Quality Assessment and Performance Improvement (QAPI) Work Plan January 2026- June 2027

March 2026

Presented By:

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

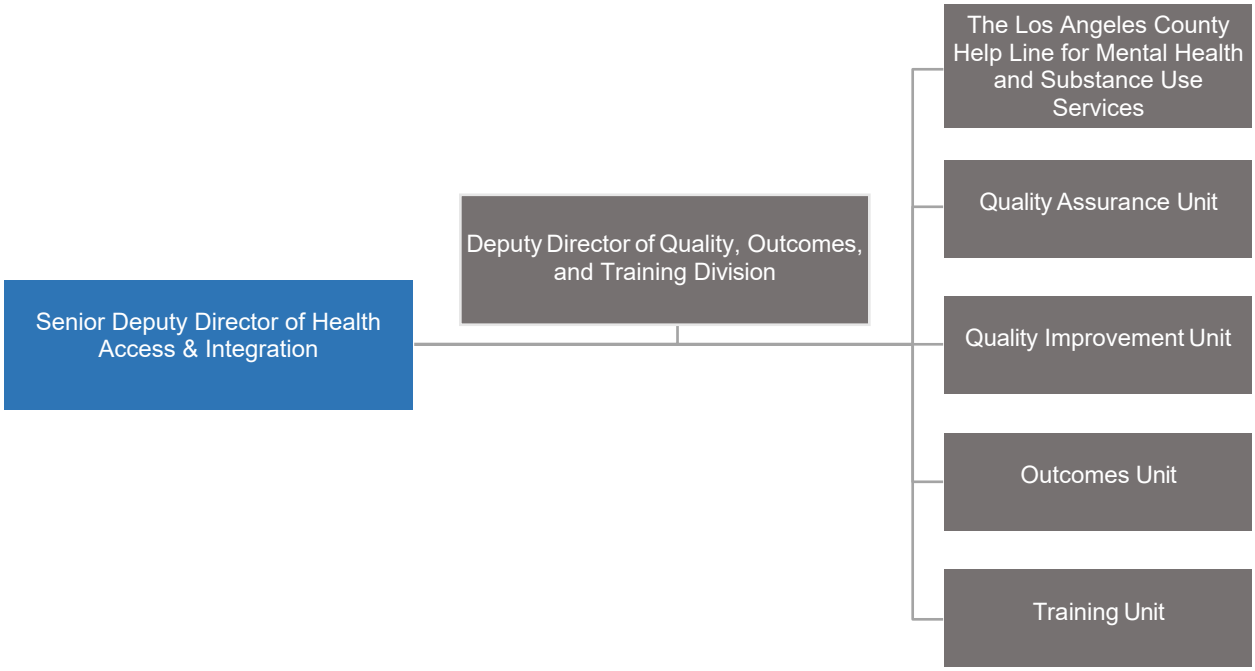
Los Angeles County Department of Public Health
Substance Abuse Prevention and Control, Quality Improvement Branch

CONTENTS

QUALITY IMPROVEMENT (QI) PROGRAM PURPOSE AND SCOPE

Department of Mental Health

Under the leadership of the Senior Deputy Director of Health Access and Integration, the Deputy Director of Quality, Outcomes, and Training Division (QOTD) oversees the units responsible for assessing accessibility of services, assessing member satisfaction, establishing qualitative measures to assess performance, identifying areas in need of improvement, and overall monitoring of the quality of the Department's services in conformance with Federal, State, and local QI requirements. These units include Quality Assurance (QA), Quality Improvement, Outcomes, Training, and The Los Angeles County Help Line. QOTD's organizational structure facilitates a downward and upward communication loop between Specialty Mental Health Services (SMHS) providers countywide, various units within the department responsible for monitoring performance throughout the operations of the Los Angeles County Department of Mental Health (LACDMH), and 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; and advocates for the MHP's position on SMHS-related issues with DHCS, the County Behavioral Health Director's Association (CBHDA), and other entities. The QA Unit ensures adherence to prescribed site review protocols and timelines, such as those assigned during triennial oversight reviews and External Quality Review Organization (EQRO) audits. In addition, the QA Unit is 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. The QA unit is responsible for the Department's Annual Test Calls to identify areas in need of improvement with regards to cultural and linguistic responsiveness, customer service, referrals to SMHS, tracking/monitoring, and appropriate documentation of call information. They are also responsible for Medi-Cal certification of sites, LPS designation and State Fair Hearings. For more information visit: https://dmh.lacounty.gov/qa/

