

***Volume 2 of 5***  
**Medi-Cal**  
**Specialty Mental Health Services**  
**External Quality Review**  
**Technical Report**  
*Contract Year 2024–25*

*Plan-Specific Information*

California Department of Health Care Services

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## Mental Health Plan and Integrated Behavioral Health Plan Name Abbreviations

Health Services Advisory Group, Inc. (HSAG) uses the following abbreviated mental health plan (MHP) and Integrated behavioral health plan (Integrated BHP) names in this volume.

- ◆ **Alameda**—Alameda County Behavioral Health Care Systems
- ◆ **Alpine**—Alpine County Behavioral Health Services
- ◆ **Amador**—Amador County Behavioral Health
- ◆ **Butte**—Butte County Department of Behavioral Health Services
- ◆ **Calaveras**—Calaveras County Behavioral Health Services (MHP) and County of Calaveras (Integrated BHP)
- ◆ **Colusa**—Colusa County Department of Behavioral Health
- ◆ **Contra Costa**—Contra Costa County Mental Health
- ◆ **Del Norte**—Del Norte County Department of Health and Human Services
- ◆ **El Dorado**—El Dorado County Health & Human Services Agency
- ◆ **Fresno**—Fresno County Department of Behavioral Health (MHP) and County of Fresno (Integrated BHP)
- ◆ **Glenn**—Glenn County Behavioral Health
- ◆ **Humboldt**—Humboldt County Health and Human Services
- ◆ **Imperial**—Imperial County Behavioral Health Services
- ◆ **Inyo**—Inyo County Health & Human Services Behavioral Health
- ◆ **Kern**—Kern County Behavioral Health and Recovery Services
- ◆ **Kings**—Kings County Behavioral Health
- ◆ **Lake**—Lake County Behavioral Health Services Department (MHP) and County of Lake (Integrated BHP)
- ◆ **Lassen**—Lassen County Health and Social Services
- ◆ **Los Angeles**—Los Angeles County Department of Mental Health
- ◆ **Madera**—Madera County Behavioral Health Services (MHP) and County of Madera (Integrated BHP)
- ◆ **Marin**—Marin County Behavioral Health and Recovery Services (MHP) and County of Marin (Integrated BHP)
- ◆ **Mariposa**—Mariposa County Human Services, Behavioral Health & Recovery Services Division
- ◆ **Mendocino**—Mendocino County Mental Health
- ◆ **Merced**—Merced County Behavioral Health and Recovery Services
- ◆ **Modoc**—Modoc County Behavioral Health Services

- ◆ **Mono**—Mono County Behavioral Health
- ◆ **Monterey**—Monterey County Behavioral Health
- ◆ **Napa**—Napa County Health and Human Services Agency
- ◆ **Nevada**—Nevada County Behavioral Health (MHP) and County of Nevada (Integrated BHP)
- ◆ **Orange**—Orange County Behavioral Health Services (MHP) and County of Orange (Integrated BHP)
- ◆ **Placer**—County of Placer, Department of Health and Human Services
- ◆ **Plumas**—Plumas County Mental Health Services (MHP) and County of Plumas (Integrated BHP)
- ◆ **Riverside**—Riverside County Mental Health Services (MHP) and County of Riverside (Integrated BHP)
- ◆ **Sacramento**—Sacramento County Behavioral Health Services (MHP) and County of Sacramento (Integrated BHP)
- ◆ **San Benito**—San Benito County Behavioral Health
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- ◆ **San Diego**—San Diego County Behavioral Health Division
- ◆ **San Francisco**—San Francisco Community Behavioral Health Services
- ◆ **San Joaquin**—San Joaquin Behavioral Health Services (MHP) and County of San Joaquin (Integrated BHP)
- ◆ **San Luis Obispo**—San Luis Obispo County Behavioral Health Department (MHP) and County of San Luis Obispo (Integrated BHP)
- ◆ **San Mateo**—San Mateo County Behavioral Health and Recovery Services
- ◆ **Santa Barbara**—Santa Barbara Department of Behavioral Wellness (MHP) and County of Santa Barbara (Integrated BHP)
- ◆ **Santa Clara**—Santa Clara County Behavioral Health Services Department
- ◆ **Santa Cruz**—County of Santa Cruz Health Services Agency
- ◆ **Shasta**—Shasta County Behavioral Health
- ◆ **Siskiyou**—Siskiyou Behavioral Health Division
- ◆ **Solano**—Solano County Health & Social Services
- ◆ **Sonoma**—County of Sonoma
- ◆ **Stanislaus**—Stanislaus County Behavioral Health & Recovery Services (MHP) and County of Stanislaus (Integrated BHP)
- ◆ **Sutter/Yuba**—Sutter-Yuba Behavioral Health Services
- ◆ **Tehama**—Tehama County Health Services Agency
- ◆ **Trinity**—Trinity County Behavioral Health Services
- ◆ **Tulare**—Tulare County Health & Human Services Agency (MHP) and County of Tulare (Integrated BHP)

- ◆ **Tuolumne**—Tuolumne County Behavioral Health Department (MHP) and County of Tuolumne (Integrated BHP)
- ◆ **Ventura**—Ventura County Behavioral Health (MHP) and County of Ventura (Integrated BHP)
- ◆ **Yolo**—Yolo County Health & Human Services Agency

## Commonly Used Abbreviations and Acronyms

- ◆ **A&I**—Audits & Investigations
- ◆ **ACBHD**—Alameda County Behavioral Health Department
- ◆ **ACH**—Alameda County Health
- ◆ **ADHD**—attention-deficient/hyperactivity disorder
- ◆ **AI**—artificial intelligence
- ◆ **ANSA**—Adult Needs and Strengths Assessment
- ◆ **API**—Application Programming Interface
- ◆ **ASAM**—American Society of Addiction Medicine
- ◆ **ASOC**—Adult System of Care
- ◆ **BH**—behavioral health
- ◆ **BH-CONNECT**—Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
- ◆ **BHIN**—Behavioral Health Information Notice
- ◆ **BHQIP**—Behavioral Health Quality Improvement Program
- ◆ **BHRS**—Behavioral Health and Recovery Services
- ◆ **BHSA**—Behavioral Health Services Act
- ◆ **BHT**—Behavioral Health Transformation
- ◆ **CalAIM**—California Advancing and Innovating Medi-Cal
- ◆ **CalMHSA**—California Mental Health Services Authority
- ◆ **CANS**—Child and Adolescent Needs and Strengths
- ◆ **CAP**—corrective action plan
- ◆ **CARE**—Community Assistance, Recovery, and Empowerment
- ◆ **CBH**—Children’s Behavioral Health
- ◆ **CBO**—community-based organization
- ◆ **CCMU**—Crisis Care Mobile Unit
- ◆ **CCRT**—Community Crisis Response Team
- ◆ **CFR**—Code of Federal Regulations
- ◆ **CFT**—Child-Family Team
- ◆ **CHTF**—Cultural Humility Task Force
- ◆ **CHW**—Community Health Worker
- ◆ **CMS**—Centers for Medicare & Medicaid Services
- ◆ **COR**—contracting officer representative
- ◆ **CPL**—California Policy Lab
- ◆ **CPS**—Consumer Perception Survey

- ◆ **CPSS**—certified peer support specialist
- ◆ **CQI**—Compliance and Quality Improvement
- ◆ **CWS**—Child Welfare Services
- ◆ **DHCS**—California Department of Health Care Services
- ◆ **DHS**—Department of Human Services
- ◆ **DMC-ODS**—Drug Medi-Cal Organized Delivery System
- ◆ **DMH**—Department of Mental Health
- ◆ **DOB**—date of birth
- ◆ **EBPs**—evidence-based practices
- ◆ **ECM**—enhanced care management
- ◆ **EHR**—electronic health record
- ◆ **EQR**—external quality review
- ◆ **EQRO**—external quality review organization
- ◆ **FCPSS**—family certified peer support specialist
- ◆ **FHIR**—Fast Healthcare Interoperability Resources
- ◆ **FSP**—Full Service Partnership
- ◆ **FTE**—full-time equivalent
- ◆ **FY**—fiscal year
- ◆ **HCA**—Health Care Agency
- ◆ **HEDIS®**—Healthcare Effectiveness Data and Information Set<sup>1</sup>
- ◆ **HHSA**—Health and Human Services Agency
- ◆ **HIE**—Health Information Exchange
- ◆ **HIPAA**—Health Insurance Portability and Accountability Act of 1996
- ◆ **HL7**—Health Level 7
- ◆ **HR**—human resources
- ◆ **HSAG**—Health Services Advisory Group, Inc.
- ◆ **ICC**—intensive care coordination
- ◆ **IHBS**—intensive home-based services
- ◆ **Integrated BHP**—Integrated behavioral health plan
- ◆ **IT**—information technology
- ◆ **LOC**—level of care
- ◆ **LOCUS**—Level of Care Utilization System
- ◆ **MCP**—managed care health plan
- ◆ **MEDSLITE**—Medi-Cal Eligibility Data System Lite
- ◆ **MH**—mental health

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<sup>1</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- ◆ **MHP**—mental health plan
- ◆ **MHSA**—Mental Health Services Act
- ◆ **MHSIP**—Mental Health Statistics Improvement Program
- ◆ **MLPD**—Mammoth Lakes Police Department
- ◆ **MMEF**—Monthly Medi-Cal Eligibility File
- ◆ **MORS**—Milestones of Recovery Scale
- ◆ **MOU**—Memorandum of Understanding
- ◆ **MPL**—minimum performance level
- ◆ **MSW**—Master of Social Work
- ◆ **NAE**—Network Adequacy Evaluation
- ◆ **NAMI**—National Alliance on Mental Illness
- ◆ **NAV**—network adequacy validation
- ◆ **NCQA**—National Committee for Quality Assurance
- ◆ **NPI**—National Provider Identifier
- ◆ **OPFE**—Office for Peer and Family Empowerment
- ◆ **OPS**—Office of Peer Services
- ◆ **PCBH**—Plumas County Behavioral Health
- ◆ **PCP**—primary care provider
- ◆ **PDSA**—Plan-Do-Study-Act
- ◆ **PHF**—psychiatric health facility
- ◆ **PHR**—personal health record
- ◆ **PIP**—performance improvement project
- ◆ **PMV**—performance measure validation
- ◆ **PSC-35**—Pediatric Symptom Checklist
- ◆ **PSS**—peer support specialist
- ◆ **QA**—quality assurance
- ◆ **QAPI**—quality assessment and performance improvement
- ◆ **QI**—quality improvement
- ◆ **QIC**—Quality Improvement Committee
- ◆ **QIDA**—Quality Improvement and Data Analytics
- ◆ **QIPP**—Quality Improvement Performance Plan
- ◆ **QIWP**—Quality Improvement Work Plan
- ◆ **QIWPE**—Quality Improvement Work Plan Evaluation
- ◆ **QLC**—Quality Leadership Committee
- ◆ **QM**—quality management
- ◆ **R&E**—Research and Evaluation
- ◆ **SaaS**—Software as a Service

- ◆ **SAML**—Security Assertion Markup Language
- ◆ **SAPC**—Substance Abuse Prevention and Control Program
- ◆ **SCSS**—senior client support specialists
- ◆ **SDCBHS**—San Diego County Behavioral Health Services
- ◆ **SFDPH**—San Francisco Department of Public Health
- ◆ **SMHS**—Specialty Mental Health Services
- ◆ **SOC**—system of care
- ◆ **SSO**—single sign-on
- ◆ **SUD**—substance use disorder
- ◆ **TADT**—Timely Access Data Tool
- ◆ **TCM**—targeted case management
- ◆ **UR**—utilization review
- ◆ **UCSD**—University of California San Diego

## Introduction

The *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* is an annual, independent, technical report produced by HSAG, the external quality review organization (EQRO) for the California Department of Health Care Services' (DHCS') Medicaid (Medi-Cal) Specialty Mental Health Services (SMHS) Program. The purpose of this report is to provide a summary of the external quality review (EQR) activities for the DHCS contracted MHPs and Integrated BHPs. This report will sometimes refer to these MHPs and Integrated BHPs as “plans.”

This Volume 2 of the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* includes the following plan-specific information:

- ◆ Appendix A—Comparative Plan-Specific Performance Improvement Project (PIP) Information
- ◆ Appendix B—Plan-Specific EQR Assessments and Recommendations

Note that the statewide aggregate assessment of the SMHS Program for the federally mandated and optional EQR activities is included in Volume 1; comparative plan-specific compliance review scoring results are included in Volume 3; and validation of network adequacy results, including comparative, plan-specific validation of network adequacy results, are included in Volume 4.

# Appendix A. Comparative Plan-Specific Performance Improvement Project Information

This appendix provides the PIP validation criteria and confidence level definitions that HSAG uses for validating PIPs. Additionally, this appendix includes MHP- and Integrated BHP-specific PIP topics and validation findings.

## PIP Validation Criteria

HSAG conducts PIP validation in accordance with the Centers for Medicare & Medicaid Services (CMS) *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.<sup>2</sup>

Table A.1 lists the review steps and corresponding evaluation elements, including critical elements, that HSAG uses for validating each annual PIP submission. HSAG assigns a *Met*, *Partially Met*, or *Not Met* score to each evaluation element.

**Table A.1—Performance Improvement Project Validation Review Steps and Evaluation Elements**

\* Denotes a critical evaluation element.

Review Steps	Evaluation Elements
1. Selected PIP Topic	◆ The PIP topic was selected by the State and/or based on plan-specific data demonstrating an opportunity for improvement.*
2. Aim Statement(s)	◆ The Aim statement included the population, improvement strategies, and time period. The Aim statement was clear, concise, and answerable.*
3. Identified PIP Population	◆ The PIP population was accurately and completely defined.*
4. Sampling Method	◆ The plan documented the sampling frame size for each performance indicator. ◆ The plan documented the sample size for each performance indicator.*

<sup>2</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Dec 13, 2025.

Review Steps	Evaluation Elements
	<ul style="list-style-type: none"> <li>◆ The plan documented the margin of error and confidence level for each performance indicator.</li> <li>◆ The plan described the method used to select the sample.</li> <li>◆ The sampling methodology used allowed for the generalization of results to the population.*</li> </ul>
5. Selected Performance Indicator(s)	<ul style="list-style-type: none"> <li>◆ The performance indicator(s) was well-defined, objective, and could track performance over time.*</li> </ul>
6. Data Collection Procedures	<ul style="list-style-type: none"> <li>◆ The plan included clearly defined sources of data and data elements collected for each performance indicator.</li> <li>◆ The plan included a clearly defined and systematic process for collecting baseline and remeasurement data.*</li> <li>◆ A copy of the manual data collection tool used was provided, if applicable.*</li> <li>◆ The plan included the percentage of administrative data completeness at the time the data were generated, and the process used to calculate the reported percentage.</li> </ul>
7. Data Analysis and Interpretation of Results	<ul style="list-style-type: none"> <li>◆ The plan included all required data and statistical testing components for all performance indicators. The statistical testing information and data were accurate, clear, and could be replicated.*</li> <li>◆ The plan documented possible reasons for the lack of improvement, lessons learned, and next steps for each performance indicator.</li> <li>◆ The plan documented the threats to validity for each measurement period and the threats to comparability between the baseline and each remeasurement period.</li> </ul>
8. Improvement Strategies	<ul style="list-style-type: none"> <li>◆ The plan completed the Quality Improvement (QI) Team table and either described or attached the QI tool(s) used.*</li> <li>◆ The plan clearly described each intervention, and the intervention addressed root causes/barriers identified through data analysis and/or QI tools.*</li> <li>◆ The plan completed an intervention worksheet for each listed intervention in the Step 8 Barriers/Interventions table. Each intervention worksheet was completed to the point of intervention progress.</li> <li>◆ The plan tested interventions to a point in the remeasurement period that could reasonably drive improvement in performance indicator outcomes.</li> </ul>

Review Steps	Evaluation Elements
	<ul style="list-style-type: none"> <li>◆ The plan developed a methodologically sound measure(s) or process to evaluate the effectiveness and impact of each intervention.</li> <li>◆ The plan documented an accurate summary of intervention testing results.</li> <li>◆ The plan documented lessons learned, challenges encountered, and solutions to challenges for each intervention tested.</li> <li>◆ The plan documented the status of each intervention (Adopt, Adapt, Abandon, or Continue Evaluating) and the rationale for the selected status.</li> </ul>
<p>9. Likelihood that Significant and Sustained Improvement Occurred</p>	<ul style="list-style-type: none"> <li>◆ The remeasurement methodology was the same as the baseline methodology for all performance indicators.*</li> <li>◆ There was improvement over baseline performance across all performance indicators for the current reported remeasurement period.</li> <li>◆ There was statistically significant improvement (95 percent confidence level, <math>p &lt; 0.05</math>) over the baseline across all performance indicators for the current reported remeasurement period.</li> <li>◆ For any applicable indicator, sustained statistically significant improvement compared to the baseline result was demonstrated with a subsequent reported remeasurement period.</li> </ul>

## Confidence Level Definitions

HSAG assesses the validity and reliability of the results to determine whether plans, DHCS, and key stakeholders may have confidence in the reported PIP findings. For each annual PIP submission, HSAG determines the following confidence level(s), as applicable:

- ◆ Overall confidence of adherence to acceptable PIP methodology.
- ◆ Overall confidence that the PIP achieved significant improvement.

HSAG uses the following calculation to determine 1) the evaluation element score and 2) the critical element score, both of which HSAG uses to assign confidence levels related to adherence to an acceptable PIP methodology:

- ◆ The percentage score for all evaluation elements *Met* is calculated by dividing the total *Met* by the sum of all evaluation elements *Met*, *Partially Met*, and *Not Met*. The *Not Assessed* and *Not Applicable* results are removed from the scoring calculations.
- ◆ The percentage score for critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

HSAG assigns a confidence level for significant improvement only after the PIP demonstrates improvement over the baseline rate for the PIP performance indicator.

Table A.2 includes the definitions for the confidence levels HSAG assigns to each PIP submission.

**Table A.2—Performance Improvement Project Confidence Level Definitions**

Confidence Level	Definition
<b>Overall Confidence of Adherence to Acceptable PIP Methodology</b>	
<i>High Confidence</i>	All critical evaluation elements were <i>Met</i> , and 90 percent to 100 percent of all evaluation elements were <i>Met</i> across all steps.
<i>Moderate Confidence</i>	All critical evaluation elements were <i>Met</i> , and 80 percent to 89 percent of all evaluation elements were <i>Met</i> across all steps.
<i>Low Confidence</i>	Across all steps, 65 percent to 79 percent of all evaluation elements were <i>Met</i> ; or one or more critical evaluation elements were <i>Partially Met</i> .
<i>No Confidence</i>	Across all steps, less than 65 percent of all evaluation elements were <i>Met</i> ; or one or more critical evaluation elements were <i>Not Met</i> .
<b>Overall Confidence that the PIP Achieved Significant Improvement</b>	
<i>High Confidence</i>	All performance indicators demonstrated <i>statistically significant</i> improvement over the baseline.
<i>Moderate Confidence</i>	One of the three scenarios below occurred: <ol style="list-style-type: none"> <li>1. All performance indicators demonstrated improvement over the baseline, and some but not all performance indicators demonstrated <i>statistically significant</i> improvement over the baseline.</li> <li>2. All performance indicators demonstrated improvement over the baseline, and none of the performance indicators demonstrated <i>statistically significant</i> improvement of the baseline.</li> <li>3. Some but not all performance indicators demonstrated improvement over baseline, and some but not all performance</li> </ol>

Confidence Level	Definition
	indicators demonstrated <i>statistically significant</i> improvement over baseline.
<i>Low Confidence</i>	The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator; or some but not all performance indicators demonstrated improvement over the baseline, and none of the performance indicators demonstrated <i>statistically significant</i> improvement over the baseline.
<i>No Confidence</i>	The remeasurement methodology was not the same as the baseline methodology for all performance indicators, or none of the performance indicators demonstrated improvement over the baseline.

## Performance Improvement Project Validation Findings

The MHPs and Integrated BHPs submitted their first annual clinical and nonclinical PIP submissions in July 2025. Section 3 of *Volume 1 of 5* of this EQR technical report (“Validation of Performance Improvement Projects”) describes DHCS’ requirements for the clinical and nonclinical PIP topics. The MHPs and Integrated BHPs submitted one form for each required PIP. The July 2025 submissions included information about the PIP design. HSAG validated each PIP submission using the validation criteria described in Table A.1 and assigned confidence levels as defined in Table A.2.

Note that in this section:

- ◆ The *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measure is referred to as “SAA.”
- ◆ The *Follow-Up After Emergency Department Visit for Mental Illness* measure is referred to as “FUM.”
- ◆ The *Follow-Up After Emergency Department Visit for Substance Use* measure is referred to as “FUA.”
- ◆ The *Pharmacotherapy for Opioid Use Disorder* measure is referred to as “POD.”

Table A.3 lists the MHPs’ clinical and nonclinical PIP topics, evaluation element met scores, critical element met scores, and confidence levels for adherence to an acceptable PIP methodology for the July 2025 PIP submissions. Table A.4 lists the Integrated BHPs’ clinical and nonclinical PIP topics, evaluation element scores, critical element scores, and confidence levels for adherence to an acceptable PIP methodology for the July 2025 PIP submissions.

Note that HSAG includes no PIP information for Alpine in Table A.3. Alpine serves a very small mountain community with no hospital, urgent care, or primary care providers (PCPs)/clinics, and has no available data for review and analysis. Due to these challenges, HSAG, DHCS, and Alpine continue to have discussions regarding viable, meaningful clinical and nonclinical PIP topics. HSAG anticipates that both clinical and nonclinical PIP topics will be determined and that Alpine will submit both PIPs for validation in 2026. Validation findings for Alpine’s PIPs will be reported in the 2025–26 EQR technical report.

**Table A.3—July 2025 Mental Health Plan Performance Improvement Project Submission Evaluation Element Met Scores, Critical Element Met Scores, and Confidence Levels for Adherence to an Acceptable Methodology**

\* The percentage score of evaluation elements *Met* is calculated by dividing the total *Met* by the sum of all evaluation elements *Met*, *Partially Met*, and *Not Met*.

\*\* The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
Alameda	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for SMHS psychiatry services</i>	83%	80%	Low Confidence
Amador	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
Butte	<i>Improve the SAA measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for psychiatric services</i>	100%	100%	High Confidence
Colusa	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence

APPENDIX A. COMPARATIVE PLAN-SPECIFIC PIP INFORMATION

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
	<i>Improve timely access from date of prior appointment to first offered appointment for non-urgent follow-up appointments</i>	100%	100%	High Confidence
Contra Costa	<i>Improve the SAA measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for psychiatric services</i>	100%	100%	High Confidence
Del Norte	<i>Improve the SAA measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for outpatient non-urgent, psychiatric SMHS</i>	100%	100%	High Confidence
El Dorado	<i>Improve the SAA measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	67%	80%	Low Confidence
Glenn	<i>Improve the SAA measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for psychiatric service</i>	100%	100%	High Confidence
Humboldt	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence

APPENDIX A. COMPARATIVE PLAN-SPECIFIC PIP INFORMATION

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
Imperial	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
Inyo	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
Kern	<i>Improve the SAA measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
Kings	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for youth urgent appointments</i>	100%	100%	High Confidence
Lassen	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for outpatient non-urgent non-psychiatric SMHS</i>	100%	100%	High Confidence
Los Angeles	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for outpatient non-urgent non-psychiatry SMHS for members 0 to 20 years</i>	100%	100%	High Confidence

APPENDIX A. COMPARATIVE PLAN-SPECIFIC PIP INFORMATION

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
Mariposa	<i>Improve the FUM measure rate</i>	83%	80%	Low Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for outpatient non-urgent non-psychiatric SMHS</i>	50%	40%	No Confidence
Mendocino	<i>Improve the SAA measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from date of prior appointment to first offered appointment for non-urgent non-psychiatric follow-up appointments</i>	100%	100%	High Confidence
Merced	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for outpatient non-urgent non-psychiatric SMHS</i>	100%	100%	High Confidence
Modoc	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
Mono	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
Monterey	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for</i>	100%	100%	High Confidence

APPENDIX A. COMPARATIVE PLAN-SPECIFIC PIP INFORMATION

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
	<i>outpatient non-urgent non-psychiatry SMHS</i>			
Napa	<i>Improve the SAA measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	83%	80%	Low Confidence
Placer	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	83%	80%	Low Confidence
San Benito	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for outpatient non-urgent non-psychiatry SMHS</i>	100%	100%	High Confidence
San Bernardino	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
San Diego	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for any outpatient non-urgent, non-psychiatric SMHS</i>	100%	100%	High Confidence
San Francisco	<i>Improve the SAA measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to</i>	100%	100%	High Confidence

APPENDIX A. COMPARATIVE PLAN-SPECIFIC PIP INFORMATION

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
	<i>first offered appointment for outpatient non-urgent, non-psychiatric SMHS</i>			
San Mateo	<i>Improve the SAA measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from date of prior appointment to first offered appointment for non-urgent follow-up appointments</i>	100%	100%	High Confidence
Santa Clara	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for outpatient non-urgent non-psychiatric SMHS</i>	100%	100%	High Confidence
Santa Cruz	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for outpatient non-urgent non-psychiatry SMHS</i>	100%	100%	High Confidence
Shasta	<i>Improve the FUM measure rate</i>	83%	80%	Low Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
Siskiyou	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence

APPENDIX A. COMPARATIVE PLAN-SPECIFIC PIP INFORMATION

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
Solano	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for outpatient non-urgent psychiatric for children/youth</i>	100%	100%	High Confidence
Sonoma	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for non-urgent non-psychiatry SMHS</i>	83%	80%	Low Confidence
Sutter/Yuba	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for all urgent SMHS appointments</i>	100%	100%	High Confidence
Tehama	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for SMHS</i>	83%	80%	Low Confidence
Trinity	<i>Improve the SAA measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	33%	40%	No Confidence
Yolo	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service to members 18 years and older</i>	100%	100%	High Confidence

**Table A.4—July 2025 Integrated Behavioral Health Plan Performance Improvement Project Submission Evaluation Element Met Scores, Critical Element Met Scores, and Confidence Levels for Adherence to an Acceptable Methodology**

\* The percentage score of evaluation elements *Met* is calculated by dividing the total *Met* by the sum of all evaluation elements *Met*, *Partially Met*, and *Not Met*.

\*\* The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
Calaveras	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
Fresno	<i>Improve the FUM measure rate</i>	83%	80%	Low Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for non-urgent, psychiatric SMHS</i>	100%	100%	High Confidence
Lake	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
Madera	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for outpatient non-urgent, non-psychiatric SMHS</i>	50%	60%	No Confidence
Marin	<i>Improve the FUA measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for</i>	100%	100%	High Confidence

APPENDIX A. COMPARATIVE PLAN-SPECIFIC PIP INFORMATION

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
	<i>outpatient non-urgent, non-psychiatric SMHS</i>			
Nevada	<i>Improve the FUA measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
Orange	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
Plumas	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	67%	80%	No Confidence
Riverside	<i>Improve the POD measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for outpatient non-urgent, non-psychiatric SMHS for youth</i>	100%	100%	High Confidence
Sacramento	<i>Improve the POD measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
San Joaquin	<i>Improve the FUA measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence

APPENDIX A. COMPARATIVE PLAN-SPECIFIC PIP INFORMATION

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
San Luis Obispo	<i>Improve the POD measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
Santa Barbara	<i>Improve the POD measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for adult outpatient SMHS</i>	86%	83%	Low Confidence
Stanislaus	<i>Improve the POD measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence
Tulare	<i>Improve the FUA measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered appointment for outpatient SMHS</i>	100%	100%	High Confidence
Tuolumne	<i>Improve the FUM measure rate</i>	100%	100%	High Confidence
	<i>Improve timely access from first contact from any referral source to first offered non-urgent psychiatric service</i>	67%	60%	Low Confidence
Ventura	<i>Improve the POD measure rate</i>	100%	100%	High Confidence
	<i>Increase the percentage of members who receive at least one peer support service</i>	100%	100%	High Confidence

## Performance Improvement Project Interventions

The MHP and Integrated BHP July 2025 PIP submissions covered the PIP Design stage only; therefore, the plans' PIPs did not progress to the point of implementing interventions. HSAG will include PIP intervention information in the *2025–26 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report*.

## Appendix B. Plan-Specific External Quality Review Assessments and Recommendations

This appendix includes each plan’s self-reported follow-up on the 2023–24 EQR recommendations and HSAG’s assessment of the self-reported actions. Note that this is the first EQR HSAG has conducted for DHCS’ SMHS Program; therefore, HSAG obtained the recommendations made to each plan from the previous EQRO’s 2023–24 SMHS EQR technical report and requested that each plan summarize actions it took to address those recommendations. Additionally, based on HSAG’s assessment of the 2024–25 EQR activities, HSAG summarizes each plan’s strengths and weaknesses (referred to as “opportunities for improvement” in this appendix) with respect to the quality, timeliness, and accessibility of care the plan furnishes to its members. Based on the assessment, HSAG makes recommendations to each plan.

Plans that completed early behavioral health (BH) administrative integration participated in performance measure validation (PMV) and network adequacy validation (NAV) activities as MHP entities based on these activities being conducted retrospectively. Plans that opted for early BH administrative integration conducted PIPs via the Integrated BHP structure. HSAG’s PIP assessments for MHPs that opted for early BH administrative integration are included in the applicable MHP section which, in these instances, denotes that the PIPs were conducted via the Integrated BHP structure.

### Description of the Manner in Which Plan Data Were Aggregated and Analyzed and Conclusions Drawn Related to Quality, Timeliness, and Access

HSAG used the following process to aggregate and analyze data from all applicable EQR activities it conducted to draw conclusions about the quality, timeliness, and accessibility of care furnished by each plan. For each plan:

- ◆ HSAG analyzed the quantitative results obtained from each EQR activity to identify strengths and weaknesses related to the quality, timeliness, and accessibility of care furnished by the plan and to identify any themes across all activities.
- ◆ From the aggregated information collected from all EQR activities, HSAG identified strengths and weaknesses related to the quality, timeliness, and accessibility of services furnished by the plan.
- ◆ HSAG drew conclusions based on the identified strengths and weaknesses, specifying whether the strengths and weaknesses affect one aspect of care more than another (i.e., quality, timeliness, and accessibility of care).

# Alameda County Behavioral Health Care Systems

## Follow-Up on Prior Year Recommendations

Table B.1 provides the EQR recommendations directed to Alameda from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.1 to preserve the accuracy of Alameda’s self-reported actions.

**Table B.1—Alameda’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Alameda	Actions Taken by Alameda to Address the External Quality Review Recommendations
<p>1. Provide training on how to access the shared intranet and where to locate resources, policies and procedures, new-hire orientation information, and intra-department communications.</p>	<p>Training is provided on how to access the shared intranet, ALCOHub, and where to locate resources, policies and procedures, new-hire orientation information, and intra-department communications on Microsoft SharePoint (SharePoint) in both the Alameda County Behavioral Health Department (ACBHD) New Team Member Orientation and Onboarding Training and the Alameda County Health (ACH) New Employee Orientation. Alameda County’s hiring coordinators facilitate the monthly ACH New Hire Orientation. During the new employee orientation, the Human Resources (HR) Department covers both the ACH intranet and ALCOHub.</p> <p>For the ACH intranet on SharePoint, HR reviews what resources are available to employees.</p> <ul style="list-style-type: none"> <li>◆ Agency departments—ACH has four departments: <ul style="list-style-type: none"> <li>■ BH Department</li> <li>■ Environmental Health Department</li> <li>■ Office of the Agency Director</li> </ul> </li> </ul>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Alameda</b></p>	<p><b>Actions Taken by Alameda to Address the External Quality Review Recommendations</b></p>
	<ul style="list-style-type: none"> <li>■ Public Health Department HR names the department directors for each department.</li> <li>◆ Cross-Agency Functions—HR                             <ul style="list-style-type: none"> <li>■ New employees</li> <li>■ Hiring process</li> <li>■ Timekeeping and payroll</li> <li>■ HR policies</li> <li>■ HR forms                                     <ul style="list-style-type: none"> <li>○ Forms for all employees</li> <li>○ Forms for supervisors</li> </ul> </li> </ul> </li> </ul> <p>For ALCOHub, HR explains the resources available to employees:</p> <ul style="list-style-type: none"> <li>◆ Payroll/timesheet</li> <li>◆ Benefits</li> <li>◆ Compensation</li> <li>◆ Training</li> <li>◆ Employment</li> <li>◆ Retirement—Alameda County Employees’ Retirement Association website (sign-up for upcoming or past webinars)</li> <li>◆ Workplace Safety—Ergonomic form</li> </ul> <p>Every month, ACBHD’s HR Department issues a memorandum (memo) to all staff announcing registration for the monthly New Team Member Orientation and Onboarding Training. The orientation is designed to help employees understand ACBHD and its operations. During the New Team Member Orientation and Onboarding Training, the HR Department provides the following:</p> <ul style="list-style-type: none"> <li>◆ Introduces new employees to ACBHD’s core services and stakeholders.</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Alameda</b>	<b>Actions Taken by Alameda to Address the External Quality Review Recommendations</b>
	<ul style="list-style-type: none"> <li>◆ Presents ACBHD’s mission, vision, and values.</li> <li>◆ Provides an overview of the departmental units and functions, including statutory requirements.</li> <li>◆ Describes ACBHD’s current initiatives, system changes, and priorities.</li> </ul>
<p>2. Redesign the MHP’s website to highlight the provider directory to easily find contact information for all providers and to help providers expedite referrals to appropriate levels of care (LOCs) for members.</p>	<p>On December 27, 2024, the Information Systems Department redesigned the MHP’s website by highlighting the provider directory to easily find contact information for all providers and to help providers expedite referrals to appropriate LOCs for members. The Quality Improvement and Data Analytics (QIDA) Team worked in collaboration with the Systems of Care (SOC) Division directors and the Information Systems Department to incorporate the recommendations from the EQRO. The provider directory has information about organizations providing mental health (MH) specialty services to Alameda County residents who are eligible or enrolled in Medi-Cal. The updated website helps providers, especially crisis providers and those who work in the jails, to expedite referrals to appropriate LOCs.</p> <p>Regarding the provider directory enhancements, below are the changes that were made to the public-facing provider directory website:</p> <ul style="list-style-type: none"> <li>◆ Added new links to providers listed by types of service: <ul style="list-style-type: none"> <li>■ Providers by Service Modality</li> <li>■ Providers by Service Specialty</li> </ul> </li> <li>◆ Added search capability</li> <li>◆ Enabled the use of an asterisk (*) as a wildcard in the search box</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Alameda</b>	<b>Actions Taken by Alameda to Address the External Quality Review Recommendations</b>
	<ul style="list-style-type: none"> <li>◆ Added new columns by category to both the MH Services and Substance Use Disorder (SUD) directories:                             <ul style="list-style-type: none"> <li>■ Rendering Service Providers by Age Group</li> <li>■ Facility Providers by Age Group</li> <li>■ “Services” column with a drop-down menu listing the types of services offered by providers</li> </ul> </li> </ul>
<p>3. Provide ease of access to crisis numbers, 988, and after-hours services in plain sight on the MHP’s website landing page.</p>	<p>In collaboration with the Crisis Services director and QIDA, the Information Systems Department incorporated the following updates to ACBHD’s public-facing website (<a href="https://www.acbhcs.org/">https://www.acbhcs.org/</a>):</p> <ul style="list-style-type: none"> <li>◆ Increased the font size on the links at the top of the webpage to highlight the Provider Directory and Clinical Support and Referrals.</li> <li>◆ Redesigned the website to highlight crisis numbers, such as 988 and after-hours services, in plain sight on the landing page:                             <ul style="list-style-type: none"> <li>■ Moved the crisis phone numbers and information from the middle of the webpage to the top of the webpage.</li> </ul> </li> <li>◆ Added: “Need help now?” Dial 988 or (800) 309-2131 or text “Safe” or “Seguro” to 20121.</li> </ul>
<p>4. Assign a project team to assess SmartCare usage or another solution to replace the Clinician’s Gateway.</p>	<p>ACBHD created the SmartCare Steering Committee in 2020 to develop the SmartCare Billing implementation plan. The SmartCare Steering Committee updates project milestones; reviews critical decisions, issues, and risks; and devises next steps. The SmartCare Steering Committee is composed of key stakeholders from information systems, QIDA, finance, billing and benefits, and plan administration. Over the past several years, ACBHD assessed SmartCare usage and</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Alameda</b>	<b>Actions Taken by Alameda to Address the External Quality Review Recommendations</b>
	<p>worked closely with the vendor to improve system performance and usability. Additionally, ACBHD implemented an interface between SmartCare Billing and the county's Electronic Health Record (EHR), Clinician's Gateway. Currently, ACBHD is in the process of procuring a new EHR.</p> <p>On February 4, 2025, the Alameda County Board of Supervisors approved ACBHD to begin contract negotiations with Epic Systems Corporation. The Epic agreement will enable Epic to provide an EHR for clinical and billing operations software for ACBHD. The Information Systems Department is engaged with Epic to plan for the implementation of the new EHR system. Over the past few months, ACBHD has facilitated listening sessions with MH and SUD providers and stakeholders, and ACBHD employees to provide an opportunity for feedback. In addition, the Information Systems Department coordinated virtual Epic software demonstration meetings with key stakeholders in ACBHD. The county’s centralized and interoperable system supports a patient's continuity of care in the community.</p>
<p>5. Investigate certified peer support specialist (CPSS) pay equity and the ability to use billing codes to enhance an additional revenue stream.</p>	<p>On May 16, 2024, the Quality Assurance (QA) Division issued a memo to all non-fee-for-service outpatient ACBHD SMHS Medi-Cal providers and all ACBHD staff that announced the updated procedure codes for peer support services. The new Healthcare Common Procedure Coding System codes for CPSS and family certified peer support specialists (FCPSS) that were activated in SmartCare are listed below:</p> <ul style="list-style-type: none"> <li>◆ H0025 Peer Support Services Educational Skill Building Groups, 15 minutes—Use this</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Alameda</b>	<b>Actions Taken by Alameda to Address the External Quality Review Recommendations</b>
	<p>code to report peer support specialist (PSS) group services (member is present).</p> <ul style="list-style-type: none"> <li>◆ H0025 Peer Support Services Family Educational Skill Building Groups, 15 minutes—Use this code to report PSS group services to the peer’s family and/or other significant support persons (member is not present).</li> <li>◆ H0038 Peer Support Services Family Engagement/Therapeutic Activity, 15 minutes—Use this code to report individual PSS (member is present).</li> <li>◆ H0038 Peer Support Services Family Engagement/Therapeutic Activity, 15 minutes—Use this code to report individual PSS to the peer’s family and/or other significant support persons (member is not present).</li> </ul> <p>Any program wishing to designate an individual as a CPSS/FCPSS must submit a staff e-Form request to either add a new CPSS/FCPSS or update an existing staff member’s licensing information with the CPSS/FCPSS license/degree type. Once completed, ACBHD Benefits and Billing Unit will add the CPSS/FCPSS procedure codes to the program.</p> <p>On May 17, 2024, the QA Division posted the ACBHD SMHS Scope of Practice Guidelines on the QA Manual page of the provider website for details. The Scope of Practice Guidelines include the CPSS and FCPSS billing codes (H0025 and H0038). An updated version was uploaded to the website on September 20, 2024.</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Alameda	Actions Taken by Alameda to Address the External Quality Review Recommendations
	On April 28, 2025, the Office of Peer Support Services issued the new ACBHD Peer Support Services Policy. The purpose of this policy is to describe the ACBHD PSS within MH and SUD treatment services. Billing guidance is provided for Certified Medi-Cal PSSs and Certified Medi-Cal PSSs Family Specialization.

## Assessment of Alameda’s Self-Reported Actions

HSAG reviewed Table B.1, in which Alameda summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Alameda adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Alameda related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Alameda addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Alameda

Based on the overall assessment of Alameda’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Alameda’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned a *High Confidence* level to Alameda’s 2025 clinical PIP submission. Alameda met all critical and evaluation element scores for this PIP submission, reflecting that the MHP built a robust foundation in the Design stage of its clinical PIP.
- ◆ During the PMV audit process, HSAG observed that Alameda had multiple methods of validation and tracking to ensure the accuracy and completeness of claims data.

Additionally, the MHP conducted quarterly audits to address performance gaps. Finally, Alameda was prompt and thorough on all its submissions, which contributed to a well-organized and efficient virtual review process.

- ◆ Based on HSAG's NAV audit findings, HSAG determined that Alameda had robust processes in place to maintain and validate accurate provider data, which included using ProviderTrust for ongoing credentials monitoring, an attestation process, staff rosters, and forms to track changes in provider data. Additionally, HSAG observed multiple efforts to assist staff in reporting accurate, timely access data through trainings, resource documents, and reporting form design, including built-in definitions to data points within the electronic forms.

## Opportunities for Improvement

- ◆ HSAG's 2025 PIP validation determined that Alameda did not include all required details of its PIP processes for its nonclinical PIP.
- ◆ Alameda has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Alameda did not meet one or more DHCS standards for timely access indicators due to exceeding DHCS' 5 percent data error threshold.

## 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Alameda includes all required information in the MHP's 2026 annual nonclinical PIP submission.
- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Alameda did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Alameda's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Alameda as well as the plan's progress with addressing these recommendations.

# Alpine County Behavioral Health Services

## Follow-Up on Prior Year Recommendations

Table B.2 provides the EQR recommendations directed to Alpine from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.2 to preserve the accuracy of Alpine’s self-reported actions.

**Table B.2—Alpine’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Alpine	Actions Taken by Alpine to Address the External Quality Review Recommendations
<p>1. Consider recruiting a clinician who is hybrid telehealth/on-site if unable to hire an additional clinician for the Bear Valley area.</p>	<p>The MHP has one clinician who serves Bear Valley clients virtually. We will not be recruiting a clinician to go to Bear Valley in person due to impracticality of commuting during winter months when the road is closed.</p>
<p>2. Consider engaging an existing or new consultant who can augment quality management (QM) functions and sustain them during times of staff vacancies.</p>	<p>The MHP has a contracted consulting firm to assist with QM and compliance. It is not cost effective to utilize this resource unless we lack technical skills to complete audits and reviews in-house.</p>
<p>3. Identify opportunities to increase outreach and engagement activities, as well as field-based MH services. While the MHP has only 2.0 full-time equivalent (FTE) clinicians, this appears sufficient for the number of members served, and the MHP could likely serve more members. Additional outreach and field-based service delivery may engage more individuals who need care.</p>	<p>The MHP has existing executed contracts with community partners to extend our outreach and engagement programs and activities. We do an excellent job of engaging community members as evidenced by attendance at events such as “Create the Good” and events that serve youth, the elderly, and Tribal communities. We serve individuals in the Hung-a-lel-ti (Woodford’s) community from our base in that community. Our staff and contracted outreach staff work on-site five days per week and will also provide home visits. We provide wellness services online and</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Alpine	Actions Taken by Alpine to Address the External Quality Review Recommendations
	in person at Woodford’s and in Bear Valley with very positive outcomes.
4. Continue conversations with DHCS regarding potential solutions for cost-prohibitive program implementations such as mobile crisis services and Community Assistance, Recovery, and Empowerment (CARE) Court.	The MHP has ongoing conversations with DHCS regarding cost-prohibitive programs. The MHP has implemented CARE Court; however, we have had no petitions filed. Crisis Care Mobile Units (CCMUs) will not be implemented in Alpine County. It is not practical to operate a CCMU at a cost of \$500k per year to respond to less than five calls per year.
5. Initiate the development of peer employment by obtaining input from the community and active members. Consider piloting this endeavor through volunteerism.	The MHP plans to train at least one staff member as a PSS in fiscal year (FY) 2025–26.

## Assessment of Alpine’s Self-Reported Actions

HSAG reviewed Table B.2, in which Alpine summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Alpine adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Alpine related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Alpine addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Alpine

Based on the overall assessment of Alpine’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Alpine’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When

applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

## Strengths

- ◆ During the PMV audit process, Alpine provided timely responses and follow-up documentation for most audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes while navigating staffing challenges. Additionally, Alpine demonstrated commitment to addressing its members' behavioral health care despite the county's small population and staffing availability barriers.
- ◆ Based on NAV audit findings, HSAG determined that Alpine had thorough processes in place to maintain updated member demographic and eligibility data, which included capturing demographic data via an intake packet, verifying demographic information at appointments, and validating eligibility monthly.

## Opportunities for Improvement

- ◆ Alpine has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Alpine:
  - Had manual processes in place to track and report timely access data using an access and information log.
  - Did not have validation checks in place to review the Timely Access Data Tool (TADT) prior to submission to DHCS.
  - Did not meet one or more DHCS standards for timely access indicators due to a failure to submit timely access data to DHCS in a timely manner.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To improve timely access reporting:
  - Continue to work with Kings View to implement timely access data tracking capabilities in Credible, minimizing manual data entry required to populate the TADT and reducing the potential for data entry errors.
  - Consider implementing validation checks, such as a secondary review, prior to submission to DHCS to ensure accuracy and completeness of data reported in the TADT.
  - Conduct an in-depth review of the indicators for which Alpine did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.

- Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Alpine's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Alpine as well as the plan's progress with addressing these recommendations.

# Amador County Behavioral Health

## Follow-Up on Prior Year Recommendations

Table B.3 provides the EQR recommendations directed to Amador from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.3 to preserve the accuracy of Amador’s self-reported actions.

**Table B.3—Amador’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Amador	Actions Taken by Amador to Address the External Quality Review Recommendations
<p>1. Create reports on aggregate child/youth outcome measures to better understand outcomes for members and program performance.</p>	<p>Amador continues to use the state-mandated Child and Adolescent Needs and Strengths (CANS) assessment as a youth outcome tool. Amador has worked with Kings View to develop a CANS dashboard to provide an overview of performance. This dashboard can be filtered by employee, client, and date showcasing responses of “two” and “three” which suggest areas to be addressed.</p>
<p>2. Regularly reassess staff members’ need for additional training on the new EHR and in what format training would be most helpful to them.</p>	<p>Amador’s 2023–24 EQR was conducted in late August 2023, having only gone live with our new EHR on July 1, 2023. As with any system change, Amador was still in a huge learning curve at the time of the review, and staff were hesitant about the change. The need for more training with the new EHR was a very hot topic at the time. During the transition time, Amador provided the following training:</p> <ul style="list-style-type: none"> <li>◆ In-person training with a Kings View representative was offered to all staff on July 5, 2023. Amador was the only MHP to insist that Kings View have on-site representation and training during implementation.</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Amador</b>	<b>Actions Taken by Amador to Address the External Quality Review Recommendations</b>
	<ul style="list-style-type: none"> <li>◆ Providers had six hours of blocked time provided on two days to watch training videos.                             <ul style="list-style-type: none"> <li>■ Tuesday, June 27, 2023—2 to 5 p.m.—Session 1 (three hours)</li> <li>■ Wednesday, June 28, 2023—2 to 5 p.m.—Session 2 (three hours)</li> </ul> </li> <li>◆ The entirety of July 3, 2023, was blocked off for all providers for additional video viewing and/or platform familiarization. On this date, Kings View offered a full day (8:30 a.m. to 4:30 p.m.) of drop-in office hours for all staff with multiple Kings View representatives available.</li> <li>◆ Providers had access to Kings View training videos, training manual, and a training domain starting June 7, 2023.</li> <li>◆ Training manuals were available online, and three printed copies were available in the office. Employees were also made aware that they could request a printed manual if desired.</li> <li>◆ Providers had support from eight “super users” during implementation, and everyone was encouraged to drop in or schedule one-on-one training.</li> <li>◆ Kings View hosted weekly virtual drop-in office hours for four weeks following implementation to offer continued support, with each session lasting for 1.5 hours.</li> <li>◆ In-house “cheat sheets” were generated and distributed for common workflow processes.</li> </ul> <p>Now, two years after implementation, EHR training is provided via the Kings View learning management system during staff onboarding.</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Amador	Actions Taken by Amador to Address the External Quality Review Recommendations
	<p>Several printed training manuals are located in a communal space. The QI/utilization review (UR) coordinator also conducts one-on-one training at employee request and during staff onboarding.</p>
<p>3. Begin to track and trend urgent requests by age group and foster care status.</p>	<p>DHCS defines “Urgent Requests” as follows:</p> <p>An Urgent Appointment means health care is provided to a member when the member’s condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal time frame for the decision-making process would be detrimental to the member’s life or health or could jeopardize their ability to regain maximum function.</p> <p>Utilizing this definition, a beneficiary with an urgent circumstance would result in a 5150 assessment and likely inpatient hospitalization. Amador has a singular hospital in-county, and providers have one hour to respond to 5150 requests. This time frame is tracked on Amador’s 5150 coversheet forms where providers record what time they were contacted and what time they responded.</p> <p>Forms are able to be filtered by age and other basic demographic information. For foster youth tracking, Amador has built into its EHR a “Foster Program” which tracks foster youth.</p>
<p>4. Continue to monitor crisis utilization and appropriate linkage to outpatient services.</p>	<p>Amador continues to monitor crisis utilization and appropriate linkage to outpatient services. Since the time of the last EQR, the county has worked on workflows to meet <i>Follow-Up After</i></p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Amador	Actions Taken by Amador to Address the External Quality Review Recommendations
	<i>Emergency Department Visit for Mental Illness and Follow-Up After Hospitalization for Mental Illness</i> measure compliance work. Amador has also designed all crisis forms to ensure more adequate data accumulation.
5. Work with the new EHR vendor to create key reports necessary for management of MHP operations.	Amador continues to work with Kings View to create key reports and utilize the EHR in the most efficient ways available. Kings View has assisted in building requested dashboards and reports and is available upon request for training in specific ad-hoc report building when necessary.

## Assessment of Amador’s Self-Reported Actions

HSAG reviewed Table B.3, in which Amador summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Amador adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Amador related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Amador addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Amador

Based on the overall assessment of Amador’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Amador’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Amador’s 2025 clinical and nonclinical PIP submissions. Amador met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, HSAG observed that Amador had multiple methods of validation and tracking to ensure the accuracy and completeness of claims data and used reports within Credible to adequately identify and correct service errors prior to submitting 837 files to DHCS. Amador was transparent about the challenges and barriers it faced with the finder file process in place and obtaining the Plan Data Feed files, and the MHP demonstrated willingness to learn the Plan Data Feed process to enhance performance measure rate calculation.
- ◆ DHCS’ 2025 compliance review scores for Amador show that the MHP was fully compliant with most Code of Federal Regulations (CFR) standards.
- ◆ During the NAV audit process, Amador demonstrated robust oversight and monitoring of timely access reporting through the development of several reporting dashboards to ensure accuracy and completeness of member and service data in Credible, including a bimonthly member demographic report, and weekly reports to identify missing and incomplete services and notes.

## Opportunities for Improvement

- ◆ Amador has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Amador:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Enrollee Rights—§438.100

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS’ 2025 compliance review scoring process related to the following CFR standards to ensure Amador meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206

- Assurance of Adequate Capacity and Services—§438.207
- Coordination and Continuity of Care—§438.208
- Enrollee Rights—§438.100

Amador's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Amador as well as the plan's progress with addressing these recommendations.

# Butte County Department of Behavioral Health Services

## Follow-Up on Prior Year Recommendations

Table B.4 provides the EQR recommendations directed to Butte from the previous EQRO's 2023–24 SMHS EQR technical report, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.4 to preserve the accuracy of Butte's self-reported actions.

**Table B.4—Butte's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization's 2023–24 External Quality Review Recommendations Directed to Butte	Actions Taken by Butte to Address the External Quality Review Recommendations
<p>1. Continue efforts to reduce the MHP's vacancy rate by considering more flexible schedule options, more comprehensive training and onboarding, and other strategies that may improve employee engagement and, therefore, staff retention.</p>	<p>Butte worked to improve the vacancy rate in the following ways.</p> <ul style="list-style-type: none"> <li>◆ Site differentials were increased for our crisis, psychiatric health facility (PHF), and forensic staff.</li> <li>◆ A wage increase was granted for all positions in the county. <ul style="list-style-type: none"> <li>■ 8 percent increase starting July 2025.</li> <li>■ 5 percent increase for the following three years.</li> </ul> </li> <li>◆ Our QM Program revised our training and onboarding program to streamline the process for new staff. <ul style="list-style-type: none"> <li>■ This revision involved input from all levels of the organization through the formation of a training workgroup.</li> </ul> </li> <li>◆ We continue to complete employee engagement surveys every year to evaluate areas for improvement.</li> <li>◆ Butte and county leadership developed alternative schedule remote work guidance.</li> </ul>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Butte	Actions Taken by Butte to Address the External Quality Review Recommendations
	<ul style="list-style-type: none"> <li>◆ Butte issued a pilot program on alternative schedules.</li> </ul>
<p>2. Evaluate workloads and the system capacity that is available based on existing clinical staff systemwide. Consider whether caseloads are at numbers that can allow for appropriate clinical management.</p>	<p>Butte implemented the following:</p> <ul style="list-style-type: none"> <li>◆ Launched a residency program with Healthy Rural California which has brought psychiatric residents to Butte County.</li> <li>◆ Reworked our internship program to bring more clinical and nonclinical interns to Butte.</li> <li>◆ Aligned caseloads with the state-required ratios, and our 274 results support our alignment.</li> </ul>
<p>3. Continue efforts to improve comprehensiveness and accuracy of contract provider timeliness data through improved data capture.</p>	<p>We have released a standardized template for contractors to report their timely access information based on the TADT produced by the State. This allows Butte to better assess the timeliness of services.</p>
<p>4. Increase communication with contracted providers and county-operated line staff. California Advancing and Innovating Medi-Cal (CalAIM) has implemented many changes in services rendered, how to code, and how to bill.</p>	<p>Butte implemented the following:</p> <ul style="list-style-type: none"> <li>◆ Released standardized training and frequently asked questions documents to our programs and contractors for numerous topics. <ul style="list-style-type: none"> <li>■ This has allowed for better communication between our contractors and us.</li> </ul> </li> <li>◆ Through both administrative programs, developed clearer communication pathways for contracted providers, including standardized reporting documents and specific email inboxes for different topics.</li> <li>◆ Hosted support meetings for contracted providers’ executive staff members.</li> <li>◆ Our QM Program and MH Services Act Program continued their monitoring efforts, leading to more consistency in expectations for our contracted and internal providers.</li> </ul>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Butte	Actions Taken by Butte to Address the External Quality Review Recommendations
	<ul style="list-style-type: none"> <li>■ These efforts included revising the chart review format.</li> <li>◆ Reorganized our Quality Improvement Committee (QIC), leading to clearer expectations and more centralized communication.</li> </ul>
<p>5. Restart efforts to consider the development of a peer supervisory role. The MHP has many peer positions in all geographical areas; however, there is no potential for upward mobility, supervisory roles, or the ability for staff members to expand in their positions.</p>	<p>Although Butte does not currently have a peer supervisory or alternative peer leadership classification, peer staff have upward mobility within our SOC, as many have been promoted into elevated positions in non-peer specialist roles. Butte has completed comparison of surrounding county salaries for peer leadership positions and is currently in the process of drafting a classification specification.</p>

## Assessment of Butte’s Self-Reported Actions

HSAG reviewed Table B.4, in which Butte summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Butte adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Butte related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Butte addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Butte

Based on the overall assessment of Butte’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Butte’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Butte’s 2025 clinical and nonclinical PIP submissions. Butte met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, HSAG observed that Butte used the Monthly Medi-Cal Eligibility File (MMEF) uploads, real-time enrollment data batch inquiries, Medi-Cal Eligibility Data System Lite (MEDSLITE) data, and MMEF Log reports to validate, update, and improve the overall accuracy of its member enrollment data in myAvatar. Additionally, Butte implemented multiple methods of validation and tracking to ensure the accuracy and completeness of its provider data in myAvatar.
- ◆ During the NAV audit process, HSAG observed that Butte:
  - Conducted quarterly monitoring and reporting of timely access and reviewed results during QIC meetings, which were designed to highlight trends over time and develop interventions focused on any observed gaps in timely access to services.
  - Continued to improve network adequacy and access to care through initiatives such as lowering staff vacancy rates, implementing a psychiatric residency program, and setting a long-term goal of providing integrated services across three additional facilities in addition to the Chico location.

## Opportunities for Improvement

- ◆ Butte has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Butte did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Butte did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Butte's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Butte as well as the plan's progress with addressing these recommendations.

## Calaveras County Behavioral Health Services

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of Calaveras for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.5 provides the EQR recommendations directed to Calaveras from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.5 to preserve the accuracy of Calaveras’ self-reported actions.

**Table B.5—Calaveras’ Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Calaveras	Actions Taken by Calaveras to Address the External Quality Review Recommendations
<p>1. Examine engagement and retention patterns. Identify areas where strategies are necessary to deliver clinically necessary care to populations that may not currently receive what they need.</p>	<p>The lag in the data provided (calendar year 2022 data provided in calendar year 2024) creates some challenges in conducting an examination of current engagement and retention patterns, especially considering the numerous statewide changes implemented through CalAIM during this same time period. Further, Calaveras’ generally small client population (under 1,000 active clients) contributes to skewed data in many of our examinations of subgroups. Calaveras’ rates fall within statewide minimum and maximum levels; however, our initial reviews of the data provided some insights into our higher levels of members receiving one to three services and highlighted some key challenges and advantages. These include the following:</p> <ul style="list-style-type: none"> <li>◆ Calaveras responds to all crisis events at the only local hospital emergency department and in 2022 was one of the only BH clinics in the county. Since then, the increase in collaboration with the</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Calaveras</b>	<b>Actions Taken by Calaveras to Address the External Quality Review Recommendations</b>
	<p>managed care health plan (MCP) and the opening and expansion of two community MH clinic providers (Mariposa, Amador, Alpine, Calaveras &amp; Tuolumne Health Board, Inc. and Valley Springs Health &amp; Wellness Center) have provided additional options for community members.</p> <ul style="list-style-type: none"> <li>◆ Calaveras is both an MHP and county-operated BH clinic and thus provides screening and referral services to any community member who requests services. This causes an increase in members receiving only a few services if they are being referred to lower level, alternative, or specialty services.</li> <li>◆ Calaveras is aware that our lack of a standardized tool to assess LOC may contribute to clients remaining in care longer than needed. Further, the lack of community providers able to work with complex MH needs and psychiatric medications means certain categories of clients will remain in SMHS long term.</li> <li>◆ In 2024, Calaveras was finally able to hire an in-house psychiatrist who is focused on individual clients and expanding collaboration. This psychiatrist participates in the weekly client care meeting, is establishing communications with local PCPs and MH providers to facilitate member transitions to lower LOCs, and is thoughtfully examining current psychiatric caseloads to ensure individual members are receiving the appropriate LOC needed.</li> </ul>
<p>2. Implement the Level of Care Utilization System (LOCUS) in 2024 as planned and use aggregate data for both children and adult outcomes measures to plan LOC transitions.</p>	<p>Calaveras has not yet implemented LOCUS due to a combination of factors. In 2024, we experienced a series of personnel changes which impacted our ability to move forward on this project. This included all three QM staff</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Calaveras</b></p>	<p><b>Actions Taken by Calaveras to Address the External Quality Review Recommendations</b></p>
	<p>exiting their positions—two moved to other positions in the county, and the clinical QM staff person left county employment entirely. Additional personnel challenges included ongoing difficulty in hiring a clinical supervisor, causing that position to remain open all year, and key leadership positions experiencing unexpected lengthy leaves of absence. At the same time, the statewide examination of the most appropriate LOC tools and DHCS communications indicating there may be a specific LOC tool requirement led to our decision to delay implementation of any new tools until the QM and clinical supervisor positions were filled and DHCS guidance was issued. In addition, LOCUS requires use of a separate system to administer the tool that currently cannot be incorporated into our EHR; therefore, we are continuing to explore tools that will support both client care and staff workflows.</p> <p>As of August 1, 2025, Calaveras is excited to announce we have one QM position filled, a second QM staff member who onboarded this week, and one of our clinical staff members is serving as the interim clinical supervisor. We are still waiting on final recommendations from DHCS regarding LOC determination tools in county MH and will move forward with LOC tool implementation when DHCS provides that guidance.</p>
<p>3. Trend the past two years of Consumer Perception Survey (CPS) satisfaction metrics in the Quality Assessment and Performance Improvement (QAPI) plan. Share CPS findings with members and invite them to the QIC and other committee meetings for their input.</p>	<p>In late 2024, a second department analyst position was added to Calaveras’ BH staff. When the 2024 CPS results were received, the new analyst reviewed the previous and current year results to examine trends and compare outcomes. This trend will be included in the 2025–26 QAPI plan.</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Calaveras</b></p>	<p><b>Actions Taken by Calaveras to Address the External Quality Review Recommendations</b></p>
	<p>Due to the small county population and short survey period, Calaveras consistently struggles to glean meaningful results from the CPS; however, survey results were presented to both the QIC and Calaveras staff, and the report was posted on the Calaveras website for community review. While the 2025 survey results are still pending, the number of surveys completed this year was much lower than previous years; therefore, an examination of the process was conducted and discussed in administration, QIC, and cultural competence meetings.</p> <p>In addition to ideas and plans on how to address low response numbers in our annual CPS, Calaveras has decided to develop and administer an additional member survey to gather additional feedback and input from the people we serve.</p> <p>A committee was formed consisting of QM specialists, the ethnic services manager, the BH analyst, peer support services staff, and others to develop and implement this new annual survey. Plans include:</p> <ul style="list-style-type: none"> <li>◆ Involving QIC, Calaveras staff members, and peers in the survey development.</li> <li>◆ Administering the survey over a longer period of time (planned for the whole month of October 2025) to capture more responses.</li> <li>◆ Administering the survey annually in order to monitor trends.</li> <li>◆ Allowing the survey to be anonymous to capture more varied responses.</li> </ul>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Calaveras	Actions Taken by Calaveras to Address the External Quality Review Recommendations
	<ul style="list-style-type: none"> <li>◆ Including older adults in the adult survey responses due to the small population of older adults in our system.</li> <li>◆ Allowing for needed modifications in the first few years of the survey to address any challenges or flaws discovered after initial rollout and administration.</li> </ul>
<p>4. Report on staff satisfaction surveys conducted to identify focus areas for improving morale, communication, training needs, clinical supervisory presence and support, and appropriate activities to improve in these areas.</p>	<p>An all-staff in-service was held in June 2024, facilitated by an outside organization focusing on staff communication, cohesion, and care. This meeting laid the groundwork for the second all-staff in-service in December 2024 where the same organization led an examination of Calaveras values and goals. A staff survey was administered and resulted in Calaveras beginning to develop a Calaveras “DNA Code.” From there, a group of Calaveras staff led the continued refinement of staff agreements focused on communication, morale, and satisfaction. The “DNA Code” will continue to inform and guide the division in all aspects listed.</p> <p>At the same time, advocacy for and subsequent changes to job descriptions and pay scales allowed for more competitive recruitment for job openings, improved immediate staff retention, and expanded pools of candidates for key positions.</p>

## Assessment of Calaveras’ Self-Reported Actions

HSAG reviewed Table B.5, in which Calaveras summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Calaveras adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Calaveras related to the mandatory EQR activities, as applicable.

In the next annual review, HSAG will assess the extent to which Calaveras addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Calaveras

Based on the overall assessment of Calaveras’ delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Calaveras’ activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Calaveras’s 2025 clinical and nonclinical PIP submissions. Calaveras met all critical and evaluation element scores for both PIP submissions, reflecting that the Integrated BHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Calaveras demonstrated a strong commitment to improving performance measure rates, particularly for the *Follow-Up After Emergency Department Visit for Substance Use*, *Follow-Up After ED Visit for Mental Illness*, and *Follow-Up After Hospitalization for Mental Illness* measures. Additionally, Calaveras began planning implementation of specific processes to assist with performance measure improvement in alignment with the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Volume 2 Technical Specifications, including weekly meetings to discuss and review the dashboard.
- ◆ Based on HSAG’s NAV audit findings, HSAG determined that Calaveras maintained thorough processes to capture accurate and up-to-date member eligibility and demographic data using an intake packet, demographic form, checklist reviewed by Calaveras’ administrative services manager, and validation of eligibility at the time of a member’s appointment.

### Opportunities for Improvement

- ◆ Calaveras has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Calaveras:
  - Availability of Services—§438.206

- Assurance of Adequate Capacity and Services—§438.207
- Coordination and Continuity of Care—§438.208
- Coverage and Authorization of Services—§438.210
- Provider Selection—§438.214
- Grievance and Appeal Systems—§438.228
- Practice Guidelines—§438.236
- Health Information Systems—§438.242

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS’ 2025 compliance review scoring process related to the following CFR standards to ensure Calaveras meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Provider Selection—§438.214
  - Grievance and Appeal Systems—§438.228
  - Practice Guidelines—§438.236
  - Health Information Systems—§438.242

Calaveras’ responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Calaveras as well as the plan’s progress with addressing these recommendations.

# Colusa County Department of Behavioral Health

## Follow-Up on Prior Year Recommendations

Table B.6 provides the EQR recommendations directed to Colusa from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.6 to preserve the accuracy of Colusa’s self-reported actions.

**Table B.6—Colusa’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Colusa	Actions Taken by Colusa to Address the External Quality Review Recommendations
<p>1. Review the transportation system within the county and agency, and investigate alternative options.</p>	<p>Colusa has very little influence on Colusa County Transit Agency’s schedules and routes. However, we do provide transit tickets free of charge and case management services, which can include transportation services when appropriate. We also refer clients to a partner agency, Tri Counties Community Action Partnership, which provides enhanced care management (ECM) services. ECM services include transportation and linkage to medical appointments, including BH services. The MCP also provides transportation to medical appointments, with members able to schedule rides two weeks out.</p>
<p>2. Review the need to hire a data analyst with Structured Query Language skills who can assist with complex data projects that the new EHR will support.</p>	<p>Colusa is in the process of combining two currently unfilled administrative positions to create a data analyst position. This is a lengthy process as a job description needs to be written, and the position has to be approved by the County Board of Supervisors before recruitment can begin. This new data analyst position was approved in our FY 2025–26 budget. We are in the process of getting feedback from the unions to see if any changes need to occur before the position</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Colusa	Actions Taken by Colusa to Address the External Quality Review Recommendations
	goes before the Board of Supervisors for approval. We are hopeful to begin recruitment for this position in October 2025.
3. Continue efforts to implement a formal process for psychiatrist review and monitoring of MHP medication prescribing practices.	Currently, Colusa has two telehealth psychiatrists who peer review each other’s cases. The front desk staff keep a log of cases that have been reviewed and assign cases in need of review to the psychiatrists.
4. Implement a medication monitoring system for foster care youth as required by Welfare and Institutions Code Section 14717.5.	Colusa provides attention-deficient/hyperactivity disorder (ADHD) and antipsychotic medication to youth and foster youth only when medically and clinically indicated. Our EHR has a separate program for foster care youth medication. We are able to track these individuals through this program and send their charts to a psychiatrist/medical doctor (who is not the prescribing provider) for review to ensure appropriate prescribing practices. Colusa also has a policy and procedure that disallows “medication only” services for youth clients. Each youth client has an assigned therapist who supports treatment goals and sees the youth client more often than the psychiatrist sees the client.
5. Evaluate staffing needs for open access days, and ensure that staff members are comfortably able to maintain their current workload in addition to covering walk-in appointments.	Clinical staff who support walk-in intakes have been trained to block their schedules accordingly when they are on call for walk-in intakes so that no conflicts occur. Clinical staff have specific assigned days so that they always know when they are expected to be on standby to participate in walk-in intakes.

## Assessment of Colusa’s Self-Reported Actions

HSAG reviewed Table B.6, in which Colusa summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Colusa adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Colusa related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Colusa addresses these recommendations.

## **2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Colusa**

Based on the overall assessment of Colusa’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Colusa’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### **Strengths**

- ◆ HSAG assigned *High Confidence* levels to Colusa’s 2025 clinical and nonclinical PIP submissions. Colusa met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Colusa was transparent about the challenges and barriers it faced with the finder file process in place and obtaining the Plan Data Feed files, and the MHP demonstrated willingness to learn the Plan Data Feed process to enhance performance measure rate calculations. Additionally, Colusa was prepared to discuss all sections in the virtual review and prepared staff to overview all sections in scope of review.
- ◆ DHCS’ 2025 compliance review scores for Colusa show that the MHP was fully compliant with most CFR standards.
- ◆ During HSAG’s NAV audit process, HSAG observed that Colusa:
  - Implemented scheduled walk-in hours to ensure clinician availability to provide services to new walk-in members in efforts to improve and maintain access to care.
  - Had thorough processes to capture up-to-date member eligibility data, including manually validating eligibility at intake, for upcoming appointments, and at the time of a member’s appointment.

### **Opportunities for Improvement**

- ◆ Colusa has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.

- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Colusa:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100
- ◆ During the NAV audit process, Colusa noted timely access data were manually tracked in Microsoft Excel (Excel) and then input into SmartCare due to concerns about accuracy of data extracted from the system.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS’ 2025 compliance review scoring process related to the following CFR standards to ensure Colusa meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100
- ◆ Work with California Mental Health Services Authority (CalMHSA) to address timely access data accuracy and resolve any remaining system concerns. Additionally, consider using SmartCare’s embedded reporting functions, which may reduce manual data entry processes and potential data entry errors, and increase efficiency.

Colusa’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Colusa as well as the plan’s progress with addressing these recommendations.

# Contra Costa County Mental Health

## Follow-Up on Prior Year Recommendations

Table B.7 provides the EQR recommendations directed to Contra Costa from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.7 to preserve the accuracy of Contra Costa’s self-reported actions.

**Table B.7—Contra Costa’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Contra Costa	Actions Taken by Contra Costa to Address the External Quality Review Recommendations
<p>1. Continue to implement recruitment and retention strategies identified from staff survey feedback, such as testing alternate work schedules, to stabilize staffing and improve recruitment results for both clinical and quality positions.</p>	<p>In response to staff survey feedback, the MHP launched a flexible work schedule pilot in March 2023 to evaluate the impact of alternate schedules—specifically a 9/80 schedule and one remote workday per week—for staff meeting a 60 percent productivity threshold. Results to date show a slight increase in productivity, and the pilot remains active.</p> <p>The MHP continues to expand recruitment and retention strategies by maintaining this flexible schedule QI project and exploring additional options such as extended clinic hours to support a 4/10 schedule. Some programs, such as A3 mobile crisis, the Youth Stabilization Unit, and the forthcoming Oak Grove facilities, already operate with flexible hours and are attracting staff seeking more adaptable work arrangements.</p>
<p>2. Expand the use of batch files to submit service data claims or provide access for contracted providers to directly enter clinical data to eliminate double entry</p>	<p>The MHP is actively exploring multiple technical solutions to streamline service entry into Epic ccLink by contracted providers in collaboration with a working group of community-based organizations (CBOs), county information technology (IT), and</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Contra Costa</b>	<b>Actions Taken by Contra Costa to Address the External Quality Review Recommendations</b>
<p>once the Epic ccLink billing implementation is complete.</p>	<p>Epic/Nordic consultants. The two main options under consideration include: (1) submission of 837 files into ccLink or the clearinghouse, with client and service information system data entered separately; or (2) submission of service data inclusive of client and service information system data, which is more technically complex but satisfies all reporting needs in one step.</p> <p>Given the variability in IT capacity among CBOs, feasibility and system readiness are key considerations. The project is currently in the discovery phase with county IT and has been flagged as a high priority. Additional options, such as the use of Epic’s Tapestry module, are also being explored to ensure long-term sustainability and efficiency.</p>
<p>3. Clearly define a career ladder for peer employment, and provide peer support staff with information about county resources/supports to provide advancement opportunities (e.g., tuition reimbursement).</p>	<p>In a collaborative effort between BH Administration, the Office for Peer and Family Empowerment (OPFE), and Health Services personnel, the MHP has advanced work to revise existing peer classifications (community support worker I and II) and create a new classification specific to a Certified Medi-Cal PSS. This new classification aligns with State certification requirements, emphasizes recovery and wellness, and follows the Medi-Cal Code of Ethics. It represents a long-requested step toward a more clearly defined and supported peer career ladder.</p> <p>To ensure transparency and peer input, OPFE created an infographic comparing the “Current Peer Career Pathway” and the “Future Peer Career Pathway.” This was presented and discussed at multiple monthly clinical social worker meetings, offering staff the opportunity to ask questions and provide feedback. Peers</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Contra Costa</b></p>	<p><b>Actions Taken by Contra Costa to Address the External Quality Review Recommendations</b></p>
	<p>were also referred to the Teamsters 856 Memorandum of Understanding (MOU) for training reimbursement and informed about the county’s loan repayment program, both of which support career development and advancement.</p> <p>Additionally, the MHP is exploring the inclusion of the enhanced community health worker (CHW) classification as part of the peer career ladder under the Behavioral Health Transformation (BHT) initiative. While this role currently exists in the SUD system, it would be new to MH. This position offers a starting salary approximately \$10,000 higher than current clinical social worker classifications, presenting a potential opportunity to recognize peer contributions with more competitive compensation and support upward mobility.</p>
<p>4. Assess and ensure that MHP supervisors and managers receive sufficient communication and responses to questions.</p>	<p>The Communications Workgroup has prioritized strengthening communication and engagement with supervisors and managers as a core strategy. A near-term goal is to better socialize BHT/Behavioral Health Services Act (BHSA)-related information through a top-down approach, beginning with direct engagement at the leadership level.</p> <p>As part of this effort, the communication strategy was presented to senior leadership, and a high-level overview will be delivered at the next manager/supervisor meeting. This presentation will include approximately 30 minutes of content followed by a 45-minute Q&amp;A and dialogue session to address questions and gather feedback.</p> <p>In addition to this structured engagement, the MHP has implemented several ongoing</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Contra Costa	Actions Taken by Contra Costa to Address the External Quality Review Recommendations
	<p>strategies to support effective communication and responsiveness:</p> <ul style="list-style-type: none"> <li>◆ Hold monthly manager/supervisor meetings that serve as a forum for updates, questions, and two-way dialogue.</li> <li>◆ Leadership staff, including chiefs, attend weekly leadership/executive meetings where they share updates with and raise questions from supervisors and managers.</li> <li>◆ Hold town hall meetings to provide opportunities for staff to express concerns, ask questions, and hear directly from leadership. To further support workforce engagement and retention, the MHP also hosted a staff listening session.</li> </ul> <p>These efforts are designed to create a consistent and transparent communication channel, ensuring that supervisors and managers are informed, empowered, and supported in cascading key information to their teams.</p>

## Assessment of Contra Costa’s Self-Reported Actions

HSAG reviewed Table B.7, in which Contra Costa summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Contra Costa adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Contra Costa related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Contra Costa addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Contra Costa

Based on the overall assessment of Contra Costa’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Contra Costa’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Contra Costa’s 2025 clinical and nonclinical PIP submissions. Contra Costa met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Contra Costa was transparent about the challenges with following the DHCS process and obtaining the Plan Data Feed files and demonstrated willingness to learn the Plan Data Feed process to enhance its understanding of integrating these data for performance measure calculation and reporting. Additionally, Contra Costa was proactive in securing an NCQA-certified measure vendor for measurement year 2024 and understanding the importance of meeting DHCS’ audit requirements for future years’ reporting.
- ◆ DHCS’ 2025 compliance review scores for Contra Costa show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process HSAG observed that Contra Costa launched several initiatives to improve timely access to psychiatric services, which included expanding staff, identifying members who could transition to a lower LOC, and incorporating telehealth providers.

### Opportunities for Improvement

- ◆ Contra Costa has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Contra Costa:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Grievance and Appeal Systems—§438.228
  - Health Information Systems—§438.242

- Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that Contra Costa did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS’ 2025 compliance review scoring process related to the following CFR standards to ensure Contra Costa meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Grievance and Appeal Systems—§438.228
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Contra Costs did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Contra Costa’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Contra Costa as well as the plan’s progress with addressing these recommendations.

# Del Norte County Department of Health and Human Services

## Follow-Up on Prior Year Recommendations

Table B.8 provides the EQR recommendations directed to Del Norte from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.8 to preserve the accuracy of Del Norte’s self-reported actions.

**Table B.8—Del Norte’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Del Norte	Actions Taken by Del Norte to Address the External Quality Review Recommendations
<p>1. Improve tracking of timeliness to initial non-urgent and urgent appointments.</p>	<p>Del Norte collaborated with its EHR vendor, Kings View, to develop and implement the TADT within the EHR. This tool, launched on July 1, 2023, is used by staff to record and track all timeliness data, including initial non-urgent and urgent appointments.</p>
<p>2. Develop a set of current State measures and associated time-bound targets for every QAPI plan and Cultural Competence Plan goal that will be measured and evaluated at every quarterly meeting and posted in the meeting minutes.</p>	<p>Del Norte updated its Quality Improvement Work Plan (QIWP) and Quality Improvement Work Plan Evaluation (QIWPE) in its 2024 submission to align with current state-required measures, incorporating clearly defined, time-bound targets. This practice will continue in all subsequent QIWP and QIWPE submissions. Examples of measures, goals, and time-bound targets included in Del Norte’s 2024 QIWP/QIWPE are as follows:</p> <ul style="list-style-type: none"> <li>◆ Increase compliance from 20 percent reported in FY 2022–23 to at least 60 percent. <ul style="list-style-type: none"> <li>■ Although Del Norte gained additional providers, compliance with medication support and first offered psychiatry appointments decreased to 17 percent.</li> </ul> </li> </ul>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Del Norte</b></p>	<p><b>Actions Taken by Del Norte to Address the External Quality Review Recommendations</b></p>
	<p>The MHP continues to try and contract with and retain additional providers.</p> <ul style="list-style-type: none"> <li>◆ Develop a method to track the timeliness of first offered SUD appointments to ensure at least 75 percent compliance with the DHCS regulations.                             <ul style="list-style-type: none"> <li>■ Worked with Kings View to develop the TADT used to track SUD timeliness within the EHR, Credible.</li> <li>■ Implemented the developed method to track the timeliness of first offered SUD appointments within 10 business days and created a guide to train medical records clerks on how to enter SUD timeliness data into the TADT.</li> <li>■ Evaluated the timeliness data to determine the first offered SUD appointment baseline to compare to DHCS regulations. The MHP successfully implemented the SUD TADT and reported 96 percent compliance in first offered SUD appointments within 10 business days between July 1, 2024, and February 28, 2025.</li> </ul> </li> <li>◆ Develop and implement clinical and nonclinical PIPs.                             <ul style="list-style-type: none"> <li>■ In accordance with DHCS guidance, counties were to refrain from creating PIPs while DHCS transitioned to a new EQRO. PIP topics were submitted and approved by this new organization (HSAG) in 2025.</li> </ul> </li> </ul>
<p>3. Seek technical guidance regarding the implementation of LOC tools and clinical practice desk guides as an interim strategy.</p>	<p>Del Norte utilizes the CANS assessment and the Milestones of Recovery Scale (MORS) as its primary LOC tools. The CANS assessment is administered as required, and the MORS is completed at each therapy session for clients engaged in ongoing therapy services. Relevant</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Del Norte</b></p>	<p><b>Actions Taken by Del Norte to Address the External Quality Review Recommendations</b></p>
	<p>staff receive a comprehensive documentation guide outlining documentation standards, clinical workflows, and guidance on LOC tool usage. Staff also participate in initial and ongoing training to ensure consistent application of these tools. In addition, the MHP uses dashboards to monitor and report CANS and MORS outcomes.</p>
<p>4. Examine the local implementation of Pathways to Well-Being to assure that both foster care and non-foster care youth who qualify are offered services. While the MHP indicated that many families decline intensive home-based services (IHBS), the low utilization of intensive care coordination (ICC) suggests that the MHP is facilitating few child/family team meetings in which families could be engaged. This is particularly important due to the high delivery of medication services to youth.</p>	<p>Del Norte will take steps to ensure that both foster care and non-foster care youth who qualify for Pathways to Well-Being services are offered appropriate LOCs, ICC, and IHBS. To address concerns regarding low ICC utilization and potential missed opportunities for family engagement, the MHP will:</p> <ul style="list-style-type: none"> <li>◆ <b>Audit Current Screening Practices:</b> Conduct a review of existing screening procedures for ICC and IHBS to verify that all eligible youth are appropriately assessed.</li> <li>◆ <b>Implement Ongoing Chart Review:</b> Develop and implement a process to review 5 percent of youth service charts on a regular basis to confirm that ICC and IHBS screenings were completed and that clients were offered services at the appropriate level of intensity.</li> <li>◆ <b>Enhance Staff Training:</b> Request that the children’s services provider develop and implement mandatory annual training for all relevant staff on ICC and IHBS, including eligibility criteria, engagement strategies, and coordination with child/family team meetings.</li> </ul> <p>These measures will help ensure that service offerings are systematically monitored, families are consistently engaged, and ICC/IHBS are integrated into care planning—particularly</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Del Norte	Actions Taken by Del Norte to Address the External Quality Review Recommendations
	important given the high delivery of medication services to youth.
<p>5. Develop a clinical and nonclinical PIP for submission at the next EQR. As planned, procure a consultant to assist with PIP development and implementation.</p>	<p>According to guidance from DHCS, counties were to refrain from developing PIPs while DHCS transitioned to a new EQRO. The MHP submitted its proposed PIP topics in March 2025, which were approved by HSAG and include:</p> <ul style="list-style-type: none"> <li>◆ Nonclinical PIP: Improving timely access to non-urgent psychiatric SMHS.</li> <li>◆ Clinical PIP: Increasing the adherence rate to antipsychotic medications for individuals with schizophrenia.</li> </ul> <p>Additionally, the MHP submitted the required measurement description forms for both the clinical and nonclinical PIPs in July 2025.</p>

## Assessment of Del Norte’s Self-Reported Actions

HSAG reviewed Table B.8, in which Del Norte summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Del Norte adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Del Norte related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Del Norte addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Del Norte

Based on the overall assessment of Del Norte’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for

improvement, and recommendations for the plan. Note that all of Del Norte's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Del Norte's 2025 clinical and nonclinical PIP submissions. Del Norte met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Del Norte was transparent about the challenges with following the DHCS process and obtaining the Plan Data Feed and demonstrated a willingness to learn the Plan Data Feed process to enhance understanding of the audit process. HSAG observed that Del Norte had multiple methods of validation and tracking to ensure the accuracy and completeness of claims data. Additionally, the MHP's EHR and billing support vendor generated a monthly report to review denials as both prospective and retrospective reviews for monitoring purposes.
- ◆ DHCS' 2025 compliance review scores for Del Norte show that the MHP was fully compliant with most CFR standards. Additionally, through the DHCS Audits & Investigations (A&I) corrective action plan (CAP) process, Del Norte resolved the findings that DHCS identified within the following CFR standards during the DHCS 2025 compliance review scoring process:
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that Del Norte maintained numerous validation checks to ensure accuracy and completeness of data in Credible, including a process for supervisor approval of notes, peer chart reviews, and monthly reports to identify incomplete or inaccurate data.

## Opportunities for Improvement

- ◆ Del Norte has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ Del Norte has remaining findings to resolve that DHCS identified within the following CFR standards during the DHCS 2025 compliance review scoring process:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
- ◆ During the NAV audit process, HSAG observed that Del Norte did not meet one or more DHCS standards for timely access indicators due to exceeding DHCS' 5 percent data error threshold.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ To ensure Del Norte meets all CFR standard requirements moving forward, work with DHCS through the Network Adequacy Evaluation (NAE) CAP process to fully resolve the findings that DHCS identified within the following CFR standards during the DHCS 2025 compliance review scoring process:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Del Norte did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Del Norte’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Del Norte as well as the plan’s progress with addressing these recommendations.

# El Dorado County Health & Human Services Agency

## Follow-Up on Prior Year Recommendations

Table B.9 provides the EQR recommendations directed to El Dorado from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.9 to preserve the accuracy of El Dorado’s self-reported actions.

**Table B.9—El Dorado’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to El Dorado	Actions Taken by El Dorado to Address the External Quality Review Recommendations
<p>1. Work with County HR to identify job-specific qualifications to fill needed BH expertise in positions including QI data analyst, certified peer, and bilingual clinical staff positions.</p>	<ul style="list-style-type: none"> <li>◆ Collaborated with County HR to add four full-time administrative analyst positions, one program manager, and one supervising administrative analyst.</li> <li>◆ Prioritized bilingual candidates in recruitment and offered a bilingual pay differential.</li> <li>◆ Contracted with CalMHSA to provide PSS certification for qualified staff, stakeholders, and beneficiaries.</li> <li>◆ Authorized staff to pursue PSS certification during business hours.</li> </ul>
<p>2. Expand the team of data analysts and invest in data analytic software with a specific focus on generating clinical program reports and aggregating data.</p>	<ul style="list-style-type: none"> <li>◆ Added six positions with data analytics and reporting functions.</li> <li>◆ Implemented a Key Performance Indicator dashboard in the EHR.</li> <li>◆ Developing a Microsoft Teams/Power BI-based tool for automated clinical reporting and data aggregation.</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to El Dorado</b>	<b>Actions Taken by El Dorado to Address the External Quality Review Recommendations</b>
<p>3. Identify how to pull HEDIS<sup>3</sup> measure data, identify a reporting plan, and aggregate data for QI activities.</p>	<ul style="list-style-type: none"> <li>◆ Contracted with CalMHSA to extract and aggregate HEDIS-aligned measures.</li> <li>◆ Shared HEDIS data with the QIC and BH Commission to engage stakeholders in improving quality of services.</li> <li>◆ Developing a PIP focused on underperforming HEDIS measures, including adherence to antipsychotic medications.</li> </ul>
<p>4. Create outreach and access opportunities that specifically address the needs of the monolingual Spanish-speaking community.</p>	<ul style="list-style-type: none"> <li>◆ Continued support efforts to the Latino Outreach Program using Mental Health Services Act (MHSA) funds.</li> <li>◆ Implemented financial incentives for children’s SMHS providers for Spanish language service delivery.</li> <li>◆ Utilized bilingual BH staff to support outreach events in the community focused on the Spanish-speaking population such as the MHSA community planning process, events with our local department of education, and mobile crisis services outreach.</li> </ul>
<p>5. Identify and expand paid and volunteer peer employment positions throughout the SOC, including wellness centers and clinics.</p>	<ul style="list-style-type: none"> <li>◆ Identified and supported clients and staff for PSS certification.</li> <li>◆ Promoted CalMHSA and DHCS peer certification programs and allowed participation during business hours.</li> <li>◆ Selected PSS certification expansion as the 2025–27 nonclinical PIP.</li> <li>◆ Submitted and received DHCS approval to provide PSS services.</li> <li>◆ Updated EHR and billing systems to create structure for PSS services to be captured and billed in accordance with Medi-Cal standards.</li> </ul>

<sup>3</sup> HEDIS® is a registered trademark of NCQA.

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to El Dorado	Actions Taken by El Dorado to Address the External Quality Review Recommendations
	<ul style="list-style-type: none"> <li>◆ Continued MHSA-funded Family Partners embedded in Child Welfare Services (CWS).</li> <li>◆ Planning fiscal incentives for children’s SMHS providers based on peer service delivery.</li> </ul>

## Assessment of El Dorado’s Self-Reported Actions

HSAG reviewed Table B.9, in which El Dorado summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that El Dorado adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to El Dorado related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which El Dorado addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for El Dorado

Based on the overall assessment of El Dorado’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of El Dorado’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned a *High Confidence* level to El Dorado’s 2025 clinical PIP submission. El Dorado met all critical and evaluation element scores for this PIP submission, reflecting that the MHP built a robust foundation in the Design stage of its clinical PIP.
- ◆ During the PMV audit process, El Dorado provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and

commitment to the audit process and expected outcomes. Additionally, El Dorado demonstrated commitment to addressing members' behavioral health care needs through efforts to improve and expand delivery of services.

- ◆ Based on HSAG's NAV audit findings, HSAG determined that El Dorado established strong processes to manage and validate Medi-Cal eligibility data monthly from the MMEF. The QI Team effectively identified and addressed missing or incomplete data through consistent use of fallout and error reports, along with manual validation procedures. These practices contributed to the accuracy and completeness of member eligibility data.

## Opportunities for Improvement

- ◆ HSAG's 2025 PIP validation determined that El Dorado did not include all required details of its PIP processes for its nonclinical PIP.
- ◆ El Dorado has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.

## 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure El Dorado includes all required information in the MHP's 2026 annual nonclinical PIP submission.
- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.

El Dorado's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of El Dorado as well as the plan's progress with addressing these recommendations.

## Fresno County Department of Behavioral Health

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of Fresno for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.10 provides the EQR recommendations directed to Fresno from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.10 to preserve the accuracy of Fresno’s self-reported actions.

**Table B.10—Fresno’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Fresno	Actions Taken by Fresno to Address the External Quality Review Recommendations
1. Examine causes for the decrease in Hispanic/Latino members served, and develop and implement strategies to improve access for these members.	Fresno continues to identify disparities in its person-served population. Fresno utilizes this information in marketing and communication decisions, as well as in program development decisions.
2. Resume active recruitment to fill vacant peer employee positions, and increase the number of peer employees at Fresno MHP.	As of July 2025, Fresno has 112 CPSSs throughout the system. To improve the county’s peer workforce, Fresno has been working with the county’s HR. Through 2024, Fresno and county HR developed a first draft of the PSS job specifications. Fresno requested job titles for BH PSS, Certified BH PSS I, and BH PSS II. Fresno hopes to have Board of Supervisors approval and to have job specifications prepared for recruitment by November 2025.
3. Continue to meet with the MCP providers and develop an interim solution to serve members who are awaiting mild-to-moderate LOC programs.	Fresno has multiple recurring meetings with MCPs to improve coordination of care among systems. Fresno’s Planning and QM Team is beginning a PIP to discharge inactive persons served in the system, identify mild-to-moderate

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Fresno	Actions Taken by Fresno to Address the External Quality Review Recommendations
	individuals within the system, develop a transition plan to get individuals to the MCPs, and ensure care coordination through closed-loop referrals.
4. Implement and document nonclinical PIP activities.	<p>Fresno has continued to complete PIPs. Fresno has worked as a part of the Institute for Healthcare Improvement Medi-Cal Collaborative to implement PIPs for the <i>Follow-Up After Emergency Department Visit for Mental Illness</i> and <i>Follow-Up After Emergency Department Visit for Substance Use</i> HEDIS measures.</p> <p>Fresno is also developing a PIP to address timeliness to psychiatric appointment requests.</p>
5. Research, select, and implement an adult SOC outcome tool for regular use.	Fresno is awaiting guidance from DHCS regarding the available adult clinical tools that will be authorized for counties to use to satisfy DHCS regulations.

