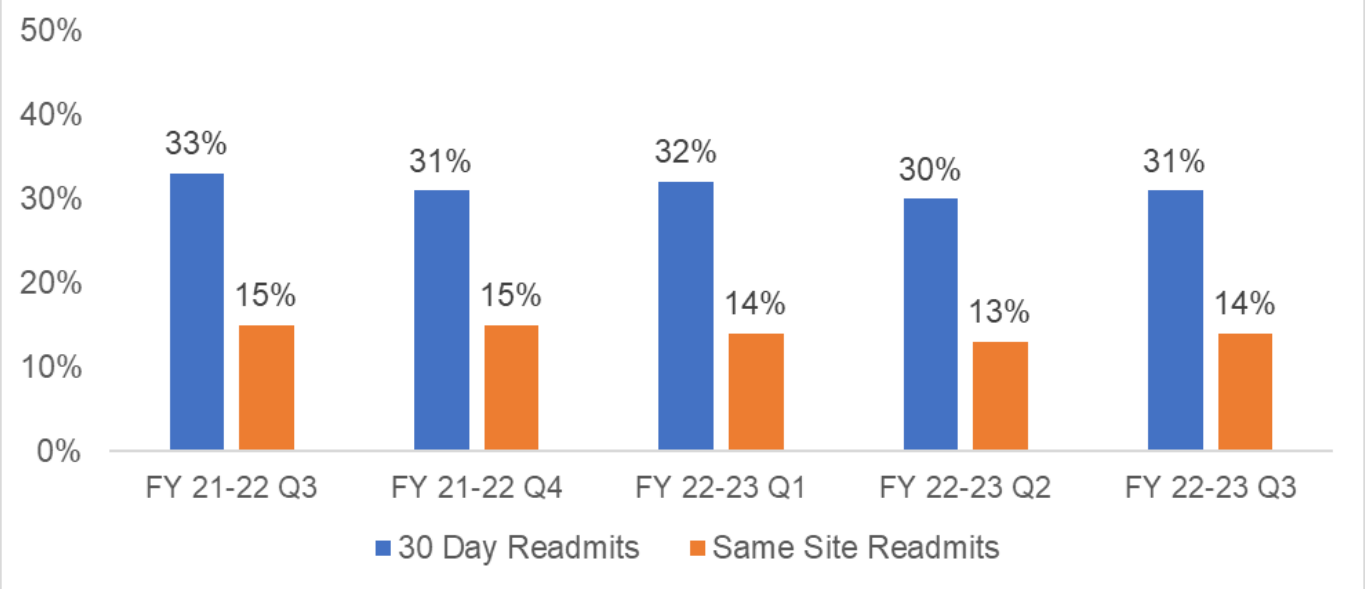


Data source: IHBIS Enhanced Care Management Census.

At all contracted hospitals during FY2021-2022 Q3 through FY 2022-2023 Q3, the percentage of 30-day hospital Re-Admission rates decreased by 2PP and the percentage of same site re-admissions decreased by 1PP. Figure 61 shows the percentage of 30-day re-admission and same site re-admissions rates at all LAC DMH contracted hospitals.

Figure

61. Percentage of 30-day Re-Admission and Same Site Re-Admission Rates at All Contracted Hospitals (Excluding IMD Population)

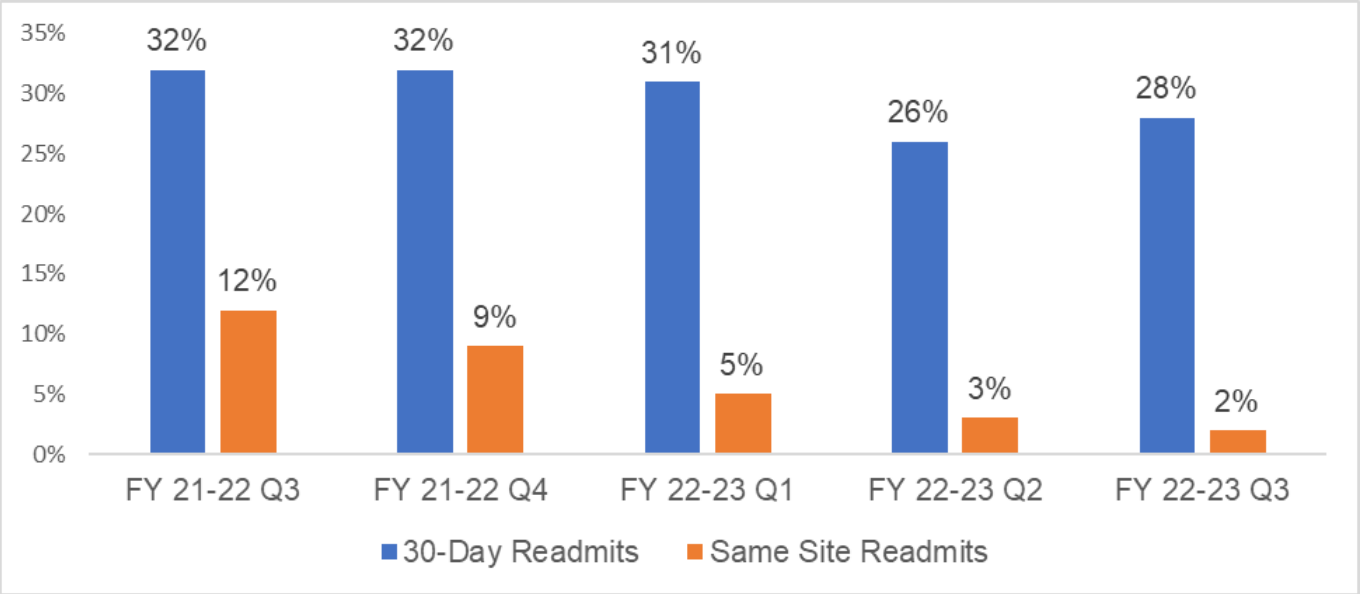


Data Source: Power BI Inpatient Re-hospitalization Report Dashboard for FY 21-22 Q3 – FY 22-23 Q3, retrieved on 06/21/23.

For both pilot participating hospitals, a larger decrease in 30-day re-admission rates was demonstrated. At LADMC during FY 2021-2022 Q3 through FY 2022-2023 Q3, 30-day re-admission rates decreased by 4PP, and same site re-admission rates decreased by 10PP. Figure 62 shows the percentage of 30-day re-admission and same site re-admissions rates at LADMC.

Figure

62. Percentage of 30-day Re-Admission and Same Site Re-Admission Rates at LADMC

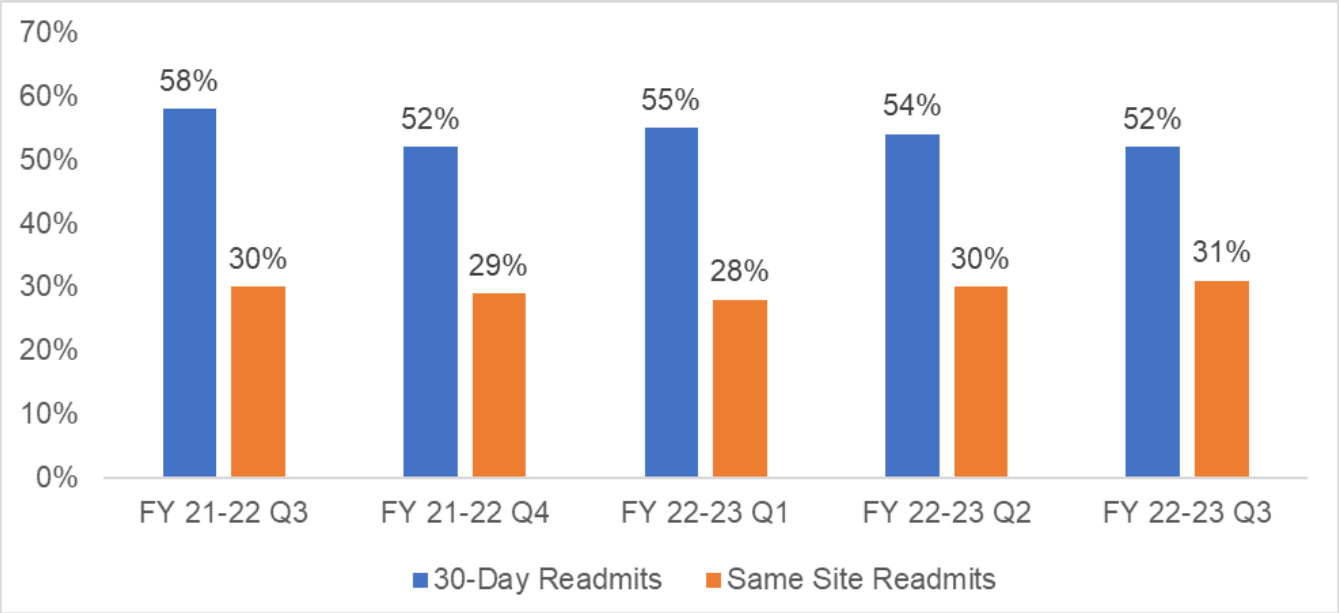


Data Source: Power BI Inpatient Re-hospitalization Report Dashboard for FY 21-22 Q3 – FY 22-23 Q3, retrieved on 06/21/23.

