Sacramento County Division of Behavioral Health Services

Quality Management Program Annual Work Plan – Fiscal Year 25/26
(July 1, 2025 to June 30, 2026)

Our Mission: *To provide a culturally competent system of care that promotes holistic recovery, optimum health, and resiliency.*

Our Vision: *We envision a community where persons from diverse backgrounds across the life continuum have the opportunity to experience optimum wellness.*

Our Equity Vision:
Sacramento County Behavioral Health Services (BHS) envisions a community where all Sacramento County residents thrive and have equitable access to optimal behavioral and emotional wellness. By racial equity we mean closing the gaps so that race does not predict one's success, while also improving outcomes for all.

Our Values:

- *Respect, Compassion, Integrity*
- *Client and/or Family Driven*
- *Equal Access for Diverse Populations*
- *Culturally Competent, Adaptive, Responsive & Meaningful*
- *Prevention and Early Intervention*
- *Full Community Integration and Collaboration*
- *Coordinated Near Home and in Natural Settings*
- *Strength-Based Integrated and Evidence-Based Practices*
- *Innovative and Outcome-Driven Practices and Systems*
- *Wellness, Recovery, & Resilience Focus*

Sacramento County Behavioral Health Services (BHS) develops an annual Quality Improvement Work Plan (QI Plan) to guide performance improvement activities, including indicator development, focused studies, and monitoring for quality care. The QI Plan continues to integrate the goals of both Substance Use Prevention and Treatment (SUPT) and Mental Health Plan (MHP) divisions within Sacramento BHS. The QI Plan incorporates State and Federal requirements, Department initiatives, client and collaborator feedback, and aligns with the California Department of Health Care Services (DHCS) goals of integration by enhancing care coordination, improving health outcomes, and promoting whole-person care through collaboration between mental health, physical health, and substance use services.

Cultural Competence is critical to promoting diversity, equity, reducing health disparities, and improving access to high-quality mental health that is respectful of and responsive to the diverse clients in Sacramento County. The BHS recognizes the importance of developing a QI Plan that integrates the goals of the BHS Cultural Competence Plan and embeds cultural competence elements to better understand the needs of groups accessing services and identify disparities. Cultural Competence Plan goals and elements are noted throughout the plans with a "(**CC**)".

Healthcare Effectiveness Data and Information Set (HEDIS) Measures are critical to ensuring quality, accountability, and consistency in the delivery of behavioral health services across Sacramento County. The BHS recognizes the importance of developing a QI Plan that incorporates HEDIS performance measures to monitor key indicators, improve clinical outcomes, and strengthen system-wide quality. Embedding HEDIS measures within the plan supports data-driven decision-making, highlights areas for improvement, and ensures alignment with state and national quality standards. HEDIS measures and related activities are noted throughout the plans with a "(**HEDIS**)".

Structure of the Plan

The QI Plan includes four essential domains: Access, Timeliness, Quality and Member Outcomes. The "SCOPE" details the areas that make up each domain. Each SCOPE contains a:

Standard: This is the threshold expectation for Sacramento County's performance.

Benchmark: A point of reference drawn from Sacramento County's own experience (historical data) and/or legal and contractual requirements. Benchmarks are used to establish goals for improvement that reflect excellence in care.

Goal: Reflects Sacramento County BHS annual goals toward reaching the identified Benchmark.

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DOMAIN	SCOPE
1. ACCESS	*1.1 Retention & Service Utilization- CC* *1.2 Penetration – CC* *1.3 Crisis Services Continuum* *1.4 Treatment Service Continuum* *1.5 24/7*
2. TIMELINESS	*2.1 Timeliness to Service– CC* *2.2 No Shows/Cancellations*
3. QUALITY	*3.1 Problem Resolution* *3.2 UR and Doc Standards* *3.3 Med Monitoring* *3.4 Coordination of Care* *3.5 Diverse Workforce – CC* *3.6 Culturally Competent System of Care – CC* *3.7 Training/Education - CC*
4. MEMBER OUTCOMES	*4.1 Member Satisfaction* *4.2 CANS and PSC-35* *4.3 ANSA* *4.4 Hospital Readmissions*

1. ACCESS
Ensuring that members have ready access to all necessary services within Behavioral Health Services: this includes access to culturally relevant and responsive services to address the unserved, underserved and inappropriately serviced communities.

1.1 Retention and Service Utilization
Member Impact: Monitoring utilization data will allow BHS to identify trends and develop strategies to ensure equal access and service delivery that is reflected across demographics.

Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
1.1a Standard: BHS will demonstrate access to behavioral health services equitably across demographics. ***1.1a Benchmark:*** Maintain or improve from the previous year. ***1.1a Goal:*** Maintain current retention rates or higher across all cultural groups.	MHP Activities: • Utilize service utilization data within the EHR to review retention, high utilizer, and mental health service costs across all cultures. • Develop trend charts to explore differences and create strategies to address disparities. • Review quarterly with Management Team and QIC. • Review dropout rates from first request for services to first treatment service. SUPT Activities: • Analyze service utilization data on a quarterly basis to identify high utilizers and inform SUPT program staff. • Create a report in SmartCare to track high cost/high utilization. Determine a baseline and include demographics in the report. • Use report for monitoring purposes. Educate providers how to run and use reports for improving outcomes and identifying level of care.	MHP Team, Data Analytics, Cultural Competence/Ethnic Services (CC/Ethnic Services)	Data is reviewed quarterly with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.
1.1b Standard: BHS will demonstrate retention of members proportionately across all cultures ***1.1b Benchmark:*** Maintain or improve discharge outcomes for non-engagement year over year. ***1.1b Goal:*** Maintain current or decreased rates of discharge outcomes for non-engagement across all cultural groups.			
1.1c Standard: The percentage of new substance use disorder (SUD)			

episodes that result in treatment initiation and engagement. **(HEDIS IET)** ***1.1c Benchmark:*** Increase our outcomes by 5% each year until we meet the minimum performance level. ***1.1c Goal:*** Minimum performance level: Initiation – 44.5% Engagement – 14.4%	• SUPT staff will provide case conferencing with providers to explore more appropriate treatment options that foster engagement and recovery of high utilizer members.		
1.1d Standard: Members that have a high utilization of services will be no more than 20% of average cost per client. ***1.1d Benchmark:*** Maintain or decrease rate of members utilizing more than 20% of average cost year over year. ***1.1d Goal:*** Reduce high-cost utilization by 5% annually until standard is met.			
1.2 Penetration (CC) **Member Impact:** Penetration rates allow BHS to identify disparities in accessing services. When disparities are identified, strategies will be implemented to ensure members have equitable access to all services.			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
1.2 Standard: There is equal access to BHS for all cultures. ***1.2 Benchmark:*** **MHP** – Penetration rates for unserved, underserviced and inappropriately served	• Utilize Medi-Cal eligible data provided annually by the Department of Finance to track and trend penetration rates by age, gender, race/ethnicity, and language (when data is available) based on Medi-Cal eligibility	MHP Team, Data Analytics, CC/Ethnic Services	Data is reviewed quarterly with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.

population increase 1.5% over prior year's rate. **SUPT** – Identify the prevalence rates in FY 24-25 in order to determine meaningful benchmark for SUPT. 2.5 ***1.2 Goal:*** MHP 5.5% and SUPT 1.25% as the targeted penetration rates for FY 24–25	data as well as MHP all services data. • Utilize published prevalence rates and analyze Sacramento County penetration rates in comparison to other large county and Statewide penetration rates to determine possible concerns for equal access for certain cultures. • Implement 274 expansion project. • Use data when developing new or expanded program sites. • Continued use of Telehealth Services including those that use interpreter services.		
1.3 Crisis Service Continuum			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
1.3 Standard: BHS will have a continuum of Mental Health Crisis services available to residents in Sacramento County that align with the Behavioral Health Continuum Infrastructure Program (BHCIP). ***1.3 Benchmark:*** Increase number of diversions from hospital and ER. ***1.3a Goal:*** Reduce CSU utilization by increasing access to and use of crisis services (CWRT, CCIT, Urgent Care, MHUCC, MCST, The Source). ***1.3b Goal:***	• Continue to collaborate with community partners to come up with solutions to offer an array of crisis services to Sacramento County residents (hospital systems, law enforcement). • Monitor and report outcomes for crisis residential grants. • Increase access to crisis stabilization and crisis residential services. • Track and monitor utilization of programs already in place to address crisis services (CST, Mobile Crisis, Navigators, The Source). Analyze results to determine outcomes. • At least annually, analyze data by race, ethnicity and language, sexual orientation, and gender identity. **(CC)**	Program, DA, QM	Progress is reviewed quarterly with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.

