

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

MEETING MINUTES
July 2025

Type of meeting:	Monthly QIC Meeting	Date:	7-21-2025
Location:	Microsoft Teams	Start time:	9:00 AM
		End time:	10:30 AM
Recording:	Countywide QI Committee Meeting-20250721 - Aug 13th, 2025		
Members Present:	See table below.		
Agenda Item	Presentation and Findings	Discussion, Recommendations, and/or Needed Actions	Person(s) Responsible
I. Welcome and Introductions	Dr. Kara Taguchi shared meeting agenda and May 2025 meeting minutes.	Please email any edits for May meeting minutes to DMHQI@dmh.lacounty.gov	Dr. Kara Taguchi
II. Quality Improvement Updates <ul style="list-style-type: none"> • Purpose of CW QIC • Performance Improvement Projects (PIPs) 	Dr. Kara Taguchi stated the purpose of the CW QIC is to get feedback from its members on data presented and on our QI initiatives. Stacey Smith shared the CW QIC will cover our QI requirements as most of its members have Work Plan Goals, reviewing data, and the BH-CONNECT incentives. Dr. Kara Taguchi shared you will see our Work Plan changing next year with some quality metrics that we need to track in order to avoid	Jennifer Hallman wondered what number of completed surveys are you hoping for. Stacey Smith shared last year there were 50,000 clients who had appointments, and we had about a 20% response rate. We would love to have 50,000 surveys one year. Dr. Kara Taguchi shared we could probably look at the response	Dr. Kara Taguchi/ Stacey Smith

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<ul style="list-style-type: none"> Consumer Perception Survey (CPS) 	<p>sanctions and being more intentional as a department on what we are focusing on related to Quality Improvement. Learning from the Regional QIC meetings will be brought here as provider input.</p> <p>Stacey Smith shared units and divisions will see where you will come in as a key members of this committee especially when talking about BH-CONNECT and the incentive program.</p> <p>Stacey Smith shared update on Clinical PIP for Follow up after Emergency Department Visit for Mental Illness (FUM) and Non-Clinical PIP on access to care for children, non-psychiatry, non-urgent appointments. FUM rate for calendar year (CY) 2024 was 65.91% which is over the 50th percentile needed. Access to Care for Children rate was 70.41% in 2024. The benchmark was 80%. However, since 2024, QA has done a lot of work on improving the rate to meet the benchmark.</p> <p>Stacey Smith shared CPS preliminary numbers for 2025. We received a little over 13,000 surveys, which is an improvement over last year. This number will decrease as the data we send to UCLA gets cleaned. Surveys where consumers did not answer two or more questions are not counted. If papers surveys were photocopied, they will not be able to be scanned by the Scantron and will not be counted. Surveys have been on an upward</p>	<p>rates that other Counties are getting. We get a higher response rate than with traditional surveys that sometimes have around 9 or 10 percent.</p> <p>Kalene Gilbert shared there is a lot of use to this survey moving forward and this is valuable data because it is the only self-completed survey by our clients that we have that tells us how we/they are doing, what they think of our services, and what can be improved. We do need to do a lot of work to get more clients to complete them as we are going to make a lot more use of this in the future.</p> <p>Dr. Brian Hurley shared SAPC has around 85 or 90% response rate for their Treatment Perception Survey (TPS), and it's due to the administration of the form through multiple vehicles.</p> <p>Dr. Kara Taguchi shared that there are some elements from the CPS surveys that are a part of the contract performance measures. This was the first time we have been asked to provide data for</p>	
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	<p>trend over the last 3 years. We are grateful to everyone that helped from Outpatient Care Services, Peer Services and PIO in making this happen.</p> <p>Last year we received 2,000 open-ended comments and this year we have almost 5,000 comments that we received.</p> <p>We created a Power BI report for Exhibit M that we are able to provide to the contract division as needed. We are working on an item level report where each provider can see their answers individually.</p>	<p>Legal Entity provider response rates and ratings for CPS.</p> <p>Kalene Gilbert shared there is a trend, a middle range generally where our clients feel like our services are great but there are some standout providers that look like they were doing far better than others. There are some red flags that we should be checking and reviewing consistent comments such as “My provider does not ask me what I need”.</p> <p>Dr. Kara Taguchi shared our clients are very satisfied with the services but then there are some areas where they are less satisfied such as psychiatry timeliness. One of the places where we have struggled with is to know how much better off they are after receiving services with us.</p> <p>Dr. Debbie Innes-Gomberg agreed with Dr. Brian Hurley we need to find a way in which to message the value of completing the survey.</p> <p>Dr. Kara Taguchi shared our biggest issue is how the data can be matched back to the providers and the clients. If it comes out that</p>	
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		<p>we are not getting enough input about our system from this once-a-year survey, as a system, we need to figure out how to get more incremental satisfaction back so that we can address issues more timely in the areas that we are not showing as doing well in the annual survey.</p> <p>Jennifer Hallman shared yes technically with the data that we have received we are hitting our requirements but as more data comes in, it will impact numbers.</p>	
<p>III. Network Adequacy Certification</p>	<p>Jennifer Hallman shared that we certify our network every year. They look at our Full Time Employees (FTEs) to see if we have all the different types of service providers needed, language capacity, and timely access to care.</p> <p>For last year’s certification we met our time and distance standards which are 15 miles or 30 minutes.</p> <p>For Psychiatry with Nurse Practitioners included Adults 21+, we needed 225 FTEs, we have 246 passing the Psychiatry ratio. For Youth, we needed 131 and we had 134, so we also passed. For Outpatient Adults we needed 1,800 FTEs, we were able to report 2,700. It is a lot of FTEs over what the State expects us to have.</p>	<p>Dr. Kara Taguchi wondered if the adequacy of our network or the number of people that we serve incorporates a prevalence rate, an estimate of how many Medi-Cal eligibles might need specialty mental health to then determine how many practitioners we need.</p> <p>Jennifer Hallman shared there are a lot of things that can play into this. You could see a lot more of the mild to moderate population than you need to in Specialty Mental Health.</p>	<p>Jennifer Hallman</p>

