Quality Improvement Work Plan
Calendar Year 2021

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

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

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INTRODUCTION

The Department of Mental Health (Department, DMH) is responsible for authorizing inpatient and outpatient specialty mental health services (SMHS) for beneficiaries. DMH is the largest county mental health plan (MHP) in the country. The Department directly operates more than 35 programs, maintains approximately 300 co-located sites, and contracts with close to 1,000 organizations. There are greater than 250,000 Los Angeles County residents under the care of DMH staff, non-governmental agencies (NGA), and individual practitioners who provide a wide variety of services. With a $2.4 billion budget, DMH aims to provide *hope, recovery, and well-being* for everyone in Los Angeles County and beyond.

Mission

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

Vision

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

Services

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

Service Recipients

- Our services to adults and older adults are focused on those who are functionally disabled by severe and persistent mental illness, including those who are low-income, uninsured, temporarily impaired, or in situational crises. Services to children and youth are focused on those who are emotionally disturbed and diagnosed with a mental disorder. They include wards or dependents of the juvenile court, children in psychiatric inpatient facilities, seriously emotionally disturbed youth in the community, and special education students referred by educational institutions.

Purpose and Intent

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

At DMH, the Quality Improvement (QI) Unit facilitates the planning, design, and execution of the QIWP and publishes a summary of these activities annually. Past QI reports are available via the QI website at https://dmh.lacounty.gov/qid/ and upon request.

QUALITY IMPROVEMENT GOALS TO DRIVE CHANGE IN SUPPORT OF THE STRATEGIC PLAN

Date Last Revised: 4/29/21

The Quality Improvement (QI) Unit coordinates the Department's performance-monitoring activities countywide. The Department's continuous quality improvement (CQI) and data-driven activities include utilization review, monitoring and resolution of beneficiary grievances, fair hearings and provider appeals, assessment of beneficiary satisfaction, performance improvement projects (PIPs), and timely access to specialty mental health services (SMHS). The Quality Improvement Work Plan (QIWP) activities for the calendar year (CY) 2021 provide a blueprint of QI actions designed to ensure the overall quality of services. Through practical QI activities, data-driven decision-making, and collaboration amongst staff and clients/families, DMH meets State regulations for evaluating the appropriateness and quality of services.

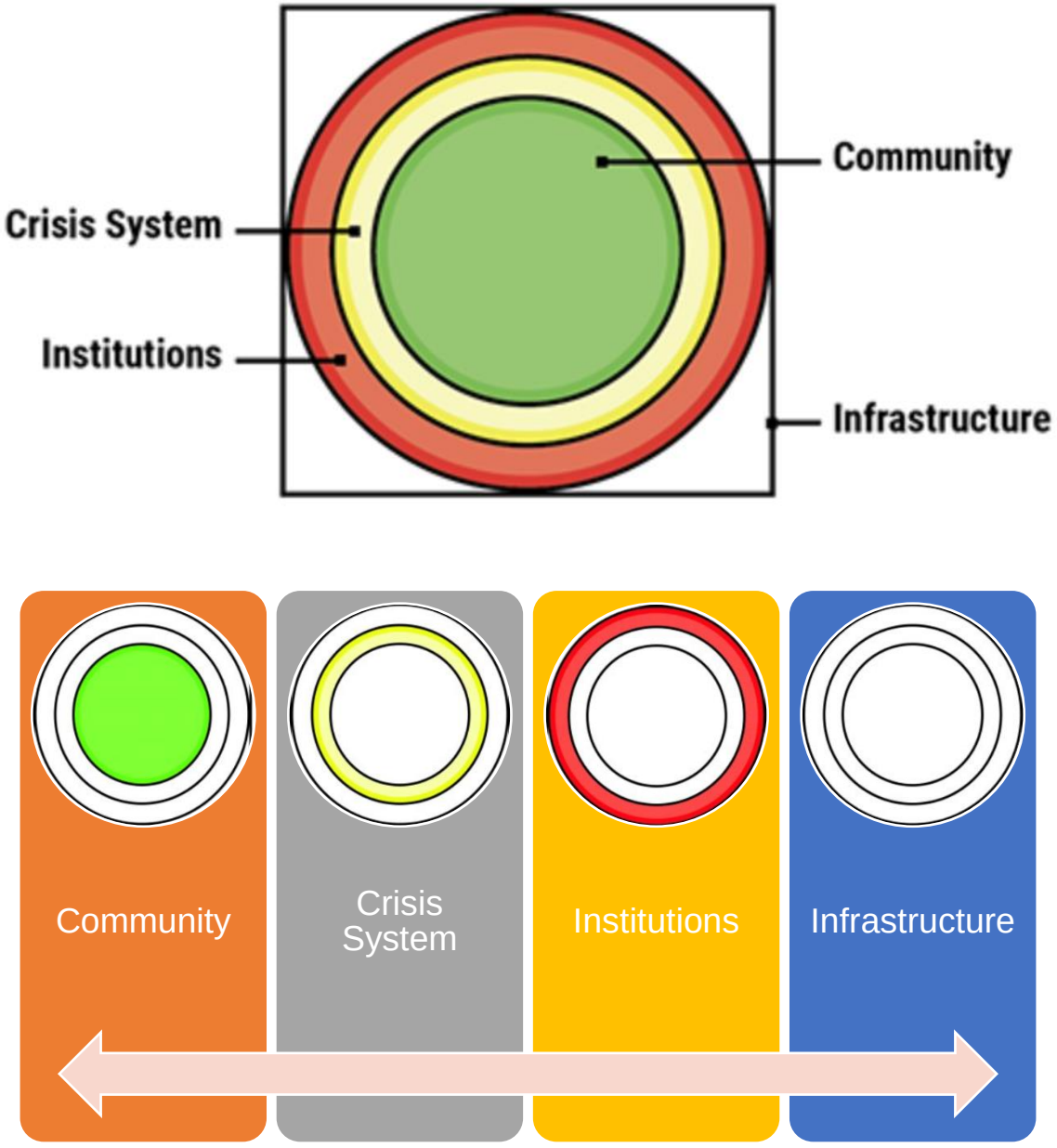
The QWIP functions as the foundation of DMH's efforts to improve services delivered to potential and existing clients. The Department's Strategic Plan functions to prioritize and organize our work ahead. The Strategic Plan and QIWP activities are interconnected and similarly CQI-oriented. To succeed, the Strategic Plan and QIWP embody the following values and principles:

- **Client Driven** – where we engage consumers, families, communities, and grassroots stakeholders as full collaborators in transformation, from care delivery to systems redesign.
- **Community Focused** – where the needs and preferences of the communities are recognized and where resources are specially designed and aggressively deployed to meet them.
- **Equitable and Culturally Competent** – where consumers, family members, and communities are cared for equitably and where services are delivered with cultural respect.
- **Accessible and Hospitable** – where all services and opportunities are readily available, easy to find, timely, and welcoming to everyone.
- **Dedicated to Customer Service** – where our core calling is to provide premier services to all of our customers, from consumers and families to DMH staff and the vast network of contractors.
- **A Heart-Forward Culture** – where we hold sacred the humanity, dignity, and autonomy of those we serve because everyone has the right to flourish and to live a healthy, free, and fulfilling life.
- **Collaborative** – where we recognize that we cannot go it alone. We need the expertise, dedication, and teamwork of many other departments and the full range of community partners.
- **Continuous Improvement** – where care is focused on meeting the needs of those we serve through best practices, where decisions are tailored and informed by outcomes, and where ongoing efforts to increase our impact are built into our work at every level, every day.

Los Angeles County – Department of Mental Health's Strategic Plan

The Department's Strategic Plan (2020-2030) aligns with the broader vision of the 2016-2021 County of Los Angeles Strategic Plan. Our strategic approach is divided into four domains, namely: Community, Crisis System, and Institutions (clinical), and Infrastructure (administrative) (Figure 1).

Figure 1. DMH Strategic Plan 2020-2030, Domains for our Strategy



Retrieved from: https://dmh.lacounty.gov/about/lacdmh-strategic-plan-2020-2030/ on 5/18/21.

