REGIONAL QUALITY IMPROVEMENT COMMITTEE (QIC)- SOUTH

MEETING MINUTES
April 2025

Type of meeting:	Regional QIC	**Date:**	4-24-2025
Location:	Microsoft Teams	**Start time:**	10:00AM
		End time:	11:30AM
Members Present:	See Table Below		

Agenda Item	Presentation and Findings	Discussion, Recommendations, and/or Needed Actions	Person(s) Responsible
I. Welcome and Introductions	Dr. Rosa Franco welcomed everyone, went over the meeting agenda, and shared the QR code for attendance. Dr. Socorro Gertmenian shared January 2025 meeting minutes. She shared importance of today being the Armenian Genocide Day of Remembrance.		Dr. Rosa Franco/ Dr. Socorro Gertmenian
II. Departmental Language Access Plan (DLAP)	Dr. Sandra Chang shared DLAP is a new board motion for a countywide language access policy to ensure all residents in Los Angeles County have equitable access to language services in their language of preference. All departments had to create their own language plan in collaboration and coordination by the Office of Immigrant Affairs (OIA). There are three specific objectives the departments will be incorporating into their overall activities around language access	Dr. Kara Taguchi wondered what improvement needs providers should be aware of. Dr. Sandra Chang shared the Call Center is a big area that we need to improve. The other area is American Sign Language services. DOs and LEs need to adhere to the cancellation requirement of cancelling at least three days in advance. We are paying vendors	Dr. Sandra Chang

	including empowering the county workforce to continue to consistently deliver linguistically and culturally responsive services, integrate language access, equity, and inclusion in every aspect of county work and supporting the county in having a flexible and efficient administrative, technological, and physical infrastructure to help meet the linguistic needs of county residents. This plan is a live document where it will continue to evolve as the different departments go through the process of becoming more mindful and more active around language. The plan will be reviewed and revised every two years and posted to our website. Dr. Sandra Chang shared the DLAP includes 11 sections. We just hired a second sign language specialist within the Cultural Competency Unit. We will be providing data on consumers served by preferred language or threshold language, highlighting the 24/7 helpline. We will be highlighting reporting on how we notify our consumers, family members, and community regarding our language assistance services. The Provider Directory is available in all the threshold languages that can be found on our website and the departmental website includes Google Translate, which allows	for services that were not rendered due to late cancellations.	

	community members to select their preferred language to review our information. We will be reporting on how we monitor language assistance effectiveness. For example we have an interpreter satisfaction survey for ASL service users and for translations we ensure our departmental bilingual certified staff review vendor translations. We now provide clients with the forms for grievance or change of provider in their preferred language. We are working with our Patients Rights department to ensure all our clients' voices are heard. We are training staff on the DLAP in different venues in the department such as the Town Hall, expanded Management Teams, and Supervisors Forums. We are utilizing the Hello DMH newsletter to have information available and posting it on our website. The Arise Division is comprised of the seven underserved cultural communities (UsCC) and subcommittees, the Cultural Competency Committee, and the 8 SALTs. We work with all these groups to provide language assistance services. We follow the lead of the California Department of Health Services (DHCS) to know which languages are considered threshold. We have a		

	new acronym LOTE which stands for Language Other Than English. Bilingual staff policy. Policy 602.01 provides how staff can become certified. The department has 36 languages currently, which is impressive. Regarding vendors and their qualifications for Language Assistance Services, we are working with two master agreements, LASMA through the Department of Public Health and ODITS. Dr. Sandra Chang shared three policies that are connected to the DLAP, Policy 200.02, Policy 200.03, and Policy 200.09 that states we cannot deny mental health services due to language barriers, that all non-English speaking persons have a right to care and services to be delivered in their preferred language, the right to culture specific rendering providers and this information needs to be made available in writing to them. For over the phone (OTP) requests Directly Operated (DO) need to contact ISD and provide the department name, employee first and last name, employee number and cost center. If you do not know your cost center, please reach out to your program manager/analyst. We have a dedicated mailbox in our division for DOs and LE/contractor providers to request		

	ASL services for clinical appointments. We do not have an online form due to HIPAA. For administrative stakeholder meetings and events, we have an online form that can be accessed through a link and QR code. Anything related to ASL services, please go through the ARISE accessibility mailbox. Dr. Sandra Chang shared appendix of PowerPoint includes policies, grievance forms in all languages, link to request for change of provider, and glossary/terminology. She would like to encourage everyone to take the time to review the entire policy and bring it up during your meetings.		
III. Work Plan Goals 2025	Stacey Smith shared Work Plan Goals for 2025. Work Plan Goals are posted on our QI website. This was our first attempt at integrating the Work Plan with SAPC. Goals encompass seven domains: ➢ Service Delivery Capacity ➢ Accessibility of Services ➢ Member Satisfaction ➢ Clinical Care ➢ Continuity of Care ➢ Provider Appeals ➢ Performance Improvement Projects (PIP) In the past EQRO would evaluate our system and provide a list of what we are doing well in and things we need to focus on. This year we	Dr. Kara Taguchi shared part of the Behavioral Health Transformation Integrated Plan requirements consists of DMH and SAPC developing an integrated plan for the entire system. Needs assessments for DMH, SAPC, MCPs, and local health jurisdictions were previously done in silos. Last year we came together and tried to at least use the same data. Hopefully this will take us to another step further in coming up with unified needs assessment and preparation for	Stacey Smith

	did not get that feedback, so we utilized our Consumer Perception Survey open-ended comments to guide what our consumers felt we needed to focus on for systemwide improvements. We have 16 goals this year. The ARISE Division will continue to focus on language accessibility and decreasing mental health stigma in underserved cultural communities. Peer Services will work on increasing quality and quantity of Peer services. The QI Unit will continue to work on improving the Consumer Perception Surveys (CPS), PIPs, and evaluating the QI program for improvements. Patients' Rights will work with the QI Unit to create a Power BI dashboard to more easily analyze their data around change of providers and grievances. The Outcomes Unit will work on publishing data reports for DMH, internal use and LE providers, Care Court data reporting requirements, and continuing to roll out the LOCUS. Outpatient Care Services will work on developing a systemwide robust customer service program. Health Access and Integration (HAI) has an ongoing goal to monitor provider appeals and reduce rehospitalizations. MHSA and QI Unit Goal will focus on laying groundwork towards an integrated plan needs assessment for Los Angeles County.	BHSA implementation on July 1, 2026. Dr. Lisa Benson shared for follow up after hospitalization the Feds are looking for master's level clinicians or higher. Jamie Chess wondered when referring to master's level, do NPs count. Dr. Lisa Benson shared yes NPs are included. Dr. Kara Taguchi shared because the denominators for the FUH and FUM are all Medi-Cal clients across LA County from our understanding, it is important that for clients that are connected to our system we ensure that we have 7 days and 30 days follow-up. Dr. Lisa Benson shared we have hospital liaisons helping with getting the clients who aren't connected to services connected. It's more challenging for clients who aren't connected, so we are hoping that we can improve our number by providing follow-ups for	

	Clinical Informatics and Pharmacy goals are important and focus on collection of HEDIS data. Starting with measurement year 2023, the State can impose sanctions if we have two or more measures below the minimum performance level or measures that don't achieve at least 5% increase over baseline. DOs and LEs are not responsible for calculating any of these, but it's important to understand the HEDIS measures and how you can do your part to ensure, for example, clients who go to an emergency room are seen for a follow-up within 7- or 30-day markers. We all need to work together to avoid sanctions. QA has been working on this and will be putting out a bulletin for what disciplines can do the follow- up and what procedure codes are allowed for follow- up after hospitalizations for a mental illness or self-harm. The last two work plan goals that we have are the Clinical and Non-Clinical PIPs. Both are very important because both have the possibility of sanctions. Our Clinical PIP is regarding HEDIS measure FUM. Non-Clinical PIP is aiming to improve access for children 0-20 years old to 80% timeliness for routine appointments within 10 days. The non-clinical PIP aligns with the corrective action plan that's already in place for LA County for children's non-psychiatry non-urgent routine appointments. QA will have workshops on	the clients who are connected to us already. Dr. Rosa Franco shared one of the first steps in the committee with the FUM is to identify what some of the barriers are to follow up after emergency visits. If you have ideas about interventions, thoughts, suggestions, or any information that you know based on your experience, that would be very helpful. You can send me an e-mail.	

	strategies to increase the percentage of timely access for children. Dr. Rosa Franco will create a PIP committee to start analyzing the data for FUM and coming up with possible interventions.		
IV. Consumer Perception Survey (CPS)	Dr. Daiya Cunnane stated the QI and Outcome teams are still working on cleaning up provider level data for CPS 2024. She shared the CPS data for 2024 that is currently available. We received a total of 12,032 surveys including almost 10,500 completed surveys, which is a 9.9% increase from the previous year. Completed surveys are surveys where the client or caregiver answered two or more questions and the survey was able to be scanned making the data usable. We noticed a decline in surveys from youth and would like any feedback on possible reasons why this happened. Dr. Daiya Cunnane shared this year UCLA was able to provide to us reasons for consumers not completing the survey. The majority of the declined/refused surveys are from Adults. We want to understand the reasons clients do not want to complete the survey so we can work on interventions to improve our response rate. Youth and Family preferred online surveys and Older Adults and Adults preferred more paper surveys. Most surveys are in English followed by Spanish. Our team noticed that our Armenian speaking clients are completing fewer surveys than we expect. If there's another	Stacey Smith shared Youth were more dissatisfied with our services than others, stating that the providers weren't culturally attuned to them. Dr. Cunnane shared Youth has had a decrease in general satisfaction across the board. Dr. Ann Lee wondered if providers could still access comments after the survey closes at 7pm. Dr. Daiya Cunnane shared that clients cannot submit any more surveys after 4pm but comments will still be readable by the provider after that time. Lala Abed Cheharmehali wondered if there is still a training on May 1st for electronic surveys and if there a link available for the electronic CPS survey that we can review. Dr. Daiya Cunnane shared that the training has moved to May 1st. We are still making last-minute	Dr. Daiya Cunnane

