Los Angeles County's Behavioral Health Quality Assessment and Performance Improvement (QAPI) Work Plan and Evaluation

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Presented By:

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

Los Angeles County Department of Public Health
Substance Abuse Prevention and Control, Quality Improvement Branch

LOS ANGELES COUNTY
DEPARTMENT OF
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COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

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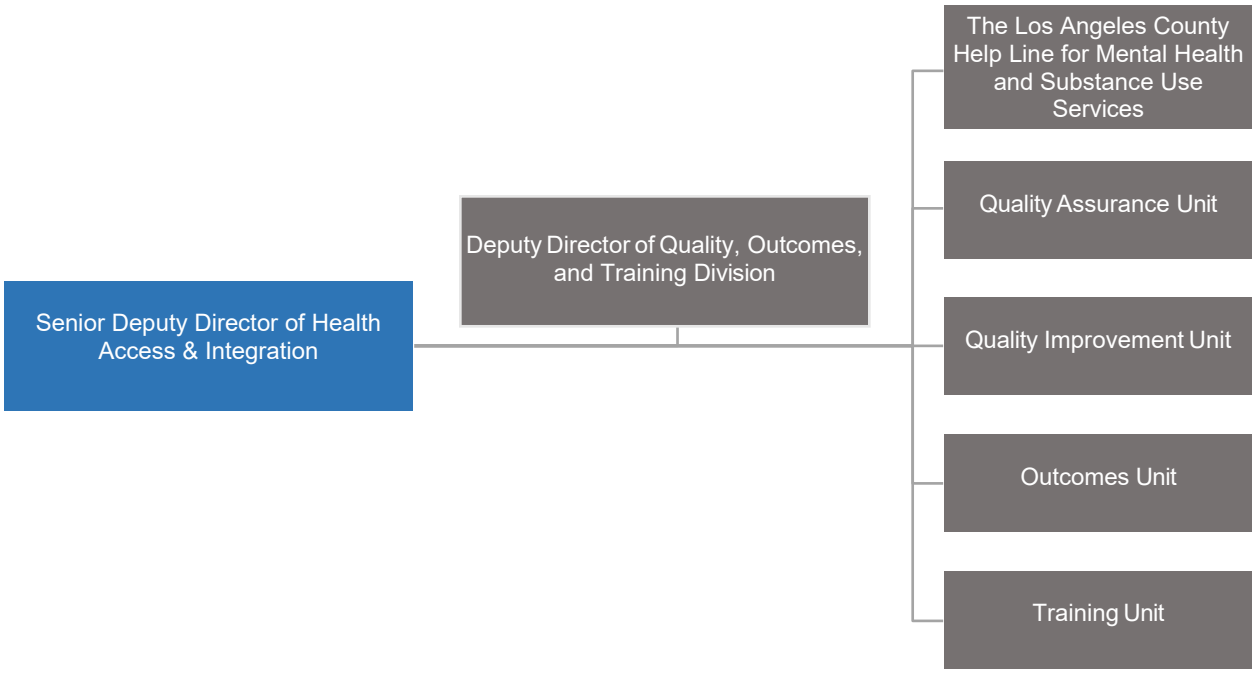
QUALITY IMPROVEMENT (QI) PROGRAM PURPOSE AND SCOPE

Department of Mental Health

The QI Unit reports to the Deputy Director of the Quality, Outcomes, and Training Division (QOTD). The Division combines four units: Quality Assurance (QA), QI, Outcomes, and Training. The Deputy Director of QOTD oversees the quality of the Department's services, coordinates training as indicated for continuous quality improvement (CQI) and conducts ongoing assessments of countywide performance outcomes. The QOTD's organizational structure facilitates a downward and upward communication loop between Specialty Mental Health Services (SMHS) providers countywide, Cultural Competency Unit, and Los Angeles County Department of Mental Health (LACDMH) executive management.



The Los Angeles County Help Line for Mental Health and Substance Use Services

LACDMH and Los Angeles County Department of Public Health Substance Abuse Prevention and Control collaboratively operate a centralized 24/7 Help Line that simplifies the road to recovery for those seeking care for mental health and/or substance use disorders. This serves as the entry point for mental health and substance use services in Los Angeles County. While the majority of calls are for information and referral, the line also facilitates the deployment of Field Intervention Teams (FITs), has a dedicated emotional support line and serves as the gatekeeper for acute inpatient psychiatric beds, interpreter services, and emergency member transportation to psychiatric emergency rooms. For more information visit:https://dmh.lacounty.gov/blog/2024/08/welcome-l-a-county-help-line-for-mental-health-and-substance-use-services/