The Strategic Plan focuses on the change required to drive change across the system. The system is fundamentally based on three clinical domains and one administrative. The domains of our strategy are branded as follows:

- The first domain, ***Community***, is represented by the green circle in the figure. This domain signifies the North Star, where we will always prefer to provide services and opportunities. A larger portion of the Strategic Plan focuses on Community and ways in which proactive and therapeutic resources can be built up countywide.
- The second domain, the ***Crisis System***, is represented by the yellow ring. This domain includes the intensive care resources needed to help individuals in crisis who are falling out of the community.
- The third domain, ***Institutions***, is represented by the red ring. This domain characterizes the Department's broad portfolio of re-entry resources (including compelled treatment) deployed to help clients who have fallen out of the community into the "open-air" asylum of the street, the "closed-air" asylum of the jail, and the personal asylum of deep isolation.
- The people and processes that guide our work across all three domains create our ever-present departmental ***Infrastructure***, represented by the square and circular lines.

Quality Improvement Work Plan, Calendar Year 2021

Date Last Revised: 5/27/21

The Department's QIWP is organized into seven major domains: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care, Provider Appeals, and Performance Improvement Projects. Each domain is designed to address service needs and the quality of services provided. Table 1 summarizes QIWP goals and their comparable strategic plan domain.

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

Table 1. Summary of Quality Improvement Work Plan Goals and Comparable Strategic Plan Domain(s), Calendar Year 2021

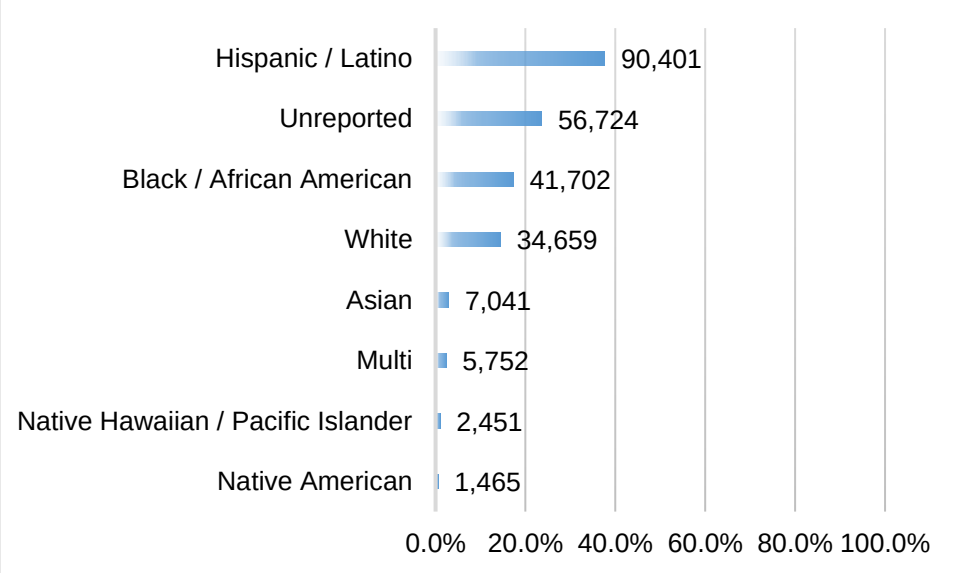
DOMAIN	NO.	GOAL	Strategic Plan Domain			
			Community	Crisis System	Institutions	Infrastructure
SERVICE DELIVERY CAPACITY	I.1.	Analyze root causes in the underrepresentation of self-identified Native Hawaiian/Pacific Islander and Black/African Americans receiving DMH services.	✓	✓	✓	✓
	I.2.	Share findings on the Department's capacity to deliver culture-specific services.	✓	✓	✓	✓
	I.3	Maintain the number of clients receiving telehealth services.	✓			
ACCESSIBILITY OF SERVICES	II.1.	DMH will meet 80% of initial requests for outpatient specialty mental health services (SMHS) with a timely appointment.	✓			
	II.2.	Reduce wait times for after-hours Psychiatric Mobile Response Teams (PMRT).		✓		
BENEFICIARY SATISFACTION	III.1.	DMH will increase the response rate on Consumer Perception Surveys (CPS) by 5% for Adults and Families and 10% for Youth and Older Adults.				✓
	III.2.	Investigate and resolve 100% of Grievance and Appeals within regulation timelines.				✓
	III.3.	Monitor requests for a Change of Provider (COP).				✓
CLINICAL CARE	IV.1.	Roll out CANS-50 and PSC-35 aggregate reporting to support children and youth program operations.	✓			
	IV.2.	Facilitate medication monitoring activities through ongoing data evaluation and prescriber to prescriber peer reviews.	✓			
	IV.3.	Facilitate data-driven continuous quality improvement (CQI) discussions with DMH DO program managers at least annually.	✓		✓	
	IV.4.	Develop and refine processes to enhance provider knowledge surrounding documentation and claiming-related requirements associated with the provision of Medi-Cal SMHS.	✓		✓	
CONTINUITY OF CARE	V.1.	Multidisciplinary Homeless Outreach Mobile Engagement (HOME) teams will provide intensive outreach, linkage to services and resources, and service-enriched housing (as needed) to no less than ten clients.			✓	
PROVIDER APPEALS	VI.1.	Monitor Provider Appeals.				✓
PERFORMANCE IMPROVEMENT PROJECTS	VII.1.	Implement a provision of staff training, a peer mentoring network, and interdisciplinary treatment groups focused on medication-assisted treatment (MAT) to increase the percentage of consumers with co-occurring substance use problems by four percent from Calendar Year 2020 to Calendar Year 2021.	✓			
	VII.2.	By the end of CY 2021, DMH will develop and implement a non-clinical PIP to improve the rate of timeliness to initial appointments from 61.5% to 70.0% for children seeking outpatient services.	✓			

Note: The data collection periods vary by objective.