	language that you see that looks on the lower side, please bring that up and any ideas or suggestions on ways to improve survey responses. Dr. Cunnane shared we have CPS Flyers that are available on our website to advertise CPS at your clinics. We only have English right now but are working on having them translated into all of our threshold languages. We have teamed with our Public Information Office (PIO) to advertise on social media. CPS survey period is Monday, May 19th through Friday, May 23rd 2025. Surveys are only for outpatient clients receiving services during that week. Links to the recordings are available for the paper and UCLA electronic survey trainings. Our DMH Electronic Survey trainings for DOs and LEs were moved to May 1st. DO staff who are going to be assisting with CPS by creating records and sending them out need to have access to our CPS application so they will need to make a service request for dynamics license and one for CPS application. LEs will need to confirm that all members of your team that are using CPS application have C numbers, after verified that the C number is active you will need to contact your liaison and request CPS application. The due date is May 9th to get all requests in, or they may not be able to access the application for the survey period. The CPS application is not functional yet, but it should be	changes and updates but are hoping to have the training environment where you can go in and practice open next week. We will be sending out an e-mail to let you know when the training and production environments are ready. Lala Abed Cheharmehali wondered if using the electronic survey, do we still need to use the UCLA Electronic survey. Dr. Daiya Cunnane shared it really depends on your site, but picking one or the other is probably best. We do suggest the DMH electronics survey, but the UCLA electronic survey is available for clients that you think could use it. Lala Abed Cheharmehali wondered if someone is coming to the Agency who is new, how can he or she fill out the survey without an IBHIS number. Dr. Rosa Franco shared for a client who is brand new, they may not have a lot of feedback to provide, but you can still offer them the survey. First is make up a number, as Dr. Cunnane has suggested	

	up and running within the next week or two. As soon as our application is active, we will send out notification so that you all can start checking to make sure that you have the icons. We need providers to check completed surveys to ensure that open-ended comments do not have any concerning information that needs to be followed up on right away. Dr. Cunnane polled the QIC on what time they would like to DMH surveys to close for clients (4pm, 7pm, or 11:59pm on May 23rd). Dr. Daiya Cunnane encouraged everyone to use the QI website and add themselves to the CPS distribution list.	maybe 1234567 like you just make up a number for that client to be able to complete the survey. And for the questions, it will have a not applicable option so they can select not applicable. There are some questions like the location was convenient and the time that they were offered was convenient that they can answer. A survey is counted if that new client completes the survey and they answer 2 or more questions. Dr. Daiya Cunnane shared reminder that we are offering surveys to clients who are coming in for any service. Suggestion for a workflow to offer surveys to new clients at the end of their appointment so that they can respond to the questions based on the service they received that day.	

Next Meeting: July 31, 2025, at 10:00am-11:30am

Attendance

NAME	AGENCY
Kara Taguchi	DMH- Quality Improvement/Outcomes
Stacey Anne Smith	DMH- Quality Improvement

Daiya Cunnane	DMH- Quality Improvement
Rosa Franco	DMH- Quality Improvement
Laarnih De La Cruz	DMH- Quality Improvement
Abby Chappell	Edelman Mental Health Center - Adult Clinic
Alben Zatarain	Enki Health Services
Alex Elliott	DMH- Quality Improvement/Outcomes
Alexandra Cifuentes	Penny Lane Centers
Alexis Garcia	Exceptional Children’s Foundation
Amanda Montelongo	Telecare ATLAS 7 FSP
Amani Khalifa	Children's Center of the Antelope Valley
Ana Gomez-Rodriguez	Crittenton
Analia Barroso	Telecare LAOA
Angela Alarid	Jaqueline Avant Medical Hubs/DMH
Angela Lee	DMH TIES for Families-South Bay
Angela Lu	Long Beach API
Angela Navata	Wellnest
Angela Wilson	South Bay Children's Health Center
Angelina Palma Williams	The Guidance Center
Ann Lee	SA 8
Anna Galindo	The Whole Child
Anthony Thai	Telecare LA HOP
Araceli Barajas	UCLA TIES for Families
Armen Yekyazarian	DMH-Quality Assurance
Berteil Eishoei	DMH Quality Assurance
Bosco Ho	Special Service for Groups - AP Recovery
Brenda Moreno	Dignity Health - California Behavioral Health Clinic
Brittany Cheong	Helpline Youth Counseling
Carl Levinger	SFC-Wateridge, 7612A
Carmen Solis, LCSW	Alma Family Services

Catherine Bermudez	The Teen Project
Cristina Magarin	DMH CMMD
Cynthia Sarmiento	Bayfront Youth & Family Services
David Calvillo	South Bay Mental Health Center
David Mora	SHIELDS for Families
Debra DeLeon	SSG-OTTP
Diana Cortez	SSG-Weber Community Center
Ebony Reado	Long Beach Child and adolescent program
Edith Cruz	7104 Amanecer CCS
Eilene Moronez	Enki Health Services, Inc.
Elizabeth Echeverria	SCHARP and Barbour & Floyd Medical Associates
Ericka Rivera	Pacific Clinics
Gabriela Hernández Trujillo	Star View Community Services
Gabrielle Snead	Project IMPACT
Greg Tchakmakjian	SA 7
Gwendolyn Lo	Community Family Guidance Center
Helen Chang	DMH-Coastal API Family MHC
Hyun Kyung Lee	DMH CMMD
Jaleesa Adams, Psy.D	Drew Child Development corporation
James B. Pelk	IMCES
Jamie Chess	Exodus Recovery
Jennifer	Eggleston Youth Centers
Jennifer Butler	Alcott Center
Jennifer Escorcia	Starview - Teammates
Jennifer Mitzner	Olive Crest
JENNIFER RAMIREZ	IMCES
Jennifer Wong	Children's Institute
Jenny Rodriguez	Tessie Cleveland Community Services Corp
Jesica Sandoval	AADAP, Inc.

Jessica Orellana	Children's Bureau/All for Kids
Joanna Caysido	The People Concern
Joanne Chen	DMH, CMMD
Jocelyn Camacho	Shields for Families
Johanna Montes	A Brighter Day
Jorge Alfaro	Providence Saint John's Health Center
Joseph Bologna	Trinity Youth Services
Joshua Freeman	The Whole Child
KARLA CANO	ST JOSEPH CENTER
Kayla McCondichie	All For Kids
Keisha White	SA 5
Khashi Khosravi	Exodus Recovery
Kirsten Pouri	California Institute of Health & Social Services Alafia Mental Health Institute
Kristen Tanji	Tessie Cleveland Community Services Corp.
Leah Gutierrez	The Guidance Center
Lesley Adams	JWCH
Linda Nakamura	Masada Community Mental Health Services & SA8 QA/QI Co-chair
Lisa Benson	Clinical Informatics
Lisbeth Vazquez	DMH Women's Wellbeing Center
Luisa Cortez	Kedren Health
Lynette Lau	Harbor-UCLA AOP
Maria Herrera	Crisis Residential Treatment Rancho Los Amigos
Maria Llamas	For The Child, Inc.
Mariana Villegas	Star View Community Services
Maribel Najar-Vargas	Hillview Mental Health Center, Inc.
MarQuisha Millsap	Star View Adolescent Center
Martha Andreani	Providence Saint John’s Health Ctr
Martin McDermott	New Concept STRTP/Humanistic Foundation, Inc.
Mashrouteh Pirhekayati	IMCES

Mireya Badillo-Vasquez	Penny Lane Centers
Mohena Moreno-Walter	Community Reentry
Myra Smith	Eggleston Youth Centers
Nadine Fimbres	Homes for Life Foundation
Nicole Watson	DMH law enforcement teams
Noemi Urgiles	DMH/ San Pedro Mental Health Center
Paola Valadez	Personal Involvement Center
Pastora Salazar	For The Child
Patricia Tyler	Heritage Clinic
Peter Sung Baek	"One in Long Beach (The LGBTQ Center Long Beach)"
Quenia Gonzalez	Star View
Rachel Villa	Haynes Family of Programs
Rebecca Farazian	CA Mentor
Rene Antonio Barrios	Didi Hirsch
Renee Lee	DMH QA PSR
Ria Rodrick	DMH SFC
Roberta Del Angel	Star View Community Service/SBHG
Robin Moten	SCHARP & Barbour and Floyd Medical Associates
Rochelle Montgomery	Compton Family MHC
Rosario Navarrete	Homes for Life Foundation
Sabrina Diaz	Vista Del Mar Child & Family Services
Sandra Chang	ARISE Division - Cultural Competency Unit
Sara R. van Koningsveld	St. Joseph Center
Sarah Monson	ChildNet 7469
Sebrena Abanum	SHIELDS for families
Silvia Padilla	Personal Involvement Center
Socorro Gertmenian	Wellnest
Sonia Zubiate	DMH - QA
Steven D’Antoni	Behavioral Health Service, Inc

Stuart Jackson	CII
Susan Osborne	MHALA
Susana Gomez	Pacific Clinics
Sybil Chacko	Maryvale
Therese Stephano	Star View Community Services
Tiffany Harvey, PsyD	Alafia Mental Health Institute 7655 and 7540
Tora Miller	Edelman Child and Family MHC
Victoria Kim	LACDMH- Women's Wellness Center
Wanta Yu	DMH-Quality Assurance
Xiomara Leal-Reyes	Hillview Mental Health Center
Zhena McCullom	DMH QA/QI
Zoila Beltran	Kedren health

Respectfully,

Quality Improvement

LACDMH Departmental Language Access Plan (DLAP)

Prevention Bureau
Anti-Racism, Inclusion, Solidarity and Empowerment (ARISE) Division

April 2025

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

Presentation Overview:

- Board Motion: Countywide Language Access Policy
- DLAP Strategic Objectives set forth by OIA
- DLAP Implementation and Reporting Requirements
- Relevance to LACDMH Programs
- ARISE Division Policies and Procedures related to Language Assistance Services (LAS)

Presentation Overview Cont.

