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

MEETING MINUTES
November 2025

Type of meeting:	Monthly QIC Meeting	**Date:**	11-17-2025
Location:	Microsoft Teams	**Start time:**	9:00 AM
		End time:	10:30 AM
Recording:	Countywide QI Committee Meeting-20251117 - Dec 1st, 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 welcomed everyone and shared the meeting agenda and September 2025 meeting minutes. Stacey Smith introduced new QI Team staff Dr. Marianne Klee and Dr. Barbara Meyer. Dr. Klee will be taking over the South Regional QIC meetings and Dr. Meyer will be taking over the North Regional QIC meetings.	Email any edits for the meeting minutes to DMHQI@dmh.lacounty.gov	Dr. Kara Taguchi/ Stacey Smith
II. Legal Entity Language Access Survey	Mirtala Parada Ward shared the Departmental Language Access Plan and Legal Entity Provider Language survey from ARISE's Language Access Unit. The survey went out for the first time on October 1st and was due October 31st, 2025. We had a 53% response rate.	Venezia Mojarro wondered for slide seven, the third highest or second highest language was unknown. What is that capturing? What is falling into that category? Mirtala Parada Ward shared it can be a dialect such as a Mayan	Mirtala Parada Ward/ Alan Wu

	Two years ago, LA County Board of Supervisors passed a board motion called the Countywide Language Access Policy. This policy ensures that every resident of the County has equitable access to language services when interacting with the County and fosters an organizational culture that realizes its commitment to equity, linguistically, and culturally responsive services. LA County has 12 threshold languages that applies to all County departments, contracted/ legal entity providers, administrative entities, and vendors conducting business on behalf of the County. All County departments will provide services and conduct internal operations, allocate resources, establish regulations, and operate facilities in a matter that supports equitable language access to all individuals that seek our services. Our unit was tasked with the responsibility of developing the first Departmental Language Access Plan and it was due in October of last year. We had to have an established process as we are telling members of the public that we will provide them with services in their preferred language and if they do not receive that service, they have the right to file a grievance in the Patients Rights' portal. We report back to the Board every two years, and our first report is due October 15, 2026. LACDMH is mandated by the Departmental	dialect, and they may feel it is not a language or if they have a tribal language. That is the reason why we gave the other option. Dr. Kara Taguchi wondered why it would be so much higher for the face-to-face survey versus the telehealth. She would assume if they were using a Language Line, they would know the language and have that information. Or maybe the LEs are not tracking or recording it, therefore they are unable to pass that on. Mirtala Parada Ward shared this is our first data set. We are speculating that more people are coming into the office and when they have language encounters, it might be easier if they are in the office with them. Jennifer Hallman shared it sounded like it was Other, but what it states there is Unknown or Unreported, which to me is different than Other and seems like their staff did not tell them what the language was.	

	Language Access Plan to monitor, track, and report all language access services and activities inclusive of all directly operated programs and contracted/ legal entity providers. Specifically for the Language Line, we have to track the face-to-face service encounters, and the telehealth service encounters for non-English language users. Most recently, the Behavioral Health Information Notice 24-020 requires that all Behavioral Health providers submit a report detailing language service encounters of language line interpretation services to provide language access to members in non-English languages. The Language Access survey for the LE providers tracks Language Line services for therapy services (individual and group) and psychiatric and case management appointments. Please note that this does not include use from clerical staff. We can capture all your employees and the language that they speak through NAPPA. If you are a LE and do not recall completing this, please go back to the name of the person who signs the contract, because that person got that e-mail to submit your data. It is not too late. We will update our report. We require the LE providers to complete a quarterly survey. The first survey covered July 1st through September 30th was due October 31st. The next one is going to cover October 1st through December 31st, and will be due January 31st of 2026. The 3rd quarter is January 1st through March 31st of	Venezia Mojarro shared since it is a high number, maybe strike it or make it more specific. Dr. Kara Taguchi shared maybe have them specify what they are putting. Also, to have an expansion of other languages to include any dialects so you get the description. Since you need this information to report to the State, maybe track what they are putting in place. Since we are required to report this, will you be contacting the providers that did not respond. Mirtala Parada Ward shared yes, we have been contacting them and presenting to the LEs. We asked if they checked with their CEO and President of their agency. When we sent the survey out, we went through the Legal Entity Contract Division, and we assume that the information was not disseminated. Jennifer Hallman shared that the issue is more that the link for the actual submission is probably getting to the wrong people and as we discussed in our QA/QI meeting, they shared that they did not get it. If you send it over to us,	

