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 2024

Lisa H. Wong, Psy.D.
Director

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

Contents

Introduction

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

MISSION

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

VISION

- We envision a 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 oppurtunities at the right time, in the right place, and 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 significantly functionally disabled by a mental health disorder or where there is a reasonable probablility of significant deterioration in an important area of life functioning due to a diagnosed mental health disorder or a suspected mental health disorder not yet diagnosed. Criteria for individuals under the age of 21 include:
  - Those who are experiencing a condition placing the individual at high risk for a mental health disorder due to various conditions leading to trauma OR the individual has a significant impairment or a reasonable probability exists that significant deterioration in an important area of life functioning
  - AND the individual has a diagnosed mental health disorder or a suspected mental health disorder that has not yet been diagnosed.

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 Assessment and Performance Improvement (QAPI) Work Plan (WP) that contains goals and needs identified by triennial oversight reviews and the LACDMH system. The Department evaluates the QAPI WP annually and with the involvement of LACDMH staff, providers, and consumers/families. The QAPI evaluation report and WP reflect countywide partnerships and shared intentions to support individuals who meet criteria for Specialty Mental Health Services to heal, grow, and flourish.

At LACDMH, the Quality Improvement (QI) Unit facilitates the planning, design, and execution of the QAPI WP and publishes a summary of these activities annually. Upon request, a summary of prior QAPI activities and findings is available via the QI website at https://dmh.lacounty.gov/qid/.

Structure of Report

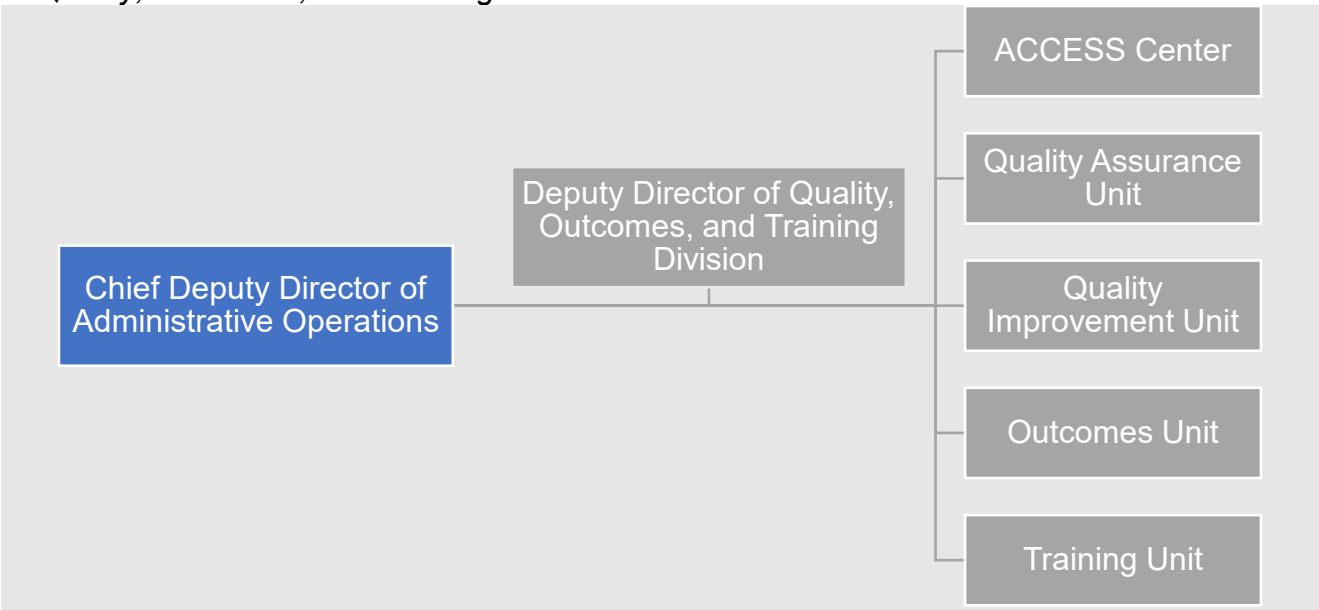
There are two sections in the following report. Section I provides a detailed overview of the QI Unit within the Quality, Outcomes, and Training Division. The QI Unit is responsible for reviewing the quality of SMHS provided to LACDMH consumers. This section describes the Unit's organizational structure and elements. Section II contains the Department's annual QAPI WP. This section details LACDMH's work plan goals for CY2024.