- LAS provided by the ARISE Division:
  - Over the Phone Request Submitted to ISD for Directly Operated Programs
  - Departmental policy for LE/Contracted Providers Seeking Language Interpreter and Translation Services
  - LACDMH Stakeholder Meetings/Events
  - American Sign Language (ASL) for Clinical Appointments for Directly Operated and LE/Contracted providers
- Summary of Presentation Key Points
- Appendix

Los Angeles County Board Motion: Countywide Language Access Policy

- Ensures every resident of the County has equitable access to language services when interacting with the County.
- Fosters an organizational culture that realizes its commitment to equity and linguistically and culturally responsive service within one of the most diverse counties in the country.
- Applies to all County Departments, administrative entities, and vendors conducting business on behalf of the County.
- All Departments will strive to provide services, conduct internal operations, allocate resources, establish regulations, and operate facilities in a manner that supports equitable language access for all individuals.
- The Department of Consumer and Business Affairs ("DCBA") and its Office of Immigrant Affairs ("OIA") will provide leadership, accountability, technical assistance, and coordination across Departments to support implementation and to ensure language services are offered in the pursuit of goals articulated in this Policy.

DLAP Strategic Objectives and Reporting Set forth by OIA

I. Empower the County's workforce to consistently deliver linguistically and culturally responsive service.

II. Integrate language access, equity, and inclusion in every aspect of County work.

III. Support the County in having a flexible and efficient administrative, technological, and physical infrastructure to help meet the linguistic needs of County residents.

Departments shall strive to incorporate the above three strategic objectives into their overall Language Access Planning.

- All Departments shall develop a DLAP in consultation with the OIA.
- Every two years, following the first submission of a DLAP, each Department shall submit to OIA an updated DLAP that addresses any changes since the prior submission.
- The policy is subject to revision by OIA due to legal requirements and/or other needs as determined by OIA in consultation with the Departments.

DLAP Structure

SECTION 1: OVERVIEW & CONTEXT

- **Department Mission**
  - LACDMH mission is to optimize the hope, wellbeing and life trajectory of Los Angeles County's most vulnerable through access to care and opportunities that promote not only independence and personal recovery but also connectedness and community reintegration.
  - LACDMH aims to reduce the negative impacts of untreated mental illness by providing services based on whole-person care, cultural responsiveness, language accessibility, equity for all cultural groups, community partnerships, integration with social service providers, and a commitment to continuous learning and improvement.

- **Department Priority Languages**
  - Arabic, Armenian, Cambodian/Khmer, Chinese inclusive of Cantonese and Mandarin, English, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese

DLAP Structure

SECTION 2: DEPARTMENT'S LANGUAGE ACCESS POLICY

- **General Policy Statement**
  - In accordance with applicable federal, state and, county policy and agreement, LACDMH will provide equal access to all Limited English Proficiency (LEP) consumers in Los Angeles County for threshold and non-threshold languages as well as consumers needing services in American Sign Language (ASL). Non-English or LEP consumers have the right to language assistance services, at no cost, in their primary or preferred language. Non-English or LEP consumers are to be informed in writing of their right to language assistance services at no cost and how to access these services.

- **Scope of Policy**
  - The language access policies of LACDMH are designed for the LA County Mental Health Plan and cover the entire system of care, including directly operated and contracted providers, as well as administrative programs. The bilingual bonus policy compensates LACDMH employees who use a language other than English to serve our diverse communities.

DLAP Structure Cont.

SECTION 3: KEY TERMS & DEFINITIONS

- A glossary of key terms and definitions related to LAS can be found in the appendix

SECTION 4: PROCEDURES

Identifying Preferred Languages

- For clinical services, which include inpatient, outpatient, and field-based services, LACDMH collects consumer demographical information, including primary/preferred language, at the first contact.
- Community members calling the LACDMH 24/7 Help Line are asked if they need an interpreter to ensure they receive assistance in their preferred language.
- For public outreach events and community stakeholder meetings, clients, family members, and community members can request language accommodations to participate fully in departmental meetings.

DLAP Structure Cont.

- **SECTION 5: Notification of Language Assistance**

LACDMH ensures that LAS are made known to LEP/LOTE-speaking consumers at different points of contact by:

  - LACDMH's directly operated or contracted legal entity provider sites are mandated to display the LACDMH Local Mental Health Plan in their lobbies and waiting rooms.
  - The Provider Directory Handbook is posted on the LACDMH website and is available in 13 different languages.
  - The departmental website includes a feature called "Toggle Goggle Translate" which allows for immediate translation of English text into over 90 different languages.
  - To utilize the browser's built-in translation function for multiple languages, users can access their browser settings and input their preferred non-English language.

DLAP Structure Cont.

- **SECTION 6: Monitoring Language Assistance Effectiveness**

A. Evaluation of Language Assistance

- LACDMH regularly assesses the quality of our language assistance provided to LOTE speakers by administrating two online satisfaction surveys to the end users of our language services. Those surveys include the following:
  - ARISE Division Interpreter Satisfaction Survey. See attached copy.
  - ARISE Division ASL Service Satisfaction Survey. See attached copy.
  - ARISE Division ensures that the translation of written materials is reviewed for accuracy by the LACDMH bilingual workforce.

DLAP Structure Cont.

B. Complaint Procedures

- Program managers shall attempt to accommodate all beneficiary requests to change the program of service and/or practitioner.
- DMH Staff shall provide the Request for Change of Provider form to beneficiaries (consumers) requesting a program of service and/or a practitioner change.
- Service delivery programs shall have Request for Change of Provider forms available or provide beneficiaries with the address to download them directly from the DMH website.
- Staff or Patients' Rights Office (PRO) Advocates shall provide beneficiaries assistance when they feel their voice is not being heard.
- Clinic staff providing services to the beneficiary shall receive the completed Request for Change of Provider form from the beneficiary.

DLAP Structure Cont.

- **SECTION 7: Training**

LACDMH is committed to training and educating our workforce about the DLAP utilizing various internal platforms, which include the following:

- DMH all staff Townhalls
- In-person extended management meetings with detailed PowerPoint presentations on new initiatives and changes pertaining to the LACDMH - DLAP
- In-services with managers, supervisors, and line staff
- Meetings with contracted/legal entity providers: Quality Improvement Council (QIC), and Quality Assurance Council (QAC).
- Hello DMH newsletter – An annual article will be published to provide updates on LACDMH DLAP.
- DMH Policy and Procedures
- Specialized trainings are available to the workforce via the Training Unit.

DLAP Structure Cont.

- **SECTION 8: Community Outreach & Engagement**

  LACDMH has a robust community stakeholder platform that allows for the DLAP to be vetted by members of the diverse linguistic communities that participate in our services. Those stakeholder groups include, but are not limited to, the following:
  - Access for All Underserved Cultural Communities Subcommittee (UsCC).
  - American Indian/Alaska Native (AI/AN) UsCC
  - Asian Pacific Islanders (API) UsCC
  - Black and African Heritage (BAH) UsCC
  - Eastern European/Middle Eastern (EE/ME) UsCC
  - LGBTQI2-S UsCC
  - The Cultural Competency Committee (CCC)
  - The Eight (8) Service Area Leadership Teams (SALTs)
  - Health Neighborhoods

DLAP Structure Cont.

- **SECTION 9: Demographic Analysis & Determination of Priority Languages**
  - LACDMH follows the listing of thresholds set by the California Department of Health Care Services, which prioritizes languages based on the number of Medi-Cal recipients in a given area. LACDMH also ensures that Language Other than English (LOTE) speakers have access to federally funded programs and services, as mandated by Title VI of the Civil Rights Act of 1964.
- **SECTION 10: Bilingual Staff Policy**
  - Per LACDMH Policy No. 602.01, Bilingual Bonus, LACDMH bilingual certified employees possess a valid Language Proficiency Certificate issued through the County's Bilingual Proficiency Examination, which tests for proficiency to speak, read, and/or write the language. Bilingual compensation is paid to certified bilingual employees whose assignments require dual fluency in English and at least one other language.

Languages represented in the bilingual bonuses Directly Operated Program Staff

The Department pays bilingual bonuses for employees hired by Directly Operated (DO) Programs in the 36 languages. The listing is inclusive of threshold and non-threshold languages:

• American Sign Language	• Farsi	• Ilocano	• Polish	• Thai
• Arabic	• Flemish	• Italian	• Portuguese	• Toi Shan
• Armenian	• French	• Japanese	• Russian	• Turkish
• Bulgarian	• German	• Korean	• Samoan	• Urdu
• Cambodian	• Greek	• Laotian	• Spanish	• Vietnamese
• Cantonese	• Hakka	• Mandarin	• Swedish	• Visayan
• Catalan	• Hebrew	• Nahuatl	• Tagalog	• Yiddish
• Chinese				

Language Access Vendors

- **SECTION 11: Vendors and Their Qualifications**
  - LACDMH has executed MOUs to utilize two (2) County Master Services Agreements for language assistance services. These two master agreements align with our department's needs, standards, and requirements.
  - Those Master Services Agreements are:
    1. Language Assistance Services Master Agreement (LASMA) and
    2. On-Demand Interpretation and Translation Services (ODITS)
- All DMH staff must ensure that all language requests are addressed and that clients, including users of LOTE, receive the necessary language support.
- If the programs cannot meet the language needs of our LOTE users, the Patient's Rights Office will address complaints and grievances.
- Programs must provide the appropriate forms to file complaints or grievances due to lack of language access.

LACDMH Policies and Procedures Related to Language Assistance Services

- LACDMH policies 200.02, 200.03, and 200.09
- These policies highlight the following:
  - Under no circumstances are consumers denied access to mental health services due to language barriers.
  - All non-English speaking and LEP consumers receive equal access to care and interpreter services in their primary or preferred language, including threshold, non-threshold languages, and American Sign Language (ASL) services.
  - Consumers have the right to culture-specific rendering providers and to receive specialty mental health services (SMHS) in their primary or preferred language.
  - Consumers are to be informed in writing or by other verified acceptable means of their right to language assistance services at no cost as well as instruction on how to access these services.