## Assessment of Fresno’s Self-Reported Actions

HSAG reviewed Table B.10, in which Fresno summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Fresno adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Fresno related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Fresno addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Fresno

Based on the overall assessment of Fresno’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Fresno’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned a *High Confidence* level to Fresno’s 2025 nonclinical PIP submission. Fresno met all critical and evaluation element scores for this PIP submission, reflecting that the Integrated BHP built a robust foundation in the Design stage of its nonclinical PIP.
- ◆ During the PMV audit process, Fresno provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, Fresno demonstrated commitment to addressing members’ behavioral health care needs through efforts to improve and expand delivery of services.
- ◆ DHCS’ 2025 compliance review scores for Fresno show that the MHP was fully compliant with most CFR standards.
- ◆ Based on HSAG’s NAV audit findings, HSAG determined that Fresno maintained strong data oversight through SmartCare, internal QA checks, and staff training to ensure that accurate and timely TADT submissions aligned with DHCS’ standards.

### Opportunities for Improvement

- ◆ HSAG’s 2025 PIP validation determined that Fresno did not include all required details of its PIP processes for its clinical PIP.
- ◆ Fresno has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Fresno:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Grievance and Appeal Systems—§438.228
- ◆ During the NAV audit process, HSAG observed that Fresno did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Fresno includes all required information in the Integrated BHP's 2026 annual clinical PIP submission.
- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Fresno meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Grievance and Appeal Systems—§438.228
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Fresno did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Fresno's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Fresno as well as the plan's progress with addressing these recommendations.

# Glenn County Behavioral Health

## Follow-Up on Prior Year Recommendations

Table B.11 provides the EQR recommendations directed to Glenn from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.11 to preserve the accuracy of Glenn’s self-reported actions.

**Table B.11—Glenn’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Glenn	Actions Taken by Glenn to Address the External Quality Review Recommendations
<p>1. Implement a system to monitor medication services for foster care members, consistent with applicable HEDIS measures.</p>	<p>Glenn has contracted with CalMHSA to calculate our required HEDIS measures. This includes the <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i> measure. Glenn’s data show we are above the minimum performance level (MPL). We further cross-section these data with Medi-Cal eligibility to identify foster youth on a quarterly basis to ensure first line psychosocial care is provided.</p>
<p>2. Review inpatient follow-up and readmission rates. Identify factors that have been creating the large variance in rates for both metrics over the past three contract years.</p>	<p>Glenn has consistently reviewed our inpatient and follow-up data, which have overall been above the MPL when we calculate our follow-up rates. Due to code set variability in the HEDIS measures, Glenn appears below the MPL for measurement year 2024 for the <i>Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days</i> measure. Glenn’s analysis of the low follow-up rate is due to the taxonomy and service exclusions of case manager-level providers and targeted case management (TCM) services. CalMHSA and Glenn agree the variability referenced in the previous EQRO’s recommendations is due to the low denominators in Glenn and these</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Glenn</b>	<b>Actions Taken by Glenn to Address the External Quality Review Recommendations</b>
	<p>low denominators being the cause of the data instability.</p> <p>Glenn monitors readmission rates on a quarterly basis at seven- and 30-day intervals. The variance in readmissions is likely due to low denominators, as the readmission counts are so low they are suppressed from larger data analysis.</p>
<p>3. Monitor results for tools that the MHP indicated were for LOC to ensure appropriate, consistent use for determination of LOC. Make any needed improvements in the process and services provided.</p>	<p>Glenn continues to use the Adult Needs and Strengths Assessment (ANSA) and CANS assessment combined with a comprehensive biopsychosocial assessment as our primary LOC determination tools. Our service verifications, client satisfaction surveys, and lack of grievances related to service provision indicate clients feel they receive the appropriate LOC from our services. As the system continues to evolve, we will consider additional LOC tools as needed.</p>
<p>4. Analyze the trend of increasing high-cost members, and consider interventions to help reduce the potential long-term fiscal impact on the system if the trend continues.</p>	<p>This recommendation has been a primary goal for Glenn and Glenn Health and Human Services Agency (HHSA) systems for multiple years. Glenn has identified a disparate number of members on Lanterman-Petris-Short Conservatorship in Glenn County compared to other County BHPs. Due to the multidisciplinary nature of this population involving Public Guardian, court systems, and psychiatric professionals, the goal to reduce the potential long-term fiscal impacts on the system of high-cost members is a complex task which must be weighed with many legal, ethical, and best practice considerations to ensure members receive the appropriate LOC. Glenn has monthly meetings with Public Guardian, Glenn HHSA executives, and the county fiscal team to ensure all possible interventions are implemented to reduce cost</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Glenn	Actions Taken by Glenn to Address the External Quality Review Recommendations
	while providing the appropriate LOC to members.
5. Review the current vehicle fleet and analyze the feasibility of purchasing new vehicles, which would help staff conduct field-based services and aid members with getting reliable rides to appointments.	Glenn has 15 vehicles and one treatment recreational vehicle in our BH fleet. We have two full-time drivers and one part-time driver who provide daily transportation to services, and crisis transportation to and from inpatient hospitals. Each BH location across the county has multiple vehicles that can be signed out by treatment staff for client services. Glenn prioritizes county vehicle use for client services. Our transportation and front office supervisor organizes vehicle availability to prioritize high-need services such as crisis and medication transportation. The drop-in centers utilize vans for group transportation. Since the previous EQRO’s recommendation was received, we added a vehicle for mobile crisis after hours which is leased to our contractor. It is not feasible at this time to add any additional vehicles to the BH fleet.

## Assessment of Glenn’s Self-Reported Actions

HSAG reviewed Table B.11, in which Glenn summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Glenn adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Glenn related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Glenn addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Glenn

Based on the overall assessment of Glenn’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Glenn’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Glenn’s 2025 clinical and nonclinical PIP submissions. Glenn met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Glenn provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, Glenn communicated plans for an expansion of services with the development of the new wellness center, which demonstrates that the MHP is proactive in its analysis of understanding the need to offer the applicable population services as needed to better serve the community.
- ◆ During the NAV audit process, HSAG observed that Glenn maintained ongoing oversight of county network adequacy for SMHS using internal performance reporting and performance review committees.

### Opportunities for Improvement

- ◆ Glenn has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Glenn did not meet one or more DHCS standards for timely access indicators due to exceeding DHCS’ 5 percent data error threshold.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:

- Conduct an in-depth review of the indicators for which Glenn did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
- Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Glenn's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Glenn as well as the plan's progress with addressing these recommendations.

# Humboldt County Health and Human Services

## Follow-Up on Prior Year Recommendations

Table B.12 provides the EQR recommendations directed to Humboldt from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.12 to preserve the accuracy of Humboldt’s self-reported actions.

**Table B.12—Humboldt’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Humboldt	Actions Taken by Humboldt to Address the External Quality Review Recommendations
<p>1. Develop a skills gap analysis and training plan that leverages the availability of continued SmartCare EHR training.</p>	<p>A survey was developed and sent to staff, and there were approximately 95 responses received; however, the responses were not fully analyzed before staff involved in the analysis either separated from Humboldt or went out on leave. At least one topic was identified, and instructions regarding the topic were distributed to all staff.</p> <p>As an addition, trainings were offered online through CalMHSA. CalMHSA has also added additional resources toward training since the review.</p> <p>The MHP contracted with CalMHSA to gain more understanding of certain modules such as the Enhanced Analytics Reporting module for analysts to gain further understanding of reporting and data.</p>
<p>2. Collaborate with partner agencies to develop and implement strategies to better identify foster care youth and improve access to MH services for these members.</p>	<p>Humboldt County Children’s Behavioral Health (CBH) has weekly meetings with Humboldt County CWS partners to coordinate care through our Interagency Placement Committee. We also have engaged in several</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Humboldt	Actions Taken by Humboldt to Address the External Quality Review Recommendations
	<p>other meetings with these partners to discuss challenges connecting foster care youth to services via the referral process from CWS. We continue to update our desk guide/training for our access staff who follow up on these referrals from CWS. Finally, we examine the data for this referral process to better understand our access process for these particular referrals.</p>
<p>3. Adopt standardized children and adult LOC tools, develop a desk guide, and provide clinician training to determine the intensity of services needed for all members.</p>	<p>We continue to use the required Youth Screening Tool in our access process to determine intensity of services and make appropriate referrals. Our access staff receive weekly supervision and regular consultation on assigning a LOC to members.</p>
<p>4. Develop a CANS assessment (and eventually LOCUS data reports) with greater granularity to bring value to clinical supervision and programmatic oversight.</p>	<p>We have had regular meetings to discuss the data challenges with the CANS assessment. Since onboarding the SmartCare system, we have not been able to produce a CANS dashboard that aggregates the data in a way that allows sufficient granularity for clinical supervision and programmatic oversight.</p>
<p>5. Develop tracking and reporting mechanisms for the required foster care HEDIS measures.</p>	<p>In 2025, the MHP contracted with CalMHSA in the QA/QI and Performance Improvement Analytic Agreement to support analysis of systems data to produce the most recent HEDIS measures.</p> <p>The following are the DHCS-required foster care HEDIS measures:</p> <ul style="list-style-type: none"> <li>◆ <i>Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days and Follow-Up Within 30 Days</i></li> <li>◆ <i>Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase</i></li> <li>◆ <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i></li> </ul>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Humboldt	Actions Taken by Humboldt to Address the External Quality Review Recommendations
	<ul style="list-style-type: none"> <li>◆ <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i></li> <li>◆ <i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents</i></li> </ul> <p>Our measurement year 2023 reports produced by CalMHSA have these measures; however, they are not yet broken down by the foster care population.</p> <p>A current workplan goal of the QI workplan is to work with program staff to reestablish the CBH data dashboards so that the required HEDIS and CANS measures can be monitored and reported.</p>

## Assessment of Humboldt’s Self-Reported Actions

HSAG reviewed Table B.12, in which Humboldt summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Humboldt adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Humboldt related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Humboldt addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Humboldt

Based on the overall assessment of Humboldt’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Humboldt’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When

applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Humboldt's 2025 clinical and nonclinical PIP submissions. Humboldt met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Humboldt demonstrated a very prepared and thorough overview of all systems and processes, which contributed to a well-organized and efficient process during the virtual review. HSAG observed that Humboldt implemented multiple methods of validation and tracking to ensure the accuracy and completeness of claims data both pre- and post-claims submission to DHCS. Additionally, Humboldt indicated that the MHP conducted quarterly audits to identify and address performance gaps.
- ◆ During the NAV audit process, Humboldt demonstrated a proactive approach to accountability and timely access tracking by involving QI staff and supervisors in referral and documentation improvements, highlighting the county's focus on aligning system usage with evolving DHCS standards.

## Opportunities for Improvement

- ◆ Humboldt has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Humboldt did not meet one or more DHCS standards for timely access indicators due to exceeding DHCS' 5 percent data error threshold.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Humboldt did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Humboldt's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Humboldt as well as the plan's progress with addressing these recommendations.

# Imperial County Behavioral Health Services

## Follow-Up on Prior Year Recommendations

Table B.13 provides the EQR recommendations directed to Imperial from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.13 to preserve the accuracy of Imperial’s self-reported actions.

**Table B.13—Imperial’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Imperial	Actions Taken by Imperial to Address the External Quality Review Recommendations
<p>1. Collaborate with CalMHSA to prioritize the development of LOC and outcome measures in the EHR so the MHP can aggregate, analyze, and report data.</p>	<p>Imperial recognizes the importance of incorporating LOC and outcome measures into the EHR to support effective service delivery, data analysis, and reporting.</p> <p>Imperial actively participates in CalMHSA’s regular county shared decision-making meetings focused on the development of the EHR and expansion of functionality. These meetings serve as a valuable forum for discussing shared priorities and contributing to the design and improvement of system features.</p> <p>At this time, a primary focus of CalMHSA has been on stabilizing and enhancing the functionality of existing DHCS-required outcome measurement tools. Imperial supports this prioritization, as significant functionality issues must be addressed before reliable data collection, aggregation, and reporting can occur.</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Imperial</b></p>	<p><b>Actions Taken by Imperial to Address the External Quality Review Recommendations</b></p>
	<p>Imperial remains committed to ongoing collaboration with CalMHSA and other county partners to advocate for and support EHR enhancements that will enable integration of both outcome measures and future LOC tools. These improvements are essential for advancing clinical insight, QI efforts, and compliance with State reporting requirements.</p>
<p>2. Implement a personal health record (PHR) to restore members’ ability to access personal health information and make and change appointments.</p>	<p>CalMHSA recently provided additional resources to assist counties in developing and implementing the current PHR functionality available within SmartCare. Imperial is actively reviewing these materials and assessing the feasibility of implementation, including technical requirements, staffing, and training needs.</p> <p>However, Imperial has identified significant usability concerns with the current PHR interface. The system is not user-friendly and presents a complex user experience that may limit accessibility and effectiveness for members. In response, Imperial is also monitoring discussions around the potential release of a more patient-friendly, web-based PHR solution in the future. This alternative may provide a more intuitive platform for beneficiaries and better support the intended goals of transparency and ease of access.</p> <p>As part of its planning process, Imperial is weighing the benefits and limitations of the current PHR against anticipated improvements and will develop an implementation strategy accordingly. Imperial remains committed to restoring and enhancing member access through a PHR that is functional, accessible, and aligned with system capabilities and user needs.</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Imperial</b>	<b>Actions Taken by Imperial to Address the External Quality Review Recommendations</b>
<p>3. Enhance the public-facing website to include important information regarding MHP services, including easy-to-locate crisis and after-hours phone numbers.</p>	<p>Imperial is actively working with the vendor who maintains the Imperial website. Imperial has requested several updates to ensure the website provides clear and accessible information regarding MHP services. This includes the addition and prominent placement of critical resources such as crisis and after-hours phone numbers. These updates are being made to improve public access to essential services and to align with best practices in service transparency and availability.</p>
<p>4. Identify and expand paid or volunteer member employment opportunities throughout the SOC including wellness centers, clinics, and committees.</p>	<p>Imperial is dedicated to expanding both paid and volunteer opportunities for individuals with lived experience across our SOC. In support of recovery-oriented practices, the department has implemented various initiatives to identify, develop, and incorporate meaningful roles for members, including at wellness centers, outpatient clinics, and program-level committees.</p> <p>Current and planned initiatives include:</p> <p><b>Wellness Centers</b></p> <ul style="list-style-type: none"> <li>◆ Peer members actively serve as volunteers and stipend-supported facilitators, leading groups such as Wellness Recovery Action Plan, creative expression, and health education.</li> <li>◆ There are ongoing efforts to formalize peer support positions by providing training through the PSS Certification Program and linking participants to paid part-time roles.</li> </ul> <p><b>Clinic-Based Integration</b></p> <ul style="list-style-type: none"> <li>◆ Pilot programs are being developed to incorporate CPSSs into clinic settings to</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Imperial</b>	<b>Actions Taken by Imperial to Address the External Quality Review Recommendations</b>
	<p>offer recovery coaching, engagement support, and linkage services.</p> <ul style="list-style-type: none"> <li>◆ Volunteer opportunities are being considered for members to participate in recovery-focused group activities, including co-facilitation and orientation support for new clients.</li> </ul> <p><b>Committees and Workgroups</b></p> <ul style="list-style-type: none"> <li>◆ Members are engaged in advisory boards, program development committees, and stakeholder planning meetings such as MHSA stakeholder sessions, the QI Council, and client satisfaction workgroups.</li> <li>◆ The department is exploring options for stipends or per diem reimbursement to promote equitable and sustained participation in these formal meetings.</li> </ul> <p><b>Collaborations and Capacity Building</b></p> <ul style="list-style-type: none"> <li>◆ Imperial is partnering with community organizations and peer-run agencies to create employment pathways for members, including internships and community-based placements.</li> <li>◆ Staff have received training to mentor and support peer employees and volunteers, ensuring clear role definitions, proper supervision, and integration within interdisciplinary teams.</li> </ul> <p>These efforts aim to empower individuals with lived experience to meaningfully contribute to service delivery while fostering recovery, community integration, and workforce development within our SOC.</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Imperial</b>	<b>Actions Taken by Imperial to Address the External Quality Review Recommendations</b>
	<p>Imperial recognizes the value of lived experience and its integration into the workforce. DHCS has approved Imperial to participate in the Medi-Cal PSS Certification Program. In alignment with this, Imperial has developed the BH PSS series, with the classification approved by the Board of Supervisors on June 24, 2025. Recruitment for these positions is scheduled to commence in FY 2025–26. Currently, 13 employees have completed the Medi-Cal PSS Certification Training and are eligible to apply for the BH PSS positions.</p>
<p>5. Identify and implement acceptable standard percentage rates for timeliness data for the entire SOC, accurately report timeliness data with these rates, and identify needed improvements.</p>	<p>The MHP follows the timeliness rates as established by DHCS. For Quarter 3 FY 2024–25, the MHP met DHCS timeliness standards as follows:</p> <ul style="list-style-type: none"> <li>◆ First offered non-urgent appointment—98.4 percent availability within 10 business days of request.</li> <li>◆ First offered follow-up—86.0 percent availability within 10 business days of the first service.</li> <li>◆ First offered urgent appointment—99.3 percent availability within 48 hours of request.</li> <li>◆ First offered psychiatry appointment—100 percent availability within 15 business days of request.</li> </ul> <p>Timeliness data for the MHP are reported to the QIC on a quarterly basis. Imperial uses the DHCS standard of 80 percent as the benchmark for corrective action.</p>

## Assessment of Imperial's Self-Reported Actions

HSAG reviewed Table B.13, in which Imperial summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Imperial adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Imperial related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Imperial addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Imperial

Based on the overall assessment of Imperial's delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Imperial's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Imperial's 2025 clinical and nonclinical PIP submissions. Imperial met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, HSAG observed that Imperial worked through challenges and barriers resulting from the EHR migration to SmartCare. As a pilot county for the SmartCare migrations, Imperial assisted with future SmartCare migrations for other counties. Additionally, Imperial has identified opportunities to improve the LOC provided to its members and is planning to implement inclusion of future potential partnerships with local managed care plans.
- ◆ Based on HSAG's NAV audit findings, HSAG determined that Imperial maintained ongoing oversight of data used to inform network adequacy reporting by reviewing completeness of timeliness forms monthly and working with providers to complete pending forms.

### Opportunities for Improvement

- ◆ Imperial has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.

Imperial’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Imperial as well as the plan’s progress with addressing these recommendations.

# Inyo County Health & Human Services Behavioral Health

## Follow-Up on Prior Year Recommendations

Table B.14 provides the EQR recommendations directed to Inyo from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.14 to preserve the accuracy of Inyo’s self-reported actions.

**Table B.14—Inyo’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Inyo	Actions Taken by Inyo to Address the External Quality Review Recommendations
<p>1. Locate or develop medication monitoring files and/or policies. Ensure timely and accurate implementation, and consider a centralized filing system for important processes or policies.</p>	<p>Medication monitoring files and policies have been located, reviewed, and utilized during the 2024 audit. The audit resulted in no findings related to the system in place, confirming that the current approach meets regulatory expectations. This recommendation has been fully implemented, and the system continues to be maintained to ensure compliance and timely monitoring.</p>
<p>2. Create outreach and access opportunities by partnering with the Spanish-speaking community and developing strategies to increase the number of Hispanic/Latino members served.</p>	<p>Efforts to strengthen outreach and service access for the Spanish-speaking and Hispanic/Latino community remain ongoing. While political and policy shifts have presented challenges, we have built partnerships with community organizations through the BHSA Community Program planning process, including hosting targeted outreach meetings. Each year, the county hosts the Mexican Consulate, where we provide program information and answer questions when people come for their appointments. Other community events also make program materials available to those in attendance. All</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Inyo	Actions Taken by Inyo to Address the External Quality Review Recommendations
	materials are available in Spanish, and outreach events are staffed by Spanish-speaking employees whenever possible. When Spanish-speaking staff are unavailable, we utilize translation technology to ensure no language barrier prevents engagement.
3. Develop and implement two required PIPs. Obtain technical assistance from the EQRO, and consider engaging a consultant for support with conducting PIPs and other relevant QI activities.	As a small county, developing and sustaining new PIPs is challenging; however, we have aligned with CalAIM-required PIPs to maximize resources and meet regulatory obligations. While no new PIPs have been initiated this year, the two existing PIPs— <i>Follow-Up After Emergency Department Visit for Mental Illness</i> and <i>Peer Support Services</i> —remain active and in progress. Both projects continue to receive monitoring and support to ensure implementation fidelity and progress toward targeted outcomes.
4. Develop timeliness tracking through the new EHR to monitor timeliness to key points in care. Monitor these data routinely, review performance over time, and initiate improvement activities where warranted.	Dashboards within the EHR have been developed to track service timeliness and are reviewed on a quarterly basis. We are in the process of transitioning from the original data capture form to a new form that allows for more comprehensive tracking of state-required timelines within our EHR. This change will provide the QA Team with improved access to data points and facilitate more precise monitoring. While substantial progress has been made, additional work is required to ensure that all required elements are consistently captured and reported.
5. Develop a comprehensive set of QAPI goals which incorporate current state-required measures and time-bound targets to evaluate performance. Leadership and other key staff and stakeholders should review results at least quarterly.	A new QAPI plan was developed and submitted, with ongoing data tracking and quarterly reporting to stakeholders. While current measures are being used to evaluate performance, the set of quality metrics is under review for refinement. The goal is to finalize updates so that by the next QAPI cycle, revised measures will be in place, fully

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Inyo	Actions Taken by Inyo to Address the External Quality Review Recommendations
	reportable, and better aligned with State requirements and program priorities
6. Seek technical guidance to support developing and implementing LOC tools including an algorithm that would utilize the MORS and CANS results as LOC placement criteria for adults and youth, respectively.	The CANS tool has been fully implemented, and our EHR is now configured to capture and track dates and assessment criteria. Work is ongoing to finalize implementation of the MORS for adults, which will complete the LOC framework. This project is being led by the BH Team, which is leveraging available technical resources and expertise to ensure a well-structured, evidence-based LOC system for both youth and adult populations.

## Assessment of Inyo’s Self-Reported Actions

HSAG reviewed Table B.14, in which Inyo summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Inyo adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Inyo related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Inyo addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Inyo

Based on the overall assessment of Inyo’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Inyo’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Inyo's 2025 clinical and nonclinical PIP submissions. Inyo met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Inyo acknowledged the transition to Credible was complex, and there were still various aspects that needed updating. Inyo appeared to understand future needs and noted that it was in process of improvements, including a completed process data flow, creation of a procedure to address eligibility, and creation of dashboards to assist with data for reporting. Inyo indicated that in collaboration with the MHP's EHR and billing support vendor, the MHP was implementing multiple methods of validation and tracking to ensure the accuracy and completeness of claims data both pre- and post-claims submission to DHCS.
- ◆ DHCS' 2025 compliance review scores for Inyo show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, Inyo's Fiscal Team demonstrated strong oversight of provider data by actively tracking credential expiration dates and coordinating timely updates in Credible. Inyo's proactive monitoring, in collaboration with administrative staff, ensured provider credentials remained current, enhancing data integrity across provider profiles.

## Opportunities for Improvement

- ◆ Inyo has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Inyo:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that Inyo did not meet one or more DHCS standards for timely access indicators due to a failure to submit timely access data to DHCS for the reporting period.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.

- ◆ Work with DHCS to resolve the identified findings from DHCS’ 2025 compliance review scoring process related to the following CFR standards to ensure Inyo meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Inyo did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Inyo’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Inyo as well as the plan’s progress with addressing these recommendations.

# Kern County Behavioral Health and Recovery Services

## Follow-Up on Prior Year Recommendations

Table B.15 provides the EQR recommendations directed to Kern from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.15 to preserve the accuracy of Kern’s self-reported actions.

**Table B.15—Kern’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Kern	Actions Taken by Kern to Address the External Quality Review Recommendations
<p>1. Continue the needs assessment and listening sessions with historically underserved communities, including the Latino/Hispanic and Asian/Pacific Islander groups, to improve access to culturally appropriate MH services.</p>	<p><b>Hispanic/Latinx Listening Sessions</b></p> <p>FY 2022–23</p> <ul style="list-style-type: none"> <li>◆ Collaborated with the Latino Coalition for a Healthy California.</li> <li>◆ Met with the Vision y Compromiso Estamos Juntos team.</li> </ul> <p>FY 2023–24</p> <ul style="list-style-type: none"> <li>◆ Dignity Health Community Health Initiative Outreach, Enrollment, Retention, and Utilization Committee meeting and identified needed MH/SUD education (October 18, 2023).</li> <li>◆ Met with Vision y Compromiso and identified needed MH/SUD education topics for Promotor(es/as) (January 11, 2024).</li> <li>◆ Platica (Chat) at Dignity Health support group (June 5, 2024)</li> </ul> <p>FY 2024–25</p> <ul style="list-style-type: none"> <li>◆ Kern Health Equity Partnership Shafter Community conversations (July 18, 2024).</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Kern</b>	<b>Actions Taken by Kern to Address the External Quality Review Recommendations</b>
	<ul style="list-style-type: none"> <li>◆ Platica (Chat) at Dignity Health support group (September 4, 2024, December 4, 2024, March 15, 2025, and June 4, 2025).</li> <li>◆ Cafecito (coffee and chat) at Mercado Latino (September 14, 2024).</li> <li>◆ Kern Health Equity Partnership Lost Hills Community conversations (October 2, 2024).</li> <li>◆ Kern Health Equity Partnership Taft Community conversations (November 2024).</li> <li>◆ Future plans:               <ul style="list-style-type: none"> <li>■ Platica (Chat) Mercado Latino.</li> <li>■ Listening session with Unidad Popular for Mixtec community needs.</li> </ul> </li> </ul> <p><b>Asian American/Pacific Islander</b></p> <p>FY 2022–23</p> <ul style="list-style-type: none"> <li>◆ Met with Jakara Movement’s Gurudwaras (CHW).</li> <li>◆ Met with Jakara Movement’s Khair program, which is made of primarily Sikh youth volunteers.</li> </ul> <p>FY 2023–24</p> <ul style="list-style-type: none"> <li>◆ Meeting with Jakara Movement’s Health and Wellness Fellow regarding MH/SUD education needs of Punjabi Indian community (February 7, 2024).</li> </ul> <p>FY 2024–25</p> <ul style="list-style-type: none"> <li>◆ A Kern medical provider is conducting a study on the barriers the Punjabi Indian community have in accessing MH/SUD services (January 2024 to present).</li> <li>◆ Future plans:</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Kern</b>	<b>Actions Taken by Kern to Address the External Quality Review Recommendations</b>
	<ul style="list-style-type: none"> <li>■ Conversations at Sikh Temples in Bakersfield.</li> <li>■ Presentation and listening session at Ridgeview High School (November 2024).</li> <li>■ Presentation and listening session at Independence High School.</li> <li>■ Presentation and listening session at Delano High School.</li> </ul>
<p>2. Continue to develop and implement strategies to better identify foster care members and improve their access to MH services.</p>	<ul style="list-style-type: none"> <li>◆ Kern has continued to collaborate and implement strategies with our child welfare partners at Kern County Department of Human Services (DHS). This includes cross-system coordination of referrals by co-locating BH staff at DHS sites and DHS staff in BH treatment teams. This also includes providing regularly occurring outreach and education to all new social workers and reviewing caseloads to assist in identifying youth who may benefit from a BH referral. The Kern foster care supervisor has attended bimonthly meetings with DHS to promote BH referrals for children 0 to 5 years of age.</li> <li>◆ Additional interventions listed below include work being done within our BH department, including contracted providers. <ul style="list-style-type: none"> <li>■ Ongoing education with BH staff to monitor screening of Pathways to Well-Being services including ICC, IHBS, and therapeutic foster care for all youth at intake and every six months thereafter.</li> <li>■ Prompting BH staff to review caseloads for foster youth who have younger siblings and providing screenings for these additional youth.</li> </ul> </li> </ul>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Kern</b></p>	<p><b>Actions Taken by Kern to Address the External Quality Review Recommendations</b></p>
	<ul style="list-style-type: none"> <li>■ Reminding BH staff that all foster youth should receive, at a minimum, monthly BH services as clinically appropriate.</li> <li>◆ Monthly monitoring of the penetration rate in our new EHR has also been a focus over the last several months. Kern IT Services has developed a new foster care penetration rate report that communicates with SmartCare and includes a new methodology. The new report will allow for real-time monitoring of numbers for foster youth accessing services provided by Kern. In the interim, our child welfare partners have been able to provide us with foster care-eligible numbers according to Safe Measures. Although in looking at their eligible number (1,764 youth) compared to the last EQRO report we received for calendar year 2022 (2,730 average number of eligibles), there is a significant difference in youth eligible to be screened.</li> <li>◆ As we continue to implement the above interventions, we are hopeful that we will continue to increase our penetration rate for foster youth in Kern County as evidenced by an increase in numbers reported to us over the last two EQRO reviews. For calendar year 2021, the foster youth penetration rate was at 32.95 percent and included 900 beneficiaries. For calendar year 2022, the foster youth penetration rate increased to 34.03 percent and included 929 beneficiaries.</li> </ul>
<p>3. Engage QI and information systems staff to develop collaboratively standardized reporting processes that will consistently support the MHP’s ability to track follow-up services that occur within seven and 30 days after psychiatric hospitalizations. Create</p>	<p>As of FY 2024–25, the QI Department will report on follow-up services that occurred within seven and 30 days after psychiatric hospitalizations utilizing ad hoc reporting within the QI Department’s EHR, SmartCare. The QI Department’s Data Team will be creating PowerBI dashboards to present this</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Kern</b>	<b>Actions Taken by Kern to Address the External Quality Review Recommendations</b>
<p>validation protocols to ensure data integrity and accuracy.</p>	<p>information to providers quarterly. Data integrity and accuracy is validated through a QI analyst peer review process monthly, quarterly, and annually.</p>
<p>4. At a minimum, develop a tracking and reporting mechanism for the required foster care HEDIS measures, and examine the feasibility of tracking the other BH HEDIS measures.</p>	<p>In May 2024, Kern entered into an agreement with CalMHSA to measure all nine BH HEDIS measures identified by DHCS. Kern will be utilizing the report provided by CalMHSA to track these HEDIS measures and to guide system improvement efforts.</p>
<p>5. Develop communication strategies for staff members and contract providers for all ongoing changes related to EHR implementation, CalAIM implementation, and payment reform. These strategies should have a built-in mechanism for feedback and frequently asked questions, as well as take into account how to make such communications timely, efficient, concise, and consistent.</p>	<p>The communication strategy for key department changes includes the following elements:</p> <ul style="list-style-type: none"> <li>◆ The department created branded email templates for staff and contractors to easily recognize the communication and alert the staff and contractors of the message and level of importance. Located at the bottom of key communication emails is contact information to provide staff and contractors the opportunity to provide feedback and ask questions. <ul style="list-style-type: none"> <li>■ Critical Alert</li> <li>■ EHR Implementation</li> <li>■ Public Information Officer Minute</li> <li>■ The Monthly Newsletter</li> </ul> </li> <li>◆ The department has implemented additional strategies for two-way communication between leadership and staff. <ul style="list-style-type: none"> <li>■ Director Connects—A weekly opportunity for staff to interact directly with the department leadership every Friday afternoon for 30 minutes. Information is shared about key events and initiatives and provides an opportunity for staff to come forward with any feedback. Typically, there is a</li> </ul> </li> </ul>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Kern	Actions Taken by Kern to Address the External Quality Review Recommendations
	<p>guest that joins the director who discusses time-relevant information about the department.</p> <ul style="list-style-type: none"> <li>■ SharePoint Feedback Form—This form is located on the front carousel of the interdepartmental website with the option for staff to remain anonymous.</li> <li>◆ The department has continued to conduct town hall meetings to provide staff with updates on EHR Implementation and CalAIM Payment Reform.</li> <li>◆ The department continues to utilize monthly and quarterly provider meetings to communicate messaging that is specific for contractors.</li> <li>◆ Communication with Kern staff also frequently focuses on employee wellness, workplace culture, and other key initiatives, including the department’s strategic plan.</li> </ul>

## Assessment of Kern’s Self-Reported Actions

HSAG reviewed Table B.15, in which Kern summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Kern adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Kern related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Kern addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Kern

Based on the overall assessment of Kern’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for

improvement, and recommendations for the plan. Note that all of Kern's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Kern's 2025 clinical and nonclinical PIP submissions. Kern met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, HSAG observed that Kern performed systemwide SmartCare training of all providers to ensure accurate data entry. These efforts demonstrated an initiative-taking approach to ensure integrity and quality of data used for reporting. Additionally, Kern had multiple methods of validation and tracking to ensure the accuracy and completeness of claims data. Finally, Kern was prepared and very thorough in demonstrations and detailed responses, which contributed to a well-organized and efficient virtual review process.
- ◆ During the NAV audit process, HSAG observed that Kern conducted targeted systemwide training for mental health providers to ensure proper data entry in SmartCare. These training efforts showed a proactive approach to data quality and focus on long-term improvement for timely access reporting processes.

## Opportunities for Improvement

- ◆ Kern has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Kern did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Kern did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Kern's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Kern as well as the plan's progress with addressing these recommendations.

# Kings County Behavioral Health

## Follow-Up on Prior Year Recommendations

Table B.16 provides the EQR recommendations directed to Kings from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.16 to preserve the accuracy of Kings’ self-reported actions.

**Table B.16—Kings’ Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Kings	Actions Taken by Kings to Address the External Quality Review Recommendations
<p>1. Track, trend, and evaluate timeliness metrics for first offered non-urgent appointments for all members served, and implement strategies to improve timeliness.</p>	<p>Both the Adult Primary Access and Children’s Primary Access programs were asked to monitor and adjust their timely access monthly to ensure systematic improvement in achieving alignment with the State’s timeliness standards. Rather than the MHP imposing a uniform intervention, the programs are able to more flexibly adjust practices within their respective programs in real time to respond to what may be impacting timely access such as staffing issues, influx of referrals/access, etc. The programs were required to submit these monthly monitoring reports to the MHP to demonstrate their monitoring as well as to list what interventions they had implemented during that month to improve or maintain timely access. The trends are reviewed quarterly at the MHP QIC meeting.</p>
<p>2. Track, trend, and review first offered urgent appointments and first offered non-urgent psychiatry appointments for children, and develop strategies to improve in these areas.</p>	<p>Due to the recent (FY 2023–24) conversion to a new EHR, SmartCare, the MHP is still working on the accurate development of timeliness reporting for psychiatry appointments. Initially, SmartCare did not have a report that included both the State TADT information and program or date of birth (DOB)</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Kings</b>	<b>Actions Taken by Kings to Address the External Quality Review Recommendations</b>
	<p>fields, making it impossible to accurately separate children from adults without looking up each individual record to determine the age/program. A few months ago, a program column was able to be added to the report. Now that it can filter by program, the MHP QA Team has been working with the programs to clean up their entries. CalMHSA, the host entity for SmartCare, had previously announced it would be adding DOB to the report, so the MHP has delayed building a custom report in hopes we could use the official one released through SmartCare by CalMHSA. Since the change has not yet been released, the MHP is moving forward with building a custom report so as to no longer delay a more real-time accurate monitoring of timeliness for psychiatry appointments.</p>
<p>3. Remove restrictions for access to the Oak Wellness Center, and open access to all plan members.</p>	<p>While there was mention of restricted access during the FY 2023–24 EQR Consumer Focus Group, there are no restrictions to access. However, to increase accessibility, the Oak Wellness Center expanded hours of operation to Saturdays as well as created a transitional-age youth group. Typically, the Oak Wellness Center estimates to serve approximately 80 unduplicated individuals annually; however, through these expanded efforts, over 160 unduplicated individuals have been served, and the number is growing.</p>
<p>4. Invite plan members to participate in the QIC, Cultural Humility Task Force (CHTF), and other key committees, and share satisfaction survey findings with plan members.</p>	<p>The MHP continues to discuss with the SOC programs the ability to have a PSS from each program attend the QIC and CHTF meetings to assist with providing a consistent lived experience perspective at these respective committees. Currently, the MHP’s PSS at the County Department attends both committees’ meetings in addition to the Department’s MH Board (Behavioral Health Advisory Board)</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Kings	Actions Taken by Kings to Address the External Quality Review Recommendations
	<p>providing a lived experience perspective and consistency in attendance and continuity between these three committees. Additionally, the 2024 consumer satisfaction survey results were received in spring 2025 with the aggregate results analyzed and presented at the April QIC meeting. The program-specific results are currently being compiled, and the programs will be required to administer the results to their staff/providers as well as notify clients via report posting within their respective lobbies.</p>

## Assessment of Kings’ Self-Reported Actions

HSAG reviewed Table B.16, in which Kings summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Kings adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Kings related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Kings addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Kings

Based on the overall assessment of Kings’ delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Kings’ activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Kings' 2025 clinical and nonclinical PIP submissions. Kings met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Kings provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, Kings indicated that the MHP identified an opportunity for providing more accessibility within the community needing appropriate care and implemented a mobile crisis program in December 2024.
- ◆ During the NAV audit process, HSAG observed that Kings maintained thorough processes to ensure accurate and complete provider data, including the provider onboarding and credentialing process through CertifyOS, biannual recredentialing, and monthly outreach to clinic managers to review provider rosters.

## Opportunities for Improvement

- ◆ Kings has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Kings did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Kings did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Kings' responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Kings as well as the plan's progress with addressing these recommendations.

## Lake County Behavioral Health Services Department

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of Lake for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.17 provides the EQR recommendations directed to Lake from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.17 to preserve the accuracy of Lake’s self-reported actions.

**Table B.17—Lake’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Lake	Actions Taken by Lake to Address the External Quality Review Recommendations
1. Implement a clinical PIP for the next review cycle.	Lake has implemented a clinical PIP for the current review cycle.
2. Submit an updated QAPI workplan evaluation for the past three FYs and a QAPI workplan for FY 2024–25 that includes clinical goals and goals related to functional outcomes data from outcome tools.	<p>Lake’s last three published QI workplan &amp; evaluation reports are available at the following links:</p> <ul style="list-style-type: none"> <li>◆ <a href="#">FY 24/25 QI Workplan and FY 23/24 Evaluation Report</a></li> <li>◆ <a href="#">FY 23/24 QI Workplan and FY 22/23 Evaluation Report</a></li> <li>◆ <a href="#">FY 22/23 QI Workplan and FY 21/22 Evaluation Report</a></li> </ul> <p>Lake’s draft FY 2025–26 QAPI workplan also includes goals related to this recommendation.</p> <p>Lake has made significant progress in implementing key clinical assessment tools to support client-centered care and outcome monitoring:</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Lake</b></p>	<p><b>Actions Taken by Lake to Address the External Quality Review Recommendations</b></p>
	<ul style="list-style-type: none"> <li>◆ The CANS assessment has been fully implemented in children’s services, with staff trained and certified. The tool is in routine use, and work is underway to build reporting capabilities to track client progress over time.</li> <li>◆ The ANSA is currently in the onboarding phase for adult MH services. Staff training is in progress (some training has occurred), and the tool is not yet available in the EHR. Full implementation and monitoring are expected in FY 2025–26.</li> <li>◆ The American Society of Addiction Medicine (ASAM) assessment is actively used in Drug Medi-Cal Organized Delivery System (DMC-ODS) programs to support LOC determinations. While reassessments occur, Lake is finalizing development of reporting tools needed to monitor clinical change and treatment progression.</li> </ul>
<p>3. Create a workgroup that includes executive leadership, the QI team, information systems staff, and program staff to ensure clear data definitions for tracking all data metrics in the new EHR. Report on the progress of the workgroup’s efforts.</p>	<p>Lake does not independently define data metrics within SmartCare. Instead, we participate in a regional partnership led by CalMHSA, our third-party EHR vendor, to collaboratively define and standardize data elements across participating counties. This coordinated approach ensures consistency, aligns with State and CalAIM requirements, and supports shared infrastructure for QI and reporting.</p> <p>While we do not manage data definitions internally, Lake actively engages in CalMHSA-led workgroups and technical advisory groups, where executive leadership, QI staff, information systems staff, and program leads provide input on data needs, validation priorities, and reporting enhancements. We will continue to report on our participation and the</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Lake</b></p>	<p><b>Actions Taken by Lake to Address the External Quality Review Recommendations</b></p>
	<p>outcomes of these collaborative efforts as system capabilities evolve.</p>
<p>4. Ensure all informational materials and forms are available in Spanish to line staff and MHP members, including website information, and improve outreach to the Latino population. Report if there is an increase in the number of Latino members served for FY 2023–24.</p>	<p>Lake has taken several steps to strengthen language access and improve outreach to Latino communities. In response to this recommendation, we have made significant updates to our website to ensure that key materials and information are available in Spanish for both line staff and MHP members. This includes translated forms, program descriptions, and access instructions.</p> <p>We also continue to conduct targeted outreach to Latino populations through community-based events, partnerships, and bilingual service coordination. While the overall percentage of Latino clients served remained consistent at 8 percent in both FY 2023–24 and FY 2024–25, the total number increased from 215 to 251 clients, reflecting progress in overall reach.</p> <p>Lake remains committed to reducing access barriers and improving culturally responsive care for Latino communities across the county.</p>
<p>5. Establish bidirectional communication with line staff members and address concerns related to high caseloads and staff turnover through an organized, consistent communication channel.</p>	<p>Lake has established several channels to support bidirectional communication with staff and address ongoing concerns related to caseloads and workforce stability. We hold regular all-staff meetings that provide an open forum for updates, discussion, and staff feedback. In addition, we conduct annual anonymous staff surveys to gather input on workplace experiences, challenges, and suggestions for improvement.</p> <p>To address staffing capacity and high caseloads, we have increased the use of</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Lake	Actions Taken by Lake to Address the External Quality Review Recommendations
	<p>contracted provider support, particularly in high-demand areas. Notably, we have implemented a contracted provider to support access teams, improving timely service delivery and reducing pressure on internal staff.</p> <p>Lake remains committed to strengthening internal communication and providing responsive support to promote staff well-being and retention.</p>

## Assessment of Lake’s Self-Reported Actions

HSAG reviewed Table B.17, in which Lake summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Lake adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Lake related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Lake addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Lake

Based on the overall assessment of Lake’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Lake’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Lake’s 2025 clinical and nonclinical PIP submissions. Lake met all critical and evaluation element scores for both PIP submissions, reflecting that the Integrated BHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Lake demonstrated multiple methods of validation and tracking to ensure the accuracy and completeness of claims data used for performance measure reporting. Additionally, Lake was transparent about the challenges it faced in contracting with a measure vendor and demonstrated willingness to learn and enhance understanding of the audit process.
- ◆ DHCS’ 2025 compliance review scores for Lake show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, HSAG observed that Lake demonstrated strong data governance and system integrity by maintaining member eligibility and provider data in SmartCare using automated processes and controlled use access.

## Opportunities for Improvement

- ◆ Lake has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Lake:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Provider Selection—§438.214

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS’ 2025 compliance review scoring process related to the following CFR standards to ensure Lake meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Provider Selection—§438.214

Lake's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Lake as well as the plan's progress with addressing these recommendations.

# Lassen County Health and Social Services

## Follow-Up on Prior Year Recommendations

Table B.18 provides the EQR recommendations directed to Lassen from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.18 to preserve the accuracy of Lassen’s self-reported actions.

