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

MEETING MINUTES
September 2025

Type of meeting:	Monthly QIC Meeting	**Date:**	9-15-2025
Location:	Microsoft Teams	**Start time:**	9:00 AM
		End time:	10:30 AM
Recording:	Countywide QI Committee Meeting-20250915 - Oct 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 to the meeting and shared the meeting agenda and August 2025 meeting minutes.	Email any edits for the meeting minutes to DMHQI@dmh.lacounty.gov	Stacey Smith
II. 2025 HEDIS Measures Quality Improvement Project (QIP)	Dr. Susana Sou shared 2025 HEDIS Measures QIP on improving the performance of behavioral health related quality measures to avoid significant financial penalties from Medi-Cal, but more importantly to provide safe and high-quality care to our clients. We have been working with Supervising Psychiatrists and Program Managers in the Directly Operated (DO) clinics this past year on some projects to improve these outcomes. We decided to target 3 HEDIS measures: Antidepressant Medication Management (AMM), Adherence to Antipsychotic Medications for Individuals with	Dr. Kara Taguchi wondered if there were concerns about moving the project to a larger group and how that would happen and any recommendations. Dr. Susana Sou shared it took a lot of work on our end. The project lasted from February until May, and we utilized 2 full-time employees during those three months to get this project completed. It was helpful that we had a Pharmacy Resident this year	Dr. Susana Kai Wai Sou

	Schizophrenia (APM-E), and Metabolic Monitoring for Children and Adolescents on Antipsychotics (SAA). Our lab monitoring QI project pilot was located at Long Beach MHC and aims at improving lab monitoring adherence for our Adult population. Our study design consisted of four parts during the preparation phase where clinical pharmacists were assigned to review each chart for lab results of 1,095 cases. It was important to standardize which labs we would be looking for and ordering. Intervention 1 focused on placing orders for any tests that have not yet been ordered or resulted. If the minimum lab parameters were already fulfilled, nothing had to be done but if any minimum labs were not ordered or not resulted, we would order the missing labs. We would help order the labs and the client's psychiatrist would review the results with the clients. Intervention 2 focused on calling clients to provide reminders and identify barriers. If the client was not opposed, our team would attempt up to 3 reminder calls depending on what was relevant to client. We explained the importance of lab monitoring for medication safety and effectiveness and if the clients had any questions about lab logistics or fasting requirements, we would answer them as this	so that was part of her project to complete before she could graduate from the program. I had to pull in other clinical pharmacists at headquarters and probably 75% of the work was done by them and the data analysis as well. To apply this for all the clinics, we would not be adequate if I only had my clinical pharmacists. Hopefully the Supervising Psychiatrists can coordinate with their staff to review the reports, place orders, and then follow through with the phone calls. This is a partnership with the clinics as we did the ordering and phone calls which I will give credit to my staff as they were the most time-consuming. The clinics helped with getting the clients to complete the labs on site by doing the blood draws, coordinating blood draw with the phlebotomist, and the psychiatrist reviewed the lab results. Dr. Kara Taguchi wondered for medication adherence is it based on filling prescriptions or taking their medications as prescribed every day.	

	creates a teaching opportunity for both clients and providers. We also found that scheduling a lab draw appointment was appreciated by clients and allowed for better coordination of phlebotomy resources. We addressed schedule conflicts, offered alternate lab draw sites or times, and for transportation issues we coordinated with their case managers for bus tokens and access services. In many cases, we found that motivational interviewing was applicable for validating client's lab related anxieties and tipping the scale of ambivalence in favor of completing labs. Lastly, Intervention 3 focused on facilitating lab draws through close coordination with the clinic front desk, nursing, and phlebotomy staff to troubleshoot issues on the day of the lab draw. Reviewing the data, we found that for lab ordering half the clients met minimum monitoring parameters at baseline, either they had pending lab orders, or they had the corresponding lab results. After we placed orders for around 520 clients, the adherence rate increased to 100%. After three rounds of outreach calls totaling about 1,900 calls over the course of three months, there was significant increase in the lab completion rate from 35% to 61% which is nearly double. The majority of clients who completed labs through DMH. Pre-Intervention 24% completed labs through DMH versus 11% through an external	Dr. Susana Sou shared as we cannot be sure if clients took their medications and we are hoping that they are, the data that the State pulls is the prescription claims and submissions. Our part is making sure that our psychiatrist puts in a prescription and that it is active in the system otherwise clients will not be able to fill it at the pharmacy. We are planning to do a survey and investigating what are some of the other barriers that we can do to improve.	