Quality Assurance Unit

The QA Unit ensures the adherence of the County Mental Health Plan's (MHP) directly operated (DO) and contracted providers to federal, state, and local laws, regulations, and requirements associated with the provision, documentation, and claiming of Medi-Cal SMHS. The QA Unit develops policies and guidelines; monitors adherence to governmental mandates; provides training and technical support; certifies the MHP's SMHS providers; supports the clinical functions of the Department's electronic health record (EHR) system; oversees the integrity, retention, and release of the Department's clinical records; acts as a liaison between the MHP and the State Department of Health Care Services (DHCS) including during the DHCS Triennial System/Chart review and Short/Doyle Medi-Cal Hospital audits; the Department's 24/7 ACCESS Line Annual Test Calls; and advocates for the MHP's position on SMHS-related issues with DHCS, the County Behavioral Health Director's Association (CBHDA), and other entities. In addition, the QA Unit is also responsible for the credentialing of clinical staff across the Specialty Mental Health System and manages the electronic data platforms that track and report on timely access and Network Adequacy. For more information visit: https://dmh.lacounty.gov/qa/

Quality Improvement Unit

The QI Unit executes mandated performance outcome studies, evaluations, and research targeting the effectiveness of LACDMH services. In conformance with Federal, State, and local QI requirements, the QI Unit oversees technical reporting related to the annual Quality Assurance and Performance Improvement (QAPI) Work Plan and Evaluation Report, member/family satisfaction data, Performance Improvement Projects (PIPs), and collaborative efforts with other programs. The QI Unit also ensures adherence to prescribed site review protocols and timelines, such as those assigned during triennial oversight reviews and External Quality Review Organization (EQRO) audits. QI staff must maintain up-to-date knowledge of QI concepts and provide technical assistance, consultation, and training for Departmental and Regional Quality Improvement Committees (QICs), stakeholder meetings, and other community organizations/agencies. Effective communication and collaboration with other LACDMH divisions, programs, and providers support the Department's accelerated use of CQI countywide. The QI Unit strives to coordinate program development and QI activities that effectively measure, assess, and continuously improve access to, and quality of care provided to LACDMH members. The QI Unit's vision is to promote a QI culture and increase the professional use of QI practices within the Department by partnering and consulting more closely with departmental improvement efforts where they occur. The QI Unit is member/family-focused and supports the Department's culture of CQI and total organizational involvement. For more information visit: https://dmh.lacounty.gov/qid/.

Outcomes Unit

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

Training Unit

The Training Unit is responsible for workforce development, ensuring a diverse workforce reflective of the members served, education, and providing training and technical assistance for the clinical and non-clinical public mental health workforce. For more information visit: https://dmh.lacounty.gov/for-providers/clinical-tools/training-workforce-development/

Access to Care Leadership Committee

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

All Programs of Excellence (APEX)

APEX is a forum that brings together supervisors, managers, and multiple divisions to address areas of the Outpatient Services Division (OSD) Performance Dashboard indicators where improvement is needed. OSD organizes APEX meetings by SA and program. Diagnosis, Patient Health Questionnaire-9 (PHQ-9), General Anxiety Disorder-7 (GAD-7), Needs Evaluation Tool (NET), and homelessness data are provided at each session. The APEX process is grounded in the following values: maintain a problem-solving approach, support positive change, remove systemic challenges, enhance coordination and communication between divisions, share evolving procedures, scale best practices, and provide excellent customer service (internal/external).

Annual Test Calls

The Department's Annual Test Calls Review identifies potential areas for QI and strengths in the ACCESS Center's 24/7-line responsiveness. The LACDMH Test Calls supports the ACCESS Center and the QA Unit in their collaborative efforts to improve cultural and linguistic responsiveness, customer service, referrals to SMHS, tracking/monitoring, and adequate documentation of call information. The QA Unit disseminates findings to the ACCESS Center management who then provides feedback to their staff and implements and identified improvements.

Chief Information Office Bureau (CIOB)

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

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

CIOB's Clinical Informatics team holds essential roles in both PIPs, from aggregating data to offering technical assistance to the clinical PIP lead tasked with analyzing the data.

Cultural Competency Unit (CCU)

The CCU is part of the Anti-Racism, Inclusion, Solidarity, and Empowerment (ARISE) Division and is overseen by the Ethnic Services Manager (ESM). The ESM provides technical assistance to the Cultural Competency Committee (CCC) and is a standing member of the Departmental QIC. This structure facilitates communication and collaboration for attaining the goals outlined in the QAPI Work Plan and Cultural Competency (CC) Plan to reduce disparities, increase capacity, and improve the quality and availability of services. Additional information on the CCU and its functions, the CCC, the Institute for Cultural Linguistic Inclusion and Responsiveness (ICLIR), a tri-Countywide Cultural and Linguistic Competency workgroup, and our most recent CC Plan is available via the CCU website at https://dmh.lacounty.gov/ccu/.