**Table B.18—Lassen’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Lassen	Actions Taken by Lassen to Address the External Quality Review Recommendations
<p>1. Increase efforts to improve recruitment and retention of clinical and peer support staff. Identify methods to promote staff retention.</p>	<p>August 4, 2025: Lassen continued to enhance its recruitment efforts by ensuring presence and engagement at local community job fairs. In FY 2023–24, these job fairs were attended by a Lassen program manager with the aim to raise awareness about available BH positions and promote employment opportunities within the department. By maintaining a visible presence at these events, staff have been able to provide informational materials, answer questions from prospective clients and job seekers, and foster collaborative relationships with other local organizations.</p> <p>Beginning in 2024, Lassen began coordinating on contracting with wraparound services/Family Urgent Response System to get staff certified as PSSs who are able to provide mobile crisis services in the county.</p>
<p>2. Explore ways to continue improving foster youth coordination. Increase coordination with the MCP to establish increased capacity to transition</p>	<p>August 4, 2025: Starting in FY 2023–24, Lassen began coordinating with the MCP on ensuring a closed-loop referral tracking system on those clients moving through the SOC between the MCP (Partnership HealthPlan of California) and the MHP. The MHP worked</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Lassen</b>	<b>Actions Taken by Lassen to Address the External Quality Review Recommendations</b>
<p>members to care under the MCP when clinically appropriate.</p>	<p>with the MCP’s contractor, Carelon, on secure transfer of referrals tracking, communicating monthly on the status and outcome of all referrals sent to the county from the MCP network, and transitions to lower LOCs from the county to Carelon. Carelon referrals are presented weekly to providers at access meetings, and monthly the closed loop tracking is presented to identify clients transitioning who have not followed up with the referral. The MHP did not have any foster youth transitioned through the MCP in FY 2023–24.</p>
<p>3. Explore ways to continue improving foster youth coordination of care with CWS to ensure foster youth have access to the appropriate LOC when services at the MHP are required.</p>	<p>August 4, 2025: In FY 2023–24, the MHP was focused on foster youth and all eligible youth receiving quality intensive services centering on coordination with child welfare, families, schools, and other important members in a youth’s life. These services include ICC/IHBS, and Child-Family Teams (CFTs).</p> <p>Through policy revision, improved EHR data configuration/form capture, and better data tracking/reporting during FY 2023–24, the MHP has been more capable of providing providers’ caseload and due-date updates, reinforcing regularity of measures/assessments and CFT meetings for foster youth, and all receiving intensive services. Additionally, starting in FY 2024–25, the MHP is capturing information on instances of coordination and CFTs presented by providers in weekly access meetings.</p>
<p>4. Coordinate with the emergency department to improve data sharing to monitor, track, and trend data for members receiving crisis services in the emergency department; initiate QI activities to address areas of concern.</p>	<p>August 4, 2025: In PIPs from FY 2023–24, the MHP coordinated with the emergency department on referrals and tracking to ensure individuals seen in the emergency department have a reinforced avenue to enter into BH services.</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Lassen	Actions Taken by Lassen to Address the External Quality Review Recommendations
	<p>In 2024, LassenLinks was adopted by county agencies to make referrals more easily available. The MHP tracks all referrals received through LassenLinks and presents to providers weekly.</p> <p>In FY 2023–24, the MHP entered into a contract with SacValley MedShare Health Information Exchange (HIE) and has been able to identify consenting BH clients seen in all participating emergency departments. The MHP now tracks, analyzes, and reports on these data to providers to indicate individuals most often overutilizing emergency department services.</p>

## Assessment of Lassen’s Self-Reported Actions

HSAG reviewed Table B.18, in which Lassen summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Lassen adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Lassen related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Lassen addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Lassen

Based on the overall assessment of Lassen’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Lassen’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Lassen’s 2025 clinical and nonclinical PIP submissions. Lassen met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Lassen provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, HSAG observed that Lassen had strong initiatives in place, including the leverage of Credible for internal measure performance validations. This included the buildout of internal performance dashboards to better understand measure production.
- ◆ DHCS’ 2025 compliance review scores for Lassen show that the MHP was fully compliant with most CFR standards. Additionally, through the A&I CAP process, Lassen resolved the findings that DHCS identified within the following CFR standards during the DHCS 2025 compliance review scoring process:
  - Grievance and Appeal Systems—§438.228
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that Lassen’s real-time demographic changes, monthly manual eligibility checks, and historical ID tracking demonstrated strong system controls.

## Opportunities for Improvement

- ◆ Lassen has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ Lassen has remaining findings to resolve that DHCS identified within the following CFR standards during the DHCS 2025 compliance review scoring process:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ To ensure Lassen meets all CFR standard requirements moving forward, work with DHCS through the NAE CAP process to fully resolve the findings that DHCS identified within the following CFR standards during the DHCS 2025 compliance review scoring process:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207

Lassen's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Lassen as well as the plan's progress with addressing these recommendations.

# Los Angeles County Department of Mental Health

## Follow-Up on Prior Year Recommendations

Table B.19 provides the EQR recommendations directed to Los Angeles from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.19 to preserve the accuracy of Los Angeles’ self-reported actions.

**Table B.19—Los Angeles’ Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Los Angeles	Actions Taken by Los Angeles to Address the External Quality Review Recommendations
<p>1. Continue and broaden the systemwide focus on reducing the seven- and 30-day rehospitalization rates.</p>	<p>In 2022, Los Angeles County Department of Mental Health (DMH) started a rehospitalization reduction pilot. Phase 1 and 2 of the pilot spanned September 2022 through October 2024 and had several key interventions including:</p> <ul style="list-style-type: none"> <li>◆ Referrals to Los Angeles County DMH’s clinical pharmacists who offered medication access and education as well as linkage.</li> <li>◆ Referrals to ECM providers to connect clients with outpatient programs.</li> <li>◆ Referrals to Los Angeles County DMH’s Full Service Partnership (FSP) programs.</li> <li>◆ Referrals to the County of Los Angeles Public Health Substance Abuse Prevention and Control (SAPC) Program for those in need of substance abuse services.</li> <li>◆ Monthly committee meetings to review data, including Los Angeles County DMH, SAPC, and pilot hospitals.</li> </ul> <p>The following actions were taken in 2024:</p> <ul style="list-style-type: none"> <li>◆ Conducted a literature review and key informant interviews to investigate causes</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Los Angeles</b>	<b>Actions Taken by Los Angeles to Address the External Quality Review Recommendations</b>
	<p>for rehospitalization and to identify new approaches and best practices to consider for Phase 3 of the pilot.</p> <ul style="list-style-type: none"> <li>◆ Los Angeles County DMH leveraged a health management consultant who released a report recommending that Los Angeles County DMH adopt an enhanced full continuum of care approach to support its role as the MHP. The Los Angeles County Board of Supervisors adopted a Board Motion, Establishing a Roadmap to Address the Mental Health Bed Shortage, with a wide array of Board directives and recommendations including developing county strategies to dramatically reduce the 30-day readmission rates for Los Angeles County residents.</li> <li>◆ Executed data sharing MOUs with the MCPs that included data on shared clients and rehospitalization rates.</li> <li>◆ Developed a list of data characteristics/indicators and reviewed the information along with potential strategies to reduce rehospitalizations. A dataset for a cohort of Los Angeles County DMH clients readmitted to the hospital within 30 days during 2023 and 2024 was developed and for those clients who had four or more hospitalizations in calendar year 2024 with the selected indicators.</li> <li>◆ Developed a Los Angeles County DMH rehospitalization dashboard to help track and trend hospital data.</li> <li>◆ Continued to implement and expand centralized scheduling processes to ensure that timely outpatient appointments (within five business days) are offered upon discharge from a hospital.</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Los Angeles</b>	<b>Actions Taken by Los Angeles to Address the External Quality Review Recommendations</b>
<p>2. Engage in a barrier analysis to determine why information on peer opportunities is not transparent, and implement changes to resolve this issue.</p>	<p>The Office of Peer Services (OPS) conducted a survey to assess the distribution methods used to relay information regarding peer opportunities. As a result of the survey and conversations with the staff Peer Advisory Council, OPS created a peer network group that informs peers of opportunities, updates, changes, and general department information. Additionally, HR now e-blasts peer opportunities to all employees.</p>
<p>3. Continue to focus resources and efforts on recruitment and retention of clinical line staff to improve timeliness to care.</p>	<p>It is important to note that DHCS has deemed that Los Angeles County DMH has an adequate number of practitioners (non-prescribers and prescribers). Having said that, Los Angeles County DMH has engaged in the following activities to recruit and retain clinical staff:</p> <ul style="list-style-type: none"> <li>◆ Recruiting for staff at the American Psychological Association convention in 2023, 2024, and 2025, and at the California Psychological Association convention in 2023 and 2024.</li> <li>◆ Recruiting for staff at the American Psychiatric Association convention annually.</li> <li>◆ Establishing academic affiliation agreements with 16 graduate programs for the purposes of serving as clinical training sites for students in master’s and doctoral level programs, as well as residency training programs for psychiatry.</li> <li>◆ Offering an \$18,000 stipend for graduating students in the fields of social work, marriage and family therapy, psychology, and psychiatric nurse practitioners to work in the public MH system. Stipends were recently initiated with graduating psychiatric technicians.</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Los Angeles</b>	<b>Actions Taken by Los Angeles to Address the External Quality Review Recommendations</b>
	<ul style="list-style-type: none"> <li>◆ Participating in comprehensive hiring fairs for student trainees who are graduating.</li> <li>◆ Hosting recruitment campaigns on social media platforms.</li> <li>◆ Having a Los Angeles County DMH psychologist conduct targeted outreach and engagement to each psychologist who applies to Los Angeles County DMH.</li> </ul>
<p>4. Continue development efforts to provide interoperability solutions for more up-to-date and aggregated data collection and reporting inclusive of contracted legal entity provider data.</p>	<ul style="list-style-type: none"> <li>◆ Expanded Application Programming Interface (API) support to include additional Fast Healthcare Interoperability Resources (FHIR) customized for LOCUS. These improvements facilitated the structured, standards-based capture and exchange of LOCUS assessments between contracted legal entity providers, the LOCUS scoring algorithm API, and county systems, enhancing data quality, timeliness, and usability for care coordination and reporting.</li> <li>◆ Integrated legal entity data into the 24/7 Access Call Center application, implementing mandated FHIR standards internally by designing the platform to consume the same FHIR APIs used by external legal entity providers and CBOs to reduce agent call times and improve care coordination. This approach enabled iterative refinement of the APIs based on real-world use and strengthened data alignment across systems.</li> <li>◆ Implemented standardized onboarding frameworks for legal entity providers, reusing templates, credentialing flows, and API guides to streamline integration and reduce onboarding time across provider and vendor systems.</li> <li>◆ Developed and deployed near-real-time synchronization logic using cloud-based</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Los Angeles</b>	<b>Actions Taken by Los Angeles to Address the External Quality Review Recommendations</b>
	<p>architecture and a proxy pattern to detect and reconcile outdated or missing data from external systems. This improved data freshness and ensured timely, accurate reporting.</p> <ul style="list-style-type: none"> <li>◆ Laid the groundwork for payer-to-payer data exchange by aligning legacy flat-file processes with modern interoperability standards and establishing new onboarding workflows for health plan organizations. These efforts supported preparation of data-sharing protocols for member information portability across plans, a critical requirement for compliance.</li> </ul>
<p>5. Consider adding data analytical positions to strengthen ongoing data and reporting efforts.</p>	<ul style="list-style-type: none"> <li>◆ Hired four new data scientists.</li> <li>◆ Went live with a new data science technology stack to provide secure access to necessary analytic software (e.g., R, Python).</li> <li>◆ Gained access to the Los Angeles County chief executive officer’s/chief information officer’s countywide datahub Databricks technology platform.</li> <li>◆ Continued ongoing collaboration with the California Policy Lab (CPL) at the University of California Los Angeles, including sponsoring embedded CPL data scientists within the Clinical Informatics Division.</li> </ul>
<p>6. Investigate issues that create barriers to effective collaborative charting, and initiate solutions.</p>	<ul style="list-style-type: none"> <li>◆ Consulted internally with those involved in related discussions with practitioners in our system and concluded that there was a general lack of awareness of available collaborative charting resources to support practitioner implementation; received some feedback regarding barriers to accessing some of the resources (e.g., versions of</li> </ul>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Los Angeles	Actions Taken by Los Angeles to Address the External Quality Review Recommendations
	<p>trainings with demonstrational video vignette examples).</p> <ul style="list-style-type: none"> <li>◆ Removed access barriers to specific training resources and distributed the resources widely.</li> <li>◆ Presented on available collaborative charting resources during monthly Central QA/QI meetings and service area QIC meetings throughout the county.</li> <li>◆ Provided a live webinar training on collaborative charting to parent partner staff from various contracted agencies throughout the county.</li> </ul>

## Assessment of Los Angeles’ Self-Reported Actions

HSAG reviewed Table B.19, in which Los Angeles summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Los Angeles adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Los Angeles related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Los Angeles addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Los Angeles

Based on the overall assessment of Los Angeles’ delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Los Angeles’ activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Los Angeles' 2025 clinical and nonclinical PIP submissions. Los Angeles met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, HSAG observed that Los Angeles had multiple processes in place to monitor performance measure data. Additionally, Los Angeles indicated that the MHP is implementing future process improvements, including transitioning the warehouse to Azure to facilitate standardizing data, and streamlining a seamless process of transition into Microsoft 365, which will enable the ability to see real-time data.
- ◆ During the NAV audit process, HSAG observed that Los Angeles demonstrated commitment to provider collaboration through proactive support and rigorous follow-up on CAPs regarding timely access data.

## Opportunities for Improvement

- ◆ Los Angeles has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Los Angeles did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Los Angeles did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Los Angeles' responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Los Angeles as well as the plan's progress with addressing these recommendations.

## Madera County Behavioral Health Services

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of County of Madera for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.20 provides the EQR recommendations directed to Madera from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.20 to preserve the accuracy of Madera’s self-reported actions.

**Table B.20—Madera’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Madera	Actions Taken by Madera to Address the External Quality Review Recommendations
<p>1. Implement a barrier analysis, create strategies and interventions, and track and report improvements in engagement as measured by a decrease in the one service only rate. Evaluate the impact of engagement after field-based crisis intervention.</p>	<p>The MHP has migrated to a new EHR twice in the last four years. This has brought about unique data-related challenges. Data ran from our current EHR show no marked improvement in this area with a total single service rate of 25.43 percent; however, we were able to drill down and found that 58.94 percent of single beneficiary services are occurring at time of assessment, while 18.19 percent are happening after mobile crisis assessments. As we continue to learn about our EHR and data reporting capabilities, we will continue to monitor these areas for improvement.</p>
<p>2. Begin to collect and trend timeliness data for contractor services for the first offered and first delivered non-urgent clinical appointments, first offered and first delivered non-urgent psychiatry appointments, and first offered urgent appointments. Include these data in</p>	<p>We have moved closer to meeting this goal by incorporating some of our contractors into our EHR. The contractors’ timeliness data are gathered within our EHR and reported on the TADT. We continue to work with contractors who are not within our EHR to align a data reporting workflow.</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Madera	Actions Taken by Madera to Address the External Quality Review Recommendations
timeliness assessments for systemwide service delivery.	
3. Investigate, develop strategies, and implement solutions to improve Madera MHP’s most frequent reasons for claims denials.	As we continue to learn more about our EHR, we are collaborating very closely with SmartCare’s Revenue Cycle Management Team to better understand our claims workflow. We meet with the Revenue Cycle Management Team weekly to address denials and rebilling. The MHP Team investigates, develops strategies, and implements solutions with SmartCare’s Revenue Cycle Management Team guidance to minimize claim denials.
4. Develop an implementation plan for the new EHR SmartCare to ensure that it includes the capability to track aggregated data by program outcomes.	SmartCare affords direct database access to allow the MHP the ability to query health records and create actionable insights.

## Assessment of Madera’s Self-Reported Actions

HSAG reviewed Table B.20, in which Madera summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Madera adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Madera related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Madera addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Madera

Based on the overall assessment of Madera’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Madera’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When

applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned a *High Confidence* level to Madera's 2025 clinical PIP submission. Madera met all critical and evaluation element scores for this PIP submission, reflecting that the Integrated BHP built a robust foundation in the Design stage of its clinical PIP.
- ◆ During the PMV audit process, Madera was transparent with HSAG on the challenges it experienced through EHR migrations and obtaining Plan Data Feed files and showed dedication to growing its current processes pertaining to collecting and maintaining data needed for integration and performance measure reporting. Additionally, Madera showed commitment to addressing its members' needs by working on initiatives, including a Sobering Center and housing for their homeless population, and expanding its outreach to the community.
- ◆ DHCS' 2025 compliance review scores for Madera show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, HSAG observed that Madera demonstrated a proactive approach to monitoring timely access data through a combination of real-time data entry, daily QA validations, and structured reporting mechanisms. Madera's use of network adequacy reporting tools within InSync, regular benchmark tracking, and cross-departmental collaboration helped identify and resolve emerging access barriers.

## Opportunities for Improvement

- ◆ HSAG's 2025 PIP validation determined that Madera did not include all required details of its PIP processes for its nonclinical PIP.
- ◆ Madera has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Madera:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228

## 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Madera includes all required information in the Integrated BHP's 2026 annual nonclinical PIP submission.

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS’ 2025 compliance review scoring process related to the following CFR standards to ensure Madera meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228

Madera’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Madera as well as the plan’s progress with addressing these recommendations.

# Marin County Behavioral Health and Recovery Services

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of Marin for activities conducted as an Integrated BHP entity.

## Follow-Up on Prior Year Recommendations

Table B.21 provides the EQR recommendations directed to Marin from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.21 to preserve the accuracy of Marin’s self-reported actions.

**Table B.21—Marin’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Marin	Actions Taken by Marin to Address the External Quality Review Recommendations
<p>1. Conduct an analysis of bilingual staff distribution and current caseloads to determine if an increase in the number of Spanish-speaking staff members is necessary, particularly in areas of the county where Hispanic/Latino members live and may have decreased access as a result.</p>	<p>While Marin has completed analysis of bilingual capacity across the SOC, it has yet to complete an analysis of current caseloads to determine if an increase in the number of Spanish-speaking staff members is necessary. However, Marin has focused on bilingual recruitments to increase Spanish-speaking capacity. We will complete this analysis as recommended.</p>
<p>2. Review timeliness for all key metrics at least quarterly, with documentation of the review and development of improvement strategies as needed.</p>	<p>Marin transitioned staff into SmartCare for documentation of timeliness data. These past several months have been dedicated to improving data collection and entry. We are reviewing the data monthly to check for errors and are providing training to staff on how to accurately enter data. We have implemented several strategies for improving timeliness to care (including moving assessments out of access and onto treatment teams) and are</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Marin</b>	<b>Actions Taken by Marin to Address the External Quality Review Recommendations</b>
	<p>also conducting a timeliness PIP with more interventions to come.</p>
<p>3. Continue to work toward a higher Access Line call-answered rate to improve member experience when seeking care.</p>	<p>Access has shifted processes in order to prioritize the core functionality of answering Access Line calls. Actions taken include moving the assessment to the treatment teams to free up more access staff to answer calls, improving the efficiency of referral processes, creating informative workflow materials to address diverse calls, underfilling a vacant MHP position with a social worker to assist with answering calls, and cross-training staff to assist in answering calls when needed. Additionally, several technical issues were identified (calls not reaching the Access Line due to historic call tree set-up, not switching to after-hours call center consistently, etc.). The Access Line continues to work with technical support/information systems technology in addressing these challenges as well as communicating to our referring partners/community organizations regarding others ways to reach the Access Team (email, comment box on the website, etc.).</p>
<p>4. Work with CalMHSA to prioritize reports in the EHR that the MHP views as essential. Build county-specific training modules for entering member data and billing information into SmartCare.</p>	<p>Marin has worked with CalMHSA to create various reports that it views as essential. Marin has been able to take advantage of dashboards that CalMHSA has created and has also had to create many of its own reports due to charges imposed by CalMHSA to create new reports. Many reports were generated on an ad hoc basis to address issues as they arose, or to have temporary fixes for reports that were not working in SmartCare. CalMHSA has also made more progress toward completing reporting templates for State reporting requirements, though there are still some modules that are not yet completed. Marin has created training material related to</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Marin</b>	<b>Actions Taken by Marin to Address the External Quality Review Recommendations</b>
	<p>entering member data and billing into SmartCare, and these materials are available on request.</p>
<p>5. Upon implementation of the LOCUS as a LOC tool, conduct an analysis of staff capacity at various LOCs based on apparent member needs in the SOC.</p>	<p>Marin faced delays in implementation of the LOCUS tool and is still awaiting access to the tool in SmartCare.</p> <p>We initially planned for the LOCUS tool to be used by the Access Line at the screening point, but it was later realized that the LOCUS tool requires assessment of clients before completion. As a result, the Access Team is piloting an enhanced screening to supplement the state-developed screening tool to help identify LOCs within the adult SOC.</p> <p>While assessments were previously completed by Access Team staff members, in order to improve accessibility for community members to the Access Line and improve timely access to care, assessments are now being completed by treatment teams (as of June 1, 2025, for the adult SOC and July 2024 for the children’s SOC). The Access Team will continue to complete urgent assessments. In line with the CalAIM No Wrong Door Policy, clients can begin services prior to the completion of the assessment, thus expediting clients’ entry into treatment.</p> <p>The adult SOC is considering use of the LOCUS tool once the staff have completed assessments in order to better determine LOC placement and to act as an outcomes tool.</p> <p>Marin will revisit the need to complete an analysis of staff capacity once the transition of assessments has been underway for a few</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Marin	Actions Taken by Marin to Address the External Quality Review Recommendations
	months and piloting of the enhanced screening is complete.

## Assessment of Marin’s Self-Reported Actions

HSAG reviewed Table B.21, in which Marin summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Marin adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Marin related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Marin addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Marin

Based on the overall assessment of Marin’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Marin’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Marin’s 2025 clinical and nonclinical PIP submissions. Marin met all critical and evaluation element scores for both PIP submissions, reflecting that the Integrated BHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, HSAG observed that Marin implemented multiple methods of validation and tracking to ensure the accuracy and completeness of claims data both pre- and post-claims submission to DHCS. Additionally, Marin maintained and demonstrated multiple reports used to validate the accuracy and completeness of member enrollment/eligibility data ingested and updated in SmartCare.

- ◆ During the NAV audit process, HSAG observed that Marin maintained strong processes to capture and report timeliness data through creating and reviewing reports of missing timeliness data and addressing data gaps via communication to providers. Additionally, Marin created a training video and written procedures detailing processes for provider-reported timeliness data.

## Opportunities for Improvement

- ◆ Marin has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.

Marin's responses to the EQR recommendation should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Marin as well as the plan's progress with addressing this recommendation.

# Mariposa County Human Services, Behavioral Health & Recovery Services Division

## Follow-Up on Prior Year Recommendations

Table B.22 provides the EQR recommendations directed to Mariposa from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.22 to preserve the accuracy of Mariposa’s self-reported actions.

**Table B.22—Mariposa’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Mariposa	Actions Taken by Mariposa to Address the External Quality Review Recommendations
<p>1. Consult with DHCS regarding parameters and expected fidelity to the CalAIM screening tool. Determine the extent to which members are not screened prior to their assessment.</p>	<p>Mariposa updated protocols on screening tools, streamlined a process to ensure each client was screened to better determine the best delivery system, and outlined the process for identifying which clients did not require a screening and went directly to assessment. Several trainings with screening staff were held, as well as monitoring of screenings to ensure compliance with the policy and procedure.</p>
<p>2. Examine service patterns for members who receive only one or two services to determine whether more attention should be given to clinical engagement or if other issues are apparent.</p>	<p>Mariposa will examine service patterns, if service patterns indicate, and will review charts around clinical engagement or other potential contributing factors.</p>
<p>3. Examine a reasonable sample of charts to determine whether psychiatry is being offered at clinically appropriate stages of care. This analysis should include participation from psychiatric providers, as well as someone with</p>	<p>Mariposa will examine a small sample of charts, focusing on clients not opting for psychiatric services at opening to review for appropriate attempts to offer services; indications of the need to offer services; and indicators such as increased contacts, crisis contacts, hospitalizations, etc. The</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Mariposa	Actions Taken by Mariposa to Address the External Quality Review Recommendations
lived experience, if possible, to help inform the process.	methodology and findings will be reviewed by a multidisciplinary team.
4. Examine service patterns for adults receiving TCM, particularly those members who are outliers receiving well above the average number of services. This may reflect an unintended service pattern or miscoding of services delivered.	Several training sessions were held with staff regarding identifying the difference between case management and rehabilitation. Mariposa monitored the percentage of case management and rehabilitation services provided each quarter through the QIC. Subsequently, we saw an increase in rehabilitation and a decrease in case management.
5. Provide a mechanism for staff members to contribute as subject matter experts when new initiatives are being discussed and planned. This should include the development and testing of workflows to provide feedback regarding the new EHR functionality and implementation.	The QA Team holds a weekly open session on Fridays from 3 to 5 p.m. for staff to stop in for questions around the EHR or an opportunity for staff to provide their feedback and ideas for improvement.

## Assessment of Mariposa’s Self-Reported Actions

HSAG reviewed Table B.22, in which Mariposa summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Mariposa adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Mariposa related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Mariposa addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Mariposa

Based on the overall assessment of Mariposa’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Mariposa’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ During the PMV audit process, HSAG observed that Mariposa used the MMEF uploads, real-time enrollment data batch inquiries, MEDSLITE data, and MMEF Log reports to validate, update, and improve the overall accuracy of its member enrollment data in InSync. Additionally, Mariposa implemented multiple methods of validation and tracking to ensure the accuracy and completeness of its provider data maintained in InSync.
- ◆ During the NAV audit process, HSAG observed that Mariposa integrating the Valenz system for license monitoring and proactive alerting reflected Mariposa’s commitment to maintain current and compliant provider records.

### Opportunities for Improvement

- ◆ HSAG’s 2025 PIP validation determined that Mariposa did not include all required details of its PIP processes for its clinical and nonclinical PIPs.
- ◆ Mariposa has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.

### 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Mariposa includes all required information in the MHP’s 2026 annual clinical and nonclinical PIP submissions.
- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.

Mariposa’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Mariposa as well as the plan's progress with addressing these recommendations.

# Mendocino County Mental Health

## Follow-Up on Prior Year Recommendations

Table B.23 provides the EQR recommendations directed to Mendocino from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.23 to preserve the accuracy of Mendocino’s self-reported actions.

**Table B.23—Mendocino’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Mendocino	Actions Taken by Mendocino to Address the External Quality Review Recommendations
<p>1. Research possible reasons for the higher Latino/Hispanic single service percentage, and design culturally appropriate ways to increase engagement. Consider conducting Hispanic/Latino focus groups to gather feedback from this population.</p>	<p>Mendocino conducted a survey of 60 individuals identified as Spanish-speaking with a single service. The survey sought to learn more about the service and feedback related to service satisfaction and whether the individual was offered follow-up services. Twenty-eight percent of the surveys sent were returned due to inadequate addresses, resulting in the determination that incorrect or temporary addresses were one factor associated with single services. Additionally, we learned that some recipients of services associated services with stigma. The survey results also indicated that individuals preferred to return to their PCP or felt they did not need follow-up services. Mendocino continues to work on reducing stigma and encouraging all individuals to follow up for services.</p>
<p>2. Consider permitting all contract providers full access to the enhanced Avatar NX EHR system to eliminate disparate EHR databases and allow 24/7 access to member health information.</p>	<p>Mendocino County Behavioral Health and Recovery Services (BHRS) has extended Avatar NX capabilities to allow all contracted SMHS providers to provide full access to Avatar NX. Contracted SMHS providers are trained and are part of the Avatar NX.</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Mendocino	Actions Taken by Mendocino to Address the External Quality Review Recommendations
<p>3. Consider the opportunity to redefine urgent services disparate from crisis services to offer an opportunity for a more complete assessment and engagement of urgent service requests. Create a process that helps to reduce the number of deferred diagnoses.</p>	<p>Mendocino County BHRS has delineated crisis and urgent services in one of its policies and procedures. We set provider standards of responding to crisis service requests as being different from urgent services.</p>
<p>4. Consider creating a peer classification and a peer-specific career ladder.</p>	<p>Mendocino County BHRS initiated creating the Peer Support Classification, and this classification is currently in the HR review process. In the interim, Mendocino BHRS is supporting existing staff who identify as peers in completing peer certification. These staff members are currently working in classifications for which they qualify, while peer-specific classifications are being created. Additionally, providers are encouraged, via the shared EHR and established diagnoses from other treating practitioners, to adopt the established diagnoses as opposed to deferring when a non-diagnosing practitioner is providing a service.</p>
<p>5. Consider including anticipated IT staffing requirements in the Avatar NX project plan as well as in the post-Avatar NX IT budget.</p>	<p>Mendocino County BHRS reviewed staffing and determined that an additional staff member was needed to support the ongoing Avatar NX project and hired an additional staff member in May 2024.</p>

## Assessment of Mendocino’s Self-Reported Actions

HSAG reviewed Table B.23, in which Mendocino summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Mendocino adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Mendocino related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Mendocino addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Mendocino

Based on the overall assessment of Mendocino’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Mendocino’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Mendocino’s 2025 clinical and nonclinical PIP submissions. Mendocino met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Mendocino demonstrated its commitment to addressing the behavioral health care needs of its members through organizational stability and efforts to improve and expand delivery of services. Additionally, Mendocino was transparent in identifying the challenges it had experienced and showed great dedication to improving its current processes specific to validation.
- ◆ During the NAV audit process, Mendocino demonstrated strong coordination across departments to ensure accurate and timely enrollment and eligibility data management. The use of multiple verification tools such as MEDSLITE and myAvatar, and manual cross-checks enabled Mendocino to consistently identify and resolve discrepancies in a timely manner.

### Opportunities for Improvement

- ◆ Mendocino has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.

Mendocino's responses to the EQR recommendation should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Mendocino as well as the plan's progress with addressing this recommendation.

# Merced County Behavioral Health and Recovery Services

## Follow-Up on Prior Year Recommendations

Table B.24 provides the EQR recommendations directed to Merced from the previous EQRO's 2023–24 SMHS EQR technical report, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.24 to preserve the accuracy of Merced's self-reported actions.

**Table B.24—Merced's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization's 2023–24 External Quality Review Recommendations Directed to Merced	Actions Taken by Merced to Address the External Quality Review Recommendations
<p>1. Revive the all-hands-on-deck approach, and implement other strategies to improve timeliness for first offered appointments.</p>	<p>Adult System of Care (ASOC) has set up regular monitoring of timeliness for first-time appointments and is mobilizing clinicians from different areas of ASOC services to assist with intakes to locations where timeliness is an issue for first-time assessment appointments.</p> <p>Additionally, ASOC is working with Merced as a whole to bring in clinician interns and clinician trainees, who then are able to work toward employment. This is increasing the candidate pool and ensuring that clinician positions that perform first-time appointments are consistently filled.</p> <p>The Justice &amp; Community Integration Department has approved temporary overtime for clinicians to assist in completing assessments in a timely manner.</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Merced	Actions Taken by Merced to Address the External Quality Review Recommendations
2. Explore barriers for timely psychiatry non-urgent appointments, and implement strategies that target these barriers.	Merced implemented blocks for first-time appointments in order to reduce barriers for first-time psychiatry appointments.
3. Review the reasons why the average wait time for urgent appointments is very long, and implement strategies that will improve timeliness.	One strategy which has been implemented is that all sites now have a “Person of the Day,” which allows more immediate response and urgent appointments to be scheduled.
4. Create a workgroup within the Compliance and Quality Improvement (CQI) Committee to implement strategies that improve timeliness, and report monthly progress to the CQI Committee.	This did not end up occurring in the CQI Committee; rather, this has been the focus of the monthly PIP meeting, as the reporting fit better in this context. This will also be incorporated into monthly data analyst meetings.
5. Consider promotoras and other effective outreach strategies to improve the Hispanic/Latino penetration rates.	<p>An employee-led workgroup called “Caminos to BH” meets monthly to work to improve outreach to the Hispanic community.</p> <p>Merced has approached a local non-profit that services the Hispanic/Latino community. We are working on an agreement to provide a Spanish-speaking clinician within this location two days per week.</p>

## Assessment of Merced’s Self-Reported Actions

HSAG reviewed Table B.24, in which Merced summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Merced adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Merced related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Merced addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Merced

Based on the overall assessment of Merced’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Merced’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Merced’s 2025 clinical and nonclinical PIP submissions. Merced met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, HSAG observed that Merced used reports within Credible to adequately identify and correct service errors prior to submitting 837 files to DHCS. Additionally, Merced implemented multiple methods of validation and tracking to ensure the accuracy and completeness of its provider data in Credible.
- ◆ During the NAV audit process, HSAG observed that Merced:
  - Implemented job aids, QA checks, and process improvements in response to an identified data issue for members with restricted charts, improving overall accuracy of member data.
  - With the implementation of Credible, leveraged the available system enhancements to increase automation and validation, staff oversight of processes, data control, and data quality, contributing to more accurate timely access reporting.
  - Implemented a reoccurring new staff eligibility notification system that helped the MHP to interview and hire new clinicians and improve appointment availability.

### Opportunities for Improvement

- ◆ Merced has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Merced:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Grievance and Appeal Systems—§438.228

- Subcontractual Relationships and Delegation—§438.230
- Enrollee Rights—§438.100

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS’ 2025 compliance review scoring process related to the following CFR standards to ensure Merced meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Enrollee Rights—§438.100

Merced’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Merced as well as the plan’s progress with addressing these recommendations.

# Modoc County Behavioral Health Services

## Follow-Up on Prior Year Recommendations

Table B.25 provides the EQR recommendations directed to Modoc from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.25 to preserve the accuracy of Modoc’s self-reported actions.

**Table B.25—Modoc’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Modoc	Actions Taken by Modoc to Address the External Quality Review Recommendations
<p>1. Submit two PIPs for validation.</p>	<p>During FY 2023–24, Modoc was fully engaged in the Behavioral Health Quality Improvement Program (BHQIP) in partnership with DHCS. This initiative involved a comprehensive transformation of our BH system, including significant changes to screening processes, documentation standards, and reporting requirements. As part of our participation, the department was actively involved in the development of the <i>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, Plan of Discharge</i>, and <i>Follow-Up After Emergency Department Visit for Mental Illness</i> PIPs. These projects were submitted to DHCS through the BHQIP email submission process. Two of these PIPs specifically focus on enhancing services for individuals receiving SUD treatment. The complexity and time commitment required to meet BHQIP expectations significantly limited our capacity to design and implement additional PIPs during the same time frame.</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Modoc</b></p>	<p><b>Actions Taken by Modoc to Address the External Quality Review Recommendations</b></p>
<p>2. Initiate the PIP that the MHP has planned to reduce no-shows.</p>	<p>The MHP developed a concept for a nonclinical PIP focused on reducing persistently high no-show rates for psychiatry services. While the project remained in the planning phase, it was intended for implementation in the upcoming FY. However, this period coincided with the transition from the previous EQRO to HSAG as the EQRO. Our original plan included receiving technical assistance from the previous EQRO to support the full development and implementation of this PIP. Due to the transition, that technical assistance was no longer available, which impacted our ability to move the project forward as planned. During this time, the MHP prioritized system development efforts aligned with the BHQIP, which required extensive internal restructuring. As a result, implementation of the nonclinical PIP was discontinued.</p>
<p>3. Demonstrate that the MHP’s foster care youth are receiving the full continuum of services with utilization rates similar to statewide and other small counties’ rates.</p>	<p>The MHP is actively working to ensure that youth receive the full continuum of services by strengthening interagency collaboration, streamlining referral and intake processes, and aligning care plans with individualized LOC needs. Efforts include expanding service options through telehealth, increasing coordination with schools and child welfare, and enhancing documentation and tracking to monitor service delivery.</p> <p>At this time, however, the MHP is unable to compare its youth service utilization rates to statewide or other county benchmarks due to the lack of access to current statewide and county-level utilization data.</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Modoc</b>	<b>Actions Taken by Modoc to Address the External Quality Review Recommendations</b>
<p>4. Complete implementation of the SacValley MedShare HIE to include automated two-way communication between the EHR and the HIE.</p>	<p>The implementation of the SacValley MedShare HIE was fully completed as of February 4, 2025. As part of this process, the MHP successfully integrated Credible Connect 2.0 and configured opt-in consent filtering within the domain to ensure alignment with privacy standards and individual data sharing preferences.</p>
<p>5. Reassure members that BH treatment is confidential, solicit suggestions from members for how they may feel more comfortable receiving treatment, and provide ways for members to further protect their privacy (e.g., telehealth services from home).</p>	<p>Modoc is committed to protecting the privacy and confidentiality of all individuals receiving services. We actively reassure members during intake, treatment planning, and ongoing care that all BH services are strictly confidential and protected under Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable State laws.</p> <p>To ensure members feel more comfortable receiving treatment, providers routinely ask for feedback and suggestions on how we can improve their sense of privacy and safety. This includes offering flexible appointment options (such as telehealth or alternate locations), adjusting how and where communications are sent, and discussing any specific concerns the member may have about confidentiality.</p> <p>Additionally, we are working toward providing members with additional information and tools to help them further protect their privacy such as setting communication preferences (text and email), using patient portals securely, and understanding their rights regarding disclosure of treatment information.</p>

## Assessment of Modoc's Self-Reported Actions

HSAG reviewed Table B.25, in which Modoc summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Modoc adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Modoc related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Modoc addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Modoc

Based on the overall assessment of Modoc's delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Modoc's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Modoc's 2025 clinical and nonclinical PIP submissions. Modoc met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Modoc was transparent with HSAG on the challenges it was experiencing and showed great dedication to growing its current processes for monitoring and validating data used in performance measure calculation and reporting. This included a focus on improving data collection processes and reporting capacity to better serve Modoc's system and meet new reporting requirements by using dashboards. Additionally, Modoc demonstrated its commitment to addressing members' behavioral health care needs by focusing on and promoting whole person health and wellness throughout its provided services.
- ◆ Through the A&I CAP process, Modoc resolved the findings that DHCS identified within the following CFR standards during the DHCS 2025 compliance review scoring process:
  - Coverage and Authorization of Services—§438.210
  - Provider Selection—§438.214
  - Grievance and Appeal Systems—§438.228

- Practice Guidelines—§438.236
- Health Information Systems—§438.242
- Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that Modoc conducted ongoing review and analysis of timely access data, and performed quality checks and month-to-month comparisons to ensure accuracy of timeliness data.

## Opportunities for Improvement

- ◆ Modoc has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ Modoc has remaining findings to resolve that DHCS identified within the following CFR standards during the DHCS 2025 compliance review scoring process:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To ensure Modoc meets all CFR standard requirements moving forward, work with DHCS through the NAE CAP process to fully resolve the findings that DHCS identified within the following CFR standards during the DHCS 2025 compliance review scoring process:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207

Modoc's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Modoc as well as the plan's progress with addressing these recommendations.

# Mono County Behavioral Health

## Follow-Up on Prior Year Recommendations

Table B.26 provides the EQR recommendations directed to Mono from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.26 to preserve the accuracy of Mono’s self-reported actions.

**Table B.26—Mono’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Mono	Actions Taken by Mono to Address the External Quality Review Recommendations
<p>1. Create an onboarding training plan for remote workers that includes countywide resources, contact information, and a description of services offered.</p>	<p>New employees at Mono receive countywide resource guides, key contact information, and an overview of services offered as part of their onboarding process. In addition, the clinical supervisor provides regular, ongoing training and updates on available community resources during routine supervision sessions and check-ins with clinical staff. This ensures remote workers remain connected, informed, and supported in their roles regardless of location.</p>
<p>2. Continue to build relationships with local law enforcement personnel by offering short trainings at their briefings on a variety of BH topics.</p>	<p>Mono is actively working to strengthen collaboration with local law enforcement. We have initiated monthly meetings with the Mammoth Lakes Police Department (MLPD) to support ongoing coordination, including efforts to refine mobile crisis workflows. These meetings are scheduled during shift change to ensure greater availability of officers and create an opportunity for targeted BH trainings during briefings.</p> <p>Additionally, representatives from both the MLPD and the Mono County Sheriff’s Department regularly attend our BH Advisory</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Mono</b>	<b>Actions Taken by Mono to Address the External Quality Review Recommendations</b>
	<p>Board meetings, providing another avenue for relationship-building and cross-system collaboration. Law enforcement personnel will also be included in upcoming law and ethics trainings facilitated by our contracted legal expert.</p>
<p>3. Evaluate barriers to timely access to initial psychiatry appointments. Develop and implement strategies to revamp and expand psychiatric services for youth and adults.</p>	<p>Mono has evaluated barriers to timely access for initial psychiatry appointments and is currently meeting the required timeliness standards. As part of our efforts to enhance service quality and capacity, we have made the strategic decision to replace a physician assistant with a licensed psychiatrist. This transition is intended to expand our ability to serve both youth and adult populations with increased clinical expertise and continuity of care.</p>
<p>4. Hold targeted conversations with staff members to develop a staff wellness initiative to address potential burnout and to promote self-care.</p>	<p>Mono is actively addressing staff wellness and potential burnout through weekly trainings and check-ins led by the department director. These weekly targeted conversations focus on topics such as the therapeutic frame, strength-based practice, setting healthy boundaries, and burnout facilitation. This initiative is part of our broader effort to promote self-care, professional resilience, and a supportive work environment.</p>
<p>5. Leverage the data reporting experience and customization of other counties implementing the SmartCare EHR in collaboration with CalMHSA.</p>	<p>Mono actively leverages the experience and expertise of other counties using the SmartCare EHR through regular participation in collaborative workgroups coordinated with CalMHSA. Our analytics team attends and contributes to the weekly SmartCare System Administrator Group, which includes representatives from over 20 counties and more than 60 participants. In addition, we engage in the monthly Revenue Cycle Management Group, which includes eight counties collaborating on billing and State</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Mono	Actions Taken by Mono to Address the External Quality Review Recommendations
	reporting. These collaborative efforts support ongoing system optimization, data reporting accuracy, and customization aligned with our operational needs.

## Assessment of Mono’s Self-Reported Actions

HSAG reviewed Table B.26, in which Mono summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Mono adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Mono related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Mono addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Mono

Based on the overall assessment of Mono’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Mono’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Mono’s 2025 clinical and nonclinical PIP submissions. Mono met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Mono provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, Mono demonstrated commitment to addressing members’ behavioral health care needs through efforts to improve and expand delivery of services.

- ◆ During the NAV audit process, Mono demonstrated its ability to maintain accurate and complete enrollment and eligibility information by conducting review and clean-up of member data every three months to identify and correct discrepancies in SmartCare.

## Opportunities for Improvement

- ◆ Mono has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Mono:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Quality Assessment and Performance Improvement Program—§438.330
  - Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that Mono:
  - Manually prepared TADT submissions and did not utilize SmartCare's embedded reporting functions.
  - Did not meet one or more DHCS standards for timely access indicators due to a failure to submit timely access data to DHCS in a timely manner.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Mono meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Quality Assessment and Performance Improvement Program—§438.330
  - Enrollee Rights—§438.100
- ◆ To improve timely access reporting:
  - Explore the utilization of SmartCare's embedded reporting functions to minimize manual entry of timely access reporting data, which may increase efficiency and reduce potential data entry errors.

- Conduct an in-depth review of the indicators for which Mono did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
- Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Mono's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Mono as well as the plan's progress with addressing these recommendations.

# Monterey County Behavioral Health

## Follow-Up on Prior Year Recommendations

Table B.27 provides the EQR recommendations directed to Monterey from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.27 to preserve the accuracy of Monterey’s self-reported actions.

**Table B.27—Monterey’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Monterey	Actions Taken by Monterey to Address the External Quality Review Recommendations
<p>1. Develop a process that ensures accurate timeliness data collection that results in accurate representation of data throughout the MHP.</p>	<p>The QI staff continually worked with access to care services managers to implement changes to workflows for capturing timeliness. Although this continues to be a challenge, Monterey is exploring innovative solutions to capture these data while avoiding additional documentation burdens on direct service providers. Monterey does not have a designated team to capture timeliness data; thus, service managers and QI staff are tasked with implementing changes, monitoring the data, and making further adjustments as needed. Additionally, it is expected that the MHP nonclinical PIP will assist with further improving the data collection process and its accuracy.</p> <p>Monterey has implemented a new psychiatry timeliness procedure as of December 18, 2023, and is accurately capturing timeliness data for psychiatry services (urgent and non-urgent).</p> <p>Monterey has implemented a new outpatient (urgent and non-urgent) timeliness procedure</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Monterey</b>	<b>Actions Taken by Monterey to Address the External Quality Review Recommendations</b>
	<p>as of April 1, 2024, and revised the procedure on July 1, 2025.</p>
<p>2. Explore the reasons for the long wait time to urgent services, and implement a process to improve timely service delivery for those with urgent needs.</p>	<p>With the implementation of the new psychiatry timeliness procedure, QI staff have evaluated the urgent request and have determined the following two areas of improvement:</p> <ul style="list-style-type: none"> <li>◆ Staff training on the definition of “urgent”</li> <li>◆ The member’s availability/acceptance of an appointment within the 48-hour time frame.</li> </ul> <p>QI staff will begin to monitor outpatient urgent requests and whether there have been any improvements as a result of the new procedure that was implemented on July 1, 2025.</p>
<p>3. Investigate high-cost member service patterns to determine if the patterns reflect the treatment needs of this population. Data from the LOC tool will be valuable for this process.</p>	<p>The QI deputy director has submitted an implementation plan for the Monterey director to review high-cost member service patterns, and the plan is under review.</p>
<p>4. Implement a process that provides training and monitors adult LOC tool utilization accuracy, and develop a process to track aggregate analyses over time for both children and adults.</p>	<p>Monterey previously used the LOC determination tool, Reaching Recovery, for adults, and the tool was retired on July 1, 2024. The current LOC tools used are the Adult Screening Tool for Medi-Cal MH Services and FSP screening tool. Other tools used include Crisis Residential, Day Rehabilitation, Adult Residential, and Day Treatment Intensive. Monterey will implement a LOC for adults once determined by DHCS.</p> <p>The tools used for children are the Youth Screening Tool for Medi-Cal MH Services, CANS, and the Pediatric Symptom Checklist (PSC-35). Additionally, there are screening tools for ICC, IHBS, therapeutic behavioral services, and therapeutic foster care.</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Monterey</b>	<b>Actions Taken by Monterey to Address the External Quality Review Recommendations</b>
	<p>For both children and adults, the LOC is also determined based on ongoing assessment of the members’ needs.</p>
<p>5. Develop strategies and implement solutions to improve morale, bidirectional communication, and concerns related to bidirectional communication in leadership clinical policy decision making.</p>	<p>Over the past year, there have been several opportunities to improve morale and bidirectional communication in leadership clinical policy decision making. For example, the quality deputy director has been facilitating a biweekly workgroup designated to obtain feedback from different levels of staff on documentation, claiming, and sustainability standards. Additionally, Monterey QI staff continue to have timeliness workgroup meetings and involve staff directly involved in this process, supervisors, and managers to contribute on ways to improve.</p> <p>Monterey QI staff have developed a QI Policy Committee and invited subject matter experts to contribute to these changes prior to the changes taking effect.</p> <p>Another committee that was created is the Behavioral Health Information Notice (BHIN) Committee. The focus of this committee is to review draft and published DHCS BHINs and prepare to update policies and implement new mandates. Monterey and its contracted providers participate in this committee.</p> <p>Lastly, Monterey QI staff continue to host the QIC meeting on a quarterly basis, and all staff and contracted providers of all levels, community partners, and members are invited to attend. The focus of this committee is to present system updates, review policies/memos, and share quarterly data and</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Monterey	Actions Taken by Monterey to Address the External Quality Review Recommendations
	workplan status (grievance and appeals, timeliness, etc.).
6. Expand in-house and/or contracted data analytic capacity to meet the reporting and analytic needs of the organization.	As of July 2024, Monterey has a fully staffed Avatar IT Team consisting of a supervisor, seven staff members, and an epidemiologist who support the entire bureau.

