

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

MEETING MINUTES  
February 2026

<b>Type of meeting:</b>	Monthly QIC Meeting	<b>Date:</b>	2-9-2026
<b>Location:</b>	Microsoft Teams	<b>Start time:</b>	9:00 AM
		<b>End time:</b>	10:00 AM
<b>Recording:</b>	<a href="#">Countywide QI Committee Meeting-20260209 - Mar 13th, 2026</a>		
<b>Members Present:</b>	See table below		
<b>Agenda Item</b>	<b>Presentation and Findings</b>	<b>Discussion, Recommendations, and/or Needed Actions</b>	<b>Person(s) Responsible</b>
<b>I. Welcome and Introductions</b>	Dr. Kara Taguchi welcomed everyone and shared the meeting agenda.  Stacey Smith shared meeting minutes. For edits, please send emails to the DMH QI mailbox.	Email any edits for the meeting minutes to <a href="mailto:DMHQI@dmh.lacounty.gov">DMHQI@dmh.lacounty.gov</a>	Dr. Kara Taguchi/ Stacey Smith
<b>II. Quality Improvement Updates</b>  <b>Countywide QIC to Quality Assurance and Performance Improvement (QAPI) Leadership Committee Meeting</b>	Stacey Smith shared the Countywide QIC will be subsumed by the Access to Care Leadership meeting which has many of the same participants. Conversations are often repeated in both meetings, which is inefficient. Access to Care Leadership meetings are twice a month on Thursday afternoons from 4:00pm to 5:00pm. At the first meeting of the month, we will stay focused solely on Access to Care and at the second meeting of the month we will focus on the other metrics that are accountable	Dr. Debbie Innes-Gomberg shared the intent for the transition is to move back to what quality improvement truly is and that is using data to assess performance and evaluate where the program and the County is and creating opportunities to improve performance. It has been hard to get people to really talk about the data that is being presented. By	Stacey Smith

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	<p>in our contract. Attendees that are not already included in the Access to Care Leadership meeting will be invited and we will be including the Discipline Chiefs. Service Area Liaisons will continue to participate in the Regional QIC meetings.</p> <p>Access to Care Leadership Meeting beginning in March will change its name to the QAPI Leadership Meeting. Policy 1100.01 will change from QI Program to QAPI Program in accordance. The QAPI Program encompasses multiple units including the Quality Assurance Unit, QI team, Office of the Medical Officer who is responsible for practice parameters, Clinical Risk Management, and Patients' Rights among others. Access to Care Action Committee that includes Legal Entity directors will also change its name to QAPI Action Committee.</p> <p>Lastly, as this will be our last Countywide QIC meeting, we want to thank everyone who has attended, participated and presented. We value all of you very much and we appreciate everyone.</p>	<p>transitioning to Access to Care Leadership, we can target what we are responsible for improving, which is a growing list of things, and what the State is holding us accountable for.</p> <p>Dr. Kara Taguchi shared for those of you that have been in this meeting, it has been difficult to get robust discussion. A lot of times we would present the data in front of the leadership team and have a robust discussion and then come here and the discussion would not quite be at the same level only because people who are in this meeting heard it before. This will also help reduce the number of meetings. We are hoping to continue to have robust discussions and are excited for things to come, but we will utilize our Regional QICs to carry the learning and suggestions forward and use it also as a two-way street to get input into QAPI Leadership meetings as well.</p> <p>Stacey Smith shared that in the Regional QIC meetings, we are going to go back to exploring what quality improvement projects</p>	
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		<p>providers are already doing where they can present on it and see if those interventions they are doing could be implemented in a larger system-wide way. We also need help from all the Service Area Liaisons who all have strong connections with the providers on how to plan for and implement it. If any Service Area Liaison has any ideas or thoughts, let us know.</p> <p>Kimber Salvaggio shared as a suggestion, as one of the things that we would usually do a couple of days before our meeting is ask, “does anyone want to discuss what is happening within your clinic?” Maybe we could do something where we can have it regularly during the Regional QIC meetings, discuss what activities they are doing within their agency, challenges they are encountering either with new policies, procedures, implementations, or what they are doing to keep talented staff in a way that they get used to and know it is coming without putting anybody on the spot.</p>	
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		<p>Stacey Smith wondered if in preparation for the Regional QIC a month before we could invite all the Service Area Liasons to discuss.</p> <p>Kimber Salvaggio shared maybe a month before is a little too long as some sudden new initiative may come up but the Service Area Liaisons are always a good place to get some good ideas.</p> <p>Stacey Smith shared we will send invitations to the meeting and figure out presentations a couple of weeks before then. We are also interested in getting volunteers for agencies to test out interventions.</p> <p>Dr. Kara Taguchi shared the Regional QICs have a critical role in relaying what they see relating to our QI efforts. As you know with Access to Care issues, Mirtala Parada Ward with language access recently mentioned to us about the increase of Russian language requests where we heard about this in the North Regional QIC probably over a year ago. It is important to have that dialogue from the ground up</p>	
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		<p>because it took a year for it to show up in the data.</p>	
<p><b>III. QI 2025 Feedback Survey</b></p>	<p>Dr. Marianne Klee shared the results of the QI Satisfaction survey that was completed in the last few weeks. The QI team sent the survey out to LA County DMH DO and LE providers, Service Area Leads, as well as administrative and executive teams that worked with the QI team in 2025. We received 57 responses, which was a small decrease from the prior year. The recommendations for improvements will be used to improve QI procedures in 2026. The survey elicited feedback on general support from the QI team, Countywide QIC, the Regional QICs, and on QI activities and projects. From the 57 responses, some of them were identified as being intended for our Quality Assurance (QA) Unit. That feedback was shared with QA.</p> <p>The ratings in the survey went from 1 (as very unsatisfied) to 5 (as very satisfied). 89.5% of respondents were satisfied or very satisfied with the level of support.</p> <p>There was a suggestion to have more time on the Consumer Perception Survey (CPS) training platform prior to the CPS administration period and providing more explicit information and examples on how to complete the survey. Another suggestion was to have more timely replies and clarity from QI. QI now has a bigger</p>	<p>Stacey Smith shared that in the QI survey, there is still confusion between QI and QA and as Dr. Marianne Klee mentioned in her presentation, we did share all the feedback with QA. We will continue to work on creating a better understanding of QI and our role in the department.</p> <p>Dr. Debbie Innes-Gomberg shared that QA is responsible for ensuring that the Department of Mental Health achieves the goals and the mandates as part of being the Mental Health Plan for the County of Los Angeles. Quality Improvement is an area that is more intervention focused. For example, wondering what the drivers of poor access to care may be. Policies at a very high level versus intervention inquiry focusing truly on making a difference and improving performance in various areas.</p>	<p>Dr. Marianne Klee</p>