	provider. Post-Intervention 53% completed lab through DMH versus 9% through an external provider. Raising the lab ordering rate to 100% was both achievable and critical because it gave us the closest to true denominator for Intervention 2. We saw that a significant increase at the end of the pilot, but there is still room for improvement. We then conducted a survey and of 468 clients who participated in this survey, approximately 55% identified no barriers and suggested that having an order in place and clear instructions is enough to support follow-through. 18% of clients identified barriers that were addressed by outreach and support processes, 4% identified limited lab hours and schedule conflicts as a barrier, which we were able to accommodate by temporarily increasing phlebotomy hours and staffing, and approximately 19% reported having completed outside lab work. Of those who reported barriers to lab completion, 48% went on to complete labs through DMH after our interventions. Based on our learning, we have developed a recipe for achieving these outcomes at both our Directly Operated and Legal Entity Outpatient clinics. The five ingredients are Order, Motivate, Remind, Facilitate, and Review. Although they are not new, the way they are prepared makes the difference and by implementing these steps,		

	each clinic can replicate this result. When ordering labs the providers should identify all necessary labs that have been ordered within the calendar year, consolidate them, and enter them in one order. This minimizes the risk of missed printouts or lab draws when the front desk staff and phlebotomist are coordinating. Next, to motivate our clients, spend time educating them on the importance of lab monitoring for the specific regimen that they are on, and address barriers. We also encourage clients to complete labs even if they have not fasted. Next, we assign trained outreach staff to schedule lab appointments, which the clients preferred over walk-ins, remind the clients and provide an opportunity to address any remaining barriers. On the day, front desk staff should be coordinating all outstanding lab order printouts and handing that to the phlebotomist. Clients should not be turned away if there is difficulty locating an order and there should be an established escalation pathway for the front desk staff, phlebotomist, and nursing staff to get help from prescribers. It is important to ensure that the results are reviewed timely with clients. If there are any issues or delays with results transmission, report to Pharmacy so that we can triage and optimize processes with the lab vendor and CIOB. For the Child and Adolescent population, our Lab Monitoring QI Intervention Project aimed at		

	improving metabolic monitoring in Child and Adolescent clients. We started this project in July 2025 during summer break period so that it's easier for the kids to come into our clinics and get labs done. We are looking at pre and post intervention for glucose monitoring and for cholesterol monitoring. This intervention is still ongoing, and they have until the end of the year to get all the clients to complete their labs. This project shows that this method of intervention is effective in improving our outcomes. To support medication adherence, we will create an electronic survey for medical staff to use with clients who are non-adherent to their medications. Once the survey is shared, the process involves monitoring adherence including assessing clients refill history and observing for signs of non-adherence. For clients with identified barriers, medical staff will complete the survey to determine the specific reasons for non-adherence and will tailor strategies to address these barriers and improve adherence based on the survey responses. If a client is non-adherent due to memory or cognitive barriers, interventions may include simplifying the regimen, setting up reminders, or using medication management aides, linking medication taking to daily routines, or providing clear and easy to follow instructions. If the barriers are related to access and logistics, interventions may include		

