AGENDA

I. Welcome and Introductions

II. Review of Minutes from December 15, 2016 meeting

III. Program Operations
   A. AOT Outreach & Engagement Report (Emergency Outreach Bureau/Linda Boyd)
   B. AOT Treatment Report (Countywide Resource Management/Jacqueline Yu)
   C. Policy and Procedure (Office of the Medical Director/Rod Shaner)
      i. AOT Clients and MIST
      ii. AOT Clients and Private Insurance
      iii. AOT-FSP Quality Measures (OMD/Shaner and UCLA/Sarah Starks)

IV. AOT Program Evaluation (UCLA/Joel Braslow)
   A. Quarterly Update

V. Other Agenda Items

Next Meeting: Thursday, June 8, 2017, 2:00PM-4:00PM
550 S. Vermont Ave., 10th Floor Conference Room, Los Angeles
MEETING MINUTES

I. Welcome and Introductions

A. Recent changes in the Department include the appointment of a new DMH Director, Jonathan Sherin. Dr. Sherin will join the AOT Oversight Committee for a meeting at a later date.

B. Forecasting issues for DMH as it relates to the Affordable Care Act.

1. The future of Medicaid Expansion.
   a. Part of the expansion is specialty mental health: Increasing the amount of services available and the population eligible for these benefits.
   b. If this expansion decreases or is repealed the Federal match dollars will no longer be available and local funds will need to be prioritized more prudently.

2. Non Specialty MH provided by Health Plans
   a. If this group is then uninsured, anticipating where they would access care is important for resource and funding allocation.
   b. Clarification on defining non-specialty mental health population: mild to moderate symptomology with some functional impairment.

3. Changes to Medi-Cal on the new Substance Abuse benefit.
   a. If changed, then the County may have less ability to provide care with a comprehensive wraparound benefit.
4. Availability of Social Services and Supports for SMI population may decrease if Whole Person Care is discontinued. WPC is part of implementation plans for Medi-Cal 2020.

5. Impact of population getting services from Emergency Departments as resources for non-emergency services may decrease.
   a. ACA has been instrumental in parity, making MH and SA services as available as primary care health services.

II. Review of Minutes from September 16, 2016 Meeting
   A. Minutes were approved without changes.
   B. OMD highlighted the attachment that compares the demographic information for All AOT Referrals with Clients served in LACDMH outpatient facilities.

III. AOT-LA Program Operations
   A. Policy and Procedure
      1. FSP Outcome Measures: Developing ways to ascertain how FSPs work and measure effectiveness of processes that include:
         a. Family communications: tracking number and frequency for input and including into treatment.
            i. LACDMH plans to provide a memo to clarify some privacy issues in regards to sharing and receiving information with and from family members.
         b. Adherence
            i. Medication Compliance
            ii. Keeping Appointments
         c. Response of AOT FSP Programs
            i. Post Handoff: Defining how handoff works between DMH and providers
            ii. To or during emergencies: tracking number of people in the hospital and if the provider went to ER during the emergency.
         d. Client Engagement
            i. Number of times a client is seen
            ii. Developing an average for client, program and provider (determine how often clients should be seen in a program like this).
            iii. Would be beneficial to add where client is seen as a way to encourage and increase client engagement.

B. AOT-LA Outreach & Engagement Report (EOB)
1. **Tracking the proportion of AOT referrals by Referral Source:** percentages remain relatively stable with a majority from treatment providers followed by family members and lastly law enforcement.

2. **Number of Unable to Locate has increased** partially because of the transient population. Another issue is if the referral is from a hospital or UCC but when O&E Teams go to outreach, the hospital or UCC does not have an adequate location listing upon the clients’ discharge.

3. Received a total of 30 referrals for people who were Felony Incompetent to Stand Trial (FIST) or Misdemeanor Incompetent to Stand Trial (MIST).
   a. 16 voluntary MIST clients and 2 under settlement agreements.

4. Clarification that the number of referrals to CRM for a warm handoff include all those who volunteered and under a settlement agreement or court order.

5. **Source of information for Acts of Violence** is the referral itself or in discussions with family or those close to the client.

C. **AOT-LA Treatment Report (CRM)**
   1. Variance in the number of referrals between EOB and CRM is accounted for by those clients that need to be re-referred to another level of care under AOT or for a continuation of care after some time of non-participation in the program.
   2. Clarification that graduation from AOT FSP program may still include client access to a regular FSP program as well as to other programs or no program, all facilitated by the program the client is exiting.

IV. **AOT-LA Program Evaluation**

   A. Presentation by UCLA program evaluation team.

   B. Intention of the program evaluation team to follow up with clients at least 6 months after graduation or termination of services for collecting data. The team will also have access to DMH service data to collect information on clients entering an outpatient program or is hospitalized or incarcerated.

   C. Because of the complexities involved in this population, an ethnographic component is being built into this evaluation that incorporates an anthropological, social science perspective.
      1. This component will also allow for the resolution or analysis of discrepancies among the perceptions of a client’s care or course of treatment.
      2. Suggestion from Mark Gale: asking about a family’s involvement in NAMI or similar advocacy group and the effect involvement of knowledge/education from involvement affects perception or involvement in care.
D. Interviews with clients will need to be a subset to include only those clients who are able to sign consents for the study. UCLA Institutional Review Board is also involved and this study will require their approval.

E. Program Evaluation Team consulted with 20 programs nationwide that are same or similar to an AOT program to build their planned study.

F. In addition to looking at general questions ("Does AOT work?") the Program Evaluation Team will also look at several components to determine what about the program worked (including factors involving any perceived coercion).