Section I. Organizational Structure of the Quality, Outcomes, and Training Division

The reorganization of LACDMH and State mandates on access and timeliness has offered multiple opportunities to highlight the value of QI practices in our collaborative work. The QI Unit has reporting responsibilities to the LACDMH Director, the Chief Deputy Director of Administrative Operations, and the Quality, Outcomes, and Training Division (QOTD; Figure 1). 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 SMHS providers countywide, the centralized, SA, and internal QI programs, Cultural Competency Unit, and LACDMH executive management.

Figure

1. *Quality, Outcomes, and Training Division*



Note: QOTD launched in January 2020.

Los Angeles County Department of Mental Health's ACCESS Center

LACDMH's ACCESS Center operates 24/7 and serves as the entry point for mental health services in Los Angeles County. While the majority of calls to the ACCESS Center are for information and referral, the line also facilitates the deployment of Field Intervention Teams, has a dedicated emotional support line, and serves as the gatekeeper for acute inpatient psychiatric beds, interpreter services, and emergency client transportation to psychiatric emergency rooms.

Quality Assurance Unit
The QA Unit ensures the adherence of the County MHP's 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 DHCS including during the DHCS Triennial System/Chart review and Short/Doyle Medi-Cal Hospital audits; 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.

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.

Training Unit
The Training Unit is responsible for workforce development, ensuring a diverse workforce reflective of the clients served, education, and providing training and technical assistance for the clinical and non-clinical public mental health workforce.

Quality Improvement Unit
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 clients. 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 client/family-focused and supports the Department's culture of CQI and total organizational involvement. QI and QA collaboration is a priority as QA focuses on testing and implementing State mandates. At LACDMH, the QA and QI Units maintain a collaborative approach to CQI work, including but not limited to efforts to improve access to our services.

Continuous Quality Improvement

CQI is a concept that incorporates quality assurance, problem resolution, and quality improvement. At LACDMH, CQI is the science of provisioning services to meet local, State, or Federal standards, engaging countywide programs and service providers in QI work; and coordinating improvement activities involving all LACDMH levels. The departmental QI Unit's design and implementation aim to ensure an organizational culture of continuous self-monitoring through practical strategies, best practices, and collaborative QI activities. The Department's annual QAPI serves as our primary tool for CQI.

Most Salient Quality Improvement Collaborations

The QAPI Work Plan fosters opportunities for input and active involvement of clients/families, licensed and paraprofessional LACDMH staff, contracted providers, and stakeholders. The Department's Quality Improvement Council (QI Council) is centralized with countywide representation and QA/QI liaisons who are heavily involved in providing oversight on QI efforts. Active and ongoing data-driven QI partnerships promote CQI efforts countywide through stakeholder engagement, Plan-Do-Study-Act (PDSA) cycles, and lessons learned.

Annual Test Calls Study

The Department's Annual Test Calls Study identifies potential areas for QI and strengths in the ACCESS Center's 24/7-line responsiveness. The LACDMH Test Calls Study supports the ACCESS Center and the QI Unit in their collaborative efforts to improve cultural and linguistic responsiveness, customer service, referrals to SMHS, tracking/monitoring, and adequate documentation of call information. ACCESS Center management and staff collaborate with the QA Unit, the QI Unit and QI Council on this project and disseminate findings.

Access to Care Leadership Committee

The Access to Care Leadership committee comprises 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 directly operated 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. Data is presented on access to care, compliance with administration of required outcome tools, number of symptom related tools administered for certain diagnoses, and claiming activities by discipline. 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).