	2026 and is due April 30th, and the 4th quarter is April 1st through June 30th and is due July 1st of 2026. The survey will take you less than 15 minutes to complete. It is very quick and user-friendly, and we will provide you with a tracking form that you can use monthly to collect this information and help you complete the quarterly surveys. Reminder that you do not need to submit the tracking form as this form is just for you. For the survey ending December 31st, we are requiring both LEs and DOs to attest that all staff completed the Cultural Competency Training requirements for the year, and for the 2nd quarter survey, you must attest that 100% of your workforce has completed the State training requirements for that calendar year. When we say your entire workforce that includes your clerical support staff, not just those providing services. Alan Wu shared a demonstration of the survey. The survey has 3 sections. Section 1 focuses on the provider's information, their name, e-mail, phone number, and indicates the reporting period for the survey. Our focus is when the service encounter uses a language line service or interpretation service, and the total number of encounters or sessions for each of the 13 threshold languages.	we will be happy to send it out to everybody. Dr. Kara Taguchi shared the next Regional QIC meeting will be held mid-January 2026, and they are required to attend these meetings. If you have a slide, we can include them in the QI updates. Mirtala Parada Ward shared we will be looking at the Unknown data and get back to you. The Russian language numbers were surprisingly high. Dr. Kara Taguchi shared that came up in the Regional QIC meeting that Service Area 4 mentioned they were having a lot of Russian language requests that they could not accommodate. Jennifer Hallman was surprised at how high Spanish interpretation was knowing that we have a lot of bilingual Spanish speaking staff. As for the Russian language, how many clients are requesting services or are there just a couple of the same clients who constantly request for it.	

	Section 2 is where the provider completing the survey would go over all these different languages that indicate total number of sessions encounters or treatment encounters for each language, including the American Sign Language or ASL. We also have them specify any additional language encountered. Section 3 is the annual State competency training requirement. They would indicate the percentage and then if they do not have 100%, they will indicate what their plan of reaching 100% compliance. Alan Wu shared the 1st quarter from July 1st to September 30th for the face-to-face survey. There is a total of 155 LE providers and out of that we had 82 responses, for a 53% response rate. For the 13 threshold languages, the top five language were Spanish, Mandarin, Russian, Armenian, and the American Sign Language. For the annual competency training, the average was 89%. The second survey was the telehealth survey, and again same number of providers at 155 with a total of 75 responses at a 48% response rate. The top five language were Spanish, Russian, Farsi, ASL, and Armenian. The average for training completion was 92%. For both surveys we still have about 50% that we have not received, and this is why we are asking you to submit your responses.	Mirtala Parada Ward shared that it is interesting that so many people request Spanish, but Russian is an emerging need because of what is going on globally with the war. There is a spike in refugees from Russia and from the Ukraine that is driving that force. For our Division, it helps plan for the budget and allocation in the future of what we need for language accessibility as a requirement for cultural competency. Dr. Kara Taguchi shared it may be that clients prefer clinicians that speak the language, then the second would be an in-person translator and third would be using the Language Line. Is that the correct order that clients prefer? Mirtala Parada Ward shared usually they will find an employee that speaks the language. They will offer the language line and sometimes clients will say I really don't like the language line. I can only speak for our DOs. They get their needs met through the language line.	