Increase diversions from inpatient and ER by tracking use of MHUCC, CR, MCST, CST/CWRT, The Source, and community discharge pathways, including the proportion of clients being treated and those meeting 5150 criteria.	• Track and analyze diversion program activities. – Mental Health Urgent Care, CSU-Dignity, Crisis Residential, Mobile Crisis, Respite, The Source, and Community Support Team. • Provide education and information about mental health resources to community. • Implement 24/7 Access/Crisis response call center including mobile response availability.		
1.4 Treatment Service Continuum			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
1.4 Standard: BHS members will have access to appropriate services based on need. Contracts for all required levels of care with capacity to serve. ***1.4 Benchmark:*** Increase successful discharge reasons for stepping down in level of care, according to the ASAM, BY 3%. ***1.4 Goal:*** Increase successful step-downs in level of care to 30%.	• Monitor enrollment by levels of care utilizing ASAM data. • Recruit additional providers specific to children and adolescent services. • Recruit additional providers for ambulatory withdrawal management Levels 1 and 2.	SUPT, DA, QM	Progress is reviewed quarterly with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.
1.5 24/7 Access Line with appropriate language access **Member Impact:** Conducting monthly test calls ensure that members are provided accurate information regarding accessing BHS and/or how to file a grievance if they are unhappy with services provided by BHS in their preferred language.			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
1.5a Standard: Provide a statewide, toll-free telephone number that can be	• Conduct year-round tests of 24-hour call line and BHS	Quality Managem ent (QM),	Data is reviewed quarterly with the CCC, MT, and the

utilized 24 hours a day 7 days a week (24/7) with language capability in all languages spoken by members of the county. ***1.5a Goal:*** Continue to have a 24/7 line with linguistic capability. (CC)	follow-up system to assess for compliance with statewide standards. • Conduct test calls in all threshold languages. **(CC)** • Provide periodic training for Access/Crisis Response Team and test callers. • Provide feedback to supervisors on results of test calls. • Provide quarterly reports showing level of compliance in all standard areas to QIC and Management Team. • Monitor timeliness of obtaining interpreter services. **(CC)** • Attend trainings provided by DHCS. • Review script regarding the Grievance Line (say at beginning). • Develop Call Log for after-hours staff to use within Sacramento County EHR. • Develop integration plan for MHP Access Line and SUPT System of Care.	DA, CC/Ethnic Services	QIC Data Subcommittee to identify trends and make changes as needed.
1.5b Standard: The 24/7 line will provide information to members about how to access behavioral health services. ***1.5b Benchmark:*** 100% of test calls will be in compliance with the standard. ***1.5b Goal:*** Increase percent in compliance annually until benchmark is met			
1.5c Standard: The 24/7 line will provide information to members about how to use the member problem resolution and air hearing processes. ***1.5c Benchmark:*** 100% of test calls will be in compliance with the standard. ***1.5c Goal:*** Increase the percent in compliance annually until benchmark is met.			
1.5d Standard: The 24/7 line will provide information to members about			

services needed to address a member's crisis. ***1.5d Benchmark:*** 100% of test calls will be in compliance with the standard. ***1.5d Goal:*** Increase the percent in compliance annually until benchmark is met.			
1.5e Standard: All calls coming into the 24/7 line will be logged with the member's name, date of the request and initial disposition of the request. ***1.5e Benchmark:*** 100% of test calls will be in compliance with the standard. ***1.5e Goal:*** Increase the percent in compliance annually until benchmark is met.			

2. TIMELINESS **Ensure timely access to high quality, culturally sensitive services for individuals and their families.**			
2.1 Timeliness to Service **Member Impact:** Timely access to services increases the likelihood that members will engage and continue with services.			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*

2.1a Standard: The time between request for BHS Outpatient Services and the initial service offered and/or provided to members will be 10 business days or less. ***2.1a Benchmark:*** 100% of adult and children will meet the 10-business day standard. ***2.1a Goal:*** Increase in percent meeting standard annually until benchmark is met.	• Produce quarterly reports that monitor benchmarks and track timely and appropriate access to mental health plan services. • Produce annual report evaluating benchmarks and timely access by race, ethnicity, language, sexual orientation, and gender identity. • Provide feedback to BHS providers of quarterly report findings at provider meetings. • Explore strategies for decreasing time to first Medi-Cal billable service after assignment. • Review data measurement and reporting methodologies to ensure accurate timeliness measurement consistent with DHCS requirements. • Utilize technical assistance from DHCS to identify timeliness strategies. • Track and report on timeliness of assignment of referrals; evaluate BHS-SAC business processes for timely, efficient referral processing. • Examine use of Navigators in linking members to appointments. • Explore EHR options for identifying/notifying providers of member hospitalizations (supports faster engagement). • Analyze Walk-In Assessment PIP findings to determine systemwide strategies. • Determine new benchmark for Walk-In Assessment options.	DA, Ethnic Services, QM	Data is reviewed quarterly with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed

	• Add UC Davis trainees to increase capacity (supports timeliness).		
2.1b Standard: The time between request for psychiatric services and the first psychiatric service offered and/or provided to members will be 15 business days or less. ***2.1b Benchmark:*** 100% of Adult and Children will meet 15-business day standard. ***2.1b Goal:*** Increase in percent meeting standard annually until benchmark is met.	• Train and collaborate with outpatient providers on appropriate psychological testing referrals (reduces bottlenecks in psychiatry schedules). • Monitor Service Code utilization (Assessment + Medication Request) to track first request for medication services. • Review psych testing referral and business processes. • Review available CPT Psychological Testing Codes for better capture of pre-service engagement (helps queue psychiatric services appropriately). • Explore strategies for decreasing time to first Medi-Cal billable service after assignment. • Add UC Davis trainees to increase psychiatry-adjacent capacity. • Explore EHR options for notifying providers of hospitalizations (supports timely follow-up scheduling).		
2.2 No Shows/Cancellations for scheduled appointments			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*

2.2a Standard: The time between assignment for BH Services and 1st engagement activity where actual verbal or face-to-face contact is made in 3 business days. (MH) ***2.2a Benchmark:*** 70% of Children and Adults will meet the 3-business day standard. ***2.2a Goal:*** Increase the percent meeting standard annually until benchmark is met.	• Evaluate current engagement activities and billing codes to assist in accurately measuring outreach and engagement efforts prior to initial appointment. • Re-train provider to use engagement codes to track these activities to improve accuracy of data to reflect the efforts of the providers.	DA	Data is reviewed quarterly with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.

3. QUALITY
Analyzing and supporting continual improvement of BHS clinical and administrative processes in order to achieve the highest standard of care, with care processes that are recovery oriented, evidence-based, and culturally sensitive.

3.1 Problem Resolution
Member Impact: By logging, tracking, and looking for trends in grievances received from members ensures that all member concerns are investigated and resolved in a timely manner and any trends identified are addressed for the good of all members served.

Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
3.1a Standard: BHS will have a Problem Resolution process that provides tracking of all grievances and appeals and ensures that all grievances and appeals are logged and resolved in a timely manner. ***3.1a Benchmark:*** Grievances and appeals logged within 1 business day. 100% of all grievances will be resolved withing 90 days.	• Monitor the problem resolution process tracking and reporting system. Make adjustments as needed to ensure integrity of data. • Track, trend and analyze member grievance, appeal, and State Fair Hearing actions. Include type, ethnicity, race, and language as part of this tracking. **(CC)** • Track the timeliness of grievance, appeals and expedited appeal resolution for non- compliance tracking.	QM	Data is reviewed quarterly with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.

100% of all expedited appeals will be resolved in 72 hours. ***3.1a Goal:*** Percent of appeals logged and resolved in a timely manner will increase annually until benchmark has been met.	• Track and analyze provider level complaint, grievance process with concomitant corrective plans quarterly.		
3.2 Utilization Review (UR) and documentation standards **Member Impact:** Utilization reviews provide evaluation of all services to ensure appropriateness and quality of services for members.			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
3.2a Standard: BHS will have a rigorous utilization review process to ensure that all documentation standards are met. ***3.2a Goal:*** Annually, 5% of open episodes will be reviewed for each provider/program.	• Conduct monthly utilization review utilizing electronic health record for providers. • Information obtained through monthly reviews will be evaluated and issues will be reviewed at UR Committees. • All agencies will complete a monthly internal chart review, which may include focused review of progress notes, assessments, and client plans. • Identify specific QI reports in EHR to develop monitoring and rapid feedback loop across system. • Create new reports and forms that will support monitoring based on feedback and needs identified through UR Committee and Provider Feedback. • Develop quality assurance measures in EHR reports to	QM	Data is reviewed quarterly with the QIC Data Subcommittee to identify trends and make changes as needed.
3.2b Standard: All members will have a current Problem List or Care Plans (NTP) documented in the EHR initiated at intake and updated when clinically appropriate. ***3.2b Benchmark:*** 100% of treatment plans from UR chart review will have a Problem List documented in the EHR. ***3.2b Goal:*** Increase in percent annually until benchmark is met.			
3.2c Standard: All client charts will have documentation justifying			