Performance Improvement Project (PIP) and Quality Improvement Project (QIP) Committees

The Department conducts PIPs to review selected administrative and clinical processes designed to improve performance outcomes. In performing PIPs, the QI Unit collaborates and coordinates with various Divisions, Programs, and Units within DMH depending on the PIP topic. In addition to PIPs, less formal QIPs are also conducted. PIP and QIP committee members are identified by their expertise in certain areas and ability to create change in our system. LACDMH strives for PIP and QIP teams that are diverse and inclusive. Each committee member participates on a volunteer basis due to special interests.

Stakeholder Engagement

The QIC encourages stakeholder involvement in all QI activities. Service Area Leadership Teams (SALTs), MHSA Community Planning Team (CPT), and Underserved Cultural Community (UsCC) meetings are all avenues for feedback from stakeholders around quality improvement needs.

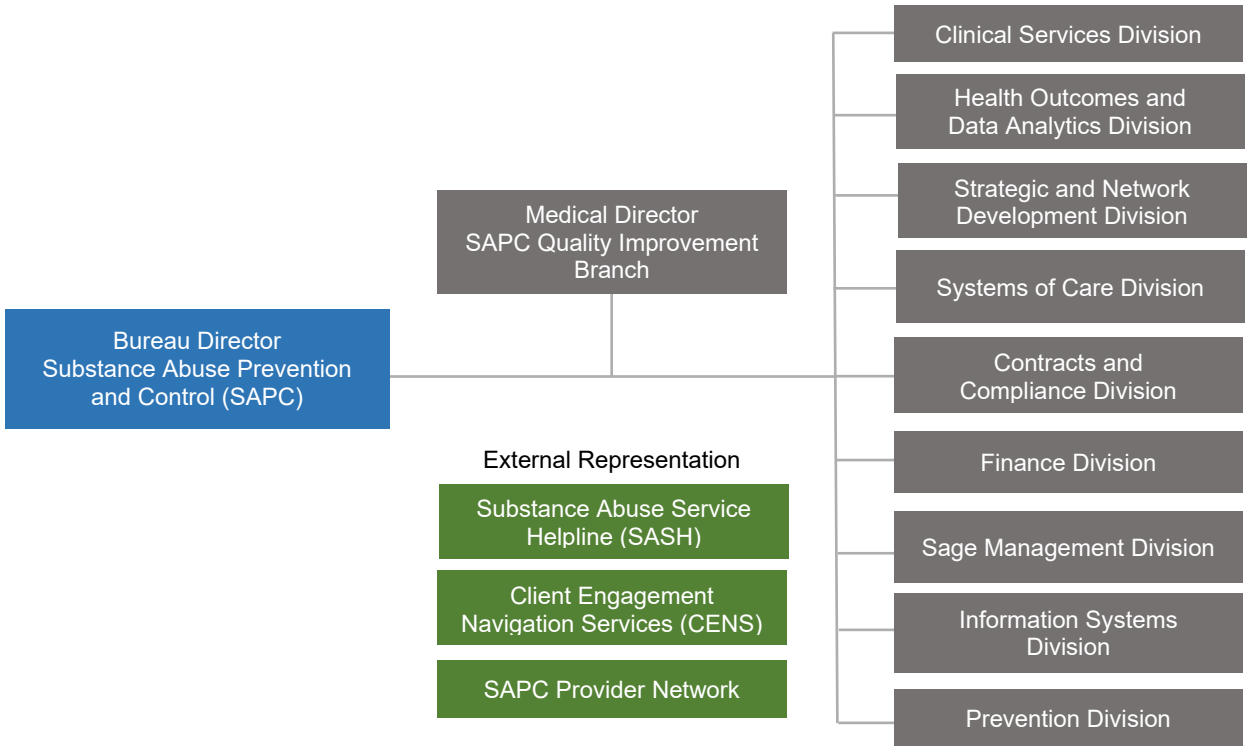
QUALITY IMPROVEMENT BRANCH (QI) PROGRAM, PURPOSE, AND SCOPE

Department of Public Health – *Substance Abuse Prevention and Control*

Los Angeles County specialty substance use disorder (SUD) system is managed by the Substance Abuse Prevention and Control Bureau within the Department of Public Health (SAPC). SAPC's provider network offers specialty SUD treatment services for youth and adults who are enrolled or eligible for Los Angeles County Medi-Cal, and/or participating in another eligible County funded program. This program continues to focus on quality improvement within the treatment network focused on:

1. Integrating physical and mental health service needs with SUD services;
2. Training quality standards to improve health outcomes;
3. Providing the full continuum of SUD services to meet the needs of patients;
4. Establishing a single benefit package for publicly funded SUD services regardless of referral source or insurance plan; and
5. Solidifying SUD's status as a chronic health condition rather than as an acute condition.