## Assessment of Monterey’s Self-Reported Actions

HSAG reviewed Table B.27, in which Monterey summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Monterey adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Monterey related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Monterey addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Monterey

Based on the overall assessment of Monterey’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Monterey’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Monterey’s 2025 clinical and nonclinical PIP submissions. Monterey met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.

- ◆ During the PMV audit process, HSAG observed that Monterey implemented multiple methods of validation and tracking to ensure the accuracy and completeness of claims data both pre- and post-claims submission to DHCS. Additionally, Monterey articulated and displayed multiple reports used to validate the accuracy and completeness of member enrollment/eligibility data ingested and updated in myAvatar.
- ◆ DHCS' 2025 compliance review scores for Monterey show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, HSAG observed that Monterey implemented initiatives to improve provider data accuracy and completeness, including data used for 274 reporting, utilizing monthly Excel reports to identify expiring licenses and reaching out to providers to obtain updated information.

## Opportunities for Improvement

- ◆ Monterey has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Monterey:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that Monterey did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Monterey meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Enrollee Rights—§438.100
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Monterey did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.

- Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Monterey's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Monterey as well as the plan's progress with addressing these recommendations.

# Napa County Health and Human Services Agency

## Follow-Up on Prior Year Recommendations

Table B.28 provides the EQR recommendations directed to Napa from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.28 to preserve the accuracy of Napa’s self-reported actions.

**Table B.28—Napa’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Napa	Actions Taken by Napa to Address the External Quality Review Recommendations
<p>1. Identify and implement acceptable standard percentages for clinical and psychiatric no-show rates for the entire SOC.</p>	<p>The MHP has not yet established standardized benchmarks for clinical and psychiatric no-show rates. However, the MHP is actively addressing no-show rates, which currently range from 32 percent to 36 percent across adult MH Access and adult and children’s medication clinics.</p> <p>To reduce these rates, several interventions have been implemented. Text message reminders began April 1, 2025, for initial MH access appointments. Medication clinic clients who cancel the same day are now placed on a standby list for a phone visit during designated times, allowing for timely and billable contact. No-show clients who later call for medication refills are also added to the standby list. Clients with repeated medication clinic no-shows are referred back to access for outreach, barrier assessment, and care plan review before resuming psychiatric appointments. This process ensures continuity of care, appropriate resource allocation, and support for reengagement. An Appointment Agreement Form introduced July 1, 2025, in the medication clinics outlines expectations.</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Napa</b>	<b>Actions Taken by Napa to Address the External Quality Review Recommendations</b>
	<p>In addition, the MHP is working to resolve data integrity issues within the EHR (Credible), where the current report structure conflates no-shows with cancellations and reschedules, resulting in unreliable no-show reporting. The MHP is moving to a new EHR (SmartCare) on October 1, 2025, and anticipates better reporting capabilities to ensure accurate tracking and performance monitoring.</p>
<p>2. Monitor and conduct quarterly reviews of the four HEDIS measures related to medication utilization and access to outpatient services for foster care youth.</p>	<p>The MHP has prioritized the monitoring and review of all HEDIS measures. To support this effort, the BH Division has contracted with CalMHSA to provide data analytics for all HEDIS data. All relevant measures have been integrated into the division’s Calendar Year 2025 Quality Improvement Plan. To ensure continuous improvement, workgroups are being established to review data, identify trends, and implement targeted QI projects. The results will be reviewed regularly by the QIC with input from stakeholders.</p> <p>In addition, the division aligns these efforts with BHT goals under BHSA, including the goal of reducing child removals from the home. Regular meetings with both internal and contract providers continue to strengthen access to care for foster care youth.</p>
<p>3. Standardize documentation and performance measures for all direct service staff members, provide accountability training to supervisors, and ensure all users are aware of current resources.</p>	<p>In June 2024, the BH Division reorganized its UR and QA functions into a unified QAPI Unit. As part of this reorganization:</p> <ul style="list-style-type: none"> <li>◆ UR staffing expanded from one to two clinicians focused on clinical documentation standardization.</li> <li>◆ A standardized chart review process was created along with office hours, training during unit meetings, and a Medicare/Medi-Cal chart review documentation checklist.</li> </ul>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Napa</b></p>	<p><b>Actions Taken by Napa to Address the External Quality Review Recommendations</b></p>
	<ul style="list-style-type: none"> <li>◆ QA efforts updated the division’s Quality Improvement Plan to include HEDIS and other performance measures.</li> </ul> <p>Performance metrics are reviewed in QIC and all-staff meetings and the annual compliance training.</p> <p>The division also evaluated reporting limitations in its current EHR system (Credible). Due to the inability to generate essential supervisor reports (e.g., staff productivity, caseloads, service timeliness), the division contracted with Mission Driven Data to support reporting. A full EHR transition to SmartCare is scheduled for October 2025 to enhance system performance and reporting functionality.</p>
<p>4. Prioritize hiring additional QA, information systems, and data analytics staff members through MHP staff positions or contracted support positions.</p>	<p>The Napa County HHSA and the BH Division have prioritized staffing expansions in QA, information systems, and data analytics. Key actions include:</p> <ul style="list-style-type: none"> <li>◆ Hiring an additional Application Support Team technician to support the EHR system.</li> <li>◆ Creating a new project manager position to lead a variety of division initiatives including HEDIS tracking, data analytics, and the EHR transition.</li> <li>◆ Reorganizing its QA, UR, and analyst functions to establish the QAPI Unit with the following new and existing roles: <ul style="list-style-type: none"> <li>■ BH manager</li> <li>■ Quality coordinator</li> <li>■ UR coordinator</li> <li>■ Two UR clinicians (one new position)</li> <li>■ Senior QM specialist (new)</li> <li>■ Supervising staff services analyst (new)</li> </ul> </li> </ul>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Napa</b></p>	<p><b>Actions Taken by Napa to Address the External Quality Review Recommendations</b></p>
	<ul style="list-style-type: none"> <li>■ Five staff services analysts (two new positions)</li> <li>■ Secretary</li> </ul> <p>In total, Napa County HHS and the BH Division added seven new internal positions dedicated to these efforts. Additionally, to maintain operational continuity amid several key vacancies within the QAPI Unit, the division has contracted with an external consultant to provide interim support for UR and QA functions until vacant positions are filled.</p>
<p>5. With input from all levels of staff, implement an annual training curriculum that includes clinical evidence-based practices (EBPs), orientation materials, and current initiatives.</p>	<p>With input from staff at all levels, BH management staff have begun developing a formal annual training curriculum that aligns with EBP requirements under Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) and the BHSA.</p> <p>To support this initiative:</p> <ul style="list-style-type: none"> <li>◆ Strengths-based training has been delivered to all MH case management staff.</li> <li>◆ UR clinicians provide ongoing documentation support through regular office hours, unit-based trainings, and documentation checklists (e.g., IHBS/therapeutic behavioral services, medical necessity) tailored for direct service staff.</li> <li>◆ Staff may submit documentation-related questions via direct email or an automated form. Submissions are tracked, compiled into a regularly updated FAQ, and used to inform future training content.</li> </ul> <p>The division is also applying a similar structured approach to prepare staff for the</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Napa</b>	<b>Actions Taken by Napa to Address the External Quality Review Recommendations</b>
	<p>October 1, 2025, SmartCare EHR transition. This training is program-specific, integrates compliance into workflows, and includes in-person practice sessions and live office hours. Staff feedback during and after training is used to continuously improve content and delivery.</p> <p>These efforts are laying the groundwork for a comprehensive annual training plan that incorporates clinical EBPs, orientation materials, and current initiatives while ensuring staff have the tools, feedback loops, and ongoing support needed to apply training in practice.</p>

## Assessment of Napa’s Self-Reported Actions

HSAG reviewed Table B.28, in which Napa summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Napa adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Napa related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Napa addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Napa

Based on the overall assessment of Napa’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Napa’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned a *High Confidence* level to Napa's 2025 clinical PIP submission. Napa met all critical and evaluation element scores for this PIP submission, reflecting that the MHP built a robust foundation in the Design stage of its clinical PIP.
- ◆ During the PMV audit process, Napa demonstrated thorough oversight and monitoring of claims data and indicated that the MHP implemented multiple methods of validation and tracking to ensure the accuracy and completeness of claims data, including annual audits based on risk scores. Additionally, Napa demonstrated multiple processes used for monitoring and validation of the accuracy and completeness of member enrollment/eligibility data ingested into Credible.
- ◆ DHCS' 2025 compliance review scores for Napa show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, Napa demonstrated thorough oversight and monitoring of timely access reporting by utilizing Credible reports and validation tools, as well as holding monthly network adequacy analyst and MHP access meetings to review performance and promptly address any issues or concerns.

## Opportunities for Improvement

- ◆ HSAG's 2025 PIP validation determined that Napa did not include all required details of its PIP processes for its nonclinical PIP.
- ◆ Napa has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Napa:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100

## 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Napa includes all required information in the MHP's 2026 annual nonclinical PIP submission.
- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.

- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Napa meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100

Napa's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Napa as well as the plan's progress with addressing these recommendations.

## Nevada County Behavioral Health

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of Nevada for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.29 provides the EQR recommendations directed to Nevada from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.29 to preserve the accuracy of Nevada’s self-reported actions.

**Table B.29—Nevada’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Nevada	Actions Taken by Nevada to Address the External Quality Review Recommendations
<p>1. Review challenges with offering timely access to care for urgent conditions, and implement training and QI activities to identify and track urgent conditions accurately and provide timely access to care for members with urgent conditions.</p>	<p>Through subsequent review and training with staff, it was determined that many staff were inputting the first appointment date that the client accepted rather than the first date that was available or offered in terms of timely access. Furthermore, Nevada QA staff members have engaged clinical staff and supervisors in several trainings regarding the DHCS definition of “urgent” to ensure accurate tracking of urgent requests for service. Finally, Nevada is implementing a dedicated BH access team whose sole responsibility will be engaging new requests for services. This new team will allow for walk-in hours for assessments as well as field-based assessments, which should alleviate challenges with timely access to care, especially for urgent conditions. For example, this new access team could meet a client in crisis in the emergency department to initiate the access process. It is anticipated that the</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Nevada	Actions Taken by Nevada to Address the External Quality Review Recommendations
	new BH access team will go live around September 2025.
2. Ensure that the evaluation of QAPI goals aligns with Assessment of Timely Access survey metrics and other data sources, and verify the accuracy of metrics reported in the QAPI work plan.	Timely access data are reviewed at least monthly at Nevada QIC meetings, including FY-to-date and month-over-month comparisons. The administrative analyst who manages oversight of timely access data reaches out to individual providers regarding identified outliers that did not meet timeliness standards, significant drops in requests for service, and timely access data forms that are likely overdue, and prompts the providers for completion and/or signature.
3. Implement a LOC tool across the system to guide data-driven transitions to appropriate LOCs and overall capacity management.	Currently, we use the MORS in our FSP LOC to determine if that LOC is appropriate and to adjust services as appropriate. Additionally, we use the Medi-Cal universal screening tool for youth and adults to help guide data-driven transitions of services between the MHP and MCP. Additionally, at initial contact with a member, Nevada utilizes the Medi-Cal screening tool to determine which LOC is appropriate. We are actively exploring the utilization of the ANSA tool to support data-driven transitions of care to use with new and existing clients. We are waiting on specific guidance from DHCS on its required tools through the BH-CONNECT initiative prior to finalizing our selection and piloting a tool.
4. Implement an adult outcomes tool to track and trend progress with treatment outcomes for adults.	We are currently using the MORS in our FSP LOC to track progress and outcomes. Additionally, Nevada collects and annually reports outcomes for MHSA-funded MH programs, including crisis trends and outcomes, FSP outcomes related to psychiatric hospitalizations, criminal justice involvement, and housing. We are waiting for specific guidance from DHCS on its required

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Nevada	Actions Taken by Nevada to Address the External Quality Review Recommendations
	tools through the BH-CONNECT initiative prior to finalizing our selection and piloting a tool.
5. Review Nevada MHP’s current capacity to address case management needs and caseloads for case managers versus clinicians to determine if there are sufficient FTEs to provide case management.	Clinical supervisors review caseloads with their staff on a weekly basis to determine clinical needs of clients. Nevada has developed a Power BI dashboard to give supervisors the tools to monitor and discuss caseloads and services to clients.

## Assessment of Nevada’s Self-Reported Actions

HSAG reviewed Table B.29, in which Nevada summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Nevada adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Nevada related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Nevada addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Nevada

Based on the overall assessment of Nevada’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Nevada’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Nevada’s 2025 clinical and nonclinical PIP submissions. Nevada met all critical and evaluation element scores for both PIP submissions, reflecting that the Integrated BHP built a robust foundation in the Design stage of each PIP.

- ◆ During the PMV audit process, HSAG observed that Nevada used the MMEF uploads and the 270/271 data exchange process to update and validate member enrollment within SmartCare, which improved the overall accuracy of its member enrollment data in the EHR. Additionally, Nevada used reports within SmartCare and Power BI to adequately monitor its services, claim submissions, denials, resubmissions, and overall claim trends.
- ◆ Based on HSAG's NAV audit findings, HSAG determined that Nevada established a robust process to keep provider data up to date and accurate through its annual directory attestation requirement and credentialing process.

## Opportunities for Improvement

- ◆ Nevada has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Nevada:
  - Faced challenges during the reassessment period of April 1, 2023, through June 30, 2023, in maintaining consistent quality oversight due to prolonged vacancies in key positions responsible for the development, review, and submission of the timely access report. As a result, several errors were identified with Nevada's original TADT submission, such as missing Client Index Numbers and other required data fields.
  - Did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To increase continuity in QA functions and timeliness reporting, create desktop processes providing consistent instructions to staff on the creation, review, and submission of timely access reports.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Nevada did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Nevada's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Nevada as well as the plan's progress with addressing these recommendations.

## Orange County Behavioral Health Services

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of Orange for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.30 provides the EQR recommendations directed to Orange from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.30 to preserve the accuracy of Orange’s self-reported actions.

**Table B.30—Orange’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Orange	Actions Taken by Orange to Address the External Quality Review Recommendations
<p>1. Continue efforts to improve the overall penetration rate, especially for adult, older adult, infant, and Asian and Pacific Islander Medi-Cal members. Evaluate the current strategies to improve access for these groups and increase their penetration rates.</p>	<p>QM Services facilitated discussions with service area leadership/stakeholders to address this recommendation. The group decided to analyze lengths of stay, waitlists, staffing, and nonbillable services to better understand these areas as contributing factors to the penetration rates. The discussion also included the increase of BH Services outreach events and exploring partnerships with hospitals and social services as well as exploring prevalence rates and the opportunities within programs that specialize in the Asian and Pacific Islander population.</p>
<p>2. Continue to streamline Orange MHP access and service information, working with both the health agency and the established search engines so that those seeking information from the outside are directed straight to the latest, most comprehensive website.</p>	<p>QM Services facilitated discussions with service area leadership/stakeholders to address this recommendation. A BH Services champion for website oversight was selected to ensure that crisis resources are easily accessible and searchable by the public. The group also discussed the enhancement of virtual engagement services and the</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Orange</b>	<b>Actions Taken by Orange to Address the External Quality Review Recommendations</b>
	<p>establishment of a contract for format and layout improvements of the Orange County BHS website.</p>
<p>3. Add additional information systems staff positions within the Orange MHP for ongoing support and development within the MHP’s SOC. Orange MHP would benefit from enhanced support from Orange County HR for the successful recruitment of vacant data analytics positions that provide key support for making data-informed decisions.</p>	<p>Orange County HR and Orange County Health Care Agency (HCA) HR worked with Orange County HCA leadership to develop a new county job classification, data scientist, which was approved by the Orange County Board of Supervisors in September 2024. The BH Services Data Analytics and Evaluation Department is currently in the process of filling four of the five new data science positions and is working with Orange County and Orange County HCA HR departments to add five data science positions. These positions support both the MHP and DMC-ODS and expand the department’s capacity to process and analyze large volumes of data quickly and consistently, thus supporting BH Services’ ability to make timely and data-informed decisions.</p>
<p>4. Incorporate the applicable HEDIS measures in the medication monitoring protocol and begin tracking the remaining Pathways to Well-Being mandated HEDIS measures for foster care members.</p>	<p>QM Services facilitated discussions with service area leadership/stakeholders to address this recommendation. It was decided to ensure a clear separation of adult and children’s medication monitoring collection tasks. The group discussed exploring getting data assistance from the University of Berkeley. It was determined that the medication monitoring process would remain a separate annual practice and the HEDIS model would be addressed separately. The group decided to focus on tracking and trending concurrent anti-psychotic medication usage in children/youth and ADHD medication trends and to develop a tracking and trending plan. HEDIS measures are now integrated into the QAPI workplan. From a technical execution perspective, the Data Analytics and Evaluation Team has developed:</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Orange</b>	<b>Actions Taken by Orange to Address the External Quality Review Recommendations</b>
	<ul style="list-style-type: none"> <li>◆ A process to ingest monthly Medi-Cal eligibility data, thus allowing a reliable method to identify foster care members.</li> <li>◆ A process to ingest paid medical and pharmacy claims data.</li> <li>◆ The coding to calculate HEDIS measure rates for measurement years 2023 and 2024 according to NCQA specifications.</li> </ul> <p>The Data Analytics and Evaluation Team will also develop the coding for measurement year 2024 HEDIS measures and begin to evaluate rates separately by MHP program and by member demographics, including foster care members.</p>
<p>5. Continue efforts to enable clinical, demographic, and financial information exchange with contract providers in lieu of a shared EHR.</p>	<p>QM Services facilitated discussions with service area leadership/stakeholders to address this recommendation. The HCA recently entered into a contract with a qualified health information organization, Los Angeles Network for Enhanced Services, and is in the process of implementing the contract. Continued goals include surveying contracted providers on their interest in and capacity to participate in the qualified health information organization, direct data exchange with the MHP, and generating 837 P files from their own EHRs and sending them to HCA rather than having them manually enter encounters/charges into the HCA billing system.</p>
<p>6. Continue to develop and implement new strategies to improve children’s timeliness to first offered non-urgent appointments.</p>	<p>QM Services facilitated discussions with service area leadership/stakeholders to address this recommendation. The MHP implemented DHCS’ Youth Screening Tool for Medi-Cal MH Services and Transition of Care Tool for Medi-Cal MH Services and collaborated with MCPs on transitioning to SMHS. Since July 2023, an additional 45 FTE</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Orange	Actions Taken by Orange to Address the External Quality Review Recommendations
	case-carrying positions were added across contracted programs and county-operated outpatient programs. We then provided needed education to staff regarding how to properly utilize the scheduling tool and understand and implement access standards correctly.

## Assessment of Orange’s Self-Reported Actions

HSAG reviewed Table B.30, in which Orange summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Orange adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Orange related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Orange addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Orange

Based on the overall assessment of Orange’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Orange’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Orange’s 2025 clinical and nonclinical PIP submissions. Orange met all critical and evaluation element scores for both PIP submissions, reflecting that the Integrated BHP built a robust foundation in the Design stage of each PIP.

- ◆ During the PMV audit process, Orange identified multiple process improvement opportunities to implement for improved automation of processes and increased quality of performance measure rate calculations. Additionally, Orange implemented a thorough process to validate data completeness and accuracy of all data merges within Databricks.
- ◆ During the NAV audit process, Orange exhibited strong procedures to maintain accurate and up-to-date provider data. These included a thorough credentialing process, monthly reviews of multiple sanction and exclusion lists, and mandatory monthly verification of provider information.

## Opportunities for Improvement

- ◆ Orange has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Orange's EHR system, Oracle, was not configured to verify Medi-Cal eligibility internally, and eligibility data were obtained manually without the use of automated tools, potentially introducing opportunities for human error.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Partner with DHCS to explore alternative solutions for obtaining Medi-Cal eligibility data, such as using the MMEF.

Orange's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Orange as well as the plan's progress with addressing these recommendations.

# County of Placer, Department of Health and Human Services

## Follow-Up on Prior Year Recommendations

Table B.31 provides the EQR recommendations directed to Placer from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.31 to preserve the accuracy of Placer’s self-reported actions.

**Table B.31—Placer’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Placer	Actions Taken by Placer to Address the External Quality Review Recommendations
<p>1. Consider the needs of members living in Auburn, California, to determine if a wellness center or similar facility is needed, and initiate necessary programs for the region.</p>	<p>In FY 2023–24, Placer County explored the options for an Auburn wellness center, including potential utilization and the possibility of having a contracted vendor provide these services, as Placer County ASOC moved and no longer has access to the old wellness center location. However, the need for an Auburn wellness center was not identified during the FY 2024–25 MHA Community Planning Process. In light of CalAIM and BHSA changes, Placer County resources were redirected to other services. If the need for an Auburn wellness center is identified during future planning processes, the county will reevaluate.</p>
<p>2. Create reports that aggregate, track, and trend contractor data to accurately represent beneficiary timeliness and outcomes throughout the SOC.</p>	<p>Placer has developed a psychiatric inpatient hospitalization dashboard and quarterly report that enables the adult SOC to aggregate, track, and analyze timeliness trends among external providers. These metrics are reviewed and discussed during quarterly QIC meetings.</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Placer	Actions Taken by Placer to Address the External Quality Review Recommendations
3. Research, choose, and implement a SOC outcome tool for regular adult use.	Placer County has a workgroup focusing on outlining the continuum of care within Placer County Adult SOC. The goal is to clearly outline how each LOC is structured and the eligibility criteria for each LOC.
4. Develop a database that replicates the SmartCare system and is updated nightly to support data analytics and reporting.	Placer County will begin working with our IT Department to explore cost-effective methods for archiving SmartCare data and potentially automating nightly updates. This approach will allow continued access to raw data for analysis and reporting, without placing additional strain on the system during periods of high-volume usage.
5. Investigate high-cost member service utilization to determine if service patterns reflect the treatment needs of this population.	Placer County is currently working to integrate high utilizer data into the psychiatric inpatient hospitalization dashboard. This enhancement will display the costs associated with frequent psychiatric inpatient hospital use by high-utilization clients. The dashboard format will enable Placer County analysts to track and identify trends within this population.

## Assessment of Placer’s Self-Reported Actions

HSAG reviewed Table B.31, in which Placer summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Placer adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Placer related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Placer addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Placer

Based on the overall assessment of Placer’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Placer’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned a *High Confidence* level to Placer’s 2025 clinical PIP submission. Placer met all critical and evaluation element scores for this PIP submission, reflecting that the MHP built a robust foundation in the Design stage of its clinical PIP.
- ◆ During the PMV audit process, HSAG observed that Placer used the MMEF uploads and the 270/271 data exchange process for updating and validating member enrollment data within SmartCare, which improved the accuracy of its member enrollment data in the EHR. Additionally, Placer used the Dimension Report dashboard to adequately monitor its claim submissions, the claimed dollar amounts, and the number of claims that were pending, approved, or denied by DHCS.
- ◆ During the NAV audit process, HSAG observed that Placer’s QM, Fiscal, and IT departments conducted weekly meetings with CalMHSA to review Placer’s performance and to address identified challenges or concerns including arranging out-of-network referrals and efforts to improve access to services.

### Opportunities for Improvement

- ◆ HSAG’s 2025 PIP validation determined that Placer did not include all required details of its PIP processes for its nonclinical PIP.
- ◆ Placer has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Placer:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Provider Selection—§438.214
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230

- Practice Guidelines—§438.236
- Quality Assessment and Performance Improvement Program—§438.330
- Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that Placer did not meet one or more DHCS standards for timely access indicators due to exceeding DHCS' 5 percent data error threshold.

## 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Placer includes all required information in the MHP's 2026 annual nonclinical PIP submission.
- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Placer meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Coverage and Authorization of Services—§438.210
  - Provider Selection—§438.214
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Practice Guidelines—§438.236
  - Quality Assessment and Performance Improvement Program—§438.330
  - Enrollee Rights—§438.100
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Placer did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Placer's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Placer as well as the plan's progress with addressing these recommendations.

## Plumas County Mental Health Services

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of Plumas for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.32 provides the EQR recommendations directed to Plumas from the previous EQRO's 2023–24 SMHS EQR technical report, along with the plan's self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.32 to preserve the accuracy of Plumas' self-reported actions.

**Table B.32—Plumas' Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization's 2023–24 External Quality Review Recommendations Directed to Plumas	Actions Taken by Plumas to Address the External Quality Review Recommendations
1. Complete development of a medication monitoring tool that conforms to national and State standards.	Plumas County Behavioral Health (PCBH) successfully contracted for a professional to conduct medication chart audits beginning June 2024. A monitoring tool was created, and audits were initiated.
2. Establish tracking mechanisms for foster care HEDIS measures.	PCBH is successfully tracking timeliness to access services, specifically for foster youth. Additionally, Plumas is tracking utilization of emergency services and follow-up from hospitalization, specifically for foster youth. PCBH will develop medication monitoring for foster youth.
3. Further explore the possibility of establishing peer positions, including navigator and volunteer positions, even if certification is not currently possible.	PCBH has increased utilization of non-certified peers by having them operate access points and collateral support groups. Two peers have successfully become certified during the 2024–25 program year. PCBH will request DHCS to allow claiming for peer services effective for July 2026. Peers will be utilized in the ongoing nonclinical PIP. PCBH is in process of developing peer-led system navigation groups.

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Plumas	Actions Taken by Plumas to Address the External Quality Review Recommendations
4. Ensure that the timeliness data for urgent appointments are fully captured and reported.	PCBH has included this recommendation in our quarterly 24/7 Access Line test calls and monitoring. PCBH has also included this topic in the annual staff training and adjusted forms to ensure easier tracking.

## Assessment of Plumas’ Self-Reported Actions

HSAG reviewed Table B.32, in which Plumas summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Plumas adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Plumas related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Plumas addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Plumas

Based on the overall assessment of Plumas’ delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Plumas’ activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned a *High Confidence* level to Plumas’ 2025 clinical PIP submission. Plumas met all critical and evaluation element scores for this PIP submission, reflecting that the Integrated BHP built a robust foundation in the Design stage of its clinical PIP.
- ◆ During the PMV audit process, Plumas demonstrated multiple processes used to validate the accuracy and completeness of member enrollment/eligibility data ingested and updated in Credible. Additionally, Plumas indicated that the MHP implemented multiple methods of

validation and tracking to ensure the accuracy and completeness of claims data that included monthly audits.

- ◆ During the NAV audit process, Plumas demonstrated thorough oversight and monitoring of timely access reporting by utilizing various dashboards and reports within Credible, as well as through monthly QA Team meetings to review performance and promptly address identified issues or concerns.

## Opportunities for Improvement

- ◆ HSAG's 2025 PIP validation determined that Plumas did not include all required details of its PIP processes for its nonclinical PIP.
- ◆ Plumas has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Plumas did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Plumas includes all required information in the Integrated BHP's 2026 annual nonclinical PIP submission.
- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Plumas did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Plumas' responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Plumas as well as the plan's progress with addressing these recommendations.

## Riverside County Mental Health Services

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of Riverside for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.33 provides the EQR recommendations directed to Riverside from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.33 to preserve the accuracy of Riverside’s self-reported actions.

**Table B.33—Riverside’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Riverside	Actions Taken by Riverside to Address the External Quality Review Recommendations
<p>1. Survey internal clinic and staff members to identify the priorities of new and long-term employees, and identify factors that support attraction, retention, and morale of clinical staff. Implement viable options to lower the clinical vacancy rate and improve Riverside MHP’s capacity to serve the large member pool.</p>	<p>The County’s Executive Office has conducted and provided the results of two countywide surveys aimed at staff retention and morale. The results were filtered and given to each department for more targeted follow-up actions. In addition, individual deputy directors have surveyed their respective programs to gain further insights about improvements that can be made with staff at the programmatic level.</p>
<p>2. Riverside MHP’s integrated MHP/DMC-ODS QAPI workplan would benefit from identifying a greater number of tracked objectives and goals and including trend data with each element, enabling the viewer to both access narrative conclusions and view the supporting data.</p>	<p>We have updated the way we receive input and format our QAPI workplan. This past year we focused on integrated goals that affected both our DMC-ODS and MH programs. Each goal had multiple objectives associated with it and milestones that made it easy to track our progress. In total, there were six different goals and 21 objectives. The milestones also gave us the opportunity to record narratives that helped provide context for our conclusions.</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Riverside</b></p>	<p><b>Actions Taken by Riverside to Address the External Quality Review Recommendations</b></p>
<p>3. Assess the difficulties experienced by line staff members who complete the CANS tool to identify ways to improve interrater reliability and generally improve the utility of this tool for clinical benefit.</p>	<p>Riverside staff completion of CANS assessments had challenges at initial implementation in 2018, which mostly revolved around CANS certification and getting staff trained to enter the CANS assessment results into the Objective Arts web-based system. There are not many staff challenges with completing the CANS assessment. We are currently working to meaningfully incorporate the CANS assessment into LOC decision making based on the CANS assessment score. Riverside CANS implementation has been supported by a specific evaluations staff member who trains providers in completing the CANS assessment in the Objective Arts data platform that is used for reporting and exporting data to the State. New providers and staff members receive support in the process they need to use to ensure staff members are certified. Additionally, providers also receive direct support and training in entering the CANS assessment into the Objective Arts data platform.</p>
<p>4. Establish a dedicated team to investigate and improve the data/document collection from contracted providers and to identify barriers or common struggles and potential solutions in collaboration with contracted providers.</p>	<p>Over the past year, our department has implemented measures to decrease electronic communication and increase in-person communication with our contracted providers. There has been emphasis on engaging contracted providers to attend more collaborative meetings where issues such as data and documentation collection can be addressed in real time. In addition, we are upgrading our EHR which will provide a better and more seamless data collection functionality for our end users. Finally, with the recent recruitment and hiring of a new QI administrator, the unit is in the process of reorganizing to provide more individualized technical assistance and on-site reviews rather than having contracted providers submit</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Riverside	Actions Taken by Riverside to Address the External Quality Review Recommendations
	documentation via our electronic portal prior to a review.
5. Identify and implement a standardized adult outcomes measurement tool. Develop the necessary training and reports to support clinical utility and to inform the system.	We are using an outcome tool called Individualized Care and Needs Assessment in a multitude of our outpatient adult clinics. The tool is based on the standardized ANSA assessment. We are following DHCS mandates to implement these assessments by January 1, 2026.

## Assessment of Riverside’s Self-Reported Actions

HSAG reviewed Table B.33, in which Riverside summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Riverside adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Riverside related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Riverside addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Riverside

Based on the overall assessment of Riverside’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Riverside’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Riverside's 2025 clinical and nonclinical PIP submissions. Riverside met all critical and evaluation element scores for both PIP submissions, reflecting that the Integrated BHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, HSAG observed that Riverside had multiple methods of validation and tracking to ensure the accuracy and completeness of enrollment and eligibility data used for reporting. Additionally, Riverside was prompt and thorough in its responses, which contributed to a well-organized and efficient virtual review process.
- ◆ During the NAV audit process, HSAG observed that Riverside implemented multiple strategies to maintain the accuracy of timeliness data reporting, which included the QI Team conducting a monthly review of timely access reports for MHP compliance metrics overall, by program and region.

## Opportunities for Improvement

- ◆ Riverside has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Riverside does not have defined time frames for contracted providers to report changes, such as credential updates or terminations. The absence of clear reporting expectations may lead to delays in updating provider information, which could affect network adequacy.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Establish a required time frame for providers to notify Riverside of any changes to provider information such as licensure, credentialing, and demographic updates to ensure provider information remains current and communicate this required time frame to providers so that expectations are aligned between Riverside and the providers.

Riverside's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Riverside as well as the plan's progress with addressing these recommendations.

## Sacramento County Behavioral Health Services

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of Sacramento for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.34 provides the EQR recommendations directed to Sacramento from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.34 to preserve the accuracy of Sacramento’s self-reported actions.

**Table B.34—Sacramento’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Sacramento	Actions Taken by Sacramento to Address the External Quality Review Recommendations
1. Obtain user and staff input when remodeling the current MHP website. Prominently display crisis access and 988 numbers and how to access the Mental Health Urgent Care Clinic.	While full Sacramento website redesign is still in process, the crisis information is easily accessible and prominently displayed on the welcome page.
2. Research and implement a project to gain access to a complete SmartCare database that is refreshed nightly and could be used to support Sacramento MHP’s distinct reporting needs. Assure that training meets the needs of those staff members who use the EHR for reporting.	SmartCare is aware of this request by Sacramento and other counties. In the meantime, all planners in the Data Analytics Unit have been trained to pull raw data from SmartCare and use these data to develop reports for internal decision making or to comply with State reporting requirements.
3. Identify and implement acceptable standard percentages for clinical and psychiatrist no-show rates, and accurately report these rates.	Due to the different methodology of tracking no-shows and cancelations in SmartCare, baseline percentages have not been determined. Baseline will be set by Q1 FY 2025–26 and monitored over time as one of Sacramento’s key performance indicators.

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Sacramento	Actions Taken by Sacramento to Address the External Quality Review Recommendations
4. Provide reporting on all first offered non-urgent psychiatry appointments to monitor wait times.	This is now tracked using the TADT in SmartCare.
5. Examine the 24-hour Access Line staffing and responsiveness.	With the integration of the MHP and DMC-ODS access lines, there has been an increase in responsiveness.

## Assessment of Sacramento’s Self-Reported Actions

HSAG reviewed Table B.34, in which Sacramento summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Sacramento adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Sacramento related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Sacramento addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Sacramento

Based on the overall assessment of Sacramento’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Sacramento’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Sacramento’s 2025 clinical and nonclinical PIP submissions. Sacramento met all critical and evaluation element scores for both PIP submissions, reflecting that the Integrated BHP built a robust foundation in the Design stage of each PIP.

- ◆ During the PMV audit process, HSAG observed that Sacramento used multiple reports and validation methods to ensure the ongoing accuracy of its active member demographic and enrollment data within SmartCare; ensure the accuracy of its service data; and monitor its claim submissions, denials, and resubmissions to DHCS.
- ◆ DHCS' 2025 compliance review scores for Sacramento show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, HSAG observed that Sacramento's Data Analytics Team and contract monitors conducted quarterly meetings with providers to address issues affecting timely access reporting, including discussions focused on enhancing scheduling processes, evaluating staffing levels, and implementing performance improvement initiatives.

## Opportunities for Improvement

- ◆ Sacramento has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Sacramento:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Quality Assessment and Performance Improvement Program—§438.330
  - Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that Sacramento currently does not use the MMEF to populate member eligibility data in SmartCare and has disabled the 270/271 functionality due to delays in receiving timely eligibility information.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Sacramento meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Quality Assessment and Performance Improvement Program—§438.330
  - Enrollee Rights—§438.100
- ◆ Collaborate with DHCS to explore potential solutions for addressing eligibility data challenges and streamlining the process, subsequently allowing Sacramento the ability to utilize the automated functions in SmartCare.

Sacramento's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Sacramento as well as the plan's progress with addressing these recommendations.

# San Benito County Behavioral Health

## Follow-Up on Prior Year Recommendations

Table B.35 provides the EQR recommendations directed to San Benito from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.35 to preserve the accuracy of San Benito’s self-reported actions.

**Table B.35—San Benito’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Benito	Actions Taken by San Benito to Address the External Quality Review Recommendations
<p>1. Examine the reasons for low retention in services. Based on this analysis, implement strategies to improve engagement in the appropriate LOC.</p>	<p>San Benito increased collaboration and coordination with the county MCP and other local providers. The county also engaged in efforts to reduce barriers to care, including helping members with transportation services, increasing staffing including telehealth providers, increasing available intake times for screenings and assessments, and continuing focus on consumer experience.</p>
<p>2. Work to improve staff retention. Finalize the line staff satisfaction survey and report outcomes to staff. Work with HR to identify how to incorporate peers into the SOC to assist in reducing staff burnout.</p>	<p>The county was not able to secure approval for a line staff satisfaction survey and instead engaged in direct efforts to improve staff morale. Staff engagement and morale continues to be a priority, and the county continues to look into ways this can be achieved through internal changes as well as vendor-provided activities/tools/trainings.</p> <p>The county overhauled its Staff Activity Committee and created The Wellness Warriors to plan and host monthly staff activities and provide treats and events through internal fundraising and use of allowable department funds. This committee is staffed by non-management employees and meets regularly.</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Benito</b></p>	<p><b>Actions Taken by San Benito to Address the External Quality Review Recommendations</b></p>
	<p>The county also increased staffing and reorganized teams to better meet service demand by SOC. The county also contracted with a telehealth provider to fill gaps in staffing where they exist.</p> <p>Incorporation of CPSSs is ongoing, and the county is participating in the CalMHSA-led peer certification project.</p>
<p>3. Include new initiatives, outcomes, and goals, and engage members to report the impact of service delivery on members when compliance percentage goals are achieved within the QAPI plan. Engage members holding a Quality Leadership Committee (QLC) and/or QIC meeting at the Esperanza Center at least once per quarter.</p>	<p>The county continues to host QLC and QIC meetings regularly. Due to construction and renovation activities, the county has not yet hosted a meeting at Esperanza Center but has plans to do so when renovations are complete.</p> <p>Clients and community members are consistently outreached to and invited to attend all community-facing events. The county has seen some success in improving community engagement through the Equity, Diversity, and Inclusion Committee and Community Education and Input meetings.</p>
<p>4. Identify separated and aggregated data within the assessment of timely access age groups, train staff on input expectations, and investigate the impact on member care and clinical no-show rates.</p>	<p>Due to reporting limitations in the county’s current EHR system, extracting data with age group details has been challenging. Progress has been made, and report development efforts continue.</p> <p>The county has seen variability in rates but no long-term significant change to no-show rates. There has been a decrease in agency-canceled appointments through changes to the access workflow and staffing. Efforts to improve attendance and member experience are ongoing.</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Benito	Actions Taken by San Benito to Address the External Quality Review Recommendations
<p>5. Improve interoperability functionality by expanding the EHR for contract provider use.</p>	<p>The county has provided controlled access to the EHR system to a subset of contracted providers for Medi-Cal claiming purposes. Discussions are ongoing about mutually agreeable expansions to shared use of the county EHR for State reporting and client outcome purposes.</p> <p>A smaller subset of contracted providers or providers with a MOU to provide specified specialty services to shared clients are also using the EHR for caseload management and continuity of care.</p> <p>The county is also participating in the CalMHSA interoperability (Connex) project to share client and provider data with other participating counties.</p>

## Assessment of San Benito’s Self-Reported Actions

HSAG reviewed Table B.35, in which San Benito summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that San Benito adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to San Benito related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which San Benito addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for San Benito

Based on the overall assessment of San Benito’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths,

opportunities for improvement, and recommendations for the plan. Note that all of San Benito's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to San Benito's 2025 clinical and nonclinical PIP submissions. San Benito met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, San Benito provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, San Benito showed willingness to collaborate with HSAG during the audit period and showed great commitment to expanding its current processes, specifically regarding monitoring and oversight of its vendors and improving internal validation and auditing processes.
- ◆ During the NAV audit process, San Benito demonstrated the ability to maintain an adequate provider network, supported by a thorough credentialing process and effective provider data management practices.

## Opportunities for Improvement

- ◆ San Benito has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.

San Benito's responses to the EQR recommendation should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of San Benito as well as the plan's progress with addressing this recommendation.

# San Bernardino County Department of Behavioral Health

## Follow-Up on Prior Year Recommendations

Table B.36 provides the EQR recommendations directed to San Bernardino from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.36 to preserve the accuracy of San Bernardino’s self-reported actions.

**Table B.36—San Bernardino’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Bernardino	Actions Taken by San Bernardino to Address the External Quality Review Recommendations
<p>1. Explore the reasons for the lower Hispanic/Latino penetration rates, and initiate a process that works toward increased access for this population.</p>	<p>Lower penetration rates for the Hispanic/Latino community are influenced by factors such as language barriers, cultural stigma around BH, limited awareness of available services, and geographic access challenges in rural regions such as the desert and mountain areas throughout San Bernardino County. To address these issues, the MHP continues to enhance culturally attuned outreach through robust department initiatives. One example includes the CHW/Promotores de Salud program which in FY 2023–24 included 318 Spanish-speaking bilingual staff focused on expanding bilingual and bicultural provider capacity, strengthening awareness and community networks through the department lead Latino Awareness Subcommittee, and maintaining Narcan training and outreach efforts in collaboration with the Mexican Consulate. With the passing of the BHSA, the department continues to prioritize the development of new collaborations along with initiatives to increase access to services, especially for those who may be underserved.</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Bernardino</b></p>	<p><b>Actions Taken by San Bernardino to Address the External Quality Review Recommendations</b></p>
	<p>Current preventive efforts that are focused on the Latino population are primarily funded by the MHSA Prevention and Early Intervention component. Similarly, the department is looking to the California Department of Public Health and its population-based prevention efforts funded under BHSA to supplement local non-BHSA funded culturally specific prevention strategies. Additionally, the department is actively collaborating with MCPs and local health jurisdictions to increase awareness of available BH prevention services for both Medi-Cal and non-Medi-Cal beneficiaries.</p> <p>Equitable service access remains a top priority for the MHP. As such, the department’s published 2025 Quality Improvement Performance Plan (QIPP), as supported by its respective subcommittees, maintains a focus on achievement of this through an established QIPP goal which states, “Maintain and analyze the penetration rates for the underserved racial/ethnic and cultural populations twice a year” (Section 4).</p>
<p>2. Research the reasons for the lower percentage of MH and TCM services, and create a process that monitors quality of care while working to increase these services.</p>	<p>Prior to the implementation of CalAIM, San Bernardino County was not contracted with the State to provide these services, previously established as a carve out. Since implementation of CalAIM, the MHP has been tasked with creating and conducting provider training on the proper service provision, documentation, and respective coding for TCM service delivery. The early stages of this initiative were further impacted by the effects of the pandemic and workforce challenges experienced. However, the MHP has committed to furthering these efforts through continued training and accessibility of technical assistance for providers, as well as establishing monitoring of this service</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Bernardino</b></p>	<p><b>Actions Taken by San Bernardino to Address the External Quality Review Recommendations</b></p>
	<p>provision using data spreadsheets produced by the department’s Research and Evaluation (R&amp;E) Unit, as well as the creation of PowerBI dashboards which allow for close monitoring of real-time productivity. As a result of these efforts, FY 2024–25 data when compared to FY 2023–24 show both an increase in the total number of unique clients who received TCM services, as well as an overall increase in the number of services provided. This supports the MHP’s ability to adequately build a process to increase TCM services.</p>
<p>3. Explore methods to improve the timeliness to first offered appointment and first service delivered for non-urgent services.</p>	<p>The first section of the department’s published 2025 QIPP emphasizes the monitoring of and continued improvement to timely access (Section 1). The respective QM Action Committee, which meets monthly, continues to drive this initiative through five bold objectives, including, but not limited to, conducting QI activities related to timeliness, enhancing reporting processes for timeliness statistics, and performing reviews to assess the MHP’s effectiveness in meeting these mandates.</p> <p>As a result of these continued QI efforts, the department has been providing ongoing training and technical assistance to providers on the requirements of timely access procedures as well as data reporting, including DHCS published timeliness standards. Additionally, the department’s QM and R&amp;E units are currently on the calendar to provide timely access training to all providers at the upcoming quarterly QM Forum scheduled for August 14, 2025, as these efforts are ongoing. Finally, to help strengthen the MHP’s collection of timely access data, the department is in the final stages of building and finalizing a timely access form accessible for submission via the MHP’s EHRs which will be made mandatory</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Bernardino</b></p>	<p><b>Actions Taken by San Bernardino to Address the External Quality Review Recommendations</b></p>
	<p>for all providers. The data which will be collected align with DHCS regulations and will result in more robust data collection and reporting outcomes to help inform a more focused action plan to address timely access. Thereafter, on a monthly basis, the department’s R&amp;E Unit will release monthly reports with noted action items to program contract monitors and managerial staff for immediate attention and response. Through the creation of dashboards within the EHR, real-time monitoring will occur.</p>
<p>4. To enable 24/7 access to member health information and increase reporting and analytic completeness, examine ways to facilitate and encourage contract providers to utilize Avatar for clinical documentation.</p>	<p>At this time, the MHP is focused on leveraging interoperability solutions that allow CBOs to submit clinical documentation for import into the department’s established EHR, termed myAvatar. This approach supports data integration while respecting provider operations, contractual autonomy, and the need for uninterrupted service delivery. Many contracted providers serve multiple counties and funding sources, and therefore utilize EHR systems tailored to their specific organizational needs. Requiring myAvatar use could introduce significant operational challenges for agencies, including the need for training across multiple platforms and adapting established workflows. As such, the MHP continues to assess best practices and strategize further initiatives.</p> <p>As the MHP recognizes the importance of centralized data, it continues to strive toward expanded integration capabilities. For example, currently, the Objective Arts interface allows CANS and ANSA completed by contract providers to be imported into myAvatar, which improves overall access to key clinical data. The MHP is actively exploring additional integration options (e.g., API and Health Level</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Bernardino</b></p>	<p><b>Actions Taken by San Bernardino to Address the External Quality Review Recommendations</b></p>
	<p>7 [HL7] interfaces) to further enhance secure, efficient data sharing between provider EHRs and myAvatar. Additionally, the Department’s 2025 QIPP places an emphasis on “Improving Health Information Exchange” through Interoperability (Section 12).</p>
<p>5. Explore ways to ensure liaison services, care coordination, and discharge planning are provided to support hospitalized individuals, including during weekends and after regular business hours.</p>	<p>The first section of the department’s published 2025 QIPP emphasizes the monitoring and continued improvement to timely access, including for those recently discharged from psychiatric hospitals (Section 1). One such initiative which supports these efforts is the MHP’s success in entering into contract with the MCPs. The department currently has an established contract with Inland Empire Health Plan as well as Molina Healthcare of California, Inc., with the most recent MOUs last updated as of April 2025. The MHP is also in the process of finalizing respective MOUs with Kaiser Foundation Health Plan, Inc. as well as Senior Care Action Network Health Plan, which are on schedule to be executed within the current FY. These contracts support data sharing and coordinated care efforts, and strengthen the ability to create a seamless transition of care within the MHP network. Additionally, the MHP as a whole allows members access to support during nontraditional business hours via the Access Line, SUD Helpline, and Community Crisis Response Teams (CCRTs) 24 hours a day. Additionally, CCRT staff perform routine follow-up on any individual hospitalized through engagement with the program.</p>

## Assessment of San Bernardino's Self-Reported Actions

HSAG reviewed Table B.36, in which San Bernardino summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that San Bernardino adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to San Bernardino related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which San Bernardino addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for San Bernardino

Based on the overall assessment of San Bernardino's delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of San Bernardino's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to San Bernardino's 2025 clinical and nonclinical PIP submissions. San Bernardino met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, HSAG observed that San Bernardino used multiple methods and/or websites, such as the MEDSLITE portal, the Medi-Cal provider portal, the 270/271 data exchange process, and the MMEF uploads to ensure the accuracy and completeness of its member data each month. Additionally, San Bernardino generated numerous reports monthly to identify and subsequently correct service errors for alignment with DHCS billing standards prior to claim submissions.
- ◆ During the NAV audit process, San Bernardino demonstrated effective oversight of network adequacy reporting through regular timeliness review meetings and multi-level validation of key indicators, such as appointment timeliness tracking, provider data, and service requests through myAvatar.