medical necessity for level of care. ***3.2c Benchmark:*** 100% of client charts from UR chart review will have documented justifying medical necessity. ***3.2c Goal:*** Increase in percent annually until benchmark is met.	establish data measurement for BHS system. Providers will use tracking measures to monitor documentation standards following minimum Medi-Cal and MHSA requirements. • Targeted chart review when significant non-compliance issues are discovered. • Provide documentation training to BHS providers monthly, or upon request for new program implementation. • Provide targeted documentation and technical assistance to providers that have identified compliance issues or at request of contract monitor. • Implement Corrective Action Plans for specific providers if above activities are unsuccessful.		
3.3 Medication Monitoring			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
3.3a Standard: Providers practice in accordance with preestablished standards of acceptable medical practice for medication/pharmacology. ***3.3a Benchmark:*** Review medication/pharmacology in 5% of open episodes for each provider/program. ***3.3a Goal:***	• Study, analyze and continuously improve the medication monitoring and medication practices in the child and adult system. • Conduct systematic medication monitoring activities, report, and discuss issues at med monitoring and P & T committee meetings. • Strongly encourage all treatment providers to use dosage and practice	MHTC, QM, Med Monitoring Committee	Data is reviewed quarterly with the Pharmacy and Therapeutics Committee and at QIC Data Subcommittee to identify trends and make changes as needed.

Continue to monitor and meet benchmark.	guidelines developed by the P&T committee for the treatment of schizophrenia, bipolar disorders, depressive disorders, and ADHD. • Continue improvements in criteria for medication monitoring of outpatient clinics based on best practices. • Create a reporting methodology for Medication Monitoring reviews. • Update P&P based on feedback from provider survey. • Develop quality assurance/management activities for Telehealth providers. • Reports trends in findings to QIC.		
3.3b Standard: The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. **(HEDIS AMM)** ***3.3b Benchmark:*** Increase our outcomes by 5% each year until we meet the minimum performance level. ***3.3b Goal:*** Minimum performance level Acute phase – 62.4% Continuous phase – 44.3%		DA, QM, Program	Data is reviewed quarterly with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.

3.3c Standard: The percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first line treatment. **(HEDIS APP)** ***3.3c Benchmark:*** Increase our outcomes by 5% each year until we meet the minimum performance level. ***3.3c Goal:*** Minimum performance level: 60.2%			
3.3d Standard: The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. **(HEDIS SAA)** ***3.3d Benchmark:*** Increase our outcomes by 5% each year until we meet the minimum performance level. ***3.3d Goal:*** Minimum performance level: 62.6%			
3.3e Standard: Percentage of members age 18 and older with an opioid use	• Increase MAT for incarcerated individuals with an OUD who are in custody		

disorder (OUD) who filled a prescription for or were administered or dispensed an FDA approved medication for the disorder during the measurement year. **(HEDIS OUD)** ***3.3e Benchmark:*** Increase our outcomes by 5% each year until we meet the minimum performance level: 60.2% ***3.3e Goal:*** Minimum performance level: 60.2%	at the Sacramento County Main Jail and the Rio Cosumnes Correctional Center (Correctional Health baseline = 24% of jail population). • Increase the administration of buprenorphine for incarcerated individuals with an OUD who are in custody at the Sacramento County Main Jail and the Rio Cosumnes Correctional Center (HEDIS MY 24 baseline performance level = 20.1%). • Enhance partnerships with other service providers/system partners to encourage referrals to MAT providers (e.g., Sacramento County Mental Health Treatment Center, Mental Health providers, APS, CPS, emergency departments, etc.) • Continue efforts to reduce stigma through training and public awareness campaigns about the effectiveness and safety of MAT for OUD.		
3.3f Standard: The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD	• Conduct analysis of contracted OTP/NTP to determine retention rates. • Conduct low retention rate case reviews by contracted OTP/NTP to determine reasons for low retention.		

