LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
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Appendix A – Department of Mental Health (DMH) Quality Assessment and Performance Improvement (QAPI) Detailed Work Plan

Calendar Year 2025

Presented By:

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

Appendix A- DMH's Detailed Work Plan 2025

Monitoring Service Delivery Capacity

Service Equity

Goal 1a.	**Improve language accessibility for our members and community stakeholders.**
Objective(s)	1. Develop and implement Departmental Language Accessibility Plan (DLAP). 2. Increase stakeholder feedback regarding language accessibility. 3. Increase language access for limited English proficiency members and family members. 4. Assess member satisfaction with American Sign Language (ASL) interpreter services.
Population	Los Angeles County limited English proficiency and deaf and hard of hearing members and families who receive outpatient SMHS from LACDMH DO and LE/Contracted providers
Performance Indicator(s)	1. Develop report on Provider Language Capacity 2. Availability of language accessibility resources for Stakeholder Meeting 3. Action plan to track and monitor translation of materials 4. Rate of member satisfaction with ASL interpreter services
Frequency of Collection	Quarterly
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	Anti-Racism, Inclusion, Solidarity, and Empowerment (ARISE) Division/ Cultural Competency Unit (CCU), Program Manager I and III

Delivering Culture-Specific Services

Goal 1b.	Enhance mental health education and decrease stigma in Asian Pacific Islander, Latino, and LGBTQ+ communities.
Objective(s)	1. Utilize Underserved Cultural Communities (UsCC). 2. Utilize Promotores. 3. Increase education regarding hate crimes and mental health so community members can access services if needed.
Population	LACDMH and LE/Contracted members and stakeholders
Performance Indicator(s)	1. Number of community presentations per language for the UsCC capacity-building projects for LGBTQ+, Latino, and API (e.g. Spanish and API languages) 2. Incorporate hate crime information in new capacity-building projects to decrease stigma for the LGBTQ+, Latino, and API communities. 3. Create LGBTQ+ workshop modules for the United Mental Health Promoters program to increase community education and awareness around LGBTQ+ issues and reduce stigma and incidence of hate crimes 4. The number of presentations delivered by the Mental Health Promoters in Spanish and API languages to reduce stigma and incidence of hate crimes
Frequency of Collection	Annually
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	ARISE/ UsCC/ United Mental Health Promoters, Program Manager III and Supervising Psychologist

Peer Services

Goal 1c.	Educate DMH workforce on Peer Services and provide training to peer workforce to improve quality and quantity of services provided.
Objective(s)	1. Increase rate of members who receive at least one peer support service by increasing the number of Peer Support Specialists. 2. Provide financial assistance for Peer Support Specialist certification to 80 Peers. 3. Expand career ladder for peers. 4. Develop quality review plan with Quality Assurance unit for peer services. 5. Create member satisfaction survey for those who received peer support services. 6. Develop Peer Services 101 as a requirement for DMH DO employees and a training conference for DMH Peers. 7. Require Supervision of Peer Workers training for supervisors of peers. 8. Work with Training Unit to host peer specific trainings 10 months out of the year. 9. Create group supervision for those who supervise CHW and peers with Chief of Peer Services. 10. Start Peer Network facilitated by Peer Services for professional development.
Population	Peer Workforce, DO members/families receiving outpatient SMHS
Performance Indicator(s)	1. Rate of members who receive at least one Peer Support Service 2. Number of Peer Support Specialists who receive financial support for certification 3. Rate of Peers who attend at least one training from their suggested curriculum
Frequency of Collection	Quarterly
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	Office of Peer Services, Chief of Peer Services

Monitoring Member Satisfaction

Goal 2a.	Evaluate Consumer Perception Survey (CPS) findings to identify areas of improvement in our system of care.
Objective(s)	1. Increase provider participation by identifying providers who have had no or low rates of submitted surveys and offering technical support. 2. Increase member participation by utilizing strategies such as expanding MyHealthPointe pilot and working with Peer Services. 3. Identify ways to increase community knowledge of the CPS by working with the Public Information Office (PIO). 4. Continue to roll out a Power BI dashboard to evaluate survey findings and report provider-level performance trends. 5. Identify systemwide areas of improvement and report to responsible units to create interventions.
Population	DO and LE/Contracted members/families receiving outpatient SMHS
Performance Indicator(s)	1. Rate of provider participation over a three-year trend 2. Rate of returned surveys over a three-year trend 3. Publication of Power BI report with accessible provider level reports 4. Publication of Provider Level Reports with domain ratings
Frequency of Collection	Annually
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	QI Unit Clinical Psychologist II

