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

Reporting Period January 2026- June 2027

Presented By:

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

Monitoring Service Delivery Capacity

Service Equity

Goal 1a.	Improve language accessibility for our members and community stakeholders.
Objective(s)	1. Update Departmental Language Accessibility Plan (DLAP). 2. Administer Needs Assessment survey around language accessibility needs amid staff and stakeholders. 3. Continue to assess member satisfaction with American Sign Language (ASL) interpreter services. 4. Increase language access for languages other than English members and family members including ASL.
Population	Los Angeles County members and families who receive outpatient SMHS from LACDMH DO and LE/Contracted providers who speak languages other than English and those who are deaf or hard of hearing
Performance Indicator(s)	1. Report on Provider Language Capacity 2. Report on findings from language Needs Assessment 3. Rate of member satisfaction with ASL interpreter services 4. Number of language accessibility resources from prior year to present
Frequency of Collection	Quarterly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Anti-Racism, Inclusion, Solidarity, and Empowerment (ARISE) Division/ Cultural Competency Unit (CCU), Program Manager III and Health Program Analyst III

Goal 1b.	80% or more of ACCESS mental health-related calls are answered within 1 minute or less, measured monthly.
Objective(s)	1. Staffing & scheduling (work closely with Workforce Management- WFM): a. Hire all vacant positions b. Analyze call volume data to create optimized schedules 2. Call workflow Improvements: a. Upload quick reference guides for common questions into Agent Assist 3. Accountability & Monitoring: a. Analyze call metrics daily to determine barriers b. Monitor the Verizon Contact Center (VCC) during peak hours to adjust skill sets c. Evaluate staff performance by utilizing weekly team performance reports
Population	All Los Angeles County Residents
Performance Indicator(s)	1. Percent of vacancies filled 2. Percent of calls answered within 60 seconds 3. Average speed of calls answered
Frequency of Collection	Monthly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	ACCESS Program Manager IIs

Monitoring Member Satisfaction

Goal 2a.	Increase Social Connectedness and Perception of Functioning domain scores for Adult Consumer Perceptions Surveys (CPS) to 80%.
Objective(s)	1. QAPI Leadership Committee and Regional QICs will identify key drivers and interventions to increase satisfaction for Adults in Social Connectedness and Perception of Functioning domains.
Population	DO and LE/Contracted members/families receiving outpatient SMHS
Performance Indicator(s)	1. Satisfaction rates in Social Connectedness and Perception of Functioning domains for Adults
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	QI Unit Supervising Psychologist

Goal 2b.	Increase the number of total Consumer Perception Surveys received by 5% from prior year.
Objective(s)	1. Increase provider participation by identifying providers who did not submit any surveys during the 2025 CPS survey period and offer technical support. 2. Work with DO and LE providers as well as TAY Division and Peer Services to identify interventions to increase participation.
Population	DO and LE/Contracted members/families receiving outpatient SMHS
Performance Indicator(s)	1. Rate of provider participation 2. Rate of participation in survey by age groups
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	QI Unit Supervising Psychologist

Member Grievances, Appeals, and Change of Provider Requests

Goal 2c.	Monitor grievances, appeals and requests for a Change of Provider (COP) to identify areas of improvement in our system.
Objective(s)	1. Work with CIOB on updating applications for Grievances and Appeals to meet State requirements. 2. Review the nature of complaints, resolutions, and COP requests for significant trends that may warrant policy recommendations or system-level improvement strategies. 3. Utilize data captured in Grievances and Appeals and COP application to identify practitioners or facilities who continuously receive grievances and appeals and COP requests. 4. Continue to develop 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 number of complaints and resolutions by type in Year 2026-27 2. COP requests by type in Year 2026-27
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Patient's Rights Office, Mental Health Program Manager I

Monitoring Clinical Care

Level of Care

Goal 3a.	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.
Objective(s)	1. Review LOCUS aggregate data monthly with DMH leaders and managers as well as Legal Entity providers for trends, recommended policy and practice changes and systemic capacity issues. 2. At that program and practitioner level, utilize LOCUS information to inform case conceptualizations, treatment planning and decisions on when and how to transition clients to higher or lower levels of care.
Population	Adult members, ages 21 and above, receiving outpatient services
Performance Indicator(s)	1. Number of staff who have completed LOCUS training by provider site 2. Percent of clients at each level of care 3. Percent of clients scoring level 0 or 1 (non-Specialty Mental Health levels of care) 4. Percent of clients with repeated administration of the LOCUS with levels of care that are higher, lower or with no change
Frequency of Collection	Monthly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Outcomes Unit Program Manager II and III