At SCH Van Nuys there was a 6PP decrease in 30-day re-admissions rates during FY 2021-2022 Q3 through FY 2022-2023 Q3. Same site re-admission rates at SCH Van Nuys showed a 2PP decrease from FY 2021-2022 Q3 through FY 2022-2023 Q1 with an increase by 1PP from FY 2021-2022 Q3 through FY 2022-2023 Q3. Figure 63 shows the percentage of 30-day re-admission and same site re-admission rates at SCH Van Nuys.

Figure

63. Percentage of 30-day Re-Admission and Same Site Re-Admissions Rates at SCH Van Nuys



Data Source: Power BI Inpatient Re-hospitalization Report Dashboard for FY 21-22 Q3-FY 22-23 Q3, retrieved on 06/21/23.

LACDMH, the Intensive Care Division, and the Re-Admission Reduction Pilot committee continue efforts to expand the pilot project to additional LACDMH contracted hospitals to further implement the identified interventions to decrease re-admission rates systemwide. In FY 2022-2023 Q4, the pilot committee identified two additional hospitals for pilot expansion, Emanate Health Inter-Community Hospital and St. Francis Hospital. Meetings between the pilot committee and both hospital teams and staff were conducted to initiate plans for implementation of interventions beginning at Emanate Health Inter-Community Hospital in June 2023 and at St. Francis Hospital in July 2023.

Monitoring Provider Appeals, Calendar Year 2022

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

This goal was met.

Objective 1: Review the Provider Appeal Tracking Log for trends and share findings with appropriate entities.

In CY 2021, the Intensive Care Division – Compliance Unit (ICD) developed a Provider Appeal Tracking log to keep track of dates of submitted appeals, resolutions, reasons for denial, and next steps, if any. The log was submitted to the QI unit quarterly along with the Denials Tracking log. These two logs supplement the unit's macro-level data reports, the Hospital Association of Southern California (HASC) report, and the Treatment Authorization Request (TAR) summary report. The HASC includes monthly data regarding the number of TARs, the number of unique consumers for whom TARS are requested, days requested, days denied, days approved, and percent of days approved overall for the first request and first and second appeals. The TAR summary report includes the same metrics as the HASC on overall TARS (i.e., number of TARs, the number of unique consumers for whom TARS are requested, days requested, days denied, days approved, and percent of days approved) in addition to the average requested and approved length of stay and cost by the hospital.

In CY 2022, the Provider Appeal Tracking Log continues to be utilized by the ICD Unit and data is collected and reviewed monthly. The log is shared internally within the Intensive Care Division with the Compliance Unit and Provider Relations Unit, the Appeals Team, psychiatrists, clinical supervisors, and clinical reviewers and is available for review with hospitals during their individual meetings with the Treatment Authorization Unit.

Table 36 presents the three-year trend in the number of TARs received, the percent approved, and the number of first appeals received and approved. The number of overall TARs received between CY 2020 (N=28,501) and CY 2022 (N=29,908) increased by 4.7%, and the percent approved increased 27.9 percentage points (PP) from 67.7% in CY 2020 to 95.6% in CY 2022. The number of first appeal TARs received decreased by 19.4% from CY 2020 to CY 2022, whereas the first appeal TARs approved was improved by 11.6 PPs.

Table

36. Three-Year Trend in TARs Received and Percent Approved

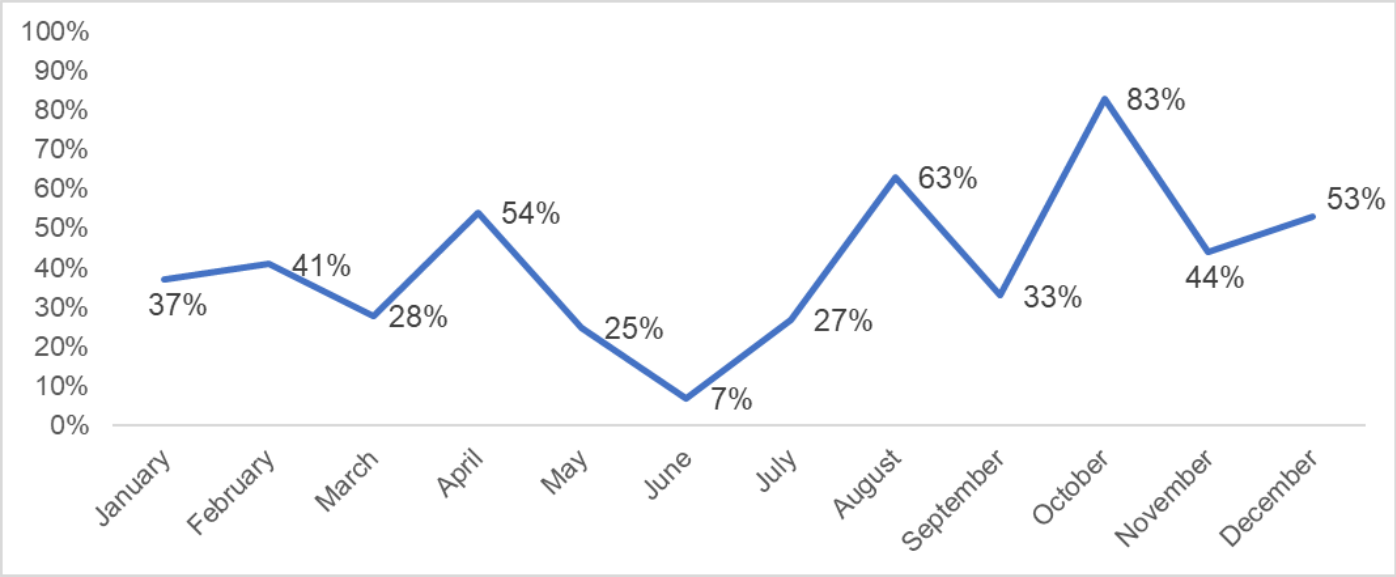
	CY 2020	CY 2021	CY 2022
Overall TARS Received	28,501	27,939	29,908
% Overall Approved	67.7%	93.0%	95.6%
First Appeal TARS Received	660	689	532
% First Appeal Approved	29.7%	34.1%	41.3%

Data Source: TARs and Appeals COGNOS reports, CY 2020-CY 2022.

Figure 64 displays the percentage of appealed days approved out of those requested for each month in CY 2022. The percent approved for first appeal days varied widely from month to month. April, August, and October 2022 were the months with the highest percentage of first appeals approved, with much lower rates in May, June, and July 2022.

Figure

64. Percent of Treatment Authorization Requests Appealed Days Approved by Month for Calendar Year 2022



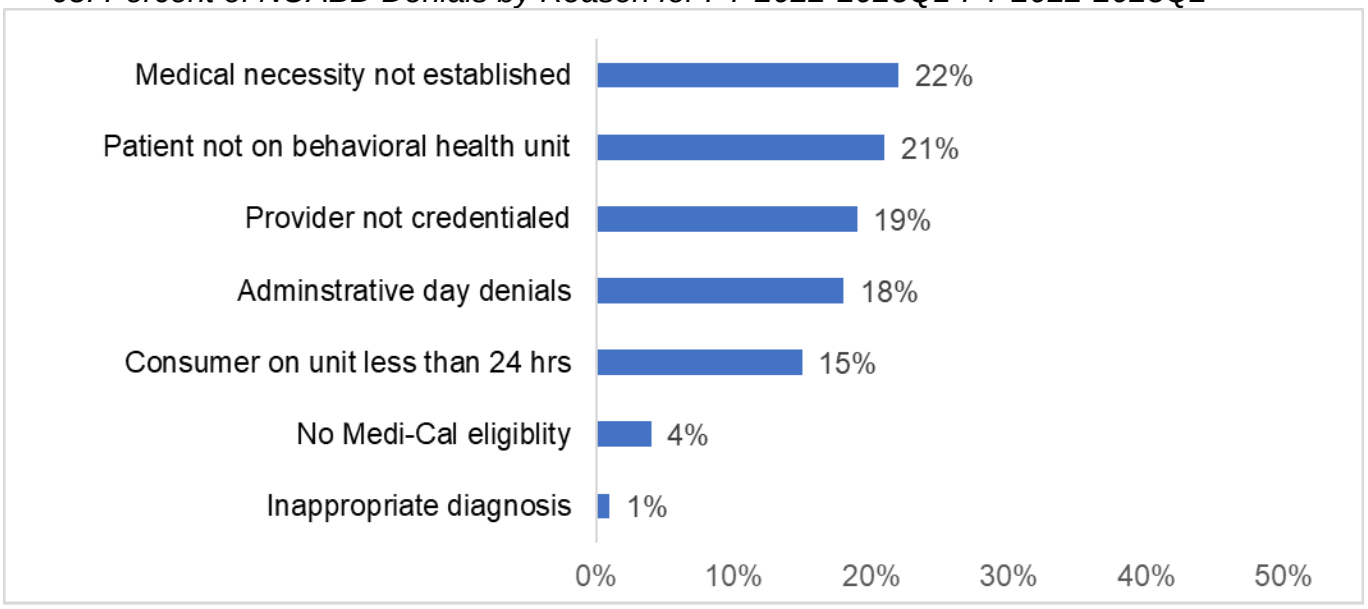
Data Source: Hospital Association of Southern California (HASC) Report, CY 2022.