California Advancing and Innovating Medi-Cal (CalAIM) Implementation

DHCS released a multilayer approach to simplifying and streamlining the Medi-Cal program, including county specialty mental health services, county social services eligibility functions, and initiatives focused on children, foster youth, and those currently experiencing homelessness or incarceration.

Chief Information Office Bureau (CIOB)

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

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

CIOB's Clinical Informatics team holds essential roles in both PIPs, from aggregating timeliness data on clients seeking routine, urgent, and follow-up appointments from outpatient providers or offering technical assistance to the clinical PIP lead tasked with analyzing client data within the EHR.

Cultural Competency Unit (CCU)

The Department's Ethnic Services Manager (ESM) oversees the CCU, provides technical assistance to the Cultural Competency Committee (CCC), and is a standing member of the Departmental QI Council. This structure facilitates communication and collaboration for attaining the goals outlined in the QAPI WP and 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/.

Office of Peer Services

The Office of Peer Services provides leadership and direction to the Department of Mental Health staff, programs and partner organizations in developing, implementing, and operating Peer Resource Centers and similar mental health assistance programs, ensuring consistent standards, policies, and performance. The Office of Peer Services functions as a subject matter expert on all issues relating to Peer advocacy, including strategic direction and governance for services, service development, planning performance, quality systems, and professional and workforce development for Peers in the DMH network, to ensure individuals of LA County have access to Peer-recovery support services in all

levels of care. The Chief of Peer Services is an instrumental member of the QI Council who is key to informing the Council on how peers are able to support QI activities such as Consumer Perception Surveys.

Health Access and Integration (HAI) Division

The Health Access and Integration Division support a variety of Mental Health Plan functions and special projects for the Department. To support the Mental Health Plan functions, there are teams dedicated to administrative and clinical support for inpatient and intensive outpatient services, specialized care coordination, and support for individual and group providers delivering outpatient specialty mental health services to the Medi-Cal population.

The HAI division also has a team dedicated to health plan operations to support coordination of care for the Medi-Cal Managed Care population and ensures the continuum of and access to care across behavioral health systems. HAI also has a team dedicated to special projects which includes implementation of CalAIM related initiatives for Justice involved population of focus. HAI works closely with QI on multiple improvement goals.

Performance Improvement Project (PIP) Teams

The Department conducts PIPs to review selected administrative and clinical processes designed to improve performance outcomes. The QI Unit engages and supports QI Council members in QI processes related to the QAPI WP, specific PIP activities, and other QI projects conducted at the SA level. The QI Unit collaborates and coordinates related QI activities with many Divisions, Programs, and Units within DMH. The QI Unit and the QA Unit, ACCESS Center, Access to Care Leadership committee, APEX, OSD, and the Outcomes Unit contribute to meaningful change in access to care and clinical outcomes for LACDMH beneficiaries. LACDMH strives for PIP teams that are diverse and inclusive. Each committee member participates on a volunteer basis due to special interests.

Quality Assurance

QA and QI collaboration is a priority as QA oversees the implementation of State mandates, and QI monitors the impact of change on client care and outcomes. The QA and QI Units co-facilitate the Centralized QA/QI Liaisons' broadcast monthly to integrate departmental QA goals alongside discussions of QI practices.

Stakeholder Engagement

The QI Council encourages stakeholder involvement in all QI activities. Recently, LACDMH QI engaged staff, providers, clients, and family members in a project to improve the Department's Consumer Perception Survey (CPS) data reports. Via in-person focus groups with Service Area Leadership Teams (SALTs) and a brief survey, stakeholders helped the QI Unit identify barriers to more user-friendly and accessible client satisfaction data. The QI Council will seek help from stakeholders to evaluate summarized data whenever possible and identify opportunities to design meaningful administrative or clinical improvement projects.