Quality Improvement Unit

The QI Unit in conformance with Federal, State, and local QI requirements oversees technical reporting related to the annual Quality Assurance and Performance Improvement (QAPI) Work Plan and Evaluation Report, coordinates efforts to assess member/family satisfaction by implementing the annual Consumer Perception Surveys (CPS) and evaluates and reports member/family satisfaction data. The QI unit is responsible for the state-mandated Performance Improvement Projects (PIPs) and their validation during External Quality Review (EQR) audits. PIP committee members are chosen by the QI Unit who have relevant experience and/or expertise with the PIP topic to ensure that improvement plans and strategies are well informed and that improvement efforts are coordinated. The QI Unit is also responsible for coordinating the Quality Improvement Committee (QIC) meetings, evaluating the population of consumers served and the services delivered to identify areas in need of improvement, and coordinate with other departmental units to develop quality improvement plans and strategies to address these areas. Additionally, the QI unit provides technical assistance, consultation, and training around the professional use of QI practices and strategies to promote a culture of Continuous Quality Improvement (CQI) and to support QI efforts where they occur. 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/

Additional Units and Divisions Outside of QOTD

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. They are also tasked with calculating LACDMH's Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Cultural Competency Unit (CCU)

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/.

Patient's Rights' Office (PRO)

The Patient's Rights Office is responsible for investigating and responding to grievances and complaints about inpatient and outpatient mental health services. They review the data from member grievances, appeals, and expedited appeals. PRO also manages all Change of Provider (COP) requests and Senate Bill (SB) 929 data. For more information visit: https://dmh.lacounty.gov/our-services/patients-rights/

Office of the Chief Medical Officer

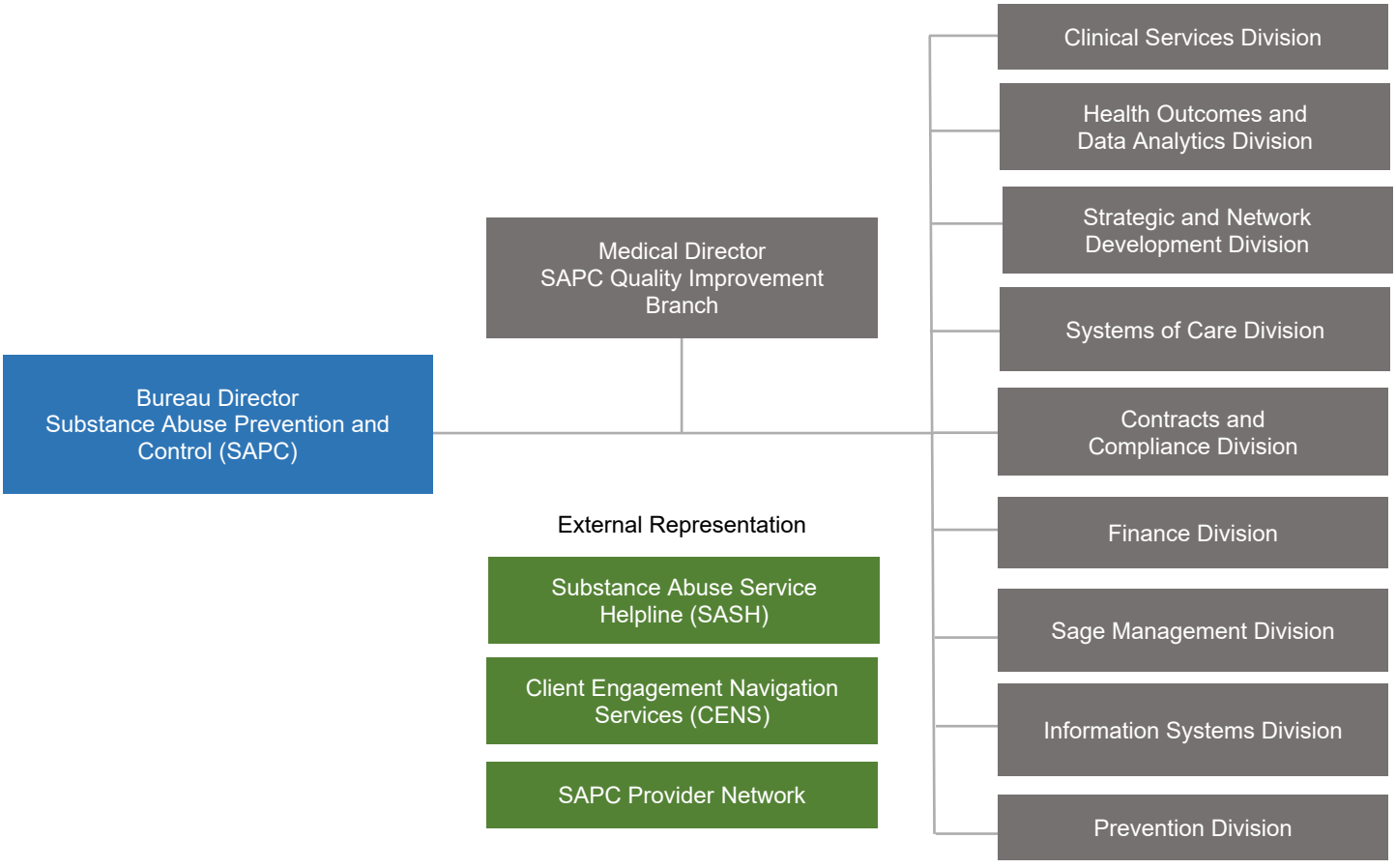
The Office of the Chief Medical Officer is responsible for ensuring practice guidelines/ parameters are based on valid and reliable clinical evidence or a consensus of health care professionals in the field, consider the needs of our members, are adopted in consultation with network providers, and are reviewed every two years and updated as appropriate. They also monitor the safety and effectiveness of medication practices and oversee the Clinical Risk Management Unit.