In FY 2022-2023 Q1 through FY 2022-2023 Q2, the ICD unit issued 651 Number of Adverse Benefits Determinations (NOABD). Analysis of these reasons indicated that the most common category for NOABD denial reason is that medical necessity is not established. Figure 65 shows the percent of NOABD denials by reasons. The lack of documented medical necessity (22%) or the consumer not on the behavioral health unit (21%) were the most common reasons for denial. The next most common reasons included the provider not being credentialed (19%), administrative day denials (18%), and the consumer being on the unit for less than 24 hours (15%). Figure 66 shows the number of NOABD denials by month from July 2022-March 2023. The majority of NOABD denials were issued in March 2023 with 18.9% followed by August 2022 with 14.6%. In addition, a total of 293, first

level appeals were received with 149 being upheld and 144 being overturned. There were 43, second level appeals that were 100% upheld.

Figure

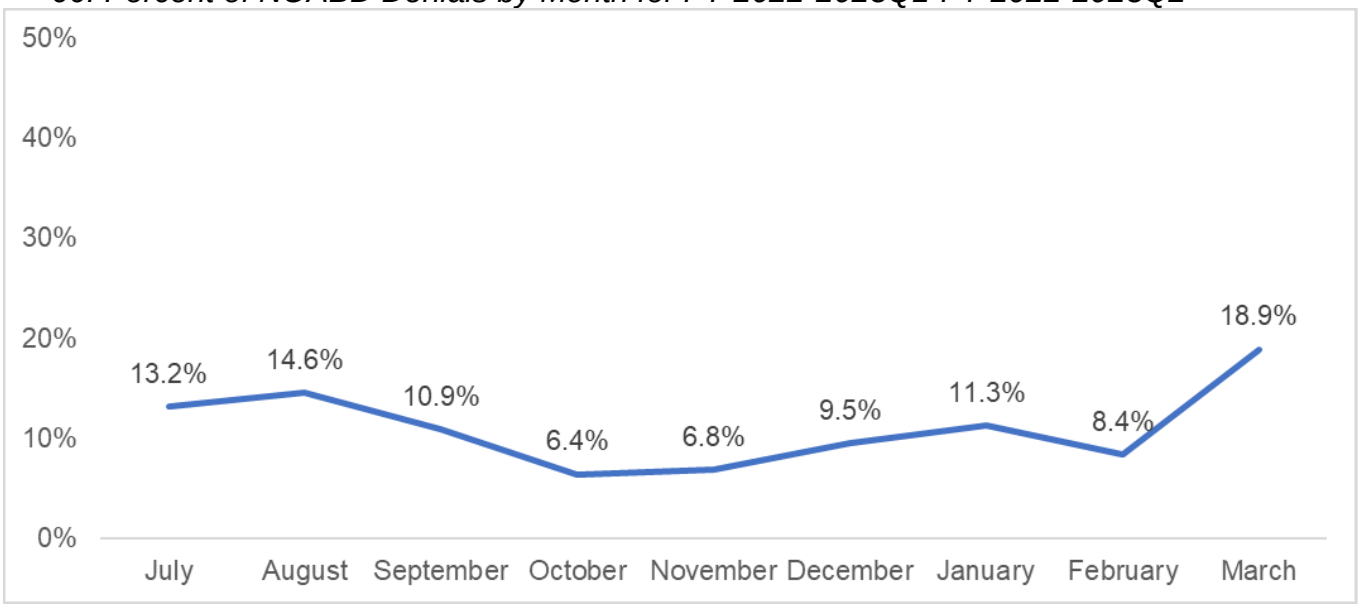
65. Percent of NOABD Denials by Reason for FY 2022-2023Q1-FY 2022-2023Q2



Data Source: Notice of Adverse Benefit Determination log, FY 2022-2023 Q1-FY- 2022-2023 Q2.

Figure

66. Percent of NOABD Denials by Month for FY 2022-2023Q1-FY 2022-2023Q2



Data Source: Notice of Adverse Benefit Determination log, FY 2022-2023 Q1-FY- 2022-2023 Q2.

The Intensive Care Division – Compliance Unit engages in several quality improvement efforts to address the NOABD data trends. They conduct multiple Technical Assistance trainings with hospital staff to ensure understanding of the procedures that must be followed to establish medical necessity, approve acute and, particularly, administrative days, to improve documentation so that the need for continuing days are clearly supported in the notes, and to increase communication around discharge planning. The unit also has a weekly standing call with the hospitals participating in concurrent review

to track the data and address any issues as they arise. The unit has been improving communication with hospitals by sending the Treatment Authorization Status form within 24 hours.

Next steps include continued collection of dates of submitted appeals, resolutions, and reasons for denial, using the Provider Appeal Tracking log on a monthly basis. The Provider Appeal Tracking log will be utilized to identify and analyze trends, incorporate trends within provider upload meetings, explore provider, system, and process issues that impact denials, analyze data to compare denials from contracted versus non-contracted and IMD Exclusion versus GACH stays, and review denials by psychiatrists.

Objective 2: Concurrent authorization will be operational at all hospitals.

Concurrent authorization is operational at all hospitals. The ICD Unit conducted a concurrent rollout for contracted providers on October 7th, 2021. An All-Provider Concurrent Authorization meeting was conducted on December 2, 2022, to ensure that all providers were informed of procedures and requirements for implementation. Standing weekly concurrent authorization meetings are held for both contracted and non-contracted providers.

Currently, 100% of contracted providers received information for the All-Provider Concurrent Authorization Implementation Meeting. All contracted providers (100%) participated in an individual concurrent review support meeting and 100% of contracted providers are utilizing the concurrent review process. For non-contracted providers, 100% received information for the All-Provider Concurrent Authorization Implementation meeting, 33% of non-contracted providers participated in an individual concurrent review support meeting, 30% of non-contracted providers are utilizing the concurrent review process, and 70% of non-contracted providers are awaiting Los Angeles County Medi-Cal Beneficiary to start the concurrent process. The ICD Unit will continue to support contracted and non-contracted providers in concurrent authorization implementation.

Monitoring Performance Improvement Projects, Calendar Year 2022

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

This goal was met.

Clinical Performance Improvement Project

The Clinical Performance Improvement Project (PIP) entitled, "Improving Treatment Services for Individuals with Eating Disorders" began in June 2021 and continued through June 2023. The improvement strategy was focused on (1) providing quality, evidence-based care to the increasing number of individuals with eating disorders (EDs) in order to reduce the need for Higher Levels of Care (HLOC), and (2) improving screening and assessment methods to address the discrepancy between expected ED prevalence rates and diagnostic rates.

The interventions employed to meet these aims included:

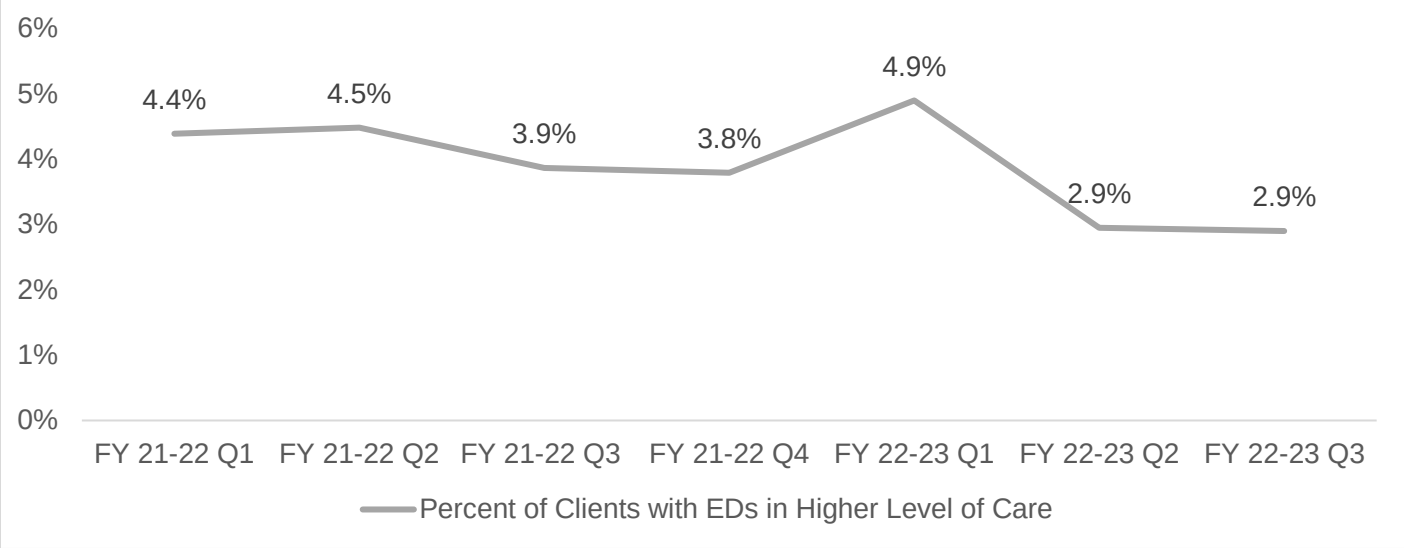
1) Development of an integrated practice network, which was originally formed in the research phase of the PIP and has continued to be active
2) Refining the ED treatment parameters and referral process, which was done by way of a QA Bulletin in July 2022
3) Offering trainings like Cognitive Behavioral Therapy-Enhanced (CBT-E), ED 101, ED 102, and Family-Based Therapy (FBT)
4) Offering a monthly clinical consultation series originally meant to support the ED 101 trainees but is now available to any DO or LE/Contracted provider who wants to improve their ED assessment and treatment skills
5) Development of a Best Practices Clinical Toolkit, which is now being hosted and maintained on the DMH public-facing website to ensure availability to both DO and LE providers

Objective 1: *Decrease the number of ED clients that require HLOC.*

After some fluctuations, both the number and percentage of clients with EDs being treated in a HLOC increased over baseline of 28 (4.4%) to 33 (4.9%) in Quarter 1 of FY 2022-23 (Figure 67). Subsequently, the number and percentage of clients declined to a fairly consistent 18 (2.9%) in March 2023, the most recent month for which data are available at the time of this writing.

