

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

MEETING MINUTES
August 2025

Type of meeting:	Monthly QIC Meeting	Date:	8-18-2025
Location:	Microsoft Teams	Start time:	9:00 AM
		End time:	10:30 AM
Recording:	Countywide QI Committee Meeting-20250818 - Sep 2nd, 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 to the meeting and shared the meeting agenda and May 2025 meeting minutes.		Stacey Smith
II. Peer Service Work Plan Goal Update	<p>Dr. Toni Robinson presented on progress towards Peer Services Work Plan Goal.</p> <p>Objective: Providing financial assistance for individuals to receive their Peer Support Specialist certification at the State level and the ability to bill Medi-Cal. Scholarships included 80 hours of training at a State certified vendor. Once they pass the State exam they receive their certification. Our scholarships cover the training with one of the vendors, the cost of taking the State exam, and a retake of the State exam if someone doesn't pass it the first time. We have funding for one retake and for recertification, which is every two years. We</p>	<p>Jennifer Hallman shared Quality Assurance (QA) worked on differentiating Peer Support, Enhance Community Health Worker (E-CHW), targeted case management, and rehab in a chart. She will send it to Dr. Toni Robinson.</p> <p>Dr. Kara Taguchi wondered does it matter what title they end up with. It is frustrating that Dr. Robinson is running into these barriers with getting distinguished items or titles. Does the State require them to</p>	Dr. Toni Robinson