Summary

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 QAPI WP and Evaluation Report, client/family satisfaction data, PIPs, and collaborative efforts with other programs. The QI Unit also assists QA with adherence to prescribed site review protocols and timelines, such as those assigned during triennial oversight reviews and CalEQRO visits. QI staff must maintain up-to-date knowledge of QI concepts and provide technical assistance, consultation, and training for Departmental QI Council and SA Quality Improvement Committees (QICs), SALTs, 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.

Quality Improvement Council Charter

Statement of Purpose

The purpose of the QI Unit is to ensure and improve the quality and appropriateness of SMHS in conformance with established local, State, and Federal service standards. The Departmental QI Council and SA QICs provide opportunities to:

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

The QI Unit is responsible for maintaining and improving its service and delivery infrastructure with its providers.

Council Membership

LACDMH has tasked the Departmental QI Council with evaluating the appropriateness and quality of services provided to LACDMH clients/families. Council membership reflects the diverse perspectives of members from centralized administrative programs and provider locations countywide. The QI Council includes representatives from:

- Compliance, Privacy, and Audit Services;
- Clinical Policy and Standards;
- Clinical Risk Management;
- Anti Racism Diversity Inclusion (ARDI) Division/Cultural Competency Unit;
- Patient's Rights Office;
- LACDMH's Help Line;
- Office of Peer Services;
- Health Access and Integration Division (HAI);
- Quality Assurance Unit;
- Quality Improvement Unit; and
- DO and LE/Contracted programs.

Authority

A licensed mental health professional supervises the QI Unit and serves as the Departmental QI Council Chair. The QI Council Chair is responsible for chairing and facilitating meetings and ensuring members receive timely and relevant information. Each SA QIC has a Chair representing DO providers, and most have a Co-Chair representing the LE/Contracted providers.

Meetings

Providers are required to participate in their local SA QICs. Each SA convenes for a SA QIC meeting at least quarterly. The Departmental QI Council meets 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. The Chair/Co-Chairs for the council and committee meetings 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/sa/ for public review.

Responsibilities

The QI Council, 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, Beneficiary Satisfaction, Clinical Care, Continuity of Care, Provider Appeals, and PIPs). The QI Council collaborates and coordinates related QAPI WP activities with multiple DMH Divisions and programs. Besides providing QOTD and CCU updates, the monthly agendas may reflect performance and outcomes management discussions led by various partners and programs across the Department.

Summary

The QI Council charter further supports LACDMH in maintaining a culture of CQI. The QI Council and SA QICs foster the ideal environments to discuss QI activities, identify possible best practices, and maintain performance standards aligned with the Department's mission and DHCS contract. The CCU supervisor is a standing member of the QI Council and supports cultural competency integration into QI Unit roles and responsibilities.

Section II. Quality Improvement Work Plan, Calendar Year 2024

Date Last Revised: 5/1/2024

The 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 QAPI Work Plan activities for CY 2024 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 focusing on access to services, timeliness, and improved outcomes for all those we serve. The Department's QAPI Work Plan is organized into seven 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 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.

Table 1.
Summary of QAPI Work Plan Goals and Comparable Domain(s), Calendar Year 2024

Domain	No.	Goal
Service Delivery Capacity	Ia.	Analyze root causes in the underrepresentation of self-identified Asian Pacific Islanders, and Communities with Physical Disabilities receiving DMH services.
	Ib.	Increase the Department's capacity to deliver culture-specific services.
	Ic.	Implement standardized scheduling for all clinics to increase access to care and ability to monitor quality of care, yielding more efficient service delivery.
	Id.	Increase the visibility of Peer Services by enhancing the skills of Peer Workers and creating a meaningful career path.
Accessibility of Services	IIa.	Improve timely access to care.
	IIb.	Develop protocols for access to care monitoring.
Beneficiary Satisfaction	IIIa.	Evaluate Consumer Perception Survey (CPS) findings and develop data-driven improvement strategies at the Service-Area level.
	IIIb.	Monitor grievances, appeals, and requests for a Change of Provider.
Clinical Care	IVa.	Rollout Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist-35 (PSC-35) aggregate reporting to support children and youth program operations.
	IVb.	Create and implement standardized training and mentoring for new staff to increase clinician competencies, satisfaction, and retention.
	IVc.	Develop a mechanism to measure and track HEDIS Measures for Quality Performance Measures.
	IVd.	Roll out Level of Care Utilization System (LOCUS) as Adult Level of Care Tool.
	IVe.	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.
Continuity of Care	Va.	Develop a systemwide strategy to reduce 7- and 30-day rehospitalization rates.
	Vb.	Increase Bed Capacity in Subacute Facilities by Reducing Time to Step Clients Down into Lower Levels of Care.
Provider Appeals	VI.	Monitor Provider Appeals.
Performance Improvement Projects	VIIa.	Clinical PIP for CY 2024 will improve the rate of 30-day and same site rehospitalization for inpatient hospitalization discharges at two pilot hospitals.
	VIIb.	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.