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

Behavioral Health Administrative Integration QI Steering Committee

Statement of Purpose

The purpose of the Behavioral Health Administrative Integration (BHAI) QI Steering Committee is for both LACDMH and LACDPH SAPC to coordinate efforts to improve service delivery for members in need of SMHS and SUD services in Los Angeles with special attention to members with co-occurring needs.

Committee Membership

LACDMH:

- QOTD Deputy
- QA Unit
- QI Unit
- Clinical Informatics

LACDPH SAPC:

- QI Branch
- Health Outcomes and Data Analytics Division

Department of Mental Health

Quality Improvement Committee (QIC) - Statement of Purpose

The purpose of the QIC is to monitor the appropriateness and quality of services provided to LACDMH members with the aim of improving the processes of providing care and better meeting the needs of our members. The QIC is a central part of LACDMH's Quality Assessment and Performance Improvement Program and shall recommend policy decisions; review and evaluate the results of QI activities, including PIPs; institute needed QI actions; ensure follow-up of QI processes; and document QAPI Committee meeting minutes regarding decisions and actions taken. LACDMH holds two types of QIC meetings, the Countywide QIC meeting and the Regional QIC meeting. In addition, there are various other meetings focused on quality improvement activities and efforts. Those meetings will be described in further detail below. The Countywide and Regional QIC meetings provide opportunities to:

- Review and evaluate data;
- Identify QI issues and projects;
- 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.

Countywide QIC

The Countywide (CW) QIC meetings occur on a monthly basis and are led by the QI Unit, which is responsible for reviewing service delivery and quality of care data, evaluating the results of QI activities including QAPI WP goals, recommending system improvements, and recommending policy changes. Effective by the end of the first quarter of 2026, the CW QIC will be subsumed by the QAPI Leadership Committee (renamed from Access to Care Leadership Committee as described below).

Committee Membership

LACDMH Quality Improvement Committee membership reflects the diverse perspectives of members from administrative programs and providers from throughout the county. SAPC began attending DMH CW QIC meetings last year in efforts to integrate QI endeavors and ensure quality improvement activities around members with co-occurring substance use disorders are addressed. The Cultural Competency Unit supervisor is a standing member of the QIC which supports integration of cultural competency goals and quality improvement efforts such as reducing disparities and improving the quality and availability of culturally responsive and linguistically appropriate services throughout the county. The QIC membership includes representatives from:

- Child Welfare
- Clinical Informatics
- Clinical Risk Management
- Compliance, Privacy, and Audit Services
- Contracts, Management and Monitoring Division
- Cultural Competency Unit
- Emergency Outreach and Triage Division
- Forensic Services
- Managed Care Operations
- Managed Plan Operations
- 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
- Training

Authority

A licensed mental health professional supervises the QI Unit and serves as the Departmental CW QIC Chair. The QIC Chair is responsible for chairing and facilitating meetings and ensuring members receive timely and relevant information.

