QUALITY IMPROVEMENT WORK PLAN

FY 2025 2026

IMPERIAL COUNTY
Behavioral Health Services
MENTAL HEALTH & SUBSTANCE USE RECOVERY

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QUALITY IMPROVEMENT (QI) PROGRAM OVERVIEW

IMPERIAL COUNTY
Behavioral Health Services
MENTAL HEALTH & SUBSTANCE USE RECOVERY

Quality Improvement (QI) Work Plan Overview

I. Introduction

Quality Improvement (QI) is an essential component of any successful organization. At its core is the belief that every client has the right to quality care - a belief that must be shared by all staff, from leadership to frontline workers. When this belief is embedded throughout an agency, resources can be focused on meaningful improvements. Doing things right the first time not only improves outcomes but also reduces costs. Outdated and inefficient processes are major barriers to delivering high-quality services.

Quality Management (QM) and QI are shared responsibilities across all units and staff. Think of the QM Program as an umbrella: the canopy represents the program itself, the ribs holding it open are staff and QI activities, and the handle is the QM Unit and leadership supporting it.

Imperial County Behavioral Health Services (ICBHS), including Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS), are jointly committed to maintaining and improving service quality. The QM Unit leads this effort by identifying improvement opportunities, recommending QI activities like Performance Improvement Projects (PIPs), and ensuring follow-through. It also reviews service documentation for compliance and supports continuous improvement processes.

The Quality Improvement Committee (QIC) reviews QI outcomes, recommends policy changes, and ensures implementation. The QI Work Plan outlines all QI activities, evaluates their effectiveness in improving care, and is updated annually to reflect progress, results, and new objectives for FY 24–25 based on input from stakeholders (e.g. SMHS, SUDS, fee-for service providers, consumers, and family members).

II. Quality Improvement Program

The goal of the QI Program is to improve access to and delivery of both SMHS and SUDS, while assuring that services are community-based, client directed, age appropriate, culturally competent, and process and outcome focused. The QI Program approach is an integrative process that links knowledge, structure, and process together to assess and improve quality. This approach is designed to coordinate performance monitoring activities throughout the organization including, but not limited to, client and system outcomes, utilization management, clinical records review, monitoring of client and provider satisfaction, and resolution of grievances and appeals.

1) QI Program Description

It is the responsibility of ICBHS as a provider of both Medi-Cal SMHS and SUDS to develop a written QI Program description, in which structure and processes are clearly defined with responsibility assigned to appropriate individuals. ICBHS' QI Program description includes the following elements:

1. The QI Program description shall be evaluated annually and updated as necessary.
2. The QI Program shall be accountable to the ICBHS Director.
3. A licensed behavioral health staff person shall have substantial involvement in QI Program implementation.
4. SMHS and SUDS staff, fee-for-service (FFS) providers, consumers, and family members shall actively participate in the planning, design, and execution of the QI Program.
5. The role, structure, function, and frequency of meetings of the Quality Improvement Committee (QIC), and other relevant committees, shall be specified.
6. The QIC shall oversee and be involved in QI activities, including performance improvement projects.
7. The QIC shall recommend policy decisions; review and evaluate the results of QI activities including performance improvement projects; institute needed QI actions; and ensure follow up of QI processes.
8. Dated and approved minutes shall reflect all QIC decisions and actions.
9. The QI Program shall coordinate performance monitoring activities throughout ICBHS including, but not limited to, client and system outcomes, utilization management, credentialing, monitoring and resolution of grievances, appeals, fair hearings, providers' appeals, assessment of client and provider satisfaction, and clinical records review.
10. Contracts with hospitals and with individual, group, and organizational providers shall require cooperation with the ICBHS QI Program, and access to relevant clinical records to the extent permitted by State and Federal laws by ICBHS and other relevant parties.

2) Quality Improvement Committee

a) Membership Composition of the QIC

Members of the QIC are key stakeholders in both the SMHS and SUDS and shall include a licensed mental health and substance use disorder professional. Each member is appointed by the ICBHS Director and serves a minimum of one-year term. The QIC consists of the following stakeholders:

Leadership

- Director
- Assistant Director
- Deputy Director – Children Services
- Deputy Director – Youth and Young Adult Services
- Deputy Director – Adult Services
- Deputy Director – Mental Health Triage & Engagement Services
- Deputy Director – Substance Use Disorder Services
- Deputy Director – Administration

Management and QM Staff

- Behavioral Health Manager – Managed Care
- Behavioral Health Manager – Access Unit
- Program Supervisor – Quality Management
- Administrative Analyst(s) – Quality Management

Providers

- Licensed Mental Health Professional
- Licensed SUD Provider

ICBHS & Consumer Representation

- Ethnic Services Representative
- Patient's Rights Advocate
- Clients of both SMHS and SUD services
- Consumer/Family Member Quality Improvement Subcommittee Chair(s)
- Family members

b) QIC Meeting

For Fiscal Year (FY) 2024–2025, QIC meetings were held on the second Thursday of each month from 1:00 p.m. to 2:30 p.m., except for August, during which no meeting is scheduled.

Beginning in FY 2025–2026, QIC meetings will be held on a bi-monthly basis. If a need arises before a scheduled meeting, an emergency meeting will be convened.

c) QIC Agenda

All departmental personnel, providers, and committee members may contribute to the agenda items. All agenda items and materials shall be submitted to the QM program clerical support prior to the first Thursday of each month by 5:00 p.m. All agenda items and materials shall be reviewed by the chairperson and the QM Unit before being saved to the QIC meeting shared file. The goal of the QM Unit is to ensure that the meeting agenda and materials are saved in the department's QIC meeting shared file at least one week prior to the scheduled meeting.

d) Meeting Minutes

The QM Unit is responsible for the QIC meeting minutes. The minutes are available to each QIC member and to ICBHS members of management. The minutes will contain, at a minimum, the following:

a. The name and location of where the meeting was held.
b. The date and time of the meeting.
c. The members present, listed by name and title.
d. The members absent, listed by name and title.
e. Issues discussed.
f. Review and evaluation of the results of QI activities, including performance improvement projects.
g. Decisions and/or recommendations made.
h. Action(s) taken.
i. Implementation of needed QI activities.
j. Ensure the follow up of QI processes.

e) Voting

The QIC shall follow these guidelines:

a. A quorum (the presence of more than half of the appointed members) is required for any decisions and/or actions taken by QIC.
b. The chairperson (or designee) is not a voting member, except in the event of a tie-vote in which case the chairperson (or designee) vote will prevail.

f) Officers

The Managed Care Behavioral Health Manager will be the chairperson for the QIC. The vice-chairperson for the QIC will be the QM Unit Program Supervisor.

g) Duties of Officers

The QIC chairperson shall preside at all meetings. The QIC chairperson is responsible for the review of agenda items and materials with the QM Unit prior to distribution. In the QIC chairperson's absence, the chairperson will arrange with the vice-chairperson to handle his or her responsibilities.

h) QIC Role and Responsibilities

The QIC plays an active role in the planning, design, implementation, and ~~execution~~ versight of the QM program. The QIC is actively involved in reviewing the annual QI Work Plan development and implementation, as appropriate.

The QIC oversees the required components of the QI Work Plan including the PIPs. It is responsible for recommending policy decisions, evaluating the results of QI activities, initiating necessary QI actions, and ensuring appropriate follow up.

As part of its oversight function, the QIC coordinates performance monitoring efforts by reviewing and evaluating reports produced by the QM Unit. These address state-mandated areas including, but not limited to:

State Mandated Areas:

1. Service delivery capacity
2. Accessibility of services
3. Client/family satisfaction
4. Service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices
5. Continuity and coordination of care with physical health care providers (PCP) and other human services agencies
6. Provider Complaints and Appeals
7. Strategies to Reduce Avoidable Hospitalizations
8. Timeliness of Services
9. No Show Rates
10. Performance Improvement Projects

3) Consumer/Family Member Quality Improvement Subcommittee

The Consumer/Family Member Quality Improvement Subcommittee (CFQIS) consists of ICBHS consumers and family members who assist in the planning, design, and execution of the QI Program. CFQIS was developed to improve access and delivery of services and assure that services are based on the needs of the community and are consumer-directed, age-appropriate, and culturally competent.

CFQIS is responsible for reviewing QI activities, identifying opportunities for improvement, planning and implementing County services, and making recommendations to the QIC. The CFQIS meets monthly, with the meeting location alternating each month between El Centro and Brawley. The chairpersons for each subcommittee are voted on by the members of each respective CFQIS and attend the QIC to address opportunities for improvement and make recommendations on behalf of the CFQIS.

4) Quality Improvement Work Plan

The Quality Improvement (QI) Program shall have a QI Work Plan that includes the required elements set forth by the Department of Health Care Services (DHCS) which include: (a) an annual evaluation of the overall effectiveness of the QI Program, demonstrating that QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and client service, and describing completed and in-process QI activities, including performance improvement projects; (b) monitoring of previously identified issues, including tracking of issues over time; (c) planning and initiation of activities for sustaining improvement; and (d) objectives and planned activities for the coming year.

5) Quality Management Unit

The QM Unit oversees the coordination of QI Program activities. The Managed Care Behavioral Health Manager, under the direction of the Director, is responsible for the implementation of QI activities and provision of leadership for the QI Program. The QM Unit is responsible to the QIC for conducting, monitoring, and evaluating QI Program activities.

The QM Unit is responsible for the development of the QI Work Plan that is consistent with the DHCS contract and attachments. The QM Unit will ensure that relevant cultural competence and linguistic standards are incorporated in the QI Work Plan.

III. CalAIM Behavioral Health Initiative – FY 2024-25 Activities

ICBHS remains committed to the successful implementation of CalAIM behavioral health reforms. The FY 2024–25 QI Work Plan includes specific monitoring activities and objectives aligned with the following CalAIM initiatives:

1. Specialty Mental Health Services (SMHS) Access Criteria

ICBHS continues to implement the revised SMHS access criteria for both adults and youth (under age 21), in alignment with CalAIM policy changes. This includes broadening service eligibility and realigning "medical necessity" definitions per WIC §14184.402 to improve access and service coordination across the care continuum.