Service Equity

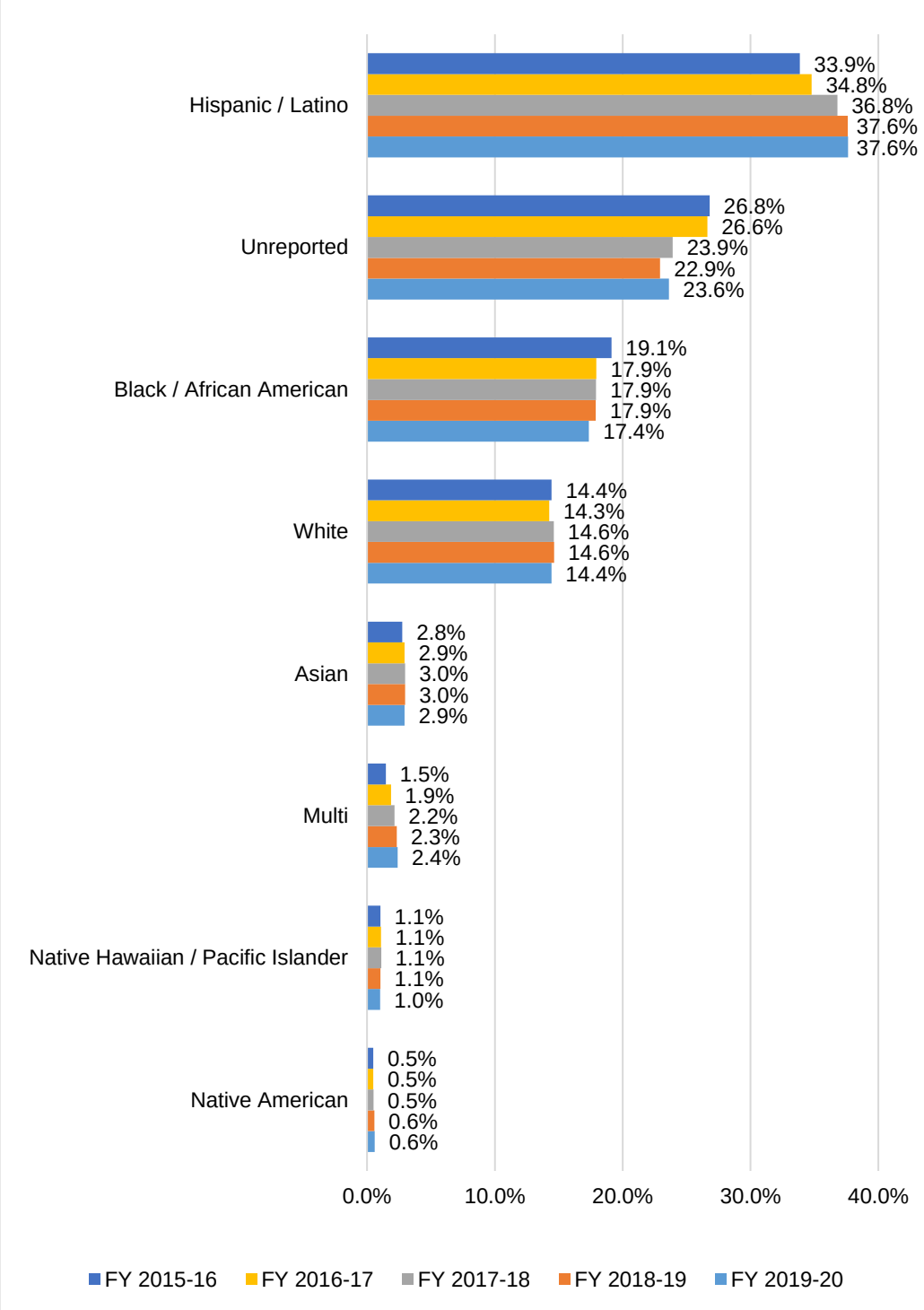
Goal I.1.	Analyze root causes in the underrepresentation of self-identified Asian, Black/African Americans, and Native Hawaiian/Pacific Islanders receiving DMH services.
Objectives:	a) Examine service utilization patterns (i.e., retention rates) to inform programs and leadership. b) Examine diversity in the DMH workforce by race/ethnicity and language fluency (or the rate at which direct service staff reflects the consumers' racial identity and threshold languages). c) Establish a disproportionality and disparities report to provide insight on system capacity for existing and potential clients by race/ethnicity. d) Designate mental health promoters to reach the Asian Pacific Islander, African American, and Native American communities.
Population:	DMH and Legal Entity (LE)/Contracted programs providing outreach and outpatient SMHS to DMH clients and the Los Angeles County community at large.
Performance Indicators:	1. Unique Client Counts by Race/Ethnicity 2. Penetration Rates for Medi-Cal Enrolled Beneficiaries by Race/Ethnicity 3. Service utilization rates to be developed (TBD) at annual evaluation

Figure 2. Unique Client Counts by Race/Ethnicity, Fiscal Year 2019-20



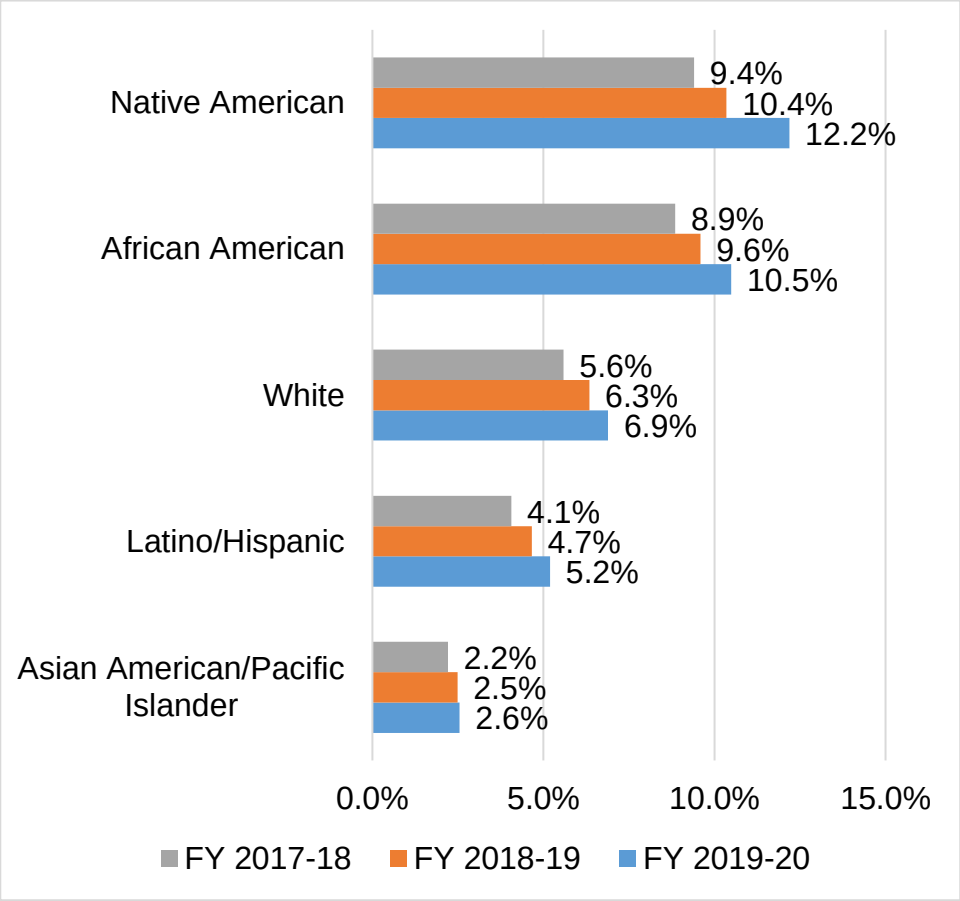
Note: A total of 240,195 unique clients received outpatient DMH services in FY 2019-20. Of which, 23.6% (N=56,724) had unreported race/ethnicities. At 37.6% (N=90,401), the Hispanic/Latino group was the most represented than the Native American group that at 0.6% (N=1,465) made up the smallest portion of our client population. Data includes all clients, no matter the funding source. **Data Source:** DMH IS/IBHIS, retrieved on 3/19/2021 by Chief Information Office Bureau (CIOB).

Figure 3. Five Year Trend in Unique Clients Served by Race/Ethnicity, Fiscal Year (FY) 2015-16 to FY 2019-20



Note: In the last five fiscal years, the number of clients served from the Hispanic/Latino group has increased by 3.8 Percentage Points (PP, N=4,930). Conversely, the client population who self-identifies as Black/African American has declined by 1.8 PP (N=6,581). Of note, the number of clients from the Native Hawaiian/Pacific Islander group, who represents a smaller portion of our client population, is trending downwards. Between FY 2015-16 and FY 2016-17, Native Hawaiian/Pacific Islanders decreased by ten (10) clients, and in FY 2019-20, DMH saw 171 fewer Native Hawaiian/Pacific Islander clients than the previous FY. **Data Source:** DMH IS/IBHIS, retrieved on 3/19/2021 by CIOB.

Figure 4. Three-Year Trend in Penetration Rates for the Medi-Cal Beneficiaries Served Population by Race/Ethnicity, Fiscal Year (FY) 2017-18 to FY 2019-20



Note: Penetration rates are trending upwards for the Medi-Cal enrolled population across all races/ethnicities. Penetration rate changes were the largest for the Native American group, at a 2.8 PP increase in the last three fiscal years. At a 0.3 PP penetration rate increase over the last three years, the Asian American/Pacific Islander group showed the smallest growth. Information on the "Other" group was not included in this table. **Data Source:** Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2017 to CY 2019, prepared by BHC/CalEQRO in July 2018, July 2019, and July 2020.

Frequency of Collection:	Annually
Data Sources:	IS-IBHIS Approved Claims, QI Unit; Network Adequacy: Provider and Practitioner Administration (NAPPA) application data, QA Unit; Medi-Cal Approved Claims Data for LOS ANGELES County MHP, BHC, Inc.