## Opportunities for Improvement

- ◆ San Bernardino has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.

San Bernardino's responses to the EQR recommendation should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of San Bernardino as well as the plan's progress with addressing this recommendation.

# San Diego County Behavioral Health Division

## Follow-Up on Prior Year Recommendations

Table B.37 provides the EQR recommendations directed to San Diego from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.37 to preserve the accuracy of San Diego’s self-reported actions.

**Table B.37—San Diego’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Diego	Actions Taken by San Diego to Address the External Quality Review Recommendations
<p>1. Evaluate barriers to timely access to first appointments and first psychiatry appointments. Develop and implement strategies to reduce wait lists for direct outpatient children and adult services. Measure the effectiveness of changes. Include input from clinical providers to understand barriers and design interventions. Consider using Plan-Do-Study-Act (PDSA) cycles as indicated.</p>	<p>San Diego County Behavioral Health Services (SDCBHS) convened a workgroup composed of subject matter experts in both adult and child/youth services to evaluate access times and explore potential QI interventions. Access time data were analyzed and programs with extended access times were identified and categorized by service population (adult or child/youth).</p> <p>Contracting officer representatives (CORs) assigned to the identified programs were invited to participate in targeted workgroup sessions focused on addressing access time challenges and identifying QI opportunities. SDCBHS introduced the PDSA model to the CORs, who agreed to collaborate with their respective programs to address access time concerns.</p> <p>SDCBHS and the CORs have continued to meet monthly to monitor progress, review updated access time data, and support the implementation of new PDSA cycles. In addition, SDCBHS was invited to present</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Diego</b></p>	<p><b>Actions Taken by San Diego to Address the External Quality Review Recommendations</b></p>
	<p>access time data and facilitate discussions with providers at both the MH Contractors Association meeting and the Adult MH Outpatient Program Managers meeting. Feedback gathered from these sessions was compiled and shared with leadership. The workgroups remain active and are ongoing, with a continued focus on improving access times across programs.</p>
<p>2. Evaluate barriers to timely transition to a lower LOC. Develop a universal LOC process to address the wait times to these transitions.</p>	<p>A cross-functional workgroup was established which included subject matter experts, deputy directors, and representatives from various LOCs across the MH system. The purpose of the group was to assess current transition processes, identify systemic barriers, and explore solutions for improving client flow and reducing wait times between LOCs. As part of this effort, the workgroup conducted a root cause analysis that revealed several key challenges contributing to delays. These included prolonged wait times for step-down services, program-specific capacity constraints, inconsistent or inefficient communication across LOCs, and gaps in standardized transition workflows.</p> <p>The single point of access process was selected as a focal mechanism to examine how clients move through services and to identify potential inefficiencies or delays.</p> <p>To inform this work, a comprehensive data project was launched in partnership with University of California San Diego (UCSD) to better understand capacity dynamics and service utilization trends across the system. The analysis examined utilization patterns based on client ZIP Codes, along with demographic data such as race, gender,</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Diego</b></p>	<p><b>Actions Taken by San Diego to Address the External Quality Review Recommendations</b></p>
	<p>housing status, and employment status. In addition, geo-mapping was used to visualize geographic disparities and highlight potentially underserved areas. As part of the evaluation, data were cross-validated across multiple sources, including the single point of access reports and internal SDCBHS Access to Services Journal entries.</p>
<p>3. Increase collaboration with contract providers. Increase MHP knowledge of contract provider challenges in current service delivery, workforce, contracts, and sustainability strategies. Use input from contract providers to address current challenges.</p>	<p>To increase SDCBHS’ collaboration with contract providers; increase SDCBHS’ knowledge of contract providers in service delivery, workforce, and contracts; and improve the use of input from contract providers to address current challenges, SDCBHS and researchers from UCSD collaborated to develop a listening session and survey to gather input from MH staff working in SDCBHS contract provider agencies. The survey was distributed to over 500 staff. The full report with feedback can be found on the SDCBHS website.</p> <p>SDCBHS also engaged with CalMHSA to review operations/requirements to streamline them in alignment with CalAIM. SDCBHS established a formal participation agreement with CalMHSA to enhance contractor oversight and strengthen collaboration with contracted providers. Overall, this effort is intended as a strategic shift from transactional oversight toward a more collaborative, insight-driven provider engagement model, in alignment with the goals of CalAIM and DHCS’ expectations for continuous QI.</p> <p>The SDCBHS Finance Unit hosted monthly/quarterly financial workgroups with providers to address fiscal/budgetary matters. These workgroups were designed to create a</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Diego</b></p>	<p><b>Actions Taken by San Diego to Address the External Quality Review Recommendations</b></p>
	<p>transparent and collaborative environment where financial policies, reimbursement methodologies, billing practices, and budget impacts can be openly discussed.</p> <p>Through the implementation of SmartCare, SDCBHS has strengthened communication efforts with providers and provided an ongoing SmartCare user group series to improve communication.</p>
<p>4. Reach out to leverage the experience of other counties implementing the SmartCare EHR in collaboration with CalMHSA.</p>	<p>SDCBHS collaborated with Kern, Sonoma, and Sacramento counties to leverage their experience in the implementation of the SmartCare EHR, in partnership with CalMHSA. By utilizing the experiences of these counties, SDCBHS merged the MH and substance use care systems SmartCare implementation process and subsequently established the SmartCare Advisory Group during the implementation phase. This group was composed of MH and substance use providers, as well as other stakeholders and decision makers. Its main goal was to collect clinical feedback to guide the design of SmartCare. SDCBHS continues to connect with other counties through regular calls with CalMHSA and participates in annual conferences with other counties in collaboration with CalMHSA. SDCBHS also organizes additional meetings with other counties as necessary.</p>
<p>5. Create and implement an information flow to allow employees to be aware of peer support employees and their duties as well as ensure that the peer support employees are educated on their role and the requirements for promotion.</p>	<p>SDCBHS’ Population Health Team, the Communications and Engagement Team, and the Quality Review Council discussed the importance of peer support and strategies to enhance communication. SDCBHS contracts with the National Alliance on Mental Illness (NAMI) to conduct training for peer employment and certification and</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Diego	Actions Taken by San Diego to Address the External Quality Review Recommendations
	<p>understanding their roles. SDCBHS also engaged with the Peer Council to coordinate with NAMI regarding planned activities to share information and for special events. For example, NAMI prepared an official statement and a flyer in support of Global Peer Support Day, which was featured on its website and discussed during upcoming Peer Council meetings. Ongoing, SDCBHS compiled newsletters highlighting peer support training opportunities and other relevant peer support resources.</p>

## Assessment of San Diego’s Self-Reported Actions

HSAG reviewed Table B.37, in which San Diego summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that San Diego adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to San Diego related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which San Diego addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for San Diego

Based on the overall assessment of San Diego’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of San Diego’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to San Diego's 2025 clinical and nonclinical PIP submissions. San Diego met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, San Diego provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, San Diego had strong validation procedures in place for claims data to ensure accuracy and completeness. This included multiple checks and validations performed on every batched run of claims.
- ◆ DHCS' 2025 compliance review scores for San Diego show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, HSAG observed that San Diego maintained comprehensive processes and documentation for developing network adequacy reports, and the Health Plan Administration Team conducted thorough analyses to identify, anticipate, and address potential or existing deficiencies.

## Opportunities for Improvement

- ◆ San Diego has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for San Diego:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that San Diego did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure San Diego meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Enrollee Rights—§438.100

- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which San Diego did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

San Diego's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of San Diego as well as the plan's progress with addressing these recommendations.

# San Francisco Community Behavioral Health Services

## Follow-Up on Prior Year Recommendations

Table B.38 provides the EQR recommendations directed to San Francisco from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.38 to preserve the accuracy of San Francisco’s self-reported actions.

**Table B.38—San Francisco’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Francisco	Actions Taken by San Francisco to Address the External Quality Review Recommendations
<p>1. Identify immediate updates to the MHP’s public website, including prominent crisis and access to services phone numbers and addresses and an updated continuum of care flow chart; provide information in primary threshold languages.</p>	<p>San Francisco completed the website updates. See the website here: <a href="https://www.sf.gov/behavioral-health">Behavioral Health   SF.gov</a></p> <p>In May 2024, San Francisco Department of Public Health (SFDPH) moved the old website from SFDPH.org to a new platform (SF.gov), which allows for easier search. Information is provided in primary threshold languages (via native webpage translation for Spanish, Chinese, Tagalog/Filipino, and Vietnamese). Users can find the selection of languages at the very top right of each webpage. Russian member materials and Russian translations of the webpages are uploaded onto the main San Francisco BH Services landing page and are searchable.</p> <p>Access information is displayed at the beginning of the page. The description of finding care includes the number to our 24/7 access line at 888.246.3333. The user can click the “Learn more” button to find the address, map, and image to the BH Access Center to get connected to our services.</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Francisco</b>	<b>Actions Taken by San Francisco to Address the External Quality Review Recommendations</b>
	<p>Additional information and how to access services is listed as the user scrolls down the page. Examples of information include crisis support, provider directories, telehealth medication treatment, etc.</p>
<p>2. Expand on two to three outcome goals within the QAPI plan by identifying impacts on member experience that coincide with achieved compliance goals.</p>	<p>San Francisco completed this recommendation. The QAPI plan for FY 2023–24 included the following two objectives that measure improvement outcomes to access/linkage and monitor treatment progress. These outcome measures are as follows:</p> <ul style="list-style-type: none"> <li>◆ Improve access to services by scheduling an appointment for appropriate requests for service calls. <ul style="list-style-type: none"> <li>■ Study the effects on time to service before and after the capability to directly schedule appointments during a call to the BH Access Line for a request for service.</li> <li>■ Study the effects on the impacts to reduce no-shows before and after the capability to directly schedule appointments during a call to the BH Access Line for a request for service.</li> </ul> </li> <li>◆ By December 31, 2024, for individuals who have an open status for more than 365 days, increase the percentage of outpatient adult clients with a LOC reassessment within 30 days of their LOC assessment anniversary from 59 percent to 75 percent. <ul style="list-style-type: none"> <li>■ Track and monitor the percentage of reassessments completed within 30 days of the client’s annual LOC assessment anniversary.</li> </ul> </li> </ul>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Francisco</b></p>	<p><b>Actions Taken by San Francisco to Address the External Quality Review Recommendations</b></p>
<p>3. Provide presentations and training to disseminate information on MHP changes and expectations for all staffing levels throughout the SOC, documenting the distribution of knowledge within the CBOs.</p>	<p>San Francisco completed this recommendation.</p> <p>The MHP QA Team coordinates trainings to inform staff of all levels and program types, including CBOs, on the many changes throughout the system such as the transition to Epic and CalAIM changes. The information and training are posted on a local SharePoint site and at Sf.Gov, which is accessible to all staff in the MHP network. To keep track of the distributed information, the QA Team developed a material inventory Excel file. The QA Team identified 41 tip sheets that required updating by December 31, 2024. The materials help providers find relevant documentation and coding information by specialty and provider type. Additionally, the QA Team hosts monthly office hours to provide updates to all participating providers and managers, and sends emails regularly with updates to all providers. All staff can reach out via email for technical assistance.</p> <p>The MHP holds standing meetings with all providers by SOC (children, transitional age youth, and adult/older adult) to provide updates and forums for questions and discussions. Leaders from the SOC, compliance, regulatory affairs, QM, billing, and information systems are represented to receive and share updates.</p> <p>The MHP sends out a biweekly email communication to the provider network with announcements, highlights, staffing, training, and resources.</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Francisco</b></p>	<p><b>Actions Taken by San Francisco to Address the External Quality Review Recommendations</b></p>
<p>4. Create a continuum of care flow chart for all staff members throughout the SOC; provide up-to-date referral, location, and contact information, and member qualifications; and ensure members receive a warm handoff when referred for services.</p>	<p>San Francisco completed this recommendation. See the user-friendly electronic provider directory here: <a href="#">Mental Health Provider Directory</a> or at <a href="https://www.sf.gov/mental-health-and-substance-use-disorder-provider-directories">https://www.sf.gov/mental-health-and-substance-use-disorder-provider-directories</a>.</p> <p>This provider directory is posted on our public website and is accessible to all staff and members and their families or caregivers. The online provider directory can be filtered by the following categories for ease of finding the best service provider to fit the members’ needs:</p> <ul style="list-style-type: none"> <li>◆ Program name</li> <li>◆ Phone number</li> <li>◆ Address</li> <li>◆ Service age group</li> <li>◆ Languages</li> <li>◆ Type of care</li> <li>◆ Type of service</li> <li>◆ Agency name</li> <li>◆ Description of services</li> <li>◆ Agency website</li> <li>◆ Provider’s first and last name</li> <li>◆ Provider’s language capabilities</li> <li>◆ Provider’s license type</li> <li>◆ Provider’s license number</li> <li>◆ Provider’s National Provider Identifier (NPI)</li> <li>◆ Whether the provider received cultural competency training</li> </ul> <p>The information is updated within 30 days (as required) to ensure access to accurate information.</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Francisco</b></p>	<p><b>Actions Taken by San Francisco to Address the External Quality Review Recommendations</b></p>
<p>5. Provide all members, their families, or caregivers throughout the SOC a continuum of care flow chart to identify all available services and resources, which includes contact information, location, languages offered, and access qualifications.</p>	<p>San Francisco completed this recommendation. See the user-friendly provider directory here: <a href="https://www.sf.gov/mental-health-and-substance-use-disorder-provider-directories">Mental Health Provider Directory</a> or <a href="https://www.sf.gov/mental-health-and-substance-use-disorder-provider-directories">https://www.sf.gov/mental-health-and-substance-use-disorder-provider-directories</a>.</p> <p>This provider directory is posted on our public website and accessible to all staff and members and their families or caregivers. The online provider directory can be filtered by the following categories for ease of finding the best service provider to fit the members’ needs:</p> <ul style="list-style-type: none"> <li>◆ Program name</li> <li>◆ Phone number</li> <li>◆ Address</li> <li>◆ Service age group</li> <li>◆ Languages</li> <li>◆ Type of care</li> <li>◆ Type of service</li> <li>◆ Agency name</li> <li>◆ Description of services</li> <li>◆ Agency website</li> <li>◆ Provider’s first and last name</li> <li>◆ Provider’s language capabilities</li> <li>◆ Provider’s license type</li> <li>◆ Provider’s license number</li> <li>◆ Provider’s NPI</li> <li>◆ Whether the provider received cultural competency training</li> </ul> <p>The information is updated within 30 days (as required) to ensure access to accurate information.</p>

## Assessment of San Francisco's Self-Reported Actions

HSAG reviewed Table B.38, in which San Francisco summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that San Francisco adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to San Francisco related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which San Francisco addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for San Francisco

Based on the overall assessment of San Francisco's delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of San Francisco's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to San Francisco's 2025 clinical and nonclinical PIP submissions. San Francisco met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, San Francisco indicated that the MHP fully implemented a citywide 24/7 Street Crisis Response Team that allowed the MHP to expand its reach to more members needing services. Additionally, San Francisco added over 400 new residential care and treatment beds, which allowed the county to serve more members needing treatment.
- ◆ During the NAV audit process, San Francisco demonstrated appropriate provider data validation processes, ensuring any missing data were identified and promptly resolved as appropriate. Additionally, San Francisco's SOC QIC, which included members of the QM staff, conducted monthly meetings to address areas in need of improvement or correction, including network adequacy.

## Opportunities for Improvement

- ◆ San Francisco has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that San Francisco:
  - Faced data completeness challenges after transitioning to its new EHR, Epic.
  - Did not meet one or more DHCS standards for timely access indicators due to exceeding DHCS' 5 percent data error threshold.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To improve timely access reporting:
  - Collaborate with DHCS and its current EHR vendor, Epic, to obtain technical assistance and guidance aimed at improving timely access data collection methods.
  - Conduct an in-depth review of the indicators for which San Francisco did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

San Francisco's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of San Francisco as well as the plan's progress with addressing these recommendations.

## San Joaquin Behavioral Health Services

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of San Joaquin for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.39 provides the EQR recommendations directed to San Joaquin from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.39 to preserve the accuracy of San Joaquin’s self-reported actions.

**Table B.39—San Joaquin’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Joaquin	Actions Taken by San Joaquin to Address the External Quality Review Recommendations
<p>1. Continue efforts to increase Hispanic/Latino member access.</p>	<p>San Joaquin conducted a PIP to increase penetration rates and claims for Latino members. San Joaquin conducted a root cause analysis with data from focus groups, including MHSA Consortium members, Cultural Competency Committee members, parents and caregivers, and staff members from a Latino-serving CBO and a county-run program.</p> <p>Key findings were related to fear and distrust, language accessibility, stigma and misinformation, social determinants of health, and provider competency.</p> <p>As a result, in Q2 of the FY, San Joaquin launched an all-staff training on the impacts of immigration on the seriously mentally ill Latinx population.</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Joaquin</b></p>	<p><b>Actions Taken by San Joaquin to Address the External Quality Review Recommendations</b></p>
	<p>In Q3 of the FY, San Joaquin developed and implemented a clinic decorating contest called Bienvenidos to promote the messages, “You are welcome” and “You are safe,” which coincided with Dia de Los Muertos and Hispanic Heritage Month. The PIP workgroup conducted a survey to measure comfort with the waiting room following the contest.</p> <p>In Q4 of the FY, the Children &amp; Youth Services Division developed an Acculturative Stress Assessment Survey, which was modeled after the Environmental Acculturative Stress Scale, and implemented it with children who had at least one family member who spoke Spanish in the home. Findings from the survey are used to develop culturally relevant treatment goals.</p> <p>Data were reported during monthly workgroup meetings and at the conclusion of the project. The evaluator produced a longitudinal report that showed monthly and annual changes in numbers served and penetration rates among Latinos and Spanish speakers. San Joaquin also produced FY 2023–24 program-level reports comparing the percentage of clients who were Hispanic/Latino to support program improvement efforts.</p> <p>Additionally, San Joaquin contracted with a new provider, the Alliance for Community Wellness La Familia. This new program is currently in start-up and will serve 50 members, with Latino members being the target population. This clinic is located off the main campus, broadening member access to services.</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Joaquin</b></p>	<p><b>Actions Taken by San Joaquin to Address the External Quality Review Recommendations</b></p>
<p>2. Evaluate any impact on members due to staff turnover or high caseload numbers, and implement additional strategies, if needed, to ensure that members receive continuous and appropriately frequent services.</p>	<p>To address the impact of staff turnover and/or high caseload numbers, San Joaquin has implemented improvements in our referral, discharge, and step-down procedures and processes. Strategies include employing locum staff to assist with ensuring continuity of care and extending clinic hours to accommodate member needs. San Joaquin has also engaged in reorganizing treatment teams and evaluating caseloads to ensure the teams and programs are aligned with capacity needs.</p>
<p>3. Evaluate data for the first offered appointment for adults; first offered non-urgent psychiatry appointment for adults; and first delivered services for adults, children, and members in foster care. If necessary, San Joaquin MHP should take action to improve results meeting the 10- and 15-day standards.</p>	<p>San Joaquin has implemented a timeliness application to track timely access data. Staff enter data into this application so that timely access data can be collected, analyzed, and reported.</p> <p>San Joaquin has established a Timeliness Committee with an overarching goal of evaluating and monitoring timely access data and compliance with established expectations. Managers from each division are assigned to the Timeliness Committee and report back to their respective divisions regarding timely access and/or data collection issues.</p> <p>On a departmental level, managers are assigned to assess timely access on a frequent basis. If concerns are noted, changes in schedules and/or coverage are coordinated to meet timely access standards. Managers are also responsible for monitoring dashboards and adjusting staffing when needed.</p> <p>In the children and youth SOC, timeliness is a standing agenda item on the leadership meeting agendas. The leadership team members discuss any concerns related to</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Joaquin</b></p>	<p><b>Actions Taken by San Joaquin to Address the External Quality Review Recommendations</b></p>
	<p>timeliness and develop strategies to address concerns.</p> <p>Timeliness for first offered appointment for foster care is at 94 percent for foster care and 98 percent for non-foster care.</p> <p>The children and youth SOC continues to monitor and evaluate the data for the first delivered services. Strategies that were implemented/employed are:</p> <ul style="list-style-type: none"> <li>◆ Offered field-based appointments to reduce transportation barriers.</li> <li>◆ Made appointment reminder phone calls.</li> <li>◆ Currently piloting a text message reminder system.</li> </ul> <p>An identified barrier for youth in foster care is that it is not uncommon for placement changes to occur. Additionally, child welfare may not be able to inform us of these changes in time to avoid appointment disruptions.</p>
<p>4. Adopt a standardized outcome tool to measure and report aggregate outcome results for adult members.</p>	<p>Client status assessments have been implemented to monitor homelessness, emergency department utilization, medication adherence, and justice involvement. The assessments are conducted twice a year. Data are monitored by the program and client.</p>
<p>5. Investigate a potential opportunity to organize or participate in a community-wide response to fentanyl use in the county.</p>	<p>In partnership with the San Joaquin County Opioid Safety Coalition Committee, San Joaquin participated in a community-wide response to fentanyl use in the county by staffing a resource table and attending a fentanyl town hall meeting. The town hall meeting included several community-wide resources for opioid use disorder treatment, a panel of families and community members impacted by fentanyl who shared their</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Joaquin	Actions Taken by San Joaquin to Address the External Quality Review Recommendations
	<p>personal stories, public health, the district attorney, County Office of Education representatives, a public speaker, and naloxone administration training. The meeting concluded with the distribution of naloxone kits.</p> <p>San Joaquin also participated in a fentanyl awareness campaign, featuring families who lost loved ones to fentanyl overdose.</p>

## Assessment of San Joaquin’s Self-Reported Actions

HSAG reviewed Table B.39, in which San Joaquin summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that San Joaquin adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to San Joaquin related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which San Joaquin addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for San Joaquin

Based on the overall assessment of San Joaquin’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of San Joaquin’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to San Joaquin’s 2025 clinical and nonclinical PIP submissions. San Joaquin met all critical and evaluation element scores for both PIP submissions, reflecting that the Integrated BHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, San Joaquin provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, San Joaquin demonstrated commitment to addressing members’ behavioral health care needs through efforts to improve and expand delivery of services.
- ◆ DHCS’ 2025 compliance review scores for San Joaquin show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, HSAG observed that San Joaquin developed an in-house timeliness web-based application that integrated member records to support network adequacy indicator reporting and that completed updates to allow for more complete data tracking capabilities.

## Opportunities for Improvement

- ◆ San Joaquin has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for San Joaquin:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS’ 2025 compliance review scoring process related to the following CFR standards to ensure San Joaquin meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230

San Joaquin’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of San Joaquin as well as the plan’s progress with addressing these recommendations.

# San Luis Obispo County Behavioral Health Department

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of San Luis Obispo for activities conducted as an Integrated BHP entity.

## Follow-Up on Prior Year Recommendations

Table B.40 provides the EQR recommendations directed to San Luis Obispo from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.40 to preserve the accuracy of San Luis Obispo’s self-reported actions.

**Table B.40—San Luis Obispo’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Luis Obispo	Actions Taken by San Luis Obispo to Address the External Quality Review Recommendations
<p>1. Establish a formal LOC and/or an outcome measure for adult members, and plan to monitor these data aggregately. Until this measure can be established in the EHR, begin by tracking and trending the currently available CANS data.</p>	<p>We will be utilizing the LOCUS adult LOC outcome measure and are currently working on a training and implementation plan. This LOC measure is already available in our EHR.</p> <p>We are working to develop reporting of our CANS data in our EHR to be able to track trends and outcome data.</p>
<p>2. Improve the accuracy and use of timeliness analytics, inclusive of contract providers, through the implementation of SmartCare tools and/or other developed methods.</p>	<p>We have accomplished this recommendation as the result of our move into a new EHR that utilizes timely access documents and reporting for all clients accessing county and contracted BH services.</p>
<p>3. Create policies and workflows to address the first follow-up within 10 business days of the initial appointment. Begin to track performance to support both accurate timeliness data and a</p>	<p>We have created policies and workflows to ensure access to follow-up services within 10 days of initial service, and we are reporting these timeliness data to the State as part of</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Luis Obispo	Actions Taken by San Luis Obispo to Address the External Quality Review Recommendations
report of members’ timely access experiences.	our network adequacy reporting. We have met this timeliness requirement consistently.
4. Ensure two active PIPs throughout the year, one clinical and one nonclinical, with broader system involvement and clearly established, regular data collection.	We consistently have two active PIPs for our BH Department, one clinical and one nonclinical. Our current PIP projects have been approved by HSAG, and we have submitted our first PIP submission forms to HSAG.
5. Implement a policy requiring password changes at mandated intervals.	<p>County staff sign into the EHR using Security Assertion Markup Language (SAML), which is a standard protocol that allows us to use single sign-on (SSO) through our county-provided secure user profiles. SSO is considered to be the industry standard and more secure than regularly changing a unique password to access a secure platform such as the EHR.</p> <p>Contractors who also access the EHR are set up with multifactor authentication, and their passwords expire every three months requiring a reset.</p>

## Assessment of San Luis Obispo’s Self-Reported Actions

HSAG reviewed Table B.40, in which San Luis Obispo summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that San Luis Obispo adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to San Luis Obispo related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which San Luis Obispo addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for San Luis Obispo

Based on the overall assessment of San Luis Obispo's delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of San Luis Obispo's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to San Luis Obispo's 2025 clinical and nonclinical PIP submissions. San Luis Obispo met all critical and evaluation element scores for both PIP submissions, reflecting that the Integrated BHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, San Luis Obispo provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, San Luis Obispo demonstrated its commitment to addressing members' behavioral health care needs through organizational stability and efforts to improve and expand delivery of services.
- ◆ DHCS' 2025 compliance review scores for San Luis Obispo show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, HSAG observed that San Luis Obispo implemented the new Integrated BHP contract with the State to eliminate barriers for members seeking care. This included the implementation of CARE Court in December 2024, which created two new housing options through the Bridge Housing program, including one new adult residential treatment facility.

### Opportunities for Improvement

- ◆ San Luis Obispo has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for San Luis Obispo:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS’ 2025 compliance review scoring process related to the following CFR standards to ensure San Luis Obispo meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Grievance and Appeal Systems—§438.228

San Luis Obispo’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of San Luis Obispo as well as the plan’s progress with addressing these recommendations.

# San Mateo County Behavioral Health and Recovery Services

## Follow-Up on Prior Year Recommendations

Table B.41 provides the EQR recommendations directed to San Mateo from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.41 to preserve the accuracy of San Mateo’s self-reported actions.

**Table B.41—San Mateo’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Mateo	Actions Taken by San Mateo to Address the External Quality Review Recommendations
<p>1. Continue efforts to comprehensively report on all required timeliness metrics. Specifically work on the following:</p> <ul style="list-style-type: none"> <li>a. Completing reporting on first offered psychiatry appointments.</li> <li>b. Streamlining staff reporting on urgent appointments and capturing urgent appointments for children.</li> <li>c. Reviewing data to determine whether all inpatient admissions are included in local inpatient analyses.</li> </ul>	<p>For 1a and 1b: Timely access is not being met due to deficiencies in our system with regard to data collection that does not correspond with the data requirements outlined in BHIN 25-013 and lack of a data feedback process by which staff and program leadership can see in real time which appointments need to be attended in order to ensure timely access to initial and follow-up appointments. The following are actions planned by San Mateo:</p> <ul style="list-style-type: none"> <li>◆ By August 1, 2025, identify resources and staffing to support prioritization of development of timely access improvements.</li> <li>◆ Develop a clear definition and shared understanding across the system regarding what constitutes an urgent and non-urgent non-psychiatry appointment and urgent and non-urgent psychiatry appointment.</li> <li>◆ By August 15, 2025, update San Mateo County BHRS Policy 18-02 and attachments to reflect data collection</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Mateo</b>	<b>Actions Taken by San Mateo to Address the External Quality Review Recommendations</b>
	<p>requirements for urgent and non-urgent appointments outlined in BHIN 25-013.</p> <ul style="list-style-type: none"> <li>◆ By August 15, 2025, conduct an internal assessment of existing data available in Avatar NX for urgent and non-urgent appointments that can support reporting of timely access data requirements for urgent and non-urgent appointments from BHIN 25-013.</li> <li>◆ By September 15, 2025, conduct an internal review of staff workflows and staffing capacity across the San Mateo County BHRS system, including county programs and BHRS programs, to determine what additional resources or supports are needed for BHRS to meet data collection requirements for timely access for urgent and non-urgent appointments.</li> <li>◆ By October 15, 2025, update the current EHR (Avatar NX) to ensure that urgent and non-urgent appointment data collection meets requirements outlined in BHIN 25-013.</li> <li>◆ By November 15, 2025, develop a standardized workflow to be used across the system to collect timely access data and allow for immediate feedback to staff members so that they know which requests for urgent and non-urgent appointments are at risk of not meeting the standard. <ul style="list-style-type: none"> <li>■ Ensure that this workflow can be used both with the current EHR (Avatar NX) and the new EHR (Epic) that is expected to launch in winter 2026.</li> </ul> </li> <li>◆ By December 15, 2025, train all staff members on timely access requirements for urgent and non-urgent appointments</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Mateo</b>	<b>Actions Taken by San Mateo to Address the External Quality Review Recommendations</b>
	<p>and provide definitions and workflow instructions.</p> <ul style="list-style-type: none"> <li>◆ By December 31, 2025, fully implement measures to address timely access for urgent and non-urgent appointments.</li> <li>◆ Submit a TADT that includes data for urgent and non-urgent appointments according to the requirements specified in DHCS BHINs for all required reporting periods.</li> <li>◆ Beginning November 2025, engage in a planning process with Epic, San Mateo County BHRS' new EHR vendor, to ensure that Epic will collect all the necessary data elements for timely access for urgent and non-urgent appointments, including a referral cue that can be used for all request types. This will allow staff members to easily access requests for service in real time and provide direct feedback to staff members regarding the time that has elapsed since the date of initial request.</li> <li>◆ Additionally, the MHP is participating in technical assistance sessions with DHCS to further address our timeliness issues.</li> </ul> <p>For 1c: The local inpatient analysis only included admissions that were billed to the MHP, whereas the analysis should have included all admissions, including those billed directly to Medi-Cal via a third-party fiscal intermediary.</p>
<p>2. Analyze members’ experience during coordination of services with different providers, and develop strategies to eliminate any mitigating circumstances hindering seamless access to care.</p>	<p>The MHP proposes to add MHP-only questions to the Mental Health Statistics Improvement Program (MHSIP) Survey process to collect input on member experience, review grievances, and review complaints. Based on the information gathered, the MHP may also conduct a series</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Mateo</b>	<b>Actions Taken by San Mateo to Address the External Quality Review Recommendations</b>
	<p>of focus groups. The first MHSIP survey questions are scheduled for the 2026 survey period as it was too late to include these questions in the 2025 survey.</p>
<p>3. Explore the reasons for lower rates of intensive case management and IHBS utilization compared to the statewide averages and whether members who truly need these services are receiving them.</p>	<p>The MHP reviewed the calendar year 2022 EQRO data for IHBS and ICC, which predates the MHP implementation of the ICC and IHBS referral process for all eligible youth and predates the contract for the service provider, which has since expanded availability and improved utilization. Upon review, it has been determined that there is a lack of familiarity among providers about the contracted service provider and what services they offer; therefore, the MHP will have the service provider promote its services to the youth providers at staff meetings and through program announcements. In calendar year 2022, TCM (comparable to ICC) was provided in San Mateo County at a rate double the statewide average.</p>
<p>4. Investigate the factors contributing to a large percentage of members being in the Not Diagnosed category.</p>	<p>In FY 2018–19, a portion of the MHP caseload was in a non-diagnosed category, and the MHP has made attempts since then to address the issue. This became a project for the assistant director and deputy medical director, and various strategies were employed, including, for those cases which involve a prescriber, prescriber review of the assessment to assure diagnosis; and for those prescribers completing their own assessment, peer review for the presence of a diagnosis. This led to a reduction in the percentage of members being in a non-diagnosed category in calendar year 2022.</p>
<p>5. Continue efforts to bolster information systems staffing levels so that QI and other performance monitoring needs</p>	<p>As part of the implementation of the new EHR, additional staff members were hired to address the rollout needs of the project. The MHP administration has been working directly with</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to San Mateo</b></p>	<p><b>Actions Taken by San Mateo to Address the External Quality Review Recommendations</b></p>
<p>can be adequately met during the new EHR implementation.</p>	<p>Health IT, which provides project management, to assure that the implementation for the MHP is adequately scoped and budgeted. Those discussions have resulted in additional funding being budgeted for implementation. This effort has resulted in engagement of the Health Plan of San Mateo for consideration in joining the implementation project and to purchase additional financial modules necessary to achieve full reimbursement of services provided. Existing QI staff members will be burdened by implementation by being called upon to provide direction and make decisions, but the burden of the implementation will not fall on these staff members. Upon completion of the rollout, additional staff members from the implementation will remain on board to support the EHR ongoing.</p> <p>Although in place at the time of the EQRO review, the MHP established the Office of Improvement &amp; Innovation, and at that time it consisted of one manager and one part-time extra-help analyst. This has since expanded to include three full-time management analysts (two filled, one in recruitment), and one senior management analyst (filled) for a total of six staff members. This team is designed to strengthen the data analysis used across the system.</p> <p>Additionally, the MHP plans to have two positions in QM reclassified by the end of September, which includes reclassifying the QA manager to a clinical services manager II, and a MH program specialist to a supervising MH clinician. Both positions are currently vacant and cannot be recruited until the changes are completed.</p>

## Assessment of San Mateo's Self-Reported Actions

HSAG reviewed Table B.41, in which San Mateo summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that San Mateo adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to San Mateo related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which San Mateo addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for San Mateo

Based on the overall assessment of San Mateo's delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of San Mateo's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to San Mateo's 2025 clinical and nonclinical PIP submissions. San Mateo met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, San Mateo provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, San Mateo demonstrated its commitment to addressing members' behavioral health care needs through organizational efforts to improve and expand delivery of services.
- ◆ During the NAV audit process, HSAG observed that San Mateo's EHR system reported on incomplete timeliness forms and provided an alert to providers on the member's record to indicate a form was incomplete, subsequently reducing instances of incomplete timely access data.

## Opportunities for Improvement

- ◆ San Mateo has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that:
  - San Mateo's EHR system tracked manual edits to provider records; however, San Mateo did not regularly review manual edits made.
  - San Mateo did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To improve timely access reporting:
  - Consider implementing a process to review manual edits to provider records to assist in maintaining accurate provider data.
  - Conduct an in-depth review of the indicators for which San Mateo did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

San Mateo's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of San Mateo as well as the plan's progress with addressing these recommendations.

## Santa Barbara Department of Behavioral Wellness

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of Santa Barbara for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.42 provides the EQR recommendations directed to Santa Barbara from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.42 to preserve the accuracy of Santa Barbara’s self-reported actions.

**Table B.42—Santa Barbara’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Barbara	Actions Taken by Santa Barbara to Address the External Quality Review Recommendations
<p>1. Identify and implement strategies to increase services to the Hispanic/Latino population. This should include advertising newly developed services.</p>	<p>Santa Barbara used data from a completed population needs assessment and culturally competent needs assessment to identify concerns from the LatinX community regarding access to care. Santa Barbara also hired a trilingual therapist who is able to provide services in English, Spanish, and Mixteco. Santa Barbara’s R&amp;E Team has been working with the EHR vendor to update the race and ethnicity categories to align with the new “Big 7” census categories that capture Hispanic or Latino within the race/ethnicity menu, rather than capturing it as a separate ethnicity. We have long suspected that many LatinX individuals in our system are enrolled through Medi-Cal race categories as “Other,” “Unknown,” or other races, which has made it difficult to monitor the impact of our outreach efforts.</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Barbara</b>	<b>Actions Taken by Santa Barbara to Address the External Quality Review Recommendations</b>
	<p>Additional strategies used include:</p> <ul style="list-style-type: none"> <li>◆ Engaging in outreach opportunities for hard-to-reach Spanish-speaking populations through health fair participation, trainings, classes, and tabling—always with a Spanish-speaking clinician.</li> <li>◆ Using social media, which is not only translated to Spanish but uses language/images/concepts specifically intended to reach this population in a manner that makes sense.</li> <li>◆ Using Spanish language radio through public service announcements as well as radio ads.</li> <li>◆ Using a social media conversion campaign to reflect which posts result in calls directly to the Access Line for assistance (when readers push “click here to call”). This is intended to help us measure the volume of persons reading our Spanish language posts and the volume of service activity connected to these.</li> </ul>
<p>2. Examine inpatient readmission rates and implement strategies to reduce readmissions.</p>	<p>Santa Barbara’s PHF has created a new process to refer patients to assisted outpatient treatment when a patient has been readmitted within 30 days and is not open to outpatient services, did not attend the scheduled initial outpatient follow-up appointment, or otherwise did not engage with outpatient services. The PHF has had assisted outpatient treatment and CARE court staff visit clients at the PHF to begin the engagement process. Santa Barbara has also created a new hospital liaison position. This position has a goal of engaging clients post-hospital discharge and to work with hospitals to assist in obtaining clinic appointments and linkage to services. The PHF FY 2024–25 30-day and 7-day</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Barbara</b>	<b>Actions Taken by Santa Barbara to Address the External Quality Review Recommendations</b>
	<p>readmission rates are both below the statewide averages. This goal has been completed.</p>
<p>3. Work with Santa Barbara County HR and internal Santa Barbara MHP staff members to create a recruitment and retention plan to improve engagement in care.</p>	<p>Santa Barbara hired a new recruiter in November 2024. Santa Barbara leadership launched a 12-part core competency training series to support staff in their work. The trainings included:</p> <ul style="list-style-type: none"> <li>◆ The purpose, mission, and vision of behavioral wellness</li> <li>◆ Secondary traumatic stress</li> <li>◆ Screening and risk assessment</li> <li>◆ Safety planning</li> <li>◆ Mandated reporting</li> <li>◆ Clinical assessment</li> <li>◆ Care planning and the Golden Thread</li> <li>◆ Co-occurring BH disorders</li> <li>◆ Family engagement</li> <li>◆ EBPs</li> <li>◆ Whole person care</li> <li>◆ Outreach engagement</li> </ul> <p>Three live trainings were offered throughout the year, and recordings were made available through our online training portal for all behavioral wellness staff and CBOs. Santa Barbara has awarded Master of Social Work (MSW) scholarships to five behavioral wellness staff members to promote higher education and career advancement within the department. Santa Barbara is currently launching a second round of MSW scholarships. In 2024, Santa Barbara awarded 15 peer stipends to fund the PSS certification process for BHP staff.</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Barbara</b>	<b>Actions Taken by Santa Barbara to Address the External Quality Review Recommendations</b>
<p>4. Conduct an analysis of the frequency of services provided and determine if the LOC is appropriate to member needs. Increase service frequency where needed.</p>	<p>Santa Barbara has increased administering and utilizing screening for appropriate LOCs internally. Santa Barbara has been collaborating with our MCP provider, CenCal Health, to increase communication and streamline stepping a client up or down in LOC by holding weekly meetings between CenCal Health and all BWELL outpatient clinics.</p>
<p>5. Consider the strengths and weaknesses of the clinical SmartCare training plan through line staff member feedback, such as focus groups and surveys. Adapt the training plan as needed to address current user challenges and to allow for successful training of new users.</p>	<p>Santa Barbara launched a provider survey in September 2024 to gather stakeholder feedback about SmartCare. In response, Santa Barbara’s Quality Care Management Team has launched monthly office hours for staff to attend and obtain technical assistance with clinical documentation in SmartCare. The Quality Care Management Team has also collaborated with the Cardenas Consulting Group, which is contracted with DHCS to create targeted training resources for staff around the use of procedure codes and documentation within SmartCare. Additionally, Santa Barbara has expanded a monthly user group to include both the MHP and DMC-ODS providers where we review updates to SmartCare and receive and work through any provider concerns.</p>
<p>6. Produce consistent reporting on timely access to care as soon as the functionality is available.</p>	<p>Santa Barbara is now fully able to produce timely access data as the timeliness records are now fully functional in SmartCare. Santa Barbara is currently using these reports to advance our new PIP which focuses on timely access to care.</p>

## Assessment of Santa Barbara's Self-Reported Actions

HSAG reviewed Table B.42, in which Santa Barbara summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Santa Barbara adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Santa Barbara related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Santa Barbara addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Santa Barbara

Based on the overall assessment of Santa Barbara's delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Santa Barbara's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned a *High Confidence* level to Santa Barbara's 2025 clinical PIP submission. Santa Barbara met all critical and evaluation element scores for this PIP submission, reflecting that the Integrated BHP built a robust foundation in the Design stage of its clinical PIP.
- ◆ During the PMV audit process, HSAG observed that Santa Barbara used the MMEF uploads and the 270/271 data exchange process to update and validate member enrollment within SmartCare, which improved the overall accuracy of its member enrollment data in the EHR. Additionally, Santa Barbara implemented multiple methods of validation and tracking to ensure the accuracy and completeness of its provider data in SmartCare.
- ◆ During the NAV audit process, Santa Barbara demonstrated effective oversight of network adequacy reporting by successfully transitioning to the SmartCare EHR system and applying structured data validation processes. These included three rounds of data migration testing with post-upload verifications, SmartCare-integrated error reporting, and ongoing manual audits to flag discrepancies in timeliness data.

## Opportunities for Improvement

- ◆ HSAG's 2025 PIP validation determined that Santa Barbara did not include all required details of its PIP processes for its nonclinical PIP.
- ◆ Santa Barbara has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Santa Barbara did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Santa Barbara includes all required information in the Integrated BHP's 2026 annual nonclinical PIP submission.
- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Santa Barbara did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Santa Barbara's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Santa Barbara as well as the plan's progress with addressing these recommendations.

