Sacramento County Division of Behavioral Health Services

Quality Management Program Annual Work Plan - Fiscal Year 24/25
(July 1, 2024 to June 30, 2025)

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 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 FY 24/25 QI Plan is the first Sacramento plan that integrates 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 stakeholder 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)".

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 Monitoring Service Capacity* *1.6 24/7*
2. TIMELINESS	*2.1 Timeliness –CC (PIP)* *2.2 No Shows*
3. QUALITY	*3.1 Problem Resolution* *3.2 UR and doc standards* *3.3 Med Monitoring* *3.4 Access to PCP* *3.5 Coordination of care* *3.6 Diverse Workforce – CC* *3.7 Culturally Competent System of Care – CC* *3.8 Training/Education - CC*
4. MEMBER OUTCOMES	*4.1 Member Satisfaction* *4.2 CANs and PSC-35* *4.3 ANSA* *4.4 Recidivism*

1.ACCESS – Ensuring that members have ready access to all necessary services within Behavioral Health Services: this includes access to culturally relevant services to address the unserved, underserved and inappropriately served communities.			
1.1 Retention and Service Utilization (CC) **Member Impact:** Monitoring utilization data will allow BHS to identify trends and develop strategies to ensure equal access and service delivery for members across all cultures.			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
1.1a Standard: BHS will demonstrate access to behavioral health services across all cultures. ***1.1a Benchmark:*** Timely access benchmarks to be determined during FY 24-25. ***1.1a Goal:*** Maintain current rates of access or higher across all cultural groups for FY 24-25.	MHP Activities: • Utilize approved claims 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 drop off rates from outpatient assessment 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. • SUPT staff will provide case	MHP Team, Data Analytics Team (DAT), Cultural Competence/ Ethnic Services (CC/Ethnic Services)	Annual Report to Cultural Competence Committee (CCC), Management Team (MT) and QIC
1.1b Standard: BHS will demonstrate retention of members proportionately across all cultures. **1.1b Benchmark:** Discharge outcomes for non-engagement will be used to measure the benchmark within the first year. ***1.1b Goal:*** Goal will be determined based on benchmark within the first year.			
1.1c Standard: Members that have a high utilization of services will be no more than 20% of average cost per client. ***1.1c Benchmark:*** ***1.1c Goal:***			

Reduce high-cost utilization by 5% annually until standard is met.	conferencing with providers to explore more appropriate treatment options that foster engagement and recovery of high utilizer members.		
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*
1.2a Standard: There is equal access to BHS for all cultures. ***1.2a Benchmark:*** **MHP**- Penetration rates for unserved, underserved and inappropriately served populations 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. ***1.2a Goal:*** Determine penetration rate goal based on the estimated need.	• 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 approved claims 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	MHP Team, Data Analytics Team (DAT), CC/Ethnic Services	Annual Report to Cultural Competence Committee (CCC), Management Team (MT) and QIC

	• 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*
1.3a 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)**.** **1.3a Benchmark:** Establish benchmark in FY 24/25. **1.3b Goal:** Track the number of diversions from IP. (Use of MHUCC, CR, discharge to community, MCST, CST, The Source).	• 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)** • Track and analyze diversion program activities. – Mental Health Urgent Care, CSU-Dignity, Crisis Residential,	Program, DAT, QM	Review periodically at Management Team, CC, QIC

	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. **1.4 Goal:** Develop a multi-tiered treatment service continuum in	• 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, DAT, QM	Review periodically at Management Team, CC, QIC
1.5 Monitoring Service Capacity			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
1.5 Standard: All inpatient TARs must be approved within 14 calendar days of receipt of final TAR**.** ***1.5 Benchmark:*** 100% of TARS will be approved or denied for inpatient TARs within 14 days of final TAR. ***1.5 Goal:*** Continue to meet the benchmark	• Analyze source data information in order to identify the data points available to track in new EHR. • Create a tracking system that captures local TARs and outsources TARs.	QM	Review quarterly at QIC

