Volume 2 of 5
Drug Medi-Cal Organized Delivery System External Quality Review Technical Report

Contract Year 2024–25

Plan-Specific Information

California Department of Health Care Services

April 2026

Property of the California Department of Health Care Services

HSAG HEALTH SERVICES ADVISORY GROUP

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Table of Contents

Volume 2: Medi-Cal Managed Care Plan-Specific Information

Table of Tables

Drug Medi-Cal Organized Delivery System Plan Name Abbreviations

Health Services Advisory Group, Inc. (HSAG) uses the following abbreviated Drug Medi-Cal Organized Delivery System (DMC-ODS) plan names in this volume.

* DMC-ODS plan that opted for early behavioral health (BH) administrative integration beginning January 1, 2025.

- **Alameda**—County of Alameda
- **Contra Costa**—County of Contra Costa
- **El Dorado**—County of El Dorado
- **Fresno**—County of Fresno*
- **Humboldt**—County of Humboldt
- **Imperial**—County of Imperial
- **Kern**—County of Kern
- **Lassen**—County of Lassen
- **Los Angeles**—County of Los Angeles
- **Marin**—County of Marin*
- **Mariposa**—County of Mariposa
- **Mendocino**—County of Mendocino
- **Merced**—County of Merced
- **Modoc**—County of Modoc
- **Monterey**—County of Monterey
- **Napa**—County of Napa
- **Nevada**—County of Nevada*
- **Orange**—County of Orange*
- **Placer**—County of Placer
- **Riverside**—County of Riverside*
- **Sacramento**—County of Sacramento*
- **San Benito**—County of San Benito
- **San Bernardino**—County of San Bernardino
- **San Diego**—County of San Diego
- **San Francisco**—County of San Francisco
- **San Joaquin**—County of San Joaquin*
- **San Luis Obispo**—County of San Luis Obispo*

- **San Mateo**—County of San Mateo
- **Santa Barbara**—County of Santa Barbara*
- **Santa Clara**—County of Santa Clara
- **Santa Cruz**—County of Santa Cruz
- **Shasta**—County of Shasta
- **Siskiyou**—County of Siskiyou
- **Solano**—County of Solano
- **Sonoma**—County of Sonoma
- **Stanislaus**—County of Stanislaus*
- **Tulare**—County of Tulare*
- **Ventura**—County of Ventura*
- **Yolo**—County of Yolo

Note: County of Lake contracted with California Department of Health Care Services (DHCS) as a DMC-ODS plan starting July 1, 2024, and opted for early BH administrative integration beginning January 1, 2025. The only external quality review (EQR) activity applicable for this plan involved performance improvement projects (PIPs) via the Integrated Behavioral Health Plan (Integrated BHP) entity based on County of Lake only operating as a DMC-ODS plan for six months. PIP summary information for this plan as an Integrated BHP is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report*.

Commonly Used Abbreviations and Acronyms

- **A&I**—Audits & Investigations
- **ACL**—Access and Crisis Line
- **AOA**—Adult and Older Adult
- **AOD**—alcohol and other drugs
- **ACBHD**—Alameda County Behavioral Health Department
- **ACCESS**—Acute Crisis Care and Evaluation for Systemwide Services
- **ADA**—Americans with Disabilities Act
- **ASAM**—American Society of Addiction Medicine
- **ASO**—administrative service officer
- **AWM**—ambulatory withdrawal management
- **BAART**—Bay Area Addiction Research and Treatment
- **BH**—behavioral health
- **BHEC**—Behavioral Health Equity Committee
- **BHIN**—Behavioral Health Information Notice
- **BHRS**—Behavioral Health and Recovery Services
- **BHS**—behavioral health services
- **BHSD**—Behavioral Health Services Department
- **CADA**—Council on Alcoholism and Drug Abuse
- **CalAIM**—California Advancing and Innovating Medi-Cal
- **CalMHSA**—California Mental Health Services Authority
- **CalOMS**—California Outcomes Measurement System
- **CAP**—corrective action plan
- **CBO**—community-based organization
- **CCSF**—City College of San Francisco
- **CMS**—Centers for Medicare & Medicaid Services
- **CSS**—Crisis Support Services
- **CST**—Contract Support Team
- **CYASOC**—Child and Young Adult System of Care
- **DBH**—Department of Behavioral Health
- **DHCS**—California Department of Health Care Services
- **DMC-ODS**—Drug Medi-Cal Organized Delivery System
- **EHR**—electronic health record
- **EQR**—external quality review
- **EQRO**—external quality review organization

- **FBO**—faith-based organization
- **FQHC**—federally qualified health center
- **FTE**—full-time equivalent
- **FY**—fiscal year
- **HCA**—Orange County Health Care Agency
- **HEDIS®**—Healthcare Effectiveness Data and Information Set[1]
- **HepC**—Hepatitis C
- **HR**—Human Resources
- **HSAG**—Health Services Advisory Group, Inc.
- **HHS**—Health and Human Services
- **HIV**—human immunodeficiency virus
- **HMA**—Health Management Associates
- **ICBHS**—Imperial County Behavioral Health Services
- **ICL**—Initial Contact Log
- **Integrated BHP**—Behavioral Health Plan
- **IOT**—intensive outpatient treatment
- **IT**—information technology
- **KernBHRS**—Kern Behavioral Health & Recovery Services
- **KPI**—key performance indicator
- **LOC**—level of care
- **MAT**—medication-assisted treatment
- **MCBH**—Monterey County Behavioral Health
- **MCP**—managed care health plan
- **MEDSLITE**—Medi-Cal Eligibility Data System Lite
- **MH**—mental health
- **MHP**—mental health plan
- **MMEF**—Monthly Medi-Cal Eligibility File
- **NAE**—network adequacy evaluation
- **NAV**—network adequacy validation
- **NCQA**—National Committee for Quality Assurance
- **NTP**—narcotic treatment program
- **OTP**—opioid treatment program
- **PATH**—Providing Access and Transforming Health
- **PHC**—Partnership HealthPlan of California
- **PIP**—performance improvement project

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- **PM**—program manager
- **PMV**—performance measure validation
- **QA**—quality assurance
- **QAPI**—quality assessment and performance improvement
- **QI**—quality improvement
- **QIC**—Quality Improvement Committee
- **QIDA**—Quality Improvement and Data Analytics
- **QIP**—quality improvement project
- **QM**—Quality Management
- **QMWP**—Quality Management Work Plan
- **RC**—recovery coach
- **RFI**—request for information
- **RFP**—request for proposal
- **RIA**—Recovery in Action
- **RM**—risk management
- **SAPC**—Substance Abuse Prevention and Control
- **SARC**—Screening, Assessment, and Referral Center
- **SMS**—Short Message Service
- **SDCBHS**—San Diego County Behavioral Health Services
- **SND**—Strategic and Network Development
- **SOC**—system of care
- **SUD**—substance use disorder
- **SUS**—Substance Use Services
- **SUTS**—substance use treatment services
- **TADT**—Timely Access Data Tool
- **TB**—tuberculosis
- **TCP**—Transformational Change Partnership
- **TPS**—Treatment Perceptions Survey
- **UCLA**—University of California, Los Angeles
- **WM**—withdrawal management

Introduction

The *2024–25 Drug Medi-Cal Organized Delivery System External Quality Review Technical Report* is an annual, independent, technical report produced by HSAG, the external quality review organization (EQRO) for DHCS' DMC-ODS Program. The purpose of this report is to provide a summary of the EQR activities for the DHCS contracted DMC-ODS plans. This report will sometimes refer to these DMC-ODS plans as "plans."

Note that beginning January 1, 2025, some DMC-ODS plans completed early BH administrative integration and voluntarily integrated county functions for specialty mental health services and substance use disorder (SUD) services and began operating under a restructured contract as an Integrated BHP. DMC-ODS plans that opted for early BH administrative integration conducted PIPs via the Integrated BHP entity, and their PIP summary information is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report*.

This Volume 2 of the *2024–25 Drug Medi-Cal Organized Delivery System External Quality Review Technical* Report includes the following plan-specific information:

- Appendix A—Comparative Plan-Specific PIP Information
- Appendix B—Plan-Specific EQR Assessments and Recommendations

Note that the statewide aggregate assessment of the DMC-ODS 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 DMC-ODS plan-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.[2]

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.*

[2] 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
4. Sampling Method	♦ The plan documented the sampling frame size for each performance indicator. ♦ The plan documented the sample size for each performance indicator.* ♦ The plan documented the margin of error and confidence level for each performance indicator. ♦ The plan described the method used to select the sample. ♦ The sampling methodology used allowed for the generalization of results to the population.*
5. Selected Performance Indicator(s)	♦ The performance indicator(s) was well-defined, objective, and could track performance over time.*
6. Data Collection Procedures	♦ The plan included clearly defined sources of data and data elements collected for each performance indicator. ♦ The plan included a clearly defined and systematic process for collecting baseline and remeasurement data.* ♦ A copy of the manual data collection tool used was provided, if applicable.* ♦ 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.
7. Data Analysis and Interpretation of Results	♦ 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.* ♦ The plan documented possible reasons for the lack of improvement, lessons learned, and next steps for each performance indicator. ♦ The plan documented the threats to validity for each measurement period and the threats to comparability between the baseline and each remeasurement period.
8. Improvement Strategies	♦ The plan completed the Quality Improvement (QI) Team table and either described or attached the QI tool(s) used.* ♦ The plan clearly described each intervention, and the intervention addressed root causes/barriers identified through data analysis and/or QI tools.* ♦ The plan completed an intervention worksheet for each listed intervention in the Step 8 Barriers/Interventions table. Each

Review Steps	Evaluation Elements
	intervention worksheet was completed to the point of intervention progress. ♦ The plan tested interventions to a point in the remeasurement period that could reasonably drive improvement in performance indicator outcomes. ♦ The plan developed a methodologically sound measure(s) or process to evaluate the effectiveness and impact of each intervention. ♦ The plan documented an accurate summary of intervention testing results. ♦ The plan documented lessons learned, challenges encountered, and solutions to challenges for each intervention tested. ♦ The plan documented the status of each intervention (Adopt, Adapt, Abandon, or Continue Evaluating) and the rationale for the selected status.
9. Likelihood that Significant and Sustained Improvement Occurred	♦ The remeasurement methodology was the same as the baseline methodology for all performance indicators.* ♦ There was improvement over baseline performance across all performance indicators for the current reported remeasurement period. ♦ There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators for the current reported remeasurement period. ♦ For any applicable indicator, sustained statistically significant improvement compared to the baseline result was demonstrated with a subsequent reported remeasurement period.

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
Overall Confidence of Adherence to Acceptable PIP Methodology	
High Confidence	All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
Moderate Confidence	All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
Low Confidence	Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
No Confidence	Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
Overall Confidence that the PIP Achieved Significant Improvement	
High Confidence	All performance indicators demonstrated *statistically significant* improvement over the baseline.
Moderate Confidence	One of the three scenarios below occurred: 1. All performance indicators demonstrated improvement over the baseline, and some but not all performance indicators demonstrated *statistically significant* improvement over the baseline. 2. All performance indicators demonstrated improvement over the baseline, and none of the performance indicators

Confidence Level	Definition
	demonstrated *statistically significant* improvement of the baseline. 3. Some but not all performance indicators demonstrated improvement over baseline, and some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
Low Confidence	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 *statistically significant* improvement over the baseline.
No Confidence	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 DMC-ODS plans 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 DMC-ODS plans 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 *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 DMC-ODS plans' 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. DMC-ODS plans that opted for early BH administrative integration conducted PIPs via the Integrated BHP entity; therefore, the plan-specific PIP summary information for these plans is included in *Volume 2 of 5* of the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report.*

Table A.3—July 2025 Drug Medi-Cal Organized Delivery System 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	*Improve the POD measure rate*	100%	100%	High Confidence
	Improve timely access from first contact from any referral source to first offered appointment for SUD residential treatment services	83%	80%	Low Confidence
Contra Costa	*Improve the FUA measure rate*	100%	100%	High Confidence
	Improve timely access from first contact from access line to outpatient services—outpatient SUD services	100%	100%	High Confidence
El Dorado	*Improve the POD measure rate*	100%	100%	High Confidence
	Improve timely access from first contact from any referral source to first offered appointment for opioid treatment program (OTP)	71%	83%	Low Confidence
Humboldt	*Improve the FUA measure rate*	83%	80%	Low Confidence
	Increase the percentage of members who receive at least one peer support service	83%	80%	Low Confidence
Imperial	*Improve the FUA measure rate*	100%	100%	High Confidence
	Increase the percentage of members who receive at least one peer support service	100%	100%	High Confidence

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
Kern	*Improve the POD measure rate*	100%	100%	High Confidence
	Increase the percentage of members who receive at least one peer support service	100%	100%	High Confidence
Lassen	*Improve the FUA measure rate*	83%	80%	Low Confidence
	Increase the percentage of members who receive at least one peer support service	83%	80%	Low Confidence
Los Angeles	*Improve the POD measure rate*	50%	40%	No Confidence
	Improve timely access from first contact from any referral source to first offered appointment for OTP services	67%	80%	No Confidence
Mariposa	*Improve the FUA measure rate*	67%	60%	Low Confidence
	Improve timely access from first contact from any referral source to first offered appointment for any residential service	100%	100%	High Confidence
Mendocino	*Improve the FUA measure rate*	83%	80%	Low Confidence
	Increase the percentage of members who receive at least one peer support service	83%	80%	Low Confidence
Merced	*Improve the FUA measure rate*	100%	100%	High Confidence
	Improve timely access from first contact from any referral source to first offered appointment for outpatient services—outpatient SUD services	100%	100%	High Confidence

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
Modoc	*Improve the FUA measure rate*	83%	80%	Low Confidence
	Increase the percentage of members who receive at least one peer support service	83%	80%	Low Confidence
Monterey	*Improve the FUA measure rate*	100%	100%	High Confidence
	Improve timely access from first contact from any referral source to first offered appointment for outpatient SUD services	100%	100%	High Confidence
Napa	*Improve the POD measure rate*	100%	100%	High Confidence
	Improve timely access from first contact from any referral source to first offered appointment for outpatient services—outpatient SUD services (youth/children ages 0 to 20/adults 21 years and older)	100%	100%	High Confidence
Placer	*Improve the FUA measure rate*	100%	100%	High Confidence
	Increase the percentage of members who receive at least one peer support service	100%	100%	High Confidence
San Benito	*Improve the FUA measure rate*	100%	100%	High Confidence
	Improve no show rate for first service for individuals requesting outpatient SUD treatment	100%	100%	High Confidence
San Bernardino	*Improve the FUA measure rate*	100%	100%	High Confidence
	Increase the percentage of members who receive at least one peer support service	100%	100%	High Confidence

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
San Diego	*Improve the FUA measure rate*	100%	100%	High Confidence
	Increase the percentage of members who receive at least one peer support service	100%	100%	High Confidence
San Francisco	*Improve the POD measure rate*	100%	100%	High Confidence
	Improve timely access from first contact from any referral source to first offered appointment for outpatient SUD services	100%	100%	High Confidence
San Mateo	*Improve the POD measure rate*	100%	100%	High Confidence
	Improve timely access from first contact from any referral source to first offered appointment for residential services	100%	100%	High Confidence
Santa Clara	*Improve the FUA measure rate*	100%	100%	High Confidence
	Improve timely access from first contact from any referral source to first offered appointment for outpatient services—outpatient SUD services	100%	100%	High Confidence
Santa Cruz	*Improve the FUA measure rate*	83%	80%	Low Confidence
	Improve timely access from first contact from any referral source to first offered appointment for residential DMC-ODS non-urgent services for adults	100%	100%	High Confidence

Plan Name	PIP Topic	Evaluation Element Met Score*	Critical Element Met Score**	Confidence Level
Shasta	*Improve the FUA measure rate*	83%	80%	Low Confidence
	Increase the percentage of members who receive at least one peer support service	83%	80%	Low Confidence
Siskiyou	*Improve the FUA measure rate*	83%	80%	Low Confidence
	Increase the percentage of members who receive at least one peer support service	83%	80%	Low Confidence
Solano	*Improve the FUA measure rate*	83%	80%	Low Confidence
	Increase the percentage of members who receive at least one peer support service	83%	80%	Low Confidence
Sonoma	*Improve the POD measure rate*	83%	80%	Low Confidence
	Increase the percentage of members who receive at least one peer support service	100%	100%	High Confidence
Yolo	*Improve the FUA measure rate*	100%	100%	High Confidence
	Increase the percentage of members who receive at least one peer support service to members 18 years and older	100%	100%	High Confidence

Performance Improvement Project Interventions

The DMC-ODS plan 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 Drug Medi-Cal Organized Delivery System 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' DMC-ODS Program; therefore, HSAG obtained the recommendations made to each plan from the previous EQRO's 2023–24 DMC-ODS 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.

In this volume, for DMC-ODS plans that completed early BH administrative integration, HSAG includes assessment of performance measure validation (PMV) and network adequacy validation (NAV) activities only. Since the DMC-ODS plans that completed early BH administrative integration conducted PIPs via the Integrated BHP structure, HSAG's includes their PIP assessments in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report*.

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).

County of Alameda

Follow-Up on Prior Year Recommendations

Table B.1 provides the EQR recommendations directed to Alameda from the previous EQRO's 2023–24 DMC-ODS 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 DMC-ODS 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
1. Conduct a thorough analysis to determine the root causes of the high no-show rates for residential treatment, and take active steps to increase the number of potential clients who attend their first scheduled appointment.	The Quality Improvement and Data Analytics (QIDA) Division and the SUD/continuum of care staff developed a fishbone analysis to determine the root causes of the high no-show rates for residential treatment. QIDA and SUD/continuum of care are working together with input from stakeholders on a quality improvement project (QIP) to address the root causes. Historically, Alameda County Behavioral Health Department (ACBHD) has faced challenges in capturing and analyzing no-show data. Instead of having explicit no-show records, our data reflect clients who were referred but did not make it to services. This nuanced distinction required us to rethink our approach to data analysis. During the analysis, it was determined that the high no-show rate may be attributed to a data tracking issue in SmartCare. Last year, providers were unable to enter data in SmartCare due to a system issue. Subsequently, the Information Systems Department developed an e-form for providers to enter timeliness data.

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
2. Determine if the level of SUD services provided at school sites by mental health (MH) providers is effectively addressing SUDs for the youth. Increase the population of youth participating in SUD treatment in the DMC-ODS plan.	QIDA, Child and Young Adult System of Care (CYASOC), and SUD/continuum of care developed a SUD Adolescent Treatment QIP to increase the number of Medi-Cal youth participating in SUD treatment, with the goal of improving our penetration rate from 0.14 percent in fiscal year (FY) 2023–24 to 0.29 percent in FY 2024–25, which would mean an estimated 136 members served, which is in line with the State's expectation for similar-sized counties. The SUD Adolescent Treatment Work Group meets monthly to review progress on the action steps in the QIP. The following action steps were developed: ♦ Refine SUD providers' outreach and engagement plans. ■ Outreach to principals and/or site Administration. ♦ Increase school district connections. ■ Explore expansion of involvement with Coordination of Services Teams. ■ Refine the referral process between school-based health centers and SUD treatment. ■ Invite SUD providers to CYASOC School-Based Behavioral Health Fall Planning meetings in August and September. ■ Develop and present appropriate materials that describe the available services and referral processes. ♦ Look into how ODS 0.5 services are connected to adolescent treatment. ♦ Collaborate with the ACBHD system of care (SOC) to identify training topics related to co-occurring MH/SUD issues

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
	related to children, young adults, and their families. Resistance to SUD services from school sites is a significant contributing factor to the small number. To address outreach and engagement, ACBHD's SUD primary prevention programs serve youth ages 12 to 17 and their families throughout the county. ACBHD has an active network of adolescent SUD outpatient treatment programs and primary prevention services that provide youth-oriented programming through local community-based organizations (CBOs) embedded in the community. These programs provide education, youth development, and leadership opportunities as key strategies toward reducing and/or preventing substance use among youth while also making community-level changes to reduce alcohol and drug-related problems. The CYASOC and SUD departments collaborated on providing SUD services at the six county clinics. The CYASOC Department worked with Dr. Kayman to provide SUD training to our youth providers. CYASOC completed a survey of all providers (14 CBOs at school-based health centers) to see what type of SUD training they wanted. Dr. Sam Himmelstein conducted the training for the MH CBOs. The training modules focused on working with youth in school settings, integrating SUD treatment into MH services, and working with transition-age youth. These half-day workshops invited participants into a discussion about a trauma-informed, mindfulness-based framework for facilitating SUD treatment with youth and young adults.

