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

Quality Assessment and Performance Improvement Work Plan 2022

Reporting Period: July 1, 2020, to December 31, 2021

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Quality Assurance and Performance Improvement Goals to Drive Change in Support of the Strategic Plan

Last Revised Date: 4/22/2022

The QI Unit coordinates the Department's performance-monitoring activities countywide. The Department's CQI and data-driven activities include utilization review, monitoring and resolution of beneficiary grievances, fair hearings and provider appeals, assessment of beneficiary satisfaction, PIPs, and timely access to SMHS. The QAPI Work Plan activities for CY 2022 provide a blueprint of QI actions to ensure the overall quality of services. Through practical QI activities, data-driven decision-making, and collaboration amongst staff and clients/families, LACDMH meets State regulations for evaluating the appropriateness and quality of services.

The QAPI Work Plan is the foundation of LACDMH'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 QAPI Work Plan activities are interconnected and similarly CQI-oriented. To succeed, the Strategic Plan and QAPI Work Plan embody the following values and principles:

- **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.
- **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.
- **Client driven** – where we engage consumers, families, communities, and all of our 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.
- **Accessible and hospitable** – where all services and opportunities are readily available, easy to find, timely, and welcoming to everyone.
- **Equitable and culturally competent** – where consumers, family members, and communities are cared for equitably, and services are delivered with cultural humility, respect, and competence.
- **Anti-racist, diverse, and inclusive** – where services are delivered with sensitivity and understanding to the impact of collective racism against Black and other communities of color.
- **Collaborative** – where we recognize that we cannot go it alone and 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 2020-2030

LACDMH is a committed partner and contributor whose Strategic Plan (Plan) intentionally aligns with the County's broader vision for addressing critical challenges and helping communities thrive. To ensure the diverse needs and perspectives of the community were reflected in the strategic plan, LACDMH engaged the Board of Supervisors, staff, stakeholders, and the community through the Mental Health Commission, the Service Area Leadership Teams (SALTs), Underserved Cultural Communities (UsCCs), the Faith-Based Advocacy Council, and the Coalitions. The plan is centered around transformational goals LACDMH strives for within the organization and support of the system (Infrastructure) as well as our three modes of service delivery (Community Services, Crisis Care, and Re-Entry Initiatives) (Figure1). The Plan focuses on the community-centric and inclusive systems we must build in Los Angeles County to prevent people with severe mental health challenges from falling out of the community due to their condition and to bring those who fall out back in to stay.

Domains for Our Strategy

The Plan is organized around three essential domains where we interface with our clients and a fourth that describes the people, places, and processes that support our work (Figure 2).

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Figure 1.
Domains for Our Strategy (Illustration)

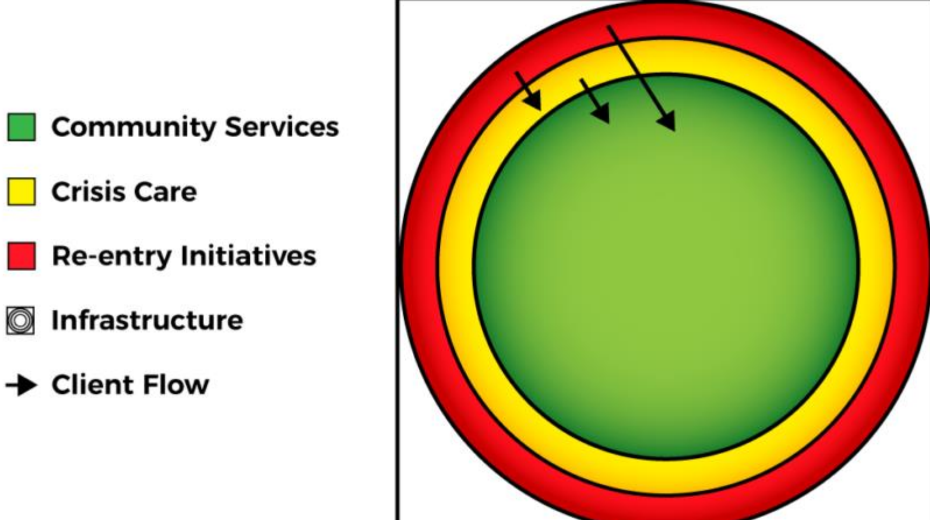
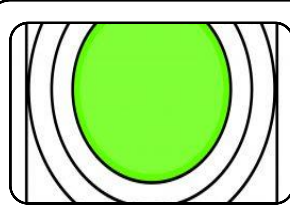
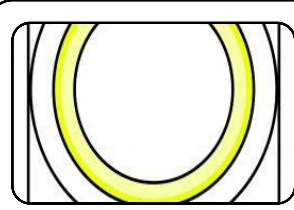


Figure 2.
Domains for Our Strategy (Brief Overview)



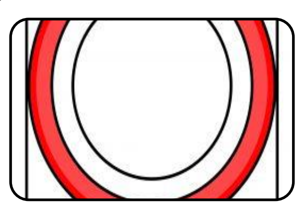
Community Services

- The first domain is represented by the green circle in the figure, signifies the North Star where we will always prefer to provide services and opportunity; half of the Plan focuses on community and ways in which proactive and therapeutic resources can be built up across the County.