Healthcare Effectiveness Data and Information Set (HEDIS) Elements

Goal 3b.	Meet or exceed Minimum Performance Levels set by DHCS for key Healthcare Effectiveness Data and Information Set (HEDIS) measures.
Objective(s)	1. Track and assess 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) • Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) • Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) • Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) • Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (ADD) • Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) 2. Continue to develop Power BI Dashboards that track HEDIS measures. 3. Continue to collaborate with Managed Care Plans (MCPs) on data exchange for timely interventions. 4. Utilize QAPI Leadership and Action Committees 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 2. Reports produced to demonstrate HEDIS Measure performance
Frequency of Collection	Quarterly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	CIOB Clinical Informatics Supervising Data Scientist and Clinical Pharmacy, Pharmacy Services Chief III

Goal 3c.	Evaluation of the Quality Assessment and Performance Improvement (QAPI) Program.
Objective(s)	1. Develop and deliver a survey to evaluate satisfaction with the QI team's processes and support to providers and other departmental units that are part of the QAPI.
Population	DMH staff and DO/LE Providers
Performance Indicator(s)	1. Rate of satisfaction of Countywide QIC/ QAPI Leadership Committee, Regional QIC, QI website, and support from QI Unit
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	QI Unit Program Manager I

Monitoring Continuity of Care

Goal 4a.	Reduce Adult 7 and 30-day rehospitalization rates.
Objective(s)	1. Build a 7 and 30-day rehospitalization PowerBI dashboard that analyzes areas of improvement by service areas and individual providing hospitals. 2. Implement Hospital Liaisons in each SA to coordinate care from inpatient to outpatient services. 3. Implement Care Coordination Teams and trainings in each SA on best practices for coordinating care. 4. Work with Managed Care Plans and Clinical Informatics team to identify high utilizers to target interventions towards. 5. Complete chart reviews on high utilizer clients to identify themes that may be impacting higher rates of rehospitalization.
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. Rate of 7-and 30-day rehospitalizations 2. Rate of 7- and 30-day follow-up with mental health services after discharge from hospital
Frequency of Collection	Monthly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Outpatient Care Services, Supervising Psychologist

Goal 4b.	Develop Population Health Management (PHM) Strategy and Evaluate PHM Plan.
Objective	1) Create a comprehensive documented PHM strategy that focuses on and has goals for the following: a) Keeping members healthy. b) Managing members with emerging risk. c) Patient safety or outcomes across settings. d) Managing multiple chronic illnesses. 2) Conduct a comprehensive analysis of the impact of the PHM strategy that includes: a) Quantitative results for relevant clinical, cost/utilization and experience measures. b) Comparison of results with a benchmark or goal. c) Interpretation of results.
Population	LACDMH members
Performance Indicator(s)	1. PHM Strategy disseminated to members 2. PHM Strategy Analysis Report
Frequency of Collection	Annually
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	QOTD Deputy Director

Accessibility of Services

Goal 5.	Ensure 100% of Psychiatry Data is Captured to Calculate Timeliness of Urgent and Routine Psychiatry Appointments for Members 0-20 and 21+.
Objective	1. Increase number of Legal Entity CSI Assessment submissions for psychiatry data by identifying providers who have submitted no records in a 3-month period and requiring an action plan by the provider to begin submitting.
Population	Members aged 0-20 and 21+ requesting psychiatry appointments.
Performance Indicator(s)	1. Rate of Timely Urgent and Routine Psychiatry Appointments for Members 0-20 and 21+
Frequency of Collection	Monthly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Quality Assurance Program Manager I

Monitoring Performance Improvement Projects

Goal 6a.	Clinical PIP for 2026- 27 will aim to improve the Follow-up After Emergency Department Visit for Mental Illness (FUM) 30-day measurement rate.
Objective	1. Complete barrier analysis utilizing QI tools (fishbone diagram etc.). 2. Continue to work collaboratively with PIP committee members to identify and implement at least one intervention. 3. Work with Clinical Informatics team to ensure accurate numerator and denominator.
Population	Members age 6+ who visit an emergency department for mental illness or intentional self-harm.
Performance Indicator(s)	1. Rate of 7-and 30-day FUM
Frequency of Collection	Quarterly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Quality Improvement Psychologist II, Clinical Informatics, Supervising Psychologist

Monitoring Performance Improvement Projects & Accessibility Of Services

Goal 6b.	Non- clinical PIP for 2026- 27 will aim to improve access from first contact from any referral source to first offered appointment for any outpatient non-urgent non-psychiatry SMHS for 0–20-year-olds.
Objective	1. Complete barrier analysis utilizing QI tools (fishbone diagram etc.). 2. Continue to work collaboratively with PIP committee members to identify and implement at least one intervention. 3. Work with Clinical Informatics team to ensure accurate numerator and denominator.
Population	Children accessing SMHS through DO and LE/Contracted providers
Performance Indicator(s)	1. Number of Child non-psychiatry routine appointments offered within 10 business days
Frequency of Collection	Quarterly
Measurement Year	January 2026- June 2027
Outcome Due Date	September 2027
Responsible Entity	Quality Assurance, Program Manager II and Quality Improvement Clinical Psychologist II