# Santa Clara County Behavioral Health Services Department

## Follow-Up on Prior Year Recommendations

Table B.43 provides the EQR recommendations directed to Santa Clara from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.43 to preserve the accuracy of Santa Clara’s self-reported actions.

**Table B.43—Santa Clara’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Clara	Actions Taken by Santa Clara to Address the External Quality Review Recommendations
<p>1. Continue to further refine the first psychiatry appointment timeliness data with DHCS’ guidance and to ensure complete, consistent reporting by the providers.</p>	<p>With the deployment of the timeliness form in the EHR system on June 4, 2024, the MHP is expecting that the reporting will improve over time. The QI Team has offered trainings and technical assistance to all providers to aid in the completion of the timeliness tool to meet reporting requirements for first offered psychiatry appointments.</p>
<p>2. Coordinate with billing and fiscal teams to research the reasons why Santa Clara’s overall denied claims rate exceeds the statewide denial rate. Develop strategies to proactively identify and remediate problematic claim lines before they are submitted to DHCS for adjudication.</p>	<p>Santa Clara BH Services Division has provided Current Procedural Terminology code training and technical assistance and developed documentation manuals for providers. The MHP is expecting to see the denial rate decrease from year to year.</p>
<p>3. Continue efforts to ensure that all recipients (e.g., providers, staff members) are aware of and understand how to apply changes communicated by the MHP related to CalAIM.</p>	<p>Improvements to the CalAIM website and dedicated staff to address questions have helped to reduce confusion. All these strategies will be improved further and adopted into the new BH-CONNECT initiative for the MHP.</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Clara	Actions Taken by Santa Clara to Address the External Quality Review Recommendations
<p>4. Continue the collaborative process with the University of Kentucky to develop and implement LOC tools for youth and adults.</p>	<p>We are nearing the completion of the youth LOC tool with the Praed Foundation (previously linked to the University of Kentucky).</p> <p>The adult programs implemented the ANSA in May 2025. In FY 2026–27, we plan to explore the structure of the LOC tool, with data and chart reviews to be worked on in FY 2027–28. That will allow for finalizing the tool.</p>
<p>5. Consider investing time and resources into producing an information systems operational continuity plan that is agency specific.</p>	<p>This recommendation continues to be on the radar for the department. Due to the county budget crisis and competing priorities, the department will look into developing a strategy to address this recommendation once the department’s budget is more stable.</p>

## Assessment of Santa Clara’s Self-Reported Actions

HSAG reviewed Table B.43, in which Santa Clara summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Santa Clara adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Santa Clara related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Santa Clara addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Santa Clara

Based on the overall assessment of Santa Clara’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Santa Clara’s activities and services affect the quality, timeliness, and accessibility of care delivered

to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Santa Clara's 2025 clinical and nonclinical PIP submissions. Santa Clara met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Santa Clara indicated that the MHP successfully completed the NCQA self-assessment, which allows counties to understand gaps in their QM and care coordination activities, assisting in the enhancement of operational performance. Additionally, Santa Clara provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes.
- ◆ DHCS' 2025 compliance review scores for Santa Clara show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, HSAG observed that Santa Clara:
  - Maintained a comprehensive provider manual detailing expectations, which included accurate and up-to-date provider data processes, timely access standards, performance standard goals, and the requirement for providers to track timeliness in myAvatar.
  - Implemented multiple tools to monitor completeness of timeliness data, including self-service tools for providers, a monitoring dashboard used by Provider Relations, and a CAP process to address deficiencies.

## Opportunities for Improvement

- ◆ Santa Clara has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Santa Clara:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that Santa Clara:
  - Reported that the completion rate for timeliness tools in myAvatar was less than 50 percent.
  - Did not meet one or more DHCS standards for timely access indicators due to exceeding DHCS' 5 percent data error threshold.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS’ 2025 compliance review scoring process related to the following CFR standards to ensure Santa Clara meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Enrollee Rights—§438.100
- ◆ To improve timely access reporting:
  - Maintain ongoing provider education and technical assistance opportunities to reinforce understanding of timeliness tracking expectations, processes, and self-service tool capabilities, and continue monitoring and compliance efforts via the monitoring dashboard and the CAP process to improve timeliness tracking completion rates.
  - Conduct an in-depth review of the indicators for which Santa Clara did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Santa Clara’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Santa Clara as well as the plan’s progress with addressing these recommendations.

# County of Santa Cruz Health Services Agency

## Follow-Up on Prior Year Recommendations

Table B.44 provides the EQR recommendations directed to Santa Cruz from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.44 to preserve the accuracy of Santa Cruz’s self-reported actions.

**Table B.44—Santa Cruz’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Cruz	Actions Taken by Santa Cruz to Address the External Quality Review Recommendations
<p>1. Investigate and improve outreach to Hispanic/Latino communities and members.</p>	<p>The following goal was in the FY 2024–25 QIWP: “The MHP will increase outreach activities to Latinx/e &amp; Hispanic, Mixteco and Triqui [indigenous languages] Medi-Cal beneficiaries to increase accessibility of services to these populations during FY 2024–25.” Each quarter, QI staff gathered and reported outreach efforts. MHP staff who are bilingual in Spanish interacted with this population at several well-attended events, such as health fairs sponsored by a large local agricultural workers agency. Additionally, we committed to MHP staff presence at monthly Spanish language community resource sessions at local CBOs. The MHP intended to track potential changes in annual penetration rates as an external measure of this topic, but DHCS has indicated it will no longer be supporting counties in providing annual penetration rate data.</p>
<p>2. Investigate and implement strategies for timelier access to first service appointments.</p>	<p>To improve timely access to first service appointments for children and youth, the MHP has implemented a comprehensive set of strategies that reflect ongoing monitoring,</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Cruz</b></p>	<p><b>Actions Taken by Santa Cruz to Address the External Quality Review Recommendations</b></p>
	<p>system coordination, and response to workforce and capacity challenges.</p> <p><b>Ongoing Monitoring and Accountability</b> Timely access to care was included as a formal goal in the FY 2024–25 QIWP. The CBH Division tracked performance on this measure quarterly. Data were reviewed regularly, and team members were held accountable for meeting timeliness goals. In FY 2024–25, CBH met timely access standards consistently for non-urgent, non-psychiatric appointments.</p> <p><b>System Coordination and Communication</b> The Children's Access Team increased communication with contracted providers, frequently connecting several times per week to assess capacity. Contractors responded by expanding their networks and adding providers. Children's leadership reviews unassigned cases at each management meeting, and access clinicians or managers initiate assessments to ensure timely engagement when necessary.</p> <p><b>Collaborative Infrastructure</b> Monthly children’s provider and partner meetings are held to review system capacity and coordinate access solutions. In early 2025, biweekly management meetings were added to enhance collaboration across BH leadership, access management, and clinical supervisors to identify and implement real-time solutions for improving access.</p> <p><b>Staffing and Workforce Strategies</b> Staffing shortages continue to impact timely access. The CBH workforce has fluctuated</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Cruz</b>	<b>Actions Taken by Santa Cruz to Address the External Quality Review Recommendations</b>
	<p>between 50 percent and 70 percent capacity due to cost-of-living challenges in Santa Cruz County, competition from neighboring counties, and a statewide shortage of licensed or waived BH professionals. To address this, BH has:</p> <ul style="list-style-type: none"> <li>◆ Increased recruitment efforts and worked with personnel to improve hiring timelines.</li> <li>◆ Partnered with CalMHSA to offer hiring bonuses for bilingual licensed staff.</li> <li>◆ Required contractors to use a standardized screening tool (now included in FY 2024–25 contracts) to streamline referrals and prioritization.</li> </ul> <p><b>Operational Improvements</b></p> <ul style="list-style-type: none"> <li>◆ The Access Team contacts families regularly with updates on appointment scheduling.</li> <li>◆ Supervisors and managers provide direct care, when possible, to increase service availability.</li> <li>◆ A streamlined CalAIM psychosocial assessment form has been implemented in the EHR.</li> <li>◆ Concurrent documentation efforts are underway to give clinicians more time with clients.</li> </ul> <p><b>Innovative Service Delivery Models</b></p> <p>To expand service options, CBH added a contract with Pacific Clinics (Santa Clara County) to improve network adequacy and provide additional access points for families.</p> <p>To improve timely access to first service appointments for adults, the MHP implemented</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Cruz</b></p>	<p><b>Actions Taken by Santa Cruz to Address the External Quality Review Recommendations</b></p>
	<p>a variety of strategies focused on staffing, workflow optimization, and leadership coordination, while continuing to investigate long-term system improvements.</p> <p><b>Staffing and Recruitment</b>                      Staffing shortages have significantly impacted the Adult Access Team’s ability to meet timeliness standards, with workforce levels fluctuating between 50 percent and 70 percent. This is due to ongoing challenges, including Santa Cruz County’s high cost of living and statewide shortages of licensed or waived BH staff. To address these issues, BH has:</p> <ul style="list-style-type: none"> <li>◆ Increased recruitment efforts and worked with county personnel to streamline hiring processes.</li> <li>◆ Partnered with CalMHSA to offer hiring bonuses for bilingual licensed staff.</li> <li>◆ Anticipated support from new staff and interns starting in fall 2025, which is expected to help restore compliance with timeliness goals.</li> </ul> <p><b>System Coordination and Oversight</b>                      As of January 2025, biweekly management meetings—including access leadership—have been implemented to collaboratively address timeliness issues across the adult system. These meetings serve as a space to monitor performance, identify barriers, and implement solutions in real time. Additionally, the Adult Access Team manager and supervisors provide direct services when their schedules allow to help meet demand.</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Cruz</b></p>	<p><b>Actions Taken by Santa Cruz to Address the External Quality Review Recommendations</b></p>
	<p><b>Operational and Workflow Improvements</b></p> <ul style="list-style-type: none"> <li>◆ The Adult Access Team has increased the number of assessment appointment options to accommodate higher demand, particularly following the implementation of the standardized screening tool and increased community stressors.</li> <li>◆ A streamlined CalAIM psychosocial assessment form has been implemented within the EHR to reduce documentation burden and expedite assessments.</li> <li>◆ Concurrent documentation practices are being developed to maximize clinician efficiency and time spent with clients.</li> <li>◆ BH leadership is exploring opportunities to shift non-billable and administrative tasks from licensed clinicians to non-licensed support staff to preserve clinical capacity for direct services.</li> </ul> <p><b>Continued Monitoring and Responsiveness</b>                      Despite efforts to increase appointment availability, adult BH is not consistently meeting timely access requirements. BH continues to closely monitor appointment data and remains committed to identifying new strategies to improve access, including real-time adjustments through biweekly management collaboration and improved use of available resources.</p>
<p>3. Investigate reasons for and determine service patterns related to high-cost members and LOC. Consider implementing a LOC tool for adults.</p>	<p>The MHP has been actively engaged in efforts to understand and address service patterns related to high-cost members and LOC needs, particularly within the adult MH system.</p> <p><b>Focus on High-Cost Beneficiaries in Residential Settings</b>                      Significant work has been done to review and monitor high-cost beneficiaries receiving care</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Cruz</b></p>	<p><b>Actions Taken by Santa Cruz to Address the External Quality Review Recommendations</b></p>
	<p>in both locked and unlocked residential settings. This includes close collaboration with residential providers to ensure appropriate documentation supporting patch payments for physical health care needs and regular case reviews to identify clients who may be appropriate for step-down to a lower LOC.</p> <p><b>Use of Functional Assessment Data (ANSA)</b>                      The MHP is using the ANSA tool to track symptom severity and functioning. ANSA data are reviewed via color- and number-coded data reports to identify patterns in client needs and inform service adjustments. These reports help teams target interventions and determine when a change in LOC or additional services may be warranted.</p> <p><b>BH Example of Stepping Down Using CANS and/or ANSA Data</b>                      In parallel, the BH system has recently launched a robust initiative led by our analysts to examine CANS and ANSA data for identifying lower-needs clients who may be candidates for step-down.</p> <p><b>Consideration of LOCUS Implementation</b>                      While we have discussed the potential implementation of the LOCUS tool for adults, it has not yet been adopted due to cost, workflow, and training considerations. The tool remains under consideration as part of longer-term planning for standardizing LOC determinations.</p> <p><b>Ongoing Monitoring and Strategy Development</b>                      Our focus to date has been primarily on high-cost members in residential care, but we</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Cruz</b></p>	<p><b>Actions Taken by Santa Cruz to Address the External Quality Review Recommendations</b></p>
	<p>recognize the need to expand this analysis to outpatient specialty MH clients who may have recurring or intensive service patterns and also do a review of data regarding inpatient psychiatric care. We are continuing to refine our data strategies and welcome further dialogue on how to deepen this work. We also have implemented a team focused on unhoused individuals to better meet the needs of clients who are unhoused and therefore more frequently utilize crisis services.</p>
<p>4. Develop and implement strategies for increased information systems and analytic support.</p>	<p>County BH added a health information manager position. County personnel reviewed and classified the position. Once the recruitment was completed, we selected and hired a new manager who started on February 15, 2025. Additionally, personnel completed a recruitment for one existing IT business analyst vacancy and one new position. Both were filled with start dates of March 10, 2025, and May 29, 2025, respectively. These staff members are currently in training.</p> <p>BH receives support from County of Santa Cruz Health Services Agency to support BH and the BH EHR, myAvatar.</p> <p>To support the BH Division, IT allocates tasks strategically—our 2.5 dedicated developers focus on specialized reporting and system enhancements, the manager and supervisor oversee priorities and coordinate workflows, and our five desktop and field support staff (four FTEs and one extra help) manage daily technical issues through the ticketing system.</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Cruz</b></p>	<p><b>Actions Taken by Santa Cruz to Address the External Quality Review Recommendations</b></p>
<p>5. Explore the needs of contract providers to ensure that they maintain the necessary service capacity. This includes timely contracting to reimburse for services provided.</p>	<p>The BH Division has taken several steps to support contracted providers in maintaining service capacity and to ensure timely contracting and reimbursement:</p> <p><b>Ongoing Communication and Monitoring</b>            BH meets regularly with contracted providers, including provider meetings and mid-year contract reviews, to evaluate capacity and performance and identify emerging needs. These meetings help surface potential barriers early and allow for timely problem-solving and support.</p> <p><b>Contractor Support Example—Encompass Electronic Data Capture Transition</b>            A recent example of targeted support is the collaborative work BH did with Encompass Community Services during its transition from electronic data capture systems. BH provided significant technical assistance and coordination to ensure service continuity and billing capacity during the transition. Adult MH continues to meet with this program to improve care coordination across the residential services it provides.</p> <p><b>Performance Monitoring Enhancements</b>            BH developed a standalone performance exhibit included in contracts that outlines key metrics for volume, outputs, and outcomes. This has enabled more structured and proactive performance monitoring. Regular performance review meetings between each contractor and contract owner were established to create more opportunity for early intervention when gaps are identified.</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Santa Cruz</b></p>	<p><b>Actions Taken by Santa Cruz to Address the External Quality Review Recommendations</b></p>
	<p><b>Contracting Process Improvements</b>                      In the past year, BH completed a contracting process improvement project. While the initiative primarily documented and clarified existing processes and staff roles, it helped ensure a shared understanding and smoother collaboration during the annual contracting cycle.</p> <p><b>Additional Improvements</b></p> <ul style="list-style-type: none"> <li>◆ Finalized boilerplate updates in advance of the FY.</li> <li>◆ Expedited contract preparation due to being almost fully staffed, which included two fairly new part-time staff members and one experienced part-time and one experienced temporary full-time contract team staff members.</li> <li>◆ Setting and meeting a goal to complete 30 percent of renewal expenditure agreements by July, significantly improving timeline adherence.</li> </ul> <p><b>Timely Payments and Board Authority</b>                      BH has long utilized the county’s Continuing Agreements List approved by the Board of Supervisors, giving the county the authority to ensure continuity of payment for services rendered in July and August, while collaboratively working on renewing these agreements. Under county policy, expenditure agreements must be renewed by October 1 to avoid delays in provider reimbursement. For FY 2024–25, the majority of contracts are on track to meet this deadline, with only a small number potentially extending beyond the deadline.</p>

## Assessment of Santa Cruz's Self-Reported Actions

HSAG reviewed Table B.44, in which Santa Cruz summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Santa Cruz adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Santa Cruz related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Santa Cruz addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Santa Cruz

Based on the overall assessment of Santa Cruz's delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Santa Cruz's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Santa Cruz's 2025 clinical and nonclinical PIP submissions. Santa Cruz met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Santa Cruz provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, Santa Cruz demonstrated commitment to addressing its members' behavioral health care needs through efforts to improve and expand delivery of services.
- ◆ DHCS' 2025 compliance review scores for Santa Cruz show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, Santa Cruz demonstrated a well-structured approach to provider data management, with internal controls that included multiple levels of credential verification, separation of duties across teams, and system restrictions to prevent billing by unlicensed providers. Automated license expiration alerts and role-based access in myAvatar further supported compliance and data integrity.

## Opportunities for Improvement

- ◆ Santa Cruz has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Santa Cruz:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that Santa Cruz did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Santa Cruz meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Enrollee Rights—§438.100
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Santa Cruz did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Santa Cruz's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Santa Cruz as well as the plan's progress with addressing these recommendations.

# Shasta County Behavioral Health

## Follow-Up on Prior Year Recommendations

Table B.45 provides the EQR recommendations directed to Shasta from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.45 to preserve the accuracy of Shasta’s self-reported actions.

**Table B.45—Shasta’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Shasta	Actions Taken by Shasta to Address the External Quality Review Recommendations
<p>1. Consider solutions that allow full contract provider access to the myAvatar EHR, including the ability to input and maintain clinical data such as progress notes and medication lists.</p>	<p>We do allow access to myAvatar, allowing providers to enter progress notes and monitor other clinical information specifically related to their organizations. Depending on the organization contract, the access may look different. The standard solution for organization provider access is to allow the organization’s access via myAvatar—ProviderConnectNX—which provides organization-specific, secured, limited access for progress notes; diagnosis/problem lists; file upload; admissions; service authorization; and service entry, for review by our administrative staff for billing purposes. Not all contracted providers are using this progress note feature as they may already have an internal EHR for their own workflow.</p>
<p>2. Investigate barriers to care for children’s services, and implement strategies to remove identified barriers.</p>	<p>Staff members have worked with parents/caregivers on transportation barriers and problem solving via child family teams, and case management and multidisciplinary teams. Due to paid parking downtown, staff have approval to use their Cal-Cards (county-issued credit cards) to pay for</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Shasta</b>	<b>Actions Taken by Shasta to Address the External Quality Review Recommendations</b>
	<p>parents’/caregivers’ parking fees if paying the fees is a hardship for the parents/caregivers.</p> <p>At this time, our MH programs are not reporting any delays in services for internal programs, referrals to contracted providers, or medication appointments. An in-person nurse practitioner was hired for children’s services, which expanded availability.</p>
<p>3. Collaborate with providers to reduce barriers, and implement interventions to improve timeliness for the first non-urgent psychiatry appointment for children and foster care youth.</p>	<p>There are continued efforts between the HHSA Technology Team, compliance analyst, program analyst, and youth program staff to accurately and consistently complete the Client Services Information assessment forms in the EHR, which feeds the data used to represent timeliness. These efforts have included monitoring and training. As noted above, an in-person nurse practitioner was hired for children’s services, which expanded availability.</p>
<p>4. Investigate the reasons for low penetration rates and develop strategies and implement solutions to improve the single service penetration rates.</p>	<p>Our Program Analyst Team gathered information and prepared an analysis, reporting an improvement from FY 2022–23 to FY 2023–24. This team continues to work with the Technology Team to identify inconsistencies and trends. Trends are then shared with leadership and stakeholders through the Compliance and QI Committee meetings to address any areas of concern.</p>
<p>5. Develop strategies and implement solutions to improve morale, bidirectional communication, and concerns related to bidirectional communication in leadership clinical policy decision making as it relates to contract providers.</p>	<p>Shasta incorporated the following strategies to help improve bidirectional communication with leadership, collaboration/communication on policy decision making, and morale:</p> <ul style="list-style-type: none"> <li>◆ Began holding weekly meetings between youth MH organization providers and county first-line supervisors/middle management. Meeting agendas include discussion on program practices, client</li> </ul>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Shasta</b></p>	<p><b>Actions Taken by Shasta to Address the External Quality Review Recommendations</b></p>
	<p>care, collaboration, and new legislation impacting SMHS. QM staff members are invited to participate as needed.</p> <ul style="list-style-type: none"> <li>◆ First-line staff/supervisors participated in the QIC, allowing for additional input in improvement initiatives by those providing direct client care.</li> <li>◆ Implemented a new meeting, Youth SOC Improvement Plan, for all staff to share concerns and suggestions with supervisors and middle management. These were collaborative meetings which allowed first-line staff to meet prior to inviting leadership into the discussion. In fall 2024, staff participation began to wane. Staff were surveyed, and most indicated that they felt the meetings were no longer needed, resulting in a standing agenda item allowing for the sharing of staff concerns to be added to another regularly scheduled youth SOC meeting.</li> <li>◆ As movement has continued throughout the agency, the HHSA director has scheduled meetings with all staff to communicate changes as needed. Individual deputy directors have incorporated meetings with middle management and occasionally attend individual team meetings to provide support with changes and open communication with direct line staff. There are also meetings taking place to allow middle management and first-line supervisors to collaborate.</li> </ul>

## Assessment of Shasta's Self-Reported Actions

HSAG reviewed Table B.45, in which Shasta summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Shasta adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Shasta related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Shasta addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Shasta

Based on the overall assessment of Shasta's delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Shasta's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned a *High Confidence* level to Shasta's 2025 nonclinical PIP submission. Shasta met all critical and evaluation element scores for this PIP submission, reflecting that the MHP built a robust foundation in the Design stage of its nonclinical PIP.
- ◆ During the PMV audit process, Shasta was transparent about the challenges it has experienced and showed great dedication to improving its current processes pertaining to validation of all data collected for claims, enrollment, and providers to align with performance measure specifications. Additionally, Shasta demonstrated commitment to addressing its members' behavioral health care needs through organizational efforts to improve and expand delivery of services.
- ◆ During the NAV audit process, HSAG observed that Shasta provided both initial service system form training and follow-up training to providers to greatly reduce errors in the service reporting process during the review period.

## Opportunities for Improvement

- ◆ HSAG's 2025 PIP validation determined that Shasta did not include all required details of its PIP processes for its clinical PIP.
- ◆ Shasta has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Shasta:
  - Had one staff member trained to submit timely access reporting to DHCS and did not have a trained backup staff member.
  - Did not meet one or more DHCS standards for timely access indicators due to exceeding DHCS' 5 percent data error threshold.

## 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Shasta includes all required information in the MHP's 2026 annual clinical PIP submission.
- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To ensure continuity in timely access reporting, explore training backup staff to be available to submit the TADT and create policies and procedures to document the TADT submission process.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Shasta did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Shasta's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Shasta as well as the plan's progress with addressing these recommendations.

# Siskiyou Behavioral Health Division

## Follow-Up on Prior Year Recommendations

Table B.46 provides the EQR recommendations directed to Siskiyou from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.46 to preserve the accuracy of Siskiyou’s self-reported actions.

**Table B.46—Siskiyou’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Siskiyou	Actions Taken by Siskiyou to Address the External Quality Review Recommendations
<p>1. Consider investing additional time and resources into coordinating with CalMHSA to accelerate the process of completing timeliness reporting from SmartCare.</p>	<p>Siskiyou County has expanded its contract with CalMHSA to include QI engagement. Internally, the Siskiyou Team implemented a new monitoring system for timeliness input which incorporates a process to have the data reviewed by a secondary administrator prior to completion of timeliness documentation in the CalMHSA/SmartCare tools.</p>
<p>2. Improve the QAPI plan by including member input when creating the updated plan.</p>	<p>The MHP uses member input from surveys in its QIWP. The QIWP is evaluated and updated annually to continually reflect responses from member surveys. Information was impacted by staff turnover, although the process continued.</p>
<p>3. Consider creating a short, internal satisfaction survey that is administered at regular intervals to systematically capture the voice of the member.</p>	<p>Internal satisfaction surveys were developed, and feedback is gathered continually. The surveys are reviewed quarterly to continually capture member voice and feedback. Survey analysis and review were impacted by staff turnover. As a result, the survey data review has now been established as a standing item in our Cultural Competency Committee meeting to reduce the likelihood of impact in the future.</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Siskiyou	Actions Taken by Siskiyou to Address the External Quality Review Recommendations
<p>4. Consider evaluating concerns regarding the high percentage of members who receive only one or two services. Develop and implement effective strategies need to promote the improvement of overall member engagement and retention.</p>	<p>The agency has incorporated peers and pre-assessment engagement in order to connect with members as quickly as possible from the time of first contact.</p> <p>Alongside these engagement interventions, the agency reviews member surveys quarterly for patterns of any discontent that may impact return to service.</p>
<p>5. Consider crafting an information system operational community plan that has an MHP-specific focus. This would better prepare Siskiyou MHP to successfully navigate through possible future events that may adversely impact critical business systems or compromise data.</p>	<p>The MHP has worked with the local emergency department to develop an MHP-focused emergency preparedness plan. The scope of the plan establishes critical programs and responses to make those critical programs available to members within 24 hours in various crisis situations. This emergency preparedness plan has provided various crisis responses for the MHP and a hierarchical structure for communication.</p>

## Assessment of Siskiyou’s Self-Reported Actions

HSAG reviewed Table B.46, in which Siskiyou summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Siskiyou adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Siskiyou related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Siskiyou addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Siskiyou

Based on the overall assessment of Siskiyou’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Siskiyou’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Siskiyou’s 2025 clinical and nonclinical PIP submissions. Siskiyou met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Siskiyou provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, Siskiyou demonstrated commitment to addressing members’ behavioral health care needs through efforts to improve and expand delivery of services to include an internal process to develop providers, foster relationships with agency partners, and incorporate additional data sources and validation efforts.
- ◆ During the NAV audit process, HSAG observed that Siskiyou worked closely with CalMHSA to integrate a report co-signer as part of the process to ensure rapid response to any timely access data gaps and enable complete and accurate timely access data capture. Use of a report co-signer was developed as a second layer of data oversight based on the QI coordinator’s review of actual rendered service dates, as Siskiyou noted that service dates were the only real-time EHR data that could be used to validate the first appointment offered date.

### Opportunities for Improvement

- ◆ Siskiyou has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Siskiyou identified implemented processes for monitoring timely access compliance based on quarterly internal review of SmartCare TADT reports; however, Siskiyou did not monitor performance within age stratifications for adult and child services.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ Consider monthly appointment availability audits for adult and child services and/or the development of a timely access performance dashboard to support ongoing gap-to-target monitoring, age group performance stratification, and trending of timely access performance.

Siskiyou’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Siskiyou as well as the plan’s progress with addressing these recommendations.

# Solano County Health & Social Services

## Follow-Up on Prior Year Recommendations

Table B.47 provides the EQR recommendations directed to Solano from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.47 to preserve the accuracy of Solano’s self-reported actions.

**Table B.47—Solano’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Solano	Actions Taken by Solano to Address the External Quality Review Recommendations
<p>1. List only the active and measurable QI efforts in a dedicated QAPI workplan. Consider creating a separate tool for ongoing quality and compliance monitoring occurring through the QIC.</p>	<p>The QIC has tracking tools for monitoring compliance.</p> <p>Solano’s QA Team has consulted with Solano BH leadership and is looking to revise the QAPI workplan to include a section that focuses solely on active/measurable QI efforts, whereas other data monitoring efforts will be focused on a different section of the workplan so that it is clear on which goals the MHP is focusing its change efforts.</p> <p>The focus of actionable goals will shift toward HEDIS measures as Solano attempts to plan for the future of QM and use the limited resources Solano has to tackle the most relevant challenges. Solano still sees value in duplicating QAPI efforts and the focus of the QIC, so significant overlap will still occur with these two initiatives.</p>
<p>2. Develop and implement strategies to offer more children and youth in foster care non-urgent psychiatry appointments within 15 business days.</p>	<p>This recommendation is related to our nonclinical timeliness PIP. Procedures and workflow were updated, the referral form was updated to include more details required for</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Solano	Actions Taken by Solano to Address the External Quality Review Recommendations
	accurate tracking, and all MHP staff and contractors were provided additional training in the referral process. The percentage of available appointments has improved.
3. Increase IT staffing to meet staffing support needs and to assure the timely completion of IT projects.	The IT Department has extended a contract for an IT specialist to support the MHP in addition to our one assigned specialist.
4. Build awareness about wellness centers, and increase the number of staff members making referrals to wellness centers.	Following the EQRO review, the MHP engaged in continued efforts to increase awareness about wellness centers through community meetings, social media, monthly newsletters, and further education of the system to increase internal referrals. Due to funding changes, wellness services were closed in June 2025. Other options for support were provided to the community including local non-county funded, community-based adult day health programs.
5. Develop a formal structure for training, supporting, effectively utilizing, and gaining feedback from peer support staff and volunteers, particularly about their experience working for the MHP beyond their direct supervisor.	The division’s Wellness and Recovery Unit is composed of a MH clinical supervisor who orients, trains, and provides monthly consultation to peer supervisors, as well as a consumer affairs liaison and MH specialist II who both provide peer coaching support to all PSSs within the MHP in addition to volunteers. The training and support they provide is inclusive of one-on-one meetings separate from their supervisors which provides an opportunity to share feedback about their experiences within their respective units.

## Assessment of Solano's Self-Reported Actions

HSAG reviewed Table B.47, in which Solano summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Solano adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Solano related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Solano addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Solano

Based on the overall assessment of Solano's delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Solano's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Solano's 2025 clinical and nonclinical PIP submissions. Solano met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Solano displayed multiple processes used to validate the accuracy and completeness of member enrollment and eligibility data ingested and updated in myAvatar. Additionally, Solano provided timely responses and follow-up documentation to all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes.
- ◆ DHCS' 2025 compliance review scores for Solano show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, HSAG observed that Solano has implemented proactive approaches to training backup personnel to ensure continuity of network adequacy timeliness reporting.

## Opportunities for Improvement

- ◆ Solano has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Solano:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
- ◆ During the NAV audit process, HSAG observed that Solano did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Solano meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Solano did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Solano's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Solano as well as the plan's progress with addressing these recommendations.

# County of Sonoma

## Follow-Up on Prior Year Recommendations

Table B.48 provides the EQR recommendations directed to Sonoma from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.48 to preserve the accuracy of Sonoma’s self-reported actions.

**Table B.48—Sonoma’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Sonoma	Actions Taken by Sonoma to Address the External Quality Review Recommendations
<p>1. Catch up on all FY 2023–24 DHCS claims, and develop workflows, procedures, and associated trainings to generate Medi-Cal claims from the SmartCare EHR.</p>	<p>The Sonoma County Fiscal Team and Revenue Management Unit have focused on strengthening claiming operations through workflow improvements, workforce expansion, and targeted training. These efforts aim to ensure timely Medi-Cal claiming and sustained compliance with regulations.</p> <p>To increase capacity and improve processing timelines, the Revenue Management Unit added extra help positions and filled vacancies within the claiming team. The team also refined internal workflows to streamline operations and address bottlenecks in the claiming process.</p> <p>The team conducted internal training and engaged in ongoing learning through participation in the County BH Directors Association of California and CalMHSA trainings and webinars. In addition, staff are scheduled to attend the SmartCare training conference in September 2025 to continue learning best practices.</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Sonoma</b>	<b>Actions Taken by Sonoma to Address the External Quality Review Recommendations</b>
	<p>As of June 2025, all Medi-Cal original claims for FY 2023–24 have been submitted for both MH and SUD programs. The MHP anticipates returning to a 60-day claiming timeline by December 31, 2025.</p>
<p>2. Create a dashboard that visualizes demand with staff capacity, and use backlog management techniques at all points of handoff.</p>	<p>Sonoma developed an analytics infrastructure and Power BI capacity to create dashboards for tracking network capacity. The dashboards display program throughput; staff caseload ratios; and performance metrics such as time to first appointment, program enrollment times, and staff productivity. These tools enable continuous monitoring of timely access, client demand, service productivity, and program capacity. The MHP continues to develop internal resources, foster a data-driven culture, and revise procedures for monitoring and continuous QI.</p> <p>The MHP continues to adjust workflows for access teams to begin providing services and case management prior to full intake assessment completion, mitigating delays to care. A UR process was implemented to monitor client assessment scores across programs and support timely transfers to the most appropriate LOC to maximize access on high acuity teams and reduce wait times.</p> <p>To support capacity and reduce service delays, the MHP evaluated and restructured hiring processes to reduce vacancy rates and added 2.0 FTE of clinical assessors and 2.5 FTE of clinical staff across adult access and program teams. This expansion aimed to increase assessment capacity and align staffing levels toward client demand.</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Sonoma</b>	<b>Actions Taken by Sonoma to Address the External Quality Review Recommendations</b>
	<p>The MHP revised the care coordination policy to streamline the care team transfer process and remove barriers within the referral process. The MHP provided division-wide training for all treatment teams on the new policy improvements.</p>
<p>3. Delegate nonclinical staff members to maintain contact with members waiting for services to maximize the time for and skills of licensed clinical staff toward therapy.</p>	<p>The MHP continues to review and restructure clinical staff duties, identifying and removing non-essential administrative processes that contributed to workload burden. In addition, the MHP will implement a direct service policy to establish clear productivity expectations for clinical staff. A direct service productivity report was introduced to monitor staff service delivery and identify inefficiencies for QI.</p> <p>The MHP developed a care coordination policy and procedures to clarify roles and responsibilities while a client transitions through the BH system. The Youth Access Team developed a workflow enabling senior client support specialists (SCSS) to engage with clients and families upon request for services, ensuring timely communication and support while clients await clinical assessment. The MHP continues to explore workflows to improve continuity of care during periods wherein the client is waiting for services or transitioning to programs.</p>
<p>4. Create a dashboard to track and analyze penetration rates and timeliness data with the new initiatives, and utilize the PDSA method as needed.</p>	<p>The MHP developed an analytics infrastructure, building dashboards with Power BI and SmartCare data, to support continuous monitoring and improvement. Dashboards were created to track timeliness of access, program throughput, staff caseloads, productivity, and enrollment timelines. These tools provide real-time visibility into system performance and inform decision making to guide improvement efforts.</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Sonoma</b>	<b>Actions Taken by Sonoma to Address the External Quality Review Recommendations</b>
	<p>The MHP uses the QIC and subcommittees to implement the PDSA methodology for improvement projects. The newly developed dashboards help to monitor trends, evaluate the impact of changes, and make timely adjustments throughout the QI process.</p>
<p>5. Investigate HR strategies that reduce burnout, and develop a bidirectional communication plan that will allow staff members to engage in planning and ensure that they stay updated.</p>	<p>The MHP implemented a multifaceted approach to reduce burnout and improve staff engagement by focusing on three key areas: 1) workforce vacancy reduction, 2) trauma-informed organizational transformation, and 3) clinical workforce development.</p> <p>The MHP implemented a QI project to reduce workforce vacancies and improve staffing levels. Through stakeholder engagement and process mapping, barriers were identified in applicant shortages, hiring delays, and onboarding inefficiencies. Interventions included establishing monthly coordination meetings with the departmental HR team, standardizing candidate interview scheduling, clarifying hiring process timelines, reducing administrative burden, and implementing process tracking. These efforts led to improved hiring timelines and a reduction in the Sonoma County BH Division vacancy rate from 19 percent to 13 percent, surpassing the FY 2024–25 workplan goal of 15 percent.</p> <p>To support a trauma-informed transformation, The plan prioritized training and organizational change strategies. Staff completed foundational trainings in trauma-informed care, harm reduction, and cultural responsiveness. Seventy-five percent of staff participated in Trauma-Informed Systems 101, and the organization conducted the Tools for a</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Sonoma	Actions Taken by Sonoma to Address the External Quality Review Recommendations
	<p>Trauma-Informed Worklife assessment to gather staff input on workplace culture. The Trauma-Informed Leadership Team, composed of 22 staff members, has met monthly to analyze assessment data, integrate staff feedback, and guide the development of a healing-centered vision and implementation plan.</p> <p>The MHP advanced clinical workforce development through multiple initiatives aimed at staff growth and retention. Monthly staff development groups were established for SCSS and clinical specialists to promote skill-building and mutual support. The SCSS graduate traineeship/practicum program was expanded, enabling SCSS staff enrolled in graduate school to complete clinical training as part of their full-time roles, increasing participation from one to two annually to six in FY 2025–26, strengthening the clinical workforce and fostering long-term career development.</p>

## Assessment of Sonoma’s Self-Reported Actions

HSAG reviewed Table B.48, in which Sonoma summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Sonoma adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Sonoma related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Sonoma addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Sonoma

Based on the overall assessment of Sonoma’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Sonoma’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned a *High Confidence* level to Sonoma’s 2025 clinical PIP submission. Sonoma met all critical and evaluation element scores for this PIP submission, reflecting that the MHP built a robust foundation in the Design stage of its clinical PIP.
- ◆ During the PMV audit process, Sonoma was prepared to discuss and review all topics in the virtual review. Additionally, Sonoma demonstrated a thorough understanding of the audit scope and great pride in the services provided to its members. Finally, Sonoma provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes.
- ◆ During the NAV audit process, HSAG observed that Sonoma’s QI staff maintained proactive monitoring of timely access data to identify outliers or trends along with strong validation procedures to ensure accuracy of timely access data submissions.

### Opportunities for Improvement

- ◆ HSAG’s 2025 PIP validation determined that Sonoma did not include all required details of its PIP processes for its nonclinical PIP.
- ◆ Sonoma has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Sonoma did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Sonoma includes all required information in the MHP’s 2026 annual nonclinical PIP submission.

- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Sonoma did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Sonoma’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Sonoma as well as the plan’s progress with addressing these recommendations.

# Stanislaus County Behavioral Health & Recovery Services

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name County of Stanislaus for activities conducted as an Integrated BHP entity.

## Follow-Up on Prior Year Recommendations

Table B.49 provides the EQR recommendations directed to Stanislaus from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.49 to preserve the accuracy of Stanislaus’ self-reported actions.

**Table B.49—Stanislaus’ Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Stanislaus	Actions Taken by Stanislaus to Address the External Quality Review Recommendations
<p>1. Research and assess concerns regarding the high percentage of members who receive only one service. Develop and implement effective strategies to improve the overall engagement and retention of members.</p>	<p>Stanislaus County BHRS IT Team has reviewed the request regarding members receiving only one service and is actively supporting this effort in collaboration with the EHR Team. As of now, there is no existing report in SmartCare that directly identifies clients with a single service episode. However, our EHR Team is currently working to develop a new report that will allow for this level of analysis.</p> <p>IT will continue to support this effort by prioritizing the development of the necessary reporting tools in SmartCare and will coordinate with program leadership and data teams once the report is ready for review and analysis.</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Stanislaus	Actions Taken by Stanislaus to Address the External Quality Review Recommendations
	<p>Once IT develops a reporting tool in SmartCare, programs will be able to analyze the data and develop a plan to address members who received only one service and were open to treatment. Meanwhile, programs will collaborate with the IT and EHR teams.</p>
<p>2. Research why Stanislaus MHP’s penetration rates for both Latino/Hispanic and African American members are less than half of the State’s rates, and develop and implement a plan to address these two populations’ needs for increased access to services.</p>	<p>The MHP identified significantly lower MH penetration rates for Latino/Hispanic and African American members compared to State averages. This disparity is concerning and requires a targeted plan to increase access and ensure equitable care.</p> <p>Research indicates several key factors contributing to these low penetration rates:</p> <ul style="list-style-type: none"> <li>◆ <b>Cultural Stigma:</b> Strong cultural norms within both Latino/Hispanic and African American communities often view MH issues with stigma, leading to reluctance to seek professional help. These communities often prioritize family support and traditional remedies.</li> <li>◆ <b>Language and Communication Barriers:</b> For Latino/Hispanic communities, a shortage of Spanish-speaking providers and culturally relevant materials hinders effective communication. For African American communities, while English is spoken, a lack of cultural understanding by providers can create communication gaps and distrust.</li> <li>◆ <b>Lack of Culturally Competent Providers:</b> There is a critical shortage of MH professionals who understand and are sensitive to the unique cultural contexts, historical experiences (e.g., systemic racism), and specific needs of these communities.</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Stanislaus</b>	<b>Actions Taken by Stanislaus to Address the External Quality Review Recommendations</b>
	<ul style="list-style-type: none"> <li>◆ Access Challenges: Economic instability, transportation issues, and limited awareness of available services create practical barriers to care. Navigating complex health care systems can be particularly daunting for these populations.</li> <li>◆ Historical Distrust: African American communities often harbor a deep-seated distrust of health care systems due to historical and ongoing experiences of discrimination and mistreatment.</li> </ul> <p>Our plan to address these disparities focuses on a multi-pronged approach:</p> <ul style="list-style-type: none"> <li>◆ Building Trust and Reducing Stigma                             <ul style="list-style-type: none"> <li>■ CHWs/Promotores Program: Expand and empower a workforce of CHWs and promotores from within Latino/Hispanic and African American communities. These trusted individuals will conduct outreach; provide MH education in culturally appropriate ways; and connect individuals to services, acting as vital bridges.</li> <li>■ Faith-Based Partnerships: Collaborate with prominent churches and faith-based organizations in both communities to host MH literacy workshops; support groups; and open dialogues in trusted, familiar settings.</li> <li>■ Culturally Tailored Campaigns: Develop and launch public awareness campaigns using culturally relevant messaging, imagery, and languages (including Spanish) to destigmatize mental illness and promote help-seeking behavior through various media channels.</li> </ul> </li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Stanislaus</b>	<b>Actions Taken by Stanislaus to Address the External Quality Review Recommendations</b>
	<ul style="list-style-type: none"> <li>◆ Enhancing Culturally Competent Care                             <ul style="list-style-type: none"> <li>■ Workforce Development: Implement mandatory, in-depth cultural competency and humility training for all MHP staff and contracted providers, focusing on the specific cultural nuances and historical contexts of Latino/Hispanic and African American communities. Develop pipeline programs (e.g., scholarships, internships) to attract and retain diverse MH professionals.</li> <li>■ Bilingual/Bicultural Recruitment: Aggressively recruit and hire Spanish-speaking and bicultural MH professionals, as well as those with demonstrated cultural understanding for African American communities.</li> <li>■ Culturally Adapted Interventions: Support and integrate evidence-based MH interventions that are culturally adapted and consider family dynamics, spiritual beliefs, and community-specific coping mechanisms (e.g., family-focused therapy, trauma-informed care).</li> </ul> </li> <li>◆ Improving Service Accessibility                             <ul style="list-style-type: none"> <li>■ Flexible Service Delivery: Offer MH services in diverse, convenient community settings beyond traditional clinics, such as schools, community centers, and mobile units. Extend hours to include evenings and weekends and expand telehealth options with digital literacy support.</li> <li>■ Streamlined Navigation: Simplify the intake and referral process, providing clear, culturally sensitive information. Implement "warm handoffs" from</li> </ul> </li> </ul>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Stanislaus</b></p>	<p><b>Actions Taken by Stanislaus to Address the External Quality Review Recommendations</b></p>
	<p>primary care and community partners to ensure smooth transitions into MH care.</p> <ul style="list-style-type: none"> <li>■ Strong CBO Partnerships: Strengthen existing and forge new partnerships with local CBOs that already serve these populations. These CBOs can serve as effective referral sources and even co-location sites for services.</li> </ul> <p>Implementation and Evaluation: This plan will be implemented in phases, starting with foundational outreach and training, then expanding services and integrating culturally specific programs. Regular data collection on penetration rates, client demographics, service utilization, and client satisfaction will be crucial. Continuous feedback from community members and ongoing evaluation will allow for agile adjustments to ensure the plan's effectiveness in achieving equitable access to MH services for all Stanislaus County residents.</p>
<p>3. Update the information systems strategic plan to ensure the strategic plan meets current technological demands.</p>	<p>To address this finding, Stanislaus County BHRS IT has initiated the process of modernizing its information systems strategic plan to reflect current and emerging technological demands. Actions taken and planned include:</p> <ul style="list-style-type: none"> <li>◆ Strategic Plan Review: Stanislaus County BHRS IT is currently reviewing the county’s 2017 IT strategic plan alongside new platforms (Connex for HIE), and technology advancements including data interoperability.</li> <li>◆ Security Risk Assessment Completed: In Q2 2025, Stanislaus County BHRS IT conducted a comprehensive security risk assessment. We are now working with compliance, privacy, and other internal</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Stanislaus</b>	<b>Actions Taken by Stanislaus to Address the External Quality Review Recommendations</b>
	<p>partners to review findings and implement next steps. Insights from this process will inform our updated information systems strategic goals, particularly around data protection and infrastructure modernization.</p> <ul style="list-style-type: none"> <li>◆ <b>AI Use Governance Established:</b> In February 2025, Stanislaus County BHRS adopted an Artificial Intelligence (AI) Use Policy outlining responsible and compliant use of generative AI technologies. This policy supports the strategic goal of fostering innovation while safeguarding protected health information, personally identifiable information, and system integrity.</li> <li>◆ <b>Planning Workgroup Formation (Planned):</b> A cross-functional Information Systems Strategic Planning Workgroup will be established to guide development of the updated plan. Participants will include leads from IT, compliance, fiscal, Office of Emergency Management, and the Senior Leadership Team.</li> <li>◆ <b>Gap Analysis and Draft Plan (Planned):</b> Following the workgroup launch, a formal gap analysis will be conducted to identify unmet technology needs and risks. A revised information systems strategic plan will be developed based on those findings and is targeted for draft completion by early 2026.</li> <li>◆ <b>Ongoing Governance:</b> Once finalized, the updated plan will be reviewed on a recurring cycle to remain responsive to evolving requirements and innovation opportunities.</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Stanislaus</b>	<b>Actions Taken by Stanislaus to Address the External Quality Review Recommendations</b>
<p>4. Coordinate and plan to begin the data exchange process through the HIE.</p>	<p>Stanislaus County BHRS is actively coordinating with CalMHSA to initiate data exchange services through CalMHSA Connex, a managed interoperability Software as a Service (SaaS) solution. This solution is designed to support counties in meeting State and federal HIE requirements, including those outlined under the California Data Exchange Framework and CMS Interoperability and Patient Access rules.</p> <p>Through Connex, the county is preparing for bidirectional data exchange using industry-standard protocols such as HL7 FHIR and Integrating the Healthcare Enterprise-based architecture.</p> <p>These efforts are intended to ensure full compliance with HIE standards and enhance data sharing capabilities. CalMHSA has already begun supporting the county in developing the necessary infrastructure and staff training needed for successful implementation.</p>
<p>5. Initiate efforts to create a defined peer support career ladder.</p>	<p>Below is the defined peer support career ladder at Stanislaus County BHRS:</p> <ul style="list-style-type: none"> <li>◆ Peer Aide—Part-Time</li> <li>◆ Clinical Service Tech I with PSS Certification</li> <li>◆ Clinical Service Tech II with PSS Certification</li> <li>◆ BH Advocate with PSS Certification</li> <li>◆ BH Specialist I with PSS Certification</li> <li>◆ BH Specialist II with PSS Certification</li> <li>◆ BH Coordinator with PSS Certification</li> </ul>

## Assessment of Stanislaus' Self-Reported Actions

HSAG reviewed Table B.49, in which Stanislaus summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Stanislaus adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Stanislaus related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Stanislaus addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Stanislaus

Based on the overall assessment of Stanislaus' delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Stanislaus' activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Stanislaus' 2025 clinical and nonclinical PIP submissions. Stanislaus met all critical and evaluation element scores for both PIP submissions, reflecting that the Integrated BHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Stanislaus provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, Stanislaus demonstrated commitment to addressing members' behavioral health care needs through efforts to improve and expand delivery of services.
- ◆ During the NAV audit process, HSAG observed that Stanislaus implemented numerous customized SmartCare reports to ensure accuracy and completeness of member and provider data, including reports to monitor and track timeliness record completion and metrics.