Figure

67. Percent of Clients with EDs that Received Higher Levels of Care by Quarter

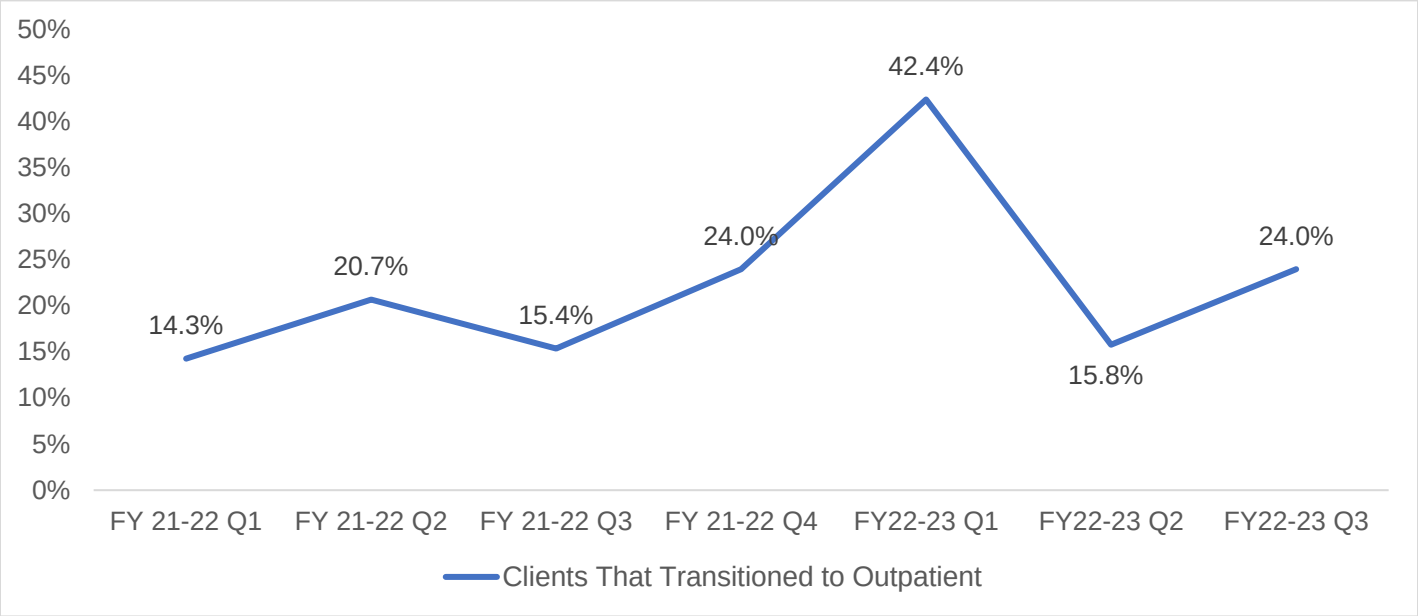


Objective 2: Increase the number of ED clients that step down from HLOC.

As seen in Figure 68, the number and percentage of clients with EDs who transitioned to outpatient care after being in a HLOC increased from a baseline of four (14.3%) in Q4 of FY2021-22 to 14 (42.4%) in Q1 of FY2022-23, before dropping again to an average of six (24.0%) in the most recent quarter for which data are available. It appears that there could be seasonal variation in the transition to outpatient services.

Figure

68. Percent of Clients in Higher Level of Care that Transitioned to Outpatient Care by Quarter

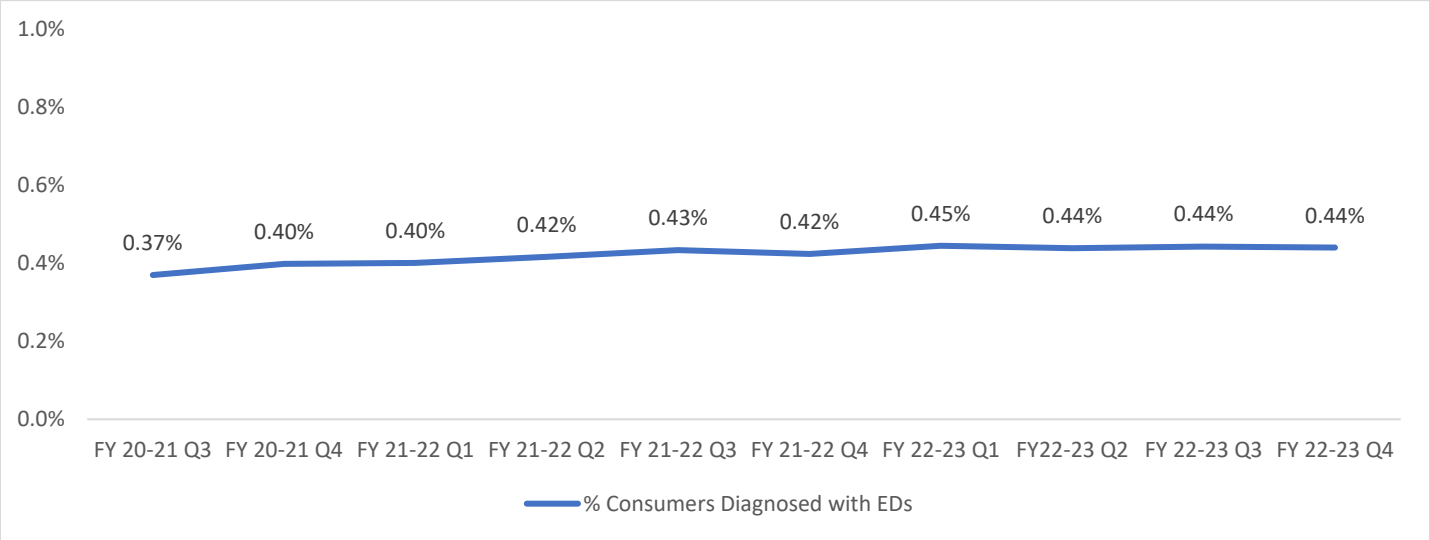


Objective 3: Increase screening and diagnosis of EDs at intake.

The number and percentage of clients with EDs being served in the Los Angeles County Department of Mental Health System of Care increased steadily between Q3 of FY2020-21 and Q1 of FY2022-23 and has levelled off since then, as seen in Figure 69. In Calendar Year 2019, there were 744 individuals diagnosed with EDs (0.29% of those served). While in Calendar Year 2022, there were 980 individuals diagnosed with EDs, which accounts for 0.43% of those served. So far in 2023, 0.44% of those served were diagnosed with Eating Disorders.

