OFFICE OF ADMINISTRATIVE OPERATIONS
QUALITY, OUTCOMES, AND TRAINING DIVISION – QUALITY IMPROVEMENT UNIT
COUNTYWIDE QUALITY IMPROVEMENT COMMITTEE (QIC)

MEETING MINUTES
March 2025

Type of meeting:	Monthly QIC Meeting	**Date:**	3-17-2025
Location:	Microsoft Teams	**Start time:**	9:00 AM
		End time:	10:30 AM
Recording:	Countywide QI Committee Meeting-20250317 - Mar 27th, 2025		
Members Present:	See Table Below		

Agenda Item	Presentation and Findings	Discussion, Recommendations, and/or Needed Actions	Person(s) Responsible
I. Welcome and Introductions	Stacey Smith welcomed everyone, wished everyone a Happy St. Patrick's Day, and reviewed the meeting agenda and minutes from the meeting in February.		Stacey Smith
II. Level of Care Utilization System (LOCUS) Phase I Implementation	Dr. Debbie Innes-Gomberg wished everyone a Happy St. Patrick's Day. She shared adult level of care tool LOCUS went live in December of 2024 for the first phase of implementation. Implementation began with 8 Directly Operated (DO) programs during the third week of December and the second phase went live a week ago with another 8 DO programs. A level of care tool was selected to use data to manage capacity in our system. With network adequacy and access to care mandates and reports, we must be as timely as possible as we bring clients into our system and manage the clients	Nicole Gutman wondered if our system has the capacity to accommodate realigning of clients based on severity as a lot of clinic clients could belong in FSP. Dr. Debbie Innes-Gomberg shared we will be looking within programs, service areas, or geographic regions in general, if we have the capacity that the LOCUS says we should have. QA sees a lot of clinical encounters that are non-billable, particularly in the directly	Dr. Debbie Innes-Gomberg

	that are already in the system. The value of the LOCUS is that it's a capacity management tool and clinical decision aid. This is not taking away clinical decision making but to support and show you data around that. A QA bulletin outlined everything you need to know about the LOCUS and summarize lessons learned. We have been meeting with programs every other week since the beginning of the year. Legal Entities serving adults, people 21 and over, received a companion guide to develop an API application program interface. They have about 120 days to build out their system so that they can begin collecting LOCUS information and utilizing it. QA Bulletin issued in November 2024 on LOCUS implementation highlights the levels of care that go up to Level 6. What's key to each level is the service frequency, intensity, and service type. Level 5 is where clients are seen multiple times per week, medically managed residential programs. Level 4 goes to full-service partnerships, assertive community treatment, and as we move into implementing day treatment, it would fall into this category. Level 3, moderate clinical intervention where clients might be seen two to four times a month depending upon the type of service will fall into this category. Level 2 the risk of harm is relatively low, managing recovery with limited clinical interventions focused on recovery and reintegration. Level 1 is higher functioning	operated system. We want to move away from non-billable check-ins to a real intervention, not only to claim but to make a difference. There will be challenges but it's a way to help us serve our clients with the goal that they can and do recover. Jennifer Hallman shared we should also make sure we don't think that we have to change the entire system all at once, doing small changes that might be more manageable such as moving people over to the managed care plans. Dr. Debbie Innes-Gomberg stated last week Jennifer Hallman, and her team convened a meeting on Day Treatment Intensive and Day Treatment Rehab to bring it back as a as a service because we should have it. What data can we use to identify what the need is? According to LOCUS this is a Level 4 program. Dr. Kara Taguchi there might be several different types of services and programs that fall into a Level 3, Level 4, and whether the LOCUS can discern between	