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	<p>also provided DMH employees with State exam prep courses. 92 CalMHSA scholarships were given.</p> <p>Objective: Create a logic model for the implementation of Peer Support Specialist item for those who are certified. We put together a logic model and justification and highlighted information that distinguishes the work of Peer Support Specialists from Community Health Workers. We had two different job duties and worked with our Peer Advisory Council, the Community Council, and the Staff Peer Advisory Council to come up with what makes the two positions different. We also looked at other State and other County departments. We submitted the information to HR, but they let us know that it was not enough for us to get a new item as the work is too similar. We are in the process of going deeper before we submit to the CEO so that it doesn't get sent back and we have to start all over again.</p> <p>Objective: Negotiate bonus in the interim, while Peer Specialist item is being created to differentiate skills from Community Health Workers. As a department we agreed to move forward with the bonus. Dr. Wong approved \$225.00 a month and making it retroactive to July 1, 2024. We are still waiting for full County approval, but Department approval is completed.</p>	<p>have these distinguished items to match the function?</p> <p>Jennifer Hallman shared it does not matter to the State, although it was brought up to them in an informal way as we heard LA is using CHWs for everything.</p> <p>Dr. Kara Taguchi wondered if there has been or have you incorporated any strategies or reached out to maybe people of color or underserved populations to foster smoother transition into our workforce as a strategy to have our workforce mimic more of our client population.</p> <p>Dr. Toni Robinson shared we have not gotten that far yet. First, we are trying to see where we are and to work with what we have. Now we are in the phase of getting the WOW volunteers onboard and we will start working with the TAY Division to get those individuals onboard. Once we get that off the ground, then we will see how we can recruit more people to be in the internship. We will be sure to look at our population when we are doing that process.</p>	
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	<p>Objective: Create a career ladder. We have the draft ready, but it has not been approved yet. We are working with HR to see if we can have some level of flexibility for example, by using “or” instead of “and” for number of years of experience. We have two positions that received PIDs last week for Community Service Coordinators which will be a promotional role after Supervising CHW.</p> <p>Objective: Develop an internship program for those with lived experiences as a pathway into employment as Peer Specialists. WOW Volunteer program is now under the Office of Peer Services. WOW volunteers work at clinics and with different programs. We are making slight changes to the program to make sure that it is a pathway to employment. We are also looking at piloting an internship program with the TAY Division for individuals 18 to 25 years old who have already taken their State exam and been certified and as a partnership with the City of Los Angeles. They will be working for the TAY Division and will shadow and do site visits to get a feel for how Peers work throughout our department.</p> <p>Objective: Engage in a barrier analysis of why information on peer opportunities was not more well known and use this information to create a system to increase information flow to ensure Peers know of promotional opportunities, requirements, and how to apply. Individual staff members stated they weren't receiving</p>	<p>Dr. Kara Taguchi shared this was a part of External Quality Review (EQR) feedback from 2024.</p> <p>Nicole Gutman wondered if we still have Peer Support items or are they all Community Health Worker items. Once Peers move to Community Health Worker items, they usually no longer want to identify as Peers anymore. I wonder if it would change things for them if they knew they had access to Peer Support Networks, etc.</p> <p>Dr. Toni Robinson shared we do not, but we are working to get Peer Support Specialist items. That is our goal.</p> <p>Jennifer Hallman wondered if everyone on the treatment team would be required to take the training, not just Peers.</p> <p>Dr. Toni Robinson shared we want to make sure that our service delivery system is well informed on what Peer work is and Peers know what they are supposed to be doing. The training is for everyone.</p>	
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	<p>information about new employment opportunities throughout our service delivery system. We received feedback that our Community Health Workers were feeling that they were not being made aware when Senior Community Health worker positions would open or Supervising positions. We talked to HR and looked at ways that we could make sure that information was getting out to our Peers in different ways. Now HR sends out email blasts for all different positions and we are making sure that they are seen by our Community Health Workers. We also started a Peer Network group that meets the last Wednesday of every month. They can log in and get information, post information about different events going on, ask questions, and learn about what other programs and projects we have going on throughout the Department.</p> <p>Objective: Educate the workforce on the duties of the Peer Support Services. We developed Peer Services 101. The goal is to be able to create tracks for clinicians and/or care teams to use Peers effectively. Having a different track for Clinicians and a different track solely for Peers.</p> <p>Dr. Toni Robinson shared performance indicators are to increase Medi-Cal certified Peer Support Specialists from 7-10% to 30% this year and to create training materials for new clinicians on the role of Peer services and ways Peers can help advance service delivery</p>	<p>Nicole Gutman asked how can we connect people to the Peer Resource Network.</p> <p>Dr. Toni Robinson shared we will be sending information and slides to Stacey who can disseminate the information.</p> <p>Jennifer Hallman wondered what the 7 to 10% to 30% percentages are.</p> <p>Dr. Toni Robinson shared that the numbers are the amount of CHWs we had in our service delivery system who self-identified as being Peers.</p> <p>Jennifer Hallman wondered what they are claiming if they are not claiming as Certified Peers because we only have 5 Peers claiming currently.</p> <p>Dr. Toni Robinson shared most of them are not claiming as Peers because they do not want to claim until they are receiving their bonus or until they are paid at a rate of a Peer Specialist.</p> <p>Jennifer Hallman shared whether they got the bonus or not, documentation would be a lot easier for them as a Peer. It gets</p>	
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	<p>goals. We had challenges as all our Peers worked under the Community Health Worker item making it is difficult for us to distinguish who are Peer Support Specialists and who are not. When considering sending a survey about experience and experience in daily work, HR informed us that we cannot ask people about their diagnoses. We were able to increase the number of certified Peer Support Specialists from 19 to 58 in a year in Directly Operated (DO) programs. We have 11 who are in the exam prep stage, 13 who are currently in training, and 15 who are in the application process.</p>	<p>confusing and we end up voiding a lot of claims or correcting them. We are seeing a lot of issues on the billing side and at times the supervisor and the Peer are not on the same page.</p> <p>Jennifer Hallman shared we often get questions about Peer Services, and it recently came up in a meeting with the Board where we had to provide some data broken out by Service Area because they want to know how it is being implemented. There are 30 to 60 certified Peers, but they are not Medi-Cal certified, so they do not provide Peer Support Services.</p> <p>Stacey Smith shared on the incentives that we needed Peers who have a forensic specialty and wondered about efforts to increase the number as we only have one in our system right now.</p> <p>Dr. Toni Robinson shared we have on our plan to encourage people to take the forensic specialty. This week we will be announcing our scholarships and training and put special emphasis on the forensic specialization. We will work with our team and our Justice and Law</p>	
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		<p>team to try to get their Peers certified in forensics as well.</p>	
<p>III. Behavioral Health Transformation (BHT) 14 Goals- Continued</p>	<p>Dr. Kara Taguchi shared he last CW QIC meeting provided an introduction to the 14 broad Behavioral Health goals so that clients will be able to receive care whenever they want and to be more satisfied with their care that will reduce the time of untreated mental illness and time spent in institutions, reduce homelessness keep families more intact, and reduce the removal of children from the home. The State provided data based on publicly available data for 2021 to 2022 to be able to compare Countywide to Statewide metrics.</p> <p>Dr. Kara Taguchi shared the penetration rates for children and youth under 21 years of age that received one or more Specialty Mental Health services by Race/Ethnicity for LA County compared to the State. The State provided an overall penetration rate and encouraged Counties to stratify the data by Race/Ethnicity, Age, and Gender. Looking at the distribution of Race/Ethnicity for clients who received one or more Specialty Mental Health Service in LA County compared to their distribution in the overall Medi-Cal population for children our penetration rates for Specialty Mental Health are a little skewed because of how far off the Alaskan Native and American Indian (AN/AI) number are. Their numbers are very low in our system and likely more largely represented in our system than they are in the Medi-Cal</p>	<p>Dr. Debbie Innes-Gomberg wondered if it is fair to say that because our penetration rates are higher than the State average, does that translate into enhanced performance in terms of opportunities for people to access care in these areas.</p> <p>Dr. Kara Taguchi shared we are doing better than the State in terms of the number of people who are part of Medi-Cal population getting a service but what doesn't factor into this is for the denominator of people who have Medi-Cal what percentage of that population would qualify for Specialty. This is why the percentages seem so low because automatically we know we are doing better than this but that is the fault of that denominator.</p> <p>Jennifer Hallman wondered are our percentages higher because we are serving people in our system that may not need to be in our system. Other counties are turning people away because they are not Specialty so if we</p>	<p>Dr. Kara Taguchi</p>