2. SUDS Policy Improvements I Health Services (SMHS) Access Criteria

Building on early implementation experience, ICBHS has adopted SUDS policy refinements to improve clinical care and reduce administrative burden. FY 24–25 QI efforts include monitoring service delivery enhancements and measuring client outcomes resulting from these improvements.

3. Documentation Redesign – SMHS and SUDS

As part of CalAIM's documentation reform, ICBHS has implemented streamlined clinical documentation practices to enhance efficiency, promote person-centered care, and ensure compliance with quality standards. The QM Unit continues to evaluate documentation outcomes, support staff training, and track system-level changes during FY 24–25.

4. No Wrong Door Policy

ICBHS upholds the "No Wrong Door" approach, ensuring beneficiaries receive timely mental health and/or substance use disorder services regardless of where they initially seek care (ICBHS or MCP). The QI Work Plan includes objectives to monitor timely access, assess coordination during service transitions, and ensure appropriate reimbursement pathways are in place.

5. Standardized Screening and Transition Tools

ICBHS has adopted DHCS-mandated standardized tools to:

- Appropriately screen and refer beneficiaries to the correct delivery system (ICBHS or MCP).
- Support transitions between delivery systems and services with continuity of care.

The QM unit continues to monitor tool usage, implementation fidelity, and coordination of care as part of FY 24-25 quality assurance activities.

6. Behavioral Health Payment Reform

ICBHS is transitioning from cost-based reimbursement toward value-based payment models that promote quality, efficiency, and better health outcomes. The FY 24–25 QI Work Plan includes performance monitoring activities tied to emerging payment structures and client-centered outcomes.

While SmartCare has enhanced ICBHS ability to deliver aligned CalAIM services, some functionalities remain in development and will be introduced in phases. The QM Unit continues to evaluate the system's effectiveness, track gaps, and provide recommendations for improvement.

The ICBHS FY 24-25 QI Work Plan incorporates monitoring, evaluation, and continue quality improvement efforts directly related to CalAIM. The QM Unit and QIC remain actively involved in assessing CalAIM related performance indicators, compliance with policy updates, and the overall impact on client care.

SERVICE DELIVERY CAPACITY

IMPERIAL COUNTY
Behavioral Health Services
MENTAL HEALTH & SUBSTANCE USE RECOVERY

Service Delivery Capacity

I. Service Delivery Capacity

As the SMHS and SUDS provider for the County of Imperial, ICBHS provides services in a rural area that extends 4,482 square miles. Described below are the current number, types, and geographical distribution of Imperial County Behavioral Health Services within SMHS and SUDS delivery system and Federal Network Adequacy Standards for FY 24-25.

A. Update on the objectives and activities for FY 24-25:

The QM Unit compiled information on the current number, type, and geographical distribution of SMHS and SUDS services provided by ICBHS through staff providers and contract providers. The information provided includes the geographic distribution of services, the target population, the type of service, client demographics, the number of beneficiaries served, and the number of services claimed in FY 24-25.

ICBHS is responsible for providing or arranging medically necessary SMHS and SUDS services. Imperial County residents may access services in person by walking into one of ICBHS outpatient clinics (during hours) or by calling the toll-free telephone number (during and after hours). Access staff assigned to the 24-hour toll-free telephone line will provide information on how to access services, including services needed for urgent requests. For SMHS requests the access staff will proceed and administer a screening tool and if it is determined that the individual meets the criteria for SMHS, the access staff will coordinate an appointment within 10 business days from the date of request for an initial assessment at any of the SMHS outpatient clinics near the client's city of residence. For SUDS requests the access staff will coordinate an appointment within 10 business days from the date of requests for a screening at any of the SUDS clinics near the client's city of residence.

ICBHS is also responsible for authorizing client requests for SUDS residential treatment. Beneficiaries who are determined to need residential treatment are referred to one of ICBHS' out-of-county contracted residential treatment facilities. ICBHS provides transportation and care coordination services to beneficiaries receiving residential treatment services to ease the transition to a facility located outside the county.

Requests for NTP services are made directly to ICBHS' contracted NTP provider. Beneficiaries requesting NTP services are offered an intake appointment within 3 business days from the date of the request.

ICBHS and contracted providers provide accommodation to serve people with physical disabilities, including vision and hearing impairments, if needed. In addition, services are made available to all

individuals with mobility, communication, or cognitive impairments as required by federal and state laws and regulations.

1) SMHS Direct Service Providers

a) Geographic Location of Programs and Population Served

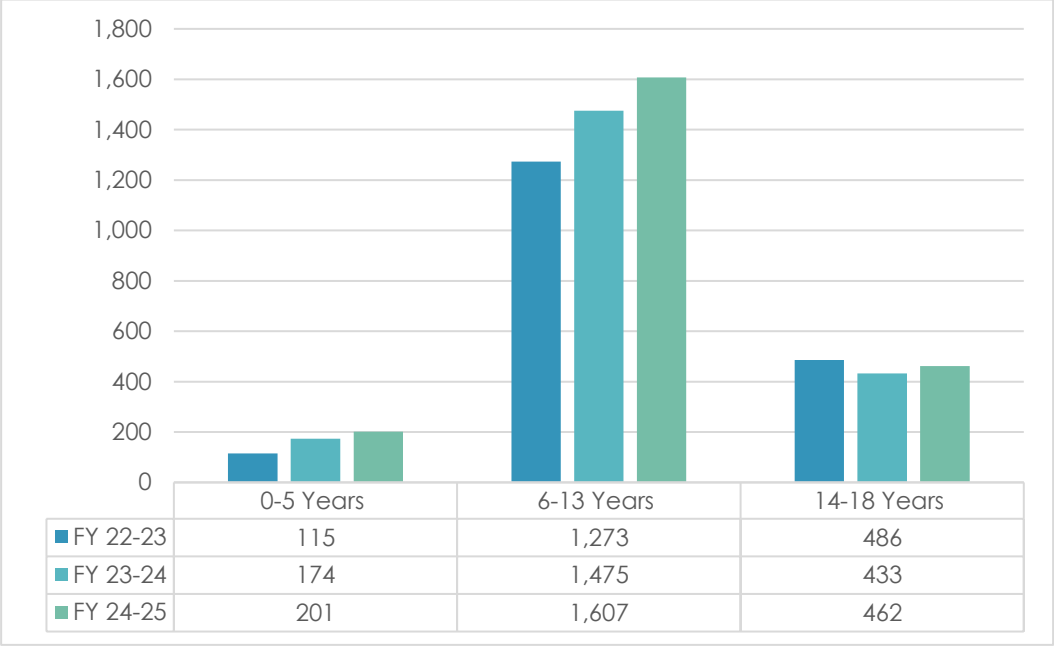
During FY 24-25, ICBHS provided SMHS at 25 Medi-Cal Sites. Each site provides services according to the client's age group and residence.

Region	Sites	Address	Provider No.
Northern Region	Team 6: Child. & Adol. Outpatient	195 S. 9th St., Brawley, CA 92227	1384
	Brawley Vista Sands	1401 "B" St. Brawley, CA 92227	1334
Central Region	Team 5: Child. & Adol. Outpatient	120 N. Eighth St., El Centro, CA 92243	1301
	Team 12: Child. & Adol. Outpatient	651 Wake Ave., El Centro, CA 92243	1398
	El Centro Vista Sands	1530 Waterman Ave., El Centro, CA 92243	1332
	Prevention and Early Intervention - TF-CBT	313 Waterman Ave., El Centro, CA 92243	1382
	First Step to Success	801 Broadway St., El Centro, CA 92243	1364
	Middle School Behavioral Modification Program	1052 Heber Ave, Room 105-106	13A9
Southern Region	Team 4: Child. & Adol. Outpatient	101 Hacienda, Ste. C., Calexico, CA 92231	1350
	Calexico Vista Sands	2300 Rockwood Ave. Rm. 30 Calexico, CA 92231	1335
Eastern Region	San Pascual FRC - Children	676 Baseline Rd., Winterhaven, CA 9	1364

Children's Division

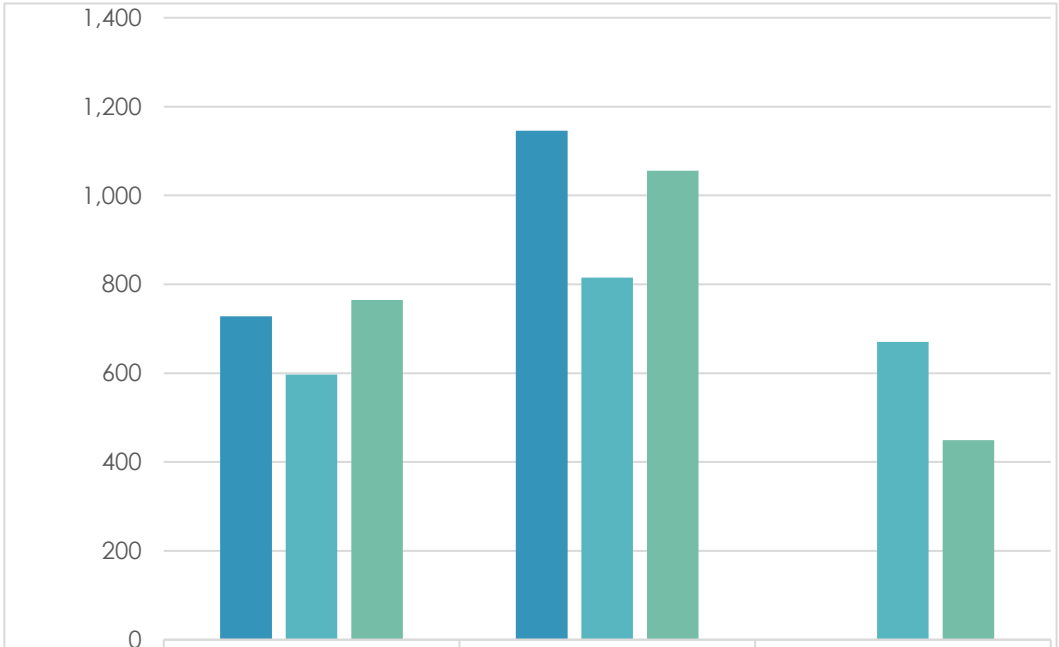
Charts 1.1-1.6 indicate the demographic information for beneficiaries served by Children Services.