These enhancements enable SUD patients to receive quality services that match their individualized needs and preferences and overall improve health and social outcomes.



Quality Improvement Branch

SAPC's Quality Improvement (QI) Branch is focused on the identification and development of quality improvement projects, specifically including the identified Performance Improvement Projects (PIPs). The QI Division conducts provider-interfacing quality improvement around access to priority clinical services (such as MAT), conducts biannual documentation review of key quality metrics, and holds member focus groups to learn more about the patient perspective on treatment delivered by the SAPC provider network. The branch centralizes the process of clinical grievances and appeals (G&A) and spends a portion of their time processing authorizations for treatment in collaboration with SAPC's overall Clinical Services Division. The QI Branch interfaces with other key SAPC units to carry forward SAPC's quality improvement initiatives (such as harm reduction and access to care).

Quality Improvement Accountability, Governing Body, and Committee Structure

SAPC's Quality and Risk Management Committee provides a forum for discussion and the provision of direction to the other units with SAPC and is the framework for organizational quality improvement and oversight responsibilities. Most committees are internal and attended by SAPC branch representatives and relevant parties. There are two committees that include external stakeholders, including member referral services and representatives from the SAPC provider network. Each committee is independently governed but report to the Quality Improvement & Risk Management Committee as lead committee.

QUALITY IMPROVEMENT COMMITTEE AND STRUCTURE

Department of Mental Health

Quality Improvement Committee (QIC) - Statement of Purpose

The purpose of the QI Unit is to ensure and improve the quality and appropriateness of SMHS in compliance with established local, State, and Federal service standards. The QIC supports LACDMH in maintaining a culture of CQI. The Departmental QIC and Regional QICs provide opportunities to:

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

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

Committee Membership

LACDMH has tasked the Departmental QIC with evaluating the appropriateness and quality of services provided to LACDMH members/families. Committee membership reflects the diverse perspectives of members from centralized administrative programs and provider locations countywide. SAPC has joined DMH's attendees this year in efforts to integrate the QICs. The Cultural Competency Unit supervisor is a standing member of the QIC and supports cultural competency integration into QI Unit roles and responsibilities. The QIC includes representatives from:

- Child Welfare
- Clinical Informatics
- Clinical Risk Management
- Compliance, Privacy, and Audit Services
- Cultural Competency Unit
- Emergency Outreach and Triage Division
- Forensic Services
- Housing
- LACDMH's Peer Resource Center
- The Los Angeles County Help Line for Mental Health and Substance Use Services
- Mental Health Services Act (MHSA)
- Outcomes
- Outpatient Care Services
- Patients' Rights Office
- Peer Services
- Pharmacy/ Psychiatry
- Quality Assurance Unit
- Quality Improvement Unit

- Veteran and Family Services
- DO and LE/Contracted programs

Authority

A licensed mental health professional supervises the QI Unit and serves as the Departmental QIC Chair. The QIC Chair is responsible for chairing and facilitating meetings and ensuring members receive timely and relevant information. Each Regional QIC has a lead from the QI Unit and a co-lead representing either a DO or LE/Contracted provider.

Meetings

Providers are required to participate in their local Regional QICs. The Northern Regional QIC encompasses Service Areas 1-4 and Southern Regional QIC has members from Service Area 5-8. Each Region convenes for a Regional QIC meeting at least quarterly. The QI Unit hosts the Departmental QIC monthly and co-hosts a monthly QA/QI meeting with QA. This approach fosters integrative discussions of departmental QA goals in concert with QI practices. Each committee meeting provides a structured forum for identifying QI opportunities to address challenges and barriers unique to their respective SAs/Regions. The chairs/leads for the committee are responsible for the agenda/minutes and steering members through the plan. Meeting minutes and recordings (when applicable) are posted online at https://dmh.lacounty.gov/qid/ for public review.

Responsibilities

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

Department of Public Health – *Substance Abuse Prevention and Control*

Quality Improvement and Risk Management Committee

In accordance with the Special Terms and Conditions (STCs) of California's Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver, and the Quality Improvement (QI) and Utilization Management (UM) sections of the Provider Manual, the purpose of the QI & RM Committee is to provide a forum by which various relevant divisions across the organization can regularly meet to discuss issues related to network performance, outcomes, capacity, training, and concerns, all with the overarching goal of optimizing outcomes and minimizing the possibility of adverse outcomes or loss. In doing so, the QI & RM Committee will request, review, and lead the administrative and clinical quality improvement activities within SAPC, including problem identification and the formulation of quality improvement plans. The QI & RM Committee meets every other month with representatives from all SAPC areas responsible for managing the SAPC SUD treatment provider network.