Goal I.2.	Share findings on the Department's capacity to deliver culture-specific services.
Objective:	Evaluate and disseminate results from the 2019 Cultural Competency Organizational (CC Org) Assessment through presentations with the Cultural Competency Committee, Countywide QI Council, and all eight Service Area Quality Improvement Committees. • Each presentation will highlight knowledge gaps, document feedback from clients/families and stakeholders (if any), and identify potential next steps.
Population:	DMH DO staff (administrative and clinical) overseeing the quality or delivery of SMHS to DMH clients/families.
Performance Indicator:	The number of CC Org Assessment presentations facilitated in CY 2021.
Frequency of Collection:	Annually
Data Source:	Cultural Competency Unit (CCU) activity report, CCU.

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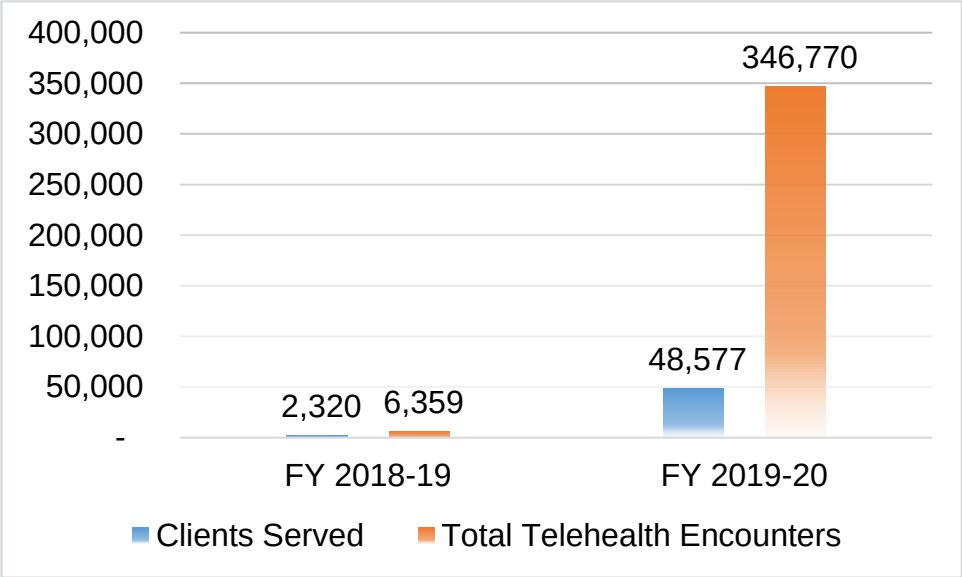
Telemental Health

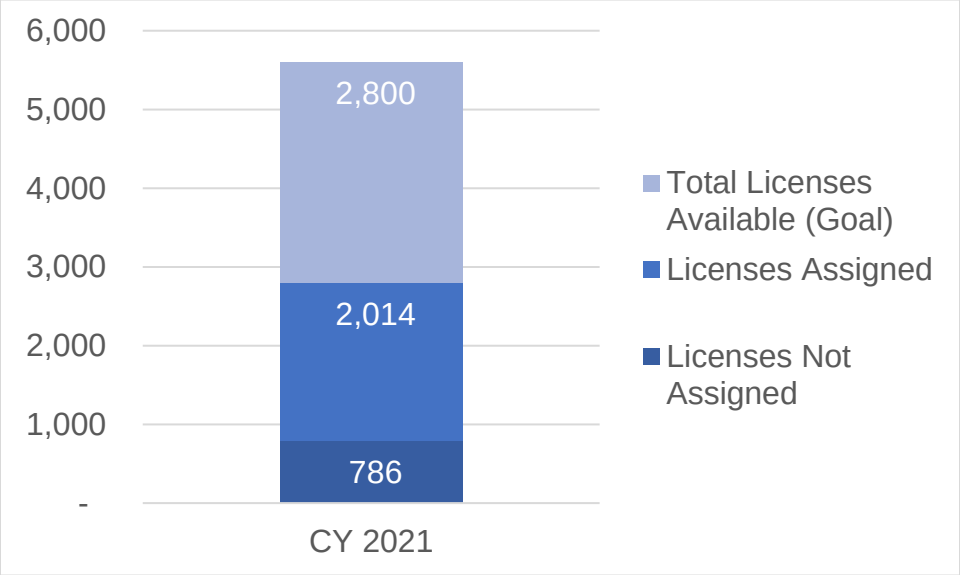
Goal I.3.	Maintain the number of clients receiving telehealth services.
Objectives:	a) Establish a demographic profile of the clients served through tele-mental health (TMH), including location, age, and preferred language. b) Increase the number of telehealth encounters in DO programs via video, specifically, VSee, a HIPAA compliant telehealth application.
Population:	Clients/families receiving outpatient SMHS.
Performance Indicators:	1. Total clients served, including the number of telehealth encounters (services) provided in FY 2020-21. 2. Total Count of VSee Licenses Assigned in CY 2021. 3. VSee utilization (active accounts, logins, visits).

Figure 5. Overview of Telehealth Services by Client Counts and Telehealth Encounters, Fiscal Year (FY) 2018-19 and FY 2019-20



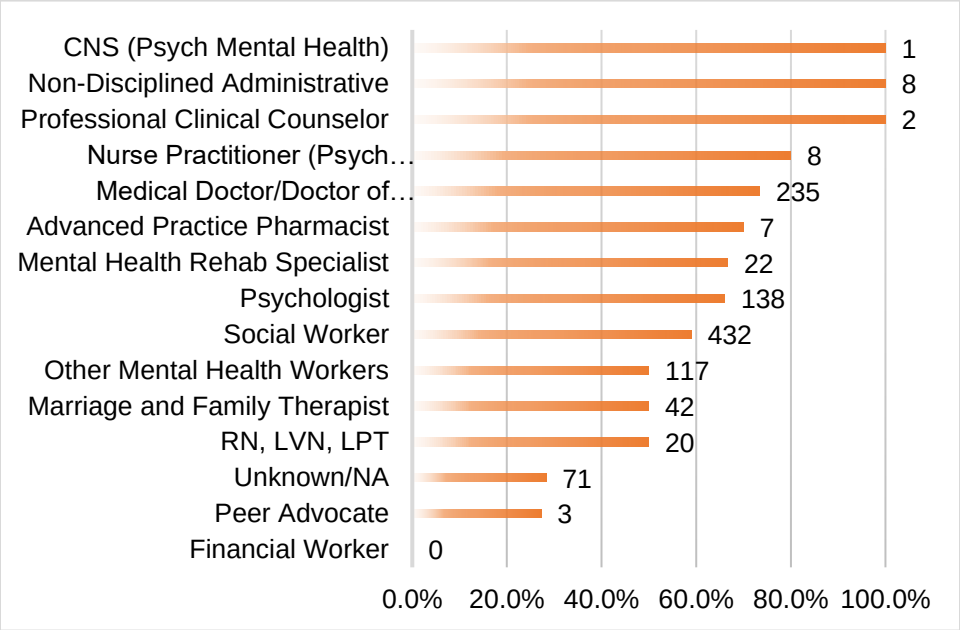
Note: Between FY 2018-19 and FY 2019-20, the number of clients receiving telehealth services increased by approximately 1994%, and telehealth encounters increased by more than 5000%. Data above includes indigent and uninsured clients. **Data Source**: Information Systems Capabilities Assessment (ISCA), dated August 2020.