pharmacotherapy event. **(HEDIS POD)** ***3.3f Benchmark:*** Increase our outcomes by 5% each year until we meet the minimum performance level ***3.3f Goals:*** Minimum performance level: 25.3%	• Review analyses with contracted OTP/NTP to identify and implement strategies to increase retention rates.		
3.4 Coordination of Care			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
3.4a Standard: BHS will collaborate with other government agencies and partners to facilitate coordination and collaboration to maximize continuity of services for clients with mental health needs. ***3.4a Goal:*** Continue to work with our partners to provide coordination and collaboration.	MHP Activities: • Pathways to Wellness -Monitor the use of ICC, ICC-CFT and IHBS services for all children receiving intensive services, and specifically children involved in the child welfare system. • Collaboration with Child Welfare for completion and submission of CANS and PSC-35 documents required by State agencies. • Use the CPS-MH Team to participate in CFTs for all children who are involved with CPS and unlinked to the MH System. • FFPSA implementation meetings with Child Welfare and Probation. • Qualified Individual – Staff from the CPS/MH and Probation/MH teams will provide a MH assessment prior to any placement of a foster child into an STRTP, unless it is an emergency placement Actively participate in CFTs for children	Met	Progress is reviewed quarterly with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.

	involved with Probation and Child Welfare. SUPT Activities: • Monitor members referred to the Mental Health Plan (MHP) from SUPT and to SUPT from the MHP using the Screening Tool. • Use the Transition of Care Tool for step up or step-down services. • Explore methods of tracking care coordination between GMC, PCP and SUPT. Develop and implement a bi-lateral screening and referral tool. • Track ECM services. • Explore data sharing across public agencies. • Evaluate data by age, ethnicity, race, language, and gender to look for disparities. **(CC)** BHS Activities: • Monitor the use and usefulness of the Transition of Care Tool. • Evaluate data by age, ethnicity, race, language, sexual orientation, and gender to look for disparities. **(CC)** • Update Releases of Information practices/guidelines/review current consent form. • Work with CalMHSA EHR team to determine implementation strategies for interoperability for exchange of Continuity of Care Documents. • Participate in standing dependency and delinquency court meetings.		

	• Continue to have representatives on task forces, initiatives and projects that involve clients with behavioral health issues (Commercially Sexually Exploited children, Children's System of Care, Child Abuse Prevention Cabinet, MH Courts, TAY Homeless Initiative, Whole Person Care, etc.)		
3.5 Diverse Workforce (CC)			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
3.5a Standard: BHS will have a diverse workforce that is representative of the clients and community they serve. ***3.5a Benchmark:*** The make-up of direct services staff is proportionate to the racial, cultural, and linguistic make-up of Medi-Cal members. ***3.5a Goal:*** Increase the diversity of direct service staff by 5% each year until benchmark is met.	• Complete the annual Human Resources Survey and Language Proficiency Survey and analyze findings. • Share results with service providers. • Update staff registration policy to gather information to support 274 expansion projects. • Increase recruitment efforts focused on areas of need found in HRS findings. • Increase outreach to the African American/Black/African Descent (AA/B/AD) community regarding job openings, application processes, and career pathways. Partner on outreach with local and national groups known to focus on the AA/B/AD community. • Increase recruitment, retention, and leadership development of AA/B/AD and transgender individuals who know the community. • Collaborate with service providers to recruit culturally diverse staff.	In Process	Data is reviewed quarterly with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.

	• Recruitment and training of workforce will align with the Behavioral Health Racial Equity Collaborative Charter. • Use the Human Resource Survey to improve the percentage of staff that represent the community we serve. • Provider Incentive: Identify demographics of clients in service and develop and implement hiring and retention policies and procedures designed to attract and keep staff that are representative of the demographics.		
3.6 Culturally Competent system of care (CC)			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
3.6a Standard: BHS will have a culturally and linguistically appropriate, equitable system of care. ***3.6a Goal:*** BHS will complete a biennial system wide Agency Self-Assessment aligned with National CLAS standards and equity metrics.	• Review organizational self-assessments containing equity measures aligned with National Culturally and Linguistically Appropriate Standards (CLAS) and select one to use within BHS county operated and contract provider agencies. • Starting in FY 2026-27, biennially complete and analyze a system- wide Agency Self-Assessment aligned with National CLAS standards and equity metrics. • Results will be shared with providers, and training and other resources will be offered to enhance culturally and linguistically appropriate care. • Ensure all direct service staff complete required Cultural		Data is reviewed annually with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.