	<p>team, with 3 new psychologists to respond to and assist programs. Another suggestion was to provide more training for staff, both for new staff and returning staff and to send out slides and agendas for meetings in advance so that attendees can better anticipate topics, have their questions ready and developed to maximize time in the meetings. Conducting more discussions around QI projects by having the opportunity for providers to share their QI projects and discussing how those projects have impacted their programs during the meeting was recommended. Another suggestion was to create more space for discussion and answering questions in the meetings to foster more interactions among attendees.</p> <p>Of the 57 survey respondents, 46 attended the Countywide QIC and out of those 46, 80.4% or 37 respondents said that they were satisfied or very satisfied with the meeting. A suggestion was to have a Q&amp;A or a frequently asked question sheet developed to summarize what has been discussed in meetings and to post where to find scheduled meetings and minutes.</p> <p>For the Regional QIC meetings, out of 57 respondents, 43 (75.4%) reported attending the meetings last year and of those who attended, 34 (79.1%) were satisfied or very satisfied with the meetings. Out of the 43 who did attend, 17 (39.5%) went to the North Regional QIC</p>		
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	<p>meetings (Service Areas 1-4) and slightly fewer attended the South meetings (Service Areas 5-8), at 34.8%. However, about 1/4 of the respondents attended both North and South Regional QIC meetings..</p> <p>For the Regional QIC meetings, comments included that the North and South meetings appeared to sometimes be different in the information presented, some pointed out that they felt the information was repetitive, but acknowledged that different questions asked at the meetings could be beneficial for people to hear. Also, some pointed out that the Regional QIC meetings are both at 10:00 am on Wednesdays, and that time could be problematic for some people who have standing meetings that cause conflict and therefore would not be able to attend either one. We will be looking at this and figure ways to stagger the days and times. There were also suggestions for assistance in tracking QI projects at clinics.</p> <p>Regarding satisfaction and comments on the QI team's support pertaining to QI activities and projects, there were 8 respondents and they all reported being satisfied or very satisfied with support. A few provided specific comments with training for new staff who are coming on board and needing familiarization with the projects, additional help with data, and needing more time for discussion and interaction in meetings.</p>		
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	<p>As for the QI website, 47 out of 57 respondents (82.5%) reported being satisfied or very satisfied with the site. Comments include the need for more frequent updates to the site and that it was difficult to find certain things. However, other respondents felt that it improved and the site is organized. A few more comments include requests to post meetings, where to find minutes and contact lists, a suggestion highlighting fiscal year updates on the site to really spell out changes that would be helpful for people who are new, and additional requests for more training. There was appreciation for more timely feedback on the CPS, including the report that goes out to providers.</p> <p>There was a request for invitations to meetings to make sure that staff were getting invites. We do have a staff member on our QI team checking the inbox daily to address those requests promptly.</p> <p>In summary, we looked at all survey comments for suggested improvements. We will continue working on improving in those areas.</p> <p>Moving forward, we will develop a calendar of meetings and events for posting on the QI website, strive to foster more interaction in meetings by carving out time for questions and discussions, and create ways for providers to share more on the QI efforts that others are</p>		
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	<p>doing and the impact that those have had on their programs. We will also work on scheduling the North and South Regional QIC meetings at different times and days to allow more people to attend and distribute agendas and slides in advance of the meetings. Regarding CPS, we will improve the speed of distributing results to providers, give examples on QI being applied in clinic settings, increase the user friendliness of the QI website, and provide more frequent and clear updates. We will also plan on adding a FAQ page to the QI website and providing more training.</p>		
<p><b>IV. LOCUS</b></p>	<p>Dr. Debbie Innes-Gomberg shared important information about early learning from the Level of Care Utilization System (LOCUS) implementation. DMH began training and implementation on the LOCUS in December of 2024. Training became available in our own training environment in October of 2024, and we worked with a company called Deerfield Solutions, which holds the license to LOCUS, to put it in IBHIS/Avatar. CIOB has worked with Deerfield Solutions to be able to create a technology companion guide for our Legal Entity outpatient adult contractors we will have to have their EHR vendors build an application program interface to be able to enter and transmit LOCUS data. The first thing we did in the Directly Operated adult programs was create 3 or 4 cohorts of implementation clinics.</p>	<p>Dr. Kara Taguchi shared where there was agreement between the recommended level of care and the actual level of care assigned was about 20%. In levels 5 and 6 is where the most disagreement occurs. An example would be somebody who recently had a hospitalization or has heavy substance abuse and needs a higher level of care, but the client does not want it.</p> <p>Stacey Smith shared she likes talking to clients about the idea that you will not stay here forever and making the client as self-sufficient as they could be. Some of the clients have gotten the</p>	<p>Dr. Debbie Innes-Gomberg</p>