	Mirtala Parada Ward shared for the Directly Operated programs; we capture the data at the ARISE Division and process all the interpretation data and manage the contract for the Language Line internally. This survey is only for the LEs.	Dr. Kara Taguchi asked so the Language Line is preferred over an in-person translator. Mirtala Parada Ward shared yes and same with ASL. We have two ASL interpreters and about 70% of their platform is they do virtual sessions and what they do is they put the ASL interpreter, the client, and the clinician in the office but the interpreter is on the screen. Most of our ASL sessions are done virtually. Antelope Valley, Service Area 1, has the highest ASL population right now, where we get a lot of requests. Occasionally our interpreters have to travel all the way to the Antelope Valley as we receive tough cases like the DCFS cases where they have to go in person. Also, ASL has never made it to the top five since I have been in the Department. It's good that we have made a great dent in that area. Dr. Kara Taguchi wondered now that you have this information, what are you going to do with it or how do you think it ties to other things in the department whether	

		it's Quality of Services or Access to Care. Mirtala Parada Ward shared this part of the the cultural competency plan and when we start looking at staffing and looking at language access for the Department, we are going to use this data to help us drive where the needs are and report out on the DLAP and look at trends. We also look at how many language requests grievances we got and that helps us to know where we are at, and the progress that we are making. Jennifer Hallman shared from QA perspective the requirement we have unfortunately has been out of compliance for several years. We have to report Language Line usage across our entire system. Do you know if fee for service or individual group providers, also get the survey? The reason this is looked at is to have the ability to make services available in the client's preferred language and this gives us another data point on are we able to make it available in their language. On the progress notes if the language was provided in a	

		language other than English, it documents if it was the staff themselves or through the Language Line so we can get an idea and how we provide those services in the language, and where do we need to put some efforts around staffing. Mirtala Parada Ward shared that no, this does not include fee for service or individual group providers. We would like to meet with you to give the data. This is only for Legal Entity providers. Dr. Kara Taguchi wondered is the use of the Language Line an indicator of where we need to do more outreach to get staff that speak that language or is it more of a preference. Does the client say I want to use the Language Line versus an in-person interpreter? Mirtala Parada Ward shared clients will not say that. The clients will say they want their services in Chinese, but it is the provider that says we have a Language Line and client says yes. We have rare instances where the client says	

		they do not want to use the Language Line, and they want an interpreter to come to Arcadia for example. So now we tell the clinician to submit the request 15 days in advance and plan it because we must arrange for an in person interpreter. But sometimes when we say we have to reschedule appointments to get the interpreter in person, the client will say they are ok to use the Language Line but request the interpreter for their next session. Most providers will offer the Language Line first and most clients are satisfied with that. Dr. Kara Taguchi stated but the 15 days soonest availability on initial appointment does not meet with Access to Care requirement. Mirtala Parada Ward agreed. We try to do it as soon as possible. If it is an ASL interpreter, sometimes those are urgent, then we have the two ASL interpreters in house. Our Language Line contracts do not align with Access to Care. The two master agreement contracts are shared among twelve different County departments for different	

		needs. We do build relationships, and they are willing, but sometimes we cannot guarantee it. Dr. Kara Taguchi shared even if we share amongst different County departments, not every County department has the same requirements or mandates from their governing body. I don't know about contracting for something that puts us where we are not meeting Access to Care guidelines. Mirtala Parada Ward shared the clients are not saying that they want an in-person interpreter. We offer them the Language Line, and they are satisfied with that, but if they say they prefer in-person, we make it happen. This is very rare. If we want to improve, Kaiser has the iPad with the portal and will get an interpreter on the screen right there and then for you. This is my recommendation to CIOB. We have met with a company that does that. DHS already has it, so we just need to piggyback on DHS' contract.	

		Dr. Kara Taguchi shared that it sounds good. When it comes to grievances, how are the grievances for Language Access, do you know? Mirtala Parada Ward shared the number of grievances is very low. We track the grievances for the DLAP. Our report is due December 31st, and we are in the process of gathering that data now. Venezia Mojarro shared I want to caution us that Language Access grievances are low because there is a cultural layer there. Mirtala Parada Ward shared yes. One of the biggest components of the plan is that if an agency does not provide language access, what are the client's rights and the process. We had to outline our entire grievance process for LEs and DOs. Now that we are promoting language access, we noticed that ASL has increased. We also have posters at the entrance of every clinic promoting that language accessibility in their preferred language is a requirement.	