COMMITTEE RESPONSIBLITIES

Core responsibilities of the **QI & RM Committee** include the following:

- Establish and maintain an integrated strategy to ensure patient safety and satisfaction, quality of care, and organizational efficiencies.
- Review and evaluate the result of quality improvement activities.
- Develop, implement, and manage the two PIPs that counties are required to implement on an annual basis, with one PIP focusing on a clinical issue and another PIP focusing on a non-clinical issue.
- Track, monitor, prepare, and ensure compliance with EQRO and other State requirements by reviewing subcommittee reports on a biannual basis.
- Review targeted clinical records associated with flagged complaint/grievance and appeals filed by patients, their representatives, and/or providers.
- Recommend policy decisions related to quality improvement and risk management.

COMMITTEE STRUCTURE

The QI & RM Committee shall be led by a chair (SAPC Director) and co-chair (SAPC Deputy Director) (or their designees as needed). Members of the Committee shall be decided by consensus of the Committee, under the leadership of the chair and co-chair.

Members of the QI & RM Committee shall represent the following SAPC Branches and Divisions:

- Executive Office (SAPC Director and Deputy Director of Treatment)
- *Clinical Service Division*
- *Health Outcome and Data Analytics Division*
- *Strategic and Network Development Division*
- *Systems of Care Division*
- *Contracts and Compliance Division*
- *Finance Division*
- *SAGE Management (Electronic Health Record) Division*
- *Information Systems Division*
- *Prevention Division*

External representation will include:

- The Los Angeles County Help Line for Mental Health and Substance Use Services
- Client Engagement Navigation Services (CENS)
- SAPC Provider Network

PROCEDURES

The procedures for the QI & RM Committee are indicated below:

Meetings. The Committee chairs, in consultation with other members of the Committee, will determine the frequency and length of the Committee meetings. However, the Committee shall meet at minimum every other month. The committee will meet regularly on dates that are announced in advance and the agenda will be developed by the chairs of the Committee in consultation with the Committee's membership. Attendees of meetings will be at the discretion of the Committee in consultation with involved stakeholders.

Reports. Meeting minutes serve to document the Committee's activities and may include information regarding outcomes, recommendations, actions taken, and follow up items from previous meetings. Minutes shall be circulated during and/or prior to the scheduled Committee meetings.

Performance Improvement Projects. The Committee will develop, implement, and manage the two PIPs that counties are required to implement on an annual basis, with one PIP focusing on clinical issues and another PIP focusing on non-clinical issues.

External Quality Review Organization (EQRO) Responsibilities. The Committee will track, monitor, prepare, and ensure compliance with EQRO and other State requirements.

Oversight. The Committee will review and monitor the following provider submissions:

- Reportable Incidents: Reportable incidents are patient safety events that result in death, permanent harm, severe temporary harm, and/or intervention required to sustain life. Reportable Incidents must be reported to the SAPC Contracts and Compliance Division, which will then ensure that the appropriate entities within SAPC are included and raise this to the QI & RM Committee. Additionally, the Risk Management Committee at the provider agency level is also required to investigate Reportable Incidents.
- Adverse Events: Adverse Events are incidents that have a direct or indirect impact on the community, patients, staff, and/or the entire provider agency. Adverse Events must be addressed by the Risk Management Committee at the provider agency level and are submitted to SAPC at provider discretion. If the SAPC Contracts and Compliance Division deems an Adverse Event as requiring input from the QI & RM Committee, it can be submitted to the Committee for review.
- Complaint/Grievance: A complaint or grievance from patients or providers are an expressed dissatisfaction with elements of care including, but not limited to, quality of care, services, and/or treatment. These occurrences will be addressed as a component of the SAPC Contracts and Compliance Division and typically will not be reviewed by the QI & RM Committee unless a specific complaint/grievance is identified and rises to the level of requiring involvement of the QI & RM Committee.

Record Keeping. Documentation and reviews of Reportable Incidents, and applicable Adverse Events and Complaints/Grievances will be maintained, and such records may be kept in hard copy, electronically, or both. In either case, sufficient safeguards will be established (e.g., locked cabinets for hard copy files, password protection and encryption for electronic files, access for authorized staff only) to maintain confidentiality.

Committee Findings. Notable findings of the QI & RM Committee will be incorporated into provider educational programs, the re-credentialing and contracting process, and annual review evaluations. All quality improvement and risk management activities and resulting actions will be documented to demonstrate the Committee's impact on improving service delivery across the SAPC network. Additionally, quality improvement and risk management activities will recognize the importance of constructive outcomes as well as correcting instances of deficient practice. In instances of deficient practice, written Corrective Action Plans (CAPs) will be submitted to and reviewed by the Committee. CAPs will fall into one of three categories: systems actions, educational actions, or individual follow-up and will detail what was done, who was responsible, and the timeframe for completion and follow-up.