Member Grievances, Appeals, and Change of Provider Requests

Goal 2b.	Monitor grievances, appeals, and requests for a Change of Provider (COP).
Objective(s)	1. Review the nature of complaints, resolutions, and COP requests for significant trends that may warrant policy recommendations or system-level improvement strategies. 2. Utilize data captured in COP application to identify practitioners or facilities who continuously receive COP requests. 3. Create PowerBI Dashboard to visualize trends in data.
Population	Los Angeles County residents engaging in DMH services [outpatient, inpatient, Fee for Service (FFS)]
Performance Indicator(s)	1. Total member complaints and resolutions by type in Calendar Year 2025 2. COP requests by type in Calendar Year 2025
Frequency of Collection	Annually
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	Patient's Rights Office, Mental Health Program Manager I

Monitoring Clinical Care

Clinical Reporting

Goal 3a.	Publishing data reports for DMH internal use and Legal Entity providers.
Objective(s)	1. Validate Full-Service Partnership (FSP) Outcome Measures Application (OMA) reports on data quality, introduce row level security for providers to be able to access their data and only their data, and test security with providers. 2. Recommend improvements to existing FSP OMA reports and work with developers to implement the changes. 3. Work with staff and CIOB to create a new FSP OMA error report to evaluate if errors are being fixed. 4. Finalize CANS client level report with CIOB and release to production environment for legal entity and DO programs.
Population	All members receiving FSP and or EPSDT services
Performance Indicator(s)	1. Number of published reports 2. Monitor use and need for support 3. Completion of FSP OMA Error Report
Frequency of Collection	Annually
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	Outcomes Unit, Program Manager II and III

Goal 3b.	Implement changes to Care Court data reporting requirements.
Objective(s)	1. Review Senate Bills 1400 and 42 and DHCS CARE draft revised data dictionary to understand new reporting requirements for Care Court and develop and plan for implementing requirements. 2. Identify data source for every new required data element for Care Court and work with CIOB on revisions to data collection forms and revisions to data extract file for transfer of data to DHCS. 3. Review data file for errors and make initial submission for revised data elements. 4. Correct any errors with revised data submission process, ensure there is a process in place for monitoring ongoing submission of care court data. 5. Complete next successful submission of revised data to DHCS.
Population	Adult members that are part of Care Court
Performance Indicator(s)	1. Number of completed monthly assessments 2. Errors corrected and fewer errors over time
Frequency of Collection	Monthly
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	Outcomes Unit, Program Manager II and III

Customer Service

Goal 3c.	Develop robust Customer Service systemwide.
Objective(s)	1. Support members by offering flexible scheduling including evening and weekend appointments. 2. Encourage providers to have all staff in clinics trained in customer service skills annually. 3. Clinics to provide services predominately in person unless client's request telehealth options.
Population	DO and LE/Contracted members/families receiving outpatient SMHS
Performance Indicator(s)	1. Number of providers who provide evening hours at least 2 times a week 2. Rate of in-person vs telehealth services 3. Consumer feedback on Consumer Perception Surveys open-ended comments
Frequency of Collection	Annually
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	Outpatient Care Services Deputies and Senior Deputy

Healthcare Effectiveness Data and Information Set (HEDIS) Elements

Goal 3d.	Continue to further develop a mechanism to measure and track HEDIS Measures.
Objective(s)	1. Define measurement process for DMH to track progress on the following County MHP Priority Performance 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) • Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (ADD) • Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) 2. Create Power BI Dashboard that tracks HEDIS measures related to medication and laboratory monitoring. 3. Collaborate with Managed Care Plans (MCPs) on data exchange for a more comprehensive data set. 4. 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 the above HEDIS measures
Performance Indicator(s)	1. Meet MPLs set by DHCS or achieve at least a 5Percent increase over the year prior's baseline for any particular measure 2. Reports produced to demonstrate HEDIS Measure performance
Frequency of Collection	Quarterly
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	CIOB Clinical Informatics Supervising Psychologist, Clinical Pharmacy, Pharmacy Services Chief III

Level of Care

Goal 3e.	Continue the roll out of Level of Care Utilization System (LOCUS) as Adult Level of Care Tool.
Objective(s)	1. Continue the LOCUS Workgroup for Pilot providers. 2. Continue to work with contracted providers and CIOB to develop mechanisms for data collection and submission of results. 3. Review data collected by Directly Operated clinics utilizing Netsmart built tool for LOCUS.
Population	Adult members 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 members receive
Frequency of Collection	Annually
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	Outcomes Unit Program Manager II and III

Goal 3f.	Evaluation of the Quality Improvement Program.
Objective	1. Develop and deliver a survey to evaluate satisfaction with the QI Unit's processes and support to providers and other departmental units. 2. Review and analyze provider feedback survey regarding support during CPS. 3. Continue to integrate QI administrative processes with SAPC.
Population	DMH staff and DO/LE Providers
Performance Indicator(s)	1. Rate of satisfaction of Countywide QIC, Regional QIC, QI website, and support from QI Unit 2. Rate of satisfaction with CPS support 3. Integrated Work Plan, QAPI, and planning to integrate QIC
Frequency of Collection	Annually
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	QI Unit Program Manager I