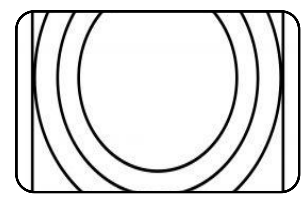
Crisis Care

- The second domain is represented by the yellow ring, includes the intensive care resources needed to help individuals in crisis who are falling out of community.



Re-Entry Iniatives

- The third domain is represented by the red ring, where our broad portfolio of re-entry resources (including compelled treatment) is deployed to help clients who have fallen out of community into the "open-air" asylum of the street, the "closed-air" asylum of the jail, and the personal asylum of deep isolation.



Infrastructure

- The people and processes that guide our work across all three domains create our ever-present department infrastructure, which is represented by the square and circular lines.

Section V. Quality Improvement Work Plan, Calendar Year 2022

Date Last Revised: 5/27/21

The Department's QAPI Work Plan 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 service quality. Table 1 summarizes QAPI Work Plan goals and their comparable strategic plan domain.

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

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Table 1.
Summary of QAPI Work Plan Goals and Comparable Strategic Plan Domain(s), Calendar Year 2022

Domain	No.	Goal	Strategic Plan Domain			
			Community Services	Crisis Care	Re-Entry Initiatives	Infrastructure
Service Delivery Capacity	Ia.	Analyze root causes in the underrepresentation of self-identified Asian, Black/African Americans, and Native Hawaiian/Pacific Islanders receiving DMH services.	X	X	X	X
	Ib.	Share findings on the Department's capacity to deliver culture-specific services.	X	X	X	X
	Ic.	Maintain the number of clients receiving telehealth services.	X			
Accessibility of Services	II.	DMH will meet 80% of initial requests for outpatient SMHS with a timely appointment.	X			
Beneficiary Satisfaction	IIIa.	Evaluate Consumer Perception Survey (CPS) findings and develop data-driven improvement strategies at the Service-Area level.				X
	IIIb.	Monitor grievances, appeals, and requests for a Change of Provider.				X
Clinical Care	IVa.	Rollout Child and Adolescent Needs and Strengths – 50 (CANS-50) and Pediatric Symptom Checklist-35 (PSC-35) aggregate reporting to support children and youth program operations.	X			
	IVb.	Develop and refine processes to enhance provider knowledge surrounding documentation and claiming-related requirements associated with the provision of Medi-Cal SMHS.	X			
	IVc.	Develop a mechanism to measure and track HEDIS Measures for children and youth.	X			
	IVd.	Roll out an Adult Level of Care Tool.	X	X		
Continuity of Care	V.	Develop a systemwide strategy to reduce seven- and 30-day rehospitalization rates.		X		
Provider Appeals	VI.	Monitor Provider Appeals.				X
Performance Improvement Projects	VII.	Develop and implement two (clinical, administrative) data-driven performance improvement projects to improve client access, service quality, timely access to care, or information systems with direct beneficiary impact.	X	X	X	X

Note: Reporting periods will vary by objective.

Monitoring Service Delivery Capacity, Calendar Year 2022

Service Equity

Goal Ia.	**Analyze root causes in the underrepresentation of self-identified Asian, Black/African Americans, and Native Hawaiian/Pacific Islanders receiving DMH services.**
Objective(s)	1. Work collaboratively with LACDMH stakeholders to develop a United Mental Health Promoters program curriculum for the Black/African American and Asian Pacific Islander communities. • Prioritize unique community needs, current affairs (i.e., community violence and COVID-19 response), and fluid resources 2. Utilize the Speakers Bureau for ongoing outreach and engagement.
Population	LACDMH and Legal Entity (LE)/Contracted programs providing outreach and outpatient SMHS to LACDMH clients and the Los Angeles County community at large.
Performance Indicator(s)	1. Unique Client Counts by Race/Ethnicity 2. Penetration Rates for Medi-Cal Enrolled Beneficiaries by Race/Ethnicity 3. Service Equity Analysis Report Findings *Figure 3.* Penetration Rates for Medi-Cal Beneficiaries in the African American Group 10.6% 10.4% 10.2% 10.0% 9.8% 9.6% 9.4% 9.2% 9.0% FY 2018-19: 9.6%; FY 2019-20: 10.5%; FY 2020-21: 9.9% Note: The Ns for Medi-Cal Beneficiaries from the African American group served in FY 2018-19 was 37,455, 40,669 in FY 2019-20, and 38,300 in FY 2020-21. Uninsured/indigent clients are not reflected in this data. Data Source: Medi-Cal Approved Claims Data for Los Angeles County MHP CY 2019 to CY 2021, prepared by BHC/CalEQRO in July 2019, July 2020, and July 2021.