ARISE Division-LAS: Over the Phone Request Submitted to ISD for Directly Operated Programs

1) For over the phone (OTP) interpreter requests submitted to ISD, the requesting employee must provide the following required information:

   - **Full Department Name**
   - **Employee First and Last Name**
   - **Employee Number**
   - **Cost Center Number** (the Cost Center number differs from the Provider Number). *This information is essential for the billing process and for generating precise expense reports for the Department.* ***This service is only for DOs, not LEs.***

It is essential for all staff to know the cost center number for their program and to have it at close reach.

ARISE Division: Language Access Services

- All requests for Over-The-Phone (OTP) interpretation services are managed by ISD. The LA County phone numbers to call for OTP services is listed on Attachment I below.

Attachment I

HOW TO ACCESS OVER THE PHONE (OTP) INTERPRETATION SERVICES

To ensure prompt and accurate service delivery as well as correct billing, please provide the following information when requesting interpretation services.

REQUIRED INFORMATION:

- **Full Department Name**
- **Employee First and Last Name**
- **Employee Number**
- **Cost Center Number (*Please coordinate with the budget analyst within your unit to obtain this information. It is important to note that the Cost Center number differs from the Provider Number assigned to your clinic.)***

Note: All Users must call vendors on a rotational basis. This list is for **DMH internal use only** and must not be shared with Legal Entities or Contract Providers.

COST CENTER #: _____

911 Interpreters Dial Phone Number: (866) 516-7731	**Avaza Language Services** Dial Phone Number: (866) 284-0303 or (213) 340-0303	**Focus Interpreting** Dial Phone Number: (760) 640-0562 Pin: 0000
Hanna Dial Phone Number: (855) 803-8250 Provide the customer code: 681974	**Language Arts** Dial Phone Number: (323) 577-6611	**Language Line Solutions** Dial Phone Number: (855) 267-1141
Transperfect Dial Phone Number: (855) 784-4523	**World Language Communications** Dial Phone Number: (213) 523-3216 Access Pin: 5891#	**WorldWide Interpreters** Dial Phone Number: (855) 574-3335

ARISE Division: ASL LAS for Directly Operated and LE/ Contracted Providers

LACDMH coordinates and funds ASL services for DO and LE providers for clinical appointments, which include psychotherapy and psychiatric services.

How to book ASL clinical appointments through LACDMH's ARISE Division:

1. Step 1 is to always submit the request for services via our designated mailbox ARISEaccessibility@dmh.lacounty.gov. Contact us to learn the information we require by to book the desired ASL clinical service
2. Requesting programs should not initiate contact with a vendor to arrange for services from any vendor without submitting a request to the ARISE Division (inbox mentioned above) to avoid confusion and budgetary issues.
3. Early/timely submission of LAS requests maximizes the likelihood of successfully fulfillment.
4. Requestor program must report **cancellations at least three (3) business days (72 hours) to** ARISEaccessibility@dmh.lacounty.gov before the scheduled service. This will prevent DMH from incurring vendor expenses for services not provided.
5. Completion of the online ASL Services Satisfaction Survey by the ASL service user at the end of the clinical appointment: https://forms.office.com/g/xEkqqkE8aL

ARISE Division-LAS for LACDMH Stakeholder Meetings/Events

- To request interpreter services, LACDMH Directly Operated programs shall access and submit the online form to the LAS Team via this link: **LAS Form**
  - Incomplete form submissions will delay the process of scheduling services.

- Processing of requests submitted to the LAS Team require a minimum of **15 business days** for processing prior to needed services. Please do not contact vendor.

- For meetings with multiple breakout rooms and more than one team of interpreters, the ARISE Division requires a **minimum of three (3) weeks.**

ARISE Division-LAS for LACDMH Stakeholder Meetings/Events Cont.

- Step 1 is to always submit the request for services via the **LAS Form**
- Do not contact the Vendor or provide meeting information directly or ask for services from any Vendor without submitting the LAS form to avoid confusion and budgetary issues.
- Early/timely LAS form submission maximizes the likelihood of successfully fulfilling requests by the ARISE Division.
- The LAS team is not responsible for emergency LAS vendor searches and hiring. Programs that submit requests close to the event run the risk of not getting the needed LAS services.
- Once LAS staff secure the service, a confirmation email is provided to the requestor that includes the vendor information and the names of the interpreters/captioners.
- Bookings for ASL services require a still audience.
- Requesting program must report **cancellations at least three business days (72 hours)** before the scheduled service to the ARISE-LAS Team at ARISELAS@dmh.lacounty.gov
- This will prevent LACDMH from incurring vendor expenses for services not provided.

LAS Summary Points

- To coordinate scheduled Sign Language interpretation services for DO and LE providers for clinical appointments, which include psychotherapy and psychiatric services, please submit the request for services via our designated mailbox, ARISEaccessibility@dmh.lacounty.gov.
- To coordinate interpretation services, including ASL for LACDMH stakeholder meetings and events, please submit the request for services via our online form, LAS Form
- To coordinate the translation of written materials, please submit the request for services via our online form, LAS Form

Summary of Key Points from this Presentation

1. LACDMH is required to have a DLAP
2. Employees must be knowledgeable on how to access services for our clients
3. The Department has P&P regarding language access
4. If a program cannot provide LAS, the end users/consumers need to be connected to Patients Rights to file a complaint
5. We empower use of this PPT with employees/staff at the program level, including the glossary of terms
6. Regarding Language Assistance Services:
   - LACDMH only provides ASL services for clinical appointments for Directly Operated and Legal Entities/Contracted Providers and coordination is done via the ARISE Division
   - Directly Operated programs in need of over the phone (OTP) interpreters are to contact ISD
   - Legal Entities and Contracted Providers are responsible for developing their own procedures and procurement for Language Assistance Services

Appendix

- Links to DMH P&P pertinent to language services
  - P&P 200.02:Interpreter Services for the Deaf and Hard of Hearing Community
    - Link DMH P&P 200.02
  - P&P 200.03: Language Translation and Interpreter Services
    - Link DMH P&P 200.03
  - P&P 200.09 Culturally and Linguistically Inclusive Services
    - Link DMH P&P 200.09

Grievance and Appeal Forms

The Grievance/Appeal Form allows consumers, family members, friends, and even staff to express concerns about services provided under the Mental Health Plan.

- Grievance/Appeal Form – Arabic
- Grievance/Appeal Procedures – Arabic

- Grievance/Appeal Form – Armenian
- Grievance/Appeal Procedures – Armenian

- Grievance/Appeal Form – Cambodian
- Grievance/Appeal Procedures – Cambodian

- Grievance/Appeal Form – Chinese
- Grievance/Appeal Procedures – Chinese

- Grievance/Appeal Form – English
- Grievance/Appeal Procedures – English

Grievance and Appeal Forms

- Grievance/Appeal Form – Farsi
- Grievance/Appeal Procedures – Farsi

- Grievance/Appeal Form – Korean
- Grievance/Appeal Procedures – Korean

- Grievance/Appeal Form – Russian
- Grievance/Appeal Procedures – Russian

- Grievance/Appeal Form – Spanish
- Grievance/Appeal Procedures – Spanish

- Grievance/Appeal Form – Tagalog
- Grievance/Appeal Procedures – Tagalog

- Grievance/Appeal Form – Vietnamese
- Grievance/Appeal Procedures – Vietnamese

Change of Provider Form

- DMH P&P 200.05: Request for Change of Provider:
  - http://file.lacounty.gov/SDSInter/dmh/1041262_200_05_Att_1_English.pdf
  - Consumer drives the request and work directly with programs
  - PRO may serve as a liaison when consumers determine they are not being heard.

LACDMH Glossary of Terms

- **American Sign Language (ASL)**: The sign language used in the USA and Canada.
- **Back translation:** the translated document gets translated back into the source language by another translator. Both source and target language translations are compared to ensure content accuracy.
- **Communication Access Realtime Translation (CART):** The creation of an instant record of spoken language into text format via the utilization of a stenotype machine, computer or specialized software. The text produced by the CART service can be displayed on the user's computer monitor, mobile phone, projected onto a screen, or other display systems.
- **Departmental Language Access Plan (DLAP):** This document establishes the minimum requirements for County departments to ensure that they strive to provide consistent, high-quality language access.
- **Face-to-Face Interpreter Service**: DMH services that involve the physical presence of a language interpreter to facilitate oral language communication, in real time, between two (2) or more people who are not fluent in each other's languages. Language interpreters take into consideration the spoken language and the cultural differences related to nonverbal forms of communication, including facial expressions, eye-to-eye contact, physical space, body posturing, and gestures. (National CLAS Standards)

LACDMH Glossary of Terms Cont.

- **Field testing:** the translated document is reviewed by consumers/family members/community members or DMH bilingual certified employees who are proficient in the target language. This process ensures that the translated document has meaning beyond a literal translation.

- **Interpreter:** A speech-certified professional who orally converts and conveys messages from the source language to the target language.

- **Interpreter:** A certified professional who creates a written copy of either video or audio content. Also called Transcriptionists or Captioners, Transcribers convert recorded or live human speech into text format. Interpreters facilitate communication to ensure that a person/group who is not proficient in the source language receive the information in their preferred language.

- **Language Assistance Services:** Refers to language and communication-based supports that include translation (written), interpreter (oral), sign language, and closed-captioning (i.e., CART) services at no cost to consumers.

- **Languages Other Than English (LOTE):** Also known as Limited English Proficiency (LEP) or English Language Learner (ELL). This designation refers to individuals who do not speak English as their primary language and who do not read, write or speak English.

LACDMH Glossary of Terms Cont.

- **Limited English Proficient (LEP):** A limited level of English language communication that, within the context of accessing mental health services, should call into question the consumer's ability to adequately understand and respond to issues related to his or her treatment. (DMH Information Notice 10-02)

- **Non-spoken Language:** The transfer of information/communication from one person to another without the use of words or spoken language. Nonverbal communication can occur in a variety of ways, including through facial expressions, gestures, and body posture or position.

- **Non-Threshold Language:** Other non-English languages that do not meet threshold language criteria described in this policy.

- **Oral Interpreter Service:** A conversion of a message from an oral source language, into an equivalent oral target language. This service may be provided in person, by telephone or video call.

- **Primary or Preferred Language:** The language that must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary. (9 CCR § 1810.410(a)(2))

LACDMH Glossary of Terms Cont.