Regional QIC Meetings

Regional QIC meetings are convened on a quarterly basis. The Northern Regional QIC encompasses Service Areas 1-4 and Southern Regional QIC has members from Service Areas 5-8. QI Unit staff co-lead the meetings along with a SA Lead. LACDMH providers are required to identify a QI staff from their agency or clinic to attend and participate in Regional QIC meetings. Many of the staff in attendance are also practitioners within their clinics. The Regional QIC includes sharing data on quality improvement efforts such as the PIPs, CPS, and WP goals and solicitation of QIC members' input/feedback to improve our system of care. Each committee meeting provides a structured forum for identifying QI opportunities to address challenges and barriers unique to their respective SA or region. Providers are asked to share quality improvement projects in their SAs or clinics. This approach fosters integrative discussions of departmental QA goals in concert with QI practices. Meeting minutes and recordings (when applicable) are posted online at https://dmh.lacounty.gov/qid/ for public review.

Additional QAPI Committees and Meetings

Access to Care Leadership Committee (will be renamed QAPI Leadership Committee)

The Access to Care Leadership committee is comprised of core managers from various sectors of LACDMH's 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 with the goal of improving overall access to care. 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 reviewing service and outcome data and gaining leadership recommendations and direction on performance improvement. The group meets twice monthly to address access and timeliness performance across Specialty Mental Health. In March 2026 it will be broadened to include metrics the MHP is responsible for reporting on and achieving.

Access to Care Action Committee (will be renamed QAPI Action Committee)

This committee meets every other month and is inclusive of network providers who work jointly with DMH leadership to identify strategies to improve performance on timely access to care and follow up access to care, network adequacy and system capacity. This committee provides valuable input into developing adult and child levels of outpatient care and has been a partner in mapping CANS data to child levels of care and LOCUS implementation for adult clients.

Stakeholder Engagement

The QICs encourage 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.

All Programs of Excellence (APEX)

APEX is a forum that brings together supervisors, managers, and multiple divisions to address areas of the Outpatient Care Services (OCS) Performance Dashboard indicators where improvement is needed. OCS organizes APEX meetings by SA and program. Types of services provided, number of new assessments completed, active and inactive clients, hospitalization and 30 day rehospitalization rates, access to care rates, service location (telehealth, telephone, or in person), overdue UMDAPs, denied claims reasons, mental health diagnoses and co-occurring SUD diagnoses, percent of clients with SUD diagnosis who receive Medication Assisted Treatment (MAT) services, Child and Adolescent Needs and Strengths (CANS), Level of Care Utilization System (LOCUS), Patient Health Questionnaire-9 (PHQ-9), General Anxiety Disorder-7 (GAD-7), Needs Evaluation Tool (NET), and housing status data are provided at each session by month. 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).

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 results 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 WORKPLAN

Department of Mental Health

DMH reviews metrics for the following areas for improvement opportunities at least quarterly:

- Timeliness of first initial contact to face-to-face appointment or synchronous video or audio-only interaction, consistent with BHIN 23-018 or any subsequent Departmental guidance.
- Frequency of follow-up appointments.
- Access to after-hours care.
- Responsiveness of the member access line.
- Strategies to reduce avoidable hospitalizations.
- Coordination of physical, mental health, and SUD services at the provider level.
- Assessment of the members' experiences.
- Telephone access line and services in the prevalent non-English languages.
- Member grievances, appeals, expedited appeals, State Hearings, expedited State Hearings, provider appeals, and clinical records reviews as required by 9 C.C.R. section 1810.440(a)(5) and 42 C.F.R. section 438.416(a) and our Contract.
- Evidence that QI activities, including PIPs, have contributed to meaningful improvement in clinical care and member service.

DMH's QAPI Work Plan for 2026- 27 is organized into six significant domains: Service Delivery Capacity, Member Satisfaction, Clinical Care, Continuity of Care, Accessibility of Services and Performance Improvement Projects. Each domain is designed to address service needs and service quality. Work Plan goals are identified based on feedback from Triennial audits, External Quality Reviews, member satisfaction data, quality metrics, and other reports indicating areas needing improvement. For 2026-27, Accessibility of Services is the focus of the Non-clinical Performance Improvement Project.

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 2026- 27 is available in Appendix A.