		Dr. Barbara Meyer shared regarding Spanish, if the child is English speaking that sometimes the staff might use the Language Line for Spanish speaking caregivers, especially for older children or teenagers. When the clients are offered the Language Line, do they know that they could request an in-person interpreter? Mirtala Parada Ward shared when I went and presented at the Supervisors Forum and the Program Manager's meeting, I explained to them that they must have Language Access. I also explained what we have available. If everyone were to request in-person interpreters, there is severe shortage nationwide and we would not meet the Access to Care requirement. We do not have enough interpreters in our pool. There is a severe shortage of ASL interpreters, especially ones that are willing to travel far distances. Also, for tactile interpreting we pay almost double for that person to go all the way to Antelope Valley. We have three or four cases for tactile ASL.	

		Dr. Kara Taguchi shared thank you for this data and information and maybe when you hear back from the LEs, we are interested to see if the data changes and we look forward to what you will do with the data after. Mirtala Parada Ward shared yes. Our goal is to share the data on a quarterly basis. We now have enough data to report and to do improvement plans around Language Access.	
III. Health Plan Operations (HPO) Unit- Care Coordination	Fady Shehatta shared we are a new unit in the Department in coordinating care between the Department and the Managed Care Plans. We are under our Deputy Director for Managed Care Operation, Dr. Paul Arns. We have our Medical Director, Dr. Carol Eisen. I am the Program Manager for the unit, and we have two Health Program Analyst (HPA) IIIs Jeanna Polard and April Newman. Jeanna Polard handles the Care coordination for Electroconvulsive Treatment (ECT), and she has two HPA IIs under her. April Newman handles the high level of care for Eating Disorder (ED). We also have 3 RNs. Our unit handles the Memorandum of Understanding (MOUs) with MCPs, the care coordination and overview of our mailbox (ICD	Stacey Smith wondered with your work with Molina around the FUM, do you include Shelly Hsu to understand the specifications of the measure. Do you have a rate of what you see for people being able to meet 7 and 30 day follow up visits? Jeanna Pollard shared we are in our 4th week of receiving reports from Molina. I was able to meet with the Care Court team and develop a new workflow with them. Next quarter, this should improve greatly just in terms of the 7 day and the 30-day follow-ups with Molina. We will also be receiving	Fady Shehatta

	and ECT), high level of care for Eating Disorders, our upcoming centralized Transition of Care (TOC) that we are actively working with Quality Assurance on, and the Healthcare Effectiveness Data and Information Set (HEDIS) measure Follow-Up After Emergency Department Visit for Mental Illness (FUM) pilot with the Managed Care Plan. The Health Plan Operation Unit specifically was designed to meet the requirement after the State requirement for the coordination between the two systems of Specialty Mental Health and Non-Specialty Mental Health. The purpose is to bridge these two systems for our Medi-Cal members. We are actively working with Kaiser and SCAN and to hopefully execute MOUs with them by next year. Our responsibility is also overseeing data sharing on HEDIS measure, collaboration ensuring MOU compliance, and providing technical support to our DOs and LEs when needed. Three of our major MOUs have been fully executed. We hold a monthly meeting with the MCPs where we review the TOC and address any escalated cases. During our monthly meeting, we also go over the screening tools to be sure that we do not have any duplicated services to comply with our MOU requirement, and we provide communication channels to the MCPs and to our DOs via the ICD mailbox. We have the ED/ECT mailbox for	the FUM reports from Health Net, and we hopefully will get them by December 31st and then every week. Stacey Smith reflected that HPO is already part of the FUM PIP committee and wondered if they can bring this data to the meeting every month. Fady Shehatta shared yes we can. Dr. Kara Taguchi wondered about the Transition of Care, is this the same as what was mentioned during the LOCUS implementation meeting. What was not clear to us in that meeting is that there are some things that go beyond individual client transitions and that there may be a policy that we need to work on as a system, in coordinating on a larger scale with our MCPs than individual client care coordination. April Newman shared in her care coordination meetings with Blue Shield; they have expressed an interest in presenting to our providers the services that the MCPs provide and how they can	