V. Other Agenda Items

A. Anthony Hernandez presented on the recent signing of the 21st Century Cures Act by President Obama.
Overview

Since the inception of the Assisted Outpatient Treatment for Los Angeles (AOT-LA) program on May 15, 2015, the Department of Mental Health's Emergency Outreach Bureau AOT Outreach and Engagement (AOT O&E) Team has referred 269 clients to Countywide Resource Management (CRM) AOT. Upon receipt of referrals, CRM works with AOT O&E to assign clients for enrollment in either an AOT Full Service Partnership (FSP) or Enriched Residential Services (ERS) program, also known as an Institution for Mental Diseases (IMD) Step-down program, to begin the AOT client's treatment on either a voluntary, voluntary Settlement Agreement, or court-ordered basis. For court-ordered or Settlement agreement clients, assignment to either an FSP or ERS is made in accordance with the AOT client's treatment plan developed by AOT O&E and authorized by the Court. AOT O&E and CRM AOT facilitate a warm hand-off of the AOT client to the assigned FSP or ERS program. Responsibility for continued outreach and engagement and care is then transferred to the assigned program.

AOT-LA FULL SERVICE PARTNERSHIP ENROLLMENT STATUS

Based on clinical examination and/or review of the AOT candidate’s health and hospitalization records, mental health and incarceration histories, and information obtained from the candidate’s significant others and mental health providers, a large number of referrals are determined by AOT O&E to be more appropriate for the FSP level of care than ERS. These specialized FSP programs provide recovery-oriented, intensive field-based services for individuals that require wrap-around services in order to successfully transition to the least restrictive community setting. Average length of stay for AOT clients enrolled in the FSP programs has been approximately six months. Chart 1 provides enrollment data for the referrals received from AOT O&E that were assigned to FSP level of care.

Chart 1:

<table>
<thead>
<tr>
<th>AOT-LA FULL SERVICE PARTNERSHIP (FSP)</th>
<th>TOTAL AOT-LA FSP ENROLLMENT STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of FSP Assignments 1</td>
<td>Total # of FSP Enrolled</td>
</tr>
<tr>
<td>Total # of FSP Assigned</td>
<td>Total # Currently Enrolled</td>
</tr>
<tr>
<td>Total # of Pending Enrollments</td>
<td>Total # Not Enrolled</td>
</tr>
<tr>
<td>229</td>
<td>108</td>
</tr>
<tr>
<td>99</td>
<td>99</td>
</tr>
<tr>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>

1 Includes duplicate clients because clients can exit and reenter the program.
COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE RESOURCE MANAGEMENT

ASSISTED OUTPATIENT TREATMENT FOR LOS ANGELES (AOT-LA)
QUARTERLY AOT-LA OVERSIGHT COMMITTEE REPORT

The table below (Table 1) provides the post-enrollment status of the 168 unique AOT clients that have been enrolled in AOT-LA FSP programs since inception of the AOT-LA program. The category "Approved 6-month Extension" pertains to an additional AOT treatment period that can be sought by the client's treatment provider after the expiration of the initial 6-month court order, voluntary six months of treatment, or Settlement Agreement if the client's provider determines that the client requires continued treatment. The category "Discharged Clients" includes clients that left the program against advice, cannot be located, were hospitalized or incarcerated or for other reasons did not complete the program. Currently, 44 AOT clients have successfully graduated from the FSP programs and 30 have been discharged without successfully completing the program.

Table 1:

<table>
<thead>
<tr>
<th>AOT-LA FSP POST-ENROLLMENT STATUS</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL ENROLLED</td>
<td>168</td>
</tr>
<tr>
<td>TOTAL APPROVED 6 MONTH EXTENSION</td>
<td>64</td>
</tr>
<tr>
<td>TOTAL LPS CONSERVED</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL GRADUATED</td>
<td>44</td>
</tr>
<tr>
<td>TOTAL DISCHARGED 1,2</td>
<td>30</td>
</tr>
</tbody>
</table>

1 Includes duplicated clients (e.g., clients that have left the program and are then re-enrolled in the program or move between levels of care).
2 Unable to locate, incarcerated, moved out of county, etc.

AOT-LA ENRICHED RESIDENTIAL SERVICES ENROLLMENT STATUS

Of the 269 referrals received from AOT O&E, 66 had been determined by AOT O&E to need ERS level of care and were accordingly assigned to ERS programs by the CRM AOT coordinator. ERS provide intensive field-based services and link clients to supportive housing in licensed Adult Residential Facilities. Average length of stay for clients in the ERS programs has been approximately 3 months. Chart 2 provides enrollment data for the referrals received from AOT O&E that were assigned to the ERS level of care.

Chart 2:

Includes duplicate clients because clients can exit and reenter the program.
As previously noted, after treatment has been ordered by the court, AOT client agrees to services voluntarily, or a voluntary Settlement Agreement reached, AOT O&E and CRM AOT facilitate the transition of the client to the assigned FSP or ERS program to begin treatment. Responsibility for continued outreach and engagement is then transferred to the assigned ERS program. A total of 29 AOT clients have been enrolled in ERS programs. Table 2 provides the post-enrollment status of the clients that have been enrolled in ERS programs since inception of the AOT LA program. Currently, seven have successfully graduated from the ERS program.

Table 2:

<table>
<thead>
<tr>
<th>AOT-LA ERS POST-ENROLLMENT STATUS</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL ENROLLED</td>
<td>29</td>
</tr>
<tr>
<td>TOTAL APPROVED 6 MONTH EXTENSION</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL LPS CONSERVED</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL GRADUATED</td>
<td>7</td>
</tr>
<tr>
<td>TOTAL DISCHARGED 1,2</td>
<td>19</td>
</tr>
</tbody>
</table>

1 Includes duplicated clients (e.g., clients that have left the program and are then re-enrolled in the program or move between levels of care).
2 Unable to locate, incarcerated, moved out of county, etc.