	individuals with minimal impairments If they score in Level 1, they would be transitioned to either Managed Care Plans or Primary Care if they don't have Medi-Cal. Level 0 is prevention. The key to the LOCUS is that clients can and do recover, learning about the data, focusing on how that gets operationalized, and to continue to instill that not only in our staff, but in our clients as they come in presenting for services. To get the message across that the expectation for clients is transitioning out. Dr. Debbie Innes-Gomberg presented data pulled on 3-11-2025. There are 3,231 LOCUS assessments so far. Each clinic that has implemented has chosen whether they want to start with new clients, existing clients, and for programs that have FSP programs whether or not to include them. We meet with the program managers and some supervisors every two weeks to discuss what we're learning, what the data is showing us so far and why there are clients that are scoring in Level 0, which is prevention and health maintenance services. Dr. Debbie Innes-Gomberg shared discussion/issues that came up in meetings included: • Requests if the LOCUS questions can be translated into a language other than English. We referred a local company to AACP, which is the trainer for LOCUS.	those programs. Clinicians are learning how to use the LOCUS, having discussions with their supervisors, experiencing the learning curve, and over time they will come to understand better what the data is showing. Helena Ditko shared she is fascinated by the Level 3 and Level 4. FSP programs are already doing a lot more of Level 4. Dr. Debbie Innes-Gomberg noted this is only 8 adult programs from March 11th and some of those programs didn't include or have FSP programs. General outpatient non FSP is where the bulk of the initial assessments came from. Dr. Kara Taguchi shared it's been interesting to have the discussion and hear what some of the issues that have come up around the distribution of LOCUS scores. There is work to do with our Managed Care Programs. Ideas have been proposed around centralizing some of those tasks. Dr. Kara Taguchi thanked Dr. Innes-Gomberg for this data as it is in line with the kind of information that we want to present here at the	

	• Programs that are considering how they implement the LOCUS, whether at intake or not. The important thing to consider is that the more you know your client, the easier it is to do the LOCUS. • What point do we transition a client to the Managed Care Plan and how do we facilitate these successful transitions. • Utilizing motivational interviewing to engage clients in readiness for change. QA is going to discuss with Supervising Psychiatrists being aligned with LOCUS and with the rest of the team, strategies to do warm handoffs to the Managed Care Plan and using the data in treatment. • Discussed creating training for staff on messaging and culture change that supports the parameters for Specialty Mental Health and MCP responsibilities. • Interracial reliability and the possibility of needing a booster or specialty training once a clinic has implemented LOCUS. It's been a good process so far and it's been one that that we are determined to ground in learning versus reporting. We are curious about what the state is showing us, what we need to do and how we can support client flow.	Countywide QIC, where we look at data to inform us about our system and using that data to make changes.	
III. Revisiting Service Equity Data Analysis Continued	Dr. Rosa Franco shared telehealth data (via phone or video) by race, primary language, and age group for the Service Equity Report. 76.9%	Jennifer Hallman shared that as Dr. Innes-Gomberg just presented there have been claims that	Dr. Rosa Franco

	of DMH clients received at least one telehealth service. If we are using 76.9% as a point of comparison, we can see that several groups are receiving at least one telehealth service at a rate that is higher than the DMH rate. For Native American clients, it looks like they are receiving a rate that is 10.2% higher than the rest of DMH. When looking at White clients, they're only receiving services at a rate that's 1.3% higher and Black clients are receiving telehealth at a rate that is 2.5% higher. Dr. Rosa Franco shared telehealth rates by primary language. There are around 66 different languages, but this data only looks at threshold languages. 80% of clients that spoke these languages received at least one telehealth visit which is close to the 76.9%. Some of the primary languages have higher rates than the DMH rate of 80%, Cambodian at 13.5% higher than the overall rate for DMH, Armenian at 9.1% higher, Farsi at 8.6% higher, and Cantonese at 6.2% higher. Several of the Asian languages seem to be on the higher side; Chinese, Korean, and Tagalog are higher than the 80% rate. English and Russian were the only two groups who received telehealth services at a rate that was lower than the DMH rate. For clients who received telephone services by primary language, the rate for DMH was 26.1% and for video was 15%. By breaking it down by language, we used 26.1% of services as our	probably aren't billable for both Directly Operated and Contractors. It seems that 77% seems high. Dr. Kara Taguchi shared this may be strictly by codes and not necessarily by quality of the telehealth service. The number of distinct clients receiving a telehealth service is 172,958. The percentage is dividing the number of distinct clients receiving telehealth by the total number of clients in that race/ ethnicity served which showed the high percentage. Dr. Lisa Benson agreed that there are not high clinical value services that are getting included. Dr. Kara Taguchi cautioned about calculations for languages with low numbers, as it could greatly affect the percentages. There are many factors that play into these. There may still be some clinics in our system who may favor telehealth, but this is the whole point to think about the data and what we might be seeing. Dr. Rosa Franco shared the numbers are low for some of these languages, but those primary	