Note: Reporting periods will vary by objective.

Monitoring Service Delivery Capacity, Calendar Year 2024

Service Equity

Goal Ia.	Analyze root causes in the underrepresentation of self-identified Asian Pacific Islanders, and Communities with Physical Disabilities receiving DMH services.
Objective(s)	1. Implement learning from participation in the Solano County Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) Learning Collaborative work with LACDMH stakeholders to develop a plan addressing barriers for engagement of Asian Pacific Islanders and communities with physical disabilities. • Utilize recommendations from the ICCTM project to prioritize funding of community capacity building projects. 2. Standardize data collection for persons with disabilities to be able to better assess level of participation in DMH services using new demographic data in IBHIS.
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 and Physical Disabilities 2. Penetration Rates for Medi-Cal Enrolled Beneficiaries by Race/Ethnicity 3. Development of standards for disability reporting for all mental health service providers that meet local, state, and federal requirements 4. Service Equity Analysis Report Findings
Frequency of Collection	Annually
Responsible Entity	Anti-Racism Diversity and Inclusion (ARDI) Division/ Cultural Competency Unit (CCU)

Delivering Culture-Specific Services

Goal Ib.	Increase the Department's capacity to deliver culture-specific services.
Objective(s)	1. Increase language access for Limited English Proficiency clients and family members by ensuring key informational materials are available in all threshold languages. 2. Increase response rate for assessing client satisfaction with American Sign Language (ASL) interpreter services by using new ASL Specialist to reach out to members who received services, identify areas for improvement, and review findings with providers.
Population	Los Angeles County's clients/families and deaf and hard of hearing clients and family members receiving outpatient SMHS in ASL from LACDMH DO and LE/Contracted providers and clients
Performance Indicator(s)	1. Assess which materials are needing additional translations and create a plan for completion and track progress 2. Show an increase in client perspective of satisfaction with ASL interpreter services to be combined with experience information from service provider requesting interpreter services
Frequency of Collection	Annually
Responsible Entity	ARDI/ CCU

Standardized Scheduling

Goal Ic.	Implement standardized scheduling for all clinics to increase access to care and ability to monitor quality of care, yielding more efficient service delivery.
Objective(s)	1. Standardize scheduling prioritizing psychiatric appointments and moving towards standardization of all disciplines to optimize accessibility of services and staff performing at highest level. 2. Front desk staff will have standardized appointments on set days for intakes, groups, and follow-up appointments which will reduce inconsistent scheduling practices. Meetings, times for consultation, and Officer of the Day will be blocked on schedules. 3. Create training and communication plan for staff on the new process and start dates.
Population	DO staff and clients/families receiving outpatient SMHS
Performance Indicator(s)	1. Number of Clinics and Psychiatrists set up for Standardized Scheduling 2. Meeting standard for first psychiatry appointments offered and urgent appointments
Frequency of Collection	Annually
Responsible Entity	Outpatient Care Services