MULTNOMAH COMMUNITY ABILITY SCALE – REVISED (MCAS-R) OUTCOMES

The AOT-LA program utilizes the Multnomah Community Ability Scale – Revised (MCAS-R) to track a client’s level of functioning. The MCAS-R is a valid and reliable, 17-item assessment that is administered on a monthly basis to observe a client’s progress over time and assist treatment teams in developing and identifying treatment plan needs. The MCAS-R measures four areas of functioning: 1) Health; 2) Adaptation; 3) Social Skills; and 4) Behavior.

MCAS-R scores are tracked by clients’ current status in the AOT-LA program. A client receives a score upon admission into the program (Admit). The MCAS-R is then administered each month the client is in treatment (In Treatment) and a final time when the client exits the program (Exit). Chart 3 below demonstrates how a client’s scores change over time from admission to exit from the program. The data below contains only information from complete reports, i.e. reports that track a client’s entire course of treatment (Admit through Exit). For this analysis, 35 complete reports were used from FSP programs. Twenty-five of the completed reports represented clients that had successfully completed the AOT-LA program and 10 pertained to clients that were unsuccessful in completing the program. Average scores on admission, in treatment and at exit are provided in the chart below. A change of 10 or more points in the total MCAS-R score represents a clinically significant change.

Norms for the MCAS-R:
High (Little Disability): 63-85
Medium (Some Disability): 48-62
Low (More Disability): 17-47
The charts below show the average MCAS-R scores for the four areas of functioning for successful program completions and unsuccessful completions.

Chart 4:

Average MCAS-R Scores for AOT-FSP Program Completions Across Four Areas of Functioning

Chart 5:

Average MCAS-R Scores for AOT-FSP Unsuccessful Completions Across Four Areas of Functioning
AOT CLIENT SATISFACTION SURVEY

CRM AOT requests contract providers to have their clients complete satisfaction surveys based on their experience with the AOT-LA program. Clients enrolled in the program are given the option of rating several statements either “Strongly Agree”, “Agree”, “Neutral”, “Disagree”, or “Strongly Disagree”. Clients are also given the option of choosing a “Does Not Apply” response. A total of 17 surveys were completed during the December 2016 to February 2017 period.

Responses are assigned the following values: five for “Strongly Agree”; four for “Agree”; three for “Neutral”; two for “Disagree”; and one for “Strongly Disagree”. The average scores for each section are presented in the table below. Please note Quarter 1 includes data from a previous quarter as reporting for this report had not yet started.

Table 3:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SATISFACTION WITH SERVICES</strong></td>
<td>Quarter 1</td>
<td>Quarter 2</td>
<td>Quarter 3</td>
</tr>
<tr>
<td>I am satisfied with how the agency welcomed me into the program.</td>
<td>4.5</td>
<td>4.6</td>
<td>4.4</td>
</tr>
<tr>
<td>I am satisfied with the services I received here.</td>
<td>4.4</td>
<td>4.4</td>
<td>4.4</td>
</tr>
<tr>
<td>I am satisfied with how the agency addressed any concerns I had.</td>
<td>4.1</td>
<td>4.6</td>
<td>4.2</td>
</tr>
<tr>
<td>I liked the groups offered by the agency.</td>
<td>3.2</td>
<td>4.0</td>
<td>3.6</td>
</tr>
<tr>
<td>I liked my mental health team.</td>
<td>4.4</td>
<td>4.4</td>
<td>4.5</td>
</tr>
<tr>
<td>If I could I would return to this agency for services.</td>
<td>4.2</td>
<td>3.9</td>
<td>4.1</td>
</tr>
<tr>
<td><strong>ACCESS TO SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with how quickly the staff responded when I needed something.</td>
<td>4.5</td>
<td>4.4</td>
<td>4.4</td>
</tr>
<tr>
<td>I was able to get the mental health care I needed.</td>
<td>4.5</td>
<td>4.2</td>
<td>4.2</td>
</tr>
<tr>
<td>My psychiatrist helped me when I had questions about my medication.</td>
<td>4.5</td>
<td>4.3</td>
<td>3.9</td>
</tr>
<tr>
<td>If I needed medication it was readily available.</td>
<td>4.5</td>
<td>4.4</td>
<td>3.9</td>
</tr>
<tr>
<td>I was offered information on job-readiness and educational opportunities.</td>
<td>4.0</td>
<td>4.3</td>
<td>3.6</td>
</tr>
<tr>
<td>I was offered information on support groups in my area.</td>
<td>3.8</td>
<td>4.1</td>
<td>4.1</td>
</tr>
<tr>
<td><strong>APPROPRIATENESS OF SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff was sensitive about my cultural background.</td>
<td>4.4</td>
<td>4.6</td>
<td>4.2</td>
</tr>
<tr>
<td>I feel staff respected me.</td>
<td>4.6</td>
<td>4.6</td>
<td>4.5</td>
</tr>
</tbody>
</table>
Table 3 continued:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
<th>Score</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPROPRIATENESS OF SERVICES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel staff listened to me.</td>
<td>4.6</td>
<td>4.6</td>
<td>4.5</td>
</tr>
<tr>
<td>I felt safe where I live.</td>
<td>4.6</td>
<td>4.4</td>
<td>4.0</td>
</tr>
<tr>
<td>I was given information about my rights.</td>
<td>4.1</td>
<td>4.5</td>
<td>3.8</td>
</tr>
<tr>
<td>PARTICIPATION IN TREATMENT PLANNING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was able to decide my treatment goals.</td>
<td>4.2</td>
<td>4.7</td>
<td>3.9</td>
</tr>
<tr>
<td>I was able to ask questions about my treatment and the services I</td>
<td>4.4</td>
<td>4.8</td>
<td>4.5</td>
</tr>
<tr>
<td>received.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SERVICE RESULTS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As a result of the services I received I feel ready to be more independent.</td>
<td>4.2</td>
<td>4.5</td>
<td>3.8</td>
</tr>
<tr>
<td>As a result of the services I received I am able to cope with crisis.</td>
<td>4.2</td>
<td>4.3</td>
<td>3.6</td>
</tr>
<tr>
<td>As a result of the services I received my symptoms are better.</td>
<td>4.2</td>
<td>4.4</td>
<td>3.9</td>
</tr>
<tr>
<td>As a result of the services I received I feel I have more control over</td>
<td>4.3</td>
<td>4.4</td>
<td>3.8</td>
</tr>
<tr>
<td>my life.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMMUNITY-READINESS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I belong in my community.</td>
<td>4</td>
<td>4.5</td>
<td>3.6</td>
</tr>
<tr>
<td>I feel more connected to others.</td>
<td>4</td>
<td>4.4</td>
<td>3.8</td>
</tr>
<tr>
<td>I feel I can rely on others for help</td>
<td>3.8</td>
<td>4.2</td>
<td>4.0</td>
</tr>
<tr>
<td>I feel I know how to ask for help.</td>
<td>4.3</td>
<td>4.4</td>
<td>4.1</td>
</tr>
</tbody>
</table>
Introduction
On Tuesday, July 15, 2014, the Los Angeles County Board of Supervisors voted unanimously to implement Assisted Outpatient Treatment (AOT) - also known as Laura’s Law. LA County’s implementation took nearly a year to plan and coordinate due to the complexity of organizing the bureaucracies involved. The Program launched Countywide on May 15, 2015. Los Angeles County was the third major California county - and the largest - to embrace court-ordered treatment as a tool for making treatment possible to individuals with severe mental illness who are too ill to seek help for themselves.