Figure

69. Percent of Consumers Diagnosed with EDs by Quarter



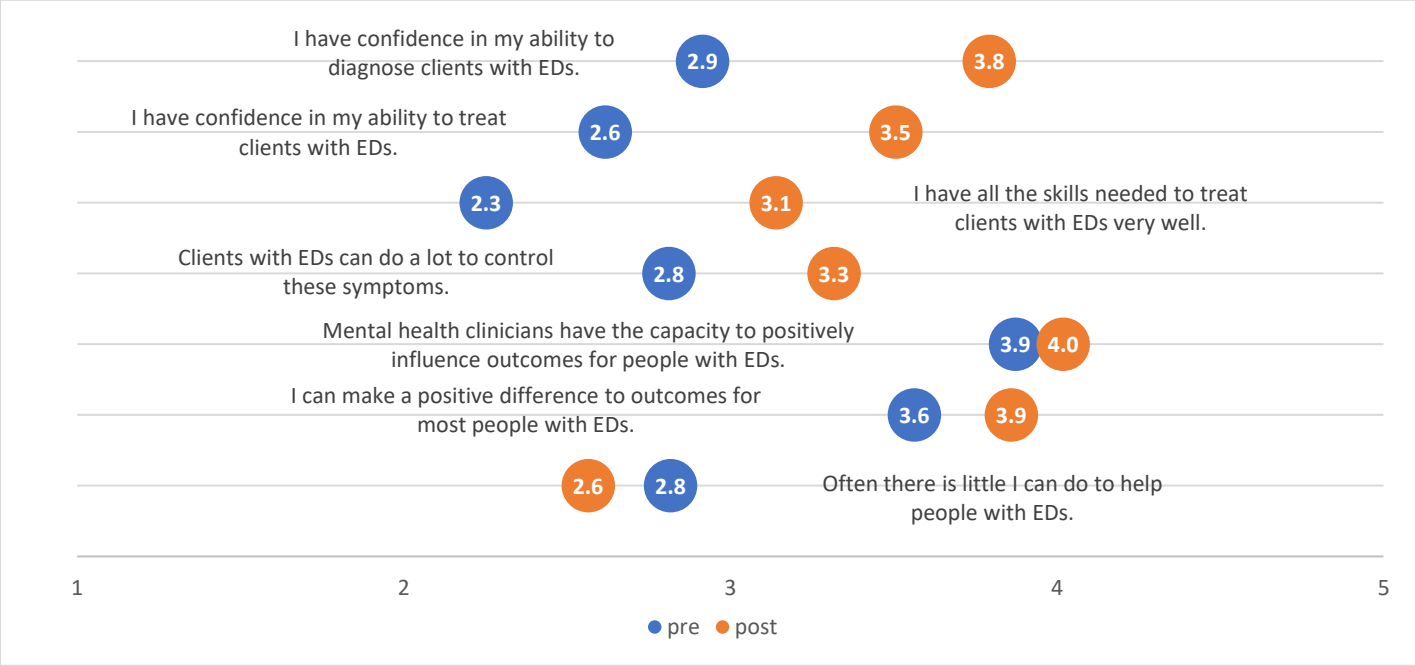
Objective 4: Increase practitioner confidence in working effectively with clients with EDs.

Practitioners who participated in the CBT-e, ED101, ED102, and FBT trainings between June 2022 and June 2023 were surveyed about their confidence and comfort working with clients with EDs. Their pre-

training and post-training responses were aggregated and are shown in Figure 70. Where 1 is strongly disagree, 3 is neutral, and 4 is strongly agree, participants went from a 2.9 before the training to a 3.8 after the training (on average) for the item "I have confidence in my ability to *diagnose* clients with EDs". For the item "I have confidence in my ability to *treat* clients with EDs," participants went from 2.6 on average to 3.5 on average. The item "I have all the skills needed to treat clients with EDs very well" increased from 2.3 to 3.1 on average.

Figure

70. Attitude Change Scores Pre and Post: Average Aggregate of Four different (CBT-e, ED 101, ED 102, FBT) Trainings between June 2022 and June 2023

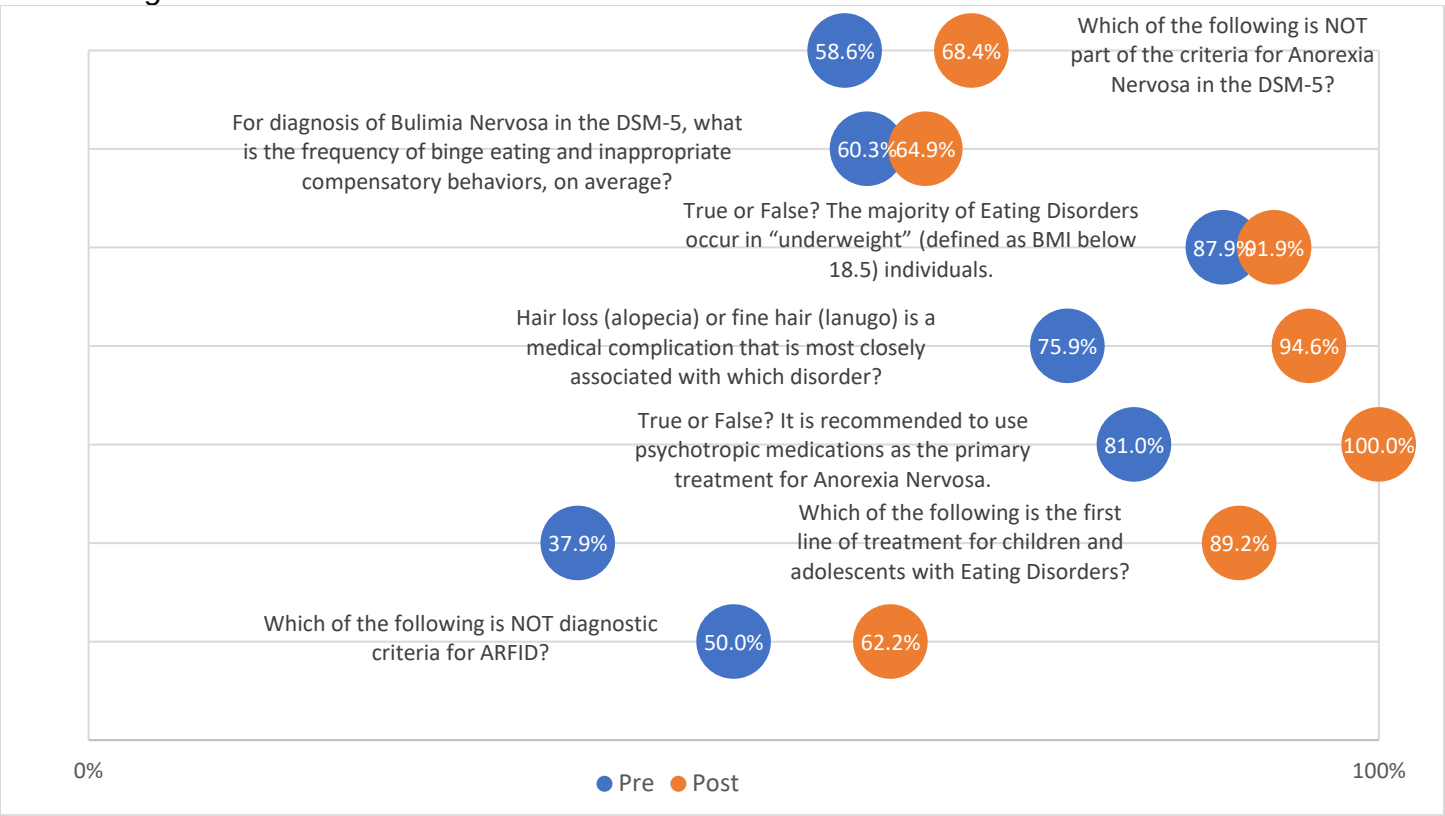


Objective 5: Increase practitioner knowledge in working with clients with EDs.
Participants in the different trainings mentioned above were given different knowledge assessments before and after their trainings. Scores were only aggregated for survey responses from the same knowledge tests. However, scores increased across the board, as the following examples show.

Figure 71 shows the pre and post ED 102 trainings knowledge test results. Before the ED 102 trainings in March and June of 2023, only 37.9% of the participants responded correctly to the question "Which of the following is the first line of treatment for children and adolescents with Eating Disorders?" After the training, 89.2% got the correct answer.

Figure

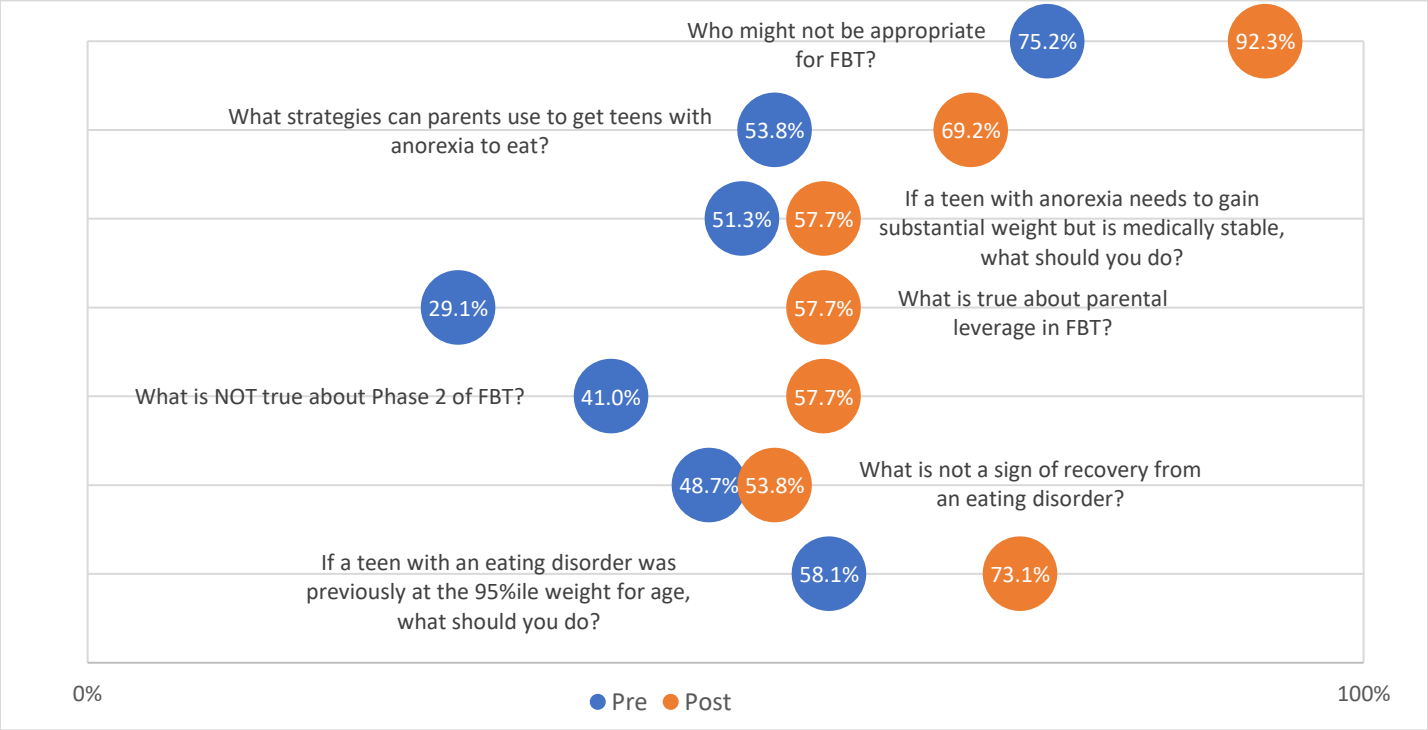
71. Percentage Correct on Knowledge Tests Pre and Post ED 102 (March and June 2023) Trainings