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
	Specific techniques and approaches were taught for engagement and clinical growth. As a result of the SUD adolescent treatment QIP, the number of members served ages 12 to 17 increased from 65 members served to 180 members served (a 176.92 percent increase). In addition, the number of eligible members ages 12 to 17 increased from 46,831 members to 53,621 members (a 14.50 percent increase). Notably, the Medi-Cal penetration rate increased from 0.14 percent to 0.30 percent (a 114.29 percent increase).
3. Take steps to learn how many Medi-Cal members are receiving medication-assisted treatment (MAT) from allied health care providers such as federally qualified health centers (FQHCs) and The Bridge Clinic to obtain a more accurate picture of MAT utilization and the success of expansion activities in Alameda County.	QIDA conducted a data analysis on Medi-Cal beneficiaries who were provided MAT in FQHCs and The Bridge Clinic. During the review, it was identified that our DMC-ODS plan could improve on MAT (non-methadone) education, offering, and partnering with FQHCs (since they also provide MAT). The Bridge Clinic contract/service augmentation is to help with the above, and more specifically for in-reach (MAT education, referral, and linkage for MAT initiation and adherence) at DMC-ODS sites (i.e., Cherry Hill, Residential). We can report on our clients who are Medi-Cal beneficiaries who received MAT outside the SUD system using the DHCS pharmacy claims data, available through the Plan Data Feed, which is a data exchange process by which we send DHCS a finder file of beneficiaries served in our systems in the last 30 days, and DHCS returns claims for those beneficiaries for the prior 12 months. By matching clients to their pharmacy claims through the Client Identification Number and linking their prescriptions to our MAT drug matching table, we can identify the types of MAT drugs

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
	provided. Our reports will include details such as whether beneficiaries received MAT, the type and category of the drug, and the prescriber. In 2023, 1,264 clients received MAT for opioid use disorder from 43 identifiable organizations outside our system. Notably, a significant portion of these clients (45.5 percent) obtained their MAT from facilities within Alameda Health Systems, with Highland Hospital accounting for 42.48 percent of those prescriptions. Additionally, 61 percent of clients who received MAT for opioid use disorder outside our system had open SUD episodes with Center Point Helpline, Horizon, or Alameda Health Systems at the time they received their dose. Furthermore, around 80 percent of these clients accessed MAT in settings such as hospital emergency departments, hospital primary care, or clinics connected to hospitals.
4. Take steps to determine the root causes of the high rate of discharges prior to completion of treatment, and take active steps to decrease the number of members discharging prematurely.	In FY 2023–24, ACBHD had a *Care Coordination for Residential SUD Services* clinical PIP. The focus of the PIP was to support beneficiaries in residential treatment by providing care coordination services. The PIP focused on increasing the number of clients who engage and benefit from these coordination services, helping to connect to ongoing care and transition. By increasing care coordination services, Alameda County is working to support improved recovery as clients will remain more engaged with services leading to positive progress in treatment. In January 2025, ACBHD revised the PIP to a QIP. In Alameda County, residential treatment facilities offer care coordination services in

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
	addition to services that are included in the daily bundled rate. In collaboration with SUD and utilization management, QIDA developed a QIP to increase care coordination/case management service delivery and improve treatment outcomes for beneficiaries in substance use residential treatment. The following action steps were created: ♦ Train contracted providers to properly code case management. ♦ Increase the number of residential clients who receive case management/care coordination services. ♦ Update the dashboard to monitor case management service delivery and client outcomes. ♦ Analyze data and draw conclusions to improve interventions.
5. Take active steps to develop a 24/7 Access Line with SUD-trained staff available to provide a brief screening and referral after business hours, comparable to what is provided during business hours.	ACBHD contracts with Crisis Support Services (CSS) of Alameda County to provide 24-hour crisis line services, after-hours coverage for Acute Crisis Care and Evaluation for Systemwide Services (ACCESS), and the Substance Use Access and Referral Helpline. The executive director of CSS, Narges Dhillon, noted that all staff are trained on co-occurring disorders. The co-occurring training module provides staff guidance on how to manage crisis line calls with callers struggling with substance use and MH challenges. The training includes harm reduction strategies and motivational interviewing to reduce the negative impact of drug use. The instructor, Mackenzie Stuart, is a professor at Wright Lifeline Learning. The co-occurring training module is part of Lifeline Learning's 988-related training, which also covers various ways to work with callers who use substances

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
	or are intoxicated. In addition, all staff members take a class on "after-hours" which includes working with ACCESS, Center Point, and Cherry Hill.

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 DMC-ODS plan 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 DMC-ODS plan 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.

- DHCS' 2025 compliance review scores for Alameda show that the DMC-ODS plan was fully compliant with most CFR standards.
- During the NAV audit process, HSAG observed 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.
- DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Alameda:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Quality Assessment and Performance Improvement Program—§438.330

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 DMC-ODS plan's 2026 annual nonclinical PIP submission.
- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Alameda 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

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.

County of Contra Costa

Follow-Up on Prior Year Recommendations

Table B.2 provides the EQR recommendations directed to Contra Costa from the previous EQRO's 2023–24 DMC-ODS 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 Contra Costa's self-reported actions.

Table B.2—Contra Costa's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Enhance communications for system contractors with more engagement and debriefing related to the new rate model, payment reform implementation challenges, California Advancing and Innovating Medi-Cal (CalAIM) requirements, and delays impacting this year's contracts.	A monthly workgroup that focuses on SmartCare/information technology (IT) and finance/billing was established as a direct result of this recommendation. This highly functional standing group brings together providers and county finance/IT to address SmartCare priorities, operational needs, and Medi-Cal claiming, and to troubleshoot any issues providers may have. Contracting staff are meeting with individual providers to help prepare agency contracts. This will lessen errors that create longer waits for contract implementation. Ongoing training is provided to staff members and providers on SmartCare changes and optimizations. Various reports are now available to providers to enhance data transparency. Additionally, key regulatory updates are communicated through a monthly newsletter and at regularly established meetings.

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
2. Improve timely access to MH treatment services for members in SUD outpatient and residential treatment who have co-occurring disorders.	Coordination with MH has improved as MH has streamlined the process to access therapists posted in the provider directory without going through the Access Line. Staff from the Access Line attend quarterly meetings with providers to improve access for individuals with co-occurring disorders. The county also hired a care coordinator to support provider efforts in accessing MH services and system navigation. Contra Costa MH has also increased various outreach services for individuals needing immediate help, including transition teams; A3; and the Coordinated Outreach, Referral, and Engagement teams.
3. Identify those at risk of service withdrawal, and enhance engagement in discharge planning to reduce administrative discharges in the California Outcomes Measurement System (CalOMS).	To address the number of administrative discharges, the county did an in-depth review of the CalOMS data to assess the contributing factors. In collaboration with providers, the county conducted a Brown Bag training session with providers to increase awareness, get buy-in, and improve the quality of our data. Following this intervention, the county has continued to monitor data to assess changes. Thus far, our data indicate that the administrative discharge rate has improved significantly from FY 2023–24 to FY 2024–25.
4. Identify additional IT resources for transitions for key projects related to SmartCare, the interface with the Epic MH electronic health record (EHR); CalAIM initiatives; and workflows required by the provider network.	We continue to collaborate with the California Mental Health Services Authority (CalMHSA) for ongoing SmartCare support, including interoperability. Contra Costa has also secured two additional contracts with CalMHSA to enhance CalAIM initiatives and support workflows required by the provider network.
5. Create a plan for adding vital DMC-ODS services for monolingual women and youth residential treatment.	Outreach efforts toward adding services for monolingual women and youth continue. Solicitation proposals were issued without success. The county also secured a contract with a provider to dedicate a bed within a residential program to accommodate

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
	monolingual women to include a Spanish-speaking staff, while increasing outreach in the community and the jails. In addition, a youth residential treatment contract was established with an out-of-county provider, Muir Wood. The county continues to support the SUD Latino workgroup to elicit the input from staff to address the low penetration rate. The county has obtained Medi-Cal certification for its Spanish-speaking outpatient program, Nuevo Comienzo, and continues to grow that service.

Assessment of Contra Costa's Self-Reported Actions

HSAG reviewed Table B.2, 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 DMC-ODS plan 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 a National Committee for Quality Assurance (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 DMC-ODS plan was fully compliant with most CFR standards.
- During the NAV audit process, Contra Costa demonstrated a robust process to keep provider data up to date and accurate, including its credentialing process and monthly monitoring of multiple sanction/exclusion lists. Additionally, HSAG observed that Contra Costa has undertaken several initiatives to meet timely access indicators, including continuous provider recruitment and expanded staffing efforts.

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
  - Quality Assessment and Performance Improvement Program—§438.330

2024–25 External Quality Review Recommendations

- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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
- Quality Assessment and Performance Improvement Program—§438.330

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.

County of El Dorado

Follow-Up on Prior Year Recommendations

Table B.3 provides the EQR recommendations directed to El Dorado from the previous EQRO's 2023–24 DMC-ODS 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 El Dorado's self-reported actions.

Table B.3—El Dorado's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Research and develop methods to centralize the process of collecting timeliness data, which includes provider entries, tracking, and evaluating timeliness information (e.g., model a form into Avatar to capture data). This recommendation applies to all six-timeliness metrics, using DHCS standards. Data for this EQR were not provided for follow-up appointments after residential treatment.	El Dorado invested in a key performance indicator (KPI) dashboard through Netsmart to improve data collection and analysis. Additionally, El Dorado developed a form in Avatar to input and track timeliness data. This method has allowed us to move away from using Microsoft Excel (Excel) spreadsheets and centralize the process of collecting timeliness data and better evaluate timeliness information.
2. Collaborate with providers and research best practices for engagement, with an additional focus on intensive outpatient treatment (IOT) services, and develop strategies to increase member engagement and retention in treatment services.	El Dorado worked with providers, namely Recovery in Action (RIA), to develop strategies to increase participation in IOT services. RIA implemented a new curriculum to increase engagement and retention in IOT services.
3. Continue to rebalance the Quality Management Work Plan (QMWP) as a QI instrument that is similar to PIPs. Measure impacts of selected interventions and strategies through data analysis, and determine if goals	El Dorado updated its FY 2024–25 QMWP to include QI initiatives in addition to the required compliance measures.

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
are met or not met. For met goals, determine whether they improve the quality of member treatment, other services, and/or other areas of the SOC.	
4. Work to increase engagement of youth in SUD treatment.	El Dorado's SUD Services identified that part of the reason for low engagement was due to lack of capacity. El Dorado tried to identify DMC youth providers to contract with for residential and withdrawal management (WM) services. Lack of resources and providers in California, specifically Northern California, made contracting efforts even more difficult; however, El Dorado used some of it opioid settlement funds to contract with Muir Woods for both services. The contract is currently in the final phases of development and is expected to go to the Board of Supervisors in early September 2025.
5. Collaborate with the narcotic treatment program (NTP) provider, Aegis, to improve timely access to care for members requesting NTP/OTP services.	El Dorado SUD services implemented an ongoing QIP with Aegis from June 12, 2024, through December 31, 2024. The improvement project significantly increased quality of care by improving timely access to care: ♦ FY 2023–24 Q3—8.13 days from initial request for service to first dose appointment ♦ FY 2023–24 Q4—5.38 days from initial request for service to first dose appointment ♦ FY 2024–25 Q1—1.93 days from initial request for service to first dose appointment ♦ FY 2024–25 Q2—1.29 days from initial request for service to first dose appointment

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
6. Consider implementing a data warehouse for improved analytic reporting.	El Dorado invested in a KPI dashboard through Netsmart to improve data collection and analysis. El Dorado County SUD services is also implementing Microsoft Power BI to improve analytic reporting.

Assessment of El Dorado's Self-Reported Actions

HSAG reviewed Table B.3, 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 DMC-ODS plan 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' BH care needs through efforts to improve and expand delivery of services.

- DHCS' 2025 compliance review scores for El Dorado show that the DMC-ODS plan was fully compliant with most CFR standards.
- During the NAV audit process, HSAG observed that El Dorado established strong processes to manage and validate Medi-Cal eligibility data monthly from the Monthly Medi-Cal Eligibility File (MMEF) uploads. 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.
- DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for El Dorado:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207

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 DMC-ODS plan's 2026 annual nonclinical PIP submission.
- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 El Dorado meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207

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.

County of Fresno

This plan completed early BH administrative integration beginning January 1, 2025. As indicated previously, PIP activities were conducted by the Integrated BHP entity, and all PIP summary information is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* for this plan.

Follow-Up on Prior Year Recommendations

Table B.4 provides the EQR recommendations directed to Fresno from the previous EQRO's 2023–24 DMC-ODS 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 Fresno's self-reported actions.

Table B.4—Fresno's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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. Ensure the DMC-ODS plan's website information is monitored, current, and scheduled for regular updates.	Fresno is currently evaluating the website and determining how to best update and format the site. Currently, Fresno has created an improved central notification page in order to give providers access to necessary documentation and information.
2. Make the provision of family-centered therapies available to appropriate members, including perinatal programs. Additionally, expand the DMC-ODS plan's workforce for residential and other SUD programs experiencing critical staffing challenges.	Fresno continues to face critical staffing challenges throughout the MH and DMC-ODS plan systems. Fresno promotes co-occurring treatment for all persons served who present with symptoms that necessitate treatment. Fresno has implemented the necessary releases of information for DMC-ODS programs to refer individuals to MH treatment, and vice versa.
3. Take meaningful steps to establish a MAT oversight committee to review trends related to treatment and overdose data, and expand access to	Fresno has not yet determined the viability of a MAT oversight committee.

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
MAT services within the DMC-ODS plan.	
4. Provide sufficient resources, time, and staffing to oversee, implement, report, and track the two required PIPs (clinical and nonclinical).	Fresno has continued to complete PIPs and has worked as a part of the Institute for Healthcare Improvement Medi-Cal Collaborative to implement PIPs for the *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Emergency Department Visit for Substance Use* Healthcare Effectiveness Data and Information Set (HEDIS) measures. Fresno is also developing a PIP to address timeliness to psychiatric appointment requests.
5. Create a formal QI process for discussions with staff, providers, and other interested stakeholders that supports and considers input.	The Fresno Quality and Performance Management Team has conducted multiple rounds of focus groups with staff in order to receive stakeholder input and identify areas of improvement for workforce engagement as well as the ability for clinical staff to provide face-to-face claimable services.

Assessment of Fresno's Self-Reported Actions

HSAG reviewed Table B.4, 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

- 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' BH care needs through efforts to improve and expand delivery of services.
- DHCS' 2025 compliance review scores for Fresno show that the DMC-ODS plan was fully compliant with most CFR standards.
- During the NAV audit process, HSAG observed that Fresno maintained strong data oversight through SmartCare, internal quality assurance (QA) checks, and staff training to ensure that timely and accurate Timely Access Data Tool (TADT) submissions aligned with DHCS' standards.

Opportunities for Improvement

- 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

2024–25 External Quality Review Recommendations

- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Fresno meets all CFR standard requirements moving forward, work with DHCS through the Network Adequacy Evaluation (NAE) corrective action plan (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

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.

County of Humboldt

Follow-Up on Prior Year Recommendations

The previous EQRO did not make DMC-ODS plan-specific recommendations to Humboldt in the 2023–24 DMC-ODS EQR technical report; therefore, HSAG had no recommendations for follow-up with the DMC-ODS plan for this EQR technical report.

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

- During the PMV audit process, Humboldt, in conjunction with its subcontractor, Partnership HealthPlan of California (PHC), was prepared with pertinent staff and presentations to overview all sessions in scope of the virtual review and demonstrated willingness to collaborate with HSAG through technical assistance call requests on tasks that required further clarification.
- DHCS' 2025 compliance review scores for Humboldt show that the DMC-ODS plan was fully compliant with most CFR standards.

Opportunities for Improvement

- HSAG's 2025 PIP validation determined that Humboldt did not include all required details of its PIP processes for its clinical and nonclinical PIPs.
- Humboldt 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 Humboldt:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207

2024–25 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Humboldt includes all required information in the DMC-ODS plan's 2026 annual clinical and nonclinical PIP submissions.
- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Humboldt meets all CFR standard requirements moving forward, work with DHCS 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

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.

County of Imperial

Follow-Up on Prior Year Recommendations

Table B.5 provides the EQR recommendations directed to Imperial from the previous EQRO's 2023–24 DMC-ODS 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 Imperial's self-reported actions.

Table B.5—Imperial's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Continue to identify reasons for high rates of summary exits and high levels of unsatisfactory progress in treatment, and follow up with interventions to improve treatment outcomes.	Imperial County Behavioral Health Services (ICBHS) proactively conducted staff training to reinforce the importance of accurate coding when completing CalOMS discharge documentation. This training was held on January 11, 2024, and ensured that all relevant staff received standardized instruction. The primary objective was to reduce the number of administrative discharges and increase the use of standard CalOMS discharge codes. A high rate of administrative discharges had previously been attributed to miscoding during the discharge process. In addition to the training, program managers (PMs) and supervisors have implemented ongoing monthly monitoring of discharge data to assess improvements and ensure continued compliance with CalOMS reporting requirements. Furthermore, to improve treatment outcomes for individuals with stimulant use disorders, ICBHS voluntarily opted into the DHCS

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
	Contingency Management Pilot Program. This initiative utilizes motivational incentives to promote and reinforce abstinence, supporting long-term recovery outcomes.
2. Formulate recruiting incentives to attract administrative and direct service staff to fill vacancies and reestablish manageable DMC-ODS plan caseloads. If necessary, work with Imperial County Human Resources (HR) and executive management to expedite the hiring process and make progress toward expanding hiring to include peer support positions.	ICBHS has implemented several measures to expedite the hiring process. A live scan machine was purchased to conduct in-house background checks, reducing onboarding times by approximately 50 percent. Additionally, Imperial is proposing a one-year pilot program to the Board of Supervisors to streamline recruitment by shortening the recruitment window. Imperial County Public Health has also hired additional staff to accelerate pre-employment physical examinations. Furthermore, on August 7, 2023, ICBHS was awarded $1,109,824 through the Providing Access and Transforming Health (PATH) Justice-Involved Reentry Initiative Capacity Building Program Round 3, for the period of April 1, 2024, through March 31, 2026. These funds will support $2,500 retention stipends for direct and non-direct staff providing DMC-ODS services to justice-involved individuals during the 90-day pre-release period.
3. Continue efforts to establish a local, in-county residential treatment program with residential WM bed availability, and expand recovery residence capacity.	ICBHS was awarded $17,285,302 in grant funding through the DHCS Behavioral Health Continuum Infrastructure Program Round 5: Crisis and Behavioral Health Continuum Grants. This county-based funding supports the expansion and enhancement of BH infrastructure, providing new opportunities to address service gaps and implement sustainable improvements that better serve the residents of Imperial County. The awarded funds will be used to establish and develop a 16-bed residential SUD treatment facility in

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
	Imperial County. The facility will offer services aligned with the American Society of Addiction Medicine (ASAM) LOCs 3.2 (Clinically Managed Residential WM) and 3.5 (Clinically Managed High-Intensity Residential Services). The residential facility is anticipated to be fully constructed and operational by July 1, 2027. On January 7, 2025, ICBHS entered into an agreement with Open Door Ministry for the Broken to provide the first recovery residence services for women in Imperial County. The organization operates a designated six-bed recovery residence specifically for women and parenting women (ages 18 and older) who are receiving medically necessary treatment for SUD or recovery services. The recovery residence offers a stable, structured, and substance-free living environment that is essential to supporting sustained recovery. This setting promotes relapse prevention, continued sobriety, compliance with probation or child protective services requirements, attainment of steady income, and successful reintegration into the community. In addition to providing safe and sanitary housing, the residence offers access to counseling and comprehensive support services addressing mental, emotional, and spiritual well-being. Women and their children are also supported in navigating and accessing community resources, including job training, educational opportunities, trade schools, health and wellness services, and childcare, as appropriate. ICBHS is currently engaged in contract negotiations with Open Door Ministry for the Broken to expand recovery residence services through the development of an additional

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
	eight-bed facility for adult men (ages 18 and older). This expanded residence will be located in the southern region of the county where there is currently a lack of shelters and transitional housing options available for this population.
4. Increase collaboration with local emergency departments, health care systems, and managed care health plan (MCP) to improve and strengthen relationships with key partners.	ICBHS has strengthened collaboration with local emergency departments, health care systems, and MCPs to enhance community partnerships and improve the coordination of care. ICBHS has actively participated in monthly MCP stakeholder meetings to foster stronger relationships; increase mutual understanding of systems; raise awareness of available BH treatment services; and promote the delivery of integrated, coordinated care throughout the community. To further support these efforts, ICBHS established two recurring quarterly meetings: the SUD Champions meeting and the Behavioral Health Emergency Department Visits meeting. These meetings provide a structured forum to share updates, establish collaborative processes, and align efforts to ensure individuals treated in emergency departments are effectively connected to ICBHS for follow-up and ongoing outpatient services. The meetings have demonstrated opportunities for ICBHS and key community partners to engage in solution-focused dialogue and collectively advance low-barrier, wraparound, client-centered care.

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
5. Continue to work with CalMHSA to design reporting functionality within SmartCare for better tracking of timeliness and other features to make the system fully compatible with requirements.	CalMHSA has made available dedicated SmartCare screens to support the collection of timeliness data in alignment with the TADT requirements. These screens are designed to capture key data points needed for compliance with State reporting. As requirements continue to evolve, CalMHSA has hosted a series of county shared decision-making meetings to gather input and provide updates on modifications to the timeliness data entry screens. In addition, CalMHSA has developed and shared reporting tools that assist counties in extracting the required timeliness data for submission to DHCS. ICBHS uses these tools as part of its regular reporting processes and has further enhanced its internal oversight by building supplemental reports to monitor compliance. These reports are reviewed by clinical supervisors and management staff to ensure that timeliness standards are being met and that data are entered accurately and consistently. ICBHS will continue to work closely with CalMHSA and other county partners to refine these tools and ensure that SmartCare becomes a fully compliant and functional system capable of supporting comprehensive reporting, operational transparency, and QI.