Peer Services

Goal Id.	Increase the visibility of Peer Services by enhancing the skills of Peer Workers and creating a meaningful career path.
Objective(s)	1. Provide financial assistance for Peer Support Specialist certification. 2. Create a logic model for implementation of a Peer Support Specialist item for those who are certified. 3. Negotiate bonus in interim while Peer Specialist item is being created to differentiate skills from Community Health Workers. 4. Create a career ladder for peers. 5. Develop an internship program for those with lived experience as a pathway into employment as Peer Specialists. 6. Engage in a barrier analysis of why information on peer opportunities is not more well-known and use this information to create a system to increase information flow to ensure peers know of promotional opportunities, requirements, and how to apply. 7. Educate DMH Workforce on duties and value of Peer Support services.
Population	Peer Workforce, DO clients/families receiving outpatient SMHS
Performance Indicator(s)	1. Increase Medi-Cal certified Peer Support Specialists from 7-10% currently to 30% this year 2. Creating training materials for new clinicians on the role of peer services and ways peers can help advance service delivery goals
Frequency of Collection	Annually
Responsible Entity	Office of Peer Services

Monitoring Accessibility of Services, Calendar Year 2024

Timely Access to Services

Goal IIa.	Improve timely access to care.
Objective(s)	1. Continue regular monitoring of access to care for both directly operated (DO) and legal entity (LE) providers to ensure standards are being met. 2. Reduce outliers for routine appointments. 3. Improve access to care for hospital and urgent appointments through centralized scheduling.
Population	Any individual requesting outpatient SMHS from DMH as a client, potential client or on behalf of someone. This also includes 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)	1. Maintain 80% benchmark for routine appointments 2. Reduce range of days to appointment for routine appointments. 3. Expansion of centralized scheduling for hospital discharge planners and PMRT for urgent appointments.
Frequency of Collection	Quarterly
Responsible Entity	Quality Assurance (QA) Unit

Goal IIb.	Develop protocols for access to care monitoring.
Objective(s)	1. Establish data collection and monitoring processes for psychiatry for LE providers. 2. Establish data collection and monitoring processes for treatment services following assessment. 3. Review and revise existing processes for data collection and monitoring for psychiatry for DO providers. 4. Establish data collection and monitoring processes for providers who are not accepting new clients.
Population	Any individual requesting outpatient SMHS from DMH as a client, potential client or on behalf of someone. This also includes 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)	1. Having revised quarterly monitoring reports to gather data for psychiatry and treatment services. 2. Establishing workflows for data submission from LEs (psychiatry and treatment services). 3. Written protocols for monitoring process of providers not accepting new clients.
Frequency of Collection	Quarterly
Responsible Entity	QA Unit

Monitoring Beneficiary Satisfaction, Calendar Year 2024

Client/Family Satisfaction

Goal IIIa.	Evaluate Consumer Perception Survey (CPS) findings and develop data-driven improvement strategies at the Service-Area level.
Objective(s)	1. Review the data on different manners in which CPS surveys were collected. 2. Increase data collection of Sexual Orientation and Gender Identity (SOGI) related demographics to assess the quality and delivery of affirming care. 3. Continue to roll out a Power BI portal to evaluate and report out provider-level performance trends. 4. Monitor response rates and review the mechanism for tracking participation history and program types. 5. Pilot surveys being accessible in My Health 2.0. 6. Work with Peer Services Division on how to optimize client participation.
Population	DO and LE/Contracted clients/families receiving outpatient SMHS
Performance Indicator(s)	1. Number of returned surveys/respondents by CPS form and administration method 2. Percentage of demographic data collected vs Declined to Answer including SOGI and Race 3. Publication of Power BI report with accessible provider level reports 4. Increase in response rates and satisfaction ratings from year to year
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. • Implement new 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 CY 2024 2. COP requests by type in CY 2024
Frequency of Collection	Annually
Responsible Entity	Patient's Rights Office

Monitoring Clinical Care, Calendar Year 2024

Clinical Reporting

Goal IVa.	Rollout Child and Adolescent Needs and Strengths (CANS) 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. Develop program-level reports based on input from provider network. 3. Validate reports with a sample of providers. 4. Increase clinical utility training for supervisors and create training to expand to include line staff. 5. Implement pilot of using CANS as a Level of Care tool by working with clinicians to validate structured decision-making tool.
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. Finalized Level of Care structured decision-making tool utilizing the CANS
Frequency of Collection	Annually
Responsible Entity	Outcomes Unit, CIOB, and Outpatient Care Services