Figure 6. Status of VSee License Assignments, Calendar Year 2020



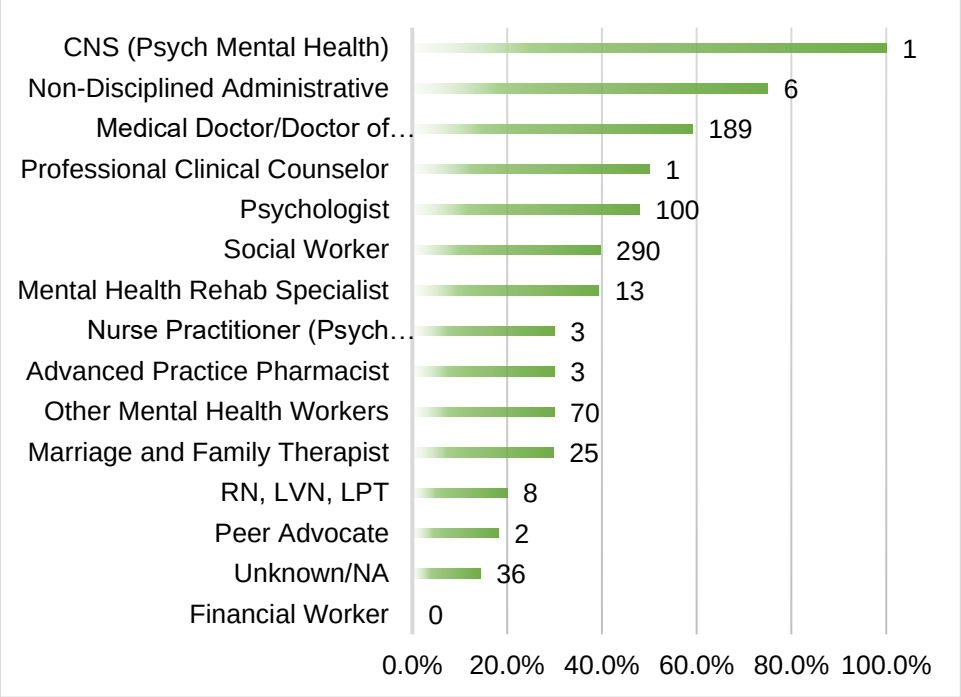
Note: Data above includes directly-operated program staff only. DMH CIOB has assigned approximately 72% of the Department's available VSee licenses. **Data Source:** VSee Status Report, prepared by CIOB on 1/5/2021.

Figure 7. Active VSee Accounts with Log-ins by Staff/Discipline, Calendar Year 2020



Note: Among the disciplines with greater than 20 active accounts, DMH MD/DOs (73.4%) had the highest number of staff who logged into their VSee accounts, followed by mental health rehab specialists (66.7%), psychologists (66.0%), and social workers (59.0%). "Unknown/NA" Discipline occurs when IT could not link the VSee User Account to an IBHIS Practitioner record. **Data Source**: VSee Utilization Report, prepared by CIOB on 12/30/2020.

Figure 8. Active VSee Accounts with Any Visit(s) by Staff/Discipline, Calendar Year 2020



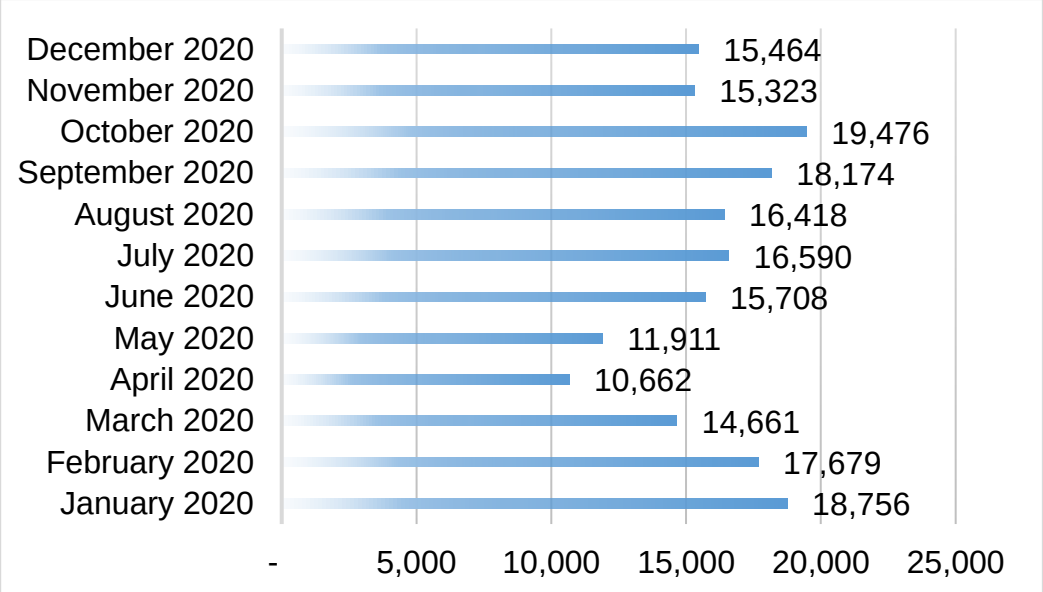
Note: 38% (N=747) of staff with active accounts have initiated a "Visit (VSee session was initiated and may include practice/training sessions)." Among the disciplines with greater than 25 active accounts (excluding Unknown/NA disciplines), DMH MD/DOs (59.1%) showed the highest number of active accounts where staff initiated at least one visit, followed by psychologists (47.8%), social workers (39.6%), and mental health rehab specialists (39.4%). **Data Source**: VSee Utilization Report, prepared by CIOB on 12/30/2020.

Frequency of Collection:	Annually
Data Sources:	IS-IBHIS Approved Claims Data, Chief Information Office Bureau (CIOB), Clinical Informatics Team

Monitoring Accessibility of Services

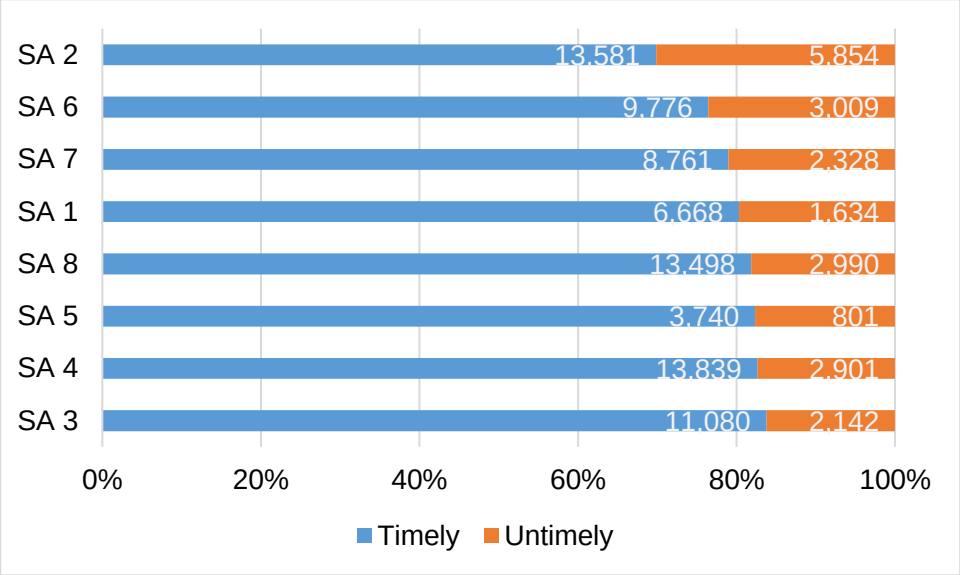
Goal II.1.	DMH will meet 80% of initial requests for outpatient SMHS with a timely appointment.
Objectives:	a) Monitor time to first offered appointment. • Providers should offer routine (non-urgent) appointments within ten business days (not including weekends and holidays) of the initial request. • Providers should offer urgent appointments within 48 hours (including weekends and county holidays) of the initial request. • Providers should offer follow-up hospital discharge or jail release appointments within five business days (not including weekends and holidays) of the initial request. b) System-wide timeliness data will be aggregated by SA, provider, and age group and track for trends. c) Implement centralized scheduling in Service Area (SA) 3 for DMH clients seeking follow-up hospital discharge appointments coordinated between their inpatient provider and ACCESS Center. d) Establish a learning collaborative among SA 2 providers to define best practices related to improving the timeliness of services.
Population:	Los Angeles County residents seeking outpatient SMHS from a DMH provider.
Performance Indicators:	Rates of timeliness by service request type (routine, urgent, and hospital discharge/jail release).