## Opportunities for Improvement

- ◆ Stanislaus has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Stanislaus did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Stanislaus did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Stanislaus' responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Stanislaus as well as the plan's progress with addressing these recommendations.

## Sutter-Yuba Behavioral Health Services

### Follow-Up on Prior Year Recommendations

Table B.50 provides the EQR recommendations directed to Sutter/Yuba from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.50 to preserve the accuracy of Sutter/Yuba’s self-reported actions.

**Table B.50—Sutter/Yuba’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Sutter/Yuba	Actions Taken by Sutter/Yuba to Address the External Quality Review Recommendations
<p>1. Monitor timeliness quarterly, with documented evidence of review and analysis.</p>	<p>In 2023, Sutter/Yuba transitioned to a new EHR system, which initially presented challenges in developing a dashboard to extract accurate timeliness data for analysis. The data reviewed during this period were often incomplete and contained errors.</p> <p>To address this, the QA staff analyst developed a workflow to generate timeliness reports on a monthly basis, with individual chart reviews to ensure data accuracy. As a result, timeliness data accuracy is now validated monthly, and findings are reviewed quarterly with leadership during Quality Improvement Council meetings.</p> <p>The timeliness data were reviewed at the following Quality Improvement Council meetings: April 11 and 18, 2024; July 11, 2024; October 10 and 17, 2024; January 9 and 16, 2025; and April 11 and 17, 2025.</p> <p>Meeting minutes document the data analysis and include discussions on strategies to improve timeliness rates, including the</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Sutter/Yuba</b></p>	<p><b>Actions Taken by Sutter/Yuba to Address the External Quality Review Recommendations</b></p>
	<p>development of an “urgent request” definition and corresponding workflow.</p>
<p>2. Use capacity, language, caseloads, and/or service data to support advocacy to improve Hispanic/Latino resources for Spanish-speaking members as measured by improvements in the penetration rate for this population.</p>	<p>Sutter/Yuba’s Latino Outreach Team continues to actively participate in community outreach events to engage Spanish-speaking individuals and families.</p> <p>Team members are responsible for registering and assessing clients who present for therapeutic services. When clients are determined to meet the criteria for SMHS, they are scheduled for services without being placed on a waitlist, ensuring timely access to care.</p> <p>To further support this effort, a clinical and site supervisor were added to the Latino Outreach Team for 18 hours per week, enhancing oversight, clinical support, and coordination of services for the Spanish-speaking population.</p>
<p>3. During the ongoing clinical staffing shortage, improve creative solutions to maintain engagement with adult members who are either awaiting ongoing therapy or being served during No Wrong Door.</p>	<p>Due to ongoing clinical staffing shortages, wait times for adult clients seeking individual psychotherapy have increased.</p> <p>To maintain client engagement during these delays, clients are offered and strongly encouraged to participate in peer-led wellness and recovery groups, as well as any other therapeutic groups available at the time.</p> <p>Additionally, Sutter/Yuba is developing a new group specifically for clients awaiting psychotherapy. This group will provide psychoeducation on various MH conditions and teach coping strategies to manage symptoms.</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Sutter/Yuba	Actions Taken by Sutter/Yuba to Address the External Quality Review Recommendations
	<p>Our resource specialist also plays a key role in maintaining engagement by connecting clients to requested resources and supports while they await ongoing services.</p>
<p>4. Develop clear protocols around urgent service requests, and train staff to accurately capture these requests in the Credible EHR.</p>	<p>Sutter/Yuba developed a set of three screening questions to help staff determine whether a service request is urgent during the initial point of contact. A workflow was created and staff were informed of the new process for identifying and scheduling urgent requests.</p> <p>It was identified that the existing Access to Service form in the EHR made it difficult to document urgent requests due to the location of the urgent request checkbox.</p> <p>To address this, the form has been redesigned to place the urgent checkbox in the first contact section. The new form is currently in the testing phase. Once finalized, all staff will receive training on the updated form and the revised procedures for determining and documenting urgent service requests.</p>
<p>5. Develop a process to improve identification of those members with Part B Medicare and/or other health care coverage to allow proper claims processing.</p>	<p>Sutter/Yuba has implemented the following procedures to improve the identification of clients with Medicare Part B and/or other health care coverage:</p> <ul style="list-style-type: none"> <li>◆ <b>At Intake:</b> Reception staff request insurance ID cards from clients during intake. If a card is not available, staff check Medi-Cal eligibility. If Medicare Part B coverage is identified, insurance ID information is retrieved directly from the Medi-Cal eligibility response.</li> <li>◆ <b>Hospital Demographics Review:</b> Demographic and insurance information received from Rideout Hospital is reviewed, and relevant insurance coverage is added</li> </ul>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Sutter/Yuba	Actions Taken by Sutter/Yuba to Address the External Quality Review Recommendations
	<p>to the client's record. Business office staff verify and update insurance coverage as needed.</p> <ul style="list-style-type: none"> <li>◆ <b>Monthly Billing Review:</b> Business office staff review monthly edits of billable services initially staged to private pay to determine whether insurance coverage is available for billing.</li> <li>◆ <b>Inovalon Software Implementation:</b> Sutter/Yuba, in partnership with Kings View, is in the process of implementing Inovalon software. This tool will conduct weekly checks of scheduled clients and generate downloadable reports to identify current insurance coverage and ensure timely updates.</li> </ul>

## Assessment of Sutter/Yuba’s Self-Reported Actions

HSAG reviewed Table B.50, in which Sutter/Yuba summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Sutter/Yuba adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Sutter/Yuba related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Sutter/Yuba addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Sutter/Yuba

Based on the overall assessment of Sutter/Yuba’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Sutter/Yuba’s activities and services affect the quality, timeliness, and accessibility of care

delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Sutter/Yuba's 2025 clinical and nonclinical PIP submissions. Sutter/Yuba met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Sutter/Yuba provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, Sutter/Yuba was transparent in the challenges it experienced and showed great dedication to growing its current processes to align with the audit requirements.
- ◆ DHCS' 2025 compliance review scores for Sutter/Yuba show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, HSAG observed that Sutter/Yuba had strong procedural training documentation in place for tracking timely access. The procedural training documentation included detailed steps to capture data elements needed to populate the TADT and indicated alignment with DHCS' timely access requirements.

## Opportunities for Improvement

- ◆ Sutter/Yuba has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Sutter/Yuba:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Grievance and Appeal Systems—§438.228
- ◆ During the NAV audit process, HSAG observed that Sutter/Yuba:
  - Did not have a required time frame for providers to notify the plan of any changes, such as credentialing or demographic updates. The absence of clear reporting expectations could delay updated provider information and impact network adequacy data.
  - Did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.

- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Sutter/Yuba meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Grievance and Appeal Systems—§438.228
- ◆ Establish a required time frame for providers to notify Sutter/Yuba of any changes to provider information, such as licensure, credentialing, and demographic updates, to ensure this information remains current. Additionally, communicate the required time frame to providers so that expectations are aligned between Sutter/Yuba and the providers.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Sutter/Yuba did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Sutter/Yuba's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Sutter/Yuba as well as the plan's progress with addressing these recommendations.

# Tehama County Health Services Agency

## Follow-Up on Prior Year Recommendations

Table B.51 provides the EQR recommendations directed to Tehama from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.51 to preserve the accuracy of Tehama’s self-reported actions.

**Table B.51—Tehama’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Tehama	Actions Taken by Tehama to Address the External Quality Review Recommendations
<p>1. Implement oversight of psychiatry services, including medication monitoring.</p>	<p>Tehama successfully hired a full-time MH director to oversee all services, including psychiatry. Tehama BH entered into a contract with a provider on October 21, 2024, to provide medication monitoring. In addition, Tehama County created a medication monitoring activities policy, trained staff on the policy, and implemented the policy on November 21, 2024.</p>
<p>2. Implement two PIPs (i.e., one clinical and one nonclinical) in priority areas and submit them for validation to the next EQR.</p>	<p>Due to the State guidance issued via all-county email and webinar communications related to the statewide BH administration integration, work on prior PIP concepts was terminated until new guidance was provided by DHCS’ EQRO on October 25, 2024. Tehama has been working with the new EQRO vendor, HSAG, on complying with the new guidance.</p>
<p>3. Complete an assessment of mechanisms to monitor all foster care referrals, access, and courses of treatment. Identify barriers and implement routine processes to monitor and ensure timely access and an appropriate LOC.</p>	<p>Tehama BH has bimonthly meetings with the Tehama County Department of Social Services to identify and coordinate service continuum for foster youth and access to services. Tehama BH monitors all incoming referrals from Tehama County Department of Social Services through a SharePoint internal tracking system with its contracted providers to</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Tehama</b>	<b>Actions Taken by Tehama to Address the External Quality Review Recommendations</b>
	<p>ensure timely access to services is being provided. In addition, this SharePoint site is used for monitoring and receiving all CANS assessments to determine LOC. A random sample of contracted services is monitored monthly for QA. Tehama is in the process of amending one of its current contracts with a local provider to include therapeutic foster care services.</p>
<p>4. Adopt standardized adult and youth LOC tools to measure, monitor, and guide members’ clinical treatment.</p>	<p>Tehama uses the DHCS-issued Screening and Transition of Care Tools for Medi-Cal MH Services as required, as well as various other tools and assessments, such as CANS, ANSA, ASAM, General Anxiety Disorder-7, Patient Health Questionnaire-9, Prodromal Questionnaire—Brief Version, PSC-35, or other clinically appropriate and indicated tools. In addition, Tehama BH is using the Problem List to identify and resolve member impairments as a guide to treatment along with TCM care planning to ensure members’ needs are being met in a clinically appropriate manner. Formal policies and procedures delineating the use of these tools have been developed and implemented with staff.</p>
<p>5. Finish developing Avatar reporting for key timeliness measures and other critical quality indicators.</p>	<p>Work on the issue of Avatar report development continues. This has been slowed by technical staff vacancies, extended staff medical leaves, and turnover of Netsmart (Avatar vendor) staff. Additionally, as DHCS continues to refine requirements for the TADT forms and reporting, the EQRO Information Systems Capabilities Assessment Tool, PIPs, and other outcome measurements, the data being tracked are changing frequently, so reports cannot be finalized. Tehama has created various committees and workgroups that meet on a periodic basis to address</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Tehama	Actions Taken by Tehama to Address the External Quality Review Recommendations
	reporting needs and discuss Avatar data, dashboards, and reports.

## Assessment of Tehama’s Self-Reported Actions

HSAG reviewed Table B.51, in which Tehama summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Tehama adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Tehama related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Tehama addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Tehama

Based on the overall assessment of Tehama’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Tehama’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned a *High Confidence* level to Tehama’s 2025 clinical PIP submission. Tehama met all critical and evaluation element scores for this PIP submission, reflecting that the MHP built a robust foundation in the Design stage of its clinical PIP.
- ◆ During the PMV audit process, Tehama provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, Tehama was transparent with HSAG about the challenges it experienced with receiving the MMEF and Plan Data Feed files and demonstrated great dedication to implementing processes to obtain these data sources for future audits.

- ◆ During the NAV audit process, HSAG observed that Tehama maintained thorough processes to ensure accurate and current provider data, including the provider onboarding and credentialing process through Office of Inspector General Compliance Now, along with a monthly review of the comprehensive provider list.

## Opportunities for Improvement

- ◆ HSAG's 2025 PIP validation determined that Tehama did not include all required details of its PIP processes for its nonclinical PIP.
- ◆ Tehama has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Tehama:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Grievance and Appeal Systems—§438.228
  - Practice Guidelines—§438.236
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that Tehama did not:
  - Use the MMEF to populate member eligibility data in myAvatar due to security limitations.
  - Meet one or more DHCS standards for timely access indicators due to exceeding DHCS' 5 percent data error threshold.

## 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Tehama includes all required information in the MHP's 2026 annual nonclinical PIP submission.
- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Tehama meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Grievance and Appeal Systems—§438.228
  - Practice Guidelines—§438.236

- Health Information Systems—§438.242
- Enrollee Rights—§438.100
- ◆ Partner with DHCS to explore potential solutions for addressing member eligibility data challenges, subsequently allowing for more automation in populating member eligibility data.
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Tehama did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Tehama’s responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Tehama as well as the plan’s progress with addressing these recommendations.

# Trinity County Behavioral Health Services

## Follow-Up on Prior Year Recommendations

Table B.52 provides the EQR recommendations directed to Trinity from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.52 to preserve the accuracy of Trinity’s self-reported actions.

**Table B.52—Trinity’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Trinity	Actions Taken by Trinity to Address the External Quality Review Recommendations
<p>1. Examine barriers to timely access to psychiatry appointments, including no-shows. Design and implement improvement strategies with input from line staff and beneficiaries. Measure the effectiveness of implemented changes.</p>	<p>With our psychiatrists both being part-time, the two strategies that were explored were: 1) hire another part-time psychiatrist or 2) ask the two current psychiatrists to hold a spot for new requests. Since both psychiatrists were agreeable to option 2, each psychiatrist holds a one-hour time slot every other week for new members. As a result of this change, our average time for first offered appointment reduced from 20 days to 12 days.</p>
<p>2. Collaborate with other small counties for support in the development of an effective, measurable, and meaningful QAPI plan and QIC process. Produce a FY 2024–25 QAPI plan that is measurable and effectively managed through an active, documented QIC process.</p>	<p>Trinity collaborated with multiple counties to develop a QAPI plan. A new plan with measurable goals was implemented. We continue to work through the effectiveness of the QAPI plan.</p>
<p>3. Complete an evaluation of reasons why the wellness center is not highly utilized by members. Incorporate input from providers, peer staff, line staff, members, and family members to identify and implement strategies for improvement. Consider having a</p>	<p>Since the addition of our new provider, we have seen a noticeable improvement in participant engagement.</p> <p>Attendance has increased and the peer team at Milestones Wellness Center engages in</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Trinity</b>	<b>Actions Taken by Trinity to Address the External Quality Review Recommendations</b>
<p>community event or identify another way to promote the wellness center.</p>	<p>discussions, both internally and with our consumers, regarding ways to improve participation. One of the most identified concerns is the location of the wellness center, which appears to be a barrier for some individuals.</p> <p>To increase awareness and engagement, we conduct outreach services in the community at least three times per year. During these events, we are available to answer any questions regarding Milestones Wellness Center and the services we offer. We distribute information about the wellness center, including flyers that outline the services offered, business hours, and contact information.</p>
<p>4. Identify and employ advocacy strategies with Kings View to resolve outstanding needs for key clinical functions, including aggregate reporting of outcome measures and routine clinical access to member charts within the SOC.</p>	<p>In January 2023, Kings View changed to a new EHR system. As more training has occurred and staff have more experience with the system, aggregate reporting has become more fluent. Additionally, we have learned workflows and have identified ways to have clinical access to member charts through the SOC.</p>
<p>5. Expand the competence of peer staff by ensuring ongoing training and support, strategically placing them throughout the system (including as part of the QIC), while expanding the billing potential of those peers who are certified.</p>	<p>Our new provider at Milestones Wellness Center is a CPSS and is currently in the process of completing training to begin billing for the services provided.</p> <p>Within our peer team, two of our five PSSs are certified, and two others are currently completing the 80-hour peer support training. All peer staff are assigned shifts during which they staff our crisis line and respond to crisis mobile calls using the dispatch tool. Their dual roles play a vital part in both peer engagement and crisis response efforts across the agency.</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Trinity	Actions Taken by Trinity to Address the External Quality Review Recommendations
	In an effort to strategically place PSSs within the system, we have also hired a PSS for our SUD program.
6. Design a path of recovery for members to step down from a higher LOC with routine clinical care to a less intensive LOC, including use of the transition tool into the MCP network of care.	Throughout the FY, a recovery path for members has been discussed. A recovery path that will seem to work best for our MHP is a customized LOC within the internal MH system. The MHP has been using the LOC tool since August 2023.

## Assessment of Trinity’s Self-Reported Actions

HSAG reviewed Table B.52, in which Trinity summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Trinity adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Trinity related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Trinity addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Trinity

Based on the overall assessment of Trinity’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Trinity’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned a *High Confidence* level to Trinity’s 2025 clinical PIP submission. Trinity met all critical and evaluation element scores for this PIP submission, reflecting that the MHP built a robust foundation in the Design stage of its clinical PIP.

- ◆ During the PMV audit process, Trinity was prompt and thorough on its audit deliverable submissions, which contributed to a well-organized and efficient audit process. Additionally, HSAG observed that Trinity implemented strong monitoring procedures to ensure accuracy and completeness of provider data, including QA director review of manual edits made by new staff to provider records to ensure appropriate and complete provider edits were made.
- ◆ During the NAV audit process, HSAG observed that Trinity:
  - Implemented strong monitoring procedures to ensure accuracy and completeness of provider data, including the QA director's review of manual edits that new staff made to provider records to ensure the edits were appropriate and complete.
  - Maintained robust procedural documentation which included instructions to correctly document timely access appointment data from intake through reporting via the TADT to DHCS.

## Opportunities for Improvement

- ◆ HSAG's 2025 PIP validation determined that Trinity did not include all required details of its PIP processes for its nonclinical PIP.
- ◆ Trinity has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Trinity:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100
- ◆ During the NAV audit process, HSAG observed that Trinity did not meet one or more DHCS standards for timely access indicators.

## 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Trinity includes all required information in the MHP's 2026 annual nonclinical PIP submission.
- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.

- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Trinity meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
  - Grievance and Appeal Systems—§438.228
  - Subcontractual Relationships and Delegation—§438.230
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100
- ◆ To ensure the MHP meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Trinity did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.
  - Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Trinity's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Trinity as well as the plan's progress with addressing these recommendations.

## Tulare County Health & Human Services Agency

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of Tulare for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.53 provides the EQR recommendations directed to Tulare from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.53 to preserve the accuracy of Tulare’s self-reported actions.

**Table B.53—Tulare’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Tulare	Actions Taken by Tulare to Address the External Quality Review Recommendations
<p>1. Analyze service patterns to determine whether the decrease in average number of approved claims per member represents any undesirable decreases in the quantity or appropriateness of services delivered.</p>	<p>The number of members served by the MH program increased by 1,004 (9.4 percent) from calendar year 2021 to calendar year 2022.</p> <p>The average approved claims per member in MH programs decreased by \$1,478 (27 percent) from calendar year 2021 to calendar year 2022.</p> <p>The No Wrong Door policy was effective July 1, 2022. This led to an increased number of members served in the last half of calendar year 2022, with many of these members receiving only assessment services by the MHP before being referred to the MCPs. This also brought down the average approved claims per member in calendar year 2022. Therefore, the MHP does not interpret these numbers as being indicative of inappropriate service delivery.</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Tulare</b>	<b>Actions Taken by Tulare to Address the External Quality Review Recommendations</b>
<p>2. Investigate reasons and develop strategies to improve the access and treatment transitions of care coordination between Tulare MHP and the MCP. Develop systems to track and monitor these processes to improve linkages.</p>	<p>We are currently collaborating with CalMHSA to pilot a closed-loop referral system designed to enhance care coordination and improve transitions of care between our department and the MCP. This system will allow for real-time tracking of referrals and follow-up, enabling both entities to confirm when clients have successfully engaged in services. We have also added monetary incentives within our contracts for contractors to complete LOC tools and send to the MCPs. The QI staff are currently encouraging and monitoring the use of the incentives tool.</p>
<p>3. Research, choose, and implement an adult SOC outcome and/or LOC tool for regular use and analysis.</p>	<p>We have made efforts to implement the Daily Living Activities tool, including finalizing a contract and training of some county staff members; however, we are pivoting efforts to align with proposed LOC tools that are included in draft DHCS guidance. A LOC sub-workgroup has been established to determine the best tool to use in Tulare County based on DHCS guidance.</p>
<p>4. Improve timely access to initial non-urgent services and initial psychiatry services, as well as identification of members with more urgent needs at the point of access.</p>	<p>The MHP created and tested a timely access dashboard in December 2024, and the dashboard was fully deployed MHP-wide on April 16, 2025. The MHP’s Reporting Team met with program directors individually to provide an in-depth training on how to utilize the dashboard and how to properly monitor timeliness on an ongoing basis. QI began meeting with provider executive management staff about dashboard information in April 2024, highlighting any areas of concern and improvement.</p> <p>Additionally, the MHP created and deployed a timely access documentation manual on March 18, 2025, which was reviewed during a timely access training for staff of all levels on March</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Tulare</b></p>	<p><b>Actions Taken by Tulare to Address the External Quality Review Recommendations</b></p>
	<p>31, 2025. The training covered how to complete each section of the TADT record and when to open or close a record.</p> <p>Lastly, the MHP has chosen to conduct a timely access PIP to put an even greater emphasis planwide on improving timeliness to first offered appointments. QI leadership has already conducted timeliness reviews with each director within the MHP to set expectations at a program level. Both internal and contracted program directors have been informed that CAPs will be assigned to programs that do not meet the DHCS timely access requirements. Policy #03-002 CAP was signed and released effective July 15, 2025.</p>
<p>5. Examine processes associated with appropriate identification of youth who qualify for ICC and IHBS. Implement improvements that increase access to these services.</p>	<p>The County utilizes the CANS tool as part of the assessment process to evaluate all youth for eligibility for ICC and IHBS. An additional screening tool created by Tulare County is integrated into the workflow and uploaded into SmartCare to ensure all youth are screened specifically for ICC and IHBS services. For youth involved with CWS, an additional screening is conducted using the level of review when referrals to MH services are made, providing another layer of evaluation for ICC and IHBS eligibility.</p> <p>Our policies were updated to formalize this process, and our clinics have implemented protocols to screen for ICC and IHBS during initial assessments and to reevaluate ongoing cases when specific triggers are identified. This ensures that youth whose needs change over time are promptly reassessed for service eligibility. To reinforce consistency and compliance, the updated process is outlined in our documentation manual, and</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Tulare	Actions Taken by Tulare to Address the External Quality Review Recommendations
	comprehensive training was provided for all staff to ensure understanding and proper implementation of these procedures.

## Assessment of Tulare’s Self-Reported Actions

HSAG reviewed Table B.53, in which Tulare summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Tulare adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Tulare related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Tulare addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Tulare

Based on the overall assessment of Tulare’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Tulare’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Tulare’s 2025 clinical and nonclinical PIP submissions. Tulare met all critical and evaluation element scores for both PIP submissions, reflecting that the Integrated BHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Tulare indicated that the MHP is planning an expansion of services at county wellness centers for moderate LOC to include peer/group services, transitional services to managed care plan community resources, and psychiatry and therapy care. Additionally, Tulare provided timely responses and follow-up documentation

for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes.

- ◆ DHCS' 2025 compliance review scores for Tulare show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, HSAG observed that Tulare's QI staff maintained proactive monitoring of timeliness record completion and established additional staff training to ensure timely access data were accurate and complete.

## Opportunities for Improvement

- ◆ Tulare has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Tulare:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Enrollee Rights—§438.100

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Tulare meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210
  - Enrollee Rights—§438.100

Tulare's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Tulare as well as the plan's progress with addressing these recommendations.

## Tuolumne County Behavioral Health Department

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of Tuolumne for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.54 provides the EQR recommendations directed to Tuolumne from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.54 to preserve the accuracy of Tuolumne’s self-reported actions.

**Table B.54—Tuolumne’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Tuolumne	Actions Taken by Tuolumne to Address the External Quality Review Recommendations
<ol style="list-style-type: none"> <li>Further examine the timeliness of non-urgent psychiatry appointments and begin initiatives to improve the rates meeting the 15-business-day standard.</li> </ol>	<p>Tuolumne transitioned the scheduling of clients from clinical workers to reception staff. The aim is to increase attendance and make sure appointment slots are full. Tuolumne will be releasing a request for proposal for additional telepsychiatry and/or in-person psychiatry hours. Tuolumne is also meeting weekly with leadership and clinical staff to strategize around timeliness tactics that can be deployed to reduce timeliness such as shifting assessment times, scheduling psychiatric appointments differently, managing no-show rates, and more. There are two nurse practitioners who are now providing 10 additional hours weekly, under the Kings View contract, who will be providing follow-up care. This will allow the current physicians to complete additional initial medication evaluations to further support timeliness to first psychiatry appointment. Kings View is continuing to recruit and vet physicians to be placed with Tuolumne.</p>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Tuolumne</b>	<b>Actions Taken by Tuolumne to Address the External Quality Review Recommendations</b>
<p>2. Track and report on urgent services within 48 hours for all categories.</p>	<p>Tuolumne leadership has discussed the tracking and reporting of urgent services in several leadership meetings including QM. Through discussion it was understood that urgent requests are happening for SMHS, but tracking and forms are not being completed, as urgent services are easily able to be seen within 48 hours. The policy, procedure, and form were revisited with the leadership team, and the clinical manager is currently updating the policy and procedure before it is further reviewed with staff. The policy and procedure will then be reintroduced for use so that tracking can be accurately reported.</p>
<p>3. Continue to investigate reasons for lack of access to transportation services, and develop and implement strategies in collaboration with the MCP providers to ensure consistent, reliable access to transportation assistance for members.</p>	<p>Tuolumne leadership continues to work directly with provider staff around supporting clients in the navigation of MCP transportation services. Each time there is a report made of a failed transport, leadership communicates directly with the MCP to give the MCP the identifying information for the necessary follow-up with transportation services. Over the last year, there have been two instances reported to the MCP and followed up on accordingly where it was determined that it was the client who had failed to respond to the transportation services. This was communicated back to the provider in an effort to further support the client. Due to the required timelines in which the transportation services require advanced notice, it is often difficult for our clients to navigate this system. Provider staff have informed leadership of reports from clients that setting up their appointment time for transportation seems complex.</p> <p>There have been ongoing conversations during the quarterly meetings with the MCPs, and they are very receptive to any and all</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Tuolumne</b></p>	<p><b>Actions Taken by Tuolumne to Address the External Quality Review Recommendations</b></p>
	<p>issues being identified with the transportation provider.</p> <p>Tuolumne continues to provide transportation to clients as often as possible when medically necessary as we continue to employ a full-time transportation coordinator and three relief transportation officers who work to greatly support our clients’ needs.</p>
<p>4. Continue to develop and begin to track and trend the foster care HEDIS measures using a process that is not dependent on the EHR implementation.</p>	<p>Tuolumne is tracking HEDIS measures and working on collecting all the data for the foster care HEDIS measures. The new EHR has the capabilities to have dashboards for HEDIS in the record. This would allow direct service providers easier access to the dashboards as they would be able to go to one place for the dashboard and chart review. The new EHR is being implemented in phases; therefore, the dashboard development and review phase has not taken place. Thus, Tuolumne is still focused on the data management aspect to have a live dashboard with real-time data available prior to the EHR implementation. The QI program has worked directly with the EHR vendor, nursing staff, clinical staff, and data teams to develop HEDIS measurements. As data are collected, the final measurements will be analyzed through the QM Committee and Quality Improvement Council.</p>
<p>5. Continue efforts to examine staff salary ranges in comparison to other MHPs and continue to make needed adjustments, as appropriate.</p>	<p>Tuolumne County BH does not have control over salaries for staff. Staff salaries are negotiated between the Tuolumne County Board of Supervisors and employee labor unions. For the last FY, the county paid for a salary study to compare Tuolumne County pay to other counties. Additionally, Tuolumne County BH provided billing data to aid in negotiations. Staff received a raise during the most recent negotiations that took place in FY</p>

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Tuolumne	Actions Taken by Tuolumne to Address the External Quality Review Recommendations
	2022–23. Current negotiations are ongoing between the Tuolumne County Board of Supervisors and employee labor unions; however, they do not involve the department, nor is the progress of staff salary increases legally permitted to be discussed outside of active negotiations. This includes sharing information on what is happening with the BH Department; thus, the department has no ability to influence or to be involved in salary ranges for staff.

## Assessment of Tuolumne’s Self-Reported Actions

HSAG reviewed Table B.54, in which Tuolumne summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Tuolumne adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Tuolumne related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Tuolumne addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Tuolumne

Based on the overall assessment of Tuolumne’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Tuolumne’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned a *High Confidence* level to Tuolumne’s 2025 clinical PIP submission. Tuolumne met all critical and evaluation element scores for this PIP submission, reflecting that the Integrated BHP built a robust foundation in the Design stage of its clinical PIP.
- ◆ During the PMV audit process, Tuolumne was prepared to discuss all sections in the virtual review and prepared staff to overview all sections in scope of review. Additionally, Tuolumne indicated that the MHP has identified opportunities to improve the LOC provided to members and is planning implementation of a new program in the coming year to expand the number of members the county is able to reach.
- ◆ During the NAV audit process, HSAG observed that Tuolumne had strong data quality checks in place and coordinated effectively with Kings View to verify accuracy and integrity of data migrated from Anasazi to Credible. Tuolumne ensured no downtime or impact to eligibility or provider data, which were used for timely access reporting to DHCS.

## Opportunities for Improvement

- ◆ HSAG’s 2025 PIP validation determined that Tuolumne did not include all required details of its PIP processes for its nonclinical PIP.
- ◆ Tuolumne has opportunities to improve internal processes to ensure meeting DHCS’ performance measure reporting requirements.
- ◆ During the NAV audit process, HSAG observed that Tuolumne did not:
  - Submit the timely access CAP submission using the appropriate DHCS TADT template.
  - Meet one or more DHCS standards for timely access indicators due to a failure to submit timely access data to DHCS in a timely manner.

## 2024–25 External Quality Review Recommendations

- ◆ Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Tuolumne includes all required information in the Integrated BHP’s 2026 annual nonclinical PIP submission.
- ◆ Thoroughly review HSAG’s detailed findings and recommendations in the MHP’s *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS’ performance measure reporting requirements.
- ◆ To improve timely access reporting:
  - Submit all timely access submissions, including the CAP submission, on the appropriate DHCS TADT template.
  - Conduct an in-depth review of the indicators for which Tuolumne did not meet the timely access requirements to determine whether the inability to meet requirements was the result of a lack of providers or lack of complete timely access data reported.

- Continue to explore strategies to mitigate barriers, such as additional staff training on tracking timely access or provider contracting efforts to ensure adequate access, as applicable.

Tuolumne's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Tuolumne as well as the plan's progress with addressing these recommendations.

## Ventura County Behavioral Health

This plan completed early BH administrative integration beginning January 1, 2025, and operates under the name of County of Ventura for activities conducted as an Integrated BHP entity.

### Follow-Up on Prior Year Recommendations

Table B.55 provides the EQR recommendations directed to Ventura from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.55 to preserve the accuracy of Ventura’s self-reported actions.

**Table B.55—Ventura’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Ventura	Actions Taken by Ventura to Address the External Quality Review Recommendations
<p>1. Continue developing a robust timeliness reporting system that accurately captures timeliness according to HEDIS or other state and national practices.</p>	<ul style="list-style-type: none"> <li>◆ Multiple training sessions were conducted throughout FY 2023–24 and FY 2024–25 to train and retrain staff in the proper use of SmartCare screens that capture timeliness data. Training materials, including Microsoft PowerPoint presentations, recordings of live sessions, frequently asked questions, and workflows are available on an ongoing basis to refresh staff or train new staff. Additionally, virtual Office Hours have been held to support staff with training, questions, or issues that arise, etc., all aimed at improving data quality.</li> <li>◆ Robust monitoring reports have been developed to provide a detailed view of the timeliness data entered into SmartCare and identify errors or incomplete data. Clinic staff review the reports weekly and correct or address errors. This has resulted in an improvement in data quality and completeness.</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Ventura</b>	<b>Actions Taken by Ventura to Address the External Quality Review Recommendations</b>
	<ul style="list-style-type: none"> <li>◆ Various performance improvement activities for timeliness-related HEDIS measures (<i>Follow-Up After Emergency Department Visit for Mental Illness, Follow-Up After Emergency Department Visit for Substance Use, Follow-Up After Hospitalization for Mental Illness</i>) are underway and in collaboration with external partners such as hospitals, MCPs, and CBOs, all aimed at improving time to service after hospital stays or emergency department visits. Enhanced workflows and coordination among external partners and internally have been established. Additionally, mechanisms to support data monitoring and reporting have been developed and continue to evolve.</li> <li>◆ A comprehensive key performance indicator reporting system and structure has been developed to track, monitor, and regularly report all key department metrics, including timeliness and HEDIS measures. This includes sharing results across the department to inform and involve relevant teams in the ongoing review and evaluation of HEDIS results and any accompanying improvement efforts.</li> </ul>
<p>2. Develop a two-way communication plan as part of a broader change management strategy that prioritizes communication with contract providers, line staff members, and plan members.</p>	<p>Several efforts were made to engage staff, including gathering direct feedback and perceptions from employees. Key outcomes of these engagement activities included:</p> <ul style="list-style-type: none"> <li>◆ Ongoing discussions within the Staff Experience QIC Subcommittee that specifically focused on increasing executive managers’ follow-through on results from the Employee Engagement Survey.</li> <li>◆ A plan was proposed by the subcommittee and voted into approval by the QIC which asked executive managers to formally</li> </ul>

<b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Ventura</b>	<b>Actions Taken by Ventura to Address the External Quality Review Recommendations</b>
	<p>acknowledge that they received the survey results, would review them in depth, would discuss findings in smaller group meetings, and would report back to the QIC on steps taken to address concerns.</p> <ul style="list-style-type: none"> <li>◆ A video message from the director to all employees was created and shared, which provided context on the pace of change and reinforced the mission-driven nature of the work.</li> <li>◆ The director and assistant director held open forum meetings with each department division to openly discuss work challenges and upcoming changes, particularly related to concerns raised in the Employee Engagement Survey</li> </ul>
<p>3. Examine the reasons for a high percentage of plan members being in the high-cost member category. Utilize the EQRO-provided approved claims analyses that show the higher costs are concentrated in certain race/ethnicity groups, age groups, service types, and aid codes.</p>	<p>The recommendation has been discussed within the QIC structure and the Fiscal Responsibility QIC Subcommittee. The subcommittee has taken the lead in analyzing data and supporting evidence, as well as developing a framework to track and monitor this metric. Specifically, an on-demand report in the SmartCare EHR is currently being developed to monitor members in the high-cost member category.</p> <p>Efforts are ongoing and evolving to ensure these data are reviewed regularly; shared with relevant parties across the department; and changes made, if needed, to address issues identified in the data. Actionable findings will be utilized to enhance targeted interventions and service delivery, as appropriate.</p>
<p>4. Develop strategies to increase plan member participation in the QIC structure.</p>	<p>The structure of the QIC is being continually evaluated to encourage and bring in increased membership, greater participation, and stronger representation of community voices. Currently, the Community Experience</p>

<p><b>Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Ventura</b></p>	<p><b>Actions Taken by Ventura to Address the External Quality Review Recommendations</b></p>
	<p>QIC Subcommittee includes representatives from two key community partners, Padres Juntos and United Parents, as well as county partners from the sheriff’s office and internal Ventura County BH peers.</p> <p>Additionally, a group referred to as the Quality Consultants has been developed to bring together a small group of peer staff and parent partners, all individuals with lived experience working closely with and in support of current clients and administrative staff. The group is facilitated by the QI Team and gathers the quality consultants three to four times per year and on an ad hoc basis, with the overarching goal of gathering feedback on QI projects or new initiatives from the perspective of the member or the member experience.</p> <p>Finally, senior leadership in each operational division (i.e., MH adults, MH youth and family, substance use services) are working with clinic administrators to identify and recruit current clients to participate in activities such as the QIC or in other opportunities in which they can provide input and feedback.</p>
<p>5. Complete the Medicare certification process and perform an analysis on the Medi-Cal claims denied due to ineligibility and non-covered charges to address higher than average denial rates.</p>	<p>Medicare certification was obtained in November 2024, contributing to a noticeable reduction in claim denials. Additionally, with the implementation of the new EHR (SmartCare) as part of the CalAIM payment reform initiative, system configurations have been optimized to minimize denials of billable services. Denied claims related to other health coverage, Medicare, or eligibility issues are systematically reviewed, and client coverage information is updated accordingly to prevent similar denials in future submissions.</p>

## Assessment of Ventura's Self-Reported Actions

HSAG reviewed Table B.55, in which Ventura summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Ventura adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Ventura related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Ventura addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Ventura

Based on the overall assessment of Ventura's delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Ventura's activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan's performance affects one specific aspect of care more than another.

### Strengths

- ◆ HSAG assigned *High Confidence* levels to Ventura's 2025 clinical and nonclinical PIP submissions. Ventura met all critical and evaluation element scores for both PIP submissions, reflecting that the Integrated BHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, Ventura provided timely responses and follow-up documentation for all audit deliverables, demonstrating engagement, partnership, and commitment to the process and expected outcomes. Additionally, HSAG observed that Ventura had strong initiatives in place, including the implementation of a billing dashboard, which leadership monitored daily for completeness.
- ◆ DHCS' 2025 compliance review scores for Ventura show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, HSAG observed that Ventura:
  - Implemented logic for generating error reports on timeliness data in SmartCare and had a weekly process to reach out to staff to notify them of missing or incomplete timeliness records.
  - Maintained detailed training materials and process documentation to assist staff in tracking complete and accurate timeliness data.

## Opportunities for Improvement

- ◆ Ventura has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Ventura:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Ventura meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coverage and Authorization of Services—§438.210

Ventura's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Ventura as well as the plan's progress with addressing these recommendations.

# Yolo County Health & Human Services Agency

## Follow-Up on Prior Year Recommendations

Table B.56 provides the EQR recommendations directed to Yolo from the previous EQRO’s 2023–24 SMHS EQR technical report, along with the plan’s self-reported actions taken to address the recommendations. Please note that HSAG made minimal edits to Table B.56 to preserve the accuracy of Yolo’s self-reported actions.

**Table B.56—Yolo’s Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization’s 2023–24 SMHS EQR Technical Report**

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Yolo	Actions Taken by Yolo to Address the External Quality Review Recommendations
1. Investigate barriers and develop and implement strategies to increase Hispanic/Latino and Asian/Pacific Islander penetration rates.	Yolo was unable to take action on this recommendation.
2. Implement the new methodology for all timely access tracking and incorporate routine review and analysis of the findings.	Yolo successfully piloted a monthly tracking process with our youth SOC. Through this pilot, we were able to make modifications to the process and are now looking to expand these efforts with our other providers beginning in October. The data will be reviewed and analyzed quarterly.
3. Research barriers, and design and implement processes to increase timeliness to first offered non-urgent clinical non-psychiatry service and first delivered non-urgent psychiatry service (inclusive of adults, children, and youth in foster care); incorporate routine review of the data and reports for accuracy.	Yolo initiated several processes to improve data integrity related to timely access, including individualized provider technical assistance and group trainings. As noted above, Yolo piloted a monthly tracking process for timely access and is looking to expand these efforts beginning in October. Increased review of the data will help us identify any clinical barriers that need to be addressed.
4. Develop operational plans for utilizing the HIE within the MHP’s county programs and consider providing	Although the HIE was successfully initiated, Yolo has been unable to develop a more robust plan for its utilization, including

Previous External Quality Review Organization’s 2023–24 External Quality Review Recommendations Directed to Yolo	Actions Taken by Yolo to Address the External Quality Review Recommendations
support to contract providers to also use the HIE.	encouraging our contracted providers to also use the HIE.
5. Create a protocol and implement a system that provides intentional supervision and support to peer employees.	Yolo is still in the process of expanding our network to include more certified peers. We have encouraged our current peer staff to work toward certification, and thus far we have 20 CPSSs in our MH SOC. Peers currently receive supervision and support from our clinical supervisors/program coordinators.
6. Design and implement a clinical PIP for the current year. Engage the EQRO for technical assistance with this process.	Yolo initiated a clinical PIP for our MH delivery system which focuses on improving the <i>Follow-up After Emergency Department Visit for Mental Illness</i> HEDIS measure rate. We submitted our initial PIP submission to HSAG in a timely manner.

## Assessment of Yolo’s Self-Reported Actions

HSAG reviewed Table B.56, in which Yolo summarized its self-reported actions to address the 2023–24 EQR recommendations from the previous EQRO. Based on the information provided, it appears that Yolo adequately addressed the 2023–24 EQR recommendations.

Beginning with this EQR technical report, HSAG will identify opportunities for improvement and make recommendations to Yolo related to the mandatory EQR activities, as applicable. In the next annual review, HSAG will assess the extent to which Yolo addresses these recommendations.

## 2024–25 External Quality Review Conclusions—Strengths, Opportunities for Improvement, and Recommendations for Yolo

Based on the overall assessment of Yolo’s delivery of quality, timely, and accessible care through the 2024–25 EQR activities, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that all of Yolo’s activities and services affect the quality, timeliness, and accessibility of care delivered to its members. When applicable, HSAG indicates instances in which the plan’s performance affects one specific aspect of care more than another.

## Strengths

- ◆ HSAG assigned *High Confidence* levels to Yolo's 2025 clinical and nonclinical PIP submissions. Yolo met all critical and evaluation element scores for both PIP submissions, reflecting that the MHP built a robust foundation in the Design stage of each PIP.
- ◆ During the PMV audit process, HSAG observed that Yolo used the Medi-Cal DHCS website and the Two-Out-of-Three Match Report to ensure manually entered enrollment data in myAvatar were accurate and complete each month and used the Dimensions dashboard to adequately monitor its claim submissions, denials, and resubmissions.
- ◆ DHCS' 2025 compliance review scores for Yolo show that the MHP was fully compliant with most CFR standards.
- ◆ During the NAV audit process, Yolo demonstrated robust coordination across departments along with various quality checks to ensure complete and accurate reporting of timely access data.

## Opportunities for Improvement

- ◆ Yolo has opportunities to improve internal processes to ensure meeting DHCS' performance measure reporting requirements.
- ◆ DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Yolo:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207

## 2024–25 External Quality Review Recommendations

- ◆ Thoroughly review HSAG's detailed findings and recommendations in the MHP's *2024–25 Validation of Measurement Years 2023 and 2024 Performance Measures* report and implement process improvements to support meeting DHCS' performance measure reporting requirements.
- ◆ Work with DHCS to resolve the identified findings from DHCS' 2025 compliance review scoring process related to the following CFR standards to ensure Yolo meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207

Yolo's responses to the EQR recommendations should reflect strategies that impact the quality and timeliness of services provided to members as well as ways to overcome barriers to accessing needed health care services.

In the next annual review, HSAG will evaluate continued successes of Yolo as well as the plan's progress with addressing these recommendations.