Chart 1.1 Children Served by Age Group



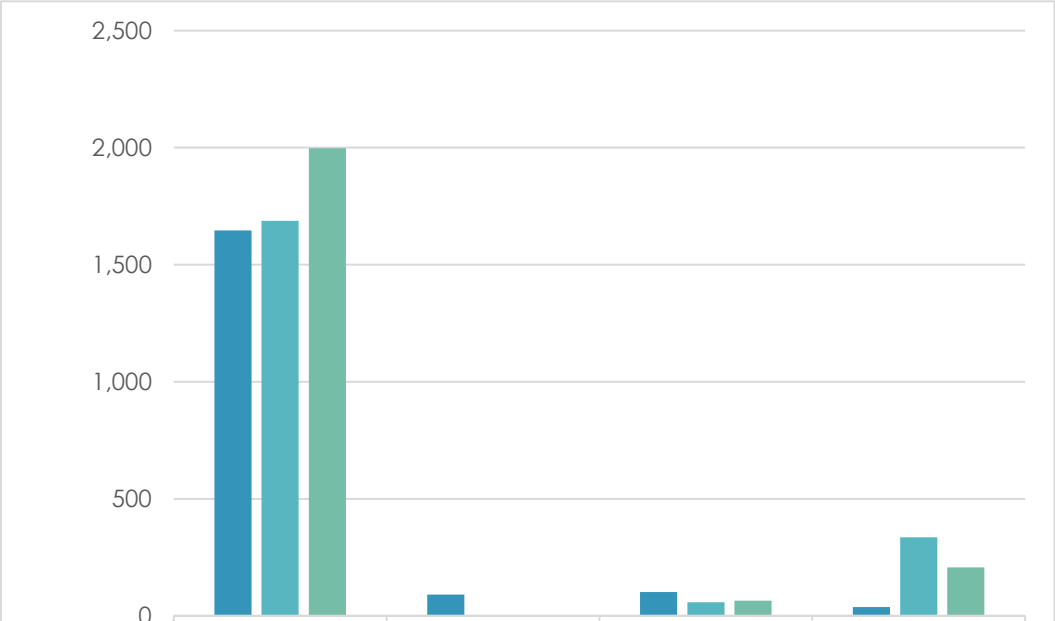
	0-5 Years	6-13 Years	14-18 Years
FY 22-23	115	1,273	486
FY 23-24	174	1,475	433
FY 24-25	201	1,607	462

Chart 1.2 Children Served by Gender



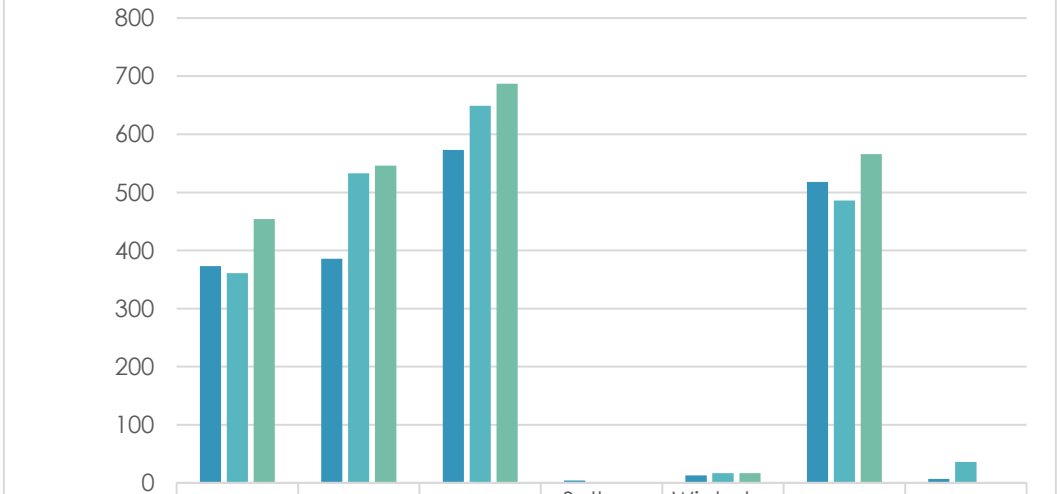
	Female	Male	Other/Unknown
FY 22-23	728	1,146	0
FY 23-24	597	815	670
FY 24-25	765	1,056	449

Chart 1.3 Children Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 22-23	1,646	90	101	37
FY 23-24	1,688	0	58	336
FY 24-25	1,998	0	65	207

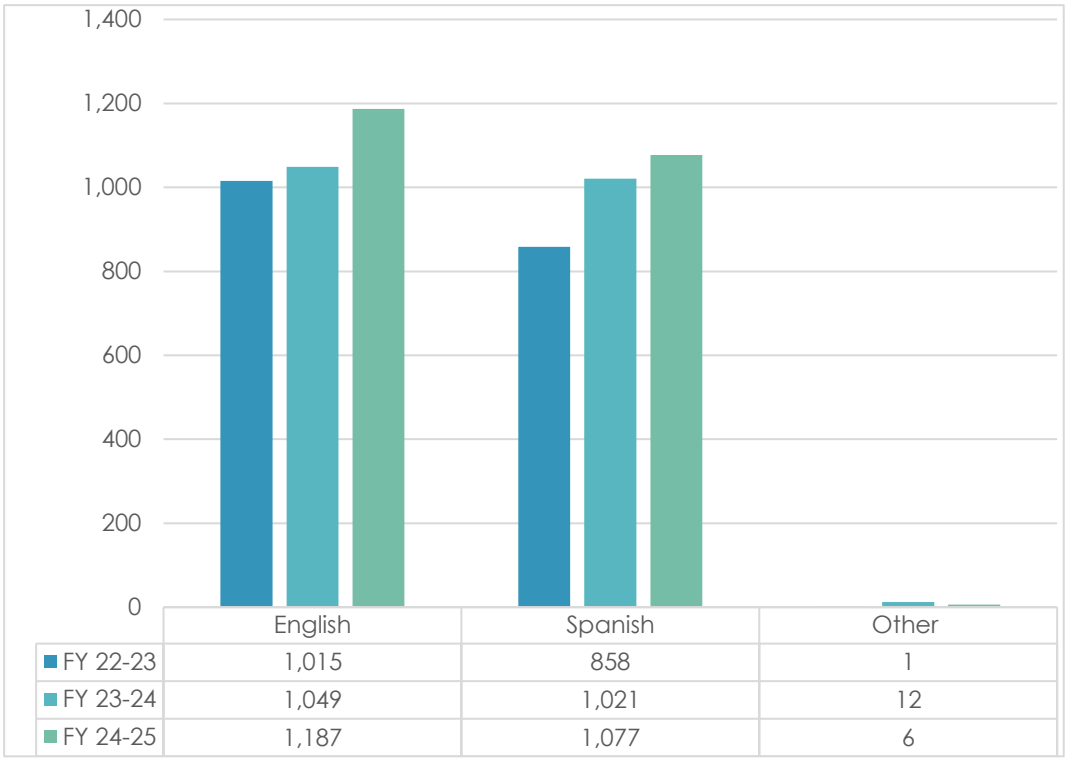
Chart 1.4 Children Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknown
FY 22-23	373	386	573	4	13	518	7
FY 23-24	361	533	649	0	17	486	36
FY 24-25	454	546	687	0	17	566	0

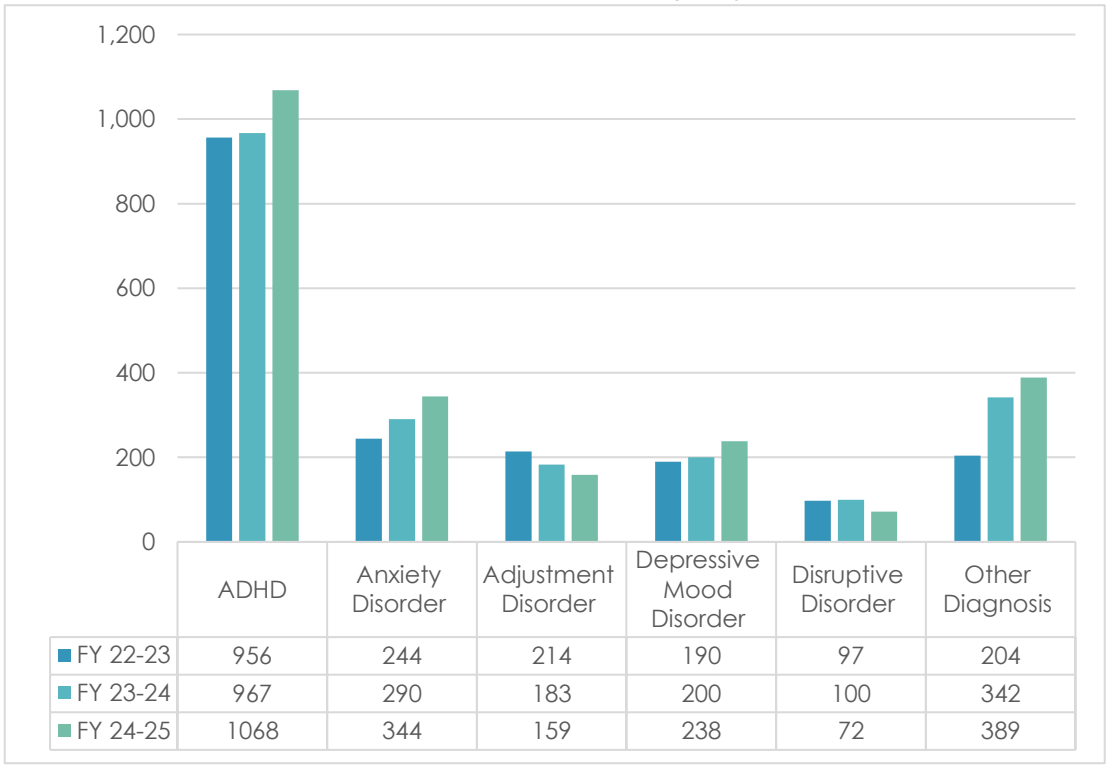
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart 1.5 Children Served by Language