In an effort to voluntarily engage individuals who are resistant to mental health treatment, and are at substantial risk of deterioration, the AOT-LA Program continues to outreach to individuals with serious mental illnesses. As of February 28, 2017, the Program has received 805 referrals. Chart 1 illustrates the number of referrals received by month since inception of the Program on May 15, 2015.

After thorough review of the referrals, the AOT Referral Review Committee determined that of the referrals received, 501 candidates (62%) were eligible for AOT. The AOT clinicians ensured that all referrals that did not meet AOT criteria were referred to appropriate mental health services.

Referral Source
Appropriate AOT referrals from Licensed Treatment Providers continue to increase which indicates that AOT presentations conducted for local mental health treatment facilities are effective in increasing awareness of the Program. Chart 2 reflects the percentage of eligible AOT referrals that were received from each referral source category.
Housing Status

Chart 3 reflects the housing status of clients eligible for AOT at the time of referral. Approximately 40% of the referrals that were eligible for AOT were for homeless clients, which explains the large number of cases that were closed due to failure to locate these transient clients. AOT clinicians exert every effort to make contact with these difficult to reach individuals. This includes going out with law enforcement, referring parties, and gathering information from collateral contacts. Unfortunately, after tireless efforts, often times, clinicians are unsuccessful in locating the clients. The 0.4% unknown reflects eligible homeless AOT clients who were referred while incarcerated or hospitalized. The clients had been released before the Referral Review Committee was able to review the referral and determine eligibility, and AOT clinicians were unable to locate them.

To overcome this issue, beginning January 2017, AOT was able to implement a method to prioritize the review of referrals for homeless hospitalized/incarcerated clients that AOT might otherwise have difficulty connecting with once discharged/released into the community.

Distribution of Referrals by Service Areas (SA)

Candidates who were eligible for AOT are widely distributed among the Los Angeles County Service Areas (SA). The majority of referrals that met criteria originated from SA 4 (Metro Area). The number of referrals for each SA has remained relatively constant in comparison with the last quarterly report. AOT staff continues to outreach to providers and families to increase awareness of the Program and its services.
Eligible AOT Referral Demographics

Although the chart below illustrates the distribution of eligible AOT referrals by MHSA age groups, AOT continues to observe an increase (36%) of referrals received from parents/siblings for youth in their twenties and younger making them constitute a large portion of the AOT population. Approximately 62% are male, followed by 37% female and 1% transgender. The racial and ethnic composition of the population is diverse with 34% being White. The charts below summarize the distribution of the population that was eligible for AOT services by age, gender, and ethnicity.

The AOT team attempts to outreach for a minimum of 30 days and a maximum of 90 days, to try to engage clients into voluntary treatment. If the AOT clinicians find that the client is receptive to voluntary treatment, the AOT team refers him/her to County Resource Management (CRM), which in turn links the client to the appropriate level of
service and provider. CRM and AOT coordinate and facilitate a warm handoff with the provider where the client, AOT clinician and the provider do a face-to-face introduction of the client to the behavioral health specialist to whom he/she is assigned. The client is then enrolled in either Full Service Partnership (FSP) or Enriched Residential Services (ERS). 53% of eligible AOT referrals were referred to CRM. Table 1 illustrates some basic AOT figures.