	referrals for ECT and high level of care Eating Disorders. All the communication that we handle with the Managed Care Plan or with our Directly Operated is tracked for accountability and quality improvement and for state requirements and audits. A report was requested to show them how we track all communication with the MCPs and escalation. For any initial escalation received, we triage it and forward it to the Account Manager who then communicates the information either with me or directly with QA. If any information is needed from the MCP, they contact the MCP directly and do all the coordination with the provider. We also process the high level of care Eating Disorder referrals and ECT. We handle the referral, communicate with the facility, and at the end we make sure we have a placement for our client. If any escalation is needed, we escalate it to the Account Manager, and they take it from there and we discuss together how we should proceed. If the problem is with the MCPs, our final resolution is to go directly to the State to get resolution. Fady Shehatta shared an overview of the new model with having MOU executed. We are currently sharing 50/50 cost with our MCPs. DMH takes the lead. We contract with the facility and we do all the authorization and the placement. We pay 100% up front and then we bill our MCPs who are now paying 50% of the	work in conjunction with the MCPs in providing services to our shared members. Blue Shield would like to reach out to other Managed Care contacts to come together and create a presentation. I am not sure which meeting would be the most appropriate and thinking maybe in quarter one we could organize something where the MCPs could come in, present, and answer any questions, particularly with our LE providers about working with the Managed Care Plans. Jennifer Hallman shared before the screening and transition tool requirements went into effect, we had several of the Managed Care Plans come and present at a QA on the Air around what services they provide and information. That was successful because people were able to ask questions that come up a lot such as transportation and some of these other services that are the responsibility of the Managed Care Plans and not us. We could use QA on the Air to do that and	

	cost to us. We are trying to expand our network as we currently only have two facilities that handle client with Eating Disorders. We are working with an additional two facilities to expand our network and provide more services to our clients. We have a high number of pending cases that are waiting to be placed. Centralized TOC is new. We are working on it actively with QA. We are hoping to have a new centralized workflow so our unit can become the central hub for the TOC screening. We can have a single point of entry for the MCP where the clinic does not have to complete the TOC and send separately to the MCP. Our team can review the TOC before distributing to the MCP, and this can be integrated into IBHIS just for tracking. This benefits and standardizes the process, improves data, and provides faster routes. We are working with QA to target two of our clinics for our pilot centralized TOC, Roybal and Antelope Valley. We are hoping for this to launch early next year. Lastly is our HEDIS measure. We have a pilot with Molina and have a weekly HEDIS report from the MCP. We contact the assigned DMH team for the seven days follow up. We process the members with excessive visits, and we track the outcome.	dedicate the entire time to the Managed Care Plans. Jeanna Pollard shared in terms of ECM and transportation, so that there are no delays, send your e-mail to the ICD mailbox. April and I already work collaboratively with the MCPs on this. Dr. Susan Cozolino shared that we received a lot of feedback from Managed Care Plans saying yes, we see individuals with ADHD that have psychostimulants, we have long acting injectables, and we do telehealth as well as in person based on the client preference. We could have some frequently asked questions for them to address. Fady Shehatta shared we can schedule and send an invite to all of them and discuss with them the benefit of having them coming to present in our meetings. April Newman shared as mentioned Blue Shield would first like to organize a meeting with the other MCPs to make sure that they are all on the same page. Then we can organize a meeting in January	

		and move forward with them and schedule to present. Dr. Kara Taguchi shared we also have Regional Quality Improvement Committee meetings if that is something that you want. We try to prevent having the same items presented in multiple meetings. QA on the Air meetings are in depth with the ability to ask and get questions answered on the spot. We also have QA/QI monthly meetings. Jennifer Hallman shared it is a need to continuously remind our providers of what the benefits are under the Managed Care Plans, what they are required to do and how to help your client access those benefits, and understand what the Managed Care Plans are responsible for. Jeanna Pollard shared one of the things that is occurring with our care coordination is that the RNs on our team are going through the charts of individuals that are critical and pointing out to the health plans if they are missing immunizations, dieticians, nutritionists, to make	