Figure 9. Total Number of Requests for Service Received by Month, Calendar Year 2020



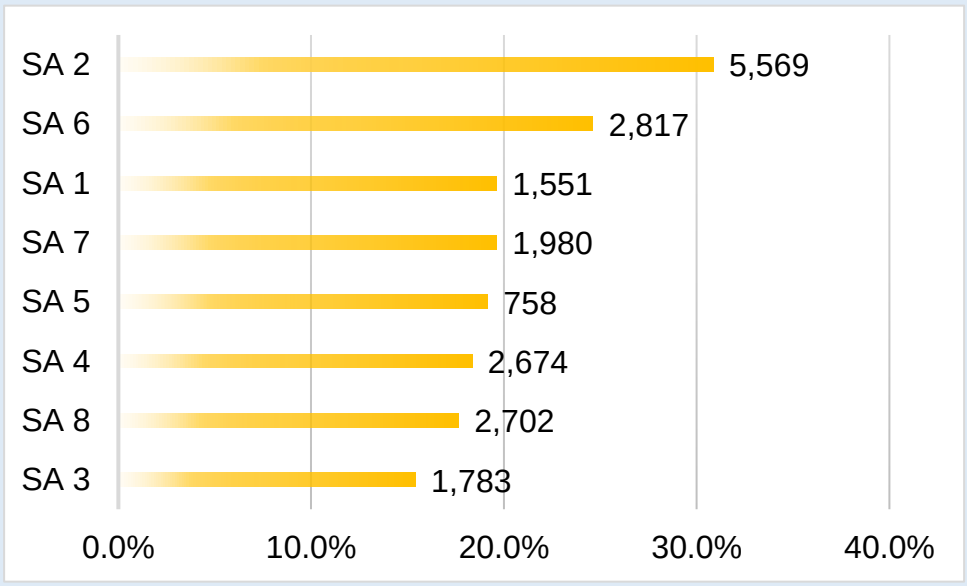
Note: Information above reflects data from multiple sources, including Contractor Service Request Log (SRL) web services (N=62,407), IBHIS (DO) SRL (N=70,315), KAEMS (N=20,924), and Service Request Tracking System (SRTS, N=18,588). The highest number of requests were received in October 2020 (N=19,476), with April 2020 (N=10,662) seeing the lowest. **Data Source**: System-wide Timely Access to Care Dashboard for CY 2020, retrieved on 3/30/21.

Figure 10. Percent of Appointments by Status Category and Service Area



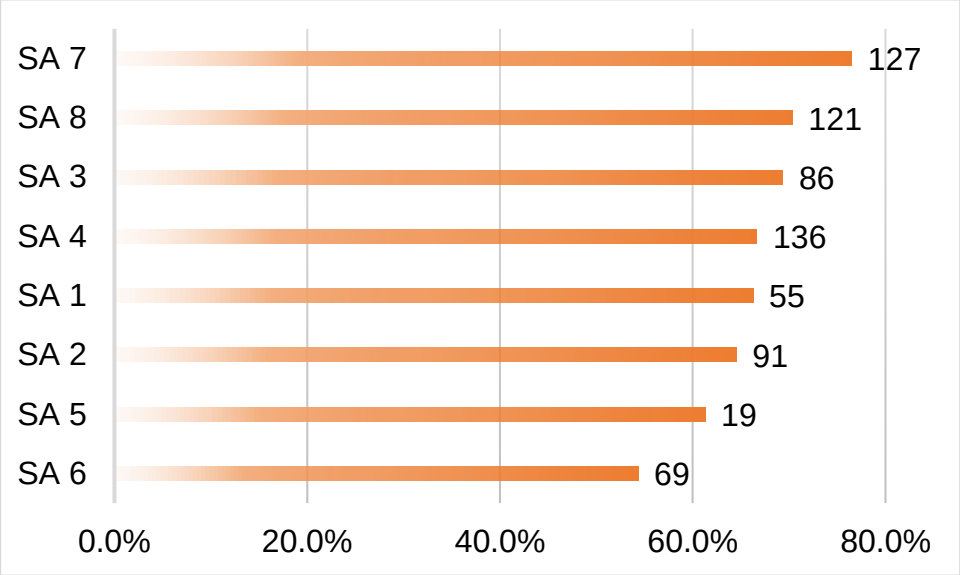
Note: In CY 2020, SA 2 (30.1%) had the highest percentage of untimely appointments, followed by SA 6 (23.5%). SA 3 (83.8%) had the highest rate of timely appointments, followed closely by SA 4 (82.7%). The "Untimely, referral declined" values are included in the "Timely" category. **Data Source**: System-wide Timely Access to Care Dashboard for CY 2020, retrieved on 4/26/21.

Figure 11. Percent of Requests for Routine Services with Untimely Appointments by Service Area, Calendar Year 2020



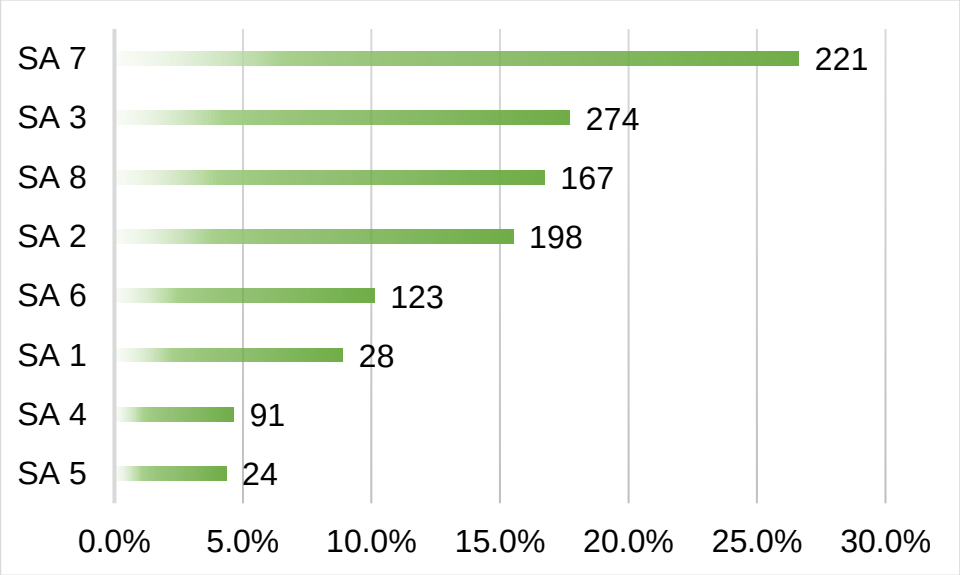
Note: In CY 2020, SA 2 (30.9%) had the highest percentage of requests for routine services met with an untimely appointment and SA 3 (15.4%) had the lowest. **Data Source**: System-wide Timely Access to Care Dashboard for CY 2020, retrieved on 4/15/21.

Figure 12. Percent of Requests for Urgent Services with Untimely Appointments by Service Area, Calendar Year 2020



Note: In CY 2020, SA 7 (76.5%) had the highest percentage of requests for urgent services met with an untimely appointment and SA 6 (54.3%) had the lowest. **Data Source:** System-wide Timely Access to Care Dashboard for CY 2020, retrieved on 4/15//21.

Figure 13. Percent of Requests for Inpatient/Jail Discharge Services with Untimely Appointments by Service Area, Calendar Year 2020



Note: In CY 2020, SA 7 (26.6%) had the highest percentage of requests for inpatient/jail discharge services met with an untimely appointment and SA 5 (4.3%) had the lowest. **Data Source:** System-wide Timely Access to Care Dashboard for CY 2020, retrieved on 4/15/21.