	providing transportation support, offering telehealth or virtual visits, arranging mail order or pharmacy delivery, selecting formulary or generic medications to reduce cost, and supporting medication access through prior authorizations or patient assistance programs. If the barriers are internal, the intervention may include building a therapeutic alliance, individual licensing medication selection to clients' preferences managing and minimizing side effects, providing clear medication education, and using motivational interviewing and community resources to enhance engagement and support. Similar to addressing laboratory monitoring barriers, effectively managing non-adherence requires a thorough assessment of the client's barriers and the implementation of targeted interventions to mitigate them. We are working on implementing these interventions and the results will not be as easily measurable as the lab monitoring projects, because we do not have access to prescription-filled data directly. By working with the psychiatrists and Program Managers in the clinic, we can provide better support to our clients by putting these insights into action and positive changes with their care.		
III. Follow-Up After Emergency Department Visit for Mental Illness	Dr. Daiya Cunnane shared update on the Clinical Performance Improvement Project (PIP) FUM.	Dr. Kara Taguchi stated when looking at the data, Latinos not only made up the largest group that had ED visits and met the	Dr. Daiya Cunnane

(FUM) Demographic Data	FUM looks at Medi-Cal clients who are six years old and up, coming into the emergency department (ED) for mental illness or intentional self-harm. We are looking at clients who receive follow-up services after their ED visit within 30 days. Our current rate of follow-up is 65.9%. We will also look at this data in terms of where there might be disparities and to get your feedback. We had a total of 10,679 ED visits for calendar year 2024 that met the criteria for the FUM. Clients who came in and had a follow up appointment within 30 days totaled 7,038 which gives us our 65.9% rate. The largest portion of the ED visits fell into the Hispanic/Latino category. We also have a higher number for the Black/African American community followed by the White community. We have about 20% of ED visits that had Unreported Race. Dr. Daiya Cunnane shared when looking at follow-up appointments the Asian community has a rate of 71.7%, followed by the Hispanic/ Latino population, and then Native American population. The groups that are receiving a lower percentage of following up with their appointments are Native Hawaiian/Pacific Islander group at 58.7% and African American group at 61.7%. The Black/African American group has a lower rate of follow up which is	criteria, but they followed up to a higher degree and were represented more in the follow up group to an even higher percentage. Understanding the directional change that happened even though it was a few percentages, is interesting. Dr. Kara Taguchi shared for all Asians that had ED visits, 71.7% of those had a follow up within 30 days. Jennifer Hallman wondered if these are people who showed up for the follow up, for Unreported race to be at 57% is surprising because you would think if they were showing up the data should have been collected. Dr. Kara Taguchi shared we are categorizing them based on ED visits. This data was not updated with information in IBHIS. Jennifer Hallman wondered if once follow up with the client is completed and they are a little bit more stable, is the provider asking the question of Race and Ethnicity.	

	concerning because they make up a large number of our ED visits. Dr. Daiya Cunnane shared the data shows that there are more males going to the ED, but females have a higher rate of follow up appointments. For age group breakdowns, 31–40-year-olds had the most ED visits, followed by 21–30-year-olds, and then 11–20-year-olds. We have similar follow-ups except for the 11–20-year-olds who have a high follow-up rate. The 31–40-year-olds have the highest ED visits but have the lowest follow up rate. The 31-40 years old group might be an age group that we need to target interventions towards. Dr. Daiya Cunnane shared Psychotic Disorders followed by Mood Disorders were the most seen diagnoses in ED visits. Intentional self-harm and Behavioral Syndromes had the lowest follow up rates followed by Psychotic Disorders at 52.1%. Psychotic Disorders would be a target for intervention as they are the most common diagnosis we are seeing in ED visits but have a low follow-up rate. Dr. Daiya Cunnane shared when calculating the FUM an individual who comes into the ED for more than one visit during a 30-day period will only be counted as one visit. We saw the majority of clients that are being counted have one ED visit at 87.3% and we have 940 clients	This may not be their priority as their priority may be clinical. Dr. Kara Taguchi shared in the Regional QICs and Service Area meetings the priority is delivering the clinical services, but collecting demographics are important as well to help the system understand who we are seeing in our services and allowing us to do analysis, see if there are really differences that need to be addressed by changing the programming or interventions to better suit certain populations. I agree, it is not the priority, but it is important. Socorro Gertmenian wondered on the chat how can you have more people following up than those coming in when looking at females. Dr. Kara Taguchi shared this is the distribution of the follow up compared to the distribution of the ED visit. Males are represented to a higher degree who have ED visits, but females follow up more often than males do is. Jennifer Hallman shared maybe the 6-20 years old are more likely to have a caregiver who will be	