Assessment of Imperial's Self-Reported Actions

HSAG reviewed Table B.5, 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 DMC-ODS plan 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.
- DHCS' 2025 compliance review scores for Imperial show that the DMC-ODS plan was fully compliant with most CFR standards.
- During the NAV audit process, HSAG observed 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.
- DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Imperial:
  - Availability of Services—§438.206

- Assurance of Adequate Capacity and Services—§438.207
- Quality Assessment and Performance Improvement Program—§438.330

2024–25 External Quality Review Recommendations

- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Imperial 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

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.

County of Kern

Follow-Up on Prior Year Recommendations

Table B.6 provides the EQR recommendations directed to Kern from the previous EQRO's 2023–24 DMC-ODS 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 Kern's self-reported actions.

Table B.6—Kern's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Take additional steps, such as offering more training for providers and/or adding CalOMS clinical and performance analytics into a data dashboard to better trend and inform opportunities for program improvement.	SUD Administration shared this recommendation at the monthly SUD treatment provider meeting. Providers gave feedback on how their staff are completing discharge forms, and guidance was also provided from our CalOMS Team that reviews admission, update, and discharge forms for accuracy before reporting to DHCS. After discussion on what considerations counselors and therapists should take when discharging a client, a brief one-page document was created to be shared with frontline staff for additional guidance. This document reminded staff that before selecting a discharge reason, they should consider progress made across the whole treatment episode, not just the last few weeks of treatment. Many times, clients stop attending treatment due to a slip, or simply due to disengaging, but this does not mean that zero progress was made. This dashboard is in development and is expected to be published in the first quarter of FY 2025–26 (either August or September KPI reporting).

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
2. Engage in partnership discussions with executive and leadership staff across agency lines with other departments that share the same population, such as child welfare and criminal justice, to collaboratively work toward increased access and coordination of care.	The CalAIM justice initiative has helped to facilitate discussions among Kern Behavioral Health & Recovery Services (KernBHRS) and several key partners such as the Kern County Sheriff's Office, Kern County Probation, a local hospital, and three MCPs. Meetings have been held throughout the year to understand the DHCS operational guide and complete implementation plans and readiness assessments. These conversations have helped to build new pathways for referrals into the DMC-ODS and will continue to grow as our local county jail and prisons go live in coordinating these Medi-Cal services to eligible inmates. KernBHRS plans to provide some pre-release services and link individuals to treatment providers as they exit incarceration. Additional communication began with the Superior Court in preparation for implementation of Proposition 36, and this has increased the number of referrals into DMC-ODS treatment.
3. QA staff members, in coordination with contract monitoring staff, should develop a review and technical assistance process with contracted providers in higher LOCs. Specifically, staff should focus on residential treatment to strengthen discharge planning and case management.	To enhance discharge planning and streamline case management coordination for clients requiring higher LOCs, particularly those in residential treatment, we have implemented the following measures: ♦ Kern offers linkage to case management services to all clients at the time of referral to treatment services. All clients entering residential treatment are connected with a case manager, thereby ensuring prompt engagement and support. Treatment providers retain the flexibility to request case management for clients at any time during the treatment episode.

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
	♦ Kern case management teams actively participate in case consultation meetings with both residential providers (Bakersfield Recovery Services and WestCare). These monthly meetings encourage collaborative discharge planning and the identification of clients who require additional support. ♦ Kern has collaborated with contracted residential providers to develop enhanced after-hours support. Recognizing the challenges associated with unplanned discharges and after-hours transitions, residential providers built processes so that when a client leaves treatment outside of regular business hours, they inform the Substance Abuse Division Substance Use Access Line to attempt to reengage the client into care. After-hours staff proactively work to facilitate reengagement by informing the client's case manager. The Substance Use Access Line works to reengage clients who have previously declined case management services. For clients with planned discharges, case management teams initiate follow-up contact within seven days post-discharge. This outreach aims to ensure continuity of care and identify any emerging needs or barriers to accessing necessary services. Bimonthly meetings with SUD Administration also allowed for technical assistance and reinforcement of the use of newly set-up processes.
4. Explore strategies and obtain agency partner or county-level support to increase residential treatment capacity, such as releasing solicitations on a recurring basis for this LOC.	Substance Abuse Division Administration staff members met with interested residential service providers to explain the need for services and the county contracting/procurement process in Kern County. The Substance Abuse Division Administration also released a request for

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
	information (RFI) to solicit interest for providing residential services in Kern County on March 18, 2024. The request solicited two proposals, one of which was from an existing DMC-ODS residential provider in Kern. Another RFI was issued by KernBHRS on August 24, 2024, to solicit interested residential providers as well as partial hospitalization providers to further fill the need for intensive services when residential services are not immediately available. The closing date of the second RFI was October 1, 2024. KernBHRS released a request for proposal (RFP) for SUD services that closed on March 21, 2025, to expand residential capacity. As of July 2025, SUD Administration is in early negotiations with two new providers in order to increase the number of residential beds in the county.
5. Continue to be proactive in exploring SmartCare functionality to fully implement automated reporting. Formalize a plan to validate data once reporting is available to ensure a complete data set.	The SUD Administration worked with the Software Development Team in order to create flow data reports, which compile important information for system monitoring. These reports allowed for more efficient data gathering as providers became more comfortable with utilizing the new EHR. SUD treatment teams and providers have been able to validate the accuracy of the data programmed into the reports through caseload and program census tracking and comparison. Although the type of information that can be gathered is not the same as with the previous EHR, adjustments have been made in the data presented to stakeholders based on current functionality. Additional reports were built for the Finance Division, which has continued to refine reports

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
	for claims to be paid to DMC-ODS providers, increasing compliance with data quality in the record to ensure accurate billing to DHCS.

Assessment of Kern's Self-Reported Actions

HSAG reviewed Table B.6, 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 DMC-ODS plan 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.

- DHCS' 2025 compliance review scores for Kern show that the DMC-ODS plan was fully compliant with most CFR standards.
- During the NAV audit process, HSAG observed that Kern conducted targeted systemwide training for SUD 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.
- DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Kern:
  - 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 DMC-ODS plan'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 Kern meets all CFR standard requirements moving forward, work with DHCS 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

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.

County of Lassen

Follow-Up on Prior Year Recommendations

The previous EQRO did not make DMC-ODS plan-specific recommendations to Lassen in the 2023–24 DMC-ODS EQR technical report; therefore, HSAG had no recommendations for follow-up with the DMC-ODS plan for this EQR technical report.

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

- During the PMV audit process, Lassen, in conjunction with its subcontractor, PHC, was prepared with pertinent staff and presentations to overview all sessions in scope of the virtual review and demonstrated willingness to collaborate with HSAG through technical assistance call requests on tasks that required further clarification.
- DHCS' 2025 compliance review scores for Lassen show that the DMC-ODS plan was fully compliant with most CFR standards.

Opportunities for Improvement

- HSAG's 2025 PIP validation determined that Lassen did not include all required details of its PIP processes for its clinical and nonclinical PIPs.
- Lassen 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 Lassen:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Subcontractual Relationships and Delegation—§438.230

- Health Information Systems—§438.242

2024–25 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Lassen includes all required information in the DMC-ODS plan's 2026 annual clinical and nonclinical PIP submissions.
- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Lassen meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Subcontractual Relationships and Delegation—§438.230
  - Health Information Systems—§438.242

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.

County of Los Angeles

Follow-Up on Prior Year Recommendations

Table B.7 provides the EQR recommendations directed to Los Angeles from the previous EQRO's 2023–24 DMC-ODS 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 Los Angeles' self-reported actions.

Table B.7—Los Angeles' Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Continue efforts to engage providers in adding MAT prescribers to their treatment programs by offering incentives.	Beginning in FY 2024–25, the Substance Abuse Prevention and Control (SAPC) program operationalized funding through which 30 treatment agencies committed to directly offer MAT managed by their own medical clinicians. In non-OTP settings, SAPC increased receipt of MAT services from FY 2023–24 to FY 2024–25 and also increased receipt of MAT services for members with opioid use disorder from FY 2023–24 to FY 2024–25.
2. Continue working with the provider network to implement the capability of documenting and tracking no-shows for admission assessments and visits as part of the EHR or other methods.	SAPC has completed the configuration of its EHR to support its provider network in documenting referral and appointment dispositions to better track no-shows and/or missed appointments. The provider network was informed of the implementation of the workflow during the regularly scheduled All Treatment Provider meeting on July 15, 2025, and formal notice will be released and trainings will begin in August 2025. The workflow is scheduled to go live on September 1, 2025.
3. Implement additional staffing resources to fully meet the needs for provider network monitoring, support for the new	SAPC requested 30 new positions to improve development and implementation of the SUD treatment under CalAIM and the DMC-ODS.

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
reimbursement system, and CalAIM requirements for developing new quality-related data and clinical documentation.	This included 30 positions in the following areas: ♦ New unit of five positions in the Sage (EHR) Division to manage record requests in CalAIM justice-involved implementation. ♦ A new unit of four positions in the Strategic and Network Development (SND) Division to manage complex efforts with the MCPs, support compliance, and enhance care coordination. ♦ A new unit of 10 positions in the Clinical Services Division to do street outreach, connect people to care, and support other county outreach teams to increase capacity to identify and refer to services. ♦ Two new senior management IT positions to direct and support the implementation of web-based solutions and design of new EHR tools. ♦ A new senior management position in the SND Division to develop and implement media campaigns and promotion efforts. ♦ Two analyst positions to expand the Fiscal Strategy Section's ability to enhance implementation of value-based care through its rates structure and incentives package for the DMC-ODS. ♦ An upgraded management position to oversee the Clinical Standards and Training Section. ♦ Five additional analyst positions in the Finance Services, Contracts and Compliance, Systems of Care, and Health Outcomes and Analytics Divisions to support implementation of CalAIM justice-involved strategies and broader DMC-ODS implementation efforts.

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
4. Increase outreach and engagement efforts as well as add potential new sites to prioritize areas of the county that have a higher concentration of overdoses.	SAPC contracts with harm reduction syringe services programs to provide low-threshold outreach and engagement in areas of highest need. From FY 2023–24 to FY 2024–25, SAPC increased the number of contracted harm reduction syringe services agencies from seven to 12, and added 44 additional outreach locations in areas of higher concentration of overdose need.
5. As part of the "95 Percent Campaign" to bring persons with SUDs into the care system, help providers review admission processes to eliminate potential barriers to admission into care, including drug testing.	♦ Created templates for admission, discharge, and toxicology testing policies in alignment with reaching the goal of 95 percent to expand SUD treatment access throughout the county. ♦ Led trainings for frontline/client-facing staff at treatment provider agencies about the need for lower barrier care and SAPC's evidence-based approach built on the needs of people with SUD. ♦ Provided one-on-one support and technical assistance (e.g., through coaching) to provider agencies to make service design more client-centered, informed by real client experiences moving through the treatment process/system.

Assessment of Los Angeles' Self-Reported Actions

HSAG reviewed Table B.7, 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

- During the PMV audit process, Los Angeles demonstrated engagement, partnership, and commitment to the PMV audit process in collaboration with HSAG. Additionally, Los Angeles demonstrated its commitment to addressing members' behavioral health care needs through organizational efforts to improve and expand delivery of services.
- DHCS assigned a 100 percent Total CFR Compliance Score during the DHCS 2025 compliance review scoring process for Los Angeles.
- During the NAV audit process, HSAG observed that Los Angeles' homegrown patient access to care portals, as source systems for timely access reporting, enabled the rapid identification and resolution of data gaps and implementation of data control processes to improve overall accuracy of timely access reporting. Additionally, Los Angeles' value-based incentive program included workforce development metrics to increase access to OTP and SUD providers, and access to care metrics designed to reduce system barriers to SUD treatment.

Opportunities for Improvement

- HSAG's 2025 PIP validation determined that Los Angeles did not include all required details of its PIP processes for its clinical and nonclinical PIPs.
- Los Angeles 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 Los Angeles includes all required information in the DMC-ODS plan's 2026 annual clinical and nonclinical PIP submissions.
- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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.

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.

County of Marin

This plan completed early BH administrative integration beginning January 1, 2025. As indicated previously, PIP activities were conducted by the Integrated BHP entity, and all PIP summary information is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* for this plan.

Follow-Up on Prior Year Recommendations

Table B.8 provides the EQR recommendations directed to Marin from the previous EQRO's 2023–24 DMC-ODS 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 Marin's self-reported actions.

Table B.8—Marin's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Research and explore options to address concerns regarding provider and member accessibility to quality translation and interpretation services.	We formed a cross-departmental language access workgroup, with representatives from Marin Behavioral Health and Recovery Services (BHRS), social services, the Office of the County Executive, and others to identify and address issues related to accessibility and the quality of translation and interpreter services. Changes since the EQR review included: ♦ The county issued an RFP for new interpreter and translation providers, which resulted in Marin selecting multiple vendors for contracting. ♦ The county developed a new webpage with detailed information on how to easily access interpreter or translation services, which substantially improved transparency and ease in accessing these services. ♦ The Office of the County Executive assumed responsibility from procurement

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
	staff to oversee language access contracts, which elevated the visibility of this work. Although contracted providers are still responsible for providing their own language access services for many functions, Marin DMC-ODS has been able to share information about the county's vendors to support the providers in establishing services, as needed.
2. Work to identify solutions and continue efforts to address issues pertaining to workforce recruitment, training, and retention, and obtain provider input for options to support staff.	Marin has enacted a multi-pronged approach to address workforce recruitment, training, and retention, including the following: ♦ Negotiated enhanced rates with providers to ensure a sustainable SUD system and allow providers to offer more competitive pay. ♦ As part of the BH Oversight and Accountability Commission grant, allowed participating agencies to be eligible for incentives to hire and engage in increased MAT prescribing. ♦ Asked providers at annual site visits for input and options for how the county can support them with staff recruitment and retention. ♦ Publicized the Medi-Cal BH Student Loan Repayment Program to staff and providers at our monthly provider meeting and via email. ♦ Utilized opioid settlement funding for provider recruitment outside of DMC-ODS with a focus on providing enhanced treatment and care coordination for Marin residents with an opioid use disorder; funds were also used to pay for clinicians to become eye movement desensitization and reprocessing certified.

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
	♦ Marin Health and Human Services (HHS) repurposed a conference room to be used by staff for mindfulness activities to reduce burnout and support stress management.
3. Take steps to clarify recovery coach (RC) functions and the availability of this service to members. Make necessary adjustments to the workflow and policies surrounding RC utilization, and assure both provider and member awareness on how to access this support service.	Since the review, Marin has engaged in the following to ensure providers, stakeholders, and members are aware of the availability and proper utilization of RCs. ♦ Conducted presentations to various stakeholders and referring partners on the RC role and how to make referrals. ♦ Created a SUD care coordination BH practitioner position to work with RCs to develop and implement a standardized referral form and process for assigning members based on needs/preference. ♦ The CalAIM Justice-Involved Workgroup is exploring adding additional RCs (contract or employees) to assist clients eligible for links to BH services. ♦ Substance Use Administration Team members participated in jail reentry team meetings to ensure timely client connection to RCs and proper utilization of RC services. ♦ Developed and distributed an RC overview document with RC roles and responsibilities, contact information, and population descriptions. ♦ Funded additional RC roles via opioid settlement funding at both Ritter Center and Marin Community Clinics to improve access to care coordination for individuals with an opioid use disorder. ♦ Funded an RC to support WM to assist clients before and after their stay.

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
4. Explore options and take meaningful steps to improve transparency, communication, and morale with the SUD provider network.	Following the EQR review with the previous EQRO, Marin DMC-ODS and EQR staff met to better understand the recommendation. EQR staff from the previous EQRO reported that the recommendation was largely based on provider feedback about tremendous challenges with SmartCare implementation. The EQR staff also noted one reference about providers' desire for more transparency with opioid settlement funding decisions. Based on the feedback, Marin implemented the following: **SmartCare Implementation Challenges** ♦ Resumed substance use-specific SmartCare office hours. ♦ Developed additional guides and resources that were posted and distributed to providers. ♦ Included key SmartCare data entry staff members in provider email distribution lists to enhance communication channels. ♦ Provided extensive training and technical assistance to providers. **Opioid Settlement Funding** ♦ Convened listening sessions and focus groups to gather additional stakeholder feedback, which was used to shape the RFPs. ♦ Formed an Opioid Disorder Free Marin Opioid Settlement Funding Ad Hoc Committee to gather stakeholder input on priorities. ♦ Launched a community-wide stakeholder feedback process, whereby the priorities identified were used to inform the pharmacy settlement spending plan.

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
	♦ Developed a website to detail all opioid settlement funding allocations, initiatives, and a summary of identified priorities and other key information: www.ODFreeMarin.org/OSF. More broadly, Marin DMC-ODS also: ♦ Convened facilitated conversations at DMC-ODS provider meetings on how to improve communication, which resulted in some shifts to the provider meeting format. ♦ Embedded into its annual provider site visit process a section on soliciting provider input on engagement and transparency in order to ensure ongoing focus. ♦ Conducted a mini retreat for providers, facilitated by experts in provider burnout and resilience.
5. Implement solutions to decrease claim denials, regain and improve data compilation and analytics efforts across multiple sources, and ensure timely delivery of data to decision makers.	Marin implemented the following solutions: ♦ Hired a department analyst II, whose primary focus is on analytics. ■ With this position's support, redesigned our invoicing process to show contracted providers which services we cannot pay them for until errors are corrected and give them more specific information about what needs to be fixed. ♦ Partnered with Marin HHS Billing, Marin BHRS EHR Team, and Quality Management (QM) to develop and implement new procedures to enhance timely and accurate claiming. ♦ Provided extensive training and technical assistance to providers to support accurate claim submission, and implemented procedures to perform extensive data

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
	quality checks prior to payment of monthly invoices. ♦ Contracted with CalMHSA for several initiatives aimed at improving data compilation and analytics, such as calculating HEDIS measures, supporting PIP development, performing revenue cycle management functions, and creating data dashboards.

Assessment of Marin's Self-Reported Actions

HSAG reviewed Table B.8, 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

♦ 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.

- DHCS' 2025 compliance review scores for Marin show that the DMC-ODS plan was fully compliant with most CFR standards.
- 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.
- DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Marin:
  - 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 DMC-ODS plan'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 Marin 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

Marin'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 Marin as well as the plan's progress with addressing these recommendations.

County of Mariposa

Follow-Up on Prior Year Recommendations

Although DHCS' contract with Mariposa began June 30, 2023, the previous EQRO made no recommendations to the DMC-ODS plan in the 2023–24 DMC-ODS EQR technical report; therefore, HSAG had no recommendations for follow-up with the DMC-ODS plan for this EQR technical report.

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

- HSAG assigned a *High Confidence* level to Mariposa's 2025 nonclinical PIP submission. Mariposa met all critical and evaluation element scores for this PIP submission, reflecting that the DMC-ODS plan built a robust foundation in the Design stage of its nonclinical PIP.
- During the PMV audit process, HSAG observed that Mariposa used the 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 InSync. Additionally, Mariposa implemented multiple methods of validation and tracking to ensure the accuracy and completeness of its provider data maintained in InSync.
- DHCS' 2025 compliance review scores for Mariposa show that the DMC-ODS plan was fully compliant with most CFR standards.
- Based on HSAG's NAV audit findings, HSAG determined 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 PIP.
- Mariposa 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 Mariposa:
  - 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 Mariposa includes all required information in the DMC-ODS plan's 2026 annual clinical PIP submission.
- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Mariposa 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

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.

County of Mendocino

Follow-Up on Prior Year Recommendations

The previous EQRO did not make DMC-ODS plan-specific recommendations to Mendocino in the 2023–24 DMC-ODS EQR technical report; therefore, HSAG had no recommendations for follow-up with the DMC-ODS plan for this EQR technical report.

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

- During the PMV audit process, Mendocino, in conjunction with its subcontractor, PHC, was prepared with pertinent staff and presentations to overview all sessions in scope of the virtual review and demonstrated willingness to collaborate with HSAG through technical assistance call requests on tasks that required further clarification.
- DHCS' 2025 compliance review scores for Mendocino show that the DMC-ODS plan was fully compliant with most CFR standards.

Opportunities for Improvement

- HSAG's 2025 PIP validation determined that Mendocino did not include all required details of its PIP processes for its clinical and nonclinical PIPs.
- Mendocino 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 Mendocino:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Health Information Systems—§438.242

2024–25 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Mendocino includes all required information in the DMC-ODS plan's 2026 annual clinical and nonclinical PIP submissions.
- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Mendocino 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

Mendocino'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 Mendocino as well as the plan's progress with addressing these recommendations.

County of Merced

Follow-Up on Prior Year Recommendations

Table B.9 provides the EQR recommendations directed to Merced from the previous EQRO's 2023–24 DMC-ODS 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 Merced's self-reported actions.