Frequency of Collection:	Quarterly
Data Source:	System-wide Access to Care Monitoring Reports, DMH Dashboard

Goal II.2.	Reduce wait times for after-hours Psychiatric Mobile Response Teams (PMRT).
Objective:	Complete hiring and facilitate the onboarding process for multidisciplinary Therapeutic Transportation (TT) team members that include peers to support five mobile mental health vans that operate 24 hours a day and seven days a week.
Population:	Los Angeles County residents seeking crisis support services.
Performance Indicators:	1. The number of complete TT teams (Peer, Psychiatric Technician, and Clinical Driver). 2. Metrics on wait and transport times TBD at annual evaluation.
Frequency of Collection:	Annually
Data Source:	TT Program data reports, Intensive Care Division

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Monitoring Beneficiary Satisfaction

Consumer Perception

Goal III.1.	DMH will increase the response rate on Consumer Perception Surveys (CPS) by 5% for Adults and Families and 10% for Youth and Older Adults.
Objective:	Increase efforts to reach a more significant percentage of all consumers seen during the survey week by expanding eligible populations (e.g., field-based consumers) and introducing a DMH-specific electronic survey version. • Target age groups that historically have lower response rates (i.e., Older Adults and Youth)
Population:	Clients and families receiving outpatient SMHS.
Performance Indicator:	Number of returned surveys/respondents by CPS form.
Frequency of Collection:	Annually
Data Source:	Performance Outcomes and Quality Improvement (POQI) Reports aggregated by DHCS and Microsoft Dynamics reports in the electronic CPS application, QI Unit,

Table 2. Completed Consumer Perception Surveys by Age Group over the Past Five Survey Periods and Estimated Goal Numbers

Time Period	Youth	Family	Older Adult	Adult
Spring 2018	2,420	5,124	781	6,791
Fall 2018	1,684	3,464	706	7,158
Spring 2019	2,681	5,443	998	7,973
Fall 2019	2,306	4,262	709	6,286
Spring 2020	981	3,359	493	3,782
Average	2,014	4,330	737	6,398
Goal	(+10%) 201 2,215	(+5%) 217 4,547	(+10%) 74 811	(+5%) 320 6,718

Note: Given that Spring 2020 was an outlier survey period during the early stages of the COVID-19 pandemic, DMH will develop goals based on average completed surveys over the past five survey periods. **Data Source:** DMH CPS data, CY 2018 to CY 2020.

Consumer Grievance

Goal III.2.	Investigate and resolve 100% of Grievance and Appeals within regulation timelines.
Objectives:	a) Maintain a written log of all Grievances, Appeals, and Expedited Appeals, including the timeliness of responses. b) Review the nature of complaints and resolutions for significant trends that may warrant policy recommendations or system-level improvement strategies.
Population:	Los Angeles County residents engaging in DMH services (outpatient, inpatient, FFS)
Performance Indicator:	Beneficiary complaints and resolutions in FY 2020-21 as documented in the Grievance log.
Frequency of Collection:	Annually
Data Source:	Grievance Log, Patient's Rights Office (PRO)

Goal III.3.	Monitor requests for a Change of Provider (COP).
Objective:	Review COP reasons and track trends in clients' requests to change practitioners/providers.
Population:	Beneficiaries receiving outpatient DMH services.
Performance Indicator:	COP requests in FY 2020-21 by reason.
Frequency of Collection:	Annually
Data Source:	Change of Provider Logs, PRO

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Monitoring Clinical Care

Reporting

Goal IV.1.	Rollout Child and Adolescent Needs and Strengths – 50 (CANS-50) and Pediatric Symptom Checklist-35 (PSC-35) aggregate reporting to support children and youth program operations.
Objective:	Develop a CANS-50 and PSC-35 aggregate report • Gather input on report elements from providers • Consolidate the CANS-50 and PSC-35 data sets for reporting
Population:	DMH Directly Operated (DO) and LE/Contracted programs providing SMHS to children and youth between ages 3 and 21 years.
Performance Indicator:	1. At least one report is available for provider use (Goal) 2. Additional targets TBD at annual evaluation
Frequency of Collection:	Annually
Data Source:	Program data report, Outcomes Unit

Medication Monitoring

Goal IV.2.	Facilitate medication monitoring activities through ongoing data evaluation and prescriber to prescriber peer reviews.
Objectives:	a) Develop dashboard review procedures highlighting data evaluation, the rollout for LE/Contracted programs in one SA, and recommended use of a review committee. b) Establish peer review procedures highlighting tracking administrative reminders, matching, records review, and replicability for prescribers in LE/Contracted programs.
Population:	Prescribers in DO and LE/Contracted programs providing outpatient SMHS to DMH clients.
Performance Indicator:	The number of peer reviews completed for prescribers in DO programs.
Frequency of Collection:	Annually
Data Source:	Program data reports, Pharmacy Services and DMH Psychiatrists

Provider-Level Improvement

Goal IV.3.	Facilitate data-driven continuous quality improvement (CQI) discussions with DMH DO program managers at least annually.
Objective:	Conduct at least one All Programs of Excellence (APEX) meeting for the DO Older Adult (GENESIS) program, collaboration programs, and combined meetings for programs in shared SAs. • Review aggregate and program-specific data, such as client financial information updates (UMDAPs), client treatment plans, and timeliness, and identify barriers, challenges, and successes. • Review demographic data on total population, poverty estimates, clients served, and homeless data. • Examine post-APEX surveys for tools and helpful recommendations, and forward findings to program managers.
Population:	DO programs providing outpatient SMHS to DMH clients/families
Performance Indicator:	Number and location of APEX meetings conducted in CY 2021
Frequency of Collection:	Annually
Data Source:	Outpatient Services Division (OSD) APEX activity reports and survey data, OSD

Goal IV.4.	Develop and refine processes to enhance provider knowledge surrounding documentation and claiming-related requirements associated with the provision of Medi-Cal SMHS.
Objectives:	a) Implement a Quality Assurance (QA) Knowledge Assessment survey to identify themes in the documentation guidelines most misunderstood by providers while granting LEs data-driven opportunities for self-directed training/improvement strategies. b) Pilot a chart review checklist that tracks the number (and percent) of criteria complying or improving over time.
Population:	LE/Contracted programs providing outpatient SMHS to DMH clients/families.
Performance Indicator:	Performance targets TBD at annual evaluation.
Frequency of Collection:	• QA will collect QA Knowledge Assessment survey data quarterly. • DMH QA will complete at least one chart review per LE every three years (Goal)
Data Source:	Completed surveys and chart review summary reports, QA Unit, Training and Operations Team

Monitoring Continuity of Care

Goal V.1.	**Multidisciplinary Homeless Outreach Mobile Engagement (HOME) teams will provide intensive outreach, linkage to services and resources, and service-enriched housing (as needed) to no less than ten clients.**
Objectives:	a) DMH will apply for outpatient conservatorship for homeless individuals who are gravely disabled but refusing voluntary mental health services. b) Establish baseline Health of the Nation Outcome Scale (HoNOS) and Vulnerability Index-Service Prioritization Decision Assistance c) Tool (VI-SPDAT) data towards a demographic profile of those served.
Population:	Los Angeles County residents deemed gravely disabled.
Performance Indicator:	1. The number of clients engaged and successfully enrolled in HOME program services. 2. The number of successful conservatorships in each supervisorial district.
Frequency of Collection:	Annually
Data Source:	HOME Program data, HOME program

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Monitoring Provider Appeals

Goal VI.1	Monitor Provider Appeals.
Objectives:	a) Develop a Provider Appeal Tracking Log to record provider appeals, resolutions, and dates of responses. b) Review the log for trends and share findings with appropriate entities.
Population:	DMH clients receiving inpatient psychiatric services from Department of Health Service (DHS), Fee-for-Service (FFS) Contracted, Non-Contracted, Non-Governmental Agency (NGA), and Contracted IMD Exclusion Hospitals.
Performance Indicator:	Number of Notice of Adverse Benefits Determinations (NOABDs) issued, including the percentage of upheld or overturned appeals.
Frequency of Collection:	Quarterly
Data Source:	Hospital Association of Southern California (HASC) TAR Report and Provider Appeal Tracking Log, ICD