- **Simultaneous Interpreter Service:** A highly complex cognitive activity requiring the interpreter to listen, analyze, comprehend, convert, edit, and reproduce in real time a speaker's message while the speaker continues to speak. This service may be provided in-person, or via telephone or video call.
- **Source Language:** A language in which a message is originally given.
- **Spoken Language:** a form of communication in which people use the mouth to create recognizable sounds. These sounds come from a large vocabulary of sequences of sounds with agreed-upon meanings. These sequences of sounds are called words, and each represents one or more objects or concepts. A shared grammar and syntax allow the speaker to form these words into statements that listeners will be able to understand.
- **Target Language**: A language into which a message is to be translated or interpreted.
- **Tele Typewriter (TTY)**: a device like a typewriter that has a small readout. It is a special device that lets people who are deaf, hard of hearing, or speech-impaired use the telephone to communicate by allowing them to type text messages. A TTY is required at both ends of the conversation to communicate, and it can be used with both landlines and cell phones. Unlike text messaging, it is designed for synchronous conversation, like a text version of a phone call. A modern digital cell phone must support a special digital TTY mode to be compatible with a TTY device.

LACDMH Glossary of Terms Cont.

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

- **Telephonic Language Interpreter Service:** A method of providing interpreters via telephone to individuals who wish to communicate with each other but have issues with the language barrier. The telephone interpreter converts the spoken language from one language to another enabling listeners and speakers to understand each other. Telephone or Telephonic Language Interpreting is carried out remotely, with the interpreter connected by telephone to the principal parties, typically provided through a speakerphone or headsets. In health care settings, the principal parties, e.g., doctor and patient, are normally in the same room, but telephone interpreting is served as a three-way teleconference. (National CLAS Standards)

- **Threshold language**: A language identified as a primary language spoken at a high proportional rate within a geographic region of the state. A countywide annual numeric identification of either 3,000 beneficiaries or five (5) percent of the Medi-Cal beneficiary population, whichever is lower, in an identified geographic area, whose primary language is not English and for whom information and services shall be provided in their primary or preferred language.

- **Translation:** A conversion of a text message or written form from the source language into an equivalent target language.

Questions?

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

ขอบคุณ

Hvala

Gracias

감사합니다

Ευχαριστώ

Merci

谢谢

شكرا!

תודה!

Cảm ơn bạn!

Grazie

Thank You

Regional Quality Improvement Committee (RQIC)

Quality, Outcomes, and Training Division

April 2025

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

Meeting Attendance- Southern RQIC

Please complete the following Microsoft Forms survey to confirm your attendance for today's meeting:

https://forms.office.com/Pages/ResponsePage.aspx?id=SHJZBzjqG0WKvqY47dusgd3PzpIfIShOkZg0l_tGS49UNUxYUlhLQUtLSUY1T0I3RFYwSVBOR0dNNC4u

Armenian Genocide Remembrance

A day for all to reflect on past and present genocides, but especially those that have felt the impact of these atrocities and groups that have found refuge in California, including, but not limited to, the Holocaust, Holodomor, and the Genocides of the Armenian, Assyrian, Greek, Cambodian, and Rwandan communities.

DEPARTMENTAL LANGUAGE ACCESS PLAN & LANGUAGE SERVICES- ARISE

Work Plan Goals 2025

Full plan posted at:
https://dmh.lacounty.gov/qid/qi-work-plan-goals/

Work Plan Goals are created in each of the following domains

- Service Delivery Capacity
- Accessibility of Services
- Member Satisfaction
- Clinical Care
- Continuity of Care
- Provider Appeals
- Performance Improvement Projects

QAPI Work Plan Goals

Work Plan Goals look at the areas that need improvement, set goals with specific objectives, develop interventions with specific timeframes, and identify who monitors progress. These goals are around member care and can include how we can make our services more accessible and staff retention.

Clinical and Nonclinical Performance Improvement Projects (PIPs) are conducted each year and part of the Work Plan. PIPs are used as smaller more targeted efforts to try out interventions. If interventions are successful, they can be expanded systemwide to make improvements for DO and LE/Contracted providers.

- Last year's Work Plan Goals were informed by External Quality Review Organization (EQRO) findings. However, since EQRO changed this year from Behavioral Health Concepts Inc. (BHC) to Health Services Advisory Group (HSAG) along with the process, we utilized Consumer Perception Survey (CPS) Open Ended Comments to inform us of the needs of our members along with input from the various divisions and units within DMH.

No.	Domain	GOAL
1a.	Service Delivery Capacity	Improve language accessibility for our members and community stakeholders.
1b.	Service Delivery Capacity	Enhance mental health education and decrease stigma in Asian Pacific Islander, Latino, and LGBTQ+ communities.
1c.	Service Delivery Capacity	Educate DMH workforce on Peer Services and provide training to peer workforce to improve quality and quantity of services provided.
2a.	Member Satisfaction	Evaluate Consumer Perception Survey (CPS) findings to identify areas of improvement in our system of care.
2b.	Member Satisfaction	Monitor grievances, appeals, and requests for a Change of Provider (COP).
3a.	Clinical Care	Publishing data reports for DMH internal use and legal entity providers.
3b.	Clinical Care	Implement changes to Care Court data reporting requirements.
3c.	Clinical Care	Develop a robust customer service systemwide.
3d.	Clinical Care	Continue to further develop a mechanism to measure and track Healthcare Effectiveness Data and Information (HEDIS) Measures.
3e.	Clinical Care	Continue the roll out Level of Care Utilization system (LOCUS) as Adult Level of Care Tool.
3f.	Clinical Care	Evaluation of the Quality Improvement Program.
4a.	Continuity of Care	Develop a systemwide strategy to reduce 7 and 30-day rehospitalization rates.
4b.	Continuity of Care	Develop Behavioral Health Transformation (BHT) Integrated Plan Needs Assessment for Los Angeles County.
5.	Provider Appeals	Monitor Provider Appeals.
6a.	Performance Improvement Projects	Clinical PIP for CY 2025 will aim to improve the Follow-up After Emergency Department Visit for Mental Illness (FUM) measurement rate.
6b.	Performance Improvement Projects & Accessibility of Services	Non-clinical PIP for CY 2025 will aim to improve access from first contact from any referrals source to first offered appointment for any outpatient non-urgent non-psychiatry SMHS for 0–20-year-olds.

ARISE Goals

Goal 1a.	Improve language accessibility for our members and community stakeholders.
Objective(s)	1. Develop and implement Departmental Language Access Plan (DLAP). 2. Increase stakeholder feedback regarding language access. 3. Increase language access for limited English proficiency members and family members. 4. Assess member satisfaction with American Sign Language (ASL) interpreter services.
Population	Los Angeles County limited English proficiency and deaf and hard of hearing members and families who receive outpatient SMHS from LACDMH DO and LE/Contracted providers
Performance Indicator(s)	1. Develop report on Provider Language Capacity 2. Availability of language accessibility resources for Stakeholder Meeting 3. Action plan to track and monitor translation of materials 4. Rate of member satisfaction with ASL interpreter services

Goal 1b.	Enhance mental health education and decrease stigma in Asian Pacific Islander, Latino, and LGBTQ+ communities.
Objective(s)	1. Utilize Underserved Cultural Communities (UsCC). 2. Utilize Promotores. 3. Increase education regarding hate crimes and mental health so community members can access services if needed.
Population	LACDMH and LE/Contracted members and stakeholders
Performance Indicator(s)	1. Number of community presentations per language for the UsCC capacity-building projects for LGBTQ+, Latino, and API (e.g. Spanish and API languages) 2. Incorporate hate crime information in new capacity-building projects to decrease stigma for the LGBTQ+, Latino, and API communities. 3. Create LGBTQ+ workshop modules for the United Mental Health Promoters program to increase community education and awareness around LGBTQ+ issues and reduce stigma and incidence of hate crimes 4. The number of presentations delivered by the Mental Health Promoters in Spanish and API languages to reduce stigma and incidence of hate crimes

Peer Services Goal

Goal 1c.	Educate DMH workforce on Peer Services and provide training to peer workforce to improve quality and quantity of services provided.
Objective(s)	1. Increase rate of members who receive at least one peer support service by increasing the number of Peer Support Specialists. 2. Provide financial assistance for Peer Support Specialist certification to 80 Peers. 3. Expand career ladder for peers. 4. Develop quality review plan with Quality Assurance unit for peer services. 5. Create member satisfaction survey for those who received peer support services. 6. Develop Peer Services 101 as a requirement for DMH DO employees and a training conference for DMH Peers. 7. Require Supervision of Peer Workers training for supervisors of peers. 8. Work with Training Unit to host peer specific trainings 10 months out of the year. 9. Create group supervision for those who supervise CHW and peers with Chief of Peer Services. 10. Start Peer Network facilitated by Peer Services for professional development.
Population	Peer Workforce, DO members/families receiving outpatient SMHS
Performance Indicator(s)	1. Rate of members who receive at least one Peer Support Service 2. Number of Peer Support Specialists who receive financial support for certification 3. Rate of Peers who attend at least one training from their suggested curriculum

QI Unit Goals

Goal 2a.	Evaluate Consumer Perception Survey (CPS) findings to identify areas of improvement in our system of care.
Objective(s)	1. Increase provider participation by identifying providers who have had no or low rates of submitted surveys and offering technical support. 2. Increase member participation by utilizing strategies such as expanding MyHealthPointe pilot and working with Peer Services. 3. Identify ways to increase community knowledge of the CPS by working with the Public Information Office (PIO). 4. Continue to roll out a Power BI dashboard to evaluate survey findings and report provider-level performance trends. 5. Identify systemwide areas of improvement and report to responsible units to create interventions.
Population	DO and LE/Contracted members/families receiving outpatient SMHS
Performance Indicator(s)	1. Rate of provider participation over a three-year trend 2. Rate of returned surveys over a three-year trend 3. Publication of Power BI report with accessible provider level reports 4. Publication of Provider Level Reports with domain ratings