<table>
<thead>
<tr>
<th>AOT Statistics</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of AOT Referrals Received</td>
<td>805</td>
</tr>
<tr>
<td>Met AOT Criteria (Includes CRM closed cases)</td>
<td>501</td>
</tr>
<tr>
<td>Currently in Outreach &amp; Engagement*</td>
<td>110</td>
</tr>
<tr>
<td>Case Closed***</td>
<td>152</td>
</tr>
<tr>
<td>Referred to County Resource Management (CRM)</td>
<td>269</td>
</tr>
<tr>
<td>Possible Petition</td>
<td>10</td>
</tr>
<tr>
<td>Petitions Pending</td>
<td>8</td>
</tr>
<tr>
<td>Petition Sustained</td>
<td>11</td>
</tr>
<tr>
<td>Settlement Agreement**</td>
<td>11</td>
</tr>
</tbody>
</table>

*Includes 30 clients referred to CRM but not yet handed off for various reasons; CRDF, being petitioned, being conserved, unable to locate
** Petition is filed but the client agrees to mental health treatment before the judge orders
*** Cases closed are for cases that have been closed and have not been referred to CRM

**Petitions/Conservatorship**

Although AOT does not have the authority to pursue conservatorship, AOT staff provided relevant clinical information and other input from community partners for 24 clients that were ultimately placed on LPS conservatorship. Table 2 provides descriptions of closed AOT cases.

<table>
<thead>
<tr>
<th>AOT Case Closed Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No longer meet criteria****</td>
<td>57</td>
</tr>
<tr>
<td>Incarcerated</td>
<td>13</td>
</tr>
<tr>
<td>Unable to Locate</td>
<td>58</td>
</tr>
<tr>
<td>Conserved</td>
<td>24</td>
</tr>
</tbody>
</table>

****Includes clients who moved out of County, referred to other services, no longer deteriorating, and withdrawn referrals

After screening all AOT referrals and determining the clients that met AOT criteria, the team begins outreach and engagement with initial interventions and offers of voluntary services. If the candidates' condition is significantly deteriorating, and client continues to refuse treatment, a court petition may be initiated.

Despite countless efforts made to obtain adherence to voluntary treatment, some clients are adamant and continue to refuse services. Ten of these clients are currently facing the possibility of a petition. A total of 30 petitions have been filed. Eleven of them were sustained and are now/will be receiving FSP services. Eleven settlement agreements* have been granted and eight petitions are still pending.

**Outreach Efforts - Voluntary Vs. Involuntary Treatment**

The average number of days that the AOT clinicians spend in outreach and engagement is approximately 60 days before the client accepts voluntary treatment. Of the 232 that have accepted voluntary treatment, 26 are pending enrollment with a provider.
MIST & FIST AOT Clients

AOT continues to receive a number of referrals for MIST clients (Misdemeanant Incompetent to Stand Trial). These referrals are for clients who were deemed incompetent to stand trial and before their max sentence date, are referred to AOT. The table below displays the distribution of number of MIST/FIST clients by eligibility for AOT.

<table>
<thead>
<tr>
<th>MIST or FIST</th>
<th>No Eligible</th>
<th>Eligible</th>
<th>Pending</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIST</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Former MIST</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>MIST</td>
<td>11</td>
<td>25</td>
<td>3</td>
<td>39</td>
</tr>
<tr>
<td>MIST After AOT</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Grand Total</td>
<td>12</td>
<td>40</td>
<td>3</td>
<td>55</td>
</tr>
</tbody>
</table>

Health Insurance Concern

Having private insurance is becoming an obstacle/hindrance to both receiving voluntarily and involuntary mental health treatment in AOT. Oftentimes, after AOT clinicians have exerted a substantial amount of effort and time into engaging a client and have reached a point where the client has voluntarily agreed to receive mental health services, the client has private insurance. Providers request authorization from private insurances to provide mental health services. This becomes a lengthy process and is a disappointment to all involved parties. To date, there has been only one private insurance client approved to receive treatment with co-pay of $4,000. AOT referrals for clients with private insurance continue to grow.

The table below illustrates the distribution of various health insurance and percentage of eligible AOT clients that have private insurance. This information is derived from the AOT referrals.

<table>
<thead>
<tr>
<th>Health Insurance</th>
<th>Met Criteria</th>
<th>Met Criteria/Case Closed</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>94</td>
<td>66</td>
<td>160</td>
<td>32%</td>
</tr>
<tr>
<td>Medi-Cal, Medicare</td>
<td>23</td>
<td>12</td>
<td>35</td>
<td>7%</td>
</tr>
<tr>
<td>Medicare</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>Private + Other*****</td>
<td>10</td>
<td>6</td>
<td>16</td>
<td>3%</td>
</tr>
<tr>
<td>Private</td>
<td>13</td>
<td>14</td>
<td>27</td>
<td>5%</td>
</tr>
<tr>
<td>Indigent</td>
<td>16</td>
<td>12</td>
<td>28</td>
<td>6%</td>
</tr>
<tr>
<td>Unknown</td>
<td>22</td>
<td>10</td>
<td>32</td>
<td>6%</td>
</tr>
<tr>
<td>(blank)</td>
<td>49</td>
<td>145</td>
<td>194</td>
<td>39%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>233</td>
<td>268</td>
<td>501</td>
<td>100%</td>
</tr>
</tbody>
</table>

*****Other may be Medi-Cal or Medicare or both
COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

PROCEDURES FOR COORDINATING THE LINKAGE OF JUSTICE-INVOLVED INDIVIDUALS WITH THE ASSISTED OUTPATIENT TREATMENT (AOT-LA) PROGRAM

Draft 2016-02-13

MIST-CBR/AOT-LA work flows [applies to justice-involved individuals enrolled in the Misdemeanor Incompetent to Stand Trial-Community Based Restoration (MIST-CBR) program who are currently being treated in an open community setting under court order for the purpose of competency restoration ]

Condition 1: Prior to MIST-CBR, individual was enrolled in a court-ordered AOT program.
1. Following resolution of the court case(s) (e.g., court finds individual cannot be restored to competency, individual reaches his/her maximum date of court-ordered detention, or individual restored to competency), the AOT-LA Outreach and Engagement Team (AOT O&E Team) evaluates the individual to determine the appropriate level of care placement pursuant to the court-ordered AOT.
2. AOT O&E Team notifies CRM AOT Coordinator to facilitate the warm hand off to the assigned Full Service Partnership or Enriched Residential Facility (previously referred to as IMD Step-down) to begin treatment (see AOT-LA Implementation Protocol commencing with Step 15 for workflow).