Similarly, prior to the FBT trainings in April and June (entitled *Eating Disorders: Working with Children and their Families*), 75.2% of participants responded correctly to the question "Who might not be appropriate for FBT?" while 92.3% responded correctly after the training. The percentage answering correctly on each question can be seen in Figure 72.

Figure

72. Percentage Correct on Knowledge tests Pre and Post FBT (April and June 2023) Trainings



The Eating Disorders PIP continued through the fourth quarter of FY 2022-23. The very popular ED 101 webinar is available on-demand until January of 2024. In addition, specific trainings such as FBT will continue to be offered to reach a wider number of practitioners systemwide and consequently increase availability of quality care for individuals with eating disorders. Furthermore, the Best Practices Clinical Toolkit has been disseminated via the DMH public facing website, and the ED Practice Network and ED Consultation Group will continue indefinitely.

Non-clinical Performance Improvement Project

In the FY 2021-22 non-clinical PIP, Improving Referral Management and Efficiency Through an Online Provider Directory, the QI, Quality Assurance (QA), and Chief Information Office Bureau (CIOB) Units worked collaboratively to evaluate LACDMH's update of the existing Provider Directory system available to providers and the community on the LACDMH website, https://dmh.lacounty.gov/pd/. The aim of the PIP was to determine whether or not to add additional provider data fields to the NAPPA application, implementing data update standards, and introducing a comprehensive Provider Directory training highlighting the system's latest developments, LACDMH will ensure providers have access to real-time program data within six months (such as clinic availability for beneficiaries) as evidenced by: a) a decrease in the number of SRTS referrals with greater than two transfers from 6.1% to 5.0% and b) a decrease in the number of business days to transfer resolution from 6.9 days to 5.0 days.

The study population included beneficiaries and incoming individuals seeking services - including individuals of any age and diagnosis. It impacted individuals requesting new enrollment and current beneficiaries seeking additional services or a higher/lower level of care. Both Legal Entity

(LE)/Contracted and Directly Operated (DO) providers that provide services to beneficiaries and new enrollees were impacted by this PIP.

A review of the Service Request Tracking System (SRTS) data from CY 2022 pre-intervention (January 1, 2022 through March 8, 2022), and post-intervention (March 9, 2022 through August 31, 2022) was completed. Data was collected from the Cognos SRTS Transfer report and the new Microsoft Power BI SRTS Transfer report. The data showed an increasing three-year trend of the number of transfer requests that required more than two days to be resolved in CY 2019 to 2021. There was an increase of 4.4 Percentage Points (PP) between 2019 and 2021.

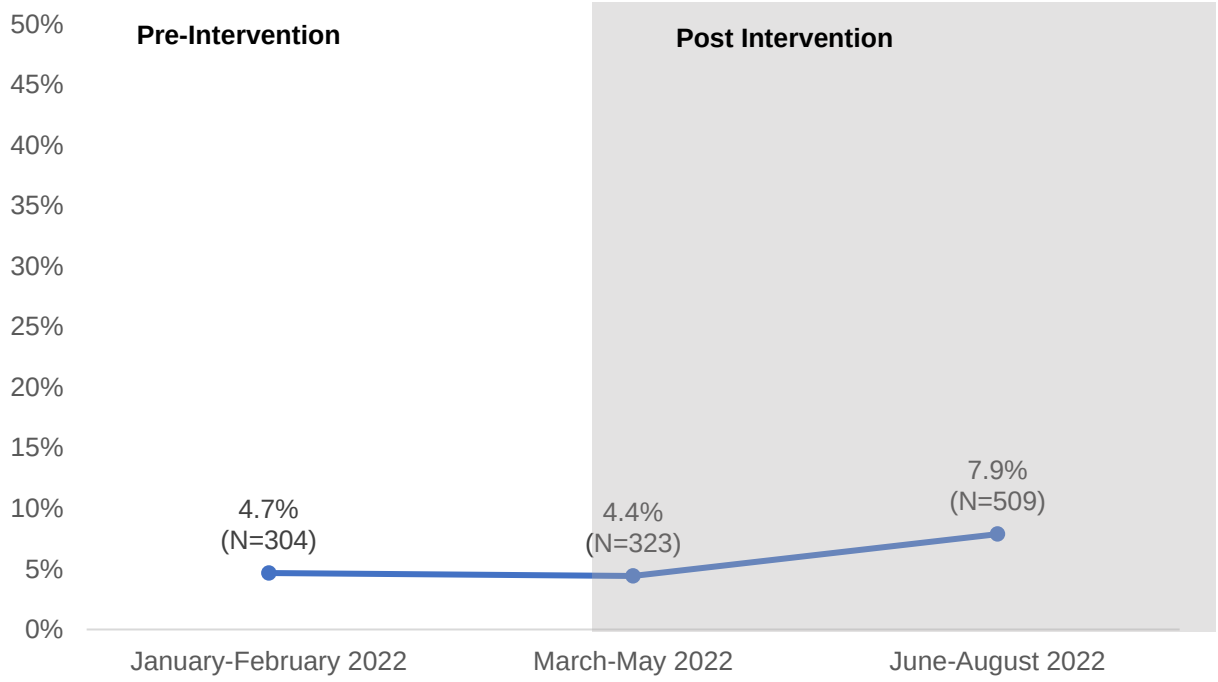
Post Intervention – Provider Directory Update

The SRTS Transfer report data showed a small increase in transfer requests during the first measurement period (March through May 2022) following the intervention of the updated Provider Directory which returned to pre intervention levels at the second measurement (June through August 2022). Referrals with multiple transfers decreased by approximately 1.4PP in the second measurement period.

Figure 73 shows the percent of business days to resolution of a transfer request increased by one day at the second measurement. Transfer requests that required more than two business days remained stable until the second measurement with an increase of approximately 3.2PP.

Figure

73. Percent of Transfer Requests with More than Two Business Days to Resolution for Pre and Post Intervention

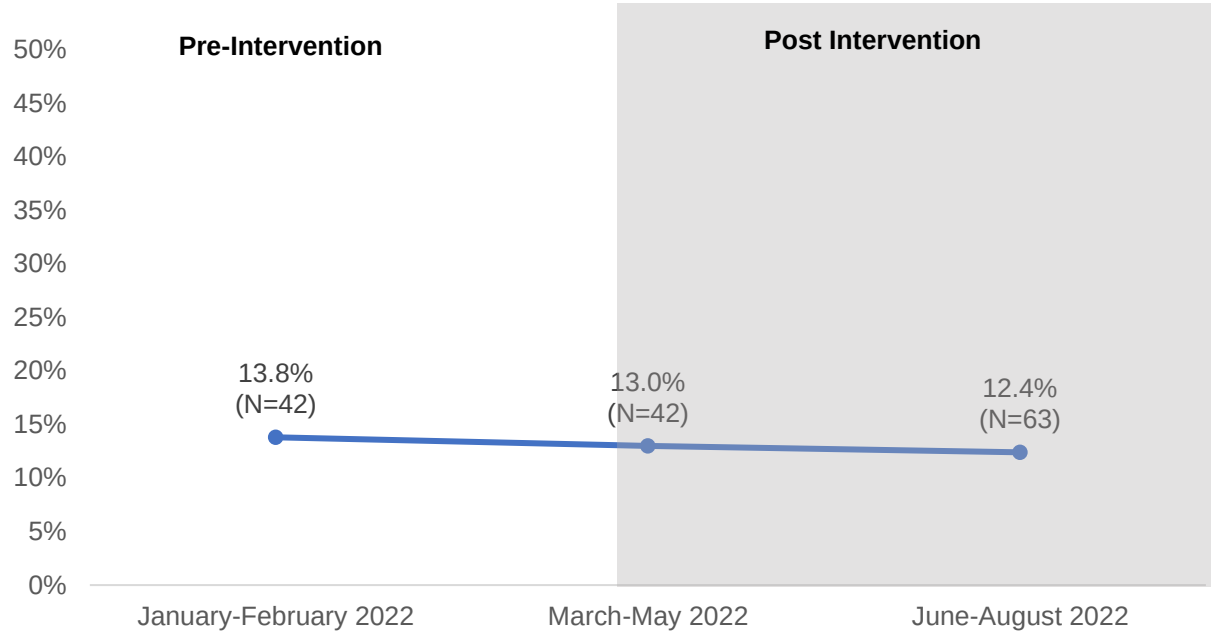


Note: The pre intervention includes the requests up to March 7, 2022. The intervention was applied on March 8, 2022.
Data source: Cognos SRTS Transfer Report, January to May 2022. Power BI SRTS Transfer Report, May to August 2022.