	English	Spanish	Other
FY 22-23	1,015	858	1
FY 23-24	1,049	1,021	12
FY 24-25	1,187	1,077	6

Chart M1.6 Children Served by Diagnosis



	ADHD	Anxiety Disorder	Adjustment Disorder	Depressive Mood Disorder	Disruptive Disorder	Other Diagnosis
FY 22-23	956	244	214	190	97	204
FY 23-24	967	290	183	200	100	342
FY 24-25	1068	344	159	238	72	389

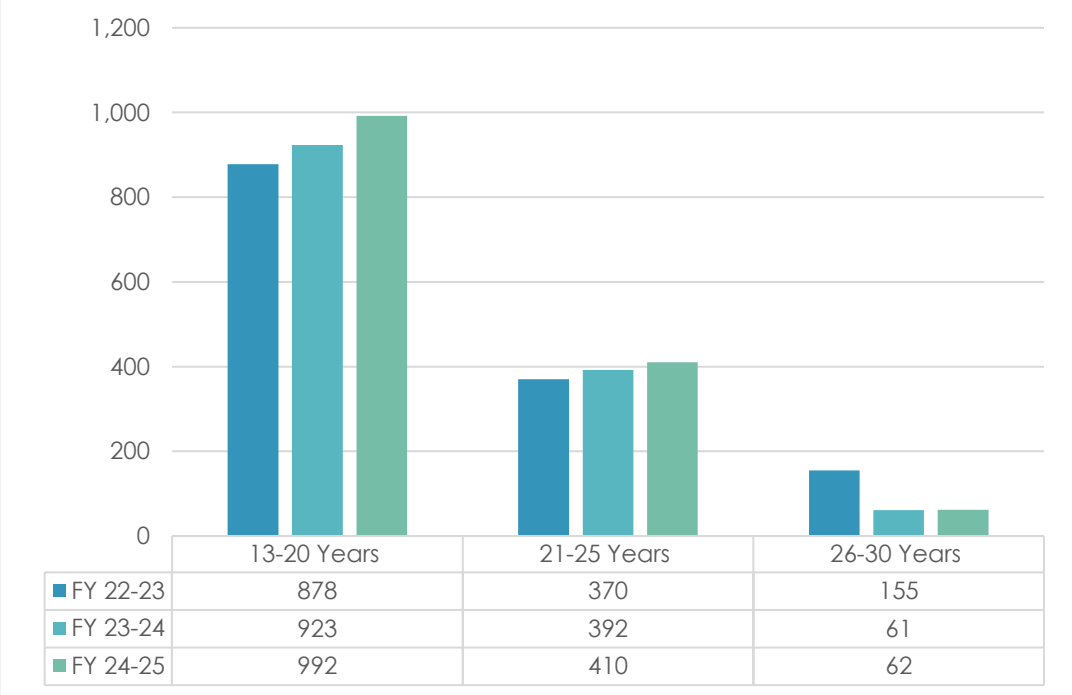
**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

Youth & Young Adults Division

Region	Sites	Address	Provider No.
Northern Region	Youth and Young Adult Brawley Family Resource Center	480 N. Imperial Ave., Rm 95 Brawley, CA 92227	1392
	Youth and Young Adult Brawley Anxiety and Depression Clinic and FSP	1535 Main Street Rm 22, Brawley, CA 92227	1381
Central Region	Adolescent Habilitative Learning Program (AHLP)	1001 W. Brighton Ave., El Centro, CA 92243	1390
	Youth and Young Adult El Centro Family Resource Center	1014 W. Brighton Ave., El Centro, CA 92243	1393
	Youth and Young Adult El Centro Anxiety and Depression Clinic and FSP	1295 State Street, El Centro, CA 92243	1329
Southern Region	Youth and Young Adult Calexico Anxiety and Depression and FSP	101 Hacienda, Calexico, CA 92231, Ste. A	1395

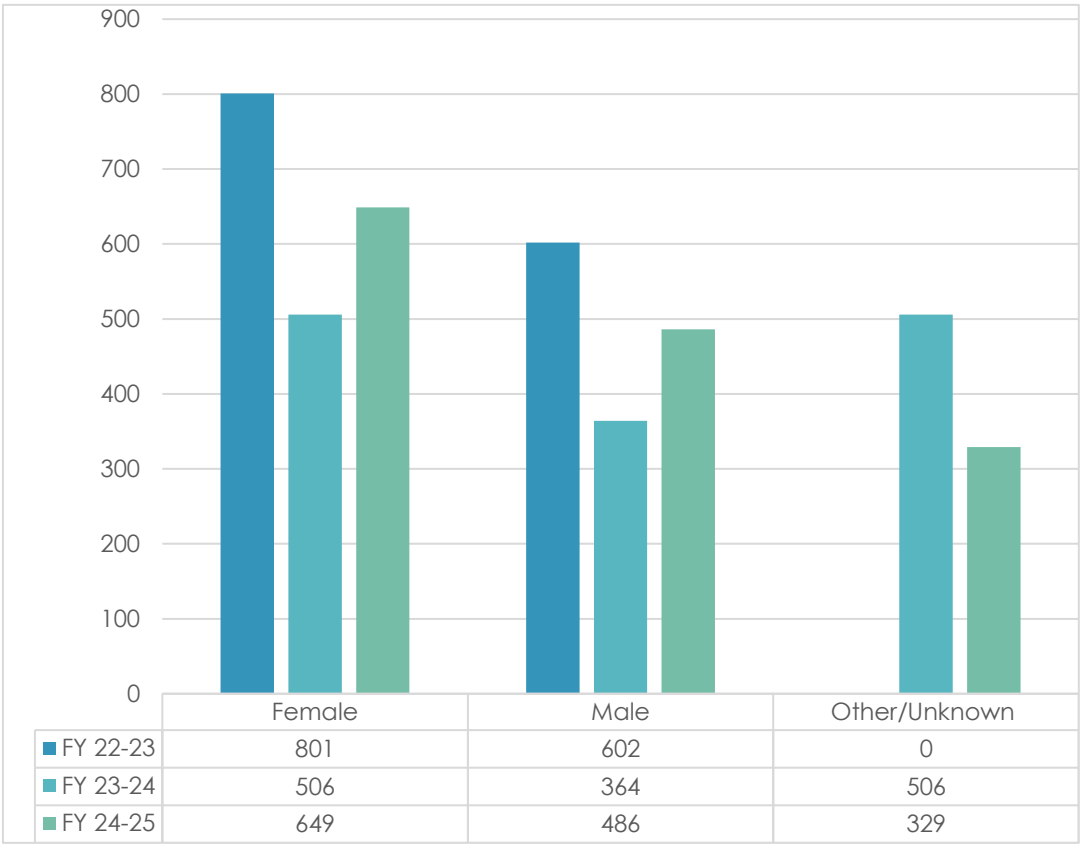
Charts M1.7-M1.12 indicate demographic information for beneficiaries served by YAYA Services.

Chart 1.7 Youth and Young Adults Served by Age Group



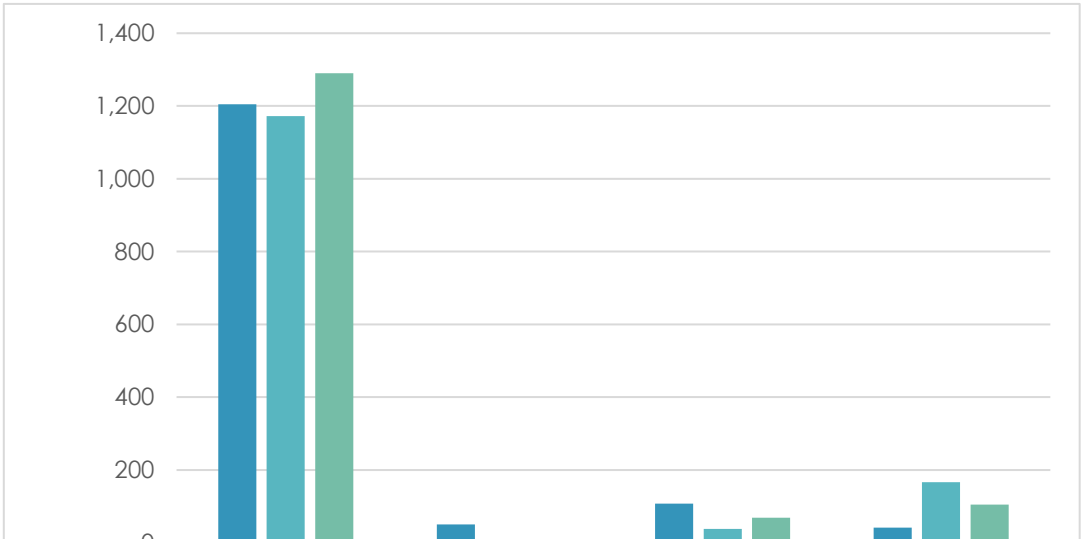
	13-20 Years	21-25 Years	26-30 Years
FY 22-23	878	370	155
FY 23-24	923	392	61
FY 24-25	992	410	62