Table B.9—Merced's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Continue efforts to implement ASAM 3.2 residential WM LOC treatment services.	Our current residential provider received ASAM 3.2 residential WM LOC designation from DHCS. We are currently in the process of updating our contract with the provider to include this additional LOC and services provided. Merced County BHRS is also developing internal workflows and training for staff to appropriately refer clients to this LOC when clinically indicated. Our target start date is December 31, 2025.
2. Take meaningful steps to reduce workforce shortage and enhance recruitment efforts to improve staffing for both county and contract providers.	Merced County BHRS streamlined the hiring process to become more responsive and efficient. Interviews for vacant positions are conducted more frequently. Open positions are discussed at all leadership/senior leadership meetings. Merced County BHRS is also expanding recruitment through partnerships with local colleges and universities, including internship pipelines. Retention strategies include enhanced supervision, training opportunities, and participation in DRIVE and other employee engagement initiatives.
3. Provide opportunities for line staff and members to give input into system changes and development through	The QIC is discussed at new employee orientation with all new Merced County BHRS employees. Leadership staff members

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
participation in the DMC-ODS plan's Quality Improvement Committee (QIC). Take steps to encourage and support consistent line staff representation. Consider offering incentives to encourage clients who are invested in their recovery to attend and participate in QIC meetings regularly.	encourage their staff to attend QIC meetings. All QIC information is public-facing on the Merced County BHRS website. Internally we identify clients and staff to participate in the QIC and ensure updates from the meeting are shared across teams.
4. Coordinate with internal and contracted providers, as well as local community secular and faith-based organizations, to study, isolate, define, and address the specific factors that are contributing to persistently low penetration rates among the Hispanic/Latino population served by the SOC.	Merced County BHRS leadership staff and other staff members partnered with the Cultural Humility Committee to further investigate the low penetration rate. Merced County BHRS continues efforts to advertise and outreach to the Hispanic population. Merced County BHRS has a radio campaign addressing four outreach areas, and one of the campaign focus areas is outreach to our Spanish population regarding services available. This includes outreach messaging and interviews in Spanish on the most listened-to Spanish station in our county. Merced County BHRS participated in the Association on Higher Education and Disability Conference to better understand service gaps. We are building new partnerships with Latinx-serving community organizations, expanding peer specialist engagement, and exploring promotora-style outreach efforts to build trust and increase access.
5. Take additional steps and investigate the CalOMS discharge ratings to identify the underlying causal factors and develop strategies to reduce the number of administrative discharges that continue to occur.	Merced County BHRS is analyzing discharge data quarterly to identify patterns by provider, location, and demographics. To reduce administrative discharges and improve engagement, strategies include peer-led welcome calls, transportation assistance, and enhanced reminder systems. CalAIM changes have helped clients enter services more quickly, with more support available during the 30-day assessment window. Merced County

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
	BHRS added two SUD peer support specialist positions to offer early support during intake. Orientation groups were also implemented to provide services before the scheduled assessment, strengthening client connection and promoting retention.

Assessment of Merced's Self-Reported Actions

HSAG reviewed Table B.9, 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 DMC-ODS plan 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.

- DHCS' 2025 compliance review scores for Merced show that the DMC-ODS plan was fully compliant with most CFR standards.
- 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 DMC-ODS plan 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
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100
- During the NAV audit process, HSAG observed that Merced 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 DMC-ODS plan'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
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100

- To ensure the DMC-ODS plan meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Merced 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.

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.

County of Modoc

Follow-Up on Prior Year Recommendations

The previous EQRO did not make DMC-ODS plan-specific recommendations to Modoc in the 2023–24 DMC-ODS EQR technical report; therefore, HSAG had no recommendations for follow-up with the DMC-ODS plan for this EQR technical report.

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

- During the PMV audit process, Modoc, in conjunction with its subcontractor, PHC, was prepared with pertinent staff and presentations to overview all sessions in scope of the virtual review and demonstrated willingness to collaborate with HSAG through technical assistance call requests on tasks that required further clarification.
- DHCS' 2025 compliance review scores for Modoc show that the DMC-ODS plan was fully compliant with most CFR standards.

Opportunities for Improvement

- HSAG's 2025 PIP validation determined that Modoc did not include all required details of its PIP processes for its clinical and nonclinical PIPs.
- Modoc 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 Modoc:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208

- Subcontractual Relationships and Delegation—§438.230
- Health Information Systems—§438.242

2024–25 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Modoc includes all required information in the DMC-ODS plan's 2026 annual clinical and nonclinical PIP submissions.
- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Modoc 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
  - Subcontractual Relationships and Delegation—§438.230
  - Health Information Systems—§438.242

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.

County of Monterey

Follow-Up on Prior Year Recommendations

Table B.10 provides the EQR recommendations directed to Monterey from the previous EQRO's 2023–24 DMC-ODS 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 Monterey's self-reported actions.

Table B.10—Monterey's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Take active steps to develop a 24/7 Access Line with SUD trained staff available to provide a brief assessment and referral after business hours, comparable to what is provided during business hours.	The after-hours staff members currently complete a mini triage and will provide SUD community resources on demand. If members are wanting to connect with their existing providers, the after-hours staff send an email to the Monterey County Behavioral Health (MCBH) Access Team to follow up during the next business day. The follow-up call may include completion of the SUD Screening Tool to determine a preliminary ASAM LOC and case management services, as needed, to refer to the contracted SUD treatment provider.
2. Provide oversight and direction to contracted NTP providers to ensure that members receive their first dose of methadone in alignment with the DHCS timeliness standard of three business days.	The Quality Improvement Team has continually worked with the alcohol and other drugs (AOD) administrator and contracted NTP providers in implementing changes to workflows for capturing timeliness. Although this continues to be a challenge, MCBH is exploring innovative solutions to capture these data while avoiding additional documentation burdens on direct service providers. MCBH does not have a designated team to capture timeliness data; thus, the AOD administrator and Quality Improvement Team are tasked with implementing changes, monitoring the

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
	data, and making further adjustments, as needed. Furthermore, there is a statewide shortage of medical providers. The DMC-ODS reimbursement rate is not competitive with mental health plan (MHP)/MCP reimbursement, thus creating a void of competent and willing medical providers. Additionally, there continues to be a stigma and discomfort around prescribing MAT.
3. Expand local residential treatment, residential 3.2 WM, and recovery residence capacities. Increase capacity for youth treatment in all LOCs.	All four SUD contracted providers in Monterey County are certified by DHCS to provide outpatient and intensive outpatient services for youth. Despite increasing capacity for youth outpatient services, enrollment and retention are low across all contracted providers, in all regions. Currently, MCBH has not received any quality check deficiencies on the 274 files for adult residential and WM. The DMC-ODS reimbursement rate for recovery residences is lower than the cost to run a recovery residence and staff the program; therefore, the contracted providers in Monterey County find no incentive in developing this service. In lieu of a recovery residence, one provider has opted to open sober living environments, including a new 16-bed facility located on the same campus as the provider's outpatient and residential programs. This same provider has had a second sober living environment with six-bed availability in our county's southernmost city for about three years, and

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
	that sober living environment is also located on the same campus as the outpatient and residential program.
4. Identify the root causes for ASAM LOC initial screening and assessment incongruence. Provide training and assistance specific to ASAM LOC to help clinicians and counselors assist members in accessing the most suitable LOC for their individual circumstances.	Currently, MCBH staff and contracted providers are required to use the SUD Screening Tool to determine LOC. Upon administering the SUD Screening Tool, the staff/provider identifies a LOC recommendation and the member chooses a preferred LOC, thus creating potential incongruencies. Other contributing factors include external pressures (probation, court-mandated, family, etc.). Prior to the administration of the SUD Screening Tool, MCBH staff and contracted providers are required to receive certification with ASAM training. Additional training and consultation are provided weekly during office hours.
5. Add resources for new information systems and data analytics positions, and expand strategies to successfully fill vacancies to meet the increased demands of CalAIM, data integration, payment reform initiatives, and ongoing EHR development and data reporting needs.	Currently, MCBH has a fully staffed Avatar IT Team consisting of one supervisor and seven staff members. BH hired an epidemiologist as of July 2024 who supports the entire bureau.

Assessment of Monterey's Self-Reported Actions

HSAG reviewed Table B.10, 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 DMC-ODS plan 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 DMC-ODS plan 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

- Provider Selection—§438.214
- Enrollee Rights—§438.100

2024–25 External Quality Review Recommendations

- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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
  - Provider Selection—§438.214
  - Enrollee Rights—§438.100

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.

County of Napa

Follow-Up on Prior Year Recommendations

Table B.11 provides the EQR recommendations directed to Napa from the previous EQRO's 2023–24 DMC-ODS 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 Napa's self-reported actions.

Table B.11—Napa's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Continue to prioritize staff retention efforts by identifying areas in need of improvement through soliciting department-wide communications, addressing workload capacity, and identifying the causes leading to workforce expressions of burnout.	The Behavioral Health Division remains committed to staff retention by fostering a supportive work environment, addressing workload concerns, and reducing burnout. Department-wide communication is maintained through regular all-staff meetings, and feedback is solicited prior to implementing significant programmatic changes. Engagement opportunities include agency-wide cultural observances (e.g., Black History Month, Latino Heritage Month), holiday events, and division manager-hosted gatherings to help strengthen team connection. Staff well-being is supported through secondary trauma sessions facilitated by a consultant, flexible scheduling (9/80 schedules and one remote workday per week for eligible staff), and recognition via service awards. The division also promotes professional growth through internal promotions, licensure support, reimbursement for licensing exam and renewal fees, and licensure pay incentives.

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
	Competitive compensation remains a key retention strategy, with salaries among the highest in the Bay Area, automatic step increases, and enhancements in the new Service Employees International Union contract (effective July 1, 2024, through June 30, 2027), including annual base wage increases, enhanced deferred compensation matching, bilingual pay, the inclusion of additional time off with Indigenous People's Day observance, and a winter recess. Additionally, a Race, Equity, Inclusion, Diversity, and Belonging survey is underway to identify areas for broader cultural and organizational improvement.
2. Establish protocols to improve staff members' and members' understanding of local practices for using telehealth services given the input from staff and members regarding telehealth utilization.	The Behavioral Health Division has strengthened its telehealth protocols to ensure staff and clients have a clear understanding of local telehealth practices. The telehealth consent section of the Admission Agreement was updated to align with all requirements in DHCS Behavioral Health Information Notice (BHIN) 23-018. All contracted and county-operated providers utilizing telehealth are required to either use the county's consent form or update their existing consents to meet these requirements if not using the EHR. To improve staff knowledge, an annual training plan is being implemented as part of ongoing staff meetings, covering telehealth policies, documentation standards, and other key topics. Additionally, a dedicated telehealth track for clients has been established, with assigned staff members facilitating telehealth groups to provide consistent support, improve engagement, and enhance the quality of telehealth services.

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
3. Research and implement ways to improve and meet time frame standards for timely transitions in care following residential treatment.	The Behavioral Health Division has implemented strategies to support timely and coordinated transitions from residential treatment to outpatient care. For new clients, the discharge planning process now includes scheduling an appointment with AOD services staff members prior to discharge, ensuring clients know when to begin outpatient treatment. For established clients, their assigned case managers provide continuity of care and maintain oversight during the transition. To further enhance warm handoffs, the division is exploring expansion of field-based services, allowing staff to meet clients at the residential facility and directly support their transition into outpatient programs. These efforts aim to reduce service gaps, improve client engagement, and meet established time frame standards for post-residential follow-up.
4. Investigate the workflow process for screening, assessment, and identification of members with more acute needs and the referral process for those with urgent needs.	The Behavioral Health Division has an established screening process through the Brief Questionnaire for Initial Placement to determine an individual's initial level of need. This process enables staff to quickly identify urgent needs and make immediate referrals to appropriate services. As part of ongoing improvement efforts, the division is reviewing and refining workflow processes for screening, assessment, and referral to ensure timely identification and intervention for members with more acute needs. This review includes mapping current procedures across access points, evaluating referral pathways, and identifying opportunities to reduce delays. Collaboration between access, crisis, and clinical teams is central to

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
	these efforts, ensuring alignment with State and county time frame requirements. The ultimate goal is to provide rapid connection to appropriate services, supported by coordinated follow-up.
5. Undertake an analysis of informational services staff members need and take steps to assure that those resources are fully utilized to fulfill mandatory DMC-ODS plan reporting requirements.	The Behavioral Health Division has implemented multiple strategies to ensure staff have the informational resources necessary to meet all DMC-ODS reporting requirements. Standardized reporting templates have been developed in Smartsheet to promote consistent data entry and submission across programs. An access log was created to track timely access data, strengthen monitoring, and ensure compliance with reporting standards. To increase data analysis and reporting capacity, the division reorganized and expanded its quality assessment and performance improvement (QAPI) staffing. Reporting limitations in the current EHR (Credible) were evaluated, revealing an inability to generate essential supervisor reports (e.g., staff productivity, caseloads, service timeliness). To address this, the division contracted with Mission Driven Data to support reporting needs. A full EHR transition to SmartCare is scheduled for October 2025 to enhance system performance and reporting functionality.

Assessment of Napa's Self-Reported Actions

HSAG reviewed Table B.11, 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 *High Confidence* levels to Napa's 2025 clinical and nonclinical PIP submissions. Napa met all critical and evaluation element scores for both PIP submissions, reflecting that the DMC-ODS plan built a robust foundation in the Design stage of each PIP.
- During the PMV audit process, Napa demonstrated thorough oversight and monitoring of claims data and indicated that the DMC-ODS plan 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 DMC-ODS plan 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 BHP Access meetings to review performance and promptly address any issues or concerns.

Opportunities for Improvement

- 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
- During the NAV audit process, HSAG observed that Napa 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 DMC-ODS plan'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
- To ensure the DMC-ODS plan meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which Napa 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.

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.

County of Nevada

This plan completed early BH administrative integration beginning January 1, 2025. As indicated previously, PIP activities were conducted by the Integrated BHP entity, and all PIP summary information is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* for this plan.

Follow-Up on Prior Year Recommendations

Table B.12 provides the EQR recommendations directed to Nevada from the previous EQRO's 2023–24 DMC-ODS 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 Nevada's self-reported actions.

Table B.12—Nevada's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Take meaningful steps to identify barriers to timely intake appointments, develop initiatives to address barriers, and assure that programs have protocols for urgent service requests which include messaging to members. Develop and implement standards and training for staff members and contractors on the new timeliness forms in the EHR that will also encourage utilization of the centralized data source location.	Starting in July 2023, all timely access data were transitioned from a separate database (Microsoft SharePoint) to the county EHR, SmartCare. Several trainings were conducted throughout the transition period with both contractors and internal staff to review the new process for centralized data collection. 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

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
	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 new BH access team will go live around September 2025.
2. Continue to assist providers with identifying staff members who need CalOMS training, and monitor to ensure provider staff attendance at CalOMS trainings.	An administrative assistant registers new employees for CalOMS training through the CalOMS training website by creating a user profile on their behalf. Information on accessing and completing the training is then provided to the employee. Administrative staff are able to pull reports of an individual provider's last login date on the training website, and certificates of completion are provided via email.
3. Engage providers in meaningful discussions focused on areas of improvement identified in the individual provider Treatment Perceptions Survey (TPS) outcome report.	The TPS outcome report is reviewed and discussed annually with contracted providers and stakeholders at one of the Nevada QIC meetings, which are held monthly. Learnings and strategies for improvements are explored during these meetings.
4. Conduct an information systems internal analysis to determine the number of full-time equivalents (FTEs) required to adequately support data analytics and information systems responsibilities for the DMC-ODS plan.	Over the past two years, Nevada has significantly expanded its data analytics and information systems capacity. Nevada has assigned a dedicated administrative analyst to support the DMC-ODS plan and a senior administrative analyst to support the EHR and data analysis and performance measure management at large. Additionally, Nevada has recently secured a dedicated information and general services analyst to support data analytics, SQL report writing, and dashboard development.

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
5. Conduct a root cause analysis of low utilization for IOT to better identify solutions to enhance its use in light of the very high ASAM congruence reported. Collaborate and strategize with providers on evidence-based practices, including motivational interviewing and stages of change. Continue efforts to increase residential services for members.	The most significant contributing factor identified was a lack of sufficient staffing capacity among our contracted treatment providers. During this period, providers reported persistent workforce shortages that limited their ability to deliver intensive outpatient program services at the scale required to meet community needs. In response, Nevada collaborated with providers to explore workforce expansion strategies, including the development of provider incentives and internship pipelines to support recruitment and retention. Recognizing the unique challenges of serving a rural population, Nevada also prioritized expanding service delivery modalities through telehealth, which proved to be a critical component in increasing access. In parallel, Nevada explored opportunities to expand access to residential LOCs, successfully contracting with one new provider and anticipating the execution of a second contract in the coming month.

Assessment of Nevada's Self-Reported Actions

HSAG reviewed Table B.12, 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

- 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.
- DHCS' 2025 compliance review scores for Nevada show that the DMC-ODS plan was fully compliant with most CFR standards.
- During the NAV audit process, HSAG observed 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.
- DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Nevada:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Coordination and Continuity of Care—§438.208
- During the NAV audit process, HSAG observed that Nevada has opportunities to improve continuity in QA functions and timeliness reporting to reduce errors in the DMC-ODS plan's TADT submissions.

2024–25 External Quality Review Recommendations

- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Nevada 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
- 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.

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.

County of Orange

This plan completed early BH administrative integration beginning January 1, 2025. As indicated previously, PIP activities were conducted by the Integrated BHP entity, and all PIP summary information is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* for this plan.

Follow-Up on Prior Year Recommendations

Table B.13 provides the EQR recommendations directed to Orange from the previous EQRO's 2023–24 DMC-ODS 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 Orange's self-reported actions.

Table B.13—Orange's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Take active steps to address the no-show rates. Conduct a comprehensive analysis that includes feedback from contracted program staff as well as the DMC-ODS-operated programs. The new SUD division could benefit by prioritizing effective information gathering on no-show rates from all program line staff members and supervisors.	The Data Analytics and Evaluation Team presented on no-show rates at the SUD Quality Improvement Coordinators meeting in March 2024. Attendees at this meeting included both county-operated and contracted program staff and facilitated a discussion of potential reasons for no-shows, including client motivation, transportation issues, conflicting appointments, and availability of appointments. There was a follow-up presentation at the in-person SUD QIC meeting in August 2024 on the feedback received at the March 2024 meeting and a discussion regarding suggestions received, including further brainstorming about strategies to reduce no-shows. Furthermore, this analysis has informed our PIP, which utilizes peer services for better engagement of clients and reducing no-shows. Beyond this, our contract monitors have worked closely with the contract providers when issues arise regarding our

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
	MCP transportation services. Addressing MCP transportation services issues has been an ongoing area of support that contract providers have needed and that contract monitors have addressed during monthly management meetings. Our contract monitors reach out to the managed care transportation service team members to problem-solve these challenges.
2. Consider creating a meeting for contract provider clinicians and line staff members, and invite them to propose ideas for improvement, provide insight into what staff members are experiencing, and share success stories.	We facilitated an in-person SUD QIC meeting in August 2024 to promote direct contact with contract program staff and invited clinicians and line staff members. We requested individualized feedback as a majority of the contract providers had already reported feeling heard and had been a part of the communication flow with frequent management meetings and open discussions. Ongoing efforts have also been made to ensure providers' participation in focus groups to provide feedback and share their experiences and areas for growth on several initiatives, as well as implementations within the last year, including payment reform, recovery incentives program, certified peer support specialist staffing, BHSA, workgroups, etc.
3. Take steps to address the extremely low MAT utilization in the county. Orange DMC-ODS plan could benefit from enhancing relationships with NTPs to allow for meaningful discussions and problem solving regarding non-methadone MAT utilization.	At the in-person SUD QIC meeting in August 2024, we facilitated a discussion with all county-operated and contracted program staff on MAT referrals and utilization, barriers, areas of opportunity, and strengths. We reviewed questions raised and followed up with additional education and guidance to facilitate MAT referrals and utilization at subsequent QIC meetings. We also provided guidance to MHP county-operated programs on appropriate SUD and MAT referrals. Ongoing discussion with NTP providers elicited feedback that clients seeking NTP services,

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
	specifically methadone treatment, require this higher LOC, as there are more stringent requirements and regulations around methadone treatment services. Beyond this, we continue collaboration with NTPs to ensure that utilization of other medication options is available, such as Sublocade and Brixadi, when deemed medically necessary.
4. Utilize the new SUD division to work in partnership with QI staff members and the Behavioral Health Equity Committee (BHEC) to develop a revised cultural competence plan specific to SUD.	BHEC members attended the in-person SUD QIC meeting in August 2024 to further expand exposure to SUD services and to facilitate a discussion about cultural competence and potential barriers to care. A SUD subcommittee was created with the goal of including clients in recovery to include lived experience in the ongoing discussion.
5. Additional information systems staff positions for the Orange DMC-ODS plan are needed for ongoing support and development within the DMC-ODS plan SOC. Orange DMC-ODS plan would benefit from enhanced support from Orange County HR for the successful recruitment of vacant data analytics positions.	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 Behavioral Health Services (BHS) Data Analytics and Evaluation Department currently is in the process of filling four of the five new data science positions and is working with the Orange County and Orange County HCA HR departments to add an additional five data science positions. These positions support both the MHP and DMC-ODS and will expand the department's capacity to process and analyze large volumes of data quickly and consistently, thus supporting BHS' ability to make timely and data-informed decisions.

Assessment of Orange's Self-Reported Actions

HSAG reviewed Table B.13, 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

- 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.
- DHCS' 2025 compliance review scores for Orange show that the DMC-ODS plan was fully compliant with most CFR standards.
- 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.

- DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Orange:
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100
- 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 DMC-ODS plan'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 Orange meets all CFR standard requirements moving forward:
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100
- Partner with DHCS to explore alternative solutions for obtaining 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

Follow-Up on Prior Year Recommendations

Table B.14 provides the EQR recommendations directed to Placer from the previous EQRO's 2023–24 DMC-ODS 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 Placer's self-reported actions.

Table B.14—Placer's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Take meaningful steps to track all standardized timeliness metrics.	Placer County has a DMC-ODS Timeliness Work Group that meets monthly to monitor standardized timeliness metrics, identify areas for improvement, and develop strategies for implementing process enhancements. The group's efforts are presented and discussed quarterly at QIC meetings. ODS timeliness performance is also tracked annually as part of the QAPI workplan, with the goal of achieving year-over-year improvements. Currently, Placer County is working on a PIP focused on follow-up after clients' visits to the emergency department for substance use—an area identified as a HEDIS timeliness metric. The DMC-ODS PIP Work Group meets biweekly and presents its progress biannually at the SOC Evaluation Committee meetings.
2. Develop a strategy to utilize the TPS report outcomes for QIPs and activities.	Following the previous EQRO's recommendation to utilize TPS report outcomes for QIPs and activities, Placer worked to stratify the TPS reported outcomes from 2018 to the present. This report was shared with management and the ODS provider network. While it was noted that the

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
	2023 outcomes for care coordination were lower than 85 percent, this has not yet led to specific QIPs or activities thus far.
3. Continue efforts to engage and improve communications with providers.	Placer utilizes the following activities to engage and communicate with providers: ♦ Monthly DMC-ODS Provider Meeting ♦ Quarterly QIC meetings with MHP and DMC-ODS providers ♦ Monthly meetings with Placer County BH leadership ♦ Monthly EHR meetings with contracted providers utilizing the SmartCare EHR ♦ Regular emails with memos regarding updates and/or new requirements ♦ Maintaining the following website: Behavioral Health Quality Management | Placer County, CA ♦ Regular contract monitoring meetings with contracted providers
4. Implement and document PIP and Behavioral Health Quality Improvement Program refinements, enhancements tracking, and monitoring as planned.	Placer's program and QM leadership have participated in two cohorts with the University of the Pacific Transformational Change Partnership (TCP). Both cohorts developed foundational skills in implementing change and PIPs. Specifically, Placer's QM Team has developed its own Change Management program, modeled after the skills taught in the TCP, and has implemented this approach in the current PIPs. The following link provides more information on Placer's work with TCP: Cohorts | University of the Pacific.
5. Continue efforts to reach the 55 percent stated goal for CalOMS satisfactory discharge ratings.	Placer participated in stakeholder meetings that included DHCS and the County Behavioral Health Directors Association of California on the issue of the CalOMS 55 percent goal for satisfactory discharge ratings. Additionally, following the release of BHIN 25-001, Placer provided training materials via email and

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
	during the monthly ODS provider meeting to all provider staff involved in the submission of CalOMS data.

Assessment of Placer's Self-Reported Actions

HSAG reviewed Table B.14, 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 *High Confidence* levels to Placer's 2025 clinical and nonclinical PIP submissions. Placer met all critical and evaluation element scores for both PIP submissions, reflecting that the DMC-ODS plan built a robust foundation in the Design stage of each 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.

- DHCS' 2025 compliance review scores for Placer show that the DMC-ODS plan was fully compliant with most CFR standards.
- 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

- 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
  - Enrollee Rights—§438.100

2024–25 External Quality Review Recommendations

- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Placer meets all CFR standard requirements moving forward, work with DHCS through the:
  - Audits & Investigations (A&I) CAP process to fully resolve the findings that DHCS identified within the Enrollee Rights CFR standard (§438.100) during the DHCS 2025 compliance review scoring process.
  - 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

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.

County of Riverside

This plan completed early BH administrative integration beginning January 1, 2025. As indicated previously, PIP activities were conducted by the Integrated BHP entity, and all PIP summary information is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* for this plan.

Follow-Up on Prior Year Recommendations

Table B.15 provides the EQR recommendations directed to Riverside from the previous EQRO's 2023–24 DMC-ODS 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 Riverside's self-reported actions.

Table B.15—Riverside's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Continue development of a tracking mechanism to monitor no-shows and first offered appointments that conforms with State guidelines for timely access to SUD care.	California Code of Regulations Title 22 (No-Shows)—Our system currently monitors no-shows through the use of codes in our EHR, which conforms to State guidelines and Title 22. Using our block time appointments for first offered services, we can determine when a member has missed an appointment so that we are able to properly log the disposition and outreach in an effort to reschedule the appointment. A similar process is observed for our contracted providers who maintain their own no-show codes and use our referral disposition form to provide real-time closed-loop communication.
2. Expand the ASAM-based continuum of care to include the provision of telehealth, WM, and NTP/MAT services in rural and remote areas.	We have been tracking this since 2021 with the use of telehealth through research reports. We take this information and are able to expand our telehealth capacity using Microsoft Teams. We have also targeted RFPs for

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
	contractors (NTP services) in the rural geographical areas.
3. Riverside DMC-ODS plan's integrated SUD/MHP QI workplan would benefit from having more tracked objectives and goals and including trend data with each element. This would enable the viewer to access narrative conclusions and review the supporting data.	We have updated the way we receive input and format our QI workplan. This past year we focused on integrated goals that affected both our DMC-ODS and MH programs. Each goal had multiple associated objectives, 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.
4. Investigate the discrepancy between Riverside DMC-ODS plan's reported average days to the first dose of methadone and the EQRO's data, and identify any potential outliers or data inconsistencies that may have contributed to this seemingly discordant finding.	We have investigated this discrepancy and have discovered that the previous EQRO's methodology was not in alignment with the way we track and report on the average dose of methadone for DMC-ODS members. We never received confirmation on which data element the previous EQRO was using to start tracking days; however, our county counts the ASAM screening date. The previous EQRO would not have had the screening date data as the starting point for tracking to first dose started.
5. Explore innovative ways to obtain funding for additional counselors, case managers, administrative support staff, and peer support specialists to alleviate contract provider staff workload burdens and ensure adequate support services.	The department has received grants through our county's Workforce Development Department that have helped us host a hiring fair and a mentored intern program through Advocates for Human Potential, Inc., allowing us to identify potential providers for our SOC.

Assessment of Riverside's Self-Reported Actions

HSAG reviewed Table B.15, 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

- 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.
- DHCS' 2025 compliance review scores for Riverside show that the DMC-ODS plan was fully compliant with most CFR standards.
- 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 DMC-ODS 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.
- DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Riverside:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Subcontractual Relationships and Delegation—§438.230
- During the NAV audit process, HSAG observed that Riverside did 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 DMC-ODS plan'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 Riverside meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Subcontractual Relationships and Delegation—§438.230
- 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.

County of Sacramento

This plan completed early BH administrative integration beginning January 1, 2025. As indicated previously, PIP activities were conducted by the Integrated BHP entity, and all PIP summary information is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* for this plan.

Follow-Up on Prior Year Recommendations

Table B.16 provides the EQR recommendations directed to Sacramento from the previous EQRO's 2023–24 DMC-ODS 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 Sacramento's self-reported actions.

Table B.16—Sacramento's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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. Take meaningful, ongoing steps to improve the Access Call Center process. Conduct ongoing SUD-specific training for all staff members, including management. Replace the full ASAM assessment with a brief screening tool to save time and relieve the pressure on staff members to complete a full ASAM assessment in one hour.	Sacramento County integrated the access lines for MH services and SUD services into a central call center. This increased the number of staff members available to respond to calls in a timely manner. All staff members were cross-trained to complete the screening tools for both MH and DMC-ODS and link individuals to a provider to complete the full clinical assessment.
2. Continue aggressively soliciting providers to expand the number of available residential beds. Engage in bidirectional discussion with providers on the challenges No Wrong Door is presenting, and engage in collaborative problem solving.	DMC-ODS management continues to recruit residential providers. Sacramento County has also focused on increasing the number of sober living environments to support linkage to outpatient services and continued support of members' recovery plans.
3. Take meaningful steps to find new and innovative ways to invite and engage line staff and DMC-ODS plan members to become involved in the QI process.	The workplan is now integrated for the MHP and DMC-ODS plan. QIC recruitment has been effective for current provider types and is ongoing as new providers are onboarded.

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
Ensure the QI workplan for SUD is clearly and consistently defined as such, and delete any misplaced MH verbiage and erroneous staff positions.	
4. Expand collaboration with provider management and line staff members to engage in a problem-solving process to address the low follow-up rates after discharge from residential treatment and the low numbers of members accessing recovery support services.	DMC-ODS has added sober living environments and recovery services into residential contracts to ensure recovery services are initiated while clients are still in residential services. The hope is that the engagement will improve the follow-up rates after discharge. (Substance Use Prevention and Treatment Services to approve.)
5. Continue to build internal information systems and data analytic capacity of SmartCare reporting simultaneously with the statewide development efforts of CalMHSA.	Sacramento has created 91 reports for local data and oversight needs in addition to CalMHSA reports that are developed to meet statewide reporting requirements.

Assessment of Sacramento's Self-Reported Actions

HSAG reviewed Table B.16, 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

- 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 DMC-ODS plan was fully compliant with most CFR standards.
- During the NAV audit process, HSAG observed that Sacramento performed extensive provider data cleanup for system transition and continued a quarterly reporting process to address missing provider data, including qualifications, licensure, and historical information.

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
  - Enrollee Rights—§438.100
- During the NAV audit process:
  - Sacramento reported that:
    - An estimated 70 percent of services for timeliness indicators were not submitted by providers.
    - The MMEF was not utilized as a resource to populate the EHR system with member eligibility data.
  - HSAG observed that Sacramento did not:
    - Conduct proactive validation of eligibility, which would include checks to identify potential duplicate member records, or validation of manual eligibility entries made in SmartCare to MMEF data, resulting in full reliance on end users to identify potential duplicate records.
    - 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 DMC-ODS plan'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 Sacramento meets all CFR standard requirements moving forward, work with DHCS through the:
  - A&I CAP process to fully resolve the findings that DHCS identified within the Enrollee Rights CFR standard (§438.100) during the DHCS 2025 compliance review scoring process.
  - 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 improve timely access reporting:
  - Consider expanding provider training opportunities to further increase understanding and emphasize the importance of tracking timeliness data in SmartCare.
  - Explore system reporting capabilities, such as self-service tools, for providers to identify and address missing or incomplete timeliness records.
  - Explore developing automated reporting methods to identify potential duplicate member records in the system and to validate manual eligibility entries made in SmartCare.
  - Explore utilizing the MMEF to allow for more automation in populating member eligibility data.
  - Conduct an in-depth review of the indicators for which Sacramento 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.

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.

County of San Benito

Follow-Up on Prior Year Recommendations

Table B.17 provides the EQR recommendations directed to San Benito from the previous EQRO's 2023–24 DMC-ODS 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 San Benito's self-reported actions.

Table B.17—San Benito's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Promote the Access Line for urgent needs, and track urgent service capacity and responses to allow for rapid engagement of members in withdrawal or who are pregnant and needing urgent substance use services (SUS).	Since this EQR, San Benito County Behavioral Health has started its mobile crisis program. During the lead-up to the implementation of this program, our agency extensively promoted all Access Line numbers. This promotion included radio, messages, billboards, theater commercials, flyers, and community meetings. San Benito County Behavioral Health staff meets with its EHR provider, CalMHSA, several times a week. One of the topics that is regularly discussed during these meetings is tracking all timeliness requirements, including urgent conditions. We are still reviewing forms in our EHR that can be utilized to better track urgent conditions.
2. Continue recruiting, hiring, and contracting efforts to establish outpatient MAT access within San Benito County, and support timely access to NTP services. Take steps to promote these services. Ensure that urgent calls to the access phone line during the day, on weekends, and in the	San Benito County Behavioral Health has provided office space to a non-contracted psychiatrist to provide MAT services to our clients biweekly. San Benito County Behavioral Health contracts with a narcotics treatment provider located in Salinas, California. We have assisted this provider with opening a location in Hollister, California. The provider

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
evening can be identified and directed to treatment.	hopes to have the facility open within the next several months.
3. Enhance member engagement related to discharge planning, and individualize treatment needs early in treatment episodes to reduce administrative discharges in CalOMS and enhance planned discharges to recovery support and community resources.	San Benito County Behavioral Health meets with our EHR provider, CalMHSA, several times a week. Our weekly State reporting review meeting with them focuses on the improvement of our CalOMS compliance and accuracy.
4. Enlist expanded support for human resource activities to prioritize, classify, and fill essential finance, information systems, and clinical positions, providing needed capacity for successfully implementing CalAIM initiatives. Areas needing support include criminal justice reform; payment reform; and clinical services such as care courts, mobile crisis services, new quality requirements, and youth initiatives.	San Benito County Behavioral Health has reviewed, updated, and developed job descriptions for our agency. Our agency has hired additional staff and contracted with partnering agencies to provide services like mobile crisis. We have continued to partner with local universities to help further develop our workforce. We have applied for and been approved for a PATH grant that will allow us to expand our workforce and provide services to justice-involved individuals.
5. Review and enhance the San Benito Behavioral Health website to improve member access to needed information. Establish a regular update process for provider numbers, locations, and information changes.	San Benito County Behavioral Health has continued to make all DHCS-required updates to our website for topics such as beneficiary handbooks, interoperability, and application programming interface. Issues related to access to care are reviewed monthly at the agency QIC meeting. A staff member has been assigned as the primary individual responsible for website updates.

Assessment of San Benito's Self-Reported Actions

HSAG reviewed Table B.17, 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 DMC-ODS plan 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.
- DHCS' 2025 compliance review scores for San Benito show that the DMC-ODS plan was fully compliant with most CFR standards. Additionally, through the A&I CAP process, San Benito resolved the findings that DHCS identified within the Enrollee Rights CFR standard (§438.100) during the DHCS 2025 compliance review scoring process.
- 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.
- San Benito 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 DMC-ODS plan'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 San Benito 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

San Benito'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 Benito as well as the plan's progress with addressing these recommendations.

County of San Bernardino

Follow-Up on Prior Year Recommendations

Table B.18 provides the EQR recommendations directed to San Bernardino from the previous EQRO's 2023–24 DMC-ODS 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 San Bernardino's self-reported actions.

Table B.18—San Bernardino's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Continue to take meaningful steps to identify barriers to timely intake appointments; develop initiatives to address the identified barriers; and ensure that programs have protocols for urgent service requests, which include messaging to members.	San Bernardino: ♦ Updated the provider directory in accordance with DHCS requirements. ♦ Informed all staff members of the availability of nearby facilities to ensure client access to multiple service locations. ♦ Conducted staff training on after-hours protocols, including emergent and urgent situations. ♦ Improved data collection processes through an updated Initial Contact Log (ICL) and conducted multiple staff and contractor trainings to support these updates. ♦ Conducted ICL training to improve data accuracy and consistency. ♦ Added a new widget to myAvatar to collect TADT data, display all open ICLs and outcomes, and track steps taken post-intake to ensure requests are resolved efficiently.
2. Take steps to ensure timely residential admissions for members who present after normal business hours, including weekends, and provide clear	♦ The San Bernardino Department of Behavioral Health (DBH) Access Line is available 24/7 to support members.

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
messaging and protocols for providers and their staff members.	♦ All residential referrals are processed through the Screening, Assessment, and Referral Center (SARC), which is the DMC-ODS access line and call center. ♦ Providers follow established residential admissions procedures. ♦ Members can contact SARC at any time for screening and authorization for residential treatment services. ♦ Residential providers are informed of SARC and are trained to assist members in the screening and referral process.
3. Develop clinical training on the use of virtual translation services, and teach staff how to remain engaged with the member rather than focusing on the mechanics of the translation service.	All staff have been trained in accordance with Office of Equity and Inclusion and San Bernardino DBH procedures.
4. Continue to conduct outreach to faith-based organizations (FBOs) and other appropriate stakeholders in the more isolated regions of the county. Develop partnerships and collaborations with a focus on enhancing existing clubhouse services and adding other needed support services.	San Bernardino did the following in response to the recommendation: ♦ Participated in Community Policy Advisory Committee meetings to strengthen community partnerships. ♦ Expanded networking efforts with FBOs. ♦ Conducted trainings at FBOs to increase awareness and support. ♦ Conducted over 300 outreach events across the county during FY 2024–25. ♦ For clubhouse services, hired AOD counselors to provide group sessions, individual counseling, and harm reduction activities. For clubhouses without permanent AOD staff, guest AOD counselors are utilized. ♦ Strengthened collaboration between SUD recovery services and clubhouse programs to enhance service delivery.

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
	♦ Deployed the Mobile Outreach Unit to reach identified hotspots and geographically isolated areas throughout San Bernardino County.
5. Update the website to include criminal justice system resources for family and adolescent services, (e.g., school resources, community centers, and other appropriate youth programs such as Friday Night Live). Review the consistency of the webpage font size to improve the ease of locating providers and other resources.	♦ The website has been updated to improve navigation and user experience. Criminal justice system resources for family and adolescent services are addressed and posted online via the provider handbook and the San Bernardino DBH Services guide. ♦ Resources are now more easily accessible to the public. ♦ Enhancements have been made to the Narcan Distribution Project, increasing the volume and tracking of Narcan distribution. ♦ Clickable banners have been added for SUD services and information, including Contingency Management and Naloxone (Narcan). ♦ The following are links to resources on the website: ■ Provider Directory ■ Services Guide, Directories and Resource Library – DBH Internet Website ■ Referral Only Programs – DBH Internet Website

Assessment of San Bernardino's Self-Reported Actions

HSAG reviewed Table B.18, 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 DMC-ODS plan 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.
- DHCS' 2025 compliance review scores for San Bernardino show that the DMC-ODS plan was fully compliant with most CFR standards.
- 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.
- DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for San Bernardino:
  - 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 San Bernardino 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 DMC-ODS plan'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 Bernardino 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
- To ensure the DMC-ODS plan meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which San Bernardino 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 Bernardino'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 Bernardino as well as the plan's progress with addressing these recommendations.

County of San Diego

Follow-Up on Prior Year Recommendations

Table B.19 provides the EQR recommendations directed to San Diego from the previous EQRO's 2023–24 DMC-ODS 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 San Diego's self-reported actions.

Table B.19—San Diego's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Take meaningful steps to increase system capacity for member access to WM services.	The last three RFPs for the reprocurement of substance use outpatient contracts included this language: *The contractor shall either implement MAT on-site or ensure direct connection to such services for eligible clients*. According to the RFP statement of work, the inclusion of ambulatory withdrawal management (AWM) services in the proposal was optional. Among the 11 reprocured adult non-perinatal substance use outpatient contracts, six proposed AWM levels 1 and 2 (two of these programs recently implemented these services, and the other four are pending certification from DHCS). Four contracts proposed to offer only AWM Level 1, which are currently active. One contract chose not to offer AWM. The two contracts, not part of the RFP, chose to add AWM Level 1 to their programs with certification from DHCS pending. Out of the six perinatal outpatient SUD treatment programs, four have been offering AWM Level 1 services (21 slots) since May 2024.

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
	The San Diego County Board of Supervisors sanctioned funding for a new facility in National City, California, which will feature 72 to 96 beds dedicated to residential treatment, WM services, and recuperative care. The program will be named Substance Use Residential Treatment Services and is designed to facilitate co-located services that enable flexible transitions between different LOCs, depending on the client's acuity and recovery requirements.
2. Continue efforts to build more capacity in both residential treatment and recovery residences.	In collaboration with the Epidemiology and Data Science teams, San Diego County Behavioral Health Services (SDCBHS) conducted a detailed analysis of SUD residential service utilization (LOC 4.0–4.5) for FY 2023–24. This analysis included geo-mapping client data by ZIP Code to identify regional patterns and gaps in service access. SDCBHS currently operates 20 residential treatment programs across four regions: eight in Central, four in East, two in North Coastal, and four in North Inland. However, the analysis highlighted notable service gaps, particularly in the South and East regions, indicating a need for expanded residential and recovery residence capacity. To address these gaps, the San Diego County Board of Supervisors has approved funding for a new facility in the South Region. This upcoming center will offer 72 to 96 residential treatment beds, WM services, and short-term housing for individuals transitioning from acute care. With 1,013 residential beds currently in operation, open procurement efforts are expected to increase total capacity to 1,114 beds. In parallel, several providers are

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
	expanding their capacity to serve clients with more complex needs at Level 3.5. As part of a broader strategy to reduce dependency on residential treatment, SDCBHS is also expanding outpatient services. Six providers across the East, South Bay, North Central, and North Coastal regions are either delivering or directly linking clients to MAT. Additionally, numerous providers are renovating their facilities to offer AWM services. This includes the expansion of AWM into outpatient and perinatal programs, procurement of five outpatient programs, and integration of AWM services into four perinatal treatment sites. These efforts reflect SDCBHS' commitment to using data-driven strategies to ensure equitable and geographically targeted access to both residential and outpatient SUD treatment services.
3. Improve and develop more transparent communication pathways with providers while continuing to engage with them to improve data tracking, analysis, and integrity via groups such as the SUD Provider Association.	SDCBHS holds monthly Quality Improvement Partners meetings with DMC-ODS providers, including members of the SUD Provider Association. These meetings provide a collaborative forum to share updates, review documentation requirements, and address provider questions. SDCBHS has also met regularly with the Contract Support Team (CST), which has shared recent communications with DMC-ODS providers. These include meeting agendas and minutes that document and reinforce key topics, particularly those related to billing and payment. All billing and payment reform updates are consistently communicated to contracted providers through email and

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
	scheduled meetings. The CST also participates in financial meetings facilitated by the SDCBHS Finance Team and is available to assist with any contract-related questions during these meetings. SDCBHS also engaged with CalMHSA to review operations/requirements to streamline 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. To enhance communication with providers, SDCBHS launched GovDelivery on July 1, 2025. This web-based platform enables direct provider staff to receive timely updates, announcements, and important information from SDCBHS via email or text message (Short Message Service [SMS]).
4. Seek to revise the Access Line's structure and processes to provide referral management and an initial ASAM screening or assessment for members seeking services. This can increase the likelihood of referral to the appropriate LOC.	The Access and Crisis Line (ACL) completes an initial ASAM screening as part of the current referral process, and SDCBHS is looking at how the SmartCare EHR can support electronic referral management processes, although this functionality is not yet available. Direct entry of information into the EHR and closed feedback loop processes for effective referral management are goals for ACL staff as SDCBHS continues to explore SmartCare functionality.