	Competence/Cultural Humility training(s).		
3.7 Training and Education **Member Impact:** By increasing the cultural and linguistic competence of our system of care ensures that all SUPT staff can understand, communicate with and effectively serve members across different cultural and/or language differences.			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
3.7a Standard: The county will provide and/or offer ongoing training opportunities to the BHS workforce. ***3.7a Goal:*** BHS will have a well-trained, culturally and linguistically competent workforce that is adequately trained to provide effective services and administer programs based on wellness and recovery. (CC) ***3.7a1 Goal:*** By the end of FY 25/26, 75% of all BHS direct service staff and supervisors will have completed the CIBHS modules and cultural competence training. (CC) ***3.7a2 Goal:*** 98% of Assisted Access staff identified as interpreters complete the approved behavioral health interpreter training and receive certification. **(CC)** ***3.7a3 Goal:*** Offer trauma informed care training for both direct services and administrative staff on a monthly basis.	• Utilize Mental Health Services Act (MHSA) principles to enhance skill level through training and education at all levels of BHS. • Continue implementation of WET Training Plan based on community input and BHS prioritization. • Identify curriculum and instructors based on training recommendations made by the Sacramento County Behavioral Health Racial Equity Collaborative. • Provide County BHS vetted online CC training opportunities to Contracted and County run Providers. • Provide re-occurring equity trainings and increase accountability for skill development and behavior change in staff following training. **(CC)** • **Administer the Participant Racial Equity Perception Survey to BHS program participants and analyze results to determine strengths and opportunities.** • Provide Behavioral Health Interpreter Training for interpreter staff and	CC/Ethnic Services, QM	Data is reviewed annually with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.

	providers who use interpreters. **(CC)** • Develop and implement curriculum for integrating cultural competency and wellness, recovery and resiliency principles for different levels and types of providers and partners. • Refine system wide implementation of trauma informed and trauma specific trainings to address all ages and cultural groups served by BHS. Utilize training/educational opportunities to include methods to enhance the array of culturally responsive and linguistically appropriate skill sets and community interfaces for behavioral health and partner agencies. **(CC)** • Conduct at least one workshop on member culture with trainers to include member/youth/parent/caregiver/family perspective on mental illness. • Conduct at least annual in-house training/consultation to BHS's mandated key points of contact to ensure competence in meeting the access needs of diverse communities. **(CC)** • Provide "*Universal Trauma-Informed Care: A Practical Guide for Helpers Training*"		

	• Provide Compassion Fatigue Training for providers and system partners. • Explore training opportunities to provide a continuum of crisis intervention trainings to address all age groups and a variety of service specific issues to enhance crisis intervention competency skills across BHS.		

4. MEMBER OUTCOMES **Ensure the accountability, quality and impact of the services provided to clients in the Sacramento County BHS through research, evaluation, and performance outcomes.**			
4.1 Member Satisfaction **Member Impact:** All services are improved when members and/or their families have a voice in the quality improvement process.			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
4.1a Standard: All members served during the Member and Treatment Perception Surveys (CPS and TPS) collection period will be given the opportunity to provide feedback on the services they receive from BHS. ***4.1a Benchmark:*** BHS will obtain a 75% response rate during each CPS collection period. BHS will obtain a 20% response rate during each TPS collection period. ***4.1a Goal:*** Increase the response rate each year until benchmark is met.	• Provide mandatory training to BHS providers on survey distribution and collection prior to survey distribution periods. • Administer State required Surveys in English, Spanish, Chinese, Farsi, Hmong, Russian, Arabic, Vietnamese, and any other available language. **(CC).** • Monitor response rate and establish protocols for both the system and those providers that fall below the benchmark. • Analyze results of both surveys and provide a written report on analysis of data. • Analysis to include examination of disparities by race, ethnicity, and language. **(CC)**	DA in collaboration with CC/Ethnic Services, BHS, SUPT	Data is reviewed annually with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.
4.1b Standard:			

Members will be satisfied with the services received in BHS. ***4.1b Benchmark:*** Percent overall agreement in the General Satisfaction domain will be 90% or greater for each CPS and TPS sampling period. ***4.1b Goal:*** Increase the percent of member satisfaction on each domain each year until benchmark has been met.	• Provide results from both surveys to providers and members via posting to BHS website, Cultural Competence Plan Update, and email notification to all distribution lists. • Distribute link to FAC, YAC, and PAC. • Monitor performance on the six perception of general satisfaction indicators for both CPS and TPS, as defined by the state, bi-annually and consider improvement project if significantly below the overall CPS percent agreement. • Results are reported in the CPS and TPS Reports.		
4.2 CANS and PSC 35			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
4.2a Standard: All children providers in the MHP will complete a CANS at intake assessment, every 6 months, and discharge for all children ages 6-21 serviced. ***4.2a Benchmark:*** 100% of children ages 6-21 will receive a CANS assessment at time of intake. 100% of children ages 6-21 will receive a CANS every six months unless discharged prior to the 6-month assessment period. 100% of children ages 6-21 will receive a CANS at discharge. ***4.2a Goal:***	• Monitor the percent completion of CANS assessment at intake, six months and at discharge. • Provide annual reports with analysis of data. Analysis to include examination of disparities by race, ethnicity, and language**. (CC)** • Provide online training and certification information to Contracted and County Owned Providers through Praed Foundation. • Offer Post Certification Training – Use of CANS/ANSA in treatment planning.		Data is reviewed quarterly with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.