Chart 1.8 Youth and Young Adults Served by Gender



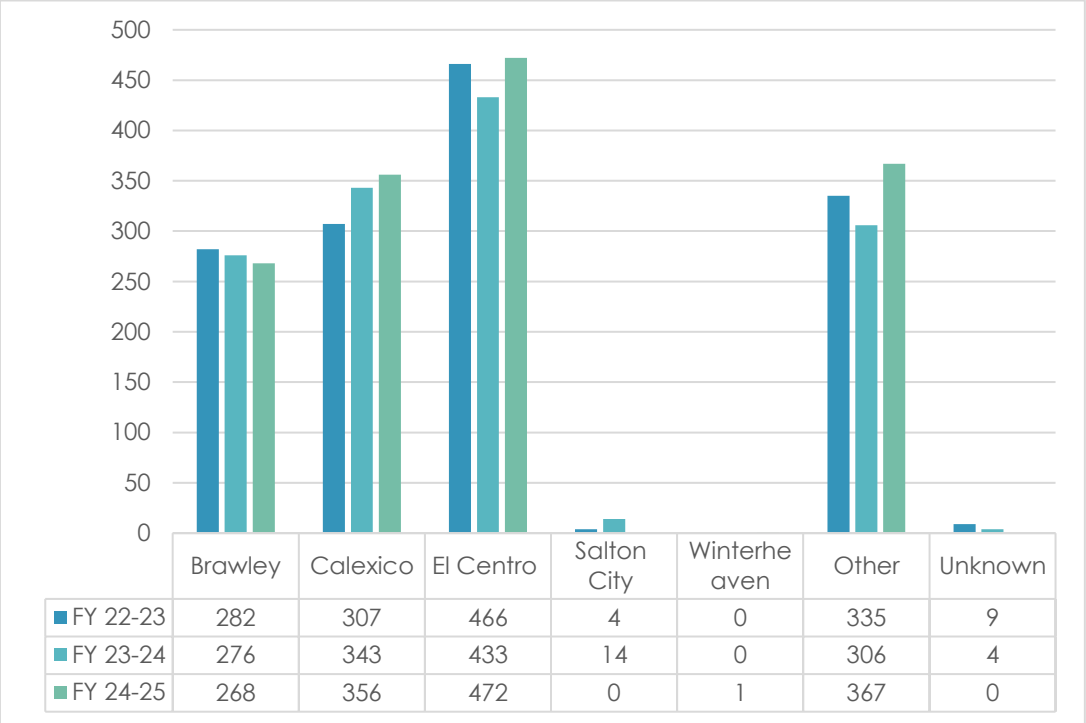
	Female	Male	Other/Unknown
FY 22-23	801	602	0
FY 23-24	506	364	506
FY 24-25	649	486	329

Chart 1.9 Youth and Young Adults Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 22-23	1,205	50	107	41
FY 23-24	1,172	0	38	166
FY 24-25	1,290	0	69	105

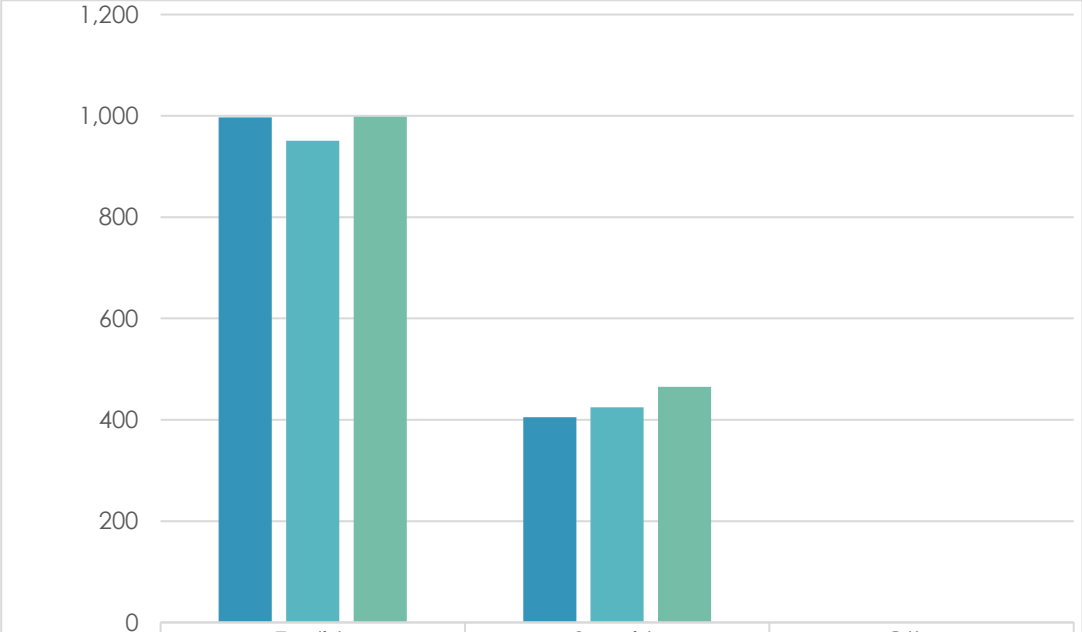
Chart 1.10 Youth and Young Adults Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknown
FY 22-23	282	307	466	4	0	335	9
FY 23-24	276	343	433	14	0	306	4
FY 24-25	268	356	472	0	1	367	0

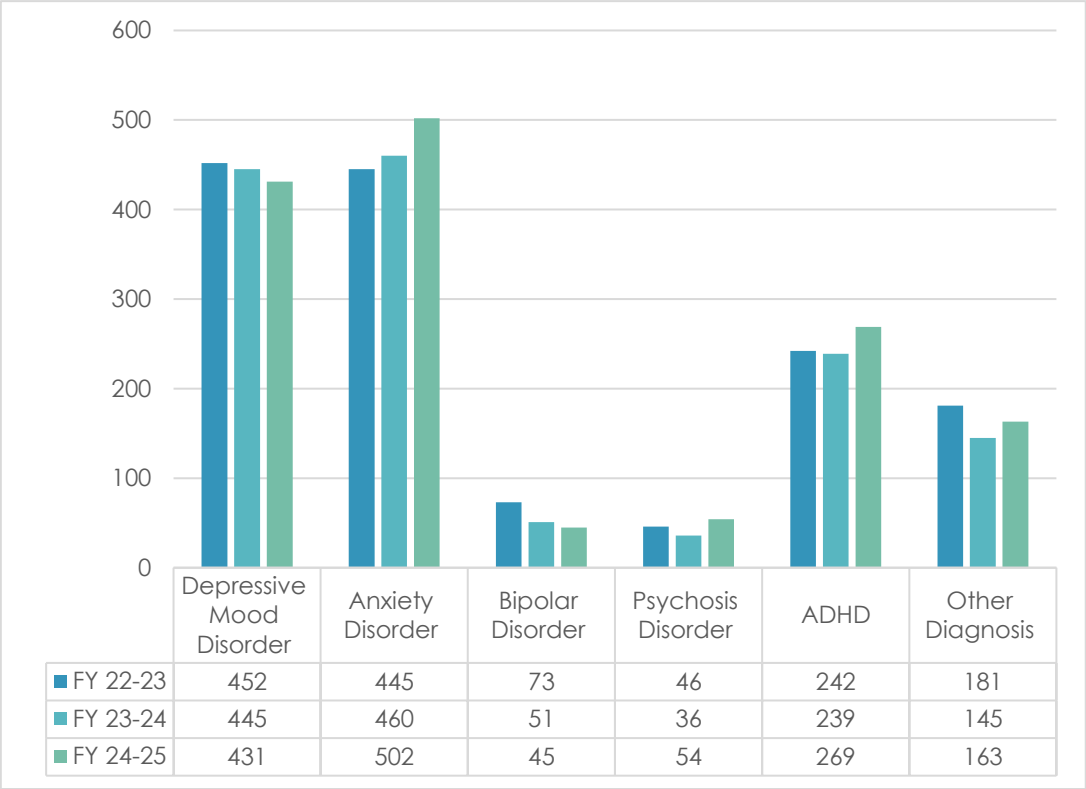
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart 1.11 Youth and Young Adults Served by Language



	English	Spanish	Other
FY 22-23	997	405	1
FY 23-24	951	425	0
FY 24-25	998	465	1

Chart 1.12 Youth and Young Adults Served by Diagnosis



	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 22-23	452	445	73	46	242	181
FY 23-24	445	460	51	36	239	145
FY 24-25	431	502	45	54	269	163

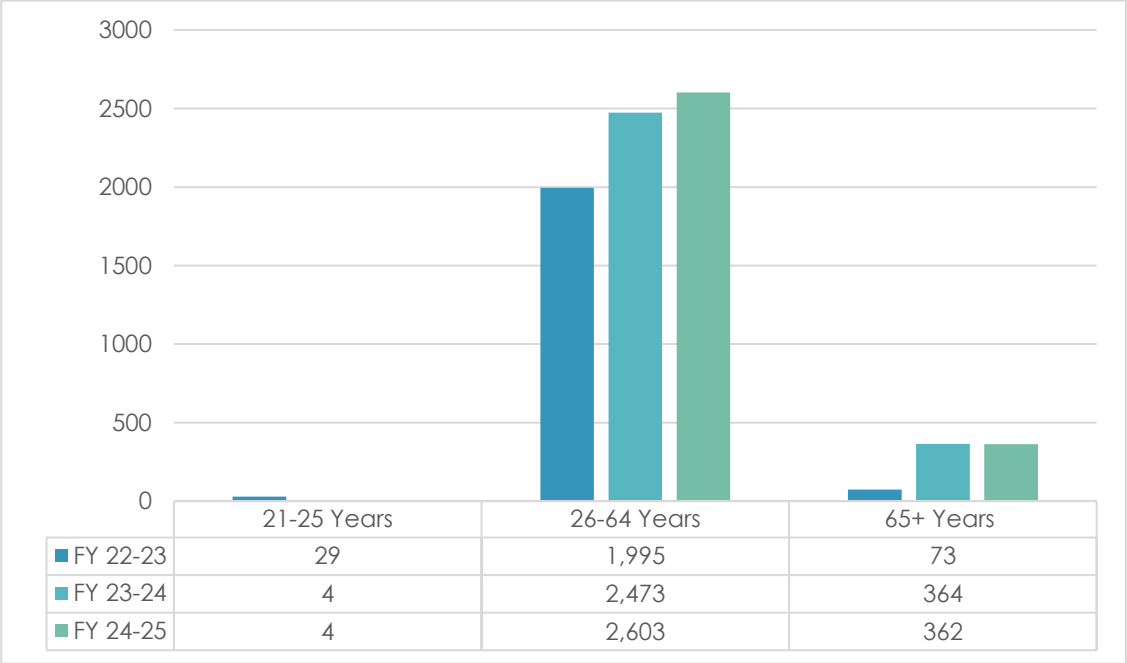
**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