1.6 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*
1.6a Standard: Provide a statewide, toll-free telephone number that can be utilized 24 hours a day, 7 days a week (24/7 line) with language capability in all languages spoken by members of the county. ***1.6a Goal:*** Continue to have a 24/7 line with linguistic capability. (CC)	• Conduct year-round tests of 24-hour call line and BHS 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.	Quality Management (QM), DAT, CC/Ethnic Services	Review quarterly at Management Team, CC, QIC
1.6b Standard: The 24/7 line will provide information to members about how to access behavioral health services. ***1.6b Benchmark:*** 100% of test calls will be in compliance with the standard. ***1.6b Goal:*** Increase percent in compliance annually until benchmark is met			Review quarterly at Management Team, CC, QIC
1.6c Standard: The 24/7 line will provide information to members about how to use the member problem resolution and fair hearing processes ***1.6c Benchmark:***			Review quarterly at Management Team, CC, QIC

100% of test calls will be in compliance with the standard. ***1.6c Goal:*** Increase the percent in compliance annually until benchmark is met.			
1.6d Standard: The 24/7 line will provide information to members about services needed to address a member's crisis. ***1.6d Benchmark:*** 100% of test calls will be in compliance with the standard. ***1.6d Goal:*** Increase the percent in compliance annually until benchmark is met.	• Same as above	Quality Management (QM), DAT, CC/Ethnic Services	Review quarterly at Management Team, CC, QIC
1.6e Standard: All calls coming in to the 24/7 line will be logged with the member's name, date of the request and initial disposition of the request ***1.6e Benchmark:*** 100% of test calls will be in compliance with the standard. ***1.6e Goal:*** Increase the percent in compliance annually until benchmark is met.			Review quarterly at Management Team, CC, QIC

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 that evaluate benchmarks and timely access to mental health plan services by race, ethnicity, language, sexual orientation, and gender identity **(CC).** • 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 provided by DHCS to identify additional	DAT, Ethnic Services, QM	Review quarterly at Management Team, CC, QIC
2.1b Standard**:* The time between assignment to provider to first Medi-Cal billable service (telehealth, phone or in person) offered and/or provided to members will be 10 business days or less. ***2.1b Benchmark: 100% of Adult and Children will meet the 10-business day standard. ***2.1b Goal:*** Increase in percent meeting standard annually until benchmark is met.			Review quarterly at Management Team, CC, QIC

2.1c Standard**:* The time between request for Outpatient services and the first psychiatric service offered and/or provided to members will be 15 business days or less. ***2.1c Benchmark: 100% of Adult and Children will meet the 15-business day standard. ***2.1c Goal:*** Increase in percent meeting standard annually until benchmark is met.	strategies to address timely access to services. • Continue to track and report on timeliness of assignment of referrals and evaluate business process at County BHS-SAC (Behavior Health Services – Screening and Coordination) team to ensure timeliness and efficiency in processing referrals. • Monitor Service Code utilization (Assessment with Medication Request) to track first request by the client and/or caregiver for medication services. • Analyze the data from the Walk-In Assessment Performance Improvement Project to determine implementation strategies for system as a whole. • Determine new benchmark for Walk-In Assessment options.		
2.1d Standard**:* The time between acute hospital discharge to first OP psychiatric service offered and/or provided to members will be 30 calendar days. ***2.1d Benchmark: 75% of Children and 75% of Adults will meet the 30-day standard. ***2.1d Goal:*** Increase the percent meeting standard annually until benchmark is met.	• Use APSS for 1st post hospital appointment for unlinked clients referred for SMHS. • Explore implementing successful strategies from Non-Clinical and Clinical PIPs across the system to address engagement and timeless to service.		Review quarterly at Management Team, CC, QIC