	<p>For Children we need 2,400 and we have 3,800.</p> <p>The State also looks at Access to Care. For routine appointments also called non-urgent non-psychiatry appointments for Adults, we passed and were at 92% timeliness and have been consistently meeting the requirements. For Child, we were at 70%. We did work and efforts have improved this rate.</p> <p>For urgent appointments, for both Adults and Children, we have met the 80% benchmark in that area.</p> <p>We are going to start digging into follow-up appointments. Psychiatry appointments are important to note. We only had Directly Operated data for this. For a regular Med appointment for Adults we were at 50%. For children we were at 60%. For urgent psychiatry, where they need to be seen by a psychiatrist right away, the numbers are small, but we are doing pretty good.</p> <p>For language capabilities, we have not been able to report out on our contractor's use of language assistance, so we are working with the ARISE Division to put a process in place to collect this data from our contractors. There are a couple of services we are in the process of getting additional providers, specifically for day treatment intensive and day rehab. For grievances, appeals, and administrative</p>	<p>Dr. Kara Taguchi asked if these are numbers DHCS provides or if you supply these numbers.</p> <p>Jennifer Hallman shared we give them all the raw data in an excel spreadsheet, then they analyze it, and provide us with the numbers.</p> <p>Dr. Kara Taguchi shared Service Area 4 for Directly Operated clinics has our highest homeless population. There might be more FTEs needed per client. It is interesting what people in different Service Areas think of these numbers.</p> <p>Kalene Gilbert shared as we opt into other services, that will start to impact what the FTE findings are as this really doesn't account for how much Outpatient versus more Intensive Service we may have.</p> <p>Jennifer Hallman shared one thing that we have seen as we start doing our needs assessment is breaking it out by programs. As a whole, we do have enough FTEs, but we will need adjustment based on where they are located and</p>	
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	<p>processes we have those in place to submit in our network whenever we have any.</p> <p>Although we have a lot of FTEs, there are certain areas where we do not have enough and so we looked at Medi-Cal populations by Service Area. SA 4 has the highest percentage over what the State would expect us to have in FTEs in having higher ratio of practitioners to Medi-Cal members than others for Psychiatry. For Psychiatry, we are below what you would expect to see in Service Area 7 and same for Service Area 8 for Adult Psychiatry. The only service area where we are below what we would expect ratios is service Area 2 for Adults. We hear a lot about the need for Children, but it was Adults that were below the FTE. We are going to dig in more to see if this is DOs or LEs or is it a specific provider and start seeing the relationship between two pieces of data and how they impact or don't impact each other.</p>	<p>which program they are assigned to.</p> <p>Dr. Kara Taguchi shared in the LOCUS implementation speaking with our Directly Operated programs the difficulties identified in transitioning clients to the MCPs affect the Service Areas differently.</p> <p>Jennifer Hallman shared it is also what services are being provided and where. In an Outpatient clinic, staff take clients on group outings, and often we do not see that clinical intervention. Group outings are an important component but maybe we can start looking at how we are using staff and what services we are providing and where is the most appropriate place to be providing that type of service.</p> <p>Dr. Debbie Innes-Gomberg encouraged everyone in the roles that they have, particularly if they are Service Area based to know what their role is, knowing how to use staff, and not go to we are going to need more staff right away.</p>	
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		<p>going to be needed. This is a change that is going to happen in our system, under BHSA. Our staff that are out there doing Outpatient are probably going to have to shift to doing more field-based services. I just want to kind of connect this with actual changes that are going to be happening in our system in the coming year so maybe start thinking about the role that not only this forum plays, but the leadership on the ground are going to be playing as part of that.</p> <p>Dr. Kara Taguchi shared it would be interesting to see how much variation there is where people get care and how we plan for that as a system.</p> <p>Jennifer Hallman shared one of our next steps is to pull in actual clients and not just the Medi-Cal population. For example, Service Area 3 has a lot of Medi-Cal population, but we are not actually serving that many people, so when looking at the FTEs and the feeling of having too many providers and when you are actually providing services, think about the people coming in the door and how does</p>	
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		<p>that feel from a timeliness and a service provision perspective. As Kalene Gilbert mentioned, it certainly says that there is room for transformation in these numbers.</p>	
<p>IV. Behavioral Health Transformation (BHT)-14 Goals</p>	<p>Dr. Kara Taguchi shared the framework for BHSA planning now encompasses our entire system. The State wants us to think about population and behavioral health goals as we are developing our integrated plan and the vision is for all Californians to have access to behavioral health services, leading to longer, healthier, and happier lives, as well as improved outcomes and reductions in disparities. There are 14 statewide behavioral goals that have been identified by DHCS. There are six priority goals that must be addressed in our integrated plan: improving access to care, reducing homelessness, reducing unnecessary institutionalization, reducing justice involvement, reducing the removal of children from the home, and improving untreated behavioral health conditions.</p> <p>Every County must pick one additional goal from improving the care experience, increasing engagement in school engagement and at work, reducing overdoses, improving prevention and treatment of occurring physical health conditions, improving the quality of life,</p>	<p>Jennifer Hallman asked if there is an expected penetration rate and does it differ by race.</p> <p>Dr. Kara Taguchi stated that there's not an expected penetration rate. What this is giving is that Los Angeles County's rate in terms of clients that received a special mental health service.</p> <p>Jennifer Hallman wondered what is this telling us? Is this good or is this bad or is it just data to have?</p> <p>Rachel Santellan shared sometimes these numbers do not reflect our systems, but the overall system. Maybe because black people have been historically marginalized and discriminated against, they are in a position where they have a higher number of people enrolled in Medi-Cal and because of racism and as such are</p>	<p>Dr. Kara Taguchi</p>