Adults Division

Region	Sites	Address	Provider No.
Northern Region	Adult Brawley Anxiety and Depression	229 Main Street, Brawley, CA 92227	1379
	Adult Brawley MHSA FSP Program		
Central Region	Adult El Centro Anxiety and Depression	313 Waterman Street, El Centro, CA 92243	1382
	Adult El Centro MHSA FSP Program	2695 S. Fourth Street, Ste. B, El Centro, CA 92243	1366
Southern Region	Adult Calexico Anxiety and Depression	1501 W. Imperial Ave., Calexico, CA 92231	1388
	Adult Calexico MHSA FSP		
Eastern Region	San Pascual FRC	676 Baseline Road, Winterhaven, CA 92283	1364

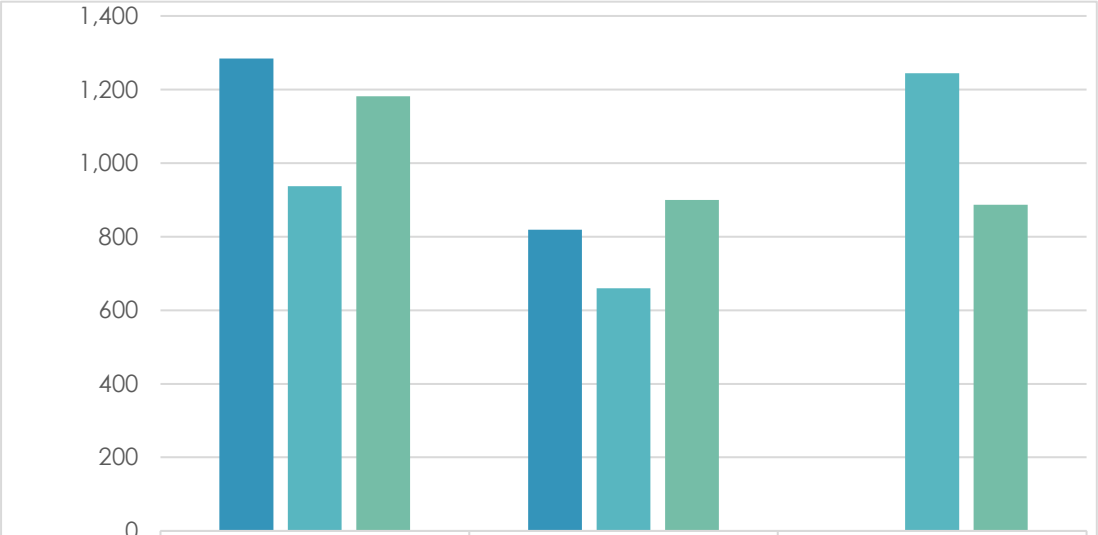
Charts 1.13-1.18 indicate the demographic information for beneficiaries served by Adults Services.

Chart 1.13 Adults Served by Age



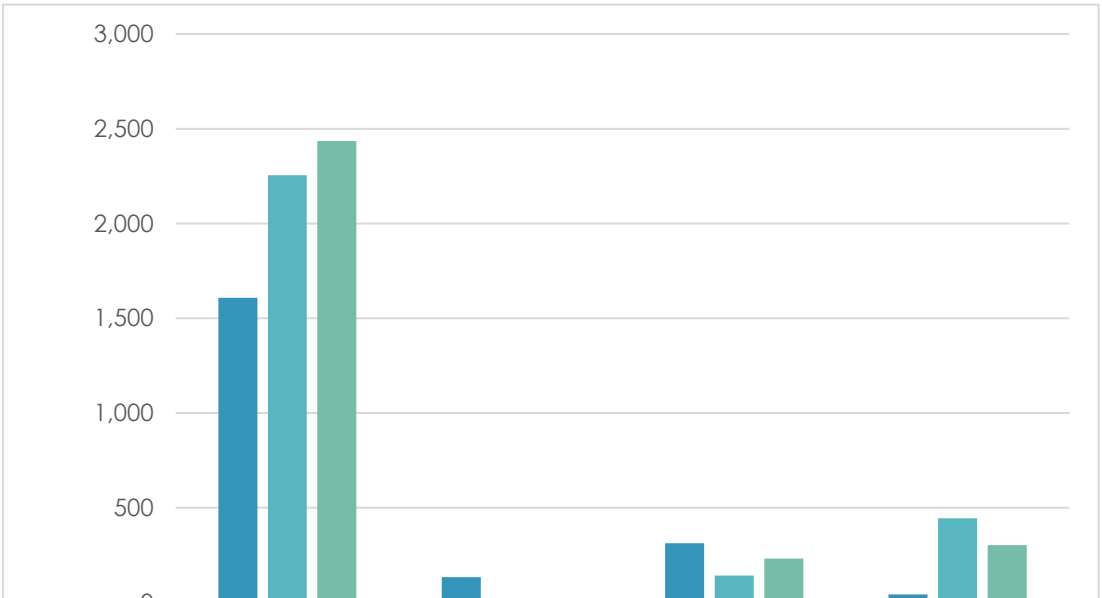
	21-25 Years	26-64 Years	65+ Years
FY 22-23	29	1,995	73
FY 23-24	4	2,473	364
FY 24-25	4	2,603	362

Chart 1.14 Adults Served by Gender



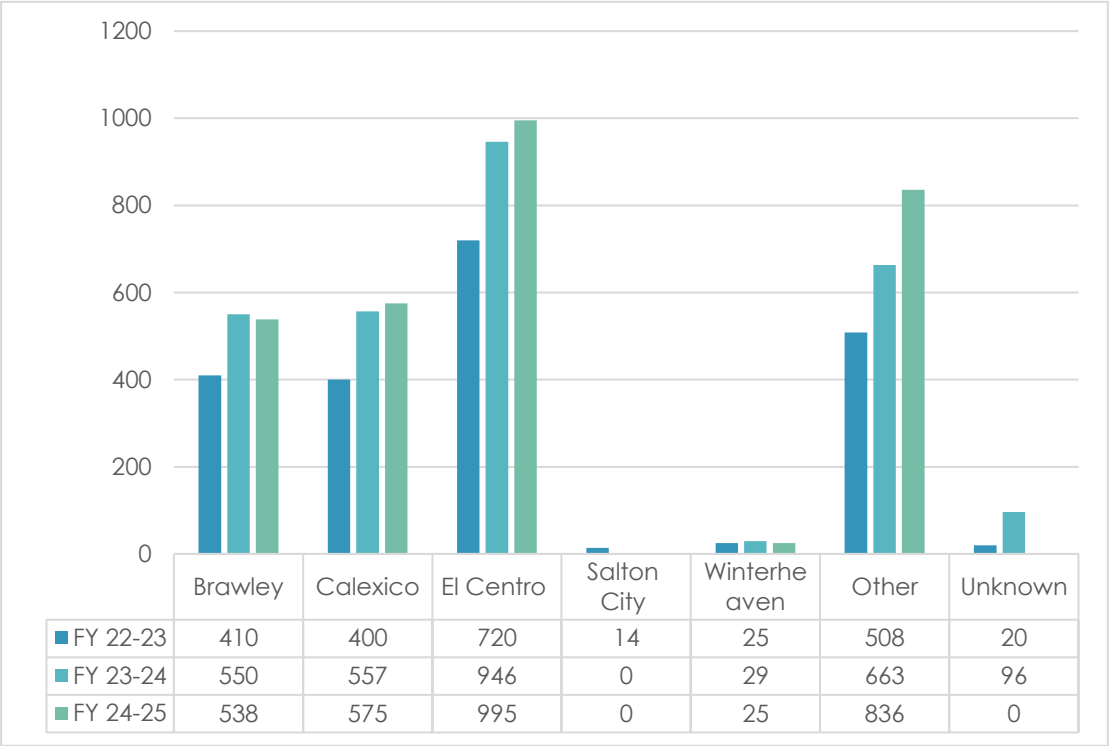
	Female	Male	Other/Unknown
FY 22-23	1,284	819	0
FY 23-24	937	660	1,244
FY 24-25	1,182	900	887

Chart 1.15 Adults Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 22-23	1,608	134	313	42
FY 23-24	2,254	0	142	445
FY 24-25	2,435	0	232	302