Confidentiality. All activities and findings of the QI and RM Committee are confidential under CA Evidence Code Section 1157.6 related to Peer Review Activities and Government Code 825 related to Personnel Records and as a Patient Safety Work Product under the Patient Safety Organization (PSO): An entity established pursuant to the Patient Safety and Quality Improvement Act of 2005, Pub. L. 109-41, 42 U.S. C. 299b-21—b26 (Reference 2) and the regulations that interpret it, 42 CFR Parts 2 and 3. All SAPC contracted providers are required to comply with Title 42, Chapter I, Subchapter A, Part 2 of the Code of Federal Regulations (Confidentiality of Alcohol and Drug Abuse Patient Records).

QUALITY IMPROVEMENT PROGRAM GOALS AND OBJECTIVES

LA County's Specialty Mental Health Services QI Work Plan Evaluation for 2024: Department of Mental Health

NO.	DOMAIN	GOAL	OUTCOME
1A.	Service Delivery Capacity	Analyze root causes in the underrepresentation of self-identified Asian Pacific Islanders, and Communities with Physical Disabilities receiving DMH services.	PARTIALLY MET
1B.	Service Delivery Capacity	Increase the Department's capacity to deliver culture (language)-specific services.	PARTIALLY MET
1C.	Service Delivery Capacity	Implement standardized scheduling for all clinics to increase access to care and ability to monitor quality of care, yielding more efficient service delivery.	NOT MET
1D.	Service Delivery Capacity	Increase the visibility of Peer Services by enhancing the skills of Peer Workers and creating a meaningful career path.	MET
2A.	Accessibility Of Services	Improve timely access to care.	MET
2B.	Accessibility Of Services	Develop protocols for access to care monitoring.	PARTIALLY MET
3A.	Beneficiary Satisfaction	Evaluate Consumer Perception Survey (CPS) findings and develop data-driven improvement strategies at the Service-Area level.	PARTIALLY MET
3B.	Beneficiary Satisfaction	Monitor grievances, appeals, and requests for a Change of Provider.	MET
4A.	Clinical Care	Rollout Child and Adolescent Needs and Strengths – 50 (CANS-50) and Pediatric Symptom Checklist-35 (PSC-35) aggregate reporting to support children and youth program operations.	PARTIALLY MET
4B.	Clinical Care	Create and implement standardized training and mentoring for new staff to increase clinician competencies, satisfaction, and retention.	PARTIALLY MET
4C.	Clinical Care	Develop a mechanism to measure and track HEDIS Measures for Quality Performance Measures.	PARTIALLY MET
4D.	Clinical Care	Roll out Level of Care Utilization System (LOCUS) as Adult Level of Care Tool.	MET
4E.	Clinical Care	Enhance provider understanding of Medi-Cal Requirements by refining mechanisms of support as well as collaborative monitoring for providers, to ensure the delivery of efficient, quality Specialty Mental Health Services that meet federal, State and County requirements.	PARTIALLY MET
5A.	Continuity of Care	Develop a systemwide strategy to reduce 7 and 30-day rehospitalization rates.	PARTIALLY MET
5B.	Continuity of Care	Increase Bed Capacity in Subacute Facilities by Reducing Time to Step Clients Down into Lower Levels of Care.	NOT MET
6.	Provider Appeals	Monitor Provider Appeals.	MET
7A.	Performance Improvement Projects	Clinical PIP for CY 2024 will improve the rate of 30-day and same site rehospitalization for inpatient hospitalization discharges at two pilot hospitals.	PARTIALLY MET
7B.	Performance Improvement Projects	Non- clinical PIP: Develop and implement an administrative data-driven performance improvement project for CY 2024 to improve follow up for mental health services after emergency department (ED) visit for mental illness (FUM) for DMH GENESIS clients.	MET

LA County's Specialty Mental Health Services Quality Assessment Performance Improvement Work Plan for 2025: Department of Mental Health

DMH's QAPI Work Plan for 2025 is organized into seven significant domains: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care, Provider Appeals, and Performance Improvement Projects. Each domain is designed to address service needs and service quality.