	coming in for two visits and 166 for three or more. We want to look at clients with multiple ED visits to see where interventions could happen. Hispanic and African American groups have the highest number of ED visits. We did some comparison looking at Race and Age, our data showed the Latino group for the 11-20 years old seem to have a higher rate of ED visits, followed by 21-30 years old, and then 31-40 years old. We also had a higher rate for Black/African Americans ages 31-40 years old going to EDs. When adding in gender we see that Latina females age 11-20 had the highest amount of ED visits. Of note as well is 31- 40-year-old males in the Black/African American community and the same age group for Hispanic/Latino males are data points that we wanted your feedback on. Dr. Daiya Cunnane shared challenges in the data include we are only able to see clients in the Plan Data Feed that have had touched our system. There are other clients out there who might be going to the ED that we aren't aware of. There are challenges in figuring out where the ED visit occurred as the Plan Data Feed sometimes only has the address of a parent company for the ED. Dr. Daiya Cunnane shared some of the other things that we are thinking about looking at	taking them to their follow-ups, and this may apply to the older adults as well whereas the adult population is more on their own. This can also relate to having somebody help them get to the appointment or remind them to get to their appointment, etc. Stacey Smith wondered if co-occurring disorders were a factor for 21–50-year-olds which could be impacting the client's ability to follow-up with care. Dr. Kara Taguchi shared transportation is something we can engage the MCPS to help with and would it improve the follow-up. Jennifer Hallman shared it will also be interesting to look at housing status. If they are unhoused, it will make the trip difficult to show up for the follow-up appointment. Dr. Kara Taguchi shared how different it is than our diagnostic picture of the clients that we serve. The people who are being counted in this metric represent a different distribution than who we see overall, and it could also be because we are looking at a	

	engagement in treatment prior to the ED visit and co-occurring disorders that may impact client's follow-up with appointments.	different level or type of care here a little bit more in depth. Jennifer Hallman was interested in a chart review from the ED to find out types and reasons for visits and not getting hospitalized but coming to our system. It would be interesting to know why they are going to the ED. Is it a high percentage of panic attacks or anxiety? Dr. Kara Taguchi shared we learned in the pilot with Genesis that clients who had ED visits weren't always specifically for a Mental Health Disorder, but the ED included the diagnosis even though that wasn't the primary reason for the visit. Stacey Smith shared there were talks in a about analyzing data from 911 calls where a sheriff or police officer comes and takes a client to the ED if they have psychotic behaviors. Dr. Kara Taguchi shared compared to 2024 there have been efforts of moving forward with diverting and routing people to the right place for follow up to avoid	

		ED visits. Maybe checking ED notes which is what Genesis was doing during that pilot. Do we know if other programs are doing that? Jennifer Hallman wondered if maybe they did not update the diagnosis, and we get claims from the ED for mental health diagnoses instead of for medical diagnoses and so they were carrying over. Dr. Kara Taguchi shared we can check in with Clinical Informatics on more of those specifics. Stacey Smith shared the data is based on the primary diagnosis for the ED visit, getting the secondary diagnosis is one of the issues we are trying to figure out. Jennifer Hallman wondered if we know what percentage of these clients were already known to our system. Do we know if that was before or after the ED visit? Dr. Kara Taguchi shared this came from Plan Data Feed information and we only get data for clients that have touched our system in some way. We submit and have a	