	<p>population. We see more Latinos in our Specialty Mental Health System than are represented in the Medi-Cal population.</p> <p>Dr. Kara Taguchi shared for Adults who received Specialty Mental Health Services, when comparing our penetration rates by age group to the State, we are above the State in all categories. The highest was for people between 57 to 68 years old, and lowest was for people over the age of 69 years old, which may be due to Medicare and other types of insurance they may have. Adults ages 45 to 68 seem to be the predominant population that we see.</p> <p>Dr. Kara Taguchi shared the goal of reducing Homelessness and the data that the State provided is from the homeless count that is done in every County. Ours is a combination of several jurisdictions and city organizations that participate. The demographic summary by Race/Ethnicity of homelessness are predominantly Latino. The next highest population for homelessness was African Americans and White. This data is from a point in time for just one night when people are going out and counting people and this may not align with the distribution of people that are placed in housing or who we are seeing on a regular basis, which is important to know. Comparing Race/Ethnicity distribution from the point in time count compared to their representation within the Medi-Cal population, Latinos and Asian Pacific Islanders are underrepresented. Whites,</p>	<p>combined this with our data from the LOCUS or our data from capacity what the State says our FTEs versus what we have.</p> <p>Dr. Debbie Innes-Gomberg shared I think this this goes way back to the culture of the County and our Department where we did not turn away indigent clients as other Counties did.</p> <p>Dr. Kara Taguchi shared the penetration rate for our Medi-Cal Managed Care Plans that received one or more non-specialty Mental Health service by race. She was not sure if the denominator for the penetration rate is solely their members, but they are showing a little bit higher.</p> <p>Jennifer Mize shared there is a very small portion of Whites around our Service Area accessing services for homelessness.</p> <p>Dr. Socorro Gertmenian stated she will inquire with her agency's team that works directly in Housing to hear their thoughts on this data.</p>	
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	<p>African Americans, and AIAN are overrepresented in the homeless population compared to the Medi-Cal population. Predominantly people without children are on the streets unsheltered.</p>		
<p>IV. Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Incentive Program</p>	<p>Stacey Smith discussed the BH-CONNECT Incentive Program. It is a \$1.9 billion incentive program to award participating Behavioral Health Plans that opted in to participate. It is over the course of five years and started January 1, 2025. To participate we completed the Managed Behavioral Healthcare Organization (MBHO) self-assessment last year in 2024 and submitted a letter to the State stating our interest in participating. We completed Submission 1 on June 17th, 2025, and received \$12.9 million. There are 15 Measures that will be evaluated for improvement each year. If we are successful, we will receive millions of dollars into our system. Everyone here has a role in getting the incentives.</p> <p>The 15 measures include improving penetration and engagement in Specialty Behavioral Health Services, improving performance on timely access for specialty services, increasing utilization of evidence-based practices (EBPs) for adults [Assertive Community Treatment (ACT), Forensic ACT (FACT), Community Supports Continuum for First Episode of Psychosis (CSC for FEP), E-CHW (Enhanced Community Health Worker), PSS (Peer Support</p>	<p>Dr. Lori Willis wondered about increasing utilization of EBPs for children, is there a baseline already and how do we know if we increased the utilization.</p> <p>Jennifer Hallman stated we can double check. It may just go from zero to an increase once we start claiming.</p> <p>Dr. Kara Taguchi shared for some of the HEDIS measures the State has set minimum or base levels and improvement over that.</p> <p>Jennifer Hallman wondered when we get the money, what are we doing with it. To incorporate in a way that we can give back to the quality of the services provided and making them more available and meaningful versus just filling gaps in our system that we already knew were there.</p> <p>Dr. Debbie Innes-Gomberg shared that is a great question and we need to bring that up to Executive</p>	<p>Stacey Smith</p>