DMH's Work Plan 2026- 27

NO.	DOMAIN	GOAL
1A.	Service Delivery Capacity	Improve language accessibility for our members and community stakeholders.
1B.	Service Delivery Capacity	80% or more of ACCESS mental health-related calls are answered within 1 minute or less, measured monthly.
2A.	Member Satisfaction	Increase Social Connectedness and Perception of Functioning domain scores for Adult Consumer Perception Surveys (CPS) to 80%.
2B.	Member Satisfaction	Increase the number of Consumer Perception Surveys received by 5% from prior year.
2C.	Member Satisfaction	Monitor grievances, appeals and requests for a Change of Provider (COP) to identify areas of improvement in our system.
3A.	Clinical Care	100% of adult outpatient Specialty Mental Health providers will utilize the LOCUS as directed in QA Bulletin 24-09R as a clinical decision aid to identify service frequency and intensity.
3B.	Clinical Care	Meet or exceed Minimum Performance Levels set by DHCS for key Healthcare Effectiveness Data and Information Set (HEDIS) measures.
3C.	Clinical Care	Evaluation of the Quality Assurance and Performance Improvement (QAPI) Program.
4A.	Continuity of Care	Reduce Adult 7 and 30-day rehospitalization rates.
4B.	Continuity of Care	Develop Population Health Management (PHM) Strategy and Evaluate PHM Plan.
5.	Accessibility of Services	Ensure 100% of Psychiatry Data is Captured to Calculate Timeliness of Urgent and Routine Psychiatry Appointments for Members 0-20 and 21+.
6A.	Performance Improvement Projects	Clinical PIP for 2026- 27 will continue to aim to improve the Follow-up After Emergency Department Visit for Mental Illness (FUM) 30-day measurement rate.
6B.	Performance Improvement Projects & Accessibility of Services	Non-clinical PIP for 2026- 27 will continue to 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.

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 QI Work Plan for 2026- 27 and updated QI Program Goals and Objectives to describe our plan to assess 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 SAPC in accordance with priority metrics.

We specifically align the QI Program metrics to accord with the DMC-ODS STCs and DHCS BHIN 24-001, as described above, and will review and update these metrics with subsequent revisions to 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.

SAPC's QI Branch collaborates with the Contracts and Compliance Division to process grievances and appeals in accordance with SAPC policies and procedures related to processing grievances, including those described within current version of the SAPC provider manual, and with all applicable state policies.

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.

SAPC's QI Branch further conducts a twice-a-year review of a sample of patient charts from the contracted provider network to review the following additional documentation metrics for CY 2026- 27:

- Percent of charts reviewed with late documentation (in accordance with BHIN 23-068)
- Percent of charts reviewed where there was missing documentation of LPHA involvement and review of Problem List or Treatment Plan.
- Percent of admissions where service hours did not align with the provided level of care.
- Percent of admissions where there was lack of alignment between ASAM Assessment and the documented plan of care.

- Percent of admissions where we identified the providers did not refer to appropriate mental health, physical health, housing, legal (DCFS, Court, Probation, etc.)
- Percent of admissions where there was not adequate discharge planning.
- Percent of care coordination notes that did not describe appropriate care coordination services.
- Percent of admissions where appropriate release of information documentation was missing.
- Percent of admissions for withdrawal management where medications for withdrawal during the treatment episode were documented
- Percent of admissions where provider agencies document that they prevented or discouraged the patient from accessing medications for addiction treatment.
- Percent of admissions for patients with opioid use disorder where medications for opioid use disorder were discussed and offered.
- Percent of admissions for patients with opioid use disorder where medications for opioid use disorder were provided, directly or through referral.
- Percent of admissions for patients with alcohol use disorder where medications for alcohol use disorder were discussed and offered.
- Percent of admissions for patients with alcohol use disorder where medications for alcohol use disorder were provided, directly or through referral.
- Percent of admissions for patients with tobacco use disorder where medications for alcohol use disorder were discussed and offered.
- Percent of admissions for patients with tobacco use disorder where medications for alcohol 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 SAPC's monitoring of our provider agencies to inform the application of appropriate corrective action plans. SAPC's recoupment is limited to instances where there was evidence of fraud waste and/or abuse. For instances of documentation noncompliance, 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 SAPC QI Branch, along with the existing SAPC Quality Improvement & Risk Management (QI/RM) Committee, will continue to update and revise the SAPC QI Work Plan throughout 2026- 27.