Mentorship Program

Goal IVb.	Create and implement standardized training and mentoring for new staff to increase clinician competencies, satisfaction, and retention.
Objective(s)	1. Create standardized training materials/videos for onboarding new staff including 'What is Community Mental Health' and 'Understanding Peer Services'. 2. Develop framework for mentorship program where clinicians receive support from more seasoned staff or supervisors to learn and demonstrate proficiency in certain areas such as assessment, concurrent documentation, and other elements of quality service provision before titrating up to a full caseload. 3. Survey new staff to find out what needs are and what needs to be tracked in terms of milestones. 4. Gauge new staff satisfaction and adjust support accordingly. 5. Commitment statement/ contract between clinician, supervisor, and manager to ensure consistent onboarding.
Population	DO and LE/Contracted clients/families receiving outpatient SMHS
Performance Indicator(s)	1. Staff Retention rates for new hires at 6 and 12 months 2. Time it takes new staff to achieve all checklist proficiencies 3. Staff Satisfaction Surveys
Frequency of Collection	Annually
Responsible Entity	Outpatient Care Services, Office of Peer Services

Healthcare Effectiveness Data and Information Set (HEDIS) Elements

Goal IVc.	Develop a mechanism to measure and track HEDIS Measures for Quality Performance Measures.
Objective(s)	1.Define measurement process for DMH to track progress on the following County MHP Priority Quality Measures: Follow Up After Emergency Department Visit for Mental Illness (FUM) Follow Up After Hospitalization for Mental Illness (FUH) Antidepressant Medication Management (AMM) Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) 2.Convene workgroups for any measures below Minimum Performance Level (MPL) to plan for interventions designed to improve performance.
Population	All Medi-Cal members that meet criteria to be included in any of these HEDIS measures
Performance Indicator(s)	1.Have regular reports to review and present findings to all levels of QI Process including upper management 2.Will achieve 50th percentile for all measures or an increase 5% over baseline year for any measure below MPL
Frequency of Collection	Quarterly
Responsible Entity	Clinical Pharmacy, QI, Health Access and Integration Division (HAI)

Level of Care

Goal IVd.	Roll out Level of Care Utilization System (LOCUS) as Adult Level of Care Tool.
Objective(s)	1. Develop training and communication plan for administering LOCUS and derived recommendation of adult Level of Care. 2. Fully define all DMH Levels of Care for adults and test fit with LOCUS recommended levels of care. 3. Work with contracted providers and CIOB to develop mechanisms for data collection and submission of results to DMH. 4. Start data collection for Directly Operated clinics utilizing Netsmart built tool for LOCUS.
Population	Adult clients receiving outpatient services
Performance Indicator(s)	1. Number of staff trained to administer LOCUS 2. Monitor progress of data collection readiness and needs for support 3. Evaluate early concordance rates with derived level of care from LOCUS with types and level of services clients receive
Frequency of Collection	Annually
Responsible Entity	Outpatient Care Services, Outcomes, QI, QA, CIOB, Clinical Informatics

Provider Level Improvement

Goal IVe.	**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.**
Objective(s)	1. Within one year, 35% of LACDMH contracted outpatient treatment providers will participate in the QA Knowledge Assessment Surveys. 2. Continue implementing and refining communication strategies with providers aimed at avoiding waste in claiming and service delivery practices in order to enhance countywide capacity. 3. Revise QA Review Process with the focus on the simplification of documentation requirements as emphasized by CalAIM.
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. Number and percent of providers attending QA information sessions and evidence of communication plan being implemented. 3. Compliance rates concerning required documentation (average compliance rate per item in CY 2024) 4. Qualitative data from providers on the effectiveness and efficiency of these processes.
Frequency of Collection	1. Collection of QA Knowledge Assessment Survey data three times a year 2. Annually conduct QA reviews of minimum of 100 LE/Contracted provider sites
Responsible Entity	Quality Assurance Unit