Condition 2: Prior to MIST-CBR, individual was enrolled in a voluntary AOT program (“AOT Client”).
1. Following resolution of the court case(s), the AOT O&E Team evaluates the individual to determine whether the individual continues to meet AOT criteria and, if so, recommends the appropriate level of care AOT placement.
   a) If the individual consents to AOT-LA treatment, he/she is enrolled in services on a voluntary basis (see AOT-LA Implementation Protocol, Step 8a).
   b) If the individual does not consent to AOT-LA treatment, then the AOT O&E Team may consider an AOT petition for court-ordered treatment (see AOT Implementation Protocol Steps 4 through 14).
2. If the AOT O&E Team determines the individual does not meet AOT criteria, the individual may be linked to other appropriate services.

Condition 3: Prior to MIST-CBR, individual was determined to be appropriate for AOT-LA by the AOT Referral Review Team (AOT RRT) but had not yet been enrolled in an AOT-LA program (“AOT Candidate”).
1. Following resolution of the court case(s), AOT O&E Team evaluates, completes an initial intervention, and offers voluntary services, including—but not limited to—AOT-services.
2. Follow AOT-LA Implementation Protocol commencing with Step 3, II.
3.

Condition 4: Individual in MIST-CBR is newly referred to AOT-LA (i.e., individual has not previously been evaluated by O&E Team).
1. MIST-CBR provider refers the individual to AOT-LA.

Non-MIST-CBR/AOT work flows (applies to individuals incarcerated in Los Angeles County-operated jail units)

Condition 1: Individual is already enrolled in court-ordered AOT-LA program.
1. The AOT-LA Treatment Provider informs Jail Mental Health Services (JMHS) that individual is receiving AOT services by court order (i.e., "court-ordered AOT client").
2. JMHS notifies AOT Treatment Provider of the AOT client’s anticipated date of release in order to coordinate treatment linkage.

Condition 2: Individual is already enrolled in a voluntary AOT-LA program.
1. The AOT-LA Treatment Provider informs JMHS that client is receiving voluntary AOT services.
2. JMHS notifies AOT Treatment Provider of the AOT client’s anticipated release date in order to coordinate treatment linkage.

Condition 3: Individual was determined to be an AOT candidate by the AOT RRT but had not yet been enrolled in an AOT-LA program.
1. AOT O&E Team informs the Public Defender, District Attorney, and criminal court that the inmate is an AOT candidate.
2. AOT O&E Team develops treatment plan and determines whether or not inmate will accept voluntary AOT services.
4. Prior to release from jail, JMHS notifies AOT O&E Team who, in collaboration with CRM, coordinates treatment linkage and warm handoff to the assigned AOT-LA Treatment Provider.

Condition 4: Inmate is newly referred to AOT-LA (i.e., individual has not previously been evaluated by AOT O&E Team).
1. JMHS refers the individual to AOT-LA.
2. Follow AOT-LA Implementation Protocol commencing with Step 2 (please note that this involves AOT O&E team providing jail in-reach to individual).
3. AOT O&E Team informs JMHS of individual’s AOT status and plan for linkage to AOT-LA Treatment Provider.
4. Prior to release from jail, JMHS notifies AOT O&E Team who, in collaboration with CRM, coordinates treatment linkage and warm handoff to the assigned AOT-LA Treatment Provider.
Purpose:
To provide a step-by-step guide to DMH AOT-LA staff working with AOT contracted providers for the provision of recommended AOT Full Service Partnership (FSP) or Enhanced Residential Services (ERS) treatment for AOT clients with Other Health Coverage (OHC) also known as a private insurance.

Background Information:
• Policy 801.06 Private Prepaid Health Care Treatment and Billing, Effective September 1, 2004
• Clients are responsible for the cost of service left unpaid by the OHC.
  o Medi-Cal will cover the cost of the service that the OHC does not pay if the client has Medi-Cal in addition to the OHC and any client liabilities have been met.
• DMH Revenue Management Division Bulletin No.: DMH 13-011 Cheat Sheet! Understanding Billing Medi-Cal and OHC, January 17, 2013

"A client may be seen with prior authorization from the Other Health Coverage (OHC) if one of the following conditions exits:
• Mental health services are not a covered benefit of the health plans.
• The client has exhausted the allowable mental health benefits under their specific insurance plan for the coverage year.
• The client requires emergency care.
• The OHC authorizes the clinic to provide services."

Guide:
Step 1: Determine client’s eligibility is through OHC
• AOT-LA Countywide Resource Management (CRM) staff will link client to the appropriate AOT provider with the initial information about client’s OHC.
• DMH AOT-LA program requires that the provider confirm whether the client’s coverage is a Medi-Cal Managed Care plan. DMH covers AOT FSP and ERS services for Medi-Cal Managed Care plans. No pre-authorization is necessary and the provider may proceed with services.
  o Continue with Step 2 if the client’s coverage is not a Medi-Cal Managed Care plan.