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
5. Explore SmartCare functionality to fully implement available system options upon transition.	SmartCare implementation efforts continue as SDCBHS has used a phased approach to meet system requirements and work collaboratively with CalMHSA and the SmartCare vendor on updates and testing as needed. Within this work, enhancements have been identified for regulatory purposes, as well as for optimization purposes, to be included on the SDCBHS EHR roadmap in efforts to fully implement available functionality over time.

Assessment of San Diego's Self-Reported Actions

HSAG reviewed Table B.19, 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 DMC-ODS plan 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 DMC-ODS plan 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
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100

2024–25 External Quality Review Recommendations

- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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
  - Health Information Systems—§438.242
  - Enrollee Rights—§438.100

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.

County of San Francisco

Follow-Up on Prior Year Recommendations

Table B.20 provides the EQR recommendations directed to San Francisco from the previous EQRO's 2023–24 DMC-ODS 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 San Francisco's self-reported actions.

Table B.20—San Francisco's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Enhance program monitoring to ensure programs have updated treatment tools, allow member input to address concerns, and are operated safely and professionally.	San Francisco remains committed to enhancing its program monitoring to ensure all programs utilize updated treatment tools, incorporate member input, and operate safely and professionally. This is accomplished through a robust grievance and appeals process, maintaining active program management, and continuous QI. The Risk Management (RM) Department plays a crucial role in addressing member input and concerns. Grievance and appeals process information is readily accessible at all program sites, ensuring members know how and have the tools to voice concerns. Members can file grievances or complaints at any time without fear of reprisal. Self-addressed envelopes are available at each site for this purpose, and these are reviewed by the RM Team. If significant concerns arise, this team investigates and makes recommendations, notifying the SOC Team for broader issues. Annually, an analysis of the collective grievances, appeals, fair hearings, and requests to change service providers is

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
	completed to identify patterns that may inform necessary policy or program changes. This analysis is comprehensive of reports and trends that pinpoint areas needing improvement, and findings are presented to the broader SOC QIC and other relevant management or provider forums. Between 2023 and 2024, the SUS SOC Team also increased its staff, including new PM positions for adult residential and adult outpatient services. The SUS PMs work closely with the Compliance Team and participate in the Agency Technical Assistance Plan, which allows us to increase the frequency of meetings with providers needing technical assistance for goal and metric setting or other improvement work such as addressing low units of service or complaints. PMs are heavily involved in program and data monitoring to consistently provide tailored technical assistance to programs. PMs also meet with programs monthly or more often as needed, allowing them to relay any new information, explain policy changes, and ensure timely and proper implementation of those changes. Examples of these activities have included monitoring of timely access policies, streamlining of corrective action processes, ensuring understanding and implementation of notices of adverse benefit determination, and adjusting to changing federal and State regulations to methadone services for OTP providers.
2. Continue efforts to engage and recruit the workforce and to optimize workflows and protocols, allowing for best use of available staff.	We are continuing our commitment to engage and recruit our workforce and optimize workflows and protocols to ensure the best use of our available staff.

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
	The SUS SOC Team made significant strides in bolstering our teams and improving our processes. The SUS SOC Team has both expanded and restructured. In the past, one person held both the AOD administrator and the deputy medical director roles. In FY 2023–24, these roles were divided into two leadership positions: 1) a deputy medical director of SUS and 2) an AOD administrator who would also hold the SUS SOC director role. This division allowed for more feasible and realistic oversight of the different components of the overall SUS SOC. In the past, the PMs acted as liaisons to SUS, working directly under Adult and Older Adult (AOA)/Adult and Children, Youth, and Their Families/Youth departments. In FYs 2023–24 and 2024–25, these positions were brought under SUS. Furthermore, it was determined that the AOA/adult portfolio was too large for one person to oversee, so it was divided into two adult PM positions to better serve our CBOs. Moreover, to enhance QI efforts, the SUS SOC Team additionally created a QI director role to collaborate with various departments within BHS, including IT and data teams, to identify and address barriers to services. For example, when the BHS data team identified a high number of individuals staying in WM for more than seven days, the SUS QI director collaborated to develop new ways to track data and streamline the process, which ultimately resulted in shortening the length of stay for individuals. Together, these specializations within the SUS Team allowed for more focused

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
	oversight and improved service delivery within these critical areas. In the BHS QM Department, a new QA Team was created. Between May 2023 and May 2025, eight positions were hired for this team, including a QA/QI manager, clinical specialists, trainers, and a clinical coordinator. This team directly supports providers by ensuring high standards of care through operational support, oversight, training, and technical assistance. Finally, although not new, the BHS Data Analytics Team within QM has also expanded significantly. Between April 2022 and February 2024, 11 new positions were hired for this team, including a data analytics director, PM, epidemiologists, and health care and principal administrative analysts. This team plays a crucial role in using data to monitor the care and services provided through a QM and QI framework. To address staffing and retention with our contracted CBOs, we continued to actively monitor staffing levels and provide targeted support to ensure our programs are adequately staffed for safety and effectiveness. As part of our program management oversight process, we continuously monitor staffing levels of programs and compare them to expected needs in order to assist programs and providers with staffing and retention. In one example, while working with the HR360 program to identify why the program was struggling to fill positions, we discovered that the offered salaries were not competitive with the current market. We addressed this discrepancy by increasing salaries to be more competitive, which enabled the program to

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
	effectively increase its staff. This was achieved through procurement of additional funding and implementing strategic budgetary allocations. Furthermore, we have continued to develop and expand on the connection between the Bay Area Addiction Research and Treatment (BAART) Methadone Program and the City College of San Francisco (CCSF) to recruit newly trained AOD counselors. We have also provided additional funds to CCSF to offer courses more frequently, allowing individuals to graduate more quickly (e.g., offering required courses twice a year instead of once a year). This partnership has so far resulted in the hiring of one counselor, with three others in the process of being hired through this hiring pipeline. We are dedicated to these ongoing efforts to strengthen our workforce and optimize our operations, ensuring the most comprehensive care for those we serve.
3. Take active steps to increase the adolescent treatment population and the number of youth treatment programs. Additionally, expand the use of recovery support services, and ensure the new EHR can effectively bill for these services.	We are actively taking steps to increase the adolescent treatment population and the number of youth treatment programs. Additionally, we are expanding the use of recovery support services and ensuring our new EHR can effectively bill for these services. Significant progress has been made in increasing our capacity for youth treatment. The SUS SOC successfully released a solicitation for SUD youth outpatient services to effectively expand this program. We have now entered into a contract with Homeless Children's Network to provide DMC-ODS ASAM levels 0.5, 1.0, and 2.1 services.

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
	SUS also successfully released a solicitation for SUD youth residential services. We have entered into a contract with Latino Commission for ODS ASAM Level 3.1 services. This is a groundbreaking development, as we anticipate becoming the only county in the Bay Area with a DMC-ODS youth residential program. There are currently only five such programs in the entire State. We are in the midst of the licensing process with the California Department of Social Services and certification with DHCS. As part of this process, the Latino Commission has successfully completed courses and passed exams toward licensure as a group home for youth residential services. In addition to program design and creating infrastructure, the Latino Commission has also acquired, renovated, and prepared the facility. This lengthy process began in FY 2023–24, and we are hoping for finalization in FY 2025–26. Finally, we are also dedicated to expanding recovery support services and streamlining the associated billing. Our SUS and IT teams provide ongoing technical assistance and support for any billing and practice guideline transitions related to our EHR and other relevant systems. Our focus remains on optimizing our EHR for current needs, especially concerning adolescent services. Finally, all providers are now able to bill for recovery support services, regardless of their specific contract, and our Billing Department has updated all necessary billing codes to ensure these codes are available to everyone.

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
4. Continue efforts to improve the capacity and timeliness of residential treatment and housing resources for members.	We have made significant progress in expanding the capacity and accessibility of residential treatment and housing resources for our members. In 2024, San Francisco County procured the former Jo Ruffin Place, soon to reopen as the 7th Street Dual Diagnosis Residential Treatment Program located in the heart of the city, as an Americans with Disabilities Act (ADA) facility with 16 residential beds meant to serve individuals with both MH disorders and SUDs. Also, during FY 2023–24, we expanded our contracts with both Horizon Services Inc. and Center Point Inc. to provide additional adult residential treatment and WM options. These contracts help us address overflow and ensure we have beds available for specific clinical needs, such as Spanish-speaking services, ADA-compliant housing, or for mothers with children. Additionally, for youth and family services, we have contracted with a youth residential provider to increase capacity and timeliness of residential treatment for youth. To minimize access issues for youth residential treatment, we have also continued to create single case agreements with private residential facilities in the Bay Area and beyond. Finally, we have been continuously working on plans to significantly expand resources throughout the city for treatment and transitional and stabilization services. In FY 2024–25, the number of treatment and interim housing wraparound services will have increased significantly. More details on this exciting advancement in full-spectrum care in San Francisco can be found here: Mayor Lurie

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
	Opens 279 New Recovery And Treatment Beds, Delivering Significant Progress On His "Breaking The Cycle" Vision For Tackling Homelessness And Behavioral Health Crisis | SF.gov.
5. Communicate results from member satisfaction surveys to providers, identify issues of poor performance, and work to address the identified issues.	We are committed to transparently communicating results from member satisfaction surveys to providers, identifying areas of poor performance, and actively working to address these identified issues. Our approach to leveraging client feedback for continuous improvement involves key steps including the annual TPS, detailed reporting by the University of California, Los Angeles (UCLA); accessible program-specific reports and support; and strong provider engagement. Each October, we administer a TPS to all SUD clients who receive face-to-face services. The survey response period is open for one week for active clients and serves as a crucial tool for monitoring client satisfaction across our system. Results from the survey are collected and submitted to UCLA where responses are then compiled into comprehensive reports that include both program- and system-level results. These reports provide valuable insights, detailing the percentage of respondents by program, language, average scores for each survey question, and transcribed open-ended responses from clients. Following this analysis, our QM data analytics team members attend provider meetings to present an overview of the TPS results, ensuring that programs are informed on how to interpret results of the survey. Following the presentations, programs then receive an email containing a link to their specific program reports. Program-specific reports are only accessible to the respective

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
	programs, and we encourage them to reach out to the SUS Team for guidance on interpreting results, exploring service improvements, and responding to client comments or questions in coordination with the QM Team. By systematically gathering and communicating client feedback, we empower our providers to identify strengths, pinpoint areas for improvement, and ultimately enhance the quality of care delivered to our members. Providers consistently find the survey results to be an invaluable resource for understanding client satisfaction with their services, whether the feedback received was positive, or whether the feedback provides an opportunity for improvement. One particularly motivating aspect for programs is the highlighting of specific praise for counselors and successful interventions. This not only celebrates good performance but also provides tangible examples of effective practices. We continue to actively work on including more specific comments, suggestions, and callouts in our reports, as programs truly appreciate both the recognition and feedback.

Assessment of San Francisco's Self-Reported Actions

HSAG reviewed Table B.20, 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 DMC-ODS plan built a robust foundation in the Design stage of each PIP.
- During the PMV audit process, San Francisco was prepared, with pertinent staff and presentations, to provide a thorough overview during all sessions in scope of the virtual review, resulting in a smooth and organized virtual review. Additionally, San Francisco demonstrated engagement, partnership, and commitment to the PMV audit process in collaboration with HSAG, including attending technical assistance calls to thoroughly understand all audit requests.
- DHCS' 2025 compliance review scores for San Francisco show that the DMC-ODS plan was fully compliant with most CFR standards. Additionally, through the A&I CAP process, San Francisco resolved the findings that DHCS identified within the Enrollee Rights CFR standard (§438.100) during the DHCS 2025 compliance review scoring process.
- During the NAV audit process, San Francisco demonstrated appropriate provider data validation processes, ensuring any missing data were identified and promptly resolved as appropriate.

Opportunities for Improvement

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

2023–24 External Quality Review Recommendations

- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 San Francisco 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

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.

County of San Joaquin

This plan completed early BH administrative integration beginning January 1, 2025. As indicated previously, PIP activities were conducted by the Integrated BHP entity, and all PIP summary information is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* for this plan.

Follow-Up on Prior Year Recommendations

Table B.21 provides the EQR recommendations directed to San Joaquin from the previous EQRO's 2023–24 DMC-ODS 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 San Joaquin's self-reported actions.

Table B.21—San Joaquin's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Continue the workforce improvements related to outstanding issues and FY 2022–23 recommendations, and provide incentives, pay adjustments, and reclassifications to enhance SUD counselor staff, MAT prescribers, and lead clinicians with SUD supervisory experience.	SUD management surveyed other counties and providers in the surrounding area to provide a comparative salary study to San Joaquin administration and the county administration to show pay disparity. While a longer-term plan is being worked out with the county at large, San Joaquin administration has allowed new employees to come in at a higher step to incentivize employees to accept positions. San Joaquin administration has also allowed managers to review current employee qualifications and request a step increase if it is warranted based on experience and education. The county is also offering a new hire retention bonus after the first, third, and sixth years of employment. There have also been efforts to include SUD program staff classifications and program locations in various student loan repayment programs as an incentive to employees to join and stay with SUD services.

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
2. Expand youth services engagement efforts by building on prevention activities and providers. Expand service opportunities to increase SUD treatment for youth. Continue efforts with school collaboration and partnerships with criminal justice and child welfare services to identify and provide SUD treatment.	The SUD program has collaborated with a San Joaquin contracted provider in the city of Tracy to utilize clinic space for youth SUD treatment. The SUD program has participated in screenings of Fentanyl High, a documentary made for teens and their families, in the cities of Mountain House, Stockton, and Manteca. The SUD program has done outreach and presentations with internal San Joaquin programs including children and youth services, juvenile justice/probation, and the San Joaquin County Opioid Coalition. Outreach efforts will continue with youth-oriented community partners and businesses. Referrals to outpatient SUD services for this population have increased in the last three months.
3. Continue efforts to expand prevention and treatment options for NTPs and MAT services in the high overdose areas of the community identified in the California Overdose Dashboard provided through the California Department of Public Health. Given the rural nature of these areas of the county with high overdose rates, expanding on the use of mobile services is a positive strategy.	San Joaquin continues mobile outreach efforts provided by our Whole Person Care Team, which goes to homeless encampments and other hard-to-reach areas. The team brings harm reduction supplies like Narcan to individuals who do not have transportation and are mostly unhoused. The Whole Person Care Team also provides referrals about MAT, but they do not provide MAT directly to individuals.
4. Expand efforts to engage and educate line staff members and supervisors within county and contract programs to assist with billing and documentation challenges and to record ASAM and CalOMS data for placements and outcomes.	All providers are using SmartCare, and set-up of the new EHR has been completed. All programs have been trained on appropriate reporting units and service codes. San Joaquin developed a capacity management program to streamline placements into the continuum of care. All CalOMS data are now being entered electronically, while there are still some reporting issues with SmartCare from time to time.

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
5. Enhance communication and planning opportunities for the SUD contract providers with senior leadership staff to support successful CalAIM initiatives and a quality continuum of coordinated care.	Through our SUD network meeting, we have utilized department leadership from QAPI, contracts, compliance, and the business office to provide presentations and take part in discussions to improve the lines of communication and ensure the contractors are informed with accurate information.

Assessment of San Joaquin's Self-Reported Actions

HSAG reviewed Table B.21, 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

- 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 DMC-ODS plan was fully compliant with most CFR standards. Additionally, through the A&I CAP process, San Joaquin resolved the findings that DHCS identified within the Enrollee Rights CFR standard (§438.100) during the DHCS 2025 compliance review scoring process.
- 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.
- San Joaquin 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 San Joaquin 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 DMC-ODS plan'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 San Joaquin 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
- To ensure the DMC-ODS plan meets all DHCS standards for timely access indicators:
  - Conduct an in-depth review of the indicators for which San Joaquin 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 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.

County of San Luis Obispo

This plan completed early BH administrative integration beginning January 1, 2025. As indicated previously, PIP activities were conducted by the Integrated BHP entity, and all PIP summary information is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* for this plan.

Follow-Up on Prior Year Recommendations

Table B.22 provides the EQR recommendations directed to San Luis Obispo from the previous EQRO's 2023–24 DMC-ODS 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 San Luis Obispo's self-reported actions.

Table B.22—San Luis Obispo's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. To increase local residential treatment capacity, continue to solicit interest in identifying new providers or supporting existing programs.	We have spoken with each of our residential treatment providers to see if they would be willing to open additional treatment facilities. We are looking into applying for grants to help with start-up costs and sustainability and have looked for potential space for a new residential treatment facility in San Luis Obispo County. We recently issued an RFP for residential treatment but did not receive responses from new providers. We have been successful in keeping all of our existing providers.
2. Review San Luis Obispo DMC-ODS plan's urgent service request definition, protocol, workflow, and tracking, and make meaningful adjustments as warranted to assure the plan can provide comprehensive identification and expeditious access for individuals who have a more acute need for SUD services.	From San Luis Obispo DMC-ODS documentation guidelines: **Urgency/Timeliness of Access** As part of screening a client for SUD services, the clinician must decide about the urgency in which the client will be seen for his or her next service (often the ASAM assessment appointment). If a client is not seen for the first

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
	service or follow-up service within the required number of business days, a Notice of Adverse Beneficiary Determination Timely Access Notice letter must be sent to the client. Urgency requirements are as follows: ♦ Crisis Within 24 Hours ■ The client must be seen within 24 hours of the request for services. The client is considered a crisis/emergency due to one or more of the following: ○ Substance use crisis ○ MH crisis (danger to self, danger to others, grave disability) ♦ Urgent Within 48 Hours ■ The client must be seen within 48 hours of the request for services. The client is considered urgent due to the following: ○ Pregnancy (must contact within 48 hours as directed by DHCS perinatal guidelines) ○ Those using drugs through intravenous methods ○ Those who are parenting children ♦ Urgent Within 72 Hours (MAT/NTP/OTP) ■ Services are urgent. The client must be seen within 72 hours of the request for services. The client is considered urgent due to one or more of the following: ○ Requesting detoxification and/or MAT services ○ Requesting NTP/OTP services (Aegis) ♦ Routine: ■ The client must be seen within 10 business days from the request for service. ♦ Follow-up:

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
	▪ The client must be seen for a follow-up service within 10 business days of the first service/screening. Additionally, interim services are provided to clients who have been screened for services but have not yet had their ASAM assessment appointment. From San Luis Obispo DMC-ODS documentation guidelines: **Interim Services** In instances when clients are waiting to be placed in a treatment LOC, the drug and alcohol services staff are required to provide interim services due to the high risk involved with substance use. Interim services can be provided in individual sessions (case management or individual counseling) or in a group setting (group counseling). The education provided must cover the following information: ♦ Human immunodeficiency virus (HIV) ♦ Tuberculosis (TB) ♦ Risk of needle sharing ♦ Risk of HIV and TB transmission to sexual partners and infants ♦ Hepatitis C (HepC) ♦ If necessary, referral to HIV, HepC, or TB treatment services For pregnant women, interim services must cover the topics above and include additional counseling on: ♦ The effects of alcohol and drug use on the fetus. ♦ Referral for prenatal care.