Increase percent completion annually until benchmarks have been met. ***4.2b Standard:*** All children providers in the MHP will complete a PSC-35 at intake assessment, every 6 months and discharge for all children ages 3-18 served. ***4.2b Benchmark:*** 100% of children ages 3-18 will receive a PSC-35 assessment at time of intake. 100% of children ages 3-18 will receive a PSC-35 every six months unless discharged prior to the 6-month assessment period. 100% of children ages 3018 will receive a PSC-35 at discharge. ***4.2b Goal:*** Increase percent completion annually until benchmarks have been met.	• Monitor the percentage completion of PSC-35 assessment at intake, six months and at discharge. • Add to Client Plan Checklist and discuss strategies for completing 6-month assessments in the Utilization Review Committee. • Provide annual reports with analysis of data. Analysis to include examination of disparities by race, ethnicity, and language**. (CC)** • Implement EHR form to increase access and accuracy of upload to DHCS. • Create reports for Providers to use to track results over time and in treatment planning.		
4.3 ANSA			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
4.3a Standard: *The MHP will have a standardized way of assessing the appropriateness of care for all adults receiving services.* ***4.3a Goal:*** *Continue use of Adult Needs and Strengths Assessment (ANSA) across the entire adult system.*	• Provide online training and certification information to Contracted and County Owned Providers through Praed Foundation. • Create reports for Providers to use to track results over time and in treatment planning. • Offer Post Certification Training – Use of CANS/ANSA in treatment planning.	*DA, QM, Program*	Data is reviewed annually with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.

	• Determine how to track and report ANSA within new EHR or separate database.		
4.4 Hospital Readmissions			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*

4.4a Standard:
The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose for which there was follow-up. **(HEDIS FUA)**
 	
4.4a Benchmark:
Increase our outcomes by 5% each year until we meet the minimum performance level.
 	
4.4a Goal:
Minimum performance level: 36.2%
	• Enhance/develop stronger collaboration between BHS-SAC and emergency departments; train/educate emergency department staff about BHS-SAC and SUPT services.
	  • Develop SUPT information packets for emergency departments:
	  o BHS-SAC QR Code Flyer
	  o BHS-SAC Online Request Form
	  o SUPT Drop-In Provider List
	  • Provide drop-in or same-day appointments for post-ED patients.
	  • Assign provider staff to conduct member outreach within 48 hours of ED discharge.
	• Monitor rates comparing with overall BHS rates from previous fiscal year.
	• Analysis to include examination of disparities by race, ethnicity, language, sexual orientation and gender identity and development of strategies to ameliorate. **(CC)**
	• Evaluate impact of crisis system rebalance
		DA, QM, Program	Data is reviewed quarterly with the CCC, MT, and the QIC Data Subcommittee to identify trends and make changes as needed.

	efforts on readmissions. • Utilize liaisons from Program and QM for coordination between inpatient hospitals and outpatient providers. • Create and implement high utilizer report.		
4.4b Standard: The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. **(HEDIS FUH)** ***4.4b Benchmark:*** Increase our outcomes by 5% each year until we meet the minimum performance level. ***4.4b Goal:*** Minimum performance level: 59.9%	• Use APSS for first post-hospital appointment for unlinked clients referred for SMHS. • Explore EHR options for identifying/notifying providers of hospitalizations. • Monitor coordination of care and discharge planning during concurrent review. • Examine use of Navigators in linking members to appointments. • Explore PIP strategies to increase engagement.		
4.4c Standard: The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider. **(HEDIS FUM)** ***4.4c Benchmark:*** Increase our outcomes by 5% each year until we meet the minimum performance level.	• Explore PIP strategies to improve engagement and timeliness. • Examine use of Navigators in linking members to appointments. • Explore new EHR options for notifying providers of ED encounters. • Monitor coordination of care and discharge planning during concurrent review.		

4.4c Goal: Minimum performance level: 53.8%	• Use APSS for post-hospital follow-up (helps prevent return ED visits).		