***2.1e Standard**:* The time between acute hospital discharge to first OP service provided to members will be 7 calendar days			Review quarterly at Management Team, CC, QIC
2.1e Benchmark: 75% of Children and 75% of Adults will meet the 7-day standard. ***2.1e Goal:*** Increase the percent meeting standard annually until benchmark is met.	• Explore new EHR options for identifying and notifying providers of member hospitalizations. • Monitor coordination of care and discharge planning activities during concurrent review process. • Examine use of Navigator in linking members to appointment.		
2.1f Standard: The time between referral for psychological testing and 1st psychological testing appointment offered and/or provided to children will be 14 days or less. ***2.1f Benchmark:*** 65% of children and youth will meet the 14-day standard. ***2.1f Goal:*** Increase the percent meeting standard annually until the benchmark is met.	• Train and collaborate with outpatient providers regarding the appropriateness of psychological testing referrals. • Review psych testing referral and business processes • Add UC Davis trainees to increase capacity. • Review available CPT Psychological Testing Codes to determine if there are more appropriate ways to capture engagement and information gathering prior to first face-to-face meeting.	DAT	Review quarterly at Management Team, CC, QIC

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 is 3 business days. **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.	DAT	Review quarterly at Management Team, CC, QIC

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 within 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	Review quarterly at, CCC, QIC
100% of all appeals will be completed within 30 days. 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 and documentation standards **Member Impact:** Utilization reviews provides 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.	QM	Quarterly at QIC
3.2b Standard: All clients 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.	• 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 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.		
3.2c 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.			Quarterly at QIC

3.3 Medication Monitoring			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
3.3a Standard: Providers practice in accordance with pre-established standards of acceptable medical practice for medication/pharmacology. BHS will achieve at minimum of the 50th percentile for all HEDIS measures related to all medication services in all of BHS. ***3.3a Benchmark:*** Review medication/pharmacology in 5% of open episodes for each provider/program. ***3.3a Goal:*** Continue to monitor and meet benchmark.	• 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 guidelines developed by the P&T committee for the treatment of	MHTC, QM, Med Monitoring Committee	Review Pharmacy and Therapeutics Committee Quarterly at QIC

	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		

3.4 Member Access to PCP			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
3.4a Standard: All clients will be connected to a primary care physician, unless otherwise indicated by the client. ***3.4a Benchmark:*** Reassess when new direction is received. ***3.4a Goal:***	• On hold for new direction on interoperability, SHIE, and Connex through SmartCare.	DAT, Program	Review annually with management, Quarterly at QIC
3.5 Coordination of Care			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
3.5a Standard: BHS will collaborate with other government agencies/stakeholders to facilitate coordination and collaboration to maximize continuity of services for clients with mental health needs. ***3.5a 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.	Met	Report annually at QIC, CCC

	• 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 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 • Update EHR to track referrals coming in from and going out to GMCs. • 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)** Use the Transition of Care Tool for step up or step down services.		

	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.)		

3.6 Diverse Workforce (CC)			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
3.6a Standard: BHS will have a diverse workforce that is representative of the clients and community they serve. ***3.6a Benchmark:*** The make-up of direct services staff is proportionate to the racial, cultural, and linguistic make-up of Medi-Cal members. ***3.6a Goal:*** Increase the diversity of direct service staff by 5% each year until benchmark is met.	• Complete the annual Human Resources Survey and analyze findings. • Share results with service providers. • Update staff registration policy to gather information to support 274 expansion project. • 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. • Recruitment and training of workforce will align with the Behavioral Health Racial Equity Collaborative Charter. • Use the Racial Equity Assessment and Human Resource Survey to improve the percentage of staff that represent the community we serve.	In Process	CCC, QIC, Management Team

	• 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.		
3.7 Culturally Competent system of care (CC)			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
3.7a Standard: BHS will have a culturally competent system of care. ***3.7a Goal:*** BHS will complete a biennial system-wide Agency Self-Assessment of Cultural Competence	• Biennially complete and analyze a system-wide Agency Self-Assessment of Cultural Competence. • Participate in the Sacramento County Behavioral Health Racial Equity Collaborative (BHREC) Implementation Phase by implementing activities identified in the Racial Equity Action Plan and measuring performance on the activities listed for each goal. • Results will be shared with providers and training and other resources will be offered to enhance culturally competent care. • Ensure all direct service staff complete required Cultural Competence training(s). • Implementing the Self-Assessment for Modification of Anti-Racism Tool (SMART)	In Process	CCC, QIC, Management Team