	<p>improving social connection, and reducing suicides.</p> <p>Dr. Kara Taguchi shared DHCS provided every County with their own data to consider in their planning process. This allows Counties to compare themselves to the statewide numbers and identify area they need to address.</p> <p>Phase 1 is the planning process that is publicly available. Our draft is due on March 1st, 2026, and integrated plans are due June 2026. The behavioral health plans must shape their plan using the six goals. The State is expecting us to look at the data for the goals and answer questions such as What did you see?, How do you relate to the rest of the state?, What disparities did you notice?, and What are you going to do about it?</p> <p>Data is equivalent to the data that EQRO used to give us. How many people are Medi-Cal eligibles in Los Angeles County, over a period of time, and received a specialty Mental Health service claim.</p> <p>Phase 2 just started. It is similar to what we have been accustomed to with MHSA, which is individual client-based data that the State will use to hold us accountable.</p> <p>Dr. Kara Taguchi shared Priority Statewide Behavioral Health Goal #1 Access to Care. One of the data measures that they provided us with</p>	<p>experiencing mental health symptoms.</p> <p>Dr. Kara Taguchi shared Latinos and Asian Americans are represented in our Specialty Mental Health services at a lower rate than they are in the Medi-Cal population. Latinos get more care through our MCPs, which are also Medi-Cal services, which may explain why they are underrepresented in our system.</p> <p>Jennifer Hallman wondered how do we tie this to an earlier conversation that we have more FTEs in our system than we need but feel like we do not have enough staff to serve people coming in and needing our services and where do we need to adjust so that we can really focus on the people who are in most need of our services.</p> <p>Dr. Kara Taguchi shared this does not speak to need but to what is, who we are serving, who showed up, and the distribution of Medi-Cal population. But it can also be that we do not have enough FTEs that culturally match those populations</p>	
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	<p>was the penetration rates for adults 21+ years and older that received one or more Specialty Mental Health service through a Mental Health Plan. They wanted us to look at where the indicator had stratified data so that we could break it down by race or ethnicity, age, gender or language, and include that in our planning process. For every race or ethnicity, our penetration rates exceed those of the State.</p> <p>Dr. Kara Taguchi shared when looking at the distribution of a particular demographic category you are looking at and comparing it to the distribution of the same demographic category in another reference population, the closer you are to one means that those distributions are matching, the further away means that there's a potential disparity. We are serving fewer Latinos in our Specialty program than in the overall Medi-Cal population.</p> <p>Dr. Kara Taguchi shared she will continue next month to discuss Non- Specialty and Homelessness.</p>	<p>and that is affecting Access to Care.</p> <p>Jennifer Mize agreed because of one's culture for example, Hispanic and Asian populations may not culturally agree with mental health and may try to hide it or keep it a secret. This plays a part and makes sense why we are not seeing them in Specialty Mental Health as much. In my specific clinic, it is very hard if a psychiatrist only speaks English. Psychiatry appointments with translations require extra time and therefore need to be booked out further as the scheduled slots are much shorter. This leads to not being able to meet access to care standards and more no shows.</p> <p>Lori Willis shared some areas have more FTEs than they actually need but are they culturally sensitive. Those numbers do tie together. For DMH as well as our contractors we can look at and drill down what we need culturally in each of our Service Areas or parts of our Service Areas that may affect Access to Care numbers.</p>	
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Next Meeting: Monday, August 18, 2025, from 9:00AM-10:30AM