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
3. Perform an additional analysis to determine the antecedents of unsuccessful CalOMS administrative discharges in order to identify and inform solutions and training needs, as well as to assure complete and accurate data are filed.	♦ New hire staff documentation training covers close reasons in detail. The difference between administrative and standard discharges are presented. Close reasons are presented in combination with CalOMS and discharge plan/summary topics. ♦ A documentation guidance document is provided to all new DMC-ODS staff members on close reasons. Multiple examples for each close reason are included. This guidance document is posted online for staff to access whenever it is needed for their reference. ♦ Program supervisors review all discharge plan/summary documents for each case that is closed. The chosen close reason is reviewed, and the program supervisor can work with the treatment staff member if a different close reason should be considered. ♦ Health information technicians review the close reason that is entered on the CalOMS discharge and the discharge plan/summary for every case that is closed. Health information technicians assure that the close reason selected matches on these documents, and if necessary, will contact the treatment staff member if it appears an administrative discharge reason was chosen but the discharge plan/summary narrative indicates the close should have been a standard close reason. The treatment staff member then reevaluates the close reason and can consult with the program supervisor as needed. ♦ During February and March 2025, a refresher training was provided to five drug

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
	and alcohol service clinics on the discharge plan/summary, which included training on close reasons.
4. Research necessary enhancements to support recovery residence contractors to expand housing for perinatal women and those who are on MAT and have children.	We have spoken with our perinatal residential treatment provider about the provider's interest in opening a recovery residence as a stepdown from residential treatment; however, the provider did not apply to our most recent recovery residence RFP. We will continue to explore this with the provider, as the provider is interested in expanding. All recovery residences are required to allow MAT medications in their homes. This has been written into their new contracts.
5. Reemphasize the importance of the TPS administration within clinics and to contractors, and provide necessary training, prompts, or incentives to increase response rates to better enable the system to benefit from consumer feedback.	For 2024 surveys, a different administrative service officer (ASO) with the Quality Support Services Division managed the TPS surveys. In July 2024, the ASO met with a UCLA staff member for one-on-one training on how to conduct the survey. At the beginning of October 2024, 2.5 weeks prior to the survey period, the ASO contacted all providers with general information about the survey. The next day, the ASO contacted all providers with survey instructions. The week before the survey period, the ASO sent communication to all providers to remind them about the survey. On the first day of the survey period, the ASO made phone calls to county program supervisors and subcontractors to remind them of the survey. The ASO ensured that the survey was available in Spanish for all providers. For 2025 surveys, the ASO will conduct the same activities above.

Assessment of San Luis Obispo's Self-Reported Actions

HSAG reviewed Table B.22, 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

- 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 DMC-ODS plan was fully compliant with most CFR standards.
- During the NAV audit process, HSAG observed that San Luis Obispo implemented the new Integrated Behavioral Health plan contract with the State to eliminate barriers for members seeking care. This included the implementation of Community Assistance, Recovery and Empowerment 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

2024–25 External Quality Review Recommendations

- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 San Luis Obispo 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

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.

County of San Mateo

Follow-Up on Prior Year Recommendations

Table B.23 provides the EQR recommendations directed to San Mateo from the previous EQRO's 2023–24 DMC-ODS 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 San Mateo's self-reported actions.

Table B.23—San Mateo's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Improve the quality and relevance of communication with program contractors, taking active steps to increase and enhance communication and involvement with these programs as system partners.	In FY 2024–25, San Mateo County strengthened its partnership with SUD treatment providers by expanding programmatic, fiscal, policy, and data monitoring support. The county enhanced staff and provider training, prioritized CalAIM implementation, and focused on improving service quality and coordination. Key initiatives included: **Programmatic and Quality Support** ♦ Monthly on-site meetings by county analysts to each provider for quality oversight, CalAIM implementation (especially documentation and fee-for-service changes), SUD services and reports review, and tailored technical assistance. ♦ Ongoing monitoring including chart reviews, credentialing, cultural competency assessments, incident report reviews, etc. ♦ Quarterly meetings with the BHRS Contracts and Performance Monitoring

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
	Team to reconcile contractor payments to DHCS paid claims. ♦ Training provided by BHRS clinical subject matter experts on various tools, assessments, and documentation requirements. **Fiscal Oversight** ♦ Strengthened financial accountability through monthly utilization reviews, billing error analysis, invoice verification, fiscal risk assessments, overpayment policies, and quarterly reconciliations. **Collaboration & Communication** ♦ Monthly meetings with providers, including: ■ AOD provider leadership (provider-led agenda). ■ Contractors Association staff (with BHRS director). ■ Treatment provider, provider outreach, and residential coordination staff. ♦ Each provider is assigned a BHRS analyst and an SUD case manager to ensure ongoing administrative and clinical support. ♦ Clinical consultations are offered for complex cases. **Outcomes** These comprehensive efforts are aimed to enhance communication, support provider capacity, ensure compliance with CalAIM, and improve client care across the SUD treatment system. In July 2025, BHRS launched our first Provider Feedback Research Plan and is conducting

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
	key informant interviews and surveys of provider executive leadership and clinical staff to hear about how we can continue to improve communication and support to SUD providers.
2. Take more robust steps to ensure the availability of linguistically competent interpretation and translation services across the continuum of care.	San Mateo County BHRS updated policy 99-01 on September 18, 2024, and January 10, 2025, requiring services to be provided to clients in their primary or preferred language. All San Mateo County BHRS staff and provider staff are required to take interpreter training every three years. Fifteen direct services provider staff took this training in FY 2024–25. All staff are required to take eight hours of cultural competency training annually. BHRS offers 527 trainings through our Learning Management System, and 77 of these trainings address cultural humility topics. Our FY 2024–25 site visit protocols incorporate assessments of cultural and linguistic access standards through multiple mechanisms including: **Annual Site Visit Monitoring** ♦ Review of personnel files to verify completion of required annual cultural competency trainings. ♦ Each cultural and linguistic access standard (2–15) is associated with policies and procedures for cultural competency compliance. ♦ Evaluation of facility environment and materials, including: ■ Availability of materials in threshold languages. ■ Visible posting of required taglines. ■ Accessibility of interpretation services.

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
	■ Cultural representation in facility displays and materials. ■ Language access: Reviewing substance use providers' efforts to recruit, train, and promote diverse staff that represent demographic patterns of the service area.
3. Conduct ASAM trainings more frequently to ensure that all staff including those newly hired are well-versed in the ASAM assessment framework. Additionally, San Mateo should consider using fidelity checks for staff members already trained to ensure their ongoing adherence to the ASAM model of assessment and placement. Finally, San Mateo should investigate and resolve any identified ASAM-related data collection discontinuities.	San Mateo County rolled out ASAM CONTINUUM with all SUD providers in November 2024 to improve fidelity to the ASAM assessment and placement. This is a validated tool developed by ASAM. All relevant provider staff were trained virtually via webinar in how to use the tool, and on-site training and technical assistance was provided to all provider agencies upon request. In addition, all new provider staff are required to complete the core ASAM trainings prior to San Mateo BHRS granting access to our EHR. In FY 2024–25, 53 new provider staff completed Module 1, 45 completed Module 2, and 44 completed Module 3 of the ASAM trainings as part of their onboarding. San Mateo County BHRS offers the following training to county staff and providers which can be taken at any time: ♦ Introduction to ASAM Criteria (ASAM-A) ♦ ASAM Criteria Training: Documentation and Other Procedures (ASAM-B) ♦ ASAM CONTINUUM Webinar ♦ What's New: The ASAM Criteria, 4th Edition ♦ Overview of the ASAM 4th Edition Webinar

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
	San Mateo County is also working with our EHR to assure all data are captured and reported on accurately.
4. Explore how San Mateo might proceed with launching the countywide overdose workgroup in conjunction with the DMC-ODS plan's hiring and onboarding of the community health planner position.	San Mateo County hired a senior community health planner in May 2024 to spearhead our countywide overdose prevention workgroup. From September 2024 to January 2025, San Mateo County BHRS hosted six focus groups across various locations to gather input for creating an overdose prevention coalition. Ninety-three participants discussed causes of drug overdoses, their hopes for the coalition, and who should be involved. In April 2025, the San Mateo County Overdose Prevention Coalition Steering Committee began developing the coalition's mission, vision, strategic goals, and governance, with diverse sector representation including lived experience, health services, law enforcement, and local government. By June 2025, the committee drafted bylaws and finalized the coalition's: ♦ Vision: A San Mateo County free from overdose through an empowered community. ♦ Mission: A community collaborative focused on reducing overdoses through education; outreach; service access; youth and policy advocacy; and data-informed, people-driven strategies. In August 2025, the committee will form action teams, finalize governance documents, and begin officer nominations. In September 2025, a series of countywide meet and greet events will introduce the coalition to the broader

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
	community ahead of a general membership meeting in October. These events aim to foster engagement and support a coordinated response to the overdose crisis.
5. Implement more information systems and analytic support to meet both CalAIM payment reform requirements and the implementation of a new EHR system.	At the end of March 2025, BHRS AOD brought on a new management analyst to support BHRS AOD's needs in the areas of quality, performance, and reporting with our team. Our new hire has a master's degree in psychology, and a doctorate in psychology with a focus on cognitive neuroscience and a minor in statistics and data analysis. This new hire brings years of professional work experience conducting qualitative and quantitative research and developing strategies to align with company priorities. This new staff person is working in close partnership with our Office of Improvement and Innovation, QM Team, Management Information Systems Team, current Avatar Team, as well as the team that will be implementing Epic. In addition, BHRS reorganized to develop an Office of Improvement and Innovation to address these needs. BHRS is currently working with our Health Policy and Planning Team to allocate part of an epidemiologist's time to further support our understanding of our SUD community health needs and trends.

Assessment of San Mateo's Self-Reported Actions

HSAG reviewed Table B.23, 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 DMC-ODS plan 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.
- DHCS' 2025 compliance review scores for San Mateo show that the DMC-ODS plan was fully compliant with all CFR standards.
- During the NAV audit process, HSAG observed that San Mateo maintained an email box dedicated to reporting potential data corrections. This allowed the MIS Team to quickly identify and correct potential data errors.

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.

2024–25 External Quality Review Recommendations

- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 implementing a process to review manual edits to provider records to assist in maintaining accurate provider data.

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.

County of Santa Barbara

This plan completed early BH administrative integration beginning January 1, 2025. As indicated previously, PIP activities were conducted by the Integrated BHP entity, and all PIP summary information is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* for this plan.

Follow-Up on Prior Year Recommendations

Table B.24 provides the EQR recommendations directed to Santa Barbara from the previous EQRO's 2023–24 DMC-ODS 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 Santa Barbara's self-reported actions.

Table B.24—Santa Barbara's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Improve access through continued efforts to expand recovery residences, residential treatment centers, and WM in the local community. Continue efforts to secure funding for additional local, in-county recovery residence beds to support the continuum of care. Santa Barbara DMC-ODS plan needs to continue exploring the financial feasibility of funding additional in-county residential and WM programs.	An additional six recovery residence beds at Stalwart Recovery were approved by the Board of Supervisors with the opioid settlement funds, for a total of 18 beds. Santa Barbara is currently in the process of concluding an RFP for DMC-ODS residential treatment services in which two providers have received awards to provide residential and WM services which will increase our capacity for these LOCs.
2. Improve participation in the TPS with expanded efforts, including paper surveys and wide distribution of results for improvement. Review areas in which TPS performance decreased to identify potential areas for improvement.	The TPS participation rate increased. In October 2024, quality care management and research and evaluation staff members met with the Council on Alcoholism and Drug Abuse (CADA) youth program staff to review TPS results, specifically the domains where the CADA programs fell below the statewide average. The quality care management staff

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
	also discussed the importance of providing outreach, engagement, and recreational activities to increase satisfaction and increasing survey participation to help bring up overall scores. The training, "A Continuum of Care: Care Coordination for Collaboration," was held on November 15, 2024. Care coordination has been discussed extensively in the alcohol and drug program users group meeting. This goal is still in progress and will continue into the next year. BeWell's quality care management and research and evaluation staff met with DMC-ODS youth providers in October 2024, and the survey was conducted in fall 2024. BeWell has met with youth providers to determine ways these providers can improve outcomes in the areas of perception of access, quality, care coordination, outcomes, general satisfaction, and therapeutic alliance. The quality care management and research and evaluation staff have also met with youth providers to review updated adolescent treatment guidelines and the requirements to provide outreach, engagement, and recreational activities.
3. Take steps to fully inform and educate members about transportation availability.	Santa Barbara collaborated with CenCal Health to create a transportation benefit card with informing materials on how to access transportation to and from clinic appointments. The cards are the size of a business card and have information in English on the front and Spanish on the back. Transportation cards have been distributed to all Santa Barbara clinics by outreach teams. A printable version of the transportation benefit card is available on Santa Barbara's website for providers to print as needed.

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
4. Identify root causes for incomplete ASAM LOC follow-up assessments. Provide training and assistance as needed specific to ASAM LOC to help clinicians and counselors assist members in accessing the LOC most conducive to successful outcomes.	Santa Barbara has investigated the ASAM LOC follow-up assessments and found that we are completing them consistently based on a report generated from our EHR system for FY 2023–24.
5. Establish an EHR workgroup to train staff, rectify errors, and reduce documentation time. This group should be open to county and contract provider staff members and provide access to EHR super users.	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 in 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.

Assessment of Santa Barbara's Self-Reported Actions

HSAG reviewed Table B.24, 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

- 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.
- DHCS' 2025 compliance review scores for Santa Barbara show that the DMC-ODS plan was fully compliant with most CFR standards.
- 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

- Santa Barbara 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 Barbara:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Enrollee Rights—§438.100

2024–25 External Quality Review Recommendations

- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Barbara meets all CFR standard requirements moving forward:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Enrollee Rights—§438.100

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.

County of Santa Clara

Follow-Up on Prior Year Recommendations

Table B.25 provides the EQR recommendations directed to Santa Clara from the previous EQRO's 2023–24 DMC-ODS 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 Santa Clara's self-reported actions.

Table B.25—Santa Clara's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Evaluate the treatment and support needs for those experiencing fentanyl withdrawal in the NTP, OTP, and across the SOC; take appropriate actions to address these needs.	We are contracting for more WM and treatment slots for DMC-ODS. Santa Clara County Behavioral Health Services Department (BHSD) recently developed an annual test call QI procedure to identify any barriers that members might be experiencing getting access to these services. The results will be shared with management to help develop strategies to improve access.
2. Invest in an agency-specific information systems operational continuity plan to avoid ransomware attacks. This will better prepare the DMC-ODS plan for successfully navigating adverse events that compromise data and the operation of care services.	This recommendation continues to be on the radar for Santa Clara County BHSD. Due to the county budget crisis and competing priorities, the department will investigate developing a strategy to address this recommendation once the Santa Clara County BHSD's budget is more stable.
3. Continue efforts to enhance the data system to track timely access to urgent services within 48 hours and other critical metrics linked to timely access and quality of care.	In June 2024, Santa Clara County BHSD implemented the BHSD Timeliness Tool in myAvatar for providers to track all requests for services, including substance use treatment services (SUTS) urgent and WM requests.
4. Continue working toward a smooth implementation of payment reform with contract providers, minimizing service	Santa Clara County BHSD is working with the contractor association to develop a strategy to reduce the fiscal impact to the SUTS

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
capacity impacts on members who need SUD specialty treatments.	providers. The BHSD is looking at workflows to reduce barriers to billing.
5. Shift more of the focus from QI to quality issues in SUD care. In addition to compliance, the plan needs balanced MH and SUD quality goals and monthly data collection to measure its success. Adding an addiction medical director and SUD division chief for oversight will benefit this effort.	Since FY 2024–25, the QAPI workplan takes a more balanced and comprehensive representation of both SUTS and MH goals and objectives. Timely access measures of first offered and first rendered services are now being captured, like the MH goals. Future plans for the QAPI workplan will involve an increased number of integrated goals and objectives when possible. All QI projects focus on both SUTS and MH outcomes.

Assessment of Santa Clara's Self-Reported Actions

HSAG reviewed Table B.25, 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 DMC-ODS plan built a robust foundation in the Design stage of each PIP.
- During the PMV audit process, Santa Clara indicated that the DMC-ODS plan 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 DMC-ODS plan 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
  - Provider Selection—§438.214
  - Grievance and Appeal Systems—§438.228
- During the NAV audit process:
  - Santa Clara reported that the completion rate for timeliness tools in myAvatar was less than 50 percent.
  - HSAG observed that Santa Clara 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 DMC-ODS plan'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
  - Provider Selection—§438.214
  - Grievance and Appeal Systems—§438.228
- 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.
  - Continue the monitoring and compliance efforts of Santa Clara's Provider Relations Team 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

Follow-Up on Prior Year Recommendations

Table B.26 provides the EQR recommendations directed to Santa Cruz from the previous EQRO's 2023–24 DMC-ODS 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 Santa Cruz's self-reported actions.

Table B.26—Santa Cruz's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Continue to look for new pathways to expand capacity for residential treatment and recovery residences, and consider securing alternative funding and discussing successful development strategies with other DMC-ODS plan counties similar in size to Santa Cruz.	Santa Cruz County has been able to expand residential capacity through a variety of providers and has secured funding for recovery residences through Proposition 47, Cohort IV grant awards, as well as through the use of some opioid settlement funds. Santa Cruz County has also newly contracted with Sun Street to provide residential treatment to Santa Cruz members if in-county providers cannot accommodate these members within timely access standards. In total, we have been able to increase residential treatment capacity by 30 percent and have increased recovery residence capacity by 150 percent.
2. Work to allocate and hire additional staff to support the EHR and informational systems functions overall.	County Behavioral Health 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 began work on February 15, 2025. Additionally, personnel completed recruitment for one existing IT business analyst vacancy and one new position. Both were filled with start dates of March 10, 2025, and May 19, 2025,

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
	respectively. These staff are currently in training. Behavioral Health receives support from the Health Services Agency to support BH and the BH EHR, MyAvatar. To support the Behavioral Health Division, IT allocates tasks strategically, Our 2.5 dedicated developers focus on specialized reporting and system enhancements. The supervisor and manager oversee priorities and coordinate workflows, and our five desktop and field support staff (four FTEs and one extra employee) manage daily technical issues through the ticketing system.
3. Continue to look for meaningful ways to address workforce issues including streamlining the hiring process, as well as considering a review of both separation and retention patterns to identify commonalities that may inform workplace adjustments to retain staff.	County SUD Services and network providers have implemented many strategies to reduce turnover. The Santa Cruz County Personnel Department has made significant improvements to expedite the hiring process for county positions which include allowing hiring departments to work from a complete list of applicants rather than 10 applicants at a time, reducing interview response time from five days to three days, and County Behavioral Health has hired an additional full-time employee to support the administrative requirements of the hiring process. Across the DMC-ODS network of providers composed of County SUD Services and community-based providers, all entities allow for flexible work schedules, remote work, and supportive supervision to reduce turnover. As the DMC-ODS administrator, County SUD Services has supported providers in providing competitive wage/benefit packages for their staff through annual increases in their contracts.

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
4. Undertake an analysis of the reasons that ASAM follow-up assessments are not being completed, and take appropriate actions to increase the timely reporting of ASAM data.	Health Services Agency IT staff assist with this data pull. This team has implemented a process that pulls together the data from MyAvatar and uploads these data appropriately so that UCLA now receives the ASAM data.
5. Increase communication and input regarding QI activities. This should include sharing outcomes data such as CalOMS data with contract providers. Additionally, QI activities and presentations should include member feedback (e.g., data from the TPS report and member focus groups).	To address the need to increase communication and input regarding QI activities, including sharing outcomes data such as CalOMS and integrating member feedback, Santa Cruz has implemented the following: ♦ **Monthly Contract Provider Meetings:** The DMC-ODS Team holds regular monthly meetings with contracted treatment providers. These meetings serve as a consistent venue to share program updates, address emerging issues, and collaboratively discuss QI priorities. ♦ **Quarterly QIC Participation:** Contract providers are invited to participate in quarterly QIC meetings where formal QI activities, plans, and outcomes are presented and discussed. These meetings offer opportunities for provider input into system-level quality initiatives. ♦ **TPS Member Feedback Integration:** TPS survey results are shared with providers via email as soon as they are available. In February 2024, the county convened a focus group with contract network providers to review TPS results and develop system-level responses. This session led to actionable changes, such as the addition of snacks during outpatient group sessions—a direct response to client feedback. A flyer titled "We Heard You," developed by county staff, was shared with providers to

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
	model and encourage client-centered service changes across programs. ♦ **TPS Results Follow-Up Planning:** TPS results for surveys conducted in October 2023 were received in April 2024. Santa Cruz is currently planning formal next steps to share these data with clients and providers, including through follow-up meetings and internal communications materials. ♦ **Bilingual SUD Services Newsletters:** The county publishes bilingual SUD Services newsletters that highlight QI efforts, client-focused messages, and provider updates. These newsletters help communicate system priorities and responses to client and provider feedback. They also serve as an accessible tool to reinforce transparency and accountability across the provider network. ♦ **CalOMS Data Sharing:** At this time, the county does not have a formal process in place to share CalOMS outcomes data with providers. However, we acknowledge this as a gap and are developing a plan to identify key metrics, analyze relevant data, and integrate CalOMS findings into upcoming provider meetings and QI activities. This process will support providers in understanding client outcomes and aligning their services with system-level quality goals.

Assessment of Santa Cruz's Self-Reported Actions

HSAG reviewed Table B.26, 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 a *High Confidence* level to Santa Cruz's 2025 nonclinical PIP submission. Santa Cruz met all critical and evaluation element scores for this PIP submission, reflecting that the DMC-ODS plan built a robust foundation in the Design stage of its nonclinical 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 DMC-ODS plan 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

- HSAG's 2025 PIP validation determined that Santa Cruz did not include all required details of its PIP processes for its clinical PIP.
- 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
  - Provider Selection—§438.214
  - Subcontractual Relationships and Delegation—§438.230

2024–25 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Santa Cruz includes all required information in the DMC-ODS plan's 2026 annual clinical PIP submission.
- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Santa Cruz meets all CFR standard requirements moving forward, work with DHCS through the:
  - A&I CAP process to fully resolve the findings that DHCS identified within the following CFR standards during the DHCS 2025 compliance review scoring process:
    - Provider Selection—§438.214
    - Subcontractual Relationships and Delegation—§438.230
  - 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

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.