Figure 74 shows the number of transfer records that required multiple transfer requests for resolution pre and post intervention. The records had a slight decrease over the first and second measurement periods.

Figure

74. Percent of Records that Required Multiple Transfer Requests for Resolution for Pre and Post Intervention



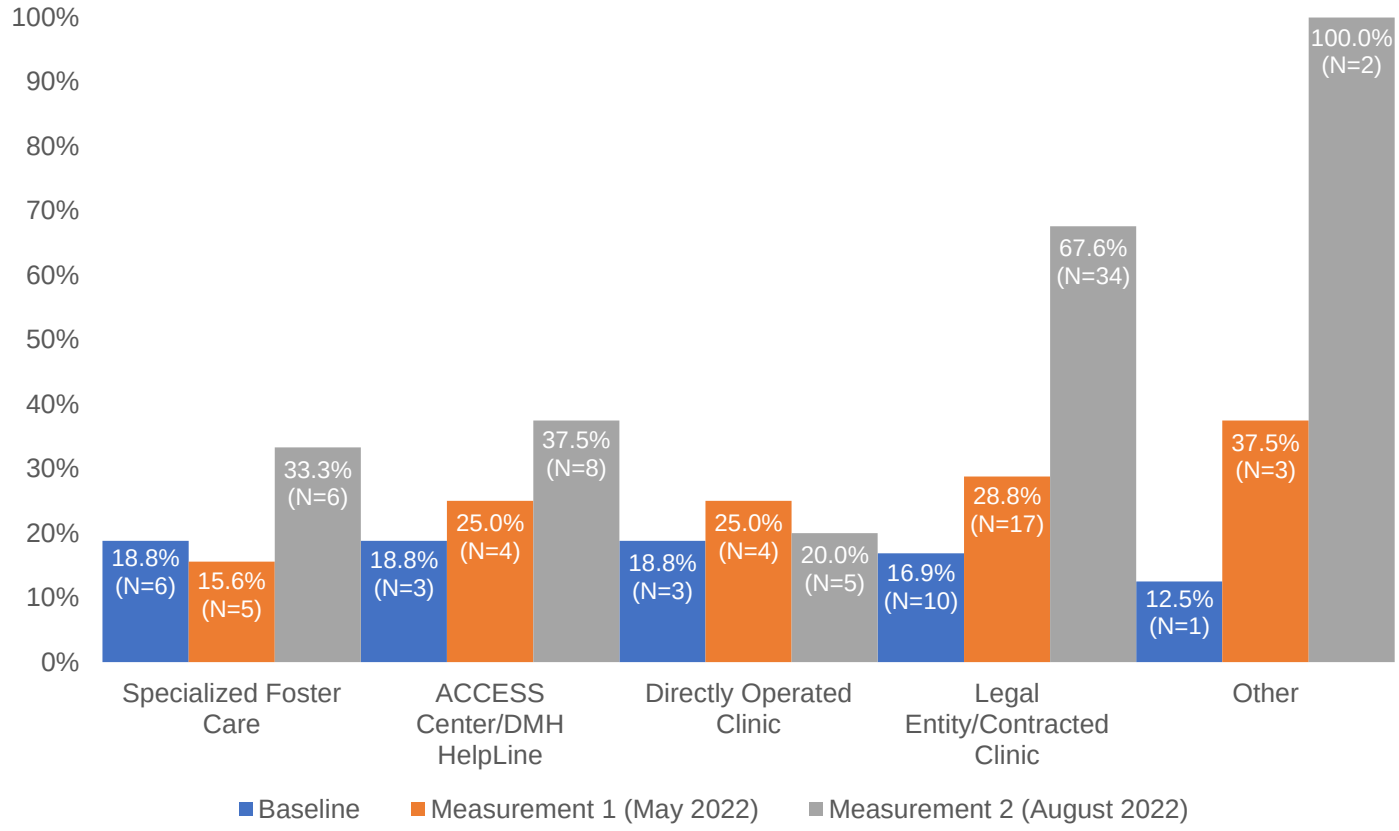
Note: The pre intervention includes the requests up to March 7, 2022. The intervention was applied on March 8, 2022.
Data source: Cognos SRTS Transfer Report, January to May 2022. Power BI SRTS Transfer Report, May to August 2022.

Additionally, data was collected from providers regarding the use of the "New" Provider Directory in May 2022 and August 2022 with the LACDMH 2022 Provider Directory Satisfaction Survey – Provider Version. In May 2022, 131 providers responded to the survey and in August 2022, 55 providers responded to the survey.

Based on feedback collected from providers who responded, Specialized Foster Care (SFC) providers reported the most use of the updated Provider Directory. LE/Contracted clinic and DO clinic providers reported using the directory the least. Most responding providers reported increased satisfaction (Satisfied to Very Satisfied) with the updated directory (Figure 75): Other category providers were at 37.5% (+25PP), LE/Contracted clinic providers were at 28.8% (+11.9PP), and ACCESS Center/DMH HelpLine and DO clinic providers were at 25% (+6.2PP). The overall average satisfaction rating for the "New" Provider Directory was 56.4% (+32PP). When satisfaction by age group served was reviewed, Older Adult providers reported the least satisfaction with the updated directory.

Figure

75. Percent of Responding Providers with Satisfied to Very Satisfied Ratings for the Provider Directories



Note: A Likert scale was used for collection rating scores: 1-Very Unsatisfied, 2-Unsatisfied, 3-Neutral, 4-Satisfied, 5-Very Satisfied. Data source: LACDMH 2022 Provider Directory Satisfaction Survey-Provider Version, May 2022, and August 2022.

Providers that responded to the survey indicated that challenges with the updated directory increased over the two measurement periods. "Accurately identifying service provider availability" and "finding the information needed quickly" were the challenges identified most often by responding providers. "Challenging to use" and "other" challenges tended to steadily increase. Providers consistently identified issues with usability and accuracy of information. Responding providers tended to report an increase in referrals (32.5%) or no change (30%) in referrals.

During the measurement periods, there appeared to be limited to no improvements indicated in the SRTS transfer report. Providers likely tried to utilize the updated directory which increased the transfer requests. However, a longer period of measurement may be needed to display change as providers need more education and experience with the directory.

The updates to the Provider Directory appeared to increase provider satisfaction with the directory. However, changes to the tool created additional challenges that need to be addressed through updating provider information and the functionality of the directory's platform. It appears providers that serve specific populations have different needs of the Provider Directory and would benefit from separate search options or unique directory pages.

QA and CIOB continually reviewed provider feedback and worked to make minor updates though the PIP process. Larger changes were earmarked for Phase II of the project.

This non-clinical PIP concluded in October 2022. However, the project will continue through collaborative efforts of the QI, QA, and CIOB Units. Plans for follow up activities include a Phase 2 of updates to the Provider Directory, spot checking randomized calls to providers to ensure adherence to data update standards, and reviewing SRTS for disparities in age, cultural group, foster care, etc.

Section IV. Quality Improvement Work Plan, Calendar Year 2023

The Department's QAPI Work Plan is organized into seven significant domains: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care, Provider Appeals, and Performance Improvement Projects. Each domain is designed to address service needs and service quality.

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

Section IV. Monitoring Service Delivery Capacity, Calendar Year 2023

Service Equity

Goal Ia.	Analyze root causes in the underrepresentation of self-identified Asian Pacific Islanders and Communities with Physical Disabilities receiving DMH services.
Objective(s)	1. Through participation in the Solano County ICCTM Learning Collaborative work with LACDMH stakeholders to develop a plan addressing barriers for engagement of Asian Pacific Islanders and communities with physical disabilities. • Prioritize unique community needs, current affairs (i.e., community violence and accessibility issues), and fluid resources. 2. Identify and address barriers to seeking mental health services for these populations. 3. Improve data collection for persons with disabilities to be able to better assess level of participation in DMH services.
Population	LACDMH and Legal Entity (LE)/Contracted programs providing outreach and outpatient SMHS to LACDMH clients and the Los Angeles County community at large.
Performance Indicator(s)	1. Unique Client Counts by Race/Ethnicity and physical disabilities 2. Penetration Rates for Medi-Cal Enrolled Beneficiaries by Race/Ethnicity 3. Service Equity Analysis Report Findings
Frequency of Collection	Annually
Responsible Entity	Quality, Outcomes, and Training Division – QA and QI Units

Delivering Culture-Specific Services

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

Telemental Health

Goal Ic.	Ensure telemental health services, for those who choose to access services in that manner, are delivered with high quality.
Objective(s)	1. Utilize telemental health platforms as a way to deliver quality mental health services Deliver telemental health services when a client requests it or prefers it.
Population	DO and LE/Contracted clients/families receiving outpatient SMHS.
Performance Indicator(s)	1. Number and percent of telehealth encounters by delivery type 2. Client satisfaction with telehealth services
Frequency of Collection	Annually
Responsible Entity	Chief Information Office Bureau (CIOB), Clinical Informatics Team