Attendance

NAME	AGENCY
Kara Taguchi	DMH-Outcomes & Quality Improvement
Stacey Anne Smith	DMH-Quality Improvement
Daiya Cunnane	DMH-Quality Improvement
Rosa Franco	DMH-Quality Improvement
Laarnih De La Cruz	DMH-Quality Improvement
Volga Hovelian	DMH-Outcomes & Quality Improvement
Stephanie Johnson	CWD- WRAP
Michelle Rittel	SA 2
Lori Willis	Children's
Julie Garcia	Outpatient Care Services
Kimber Salvaggio	DMH-Training
Tiffany Trotter	SPH-SAPC
Jennifer Mize	SA 1
Yvonne Phung	DMH-Quality Assurance
Andrew Nguyen	Pharmacy
Ann Lee - DMH	SA 8
Lisa Benson	DMH-Clinical Informatics
Rachel Santellan	DPH-SAPC
Jennifer Hallman	DMH-Quality Assurance
Brian Hurley	DPH-SAPC
Venezia Mojarro	Compliance, Privacy and Audit Services
Kalene Gilbert	DMH-MHSA
Nikki Collier	DMH-Quality Assurance

Berteil Eishoei	SA 1
Gwen Okagu	DMH-Quality Assurance
Robin Washington	DMH-Quality Assurance
Greg Tchakmakjian	SA 7
Susan Cozolino	DMH-Quality Assurance
Sharon Chapman	DMH-Outcomes
Angela Trenado	DMH-Quality Assurance
Zhena McCullom	DMH-Quality Assurance
Armen Yekyazarian	DMH-Quality Assurance
Wanta Yu	DMH-Quality Assurance
Debbie Innes-Gomberg	DMH-Quality/Outcomes/Training Division

Respectfully Submitted,

Dr. Kara Taguchi