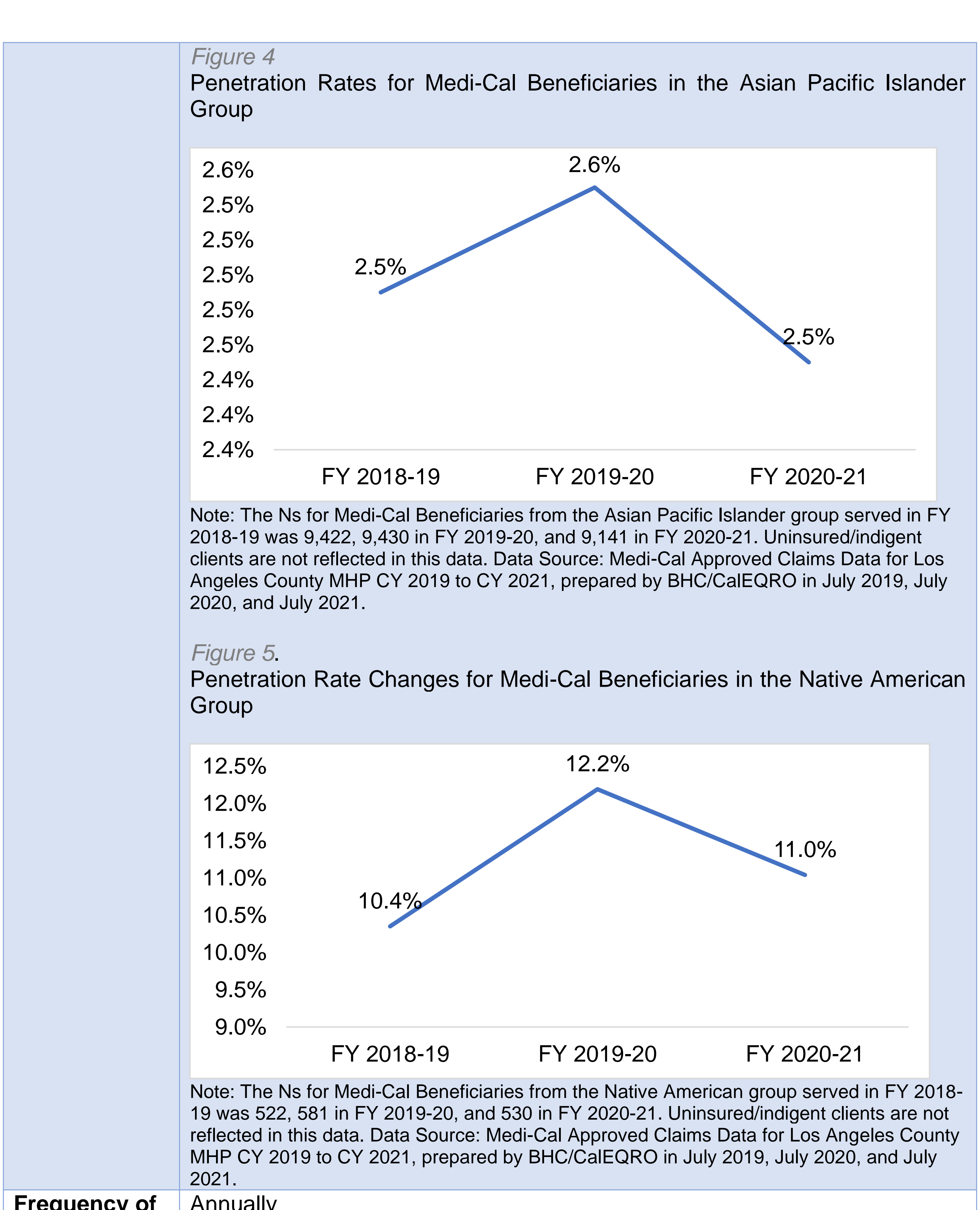

Figure 4
Penetration Rates for Medi-Cal Beneficiaries in the Asian Pacific Islander Group

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

Figure 5.
Penetration Rate Changes for Medi-Cal Beneficiaries in the Native American Group

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

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

Delivering Culture-Specific Services

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

Telemental Health

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

Monitoring Accessibility of Services, Calendar Year 2022

<u>Timely Access to Services</u>

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

Monitoring Beneficiary Satisfaction, Calendar Year 2022

Client/Family Satisfaction

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

Client Grievances, Appeals, and Change of Provider Requests

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

Monitoring Clinical Care, Calendar Year 2022

Clinical Reporting

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

Provider-Level Improvement

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

Healthcare Effectiveness Data and Information Set (HEDIS) Elements

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

Level of Care

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

Monitoring Continuity of Care, Calendar Year 2022

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

Monitoring Provider Appeals, Calendar Year 2022

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

Monitoring Performance Improvement Projects, Calendar Year 2022

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