		sure that they all have primary care physicians, etc. Overall making sure that our providers know that they are available and should ask what's needed for the client's care. Dr. Susan Cozolino shared what could come of it is clarifying what they provide. Some providers have already done this, having a standardized sheet at the outset for new clients that come in to understand the difference between specialty and non-specialty. Dr. Kara Taguchi shared all that is mentioned is great and it is not only knowing what your MCPs are supposed to provide, but also how to handle it if the MCP or a provider is saying we do not do it when you know they are supposed to. It may also help that we are trying to onboard to Medi-Cal Connect to get care managers connected with. This provides information, especially for Jeanna, about the type of work that you met with us and told us that you are doing, and to be able to see	

		more easily where the client has been. April Newman shared that for Medi-Cal Connect Blue Shield did share that they are not in yet, and the feedback that they were getting from other MCPs was that the data was old. Dr. Kara Taguchi shared there is a three-to-six-month delay because it goes through a whole process based on claim and encounter data. I am wondering what their experience has been. We were at an MCP quality meeting and they invited the Counties. There is still a lot of work to be done in terms of information sharing even when it comes to the HEDIS measures that we have in common, and we heard that DHCS wants FUM to be something to focus on because it requires us to share and work together to really achieve this. But in the County, we have a different denominator of people who we are responsible for, than the Managed Care plans as we share with multiple MCPs. Jeanna, if you can keep QI in the loop with what you are working on with Molina we	

		would like to continue to collaborate. Jeanna Pollard shared that we have had a couple of meetings with the Health Net IT department to work on the issue of getting reports from them. We are in the queue and they will try to get them to us by the end of the year. Jennifer Hallman shared probably what we should do is come up with a list of all the information sharing, the ways we share client data sets with the Managed Care Plans. It seems like it is more of a miscommunication. Maybe just having a full list of ways in which we share client files, the status, who is responsible, and our contacts will be helpful.	

Next Meeting: Monday, December15, 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

Barbara Meyer	DMH-Quality Improvement
Marianne Klee	DMH-Quality Improvement
Laarnih De La Cruz	DMH-Quality Improvement
Volga Hovelian	DMH-Outcomes/Quality Improvement
Alan Chung Chiu Wu	ARISE Division
Angela Shields	Specialized Foster Care South
April Newman	DMH-Health Plan Operations
Armen Yekyazarian	SA 2/ Quality Assurance
Berteil Eishoei	Quality Assurance
Debbie Innes-Gomberg	DMH-QI/Outcomes/Training Division
Elizabeth Powers	CMMD
Fady Shehatta	MCO-Health Plan Operations
Greg Tchakmakjian	SA 7
Jeanna Pollard	DMH- Health Plans Operations Unit
Jennifer Hallman	DMH-Quality Assurance
Jennifer Mize	SA 1
Julie Garcia	OCS
Keisha White	SA 5
Kimber Salvaggio	Training Unit/ SA 2
Lauren Nakano	HAI
Marc Borkheim	DMH-Quality Assurance
Maria Moreno (CLESGV)	SA 3
Michele Renfrow	Community and Hospital Liaison Program
Michelle Rittel	SA 2
Mirtala Parada Ward	ARISE Division
Nikki Collier	DMH-Quality Assurance
Rachel Santellan	SAPC
Robin Ramirez	MHSA Administration Division
Sandra Chang	ARISE Division

Sharon Chapman	DMH-Outcomes
Socorro Gertmenian	SA 6
Stephanie Johnson	Wraparound
Susan Blackwell	HAI-Planning
Susan Cozolino	DMH-Quality Assurance
Theodore (Ted) Wilson	Patients' Rights Office
Tiffany Trotter	SAPC-Public Health
Toni Robinson	Peer Service
Venezia Mojarro	CPAS
Veronica Chavez	ACCESS Help Line
Vicky Lin	PEI Admin
Wanyu Chang	PEI Admin
Yen-Jui Ray Lin	Clinical Informatics

Respectfully Submitted,

Dr. Kara Taguchi