	point of comparison. It appears that people whose primary language was Cambodian were at a rate of 29% higher than the DMH rate, Farsi at 21.5% higher than DMH, and English language received services via telephone at a rate of 0.5% lower than DMH. 25.9% rate of telephone services and 15% for video. We can see that the Older Adult (the smallest age group that we serve) seems to be getting about a third of all their services through telephone. Both older adult and adult age groups seem to be getting a higher proportion of their services by telephone. For video it looks like the TAY group and children seem to be on the higher rate. Some things to think about regarding telehealth: • For the younger age groups, how beneficial or effective is it for them to receive services through video. • Are the treatments that clients receive via telephone effective at reducing their mental health symptoms. • Are clients receiving services in their preferred method of service and are they being given options. • Are we offering clients services in the preferred method. Dr. Rosa Franco reviewed what we have been covering in these presentations over the past few months and what is currently in the Service	languages are receiving large percentages of telehealth. Dr. Kara Taguchi asked what are we trying to understand with this data given we're looking at clients with one telehealth session versus their service plan being telehealth versus in person. Dr. Kara Taguchi shared part of it is to make sure that there wasn't any particular threshold language where telehealth wasn't available to them to see if there were any disparities. Dr. Kara Taguchi shared from the previous slide, of the 5.8 million services 26% of them were done over the phone and 15% over video. The bulk of their services are done in some other format or in person. Dr. Lisa Benson shared we see systemwide that telehealth/video is a small proportion, and telephone obviously is a much bigger proportion. Nicole Gutman stated she'd be interested whether the services were provided with or without an interpreter. Certain languages are	

	Equity Report. She checked in with everyone to see if there was any other data points or other ways of looking at the data, we should consider including in this report to identify disparities.	often concentrated to a specific clinic and some of this may reflect differences in health and practices. Dr. Kara Taguchi stated telehealth numbers broken down by Service Area would be interesting to see and broken out by different organizations and clinics. Dr. Debbie Innes-Gomberg thanked Dr. Rosa Franco for this presentation. She asked if anyone had thoughts on how to deliver an effective Mental Health service or Med support service if you can't see the client that you're working with. How do we ensure that people are in a secure environment and to what degree are telephone only interventions effective. Dr. Kara Taguchi wondered if some clients are only willing to meet by phone. She asked if we know whether telephone visits happen more in the beginning or at the end of treatment. Dr. Lisa Benson shared I have concerns when there are cancellations, some clinicians start phone calling everyone on their caseload. This leads to adding	

		services that might not have as much clinical utility. Nicole Gutman shared a lot of times I come across notes where the client calls to say they can't make it and requests a phone session instead. Dr. Rosa Franco shared in our Consumer Perception Survey, we received comments from people saying I want to go back to in person, but they are not offering to me. Dr. Debbie Innes-Gomberg shared DHCS has told Medi-Cal members that they have the right to an in-person service, and that's important. Dr. Kara Taguchi shared I don't think anyone here is saying that we don't want to offer telephone services as there is a good purpose for some of them, but it would be concerning if they are only being seen on telephone.	
IV. Consumer Perception Survey Analysis	Dr. Daiya Cunnane presented on Continuous Quality Improvement (CQI) and CQI process for Consumer Perception Survey. One of the models that's used to assist with continuous quality improvement is Plan, Do, Study, Act	Dr. Kara Taguchi shared not every PDSA has to be laid out this way, but it is important to think about these different components as you are planning for how to address	Dr. Daiya Cunnane

	(PDSA). We look to identify where we can make changes based on data, implement interventions, and look at our results to see if there were actual changes that occurred as we implemented our interventions. Based on the results, we look at if we want to apply these interventions across our system, want to go back to the drawing board and rework some of our interventions, or go through the process again. Our Performance Improvement Projects (PIPs) are set up this way. Dr. Daiya Cunnane shared Tool Examples to understand and organize data: • Infinity diagram • Fishbone diagram (good way to start brainstorming) • Bar charts (mostly used by QI) where it is tracking something over time • Control charts where tracking something over time indicates having an upper control level and a lower control level especially trying to fall within range of performance. This tool is good to use for Timely Access or maybe one day Consumer Perception Surveys. • Scattered diagrams Dr. Daiya Cunnane shared how PSDA is used for Consumer Perception Surveys. We receive a large volume of data to process. Participation in CPS is important because data collected helps to improve the experience for our	issues in your programs. Dr. Daiya Cunnane did a really great job of outlining the different components. Our hope is that these kinds of questions or critical looks at what needs to change occur. Finding ways to highlight the successes and learning so it can be shared for the betterment of the system. Dr. Daiya Cunnane shared also basic model can help you feel organized when having to start new projects. If you receive a challenging project, going back to a basic model can help you get it structured and started Dr. Kara Taguchi shared projects do have multiple cycles sometimes, like the HEDIS measures for example, needing basic information for the plan phase can be long just to understand where our problems are. Dr. Daiya Cunnane shared during the CPS planning period we collect a lot of information so we can develop our interventions. It is really the most important phase of doing these cycles.	