	<p>Services), Clubhouse], increase EBPs for children, youth, and adolescents [Multisystemic Therapy (MST), Functional Family Therapy (FFT) , Parent-Child Interaction Therapy (PCIT), High Fidelity Wraparound (HFW)], increase Enhanced Care Management (ECM), adherence to antipsychotic medications for individuals with schizophrenia (SAA), and use of first line psychosocial care for children and adolescents and antipsychotics (APP). We did well with SAA and APP for our rates from 2023 to 2024 where we increased by 5% or were over the 50th percentile. Improve patient-reported Quality of Life (QOL) which aligns with what Dr. Kara Taguchi discussed in the BHT goals to decrease institutionalization, forensic involvement, increase school involvement, and decrease homelessness. Improve health outcomes and QOL among members utilizing EBPs, MBHO reassessment, demonstrate improved data sharing for behavioral health population, improve identification and outreach to member population eligible for Specialty Behavioral Health Services, and increase capacity to deliver crisis services.</p>	<p>Management because we will not get our first incentive until November. We need more information on the increased utilization methodology. The demonstration of years 1 and 2, which would probably be this fiscal year or part of this calendar year, is to increase the number of members who utilized the specific practices and then demonstrate years 3 through 5 by scaling it. The number of Adult members who utilized a specific EBP divided by the total number of Adult members with one or more specialty mental health claims is how they will start to look at that.</p> <p>Dr. Kara Taguchi stated this may be something similar to Children's. You can start to see how these different Initiatives and how they are tying together but the part that is new is the opportunity to earn money for us as a system and use it in a good way.</p>	
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Next Meeting: Monday, September 15, 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
Andrew Nguyen	Pharmacy
Angela Shields	Specialized Foster Care South
Ann Lee - DMH	SA 8
Armen Yekyazarian	DMH- Quality Assurance
Debbie Innes-Gomberg	DMH-QI/Outcomes/Training
Fady Shehatta	HAI
Greg Tchakmakjian	SA 7
Jennifer Hallman	DMH- Quality Assurance
Jennifer Mize	SA 1
Julie Garcia	Outpatient Care Services
Kalene Gilbert	MHSA
Keisha White	SA 5
Kimber Salvaggio	SA 2/ Training
Lori Willis	Children's
Maria Moreno (CLESGV)	SA 3
Michelle Rittel	SA 2
Nicole Gutman	SA 4
Rachel Santellan	SAPC
Robin Ramirez	MHSA
Sandra Chang	DMH-ARISE Division
Sharon Chapman	DMH- Outcomes
Socorro Gertmenian (External)	SA 6

Sonia Zubiarte	DMH- Quality Assurance
Stephanie Johnson	CWD- WRAP
Susan Blackwell	HAI - Managed Care Operations
Suzanne Wilson	Forensic Psychiatry Liaison
Tiffany Trotter	SAPC
Toni Robinson	Office of Peer Services
Yen-Jui Ray Lin	Clinical Informatics

Respectfully Submitted,

Dr. Kara Taguchi