Goal 3f.	Evaluation of the Quality Improvement Program.
Objective	1. Develop and deliver a survey to evaluate satisfaction with the QI Unit's processes and support to providers and other departmental units. 2. Review and analyze provider feedback survey regarding support during CPS. 3. Continue to integrate QI administrative processes with SAPC.
Population	DMH staff and DO/LE Providers
Performance Indicator(s)	1. Rate of satisfaction of Countywide QIC, Regional QIC, QI website, and support from QI Unit 2. Rate of satisfaction with CPS support 3. Integrated Work Plan, QAPI, and planning to integrate QIC

Patient's Rights Goal

Goal 2b.	Monitor grievances, appeals, and requests for a Change of Provider (COP).
Objective(s)	1. Review the nature of complaints, resolutions, and COP requests for significant trends that may warrant policy recommendations or system-level improvement strategies. 2. Utilize data captured in COP application to identify practitioners or facilities who continuously receive COP requests. 3. Create PowerBI Dashboard to visualize trends in data.
Population	Los Angeles County residents engaging in DMH services [outpatient, inpatient, Fee for Service (FFS)]
Performance Indicator(s)	1. Total member complaints and resolutions by type in Calendar Year 2025 2. COP requests by type in Calendar Year 2025

Outcomes Goals

Goal 3a.	Publishing data reports for DMH internal use and Legal Entity providers.
Objective(s)	1. Validate Full-Service Partnership (FSP) Outcome Measures Application (OMA) reports on data quality, introduce row level security for providers to be able to access their data and only their data, and test security with providers. 2. Recommend improvements to existing FSP OMA reports and work with developers to implement the changes. 3. Work with staff and CIOB to create a new FSP OMA error report to evaluate if errors are being fixed. 4. Finalize CANS client level report with CIOB and release to production environment for legal entity and DO programs.
Population	All members receiving FSP and or EPSDT services
Performance Indicator(s)	1. Number of published reports 2. Monitor use and need for support 3. Completion of FSP OMA Error Report

Goal 3b.	Implement changes to Care Court data reporting requirements.
Objective(s)	1. Review Senate Bills 1400 and 42 and DHCS CARE draft revised data dictionary to understand new reporting requirements for Care Court and develop and plan for implementing requirements. 2. Identify data source for every new required data element for Care Court and work with CIOB on revisions to data collection forms and revisions to data extract file for transfer of data to DHCS. 3. Review data file for errors and make initial submission for revised data elements. 4. Correct any errors with revised data submission process, ensure there is a process in place for monitoring ongoing submission of care court data. 5. Complete next successful submission of revised data to DHCS.
Population	Adult members that are part of Care Court
Performance Indicator(s)	1. Number of completed monthly assessments 2. Errors corrected and fewer errors over time

Goal 3e.	Continue the roll out of Level of Care Utilization System (LOCUS) as Adult Level of Care Tool.
Objective(s)	1. Continue the LOCUS Workgroup for Pilot providers. 2. Continue to work with contracted providers and CIOB to develop mechanisms for data collection and submission of results. 3. Review data collected by Directly Operated clinics utilizing Netsmart built tool for LOCUS.
Population	Adult members receiving outpatient services
Performance Indicator(s)	1. Number of staff trained to administer LOCUS 2. Monitor progress of data collection readiness and needs for support 3. Evaluate early concordance rates with derived level of care from LOCUS with types and level of services members receive

Outpatient Care Services Goal

Goal 3c.	Develop robust Customer Service systemwide.
Objective(s)	1. Support members by offering flexible scheduling including evening and weekend appointments. 2. Encourage providers to have all staff in clinics trained in customer service skills annually. 3. Clinics to provide services predominately in person unless client's request telehealth options.
Population	DO and LE/Contracted members/families receiving outpatient SMHS
Performance Indicator(s)	1. Number of providers who provide evening hours at least 2 times a week 2. Rate of in-person vs telehealth services 3. Consumer feedback on Consumer Perception Surveys open-ended comments

Health Access & Integration (HAI) Goals

Goal 4a.	Develop a systemwide strategy to reduce 7 and 30-day rehospitalization rates.
Objective(s)	1. Develop root cause analysis on 30-day and 12-month rehospitalizations with input from Clinical Informatics and other Subject Matter Experts (SME) to identify barriers and possible solutions that will inform Phase 3 Pilot Program interventions. 2. Establish a baseline data set including but not limited to demographics of clients who are being rehospitalized in 7 or 30-days after last discharge. 3. Research how other Mental Health Plans (MHP)/Managed Care Plans (MCP) address and track rehospitalization rates. 4. Identify key areas that have the highest impact on rehospitalization (e.g., supporting transitions of care) that will inform options for a system-wide intervention. 5. Using root cause analysis, identify and design one intervention targeting systemwide readmission rates.
Population	LACDMH members who are high utilizers of hospitals defined as those who are rehospitalized at 7 and 30 days after last discharge.
Performance Indicator(s)	1. Develop at least 3 intervention options based on completed root cause analysis

Goal 5.	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 by December 2025. The final hospitals that will be brought on to concurrent authorization are pending enhancements to the data management platform. 3. Identify trends in provider appeals and identify interventions to support provider improvements that will reduce the number of Notice of Adverse Benefits Determinations (NOABDs).
Population	LACDMH members 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)	1. The number of Notice of Adverse Benefits Determinations (NOABDs) issued and the percentage of appeals upheld or overturned

MHSA & QI Unit Goal

Goal 4b.	Develop Behavioral Health Transformation (BHT) Integrated Plan Needs Assessment for Los Angeles County.
Objective	1. Internally agree upon data sets needed and narrative in Service Equity Report. 2. Clarify the roles/responsibilities of MHP, MCPs, Local Health Jurisdictions (LHJs), and SAPC in serving Los Angeles County population. 3. Review needs assessments from SAPC, LHJs, and MCPs in Los Angeles County. 4. Utilize Advisory Committee to update data needed in Portrait of Los Angeles as basis for Integrated Needs Assessment. 5. Collaborate with MCPs, SAPC, and LHJs to work towards having one needs assessment for Los Angeles County to be implemented in 2028.
Population	Los Angeles County Population in Need of Behavioral Health Services
Performance Indicator(s)	1. Produce Service Equity Report 2. Outline steps needed to integrate Los Angeles County Needs Assessment including a list of agreed upon data sets to be included and plan developed to share data between entities.

Clinical Informatics & Pharmacy Goal

Goal 3d.	Continue to further develop a mechanism to measure and track HEDIS Measures.
Objective(s)	1. Define measurement process for DMH to track progress on the following County MHP Priority Performance Measures: • Follow Up After Emergency Department Visit for Mental Illness (FUM) • Follow Up After Hospitalization for Mental Illness (FUH) • Antidepressant Medication Management (AMM) • Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) • Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) • Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (ADD) • Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) 1. Create Power BI Dashboard that tracks HEDIS measures related to medication and laboratory monitoring. 2. Collaborate with Managed Care Plans (MCPs) on data exchange for a more comprehensive data set. 3. Convene workgroups for any measures below Minimum Performance Level (MPL) to plan for interventions designed to improve performance.
Population	All Medi-Cal members that meet criteria to be included in any of the above HEDIS measures
Performance Indicator(s)	1. Meet MPLs set by DHCS or achieve at least a 5% increase over the year prior's baseline for any particular measure 2. Reports produced to demonstrate HEDIS Measure performance

Why is the HEDIS Goal so Important?

- Starting with Measurement Year (MY) 2023 DHCS can impose sanctions if LACDMH has two (2) or more measures below the Minimum Performance Level (MPL) or measures that do not achieve at least 5% increase over baseline

- Achieving and exceeding MPLs for each measure will require a systemwide commitment to collecting and utilizing data and improving the quality of our care for these quality metrics. DMH recommends utilizing Health Information Exchanges (HIEs) such as LANES or Point Click Care to improve performance on FUM and FUH.

Measurement Year 2023

Measure Acronym	Performance Measure	Definition	Minimum Performance Level	High Performance Level
AMM	Antidepressant Medication Management (Effective Acute and Continuation Phase Treatment)	Percent of ages 18+ with a diagnosis of Major Depression and treated with an antidepressant for minimum of 3 months and for 6+ months.	Acute 60.79% Continuation 43.28%	Acute 74.16% Continuation 58.06%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Percent of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	60.22%	73.87%
FUM	Follow-Up After Emergency Department Visit for Mental Illness (Follow-Up Within 30 Days)	Percent of Emergency Department visits for ages 6+ with a principle diagnosis of mental illness or intentional self-harm who had a mental health follow up visit, within 7 days and within 30 days. *Does not include members who are admitted to the hospital as a result of the ED visit.	54.87%	73.26%
FUH	Follow-Up After Hospitalization for Mental Illness (Follow-Up Within 30 Days After Discharge)	Percent of those ages 6+ who had a follow up visit with 7 and 30 days of discharge.	57.69%	72.79%
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Percent of ages 18+ during the MY with Schizophrenia or Schizoaffective Disorder who were dispensed and remained on an antipsychotic medication at least 80% of the treatment period.	61.39%	72.61%

Clinical & Non-clinical PIPs

Goal 6a.	Clinical PIP for CY 2025 will aim to improve the Follow-up After Emergency Department Visit for Mental Illness (FUM) measurement rate.
Objective	1. Analyze demographic data of clients utilizing emergency departments for mental illness. 2. Conduct barrier analysis. 3. Identify and work collaboratively with PIP committee members. 4. Exchange data with Managed Care Plans (MCPs) for more accurate denominator and coordination of services to increase follow-up and reduce recidivism.
Population	Members age 6+ who visit an emergency department for mental illness or intentional self-harm.
Performance Indicator(s)	1. Analysis of FUM Demographic data 2. Outline barriers to follow-up after emergency department visits 3. Develop interventions for Clinical PIP 4. 7 and 30-day FUM rate for CY 2025 to be used as Baseline data for PIP Submission due in 2026