The QAPI Work Plan is a living document. The Department's QIC will review QAPI Work Plan goals and related progress bi-annually to ensure coverage of all components of the QAPI Work Plan. Moreover, the QI Unit and QICs 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. A detailed version of DMH's Work Plan for 2025 is available at https://file.lacounty.gov/SDSInter/dmh/1180606_AppendixACY2025.pdf

DMH's Work Plan 2025

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

LA County's Drug Medi-Cal – Organized Delivery System Services Quality Assessment Performance Improvement Work Plan Evaluation for 2024: Department of Public Health-Substance Abuse Prevention and Control (DPH-SAPC)

DPH-SAPC's QAPI Work Plan evaluation includes the following 11 designated DMC-ODS Prioritized Quality Metrics below:

NO.	METRIC	TARGET BENCHMARK	CY 2024	MEASURES
1	Number of days to first DMC-ODS service/follow-up appointments at appropriate level of care after referral and assessment	>70% of beneficiaries seen within 10 days of referral	92.5%	First Rendered Services: DPH SAPC Metrics, Visual Analytics
2	Existence of a 24/7 telephone access line with prevalent non-English language(s)	Presence of SASH with services in prevalent non-English languages	LA County DPH SAPC Launched the SASH on 7/1/2017 which has continually operated 24/7 since then and offers services in prevalent non-English languages in LA County.	SASH Indicators Report
3	Responsiveness of the beneficiary access line	<10% Average percentage of dropped/abandoned calls before speaking to live person out of total calls per month	6%	SASH Indicators Report
4	Access to DMC-ODS services with translation services in the prevalent non-English language(s)	>95% of beneficiaries who receives services in their preferred non-English language	97%	% beneficiaries who receives services in their preferred non-English language: DPH SAPC Metrics, Visual Analytics
5	Number, percentage of denied and time period of authorization requests approved or denied	>70% of authorization requests responded to within published timeliness standards	85.0%	Auth timeliness review; Q2 authorization request submissions from CY 2023
6	Frequency of follow-up appointments and/or services - 30d after residential	>25% of beneficiaries with follow-up within 30d of discharge from residential LOC	36.5%	Follow-Up After Residential Treatment: DPH SAPC Metrics, Visual Analytics

NO.	METRIC	TARGET BENCHMARK	CY 2024	MEASURES
7	Timeliness of services of the first dose of NTP services	>75% of beneficiaries dosed within 3 days of request	99.0%	First Offered Medication Service among OTP Patients: DPH SAPC Metrics, Visual Analytics
8	Access to after-hours care	Each SPA with After Hours Access at each LOC	115 Locations, All OP, Residential, and OTP LOCs and 8 SPAs Represented	Services available after 5 p.m.: DPH SAPC Service and Bed Availability Tool
9	Reduce avoidable high cost (residential/WM) re-admissions	<15% high-cost beneficiaries with increased DMC-ODS utilization resulting from poor clinical quality	11.3%	Number of Patients who were admitted to WM more than 1x in a CY Quarter
10	Coordination of physical and mental health services with waiver services at the provider level	>85% Beneficiaries Reporting Coordination of Physical/Mental Health as part of DMC-ODS Services	86.0%	Adult TPS Questionnaire Q8 and Q9: DPH SAPC Metrics, Visual Analytics
11	Assessment of the beneficiaries' experiences, including complaints, grievances and appeals	>85% Beneficiaries Reporting Satisfaction with DMC-ODS Services	90.0%	Overall Satisfaction per Treatment Perception Survey Q11-Q14: DPH SAPC Metrics, Visual Analytics

DPH-SAPC Utilization Management Metric CY 2024	Count/Performance
Total Authorization Requests	82,720
% of authorizations processed within PM 8 Table 12 timeframes	See item 5.
Authorization Approval: Denial Ratio	679,997:2,283 (96.9%)
Authorization Denial: Appeal Ratio	2283:160 (7.0%)

LA County's Drug Medi-Cal – Organized Delivery System Services Quality Assessment Performance Improvement Work Plan for 2024: Department of Public Health-Substance Abuse Prevention and Control (DPH-SAPC)

DPH-SAPC's Quality Improvement & Risk Management (QI/RM) Committee meets every other month, and our QI Branch meets every other week to identify opportunities to improve quality of services, manage compliance and risk management, review complaints/grievances and appeals, ensure cross-division collaboration and information exchange, and support provider-level quality improvement. We adopted this QAPI Work Plan for FY 2024-2025 and updated QI Program Goals and Objectives to describe our plan to assess DPH-SAPC-network performance against best practice guidelines and implement interventions which ensure that SUD services follow generally accepted standards of clinical practice. We elaborated three specific focus areas to this end: our EQRO Process Improvement Plans, our use of the QI/RM committee and QI branch to compile and review positive and negative variances in quality, and to ensure collaboration and information exchange related to QI within DPH-SAPC in accordance with priority metrics.