Step 2: Obtain OHC information
• If client’s OHC policy is not a Managed Care Medi-Cal plan, the provider must obtain the client’s insurance information, policy number, and member services phone number from their insurance card, if available, or an electronic database.

Step 3: Call OHC member services
• The provider must call the client’s insurance, introduce themselves as representing a DMH contract provider seeking pre-authorization to provide out of network intensive specialty mental health services as part of LA County DMH AOT-FSP program(s) and delivered by a DMH contracted provider.
• The provider should explain the requested intensity of services and provide a justification for the requested services based upon clinical symptoms, functional impairments, and why a less intensive treatment approach will not be adequate to meet the client’s needs.
• The provider must be prepared to discuss how they intend to bill for these services – including the per minute rate, fee for service (specifically what services at what frequency), and ask for any special billing instructions or restrictions on billing (for example, licensed vs. non-licensed staff or submitting claims through a portal vs. billing using a paper form).

(Continued on page 2)
DMH AOT-LA Staff Guide for Working with Contracted Providers Serving Clients with Private Pre-Paid Health Care Treatment (or Other Health Coverage)

- The best practice is for the contractor to obtain a written authorization from the OHC. The authorization should include the duration of authorization:
  - The OHC may want a review every 1-6 weeks or written updates periodically.
  - If authorization expires, payment will be denied for subsequent services. Providers must seek reauthorization from the OHC if the client is going to continue receiving services.
- The OHC might deny authorization for services. Authorization denials can be appealed:
  - If OHC is unresponsive to outreach or denies treatment authorization request then DMH AOT-LA Program suggests that the provider initiate an appeal immediately over the phone via member services.
  - Provider should inform AOT-LA CRM of the initiation of appeal.
  - Should OHC issue a written denial, DMH AOT-LA Program suggests that the provider follow any appeal procedures provided in the denial and exercise any 2nd level appeal rights through the State.
  - If the appeal is denied, provider should notify AOT-LA CRM and provide all information to DMH AOT-LA CRM (includes verbal communication and submission of written denial via secure electronic mode for the purposes of potential advocacy).

If the client has Medi-Cal in addition to the OHC, the client may be seen without appealing the denied authorization. The provider must bill the insurance in spite of the denied authorization and then bill Medi-Cal after receiving the denial. Clients with a Medi-Cal share of cost are responsible to pay the share of cost until their annual liability has been obligated in full.
Los Angeles County Department of Mental Health
Office of the Medical Director

Assisted Outpatient Treatment for Los Angeles (AOT-LA) Program

**AOT-FSP Process Measures of Program Quality (Summary)**

The following process measures are used as indicators of program quality of individual providers in relationship to overall program quality. The data is collected quarterly.

**Domain 1: Adherence to Treatment Plan**

*Medication Adherence*
- Data collected from:
  - Providers
  - Clients
  - Involved Family
  - Pharmacy Benefits Management System

*Contact Adherence*
- Data collected from:
  - Providers
  - Involved Family
  - DMH IS/IBHIS electronic health record

**Domain 2: Responsiveness of AOT-FSP Provider**

*During transfer from EOB to Provider*
- Data collected from:
  - EOB outreach and Engagement Teams

*During emergencies:*
- Data collected from:
  - DMH IS/IBHIS electronic health record

**Domain 3: Family Communication**

- Data collected from:
  - Providers
  - Involved Family

**Domain 4: Client engagement:**

- Data collected from:
  - Providers
  - DMH IS/IBHIS electronic health record
Domain 1: Adherence to Treatment Plan

Medication Adherence:

Provider: Did client adhere to psychiatric medication regimen described in treatment plan? (y/n/unk)

Provider items collected monthly

(A) Is the client currently adherent to medications? (Item 6 from MRT, starting in January 2017)
- Yes, adherent
- No, clt was evaluated by MD, meds were recommended, but clt refuses to consent
- No, clt was evaluated by MD, clt consented, but not adherent
- N/A - clt has not yet been evaluated by MD
- N/A - clt has been evaluated by MD but medications were not recommended

(B) MEDICATION ADHERENCE: How often did the person adhere to his/her prescribed medication regimen?
NOTE: Rate from 1 to 3 if someone else managed the person’s medications. (Item 14 from MCAS, starting with initial administration of MCAS)

1. Never or almost never adhered
2. Seldom adhered
3. Sometimes adhered
4. Often adhered
5. Almost always or always adhered or medications not prescribed

Note: the MCAS scores clients who have no prescribed medications as perfectly adherent. This might not be appropriate for all AOT clients. FSP providers report that clients can be resistant to seeing the psychiatrist, and encouraging this contact to take place can be a months-long process. Question (A) was added to the MRT to distinguish clients who don’t need medications from those who refuse medication entirely or have not yet seen the psychiatrist. Items (A) and (B) will be used together.

Client: Did you take your psychiatric medications as prescribed? (y/n)

Client item collected from a subset of clients in qualitative interviews, every 6 months

(C) Do you take medications now? Do you think medications might be helpful to you? Why or why not?

Involved Family: Did client generally take psychiatric medications as prescribed? (y/n/unk)

Family items collected from a subset of families in qualitative interviews, every 6 months

(D) Has his/her willingness to take psychiatric medications changed since s/he started the program?
(E) Does s/he take medications regularly now? (If no) Why do you think s/he is not taking meds?