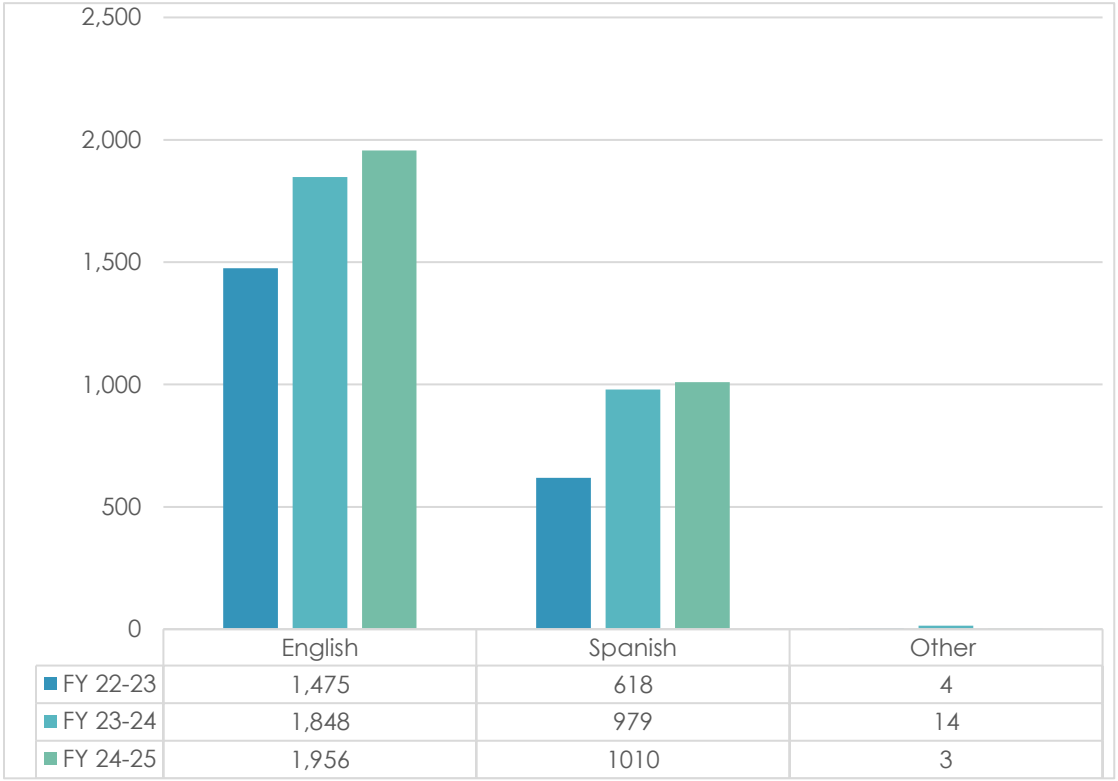
Chart 1.16 Adults Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknown
FY 22-23	410	400	720	14	25	508	20
FY 23-24	550	557	946	0	29	663	96
FY 24-25	538	575	995	0	25	836	0

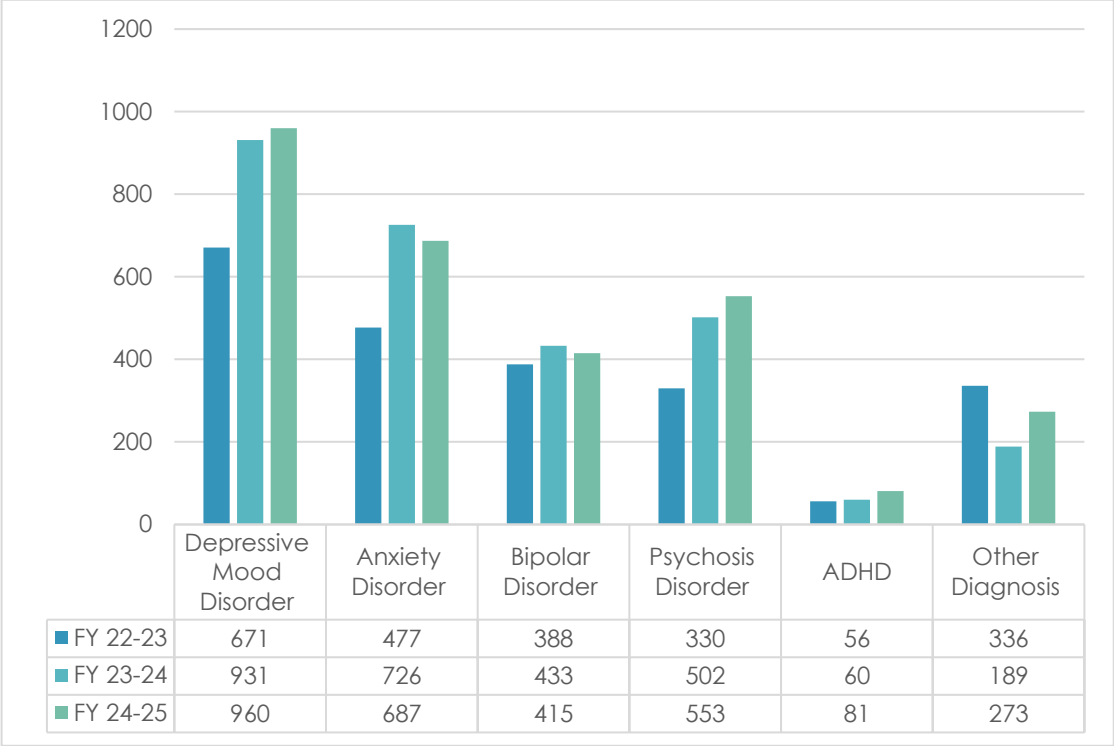
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart 1.17 Adults Served by Language



	English	Spanish	Other
FY 22-23	1,475	618	4
FY 23-24	1,848	979	14
FY 24-25	1,956	1010	3

Chart 1.18 Adults Served by Diagnosis



	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 22-23	671	477	388	330	56	336
FY 23-24	931	726	433	502	60	189
FY 24-25	960	687	415	553	81	273

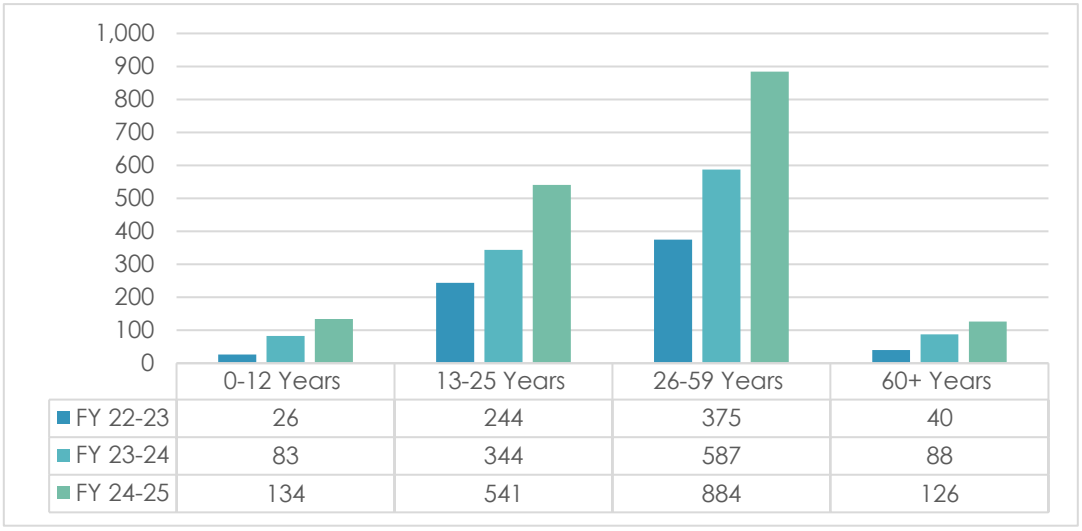
**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

Mental Health Triage Engagement

Region	Sites	Address	Provider No.
Central Region	Community Engagement Supportive Services (CESS)	1699 W. Main Street, Ste. A, El Centro, CA 92243	1394
	Transitional Engagement Supportive Services (TESS)		
	Crisis Care Mobile Unit (CCMU)	801 Broadway, El Centro, CA 92243	1373
	Mental Health Triage Unit (MHTU)	202 N. 8th Street, El Centro, CA 92243	1351

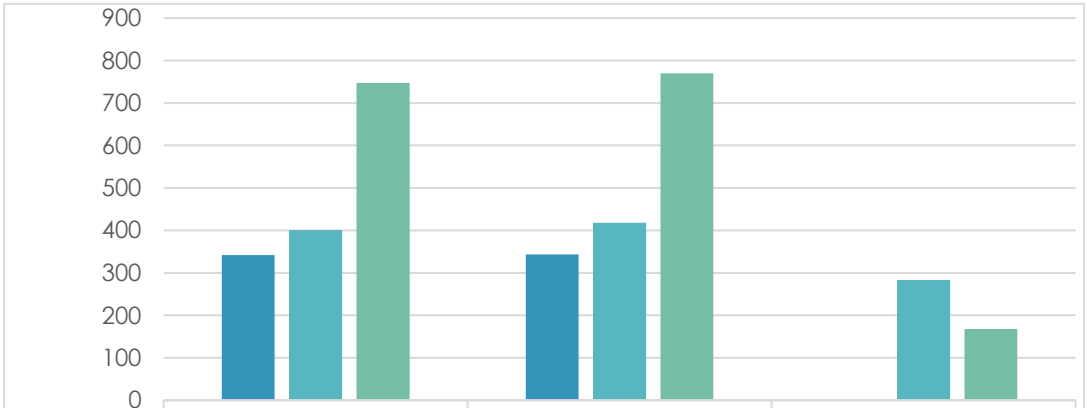
Charts 1.19-1.24 indicate the demographic information for beneficiaries served by MHTES.