		file of clients that have been known to our system, but we do not know how often that data gets checked. Dr. Yen-Jui Ray Lin shared yes, our department will send out a file and then it will match clients in the plan data. Right now, it's about every month, once a month the data will come in. Stacey Smith shared we were concerned about the data for 11-20 years olds, specifically Latino girls between 11-20 years old who are going to the ED for Mood Disorders. They are not really a concern for the FUM because they have a high follow-up rate but in terms of why the numbers are so high for this group and what might be the driving factors that may need to be addressed. Dr. Lori Willis shared we would have to investigate this more to provide feedback on the next meeting or via email, but that is an interesting finding. Jennifer Hallman wondered what the diagnosis was. It almost makes you wonder about that population	

		seems like the ED is becoming the default. Stacey Smith shared the diagnosis was for Mood Disorders. Jennifer Hallman shared it really makes you wonder what is going on with that age group for that population. Dr. Lori Willis asked if this data was pulled in 2024. Dr. Kara Taguchi shared yes this was 2024 data. This is where the layering becomes interesting and important to look at, such as for men of color, unhoused, and the regional components. Dr. Lori Willis shared there has been but can't confirm if it was in 2024 an increase in the Latino population for ages 11-20 seeking assistance, not necessarily coming to a Mental Health facility but going elsewhere to their doctor. There was an increase and I am curious if that increase still exists for 2025 as well. Dr. Kara Taguchi shared it is a little concerning with the Latino population because we expect for	

		them to show up less to seek services, maybe due to fears of reporting. I think this group is differentially affected by that. I would worry about the population that needs services but not getting them and the kind of consequences that might be. It would also be interesting to see if this pattern is held within hospitalization data or if it looks different in terms of who is showing up in our hospitals and see if that's the dynamic that is also in that level of care. Stacey Smith shared there are issues with the mapping of zip codes. We wanted to know if there were EDs with poor follow-up rates to see if interventions were needed in certain locations, but this has been challenging to identify the ED location. Dr. Kara Taguchi shared that Medi-Cal Connect may be able to help us with some of this in the future, but we will learn more about that as DHCS rolls that out.	
Next Meeting: Monday, November 17, 2025, from 9:00AM-10:30AM			

Attendance (below):	
NAME	**AGENCY**
Kara Taguchi	DMH-Outcomes/Quality Improvement
Stacey Anne Smith	DMH-Quality Improvement
Daiya Cunnane	DMH-Quality Improvement
Laarnih De La Cruz	DMH-Quality Improvement
Volga Hovelian	DMH-Outcomes/Quality Improvement
Ann Lee - DMH	SA 8
Debbie Innes-Gomberg	DMH-QI/Outcomes/Training Division
Elizabeth Powers	DMH-CMMD
Fady Shehatta	Clinical Informatics
Greg Tchakmakjian	SA 7
Jennifer Hallman	DMH- Quality Assurance
Julie Garcia	OCS
Kalene Gilbert	MHSA Administration
Keisha White	SA 5
Kimber Salvaggio	DMH-SA 2
Lori Willis	Children’s
Ly Ngo	DMH-Clinical Risk Management
Maria Moreno	SA 3
Mayra Garcia	Quality Assurance
Michelle Rittel	SA 2
Nicole Gutman	SA 4
Nikki Collier	DMH-Quality Assurance
Ray Lin	DMH-Clinical Informatics
Robin Ramirez	BHSA Administration
Sandra Chang	DMH-ARISE Division
Sharon Chapman	DMH-Outcomes Division

Socorro Gertmenian	SA 6
Sonia Zubiate	Quality Assurance
Stephanie Johnson	CWD Wraparound
Susan Blackwell	Health Access and Integration - Managed Care Operations, Planning Office
Susan Cozolino	DMH-Quality Assurance
Susana Sou	DMH-Pharmacy
Theodore (Ted) Wilson	DMH-Patients' Rights Office
Tiffany Trotter	SAPC
Toni Robinson	DMH- Peers Service
Varaga Simonian	Patients' Rights
Vicky Lin	PEI Administration
Wanyu Chang	PEI Administration
Yen-Jui Ray Lin	DMH-Clinical Informatics
Zhena McCullom	QA/QI

Respectfully Submitted,

Dr. Kara Taguchi