Goal 6b.	Non- clinical PIP for CY 2025 will aim to improve access from first contact from any referral source to first offered appointment for any outpatient non-urgent non-psychiatry SMHS for 0–20-year-olds.
Objective	1. Create workgroup of providers that are untimely and assist providers in implementing 1-2 interventions to target improvement of timeliness rates. 2. Utilize Fee for Service Providers to improve timely access to first offered appointments. 3. Develop an automated process for tracking & monitoring child providers who are not accepting new clients for general outpatient care services and Prevention and Early Intervention (PEI).
Population	Children accessing SMHS through DO and LE/Contracted providers
Performance Indicator(s)	1. Number of Child non-psychiatry routine appointments within 10 business days

Importance of Non-Clinical PIP

- Aligns with Corrective Action Plan (CAP) that is in place for LACDMH around Access to Care for Children's Non-Psychiatry Routine Appointments
- Sanctions are possible if we do not improve our rate in a timely manner

Help with FUM

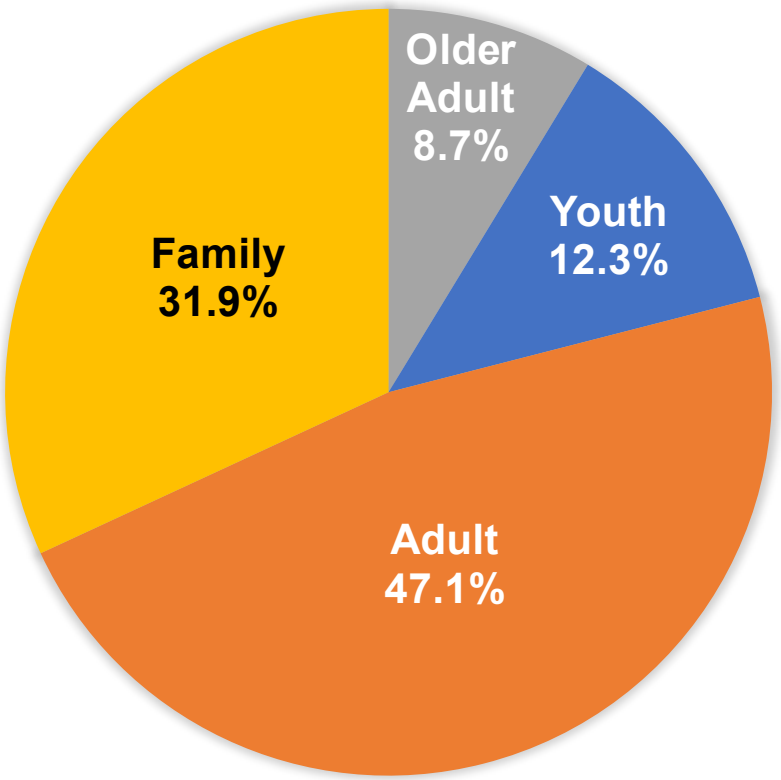
- Thoughts around what possible barriers to follow-up after emergency department visits might be.

- Ideas about possible interventions to improve follow-up.

CONSUMER PERCEPTION SURVEY

HELP US IMPROVE!

Countywide Total Completed Surveys by Age Group

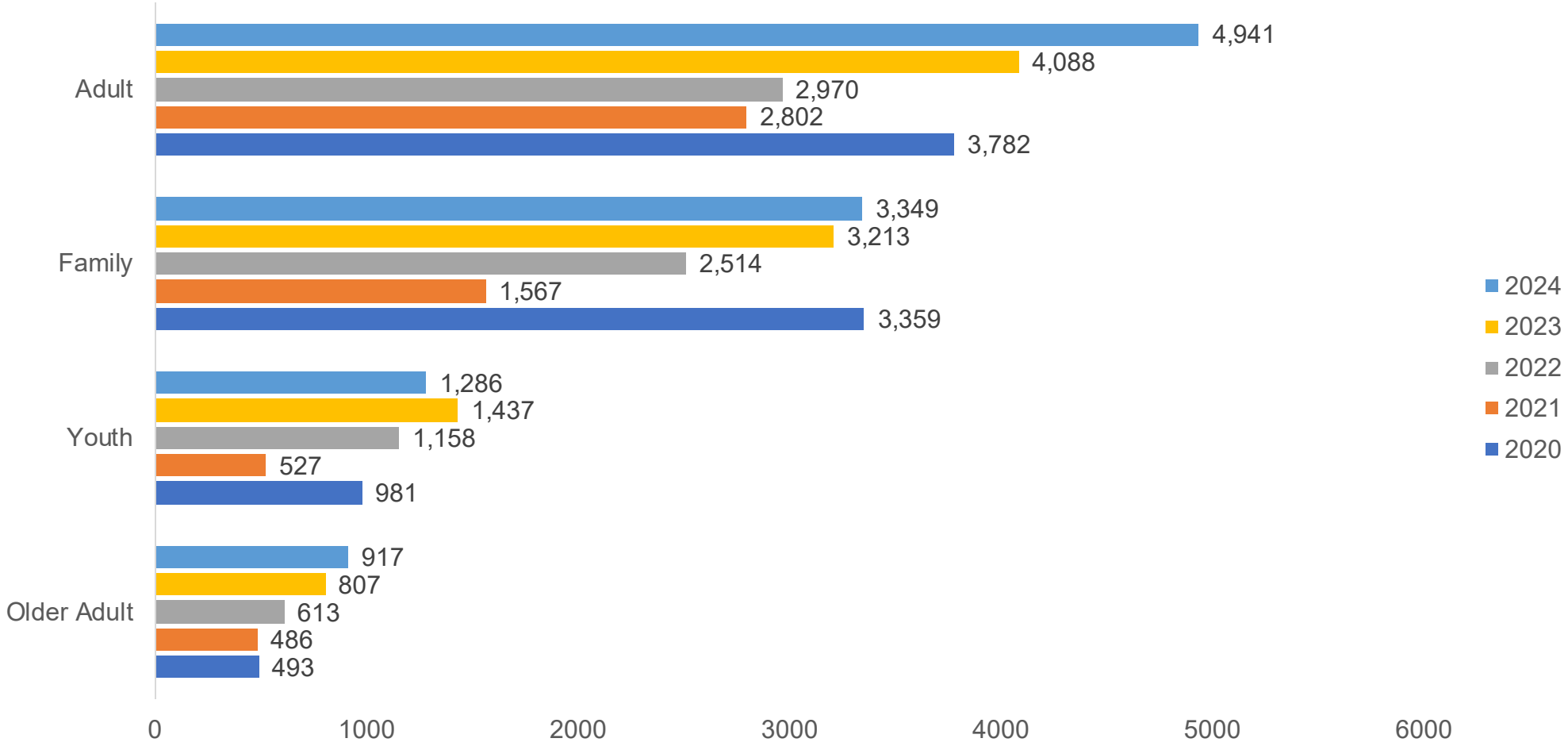


YOUTH	1,286
FAMILY	3,349
ADULT	4,941
OLDER ADULT	917
TOTAL	10,493

- Total surveys received = 12,032
- Percent completed = 87.2%
- 9.9% increase from 2023

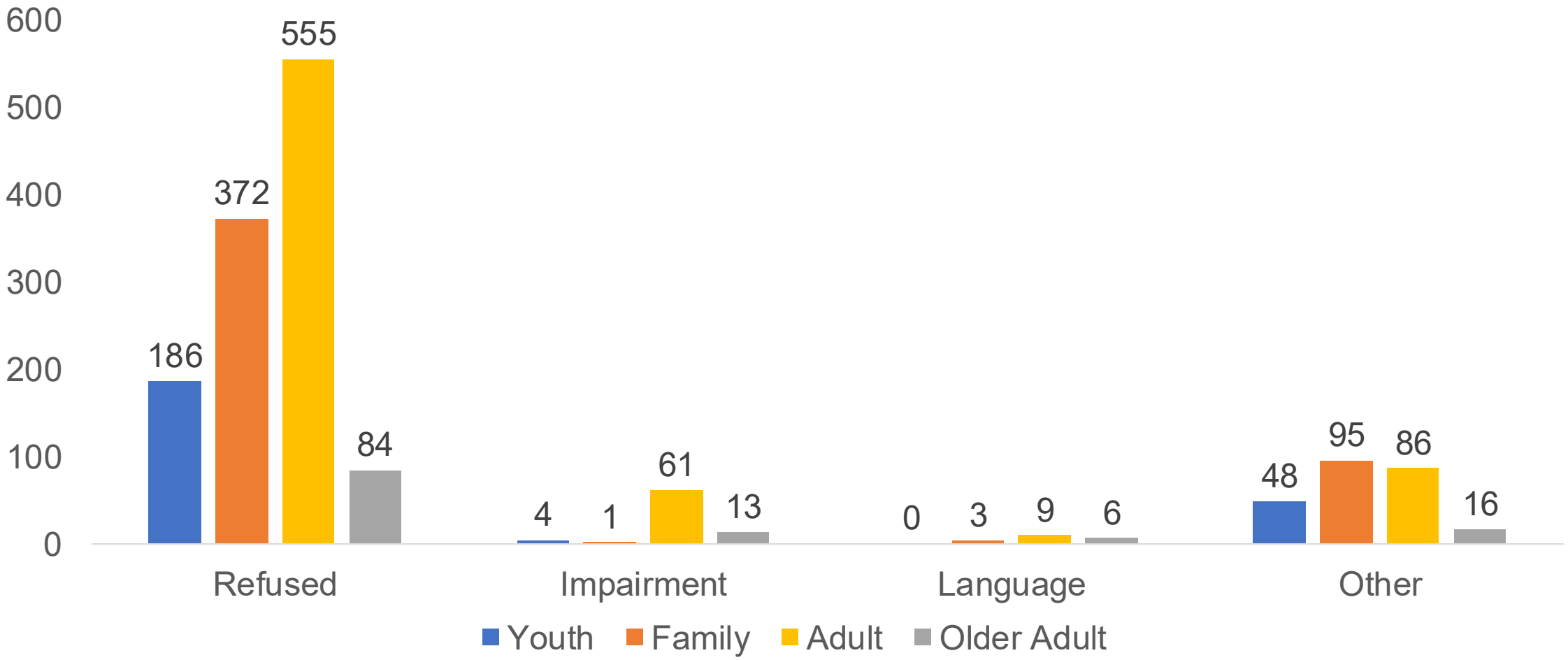
Note: Completed surveys are surveys with usable data that had more than two questions answered. Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2024 Survey Period, March 2025.