Monitoring Continuity of Care

Goal 4a.	Develop a systemwide strategy to reduce 7 and 30-day rehospitalization rates.
Objective(s)	1. Develop root cause analysis on 30-day and 12-month rehospitalizations with input from Clinical Informatics and other Subject Matter Experts (SME) to identify barriers and possible solutions that will inform Phase 3 Pilot Program interventions. 2. Establish a baseline data set including but not limited to demographics of clients who are being rehospitalized in 7 or 30-days after last discharge. 3. Research how other Mental Health Plans (MHP)/Managed Care Plans (MCP) address and track rehospitalization rates. 4. Identify key areas that have the highest impact on rehospitalization (e.g., supporting transitions of care) that will inform options for a system-wide intervention. 5. Using root cause analysis, identify and design one intervention targeting systemwide readmission rates.
Population	LACDMH members who are high utilizers of hospitals defined as those who are rehospitalized at 7 and 30 days after last discharge.
Performance Indicator(s)	1. Develop at least 3 intervention options based on completed root cause analysis
Frequency of Collection	Monthly
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	HAI-Managed Care Operations (MCO) Program Implementation Manager, Clinical Informatics, Supervising Psychologist

Goal 4b.	Develop Behavioral Health Transformation (BHT) Integrated Plan Needs Assessment for Los Angeles County.
Objective	1. Internally agree upon data sets needed and narrative in Service Equity Report. 2. Clarify the roles/responsibilities of MHP, MCPs, Local Health Jurisdictions (LHJs), and SAPC in serving Los Angeles County population. 3. Review needs assessments from SAPC, LHJs, and MCPs in Los Angeles County. 4. Utilize Advisory Committee to update data needed in Portrait of Los Angeles as basis for Integrated Needs Assessment. 5. Collaborate with MCPs, SAPC, and LHJs to work towards having one needs assessment for Los Angeles County to be implemented in 2028.
Population	Los Angeles County Population in Need of Behavioral Health Services
Performance Indicator(s)	1. Produce Service Equity Report 2. Outline steps needed to integrate Los Angeles County Needs Assessment including a list of agreed upon data sets to be included and plan developed to share data between entities.
Frequency of Collection	Annually
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	MHSA Program Manager III, QI Program Manager III and I

Monitoring Provider Appeals

Goal 5.	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 by December 2025. The final hospitals that will be brought on to concurrent authorization are pending enhancements to the data management platform. 3. Identify trends in provider appeals and identify interventions to support provider improvements that will reduce the number of Notice of Adverse Benefits Determinations (NOABDs).
Population	LACDMH members 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. The number of Notice of Adverse Benefits Determinations (NOABDs) issued and the percentage of appeals upheld or overturned
Frequency of Collection	Monthly
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	HAI Treatment Authorization Requests (TAR) Unit, Program Implementation Manager

Monitoring Performance Improvement Projects

Goal 6a.	Clinical PIP for CY 2025 will aim to improve the Follow-up After Emergency Department Visit for Mental Illness (FUM) measurement rate.
Objective	1. Analyze demographic data of clients utilizing emergency departments for mental illness. 2. Conduct barrier analysis. 3. Identify and work collaboratively with PIP committee members. 4. Exchange data with Managed Care Plans (MCPs) for more accurate denominator and coordination of services to increase follow-up and reduce recidivism.
Population	Members age 6+ who visit an emergency department for mental illness or intentional self-harm.
Performance Indicator(s)	1. Analysis of FUM Demographic data 2. Outline barriers to follow-up after emergency department visits 3. Develop interventions for Clinical PIP 4. 7 and 30-day FUM rate for CY 2025 to be used as Baseline data for PIP Submission due in 2026
Frequency of Collection	Quarterly
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	Quality Improvement Psychologist II, Clinical Informatics, Supervising Psychologist

Monitoring Performance Improvement Projects & Accessibility Of Services

Goal 6b.	**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.**
Objective	1. Create workgroup of providers that are untimely and assist providers in implementing 1-2 interventions to target improvement of timeliness rates. 2. Utilize Fee for Service Providers to improve timely access to first offered appointments. 3. Develop an automated process for tracking & monitoring child providers who are not accepting new clients for general outpatient care services and Prevention and Early Intervention (PEI).
Population	Children accessing SMHS through DO and LE/Contracted providers
Performance Indicator(s)	1. Number of Child non-psychiatry routine appointments within 10 business days
Frequency of Collection	Quarterly
Measurement Year	Calendar Year 2025
Outcome Due Date	June 2026
Responsible Entity	Quality Assurance, Program Manager II and Quality Improvement Clinical Psychologist II