We specifically align the DMC-ODS QAPI Program metrics to accord with the DMC-ODS STCs and DHCS BHINs 23-054, 23-068, 24-001, 24-004, and BHIN 24-006 so are reporting metrics in alignment with the DMC-ODS terms and conditions. We prioritized measures in the areas of access to care, timeliness of care, quality of provider documentation, quality of provider care, compliance with utilization management timeframe and standards, and care outcomes. DPH-SAPC's QI Branch collaborates with the Contracts and Compliance Division to process grievances and appeals in accordance with DPH-SAPC policies and procedures related to processing grievances, including those described within current version of the DPH-SAPC provider manual, and with all applicable state policies.

DPH-SAPC's QI Branch reviews each grievance and appeal from provider agencies resulting from adverse determinations related to patient financial eligibility and documentation to identify reasons for overturning these adverse determinations to identify instances where there was retrospective resolution to financial eligibility, including instances where the transition of the patient's county of residence, where there were adjudication errors, where there were technology errors, and in instances where retrospective changes in state policy resulted in changes in patient eligibility for services.

DPH-SAPC's QI Branch further conducts a twice-a-year review a sample of patient charts from the contracted provider network to review the following additional documentation metrics:

- % of charts reviewed with late documentation (in accordance with BHIN 23-068)
- % of charts reviewed where there was missing documentation of LPHA involvement and review (in accordance with BHIN 23-068)
- % of admissions where service hours did not align with the provided level of care (in accordance with BHIN 24-001)
- % of admissions where there was lack of alignment between ASAM Assessment and the documented plan of care (in accordance with BHIN 23-068)
- % of admissions where we identified the providers did not refer to appropriate mental health,

physical health, DCFS, Court, Probation etc.

- % of admissions where there was not adequate discharge planning and documentation (in accordance with BHIN 24-001)
- % of care coordination notes that did not describe appropriate care coordination services (in accordance with BHIN 24-001)
- % of admissions where appropriate release of information documentation was missing (in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2)
- % of admissions for withdrawal management where medications for withdrawal during the treatment episode were documented
- % of admissions where the ASAM resolved to a residential level of care and provider does did not justify placement in a non-residential level of care (in accordance with BHIN 23-068)
- % of admissions where provider agencies document that they prevented or discouraged the patient from accessing medications for addiction treatment (in violation of BHIN 23-054).
- % of admissions for patients with opioid use disorder where medications for opioid use disorder were discussed and offered (in accordance with BHIN 23-054)
- % of admissions for patients with opioid use disorder where medications for opioid use disorder were provided, directly or through referral (in accordance with BHIN 23-054)
- % of admissions for patients with alcohol use disorder where medications for alcohol use disorder were discussed and offered (in accordance with BHIN 23-054)
- % of admissions for patients with alcohol use disorder where medications for alcohol use disorder were provided, directly or through referral (in accordance with BHIN 23-054)
- % of admissions for patients with tobacco use disorder where medications for tobacco use disorder were discussed and offered
- % of admissions for patients with tobacco use disorder where medications for tobacco use disorder were provided, directly or through referral

These documentation metrics are reviewed and revised twice annually as additional documentation trends and issues are identified by QI Branch staff. The QI Branch's identification of documentation and quality findings are stratified by agency and are used during DPH-SAPC's monitoring of our provider agencies to inform the application of appropriate corrective action plans. DPH-SAPC's recoupment is limited to instances where there was evidence of fraud waste and/or abuse. For instances of documentation noncompliance, DPH-SAPC issues corrective action plans that include the provision of technical assistance and intensification of trainings and updating training content, and other appropriate non-recoupment administrative sanctions.

The DPH-SAPC QI Branch, along with the existing DPH-SAPC Quality Improvement & Risk Management (QI/RM) Committee, will continue to operationalize this Medi-Cal – Organized Delivery System Services Quality Assessment Performance Improvement Work Plan during the 2024-2025 fiscal year.

REFERENCES

1. **Appendix A – LA County's Specialty Mental Health Services Quality Assessment Performance Improvement Work Plan Evaluation Calendar Year 2024**
2. **Appendix B – LA County's Drug Medi-Cal – Organized Delivery System Services Annual Treatment Report, Fiscal Year 2023-2024**
3. **Appendix C – LA County's Drug Medi-Cal – Organized Delivery System Services Annual Treatment Report, Fiscal Year 2024-2025**
4. **Appendix – D – LA County's Drug Medi-Cal – Organized Delivery System Treatment Perception Survey (TPS) Data Brief 2024**
5. **Appendix E – LA County's Drug Medi-Cal – Organized Delivery System Community Needs Assessment**
6. **Appendix F – LA County's Drug Medi-Cal – Organized Delivery System Service and Bed Availability Tool**
7. **Appendix G – LA County's Drug Medi-Cal – Organized Delivery System Network Adequacy Certification Tool, 2024**