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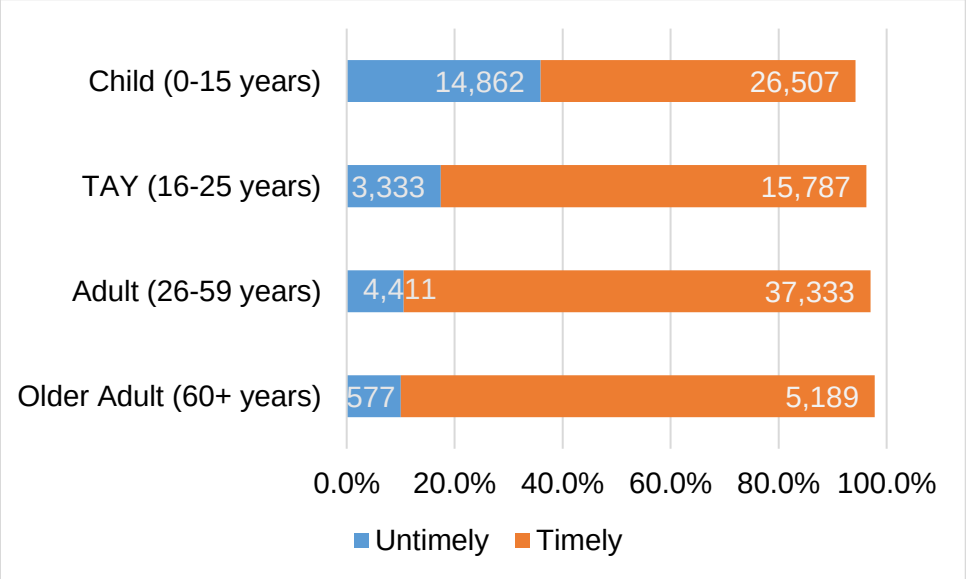
Monitoring Performance Improvement Projects

Clinical Performance Improvement Project

Goal VII.1.	**DMH will implement a provision of staff training, a peer mentoring network, and interdisciplinary treatment groups focused on medication-assisted treatment (MAT) to increase the percentage of consumers with co-occurring substance use problems MAT by four percent from Calendar Year 2020 to Calendar Year 2021.**
Objectives:	a) Increase the number of consumers receiving MAT overall. b) Increase the number of consumers with identified alcohol use disorder (AUD) and opioid use disorder (OUD) receiving MAT. c) Increase the number of prescribers that are eligible to prescribe MAT. d) Increase the number of prescribers administering MAT to at least one consumer.
Population:	DMH clients receiving outpatient co-occurring disorder (COD) services.
Performance Indicator:	1. Number of prescribers eligible to administer MATs 2. Number of prescribers administering MAT to at least one consumer 3. Number of consumers prescribed MAT (also separated by consumers with identified AUDs and OUDs) 4. Number of consumers with improved mood or anxiety ratings on Weekly Check-in 5. Number of consumers with decreased substance use and interference rating on Weekly Check-in
Frequency of Collection:	Monthly
Data Source:	PIP Development Tool FY 2021-22, *Improving the Use of Medication-Assisted Treatment for Consumers with Co-Occurring Mental Health Disorders and Substance Use,* Order Connect Data Tables, and Weekly Check-In Microsoft Forms data

Non-Clinical Performance Improvement Project

Goal VII.2.	**By the end of CY 2021, DMH will develop and implement a non-clinical PIP to improve the rate of timeliness to initial appointments from 61.5% to 70.0% for children seeking outpatient services.**
Objectives:	a) Establish a demographic profile (i.e., size, modes of service delivery, location, etc.) of providers who struggle to meet DMH timeliness standards for clients/families seeking child services. b) Implement a required QI Plan of Correction process for providers with timeliness in the 69% or less range, including identifying internal and external factors contributing to their untimely appointments and establishing an action plan.
Population:	Los Angeles County residents seeking outpatient DMH services
Performance Indicators:	1. Rate of timeliness (%) for urgent appointment requests. 2. Rate of timeliness (%) for routine appointment requests. 3. Rate of timeliness (%) for inpatient/jail discharge appointment requests. 4. Percent of no-shows to initial appointments by service request type. *Figure 14. Percent of Untimely versus Timely Initial Appointments by Age Group, Calendar Year 2020*  **Note:** At a rate of 35.9%, clients/families seeking child outpatient services are more likely to receive an untimely appointment when compared to individuals seeking TAY (17.4%), adult (10.6%), or older adult (10.0%) services. "Untimely, referral declined" values were added to the "Timely" category. **Data Source**: System-wide Timely Access to Care Dashboard for CY 2020, retrieved on 3/31/21.
Frequency of Collection:	Quarterly
Data Source:	Non-clinical PIP Development Tool FY 2021-22, System-wide Access to Care Dashboard

Data Collection and Communication Plan Overview

Date Last Revised: 2/22/21

Domain	Performance Indicators	Data Sources	Frequency of Collection	Responsible Entity	Communication Plan
Service Delivery Capacity	• Unique Client Counts by Race/Ethnicity • Penetration Rates for Medi-Cal Enrolled Beneficiaries by Race/Ethnicity • Total clients served, including the number of telehealth encounters (services) provided in FY 2020-21 • Total Count of VSee Licenses Assigned in CY 2021 • VSee utilization (active accounts, logins, visits) • Number of CC Org Assessment presentations facilitated in CY 2021	DMH Integrated Behavioral Health Information System	Annually	Quality Improvement Unit Chief Information Office Bureau	Monthly All Programs of Excellence Meetings, Quality Improvement Council meetings at least annually, and Service Area Quality Improvement Committee meetings as applicable
Accessibility of Services	• Rates of timeliness by service request type (routine, urgent, discharge/jail release) • Number of complete TT teams (Peer, Psychiatric Technician, and Clinical Driver)	System-wide Timely Access to Care Dashboard	Quarterly Annually	Quality Assurance Unit Intensive Care Division	Monthly Access to Care Leadership Committee meetings, Central Quality Assurance/Quality Improvement meetings at least quarterly, and Quality Improvement Council meetings at least annually
Beneficiary Satisfaction	• Number of returned surveys/respondents by Consumer Perception Survey form. • Beneficiary complaints and resolutions in FY 2020-21	DMH Consumer Perception Survey data Grievance Log	Annually	Quality Improvement Unit Patient's Rights Office	Quality Improvement Council and Service Area Quality Improvement Committee meetings at least annually

Domain	Performance Indicators	Data Sources	Frequency of Collection	Responsible Entity	Communication Plan
Clinical Care	• Number of aggregated CANS-50 or PSC-35 reports available for provider use • Number of peer reviews completed for prescribers in DO programs • Number and location of APEX meetings conducted in CY 2021	Program-specific data reports	Annually	Outcomes Unit Office of Clinical Operations Outpatient Services Division and Leads for Directly Operated Programs	Providers as applicable and Quality Improvement Council meetings at least annually
Continuity of Care	• Number of clients engaged and successfully enrolled in services. • Number of successful conservatorships in each supervisorial district.	Program-specific data reports	Annually	Homeless Outreach Mobile Engagement Program	Quality Improvement Council meetings at least annually
Provider Appeals	• Number of NOABDs issued, including the percentage of appeals that were upheld or overturned.	Hospital Association of Southern California Treatment Authorization Request Report and Provider Appeal Tracking Log	Quarterly	Intensive Care Division	Quality Improvement Council meetings at least annually

Domain	Performance Indicators	Data Sources	Frequency of Collection	Responsible Entity	Feedback/Input Plan
Clinical Performance Improvement Project	• Number of prescribers eligible to administer MATs • Number of prescribers administering MAT to at least one consumer • Number of consumers prescribed MAT (also separated by consumers with identified AUDs and OUDs) • Number of consumers with improved mood or anxiety ratings on Weekly Check-in • Number of consumers with decreased substance use and interference rating on Weekly Check-in	PIP Development Tool FY 2021-22, Order Connect Data Tables, and Weekly Check-In Microsoft Forms data	Monthly	Clinical PIP committee	Monthly PIP committee meetings and Quality Improvement Council meetings at least quarterly
Non-Clinical Performance Improvement Project	• Rate of timeliness (%) for urgent appointment requests. • Rate of timeliness (%) for routine appointment requests. • Rate of timeliness (%) for inpatient/jail discharge appointment requests. • Percent of no shows to initial appointments by service request type	Non-clinical PIP Development Tool FY 2021-22 and System-wide Timely Access to Care Dashboard	Quarterly	Access to Care Leadership committee, Nonclinical PIP committee, and Quality Assurance Unit	Monthly PIP committee meetings and Quality Improvement Council meetings at least quarterly