	providers and our clients/caregivers and we also receive funds for it. We look at the data to gain information about how providers are experiencing our survey and how clients are experiencing surveys. We have a Provider Evaluation of Satisfaction survey that we send out after the survey period has been completed. We collect information on questions such as: How were our trainings? Were they useful? How were our training materials? How was your experience with the electronic survey? And what are some of the recommendations that you have for improvements? We also keep a document throughout the survey period about problems that we encounter and changes that we think need to be made for the following year. We look at our prior CPS results and work on increasing our numbers of participation from clients/ caregivers and providers, and make sure we have a debriefing session with our planning committee. We receive suggestions from Peer Services, Outpatient providers, and Application Team. The QI Team has feedback to give as well in addition to answering emails throughout regarding information that wasn't clear. Dr. Daiya Cunnane shared Do is where we take information gathered and see what changes we can make. CPS has a lot of different changes going on at the same time. This includes presenting our requirements or our changes to our Application Team, implementation of the		

	MyHealthPointe pilot to improve CPS administration for Directly Operated providers, working with our Public Information Office to help with media and create interest in engaging and completing the survey for our clients and caregivers, and expanding our planning committee to our Peer Services and ADA representatives. We were able to provide feedback to UCLA on our experience, revise our materials/contents/workflows and advocate for changes to our surveys. We receive and collect large amounts of raw data that are both quantitative and qualitative throughout this process. Our estimated survey collection from 2024 shows an improvement for most of our age groups particularly Adult from the previous year. Next is Act where most of the time we are making decisions about keeping some interventions or removing some interventions and identifying new barriers and challenges for the next CPS period. This is where we begin new PDSAs.		
Next Meeting:		**April 21, 2025, from 9:00 AM to 10:30 AM**	

Attendance List

NAME	AGENCY
Kara Taguchi	QI and Outcomes
Stephanie Johnson	CWD-WRAP
Renee Lee	DMH Quality Assurance

Keisha White	SA 5
Volga Hovelian	DMH QI and Outcomes
Mayra Garcia	Quality Assurance
Laarnih De La Cruz	DMH QI
Berteil Eishoei	SA 1
Rosa Franco	DMH QI
Daiya Cunnane	DMH QI
Kimber Salvaggio	SA 2
Nancy Pelayo - DMH	Veteran and Military Services
Michelle Rittel	SA 2
Greg Tchakmakjian	SA 7
Theodore W. Wilson	Patients' Rights
Rachel Santellan	SAPC
Debbie Innes-Gomberg	DMH QI/Outcomes/Training Division
Sharon Chapman	DMH Outcomes
Maria Moreno (CLESGV)	SA 3
Suzanne Wilson	Forensic Psychiatry Liaison
Stacey Anne Smith	DMH QI
Linda Nakamura	SA 8
Robin Ramirez	MHSA
Chandler Norton	Specialized Foster Care South
Sandra Chang	ARISE Division
Nicole Gutman	SA 4
Armen Yekyazarian	DMH Quality Assurance
Ignacia Salas	Specialized Foster Care South
Engelbert Salinas	DMH QI
Helena Ditko	Policy Unit
Therese Gabra	DMH Quality Assurance
Elizabeth Powers	CMMD
Yen-Jui Ray Lin	Clinical Informatics
Lisa Benson	Clinical Informatics
Jeaqueline Monroy	CWD-Case Review Unit
Jennifer Hallman	DMH Quality Assurance
Nikki Collier	DMH Quality Assurance

Alben Zatarain	Enki
Toni Robinson	Peers Services
Eilene Moronez	Enki
Sonia Zubiate	DMH Quality Assurance
Andrew Nguyen	Pharmacy
Gwen Okagu	DMH Quality Assurance
Zhena McCullom	DMH Quality Assurance
Wanta Yu	DMH Quality Assurance
Rosalba Trias-Ruiz	SA 3
Anh Tran - DMH	Veteran and Military Services
Yvonne Phung	DMH Quality Assurance
Susan Cozolino	DMH Quality Assurance
Kalene Gilbert	MHSA
Susan Blackwell	HAI
Ly Ngo	Clinical Risk Management
Misty Aronoff	Step Up on Second

Respectfully Submitted,

Dr. Kara Taguchi