	<p>The first one went live just before Christmas of 2024 and the last cohort went live around April or May of 2025.</p> <p>The Legal Entity contractors are very close to finishing their Application Programming Interface (API) in their EHR environments and hope to have them all completed by the end of March and enter the LOCUS data by the end of this fiscal year. We see the LOCUS as a clinical decision aid and an administrative decision tool. In terms of the clinical decision at the clinic level, the LOCUS can assist clinicians with the level of care the client needs and translates into service frequency and service intensity decisions. It also directly correlates with transitions to higher and lower levels of care based on the LOCUS score. As for administratively, it is a decision aid that we are finding increasingly important to help the department manage service capacity and timely access to care.</p> <p>The LOCUS maps six levels of care and evaluates the following areas: risk of harm that a client poses to themselves, functional status, comorbidities in terms of both health comorbidities and SUD comorbidities, recovery environment in terms of the level of stress or level of support alternatively, treatment and recovery history such as do their symptoms get better and then get worse, or have they ever had a point in time where their symptoms have</p>	<p>opposite message and have been in our system for over 20+ years. We see in the Consumer Perception Survey some clients state that they would not be able to live without their provider.</p> <p>Dr. Debbie Innes-Gomberg shared that there is a document that we put together and we are just waiting for some validation from the State on a checklist in terms of how to approach a client about a transition but also, especially for clients that have been there for a long time, maybe having a transition group on how to access community resources and wellness. We have to go back to helping clients create communities for themselves and in addition to that, focus on employment. I think that this is one of the reasons supported employment IPS is such a critical intervention - because it can help people get the life that they maybe did not think that they could have when they entered our mental health system.</p> <p>Dr. Kara Taguchi shared there has been a lot of discussion about hitting it on multiple fronts that we</p>	
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	<p>remitted. Lastly, is engagement and the level of recovery status.</p> <p>To date, we have about 40,201 administrations of the LOCUS in our adult Directly Operated programs. For the most part in terms of the recommended levels of care, basic services which is a zero and Level 1, about almost 20% of the clients with LOCUS scores are scoring in that area, and tells us that these are often legacy clients who have been in our system for quite some time that are comfortable with the level of services that they are receiving and they really do not need Specialty Mental Health Services anymore. These are the clients that we have been focusing a lot on in terms of the opportunity to transition them either to natural support, other medical care or to medical Managed Care Plans. For Level 2, which is lower-level intensity being seen a couple of times a month, is about 27% of our clients. Level 3, weekly intervention, is about 35% of our clients. Level 4, which is currently FSP but in the future will be Assertive Community Treatment (ACT) and Day Treatment Intensive, is about 5.5% of the clients. Levels 5 and 6 are residential and in-patient. We see some clients score here primarily because of the comorbidities that they have, complex clinical presentations where they are often in and out of jail or in and out of the hospital.</p>	<p>change the message to clients coming in about what Specialty Mental Health is.</p>	
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	<p>Dr. Debbie Innes-Gomberg shared for a long time, we have seen ourselves as the place to get Mental Health services if you are indigent or if you have Medi-Cal. Now the State is moving us to be part of a larger system for Medi-Cal members, with the Managed Care Plans on the front end and us being on the Specialty Mental Health or higher-level end. There are staff that have not gotten behind LOCUS, or there are disagreements among treatment team members. We are making progress and have started to create an opportunity for Managed Care Operations in DMH to work much more closely with the medical Managed Care Plans to create common language. To address this 20%, we have to address the client factors, the staff factors, and the system factors. Now that we have medical directors that Dr. Bonds just hired, this may be an opportunity for them to work with us on this.</p> <p>The best practice that we are finding is using Community Health Workers or Peer Support specialists to help clients get connected initially with Managed Care Plans, which seems to be working, and we will use more of that in the future. Another practice is talking with the client about what the LOCUS score is, what it means, how it matches with how the client feels about their own treatment needs and progress, and is an opportunity to do some treatment planning and engage the client in the value of the</p>		
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	<p>LOCUS. Also, using LOCUS scores over time to identify treatment progress, treatment adjustments, and to validate especially mental health endpoints. Lastly, and an important one is that we talked a lot with our Managers and Supervisors, that especially Mental Health is not something that necessarily needs to be lifelong and there are endpoints, and the LOCUS scores can help us to identify that transition. From the American Academy of Community Psychiatry that trains on the LOCUS, when using the dimensions or scores for treatment planning, consider identifying the most significant scores and target those first - which ones are highest and targeting those and creating space for case consultations through routine weekly team consultations.</p>		
<p><b>ANNOUNCEMENT</b></p>	<p>Dr. Kara Taguchi shared thank you for your participation and for coming to these meetings, even when we were trying to revamp it over the last year and have tried several things. We will try the QAPI Leadership Committee Meeting and see if it gets us closer to what we need to do for QI in the department. We will also reinforce improving communication of what learning is coming out of that meeting.</p> <p>Stacey Smith shared thank you everyone and we will see you at the QAPI Leadership and Regional QIC meetings.</p>		<p>Dr. Kara Taguchi/ Stacey Smith</p>