3.9 **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*
3.8a Standard: The County will provide and/or offer on-going training opportunities to the BHS workforce ***3.8a 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)** ***3.8a1 Goal*:** By the end of FY 24/25, 75% of all BHS direct service staff and supervisors will have completed the CIBHS modules and cultural competence training. **(CC)**	• 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. • Increase effective and re-occurring equity trainings and increase accountability for skill	CC/Ethnic Services, QM	Annual and Periodic Report to QIC, CCC

3.8a2 Goal: 98% of staff identified as interpreters complete the approved mental health/behavioral health interpreter training and receive certification. **(CC)** **3.8a3 Goal:** Offer trauma informed care training for both direct services and administrative staff on a monthly basis.	development and behavior change in staff following training. (CC) • Provide Mental Health Interpreter training for interpreter staff and providers who use interpreters. **(CC)** • Develop and implement curriculum for integrating cultural competency and wellness, recover and resiliency principles for different levels and types of providers and stakeholders. • 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 competent skill sets and community interfaces for mental 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. **(CC)**		

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. ***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.	DAT in collaboration with CC/Ethnic Services, BHS, SUPT	Review semi-annually with management team, QIC, CCC

	• Analysis to include examination of disparities by race, ethnicity, and language. **(CC)** • Provide results from both surveys to providers and members via posting to BHS website, Cultural Competence newsletter, and email notification to all distribution lists. • Distribute link to FAC, YAC, and PAC		
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.	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.		Review semi-annually with management team, QIC, CCC

4.2 Recovery Tool			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
4.2 Standard: BHS will track and measure recovery. ***4.2 Goal:*** BHS awaiting new reporting requirements direction related to BH Connect.	• Work with MH advocates to analyze available recovery tools and develop a plan to implement a culturally sensitive recovery tool. **(CC)** • Explore other County BHS' and how they measure recovery. Implement client self-administered recovery tool options including Strengths Model as part of the Adult Services Transformation. • Implement graduation guidelines developed in partnership with Multi-County FSP innovation project.	DAT, Advocates, Management Team, CC/Ethnic Services	Annual update to QIC

4.3 CANS and PSC 35			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
4.3a 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 served. ***4.3a 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. ***4.3a Goal:*** Increase percent completion annually until benchmarks have been met.	• 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	DAT, QM	Annual Report to Management and QIC, CCC
4.3b 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. ***4.3b Benchmark:*** 100% of children ages 3-18 will receive a PSC-35 assessment at time of intake.	• Monitor the percent 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	DAT, QM	Annual Report to Management and QIC, CCC

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 3-18 will receive a PSC-35 at discharge. ***4.3b Goal:*** Increase percent completion annually until benchmarks have been met.	• 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. • Re-train staff to complete PSC-35 at the required intervals.		
4.4 ANSA			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
4.4a Standard: The MHP will have a standardized way of assessing the appropriateness of care for all adults receiving services. ***4.4a 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. • Determine how to track and report ANSA within new EHR or separate database.	DAT, QM, Program	Annual Report to Management and QIC, CCC

4.5 Hospital Readmissions			
Standard/Benchmark/Goal	*Planned Activities*	*Resp Party*	*Review Process*
4.5a Standard: Most clients will not return to acute psychiatric care within 30 days of discharge from acute psychiatric hospitalization. ***4.5a Benchmark:*** 15% Recidivism rate ***4.5a Goal:*** To reduce the readmission rate to 15% by end of FY 24/25	• 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 efforts on readmissions. • Utilize liaisons from Program and QM for coordination between inpatient hospitals and outpatient providers. • Create and implement high utilizer report. • Monitor HEDIS measures Follow-up After Emergency Department Visit for Substance Use (FUA) and Follow-Up After Emergency Department Visit for Mental Health (FUM); which include the percentage of follow-ups that occur within 30 days of the visit and within 7 days of the visit.	DAT, QM, Program	Review quarterly with Management team, QIC, CCC