Goal Va.	Develop a systemwide strategy to reduce 7- and 30-day rehospitalization rates.
Objective(s)	1. Root cause analysis on 7- and 30-day rehospitalizations with help from clinical informatics. 2. Work with Managed Care Plans (MCP) to understand how they track rehospitalization rates and what they have implemented. 3. Continue with a committee to review data monthly. 4. Identify and implement at least one intervention targeting systemwide readmission rates. 5. Train hospital staff on connecting clients to services. 6. Data mining of demographics of clients who are being rehospitalized in 7- and 30-days. 7. Increase FSP referrals from hospitals. 8. Track data of clients going into subacute centers after hospitalizations. 9. Development of a Power BI dashboard to examine rates of rehospitalization and identify any patterns to address.
Population	LACDMH clients receiving outpatient SMHS
Performance Indicator(s)	1.Decrease in rates of rehospitalization at 7- and 30-day post-inpatient discharge 2.Modify implementation plan depending on data collected on population getting re-hospitalized within 7 and 30 days of discharge
Frequency of Collection	Monthly
Responsible Entity	HAI, Outpatient Services, Clinical Informatics, QI

Goal Vb.	Increase Bed Capacity in Subacute Facilities by Reducing Time to Step Clients Down into Lower Levels of Care.
Objective(s)	1.Increase access to community-based care 2.Improve successful transitions to the community
Population	Los Angeles County clients who are ready to transition into and out of IMD level of care.
Performance Indicator(s)	1.Reduced time from referral to enrollment in community-based services 2. Increased percentage of individuals engaged in services after being successfully discharged from IMD through this intervention process.
Frequency of Collection	Quarterly
Responsible Entity	HAI, MHSA

Monitoring Provider Appeals, Calendar Year 2024

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)	1.Number of Notice of Adverse Benefits Determinations (NOABDs) issued, including the percentage of upheld or overturned appeals
Frequency of Collection	Monthly
Responsible Entity	HAI

Monitoring Performance Improvement Projects, Calendar Year 2024

Goal VIIa.	Clinical PIP for CY 2024 will improve the rate of 30-day and same site rehospitalization for inpatient hospitalization discharges at two pilot hospitals.
Objective	1. Work collaboratively with pilot team/PIP committee. 2. Refer identified beneficiaries discharged from two inpatient hospitals back to their mental health provider or provide linkage to needed mental health services. 3. Participate in health information exchange (HIE) data between LACDMH and two pilot hospitals
Population	Beneficiaries that receive care from inpatient hospitals that are existing SMHS clients or potential clients
Performance Indicator(s)	1. Rate of 30-day rehospitalization of beneficiaries that are discharged from inpatient hospitalization 2. Rate of same-site rehospitalization of beneficiaries that are discharged from inpatient hospitalization 3. Number of Enhanced Care Management (ECM) referrals 4. Number of Full-Service Partnership referrals
Frequency of Collection	Quarterly
Responsible Entity	QI, HAI, CIOB

Goal VIIb.	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 Geriatric Evaluation Networks Encompassing Services Intervention Support (GENESIS) clients
Objective	1. Connect GENESIS program to Health Information Exchange (HIE) including ED encounter alerts or enrolled beneficiaries. 2. Connect identified beneficiaries in EDs back to their mental health provider or provide linkage to needed mental health services. 3. Develop workflows and procedures to address alerts of GENESIS client encounters at EDs.
Population	Beneficiaries that receive care from EDs that are existing SMHS clients or potential clients
Performance Indicator(s)	1. Access to real time data on clients served in EDs with mental health issues 2. Reduction in percentage of clients not receiving 7- and 30-day follow-up mental health care 3. Increased percentage of clients receiving more than one SMHS claim post ED visit
Frequency of Collection	Quarterly
Responsible Entity	QI, GENESIS, CIOB