**Next Meeting: QAPI Leadership Committee Meeting****Monday, March 19, 2026, from 4:00PM- 5:00PM****Attendance (below):**

<b>NAME</b>	<b>AGENCY</b>
Debbie Innes-Gomberg	DMH- QOTD
Kara Taguchi	DMH-QI/Outcomes
Stacey Anne Smith	DMH-Quality Improvement
Daiya Cunnane	DMH-Quality Improvement
Barbara Meyer	DMH-Quality Improvement
Marianne Klee	DMH-Quality Improvement
Angelle Hill-Seetal	DMH-Quality Improvement
Laarnih De La Cruz	DMH-Quality Improvement
Volga Hovelian	DMH- QI/Outcomes
Andrew Nguyen	Pharmacy
Angela Shields	Specialized Foster Care South
Angelica Fuentes	Outpatient Care Services
Ania Ahmadi	Compliance, Privacy and Audit Services
Berteil Eishoei	SA 1
Carol Sagusti	Older Adults
Carrie Helgeson	CCR
Elida Lambrechts	Specialized Foster Care North
Elisabeth Gildemontes	Patients' Rights Office
Greg Tchakmakjian	SA 7
Jeanna Pollard	Health Plans Operations Unit
Jennifer Mize	SA 1

Keisha White	SA 5
Kimber Salvaggio	Training/ SA 2
Lori Willis	Children's
Maria Moreno (CLESGV)	SA 3
Michele Renfrow	Hospital Liaison
Michelle Rittel	SA 2
Nikki Collier	Quality Assurance
Rachel Santellan	SAPC
Robin Ramirez	BHSA Administration
Sandra Chang	ARISE Division
Sharon Chapman	DMH-Outcomes
Socorro Gertmenian	WellNest
Stephanie Johnson	CWD Wraparound
Theodore W. Wilson	Patients' Rights Office
Tiffany Trotter	SAPC
Toni Robinson	Peers Services
Venezia Mojarro	Compliance, Privacy and Audit Services
Veronica Chavez	ACCESS Helpline
Vicky Lin	PEI Admin
Wanyu Chang	PEI Admin
Yen-Jui Ray Lin	Clinical Informatics

Respectfully Submitted,

Dr. Kara Taguchi