County of Shasta

Follow-Up on Prior Year Recommendations

The previous EQRO did not make DMC-ODS plan-specific recommendations to Shasta in the 2023–24 DMC-ODS EQR technical report; therefore, HSAG had no recommendations for follow-up with the DMC-ODS plan for this EQR technical report.

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

- During the PMV audit process, Shasta, in conjunction with its subcontractor, PHC, was prepared with pertinent staff and presentations to overview all sessions in scope of the virtual review and demonstrated willingness to collaborate with HSAG through technical assistance call requests on tasks that required further clarification.
- DHCS' 2025 compliance review scores for Shasta show that the DMC-ODS plan was fully compliant with most CFR standards.

Opportunities for Improvement

- HSAG's 2025 PIP validation determined that Shasta did not include all required details of its PIP processes for its clinical and nonclinical PIPs.
- Shasta 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 Shasta:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Health Information Systems—§438.242

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 DMC-ODS plan's 2026 annual clinical and nonclinical PIP submissions.
- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Shasta 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

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.

County of Siskiyou

Follow-Up on Prior Year Recommendations

The previous EQRO did not make DMC-ODS plan-specific recommendations to Siskiyou in the 2023–24 DMC-ODS EQR technical report; therefore, HSAG had no recommendations for follow-up with the DMC-ODS plan for this EQR technical report.

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

- During the PMV audit process, Siskiyou, in conjunction with its subcontractor, PHC, was prepared with pertinent staff and presentations to overview all sessions in scope of the virtual review and demonstrated willingness to collaborate with HSAG through technical assistance call requests on tasks that required further clarification.
- DHCS' 2025 compliance review scores for Siskiyou show that the DMC-ODS plan was fully compliant with most CFR standards.

Opportunities for Improvement

- HSAG's 2025 PIP validation determined that Siskiyou did not include all required details of its PIP processes for its clinical and nonclinical PIPs.
- Siskiyou 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 Siskiyou:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Health Information Systems—§438.242

2024–25 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Siskiyou includes all required information in the DMC-ODS plan's 2026 annual clinical and nonclinical PIP submissions.
- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Siskiyou 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

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.

County of Solano

Follow-Up on Prior Year Recommendations

The previous EQRO did not make DMC-ODS plan-specific recommendations to Solano in the 2023–24 DMC-ODS EQR technical report; therefore, HSAG had no recommendations for follow-up with the DMC-ODS plan for this EQR technical report.

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

- During the PMV audit process, Solano, in conjunction with its subcontractor, PHC, was prepared with pertinent staff and presentations to overview all sessions in scope of the virtual review and demonstrated willingness to collaborate with HSAG through technical assistance call requests on tasks that required further clarification.
- DHCS' 2025 compliance review scores for Solano show that the DMC-ODS plan was fully compliant with most CFR standards.

Opportunities for Improvement

- HSAG's 2025 PIP validation determined that Solano did not include all required details of its PIP processes for its clinical and nonclinical PIPs.
- 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

2024–25 External Quality Review Recommendations

- Review the PIP Submission Form Completion Instructions and the PIP Intervention Worksheet Completion Instructions to ensure Solano includes all required information in the DMC-ODS plan's 2026 annual clinical and nonclinical PIP submissions.
- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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 Solano 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

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

DHCS' contract with Sonoma began December 1, 2024; therefore, there are no prior year EQR recommendations.

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

Based on Sonoma's contract start date, the DMC-ODS plan only participated in PIPs for contract year 2024–25.

Based on Sonoma's annual PIP submission, HSAG identified the following strengths, opportunities for improvement, and recommendations for the plan. Note that both of Sonoma's PIPs affect the quality, timeliness, and accessibility of care delivered to its members.

Strengths

- HSAG assigned a *High Confidence* level to Sonoma's 2025 nonclinical PIP submission. Sonoma met all critical and evaluation element scores for this PIP submission, reflecting that the DMC-ODS plan built a robust foundation in the Design stage of its nonclinical PIP.

Opportunities for Improvement

- HSAG's 2025 PIP validation determined that Sonoma did not include all required details of its PIP processes for its clinical PIP.

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 DMC-ODS plan's 2026 annual clinical PIP submission.

Sonoma'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 Sonoma as well as the plan's progress with addressing this recommendation.

County of Stanislaus

This plan completed early BH administrative integration beginning January 1, 2025. As indicated previously, PIP activities were conducted by the Integrated BHP entity, and all PIP summary information is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* for this plan.

Follow-Up on Prior Year Recommendations

Table B.27 provides the EQR recommendations directed to Stanislaus from the previous EQRO's 2023–24 DMC-ODS 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 Stanislaus' self-reported actions.

Table B.27—Stanislaus' Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Take meaningful steps to improve provider communication, training, and support for implementing SmartCare and payment reform.	To enhance communication with our contracted agencies regarding SmartCare implementation and payment reform, we have implemented and maintained the following strategies: ♦ Regular Q&A Sessions: We established weekly Q&A meetings open to all contractors, providing a forum to share updates and gather feedback on SmartCare-related issues. In response to evolving needs, the frequency shifted to biweekly in July 2024, and then to monthly as of November 2024. We remain flexible and are committed to revisiting the schedule as needed. ♦ Dedicated SmartCare Email Support: We maintain a dedicated email address for SmartCare inquiries, allowing contractors to submit questions or report issues. The inbox is monitored during standard

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
	business hours, and responses are typically provided within 24 hours. ♦ Ongoing Communication: For those unable to attend Q&A sessions, all relevant updates are disseminated via the SmartCare email to ensure consistent and equitable access to information. ♦ Contract Extranet Resource Hub: We maintain a dedicated contract extranet where contractors can access up-to-date materials including forms, Q&A documents, instructional guides, and minutes from each Q&A session. These items are posted to the extranet, allowing contractors to access them at their convenience. This centralized platform ensures that contractors have continuous access to essential resources to support SmartCare implementation. ♦ Ongoing Training Opportunities: Our training department hosts a recurring two-day SmartCare training every two weeks for new staff, including contractors. These sessions cover the fundamentals of SmartCare and provide opportunities to address questions. Training dates are listed on the training calendar. ♦ DMC-ODS provides technical assistance via ad hoc calls and site visits to subcontractors as needed to support payment reform changes to invoicing and EHR-related challenges. ♦ DMC-ODS provides updates via monthly network provider meetings and emails to ensure timely dissemination of information as updates occur.
2. Identify commonalities and address root causes that lead to delays, to improve the timeliness of services in accordance with regulations and appropriate clinical	Prior to the CalAIM initiatives, delays in access to DMC-ODS services occurred due to the requirement for an ASAM assessment to be completed prior to a client receiving services.

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
standards. This includes NTP services, OTP services, and urgent service requests.	Following implementation of changes to access under CalAIM in January 2023, Stanislaus' revised access practices removed assessment barriers to ensure individuals seeking services began receiving them prior to an ASAM assessment. Stanislaus has also engaged in evidence-based QIPs designed to test various access strategies to reduce long lead times for first appointments and has successfully piloted an open access scheduling protocol at an outpatient MAT program as well as a same-day admission protocol at a Stanislaus County BHRS-operated residential WM facility. The successes of these pilot projects indicate that typical appointment scheduling strategies are not always effective with people with SUDs and that the population has better outcomes (appointment attendance, MAT initiation, etc.) when access barriers like long lead times for appointments are reduced. Stanislaus will be sharing these interventions broadly with its network providers to encourage the spread of innovative approaches to access. NTP/OTP service capacity has seen a net increase of over 100 treatment slots with the addition of a medication unit in the network, thereby expanding access to crucial medication services in a county where the predominant SUD diagnosis being treated is opioid use disorder. The addition of these treatment slots increases capacity for new clients to be screened and receive services at one of three NTP/OTP sites in the county. Additionally, the subcontracted NTP/OTP has implemented options for access via website

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
	request that have led to improved timely access and initiation of treatment services.
3. Address the high rate of members who are discharging from treatment with a CalOMS discharge status of "left before completion with satisfactory and unsatisfactory progress." This should include enhanced strategies to keep and retain members, increase attendance rates, and promote persistence in care, along with other activities designed to improve treatment outcomes.	After review of relevant data and CalOMS training guides, it was determined that the high rates of documented "left before completion" statuses were a direct result of misinterpreted CalOMS guidelines regarding clients transitioning from residential SUD treatment. Data were being entered indicating that clients who were successfully completing residential treatment and transitioned to lower LOCs had left before completion when, in fact, they had successfully completed their residential treatment and should have been documented as such. To address this issue, Stanislaus is collaborating with the IT/State reporting and training divisions within the department to revise its training materials to more closely align with the CalOMS Data Collection Guide to ensure accurate data entry into the CalOMS collection forms. Once the training is developed, all DMC-ODS providers, including contracted providers, will receive the training and will be required to receive the training every two years moving forward. Newly hired staff will be required to receive the training within one month of hire and prior to completing any CalOMS collection forms. Staff training using the revised materials will begin in January 2026. Additionally, the DMC-ODS plan will continue to address CalOMS documentation and trends via the monthly network provider meeting.
4. Continue to develop a method to capture service access requests that makes data analysis feasible and reduces duplication of effort.	Reports have been established by the MHP to ensure ongoing monitoring of timely access and service provision for individuals seeking MH support.

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
5. Follow the county IT strategic plan framework and develop an agency-specific IT strategic plan to identify agency-level IT priorities and ensure that timely technology solutions and systems are implemented efficiently and are able to produce desired outcomes.	Stanislaus County BHRS IT acknowledges the recommendation and has initiated preliminary internal discussions on how to align with the county's IT strategic plan framework. Our current focus is to ensure that Stanislaus County BHRS technology efforts, including infrastructure, data reporting, and EHR enhancements, are consistent with countywide IT priorities. To help support this alignment, the county has hired an IT business analyst who is serving as a liaison between Stanislaus County BHRS and the county's IT central department. This role is intended to strengthen coordination, reduce communication gaps, and support future planning efforts. As agency needs continue to evolve, we will assess opportunities to develop more formal Stanislaus County BHRS-specific IT planning documents in collaboration with the county's IT central department and Stanislaus County BHRS executive leadership.

Assessment of Stanislaus' Self-Reported Actions

HSAG reviewed Table B.27, 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

- 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.
- DHCS' 2025 compliance review scores for Stanislaus show that the DMC-ODS plan was fully compliant with most CFR standards.
- 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.
- DHCS identified findings within the following CFR standards during the DHCS 2025 compliance review scoring process for Stanislaus:
  - Availability of Services—§438.206
  - Assurance of Adequate Capacity and Services—§438.207
  - Grievance and Appeal Systems—§438.228
  - Enrollee Rights—§438.100
- During the NAV audit process, HSAG observed that Stanislaus 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 DMC-ODS plan'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 Stanislaus 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
  - Enrollee Rights—§438.100
- To ensure the DMC-ODS plan 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.

County of Tulare

This plan completed early BH administrative integration beginning January 1, 2025. As indicated previously, PIP activities were conducted by the Integrated BHP entity, and all PIP summary information is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* for this plan.

Follow-Up on Prior Year Recommendations

Table B.28 provides the EQR recommendations directed to Tulare from the previous EQRO's 2023–24 DMC-ODS 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 Tulare's self-reported actions.

Table B.28—Tulare's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Take the necessary steps to add WM services to Tulare DMC-ODS plan's continuum of care as soon as possible.	We released an RFP in January 2025. We are in discussions/negotiations with a residential SUD provider to provide this service.
2. Prioritize expansion of non-methadone MAT services, with a focus on securing MAT providers that are not NTPs.	Two NTP programs began providing buprenorphine services—BAART Programs Visalia in November 2024 and Kings View Substance Abuse Treatment in May 2025. Outpatient providers who do not offer MAT services on-site refer clients to an appropriate NTP program for MAT services (Policy #70-12).
3. Capitalize on the collaboration with Tule River Indian Health Center to develop and implement an outreach and education plan for the Native American population.	Tulare County has a memorandum of understanding with the Tule River Indian Health Center and is working to strengthen outreach and education efforts. County staff met with the Tule River Tribe's Board on March 13, 2025, and May 5, 2025, to discuss collaboration and community needs.

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
4. Take meaningful steps now to ensure SUD has appropriate time allotted for discussion during integrated QIC meetings.	The QIC meeting combines MH and SUD. The agenda is structured to allow for SUD updates from the QI Team as well as providers. All QAPI- and data-related topics highlight MH and SUD services.
5. Prioritize the DMC-ODS plan website redesign to provide easy access to important phone numbers, such as the 24-Hour Crisis and Access Line and the 988 suicide prevention line. The numbers should be on landing pages and prominently displayed.	The website was redesigned to include important phone numbers (Access Line, 988, problem resolution) for both MH and SUD at the top of each landing page. We are in the process of transitioning to a new website platform and are in the testing phase of the conversion.

Assessment of Tulare's Self-Reported Actions

HSAG reviewed Table B.28, 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

- During the PMV audit process, Tulare indicated that the DMC-ODS plan is planning an expansion of services at county wellness centers for moderate level of care (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 DMC-ODS plan was fully compliant with most CFR standards. Additionally, through the A&I CAP process, Tulare resolved the findings that DHCS identified within the Enrollee Rights CFR standard (§438.100) during the DHCS 2025 compliance review scoring process.
- 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.
- Tulare 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 DMC-ODS plan'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 Tulare 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

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.

County of Ventura

This plan completed early BH administrative integration beginning January 1, 2025. As indicated previously, PIP activities were conducted by the Integrated BHP entity, and all PIP summary information is included in the *2024–25 Medi-Cal Specialty Mental Health Services External Quality Review Technical Report* for this plan.

Follow-Up on Prior Year Recommendations

Table B.29 provides the EQR recommendations directed to Ventura from the previous EQRO's 2023–24 DMC-ODS 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 Ventura's self-reported actions.

Table B.29—Ventura's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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
1. Revisit how requests for services are being processed by the Access Line. Ventura DMC-ODS plan acknowledges that a recent change has contributed to the number of dropped calls as well as to excessive caller wait times.	Access Line processes continue to evolve to meet the needs of the community. The MH and SUS call lines have recently been integrated, and staff have been cross-trained to ensure a timely call response for any call type or inquiry. We continue to review workflows to ensure a streamlined process is in place. Ongoing reporting has been developed to help the Access Line Team monitor call metrics and make data-informed improvement decisions. As a result, excessive caller wait times are no longer an issue, and ongoing monitoring helps to assess performance and allows Access Line management to see changes and address them in real-time, as needed.
2. Ensure that staff receive the necessary training to decrease the incidence of ASAM LOC placement incongruence due to "clinical judgment." Moreover,	All Ventura County BH SUS staff receive ASAM training upon hire and before delivering services, with yearly refresher courses to maintain proficiency. Beyond necessary

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
Ventura DMC-ODS plan should explore the feasibility of instituting post-training fidelity checks.	training efforts, clinic administrator and staff meetings include dedicated time to focus on identifying and resolving issues related to incongruent clinical placements. To further promote alignment, a monthly meeting for Licensed Practitioners of the Healing Arts is being established. This forum will facilitate critical discussions on ASAM review processes, fostering greater consistency in placement decisions across all clinics. Additionally, clinic administrators are actively spot-checking ASAM LOC determinations to ensure congruency and adherence to established guidelines. A significant factor in improving placement congruency has been the increased residential bed capacity in Ventura County, initiated through a new provider contract in April 2024. This expansion has likely mitigated previous challenges stemming from limited bed availability, which often contributed to placement incongruence. These concerted efforts have yielded measurable improvements. There was a substantial improvement in reducing the reliance on "clinical judgment" as a primary reason for mismatches, with reviewer recommendations for its usage dropping from 77 percent to 51 percent. However, the percentage of ASAM assessments wherein the indicated LOC was congruent with the actual LOC placement has declined from 65 percent to 46 percent since the last EQRO assessment, indicating that more process improvement remains to be done. Ventura County BH remains committed to these ongoing QI initiatives, continually striving

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
	for the most appropriate and effective care for our clients.
3. Prioritize the development and implementation of a strategy designed to increase the timeliness of post-residential treatment LOC transitions since Ventura DMC-ODS plan reports that it can now track timeliness data for all LOCs.	Ventura County BH began contracted services in April 2024 with a new (male only) residential provider, Khepera House, increasing capacity for ASAM levels 3.1 and 3.2 by 24 beds. Since that time, total admissions to residential treatment increased, the median number of days to post-residential follow-up at lower LOCs decreased from 19.5 to 14, and the percentage of clients discharged from residential LOCs with a follow-up at a lower LOC within seven days increased.
4. Identify and analyze the potential causes for members' precipitous termination of treatment with unsatisfactory progress, and launch an initiative aimed at reducing the frequency of such departures.	Ventura County BH initiated a new clinical PIP in early 2024, directly in response to this recommendation. An intervention was implemented wherein counselors increased the number of treatment contacts in the first 60 days of a new treatment episode. This increased contact can help build clients' motivation to stay involved in treatment and allows clinicians to identify and address factors that may lead to early treatment termination. Also in response to this recommendation, a workgroup was formed to help develop more objective criteria for determining CalOMS discharge statuses and to reach greater consensus on delineating successful versus unsuccessful completion of treatment. The workgroup met biweekly and was composed of Ventura County BH SUS clinical, nursing, QA, and QI staff members. This culminated in a guide posted to the best practices online resource maintained by the Ventura County BH QA team and a set of guidelines that clinic administrators were asked to share with their line staff.

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
5. Develop a tracking mechanism in SmartCare using the Streamline platform which will allow for greater precision in Ventura DMC-ODS plan's efforts to track the timeliness of first offered urgent appointments.	Congruent with MH timeliness efforts, significant improvements have been made to improve timeliness data quality and support for operational teams. ♦ Multiple training sessions have been conducted 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. The training sessions and materials were tailored to specific contractors and service types, and they covered information regarding data entry for first offered urgent appointments. ♦ 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. DMC-ODS error resolution reports went live in March 2024. Since then, the volume of DMC-ODS timeliness entry errors has decreased by more than 50 percent. Timeliness performance data are shared with operations quarterly. Technical assistance continues to be provided to support staff with troubleshooting and with building workflows to increase the efficiency of the timeliness data collection process.

Assessment of Ventura's Self-Reported Actions

HSAG reviewed Table B.29, 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

- 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 assigned a 100 percent Total CFR Compliance Score during the DHCS 2025 compliance review scoring process for Ventura.
- 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.

2024–25 External Quality Review Recommendations

- Thoroughly review HSAG's detailed findings and recommendations in the DMC-ODS plan'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.

Ventura'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 Ventura as well as the plan's progress with addressing this recommendation.

County of Yolo

Follow-Up on Prior Year Recommendations

Table B.30 provides the EQR recommendations directed to Yolo from the previous EQRO's 2023–24 DMC-ODS 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 Yolo's self-reported actions.

Table B.30—Yolo's Self-Reported Follow-Up on the External Quality Review Recommendations from the Previous External Quality Review Organization's 2023–24 DMC-ODS 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. Continue to expand local residential treatment, residential 3.2 WM, and recovery residence capacity, including youth services.	Yolo has made the following improvements to our network: ♦ Added an additional residential treatment provider. ♦ Added an outpatient and intensive outpatient youth treatment provider. ♦ Expanded services with one of our residential providers to now provide outpatient and recovery residence treatment. ♦ Added MAT for members 16 years and older. Additionally, we are working with our in-county residential provider to expand its services to include WM and outpatient services now that the provider has relocated to a larger facility.
2. Develop a tracking mechanism to monitor no-shows and first offered appointments that meet the State regulations for timely access to service.	After piloting a new data collection process in our MH delivery system, we notified our SUD providers that we are rolling out a quarterly collection of their timely access data. The first collection is scheduled for October 2025. We have also initiated work on a data collection

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
	tool in our EHR with hopes of moving this direction in the future.
3. Take meaningful steps to analyze and collect data relevant to addressing members leaving treatment before completing the program. Review the discharge process in CalOMS. This process should include enhancing strategies to keep and retain clients in treatment and improve treatment outcomes.	Yolo worked with our Health Management Associates (HMA) consultant this past year on residential treatment completions and revamping one of our provider's practices. We also worked with HMA on jail and MAT services specifically focused on discharge planning efforts and continuation of treatment. Our QM Team is providing oversight and technical assistance to our providers to ensure that treatment information, including discharges, is being entered accurately and in a timely manner in CalOMS.
4. Expand recovery support services to all LOC, facilitate enhanced care coordination, and work with DHCS to optimize billing options. Strongly consider introducing a peer support services model in recovery support services.	Recovery support services were expanded to all LOCs. Our contracted outpatient provider has established peer services.
5. Enhance the Quality Improvement Work Plan and evaluation report to include how data elements inform conclusions, guide decisions, and formulate next steps.	The county has initiated several processes to improve data integrity, including individualized provider technical assistance, group trainings, and running reports regularly to identify and correct data issues. We continue to invest in data integrity so that these data can be utilized to inform conclusions, guide decisions, and formulate next steps.

Assessment of Yolo's Self-Reported Actions

HSAG reviewed Table B.30, 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 DMC-ODS plan 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 DMC-ODS plan 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 DMC-ODS plan'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 Yolo 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

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.