Pharmacy: Did client generally obtain psychiatric medications and refills consistent with prescription schedule? (y/n)

Pharmacy data will be available once DMH’s new Pharmacy Benefits Management System comes online (anticipated roll-out date: July 2017).
**AOT-FSP Process Measures of Program Quality**

**Contact Adherence:**

Provider: Was the client seen by the psychiatrist at the frequency indicated? (y/n)

Provider items collected every 6 months (Clinician-Rated Treatment Goals Measure, starting in April 2017)

(F) Did the treatment plan specify that the client should see a psychiatrist or other prescribing clinician?
   a. Yes  
   b. No

(G) If yes, based on the treatment plan, how many times* should the client have seen the psychiatrist or other prescribing clinician? __________

(H) How many times* did the client actually see the psychiatrist or other prescribing clinician? __________

(I) Enter any comments: __________________________________________
   __________________________________________
   __________________________________________

* Either *since admission* (if 1st survey) or *since the previous survey* (if not the 1st survey).

**Involved family:** Did the AOT-FSP team have regular contact with the client? (y/n/unk)

Family items collected from a subset of families in qualitative interviews, every 6 months

(J) How often does/did s/he see or talk with the AOT-FSP treatment team?

(K) Do you think it would be helpful for the team to be in touch more often?

**IS/IBHIS:** How many client contacts were made?

IS/IBHIS data extracted and analyzed on a quarterly basis.

(L) Count of medication management visits during each month of AOT treatment.

(M) Count of other treatment visits during each month of AOT treatment.
AOT-FSP Process Measures of Program Quality

Domain 2: Responsiveness of AOT-FSP Provider

During transfer from EOB to Provider:

EOB: Did provider adequately facilitate handoff?

EOB items completed at the end of Outreach and Engagement for each client

(N) Did the FSP or ERS provider adequately facilitate the “warm hand-off”? (YES/NO)

(O) How many contacts did you have with treatment providers during outreach and engagement? (If not applicable, enter N/A)
   a. FSP, in person: __________________________
   b. ERS, in person: __________________________

(P) How confident are you that a treatment team will be able to engage the client after the handoff? Why?

(Q) What challenges came up during the “warm hand-off” process?

(R) What went well with the “warm hand-off” process?

During emergencies:

IS/IBHIS: #WIC 5150 detention episodes, %WIC 5150 episodes resulting in hospital admissions

IS/IBHIS data extracted and analyzed on a quarterly basis

(S) Count of:
   (a) WIC 5150 detention episodes during 6 months of AOT treatment
   (b) WIC 5150 episodes resulting in hospital admissions during 6 months of AOT treatment
   (c) WIC 5150 detention episodes during 12 months preceding AOT
   (d) WIC 5150 episodes resulting in hospital admissions during 12 months preceding AOT
Domain 3: Family Communication

EOB: What background information do we have on the client’s contact with family and openness to having the family involved in their treatment, and family’s involvement in the client’s treatment prior to AOT FSP/ERS?

**EOB items completed at the end of Outreach and Engagement for each client**

(T) Does the client have contact with their family? *(If there is contact, (U), (V), and (W) are also asked.)*
   a. No contact
   b. Limited contact or only by phone
   c. Contact but lives separately

(U) How involved is the family in the client’s mental health care?
   a. Family not involved in care
   b. Family is somewhat or inconsistently involved
   c. Family is very involved
   d. Don’t know

(V) How does family’s involvement appear to affect the client’s participation in treatment?
   a. Seems to enhance client’s participation in treatment
   b. Does not seem to affect client’s participation in treatment
   c. Seems to negatively affect client’s participation in treatment (please explain)

(W) Is the client open to having their family involved in their treatment?
   a. Actively opposed to family involvement
   b. Open to some family involvement
   c. Open to extensive family involvement
   d. Strongly prefers family involvement
   e. Don’t know

Provider: Did you meet with the involved family as part of the treatment planning? y/n

**Provider item collected every 6 months (Clinician-Rated Treatment Goals Measure, starting in April 2017)**

(X) Did you meet or talk with a client’s family member or other support person as part of the treatment planning (if 1st survey) or since the previous survey (if not 1st survey)? *(Check all that apply)*
   - Met with family member
   - Met with non-family support person
   - Client refuses family involvement
   - Client has no contact with family

Provider item collected from a subset of providers in qualitative interviews, every 6 months

(Y) Were any family members involved with the development of the treatment plan?

**Provider: Were regular monthly meetings with involved family held? y/n**

Provider item collected from a subset of providers in qualitative interviews, every 6 months

(Z) When the family wants to be involved in the treatment, how do you work with them? Do you meet/talk with them as part of the treatment plan? Do you meet/talk with them at other times? About how often?

Involved family: Did you receive treatment updates from AOT-FSP? (y/n)

**Family items collected from a subset of families in qualitative interviews, every 6 months**

(AA) Have you been able to talk to the treatment team about how your family member is doing as much as you would have liked to? *(if no) Why do you think that is?*
AOT-FSP Process Measures of Program Quality

Domain 4: Client Engagement

Provider: How many times was the client being seen?

Provider item collected monthly.

(BB) 4 items that show how many appointments (not specific to medication management) are being scheduled and what proportion were cancelled by the provider, missed by the client, or resulted in actual contact (Items 2-5 from MRT, starting in January 2017)

- Total number of appointments scheduled for the client
- Total number of canceled appointments [cancelled by provider]
- Total number of appointments client kept
- Total number of appointments client missed

*An appointment is a planned field or clinic visit where the client is expected to meet with a treatment team member.

IS/IBHIS: Number, type, and duration of face-to-face services within a given time period.

IS/IBHIS data extracted and analyzed on a quarterly basis.

(CC) Count and average duration of face-to-face outpatient treatment visits during each month of AOT treatment, stratified by type of service (e.g. medication management, case management, individual therapy, group rehabilitation, etc.).