Countywide Total Surveys Five-Year Trends



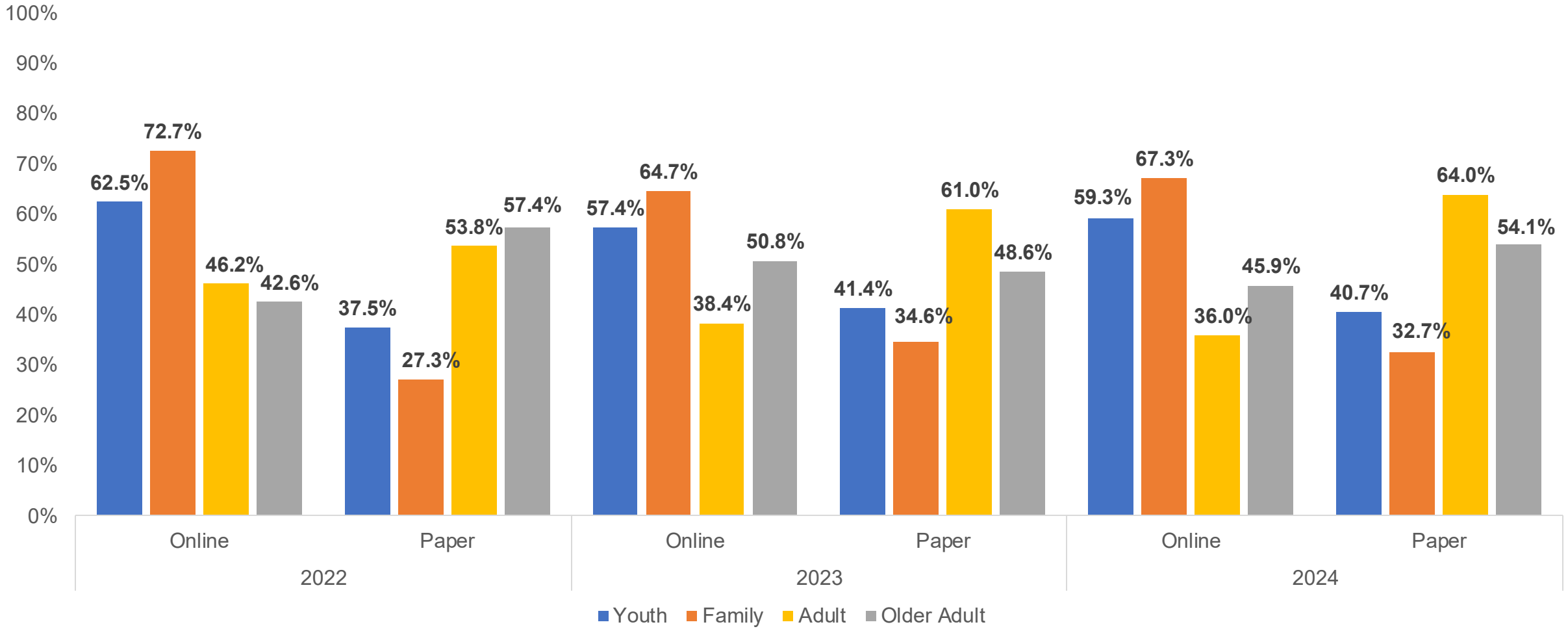
Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2024 Survey Period, March 2025.

Reason for Not Completing Survey



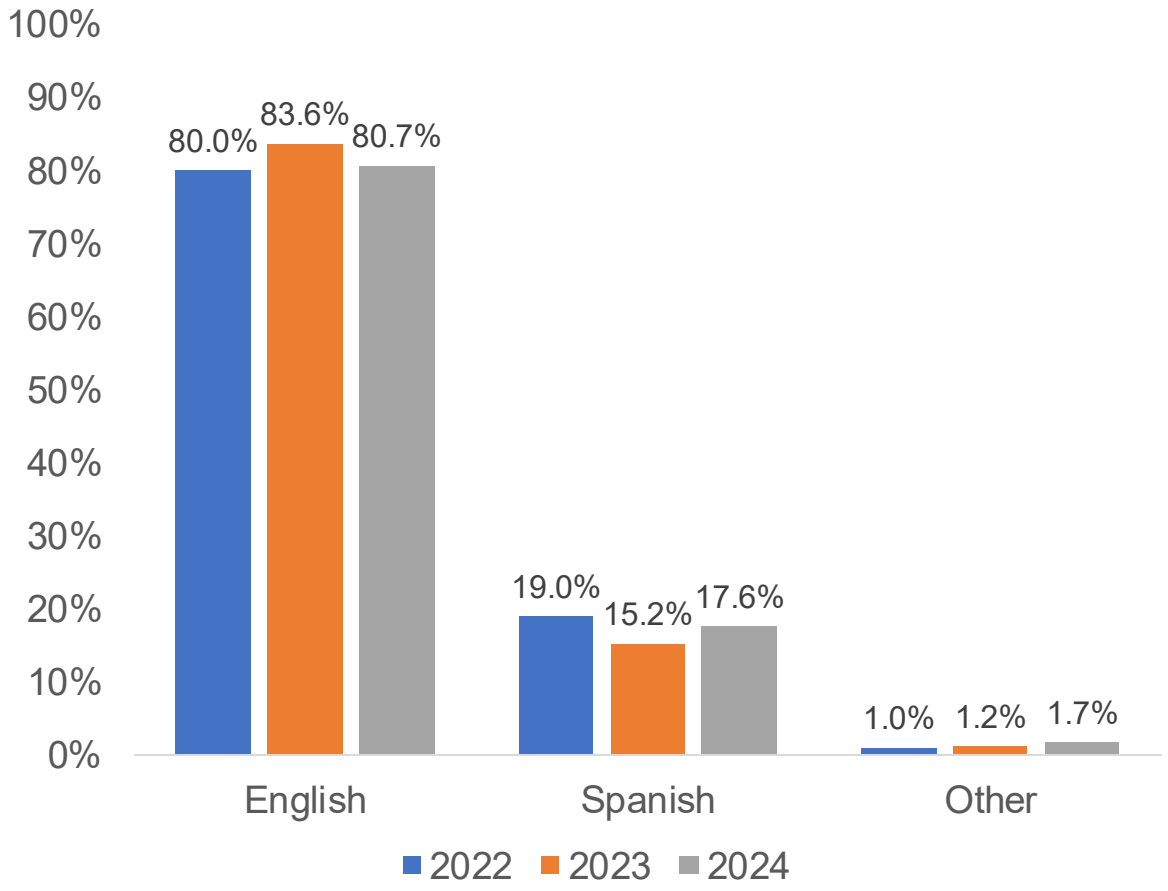
Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2024 Survey Period, March 2025.

Countywide Completed Surveys by Format, 2022-2024



Data Source: UCLA Consumer Perception Survey Los Angeles County Report May 2024 Survey Period, March 2025.

Countywide Completed Surveys by Language



Number of Other Language Surveys Received

Language	2022	2023	2024
Korean	50	59	89
Chinese	24	30	33
Vietnamese	10	0	20
Armenian	9	18	13
Farsi	6	0	7
Tagalog	2	0	1
Russian	2	1	6
Khmer	1	0	10

Data Source: Consumer Perception Survey data May 2024. Consumer Perception Survey data May 2023. UCLA Consumer Perception Survey Los Angeles County Report May 2022 Survey Period, February 2023. UCLA Consumer Perception Survey Los Angeles County Report May 2023 Survey Period, December 2023. UCLA Consumer Perception Survey Los Angeles County Report May 2024 Survey Period, March 2024.

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

CONSUMER PERCEPTION SURVEY

May 19-23, 2025

CPS 2025 Training Recordings

- **Paper Survey Training**
  - April 15, 2025
  - RECORDING LINK: https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=12780
- **UCLA Electronic Survey Training**
  - April 17, 2025
  - RECORDING LINK: https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=12784
- **LACDMH Electronic Survey Training for DOs**
  - May 1, 2025 from 9 AM to 11 AM
  - MEETING LINK: Click to Join Meeting
- **LACDMH Electronic Survey Training for LEs**
  - May 1, 2025 from 1 PM to 3 PM
  - MEETING LINK: Click to Join Meeting

Survey Technical Assistance Calls

Monday through Friday, May 19-23, 2025

MORNING CALLS

9:00-9:30 AM using Microsoft Teams

Join on your computer or mobile app

Click here to join the meeting

Or call in (audio only)

(323) 776-6996

Phone Conference ID: 352 067 221#

AFTERNOON CALLS

1:30-2:00 PM using Microsoft Teams

Join on your computer or mobile app

Click here to join the meeting

Or call in (audio only)

(323) 776-6996

Phone Conference ID: 503 390 468#

DEADLINE for LACDMH Electronic Survey Access– **May 9**

- DOs
  - DO provider staff that need a Dynamics License for the LACDMH CPS portal MUST submit a HelpDesk Service Request
- LEs
  - Legal Entity(LE/Contracted) provider staff that need a C Number for the LACDMH CPS portal MUST submit a C Number request to your agency Provider Advocacy Office (PAO) Liaison

CPS Application Access

- Access can be requested, but the application in **NOT YET ACTIVE**
- DOs
  - A separate Service Request for the DO CPS team should be made to access the CPS application in Web Applications
- LEs
  - Make a separate request to your agency PAO Liaison for CPS application access
- If you had access previously, you should still have access. Double check!

Promoting Client Participation

- 2 versions of CPS flyers are available on the LACDMH QI Website: https://dmh.lacounty.gov/qid/cps/for-providers-and-staff/cps-2025/
- Post flyers in the lobby at your sites
- Post flyers on your agency's website
- Re-Post DMH's social media post about CPS to your agency's social media
- Let clients know the survey period is coming soon

CPS
Q & A

CPS Resources: https://dmh.lacounty.gov/qid/cps/for-providers-and-staff/cps-2025/

Next RQIC will be in July 2025

Thank You!

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WEBSITE:
HTTPS://DMH.LACOUNTY.GOV/QID/