Alternative Crisis Response

Goal Id.	Create a robust, reliable, and timely 24/7 mental health alternative to law enforcement response for individuals in crisis
Objective(s)	1. Utilize the 988 Call Center for individuals experiencing a mental health crisis 2. Establish criteria for 911 operators to transfer mental health crisis calls to 988 vs. initiating a law enforcement response 3. Increase the availability of Field Intervention Teams to respond 24/7 when needed and improve response time.
Population	Persons in LA county experiencing a mental health crisis
Performance Indicator(s)	1. Number of Field Intervention Teams operating 2 Field Intervention Team time from deployment to responding on scene 3 988 Calls per month, including disposition and timely answering of calls.
Frequency of Collection	Monthly
Responsible Entity	Alternative Crisis Response Office, Chief Information Office Bureau (CIOB)

Monitoring Accessibility of Services, Calendar Year 2023

Timely Access to Services

Goal II.	**DMH will meet 80% of initial requests for outpatient SMHS with a timely appointment.**
Objective(s)	1. Monitor time to first offered appointment. • Providers should offer routine (non-urgent) appointments within ten business days (not including weekends and holidays) of the initial request. • Providers should offer urgent appointments within 48 hours (including weekends and county holidays) of the initial request. • Providers should offer follow-up hospital discharge or jail release appointments within five business days (not including weekends and holidays) of the initial request. 2. Monitor wait times to initial medication evaluation appointments.
Population	Any individual requesting outpatient SMHS from DMH as a client, potential client or on behalf of someone. This also includes Los Angeles County DMH clients receiving inpatient psychiatric services from the Department of Health Service (DHS), Fee-for-Service (FFS) Contracted, Non-Contracted, Non-Governmental Agency (NGA), and Contracted IMD Exclusion Hospitals seeking outpatient SMHS from a DMH provider
Performance Indicator(s)	1. Rates of timeliness by service request type (routine, urgent, and hospital discharge/jail release) 2. Wait times to initial medication evaluation appointments 3. Documentation and dissemination of best practices amongst providers with highest rates of timeliness
Frequency of Collection	Quarterly
Responsible Entity	Quality Assurance Unit

Monitoring Beneficiary Satisfaction, Calendar Year 2023

Client/Family Satisfaction

Goal IIIa.	Evaluate findings and develop data-driven improvement strategies at the Service-Area level.
Objective(s)	1. Review the data on different manners in which CPS surveys were collected 2. Increase data collection of Sexual Orientation and Gender Identity (SOGI) related demographics to assess the quality and delivery of affirming care 3. Roll out a Power BI portal to evaluate and report out provider-level performance trends 4. Monitor response rates and review the mechanism for tracking participation history and program types 5. Share successful strategies to increase data collection and best practices to increase consumer satisfaction
Population	DO and LE/Contracted clients/families receiving outpatient SMHS
Performance Indicator(s)	1. Number of returned surveys/respondents by CPS form and administration method 2. Percentage of SOGI data collected vs Declined to Answer 3. Publication of Power BI report with accessible provider level reports 4. Increase in response rates and satisfaction ratings from year to year
Frequency of Collection	Annually
Responsible Entity	QI Unit

Client Grievances, Appeals, and Change of Provider Requests

Goal IIIb.	Monitor grievances, appeals, and requests for a Change of Provider.
Objective(s)	1. Automate data collection processes to eliminate waste and improve the availability of real-time data. • Implement a public-facing portal to receive client grievances and complaints. • Develop a provider application to track monthly submissions of COP requests. 2. Review the nature of complaints, resolutions, and COP requests for significant trends that may warrant policy recommendations or system-level improvement strategies.
Population	Los Angeles County residents engaging in DMH services (outpatient, inpatient, FFS)
Performance Indicator(s)	1. Total beneficiary complaints and resolutions by type in FY 2022-23 2. COP requests by type in FY 2022-23
Frequency of Collection	Annually
Responsible Entity	Patient's Rights Office

Monitoring Clinical Care, Calendar Year 2023

Clinical Reporting

Goal IVa.	Rollout Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist-35 (PSC-35) aggregate reporting to support children and youth program operations.
Objective(s)	1. Providers will have access to client-level aggregate reports. 2. Develop program-level reports based on input from provider network. 3. Run tests with a sample of providers. 4. Make clinical utility training available to more supervisors through publishing a recording of training and track attendance. 5. Expand training to LE staff and supervisors. 6. Research and explore relevant and user-friendly reporting elements to include on an LACDMH public-facing dashboard. 7. Research and explore developing algorithm for using CANS as a level of care tool for children and plan pilot to implement.
Population	DMH Directly Operated (DO) and LE/Contracted programs providing SMHS to children and youth between ages 3 and 21 years.
Performance Indicator(s)	1. One client-level report 2. One provider-level report 3. Clinical utility training with supporting materials
Frequency of Collection	Annually
Responsible Entity	Outcomes Unit and Outpatient Care Services

Provider-Level Improvement

Goal IVb.	Develop and refine processes to enhance provider knowledge surrounding documentation and claiming-related requirements associated with the provision of Medi-Cal SMHS.
Objective(s)	1. Within one year, 50% of LACDMH outpatient treatment providers will participate in the QA Knowledge Assessment Surveys. 2. Create a communication strategy around changes related to documentation and claiming requirements related to CalAIM implementation. 3. Revise tools to align with revised documentation requirements.
Population	Outpatient programs providing outpatient SMHS to LACDMH clients/families.
Performance Indicator(s)	1. Number and percent of providers completing the QA Knowledge Assessment Surveys; 2. Number and percent of providers attending QA information sessions and evidence of communication plan being implemented; 3. Compliance rates concerning required documentation (average compliance rate per item in CY 2023); and 4. Qualitative data from providers on the effectiveness and efficiency of these processes.
Frequency of Collection	• QA will collect QA Knowledge Assessment Survey data quarterly. • At least 20 LE/Contracted chart reviews are completed annually.
Responsible Entity	Quality Assurance Unit

Healthcare Effectiveness Data and Information Set (HEDIS) Elements

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

Level of Care

Goal IVd.	Roll out an Adult Level of Care Tool.
Objective(s)	Review common clinical tools and identify modifications that would best meet the needs of LACDMH's adult population.
Population	Adult clients
Performance Indicator(s)	1. Select a level of care tool to use for adults 2. Adopt an algorithm to use to recommend a level of care based on information gathered on the tool
Frequency of Collection	Annual
Responsible Entity	Outpatient Services

Monitoring Continuity of Care, Calendar Year 2023

Goal V.	Develop a systemwide strategy to reduce seven- and 30-day rehospitalization rates.
Objective(s)	1. Establish a committee to review data monthly. 2. Identify and implement at least one intervention targeting systemwide readmission rates. 3. Development of a Power BI dashboard to examine rates of rehospitalization and identify any patterns to address.
Population	LACDMH clients receiving outpatient SMHS
Performance Indicator(s)	Rates of rehospitalization at seven- and 30-day post-inpatient discharge
Frequency of Collection	Monthly
Responsible Entity	Intensive Care Division, Outpatient Services, Clinical Informatics

Monitoring Provider Appeals, Calendar Year 2023

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

Monitoring Performance Improvement Projects, Calendar Year 2023

Goal VIIa.	Clinical PIP for FY22-23 focuses on improving quality of care for clients with Eating Disorders (ED) by implementing best practices and training clinicians to feel more comfortable working with this population
Objective	1. Continue to convene PIP committee. 2. Develop an ED Practice Network. 3. Develop and conduct overview training (ED 101) and CBT specific training with consultation. 4. Create place to share information related to service delivery and best practices for ED clients.
Population	Clients receiving SMHS
Performance Indicator(s)	1. The number of clinicians receiving training 2. Rate of diagnosis of clients with eating disorders pre and post training 3. Number of users of MS Teams website used for consultation and information dissemination 4. ED best practice toolkit is compiled and can be accessed
Frequency of Collection	Quarterly through June of 2023
Responsible Entity	Quality, Outcomes, and Training Division - Quality Improvement Unit

Goal VIIb.	Develop and implement an administrative data-driven performance improvement project for FY 22-23 to improve follow up mental health services after presenting in an emergency room (ER) with mental health issues (BHQIP-FUM)
Objective	1. Gain insight to clients with mental health issues that visit emergency rooms to improve post ER follow up for mental health services by creating timely exchange of data between ERs and LACDMH. 2. Connect identified beneficiaries in ERs back to their mental health provider or provide linkage to needed mental health services.
Population	Beneficiaries that receive care from ERs that are existing SMHS clients or potential clients
Performance Indicator(s)	1. Access to real time data on clients served in ERs with mental health issues 2. Reduction in percentage of clients not receiving any follow up mental health care 3. Increased percentage of clients receiving more than one SMHS claim post ER visit
Frequency of Collection	To be determined
Responsible Entity	Quality Improvement Unit, Enhanced Care Management, Chief Information Office Bureau