Chart 1.19 Emergency Services by Age Group



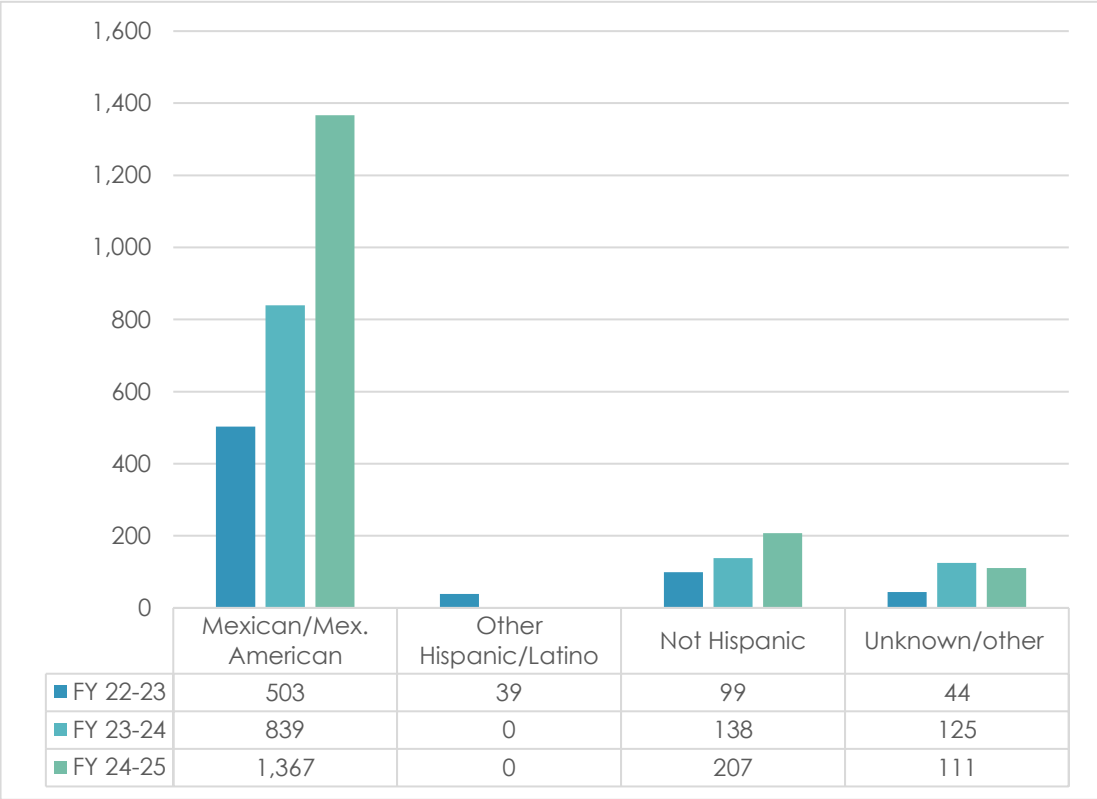
	0-12 Years	13-25 Years	26-59 Years	60+ Years
FY 22-23	26	244	375	40
FY 23-24	83	344	587	88
FY 24-25	134	541	884	126

Chart 1.20 Emergency Services by Gender



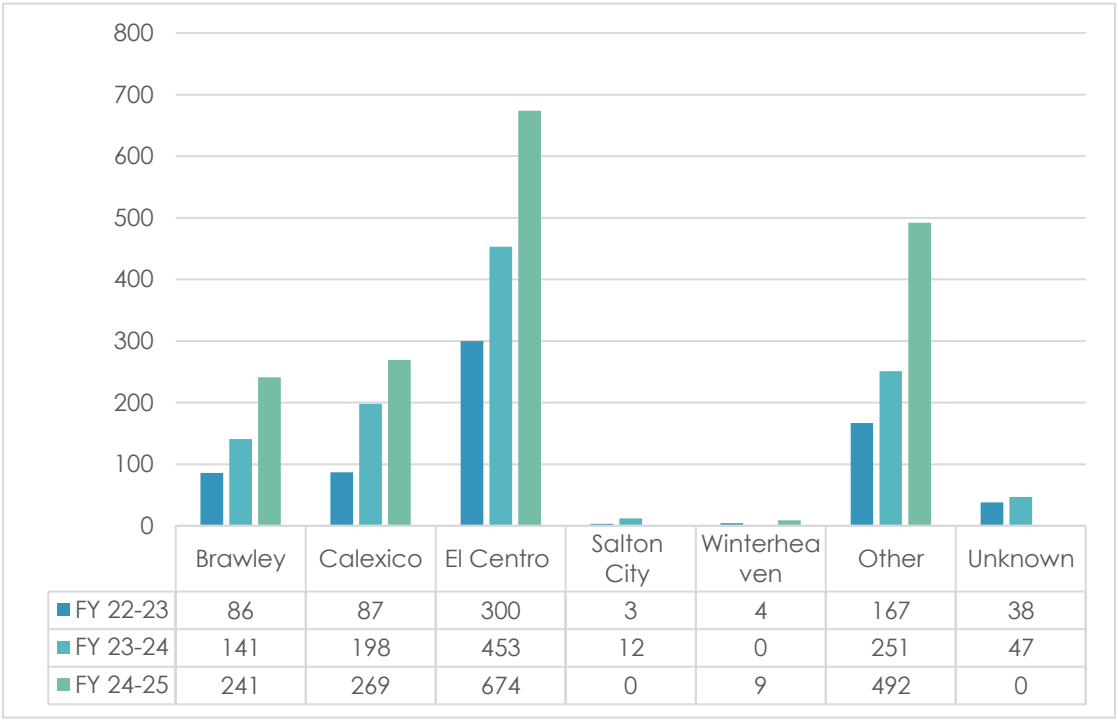
	Female	Male	Other
FY 22-23	342	343	0
FY 23-24	401	418	283
FY 24-25	747	770	168

Chart 1.21 Emergency Services by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 22-23	503	39	99	44
FY 23-24	839	0	138	125
FY 24-25	1,367	0	207	111

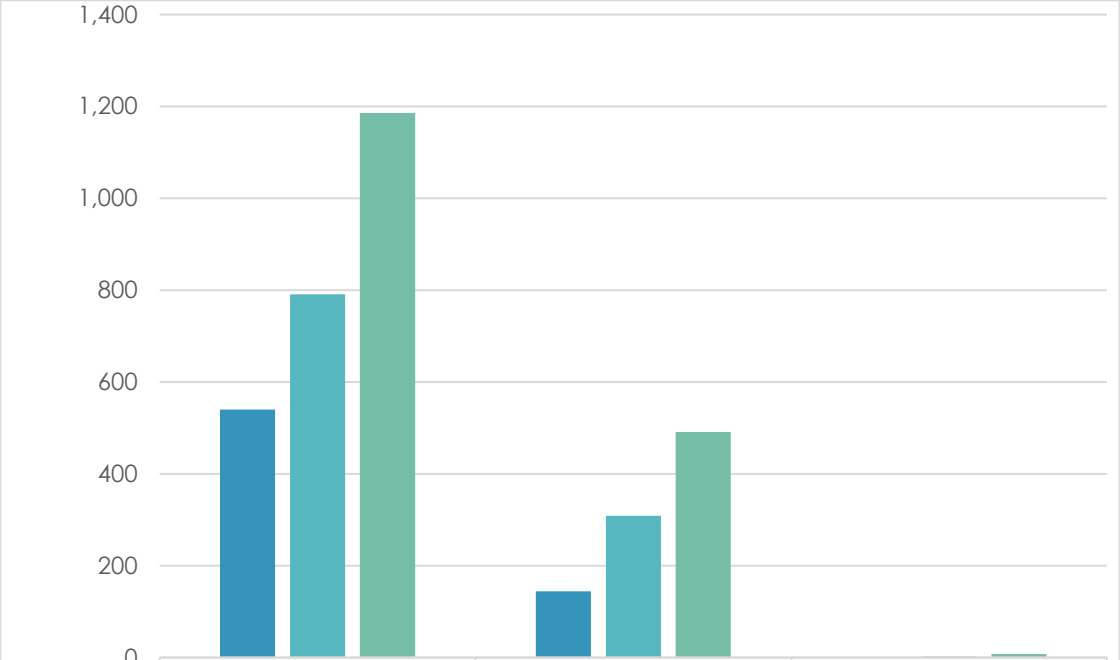
Chart 1.22 Emergency Services by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhea ven	Other	Unknown
FY 22-23	86	87	300	3	4	167	38
FY 23-24	141	198	453	12	0	251	47
FY 24-25	241	269	674	0	9	492	0

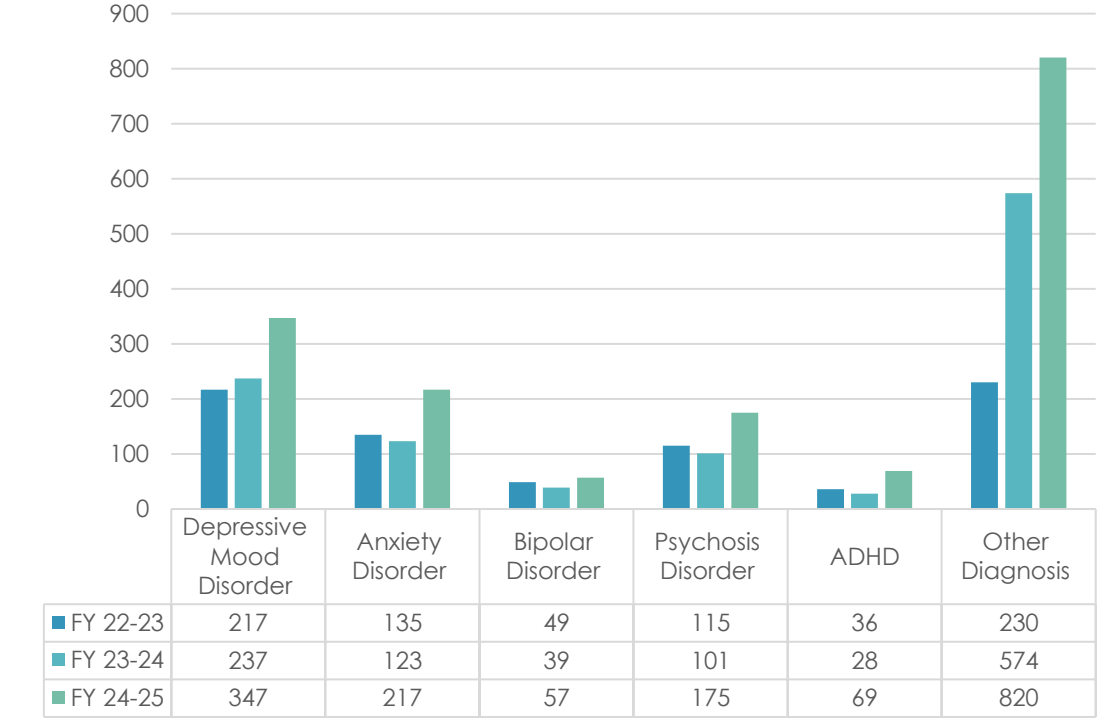
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart 1.23 Emergency Services by Language



	English	Spanish	Other
FY 22-23	540	144	1
FY 23-24	791	309	2
FY 24-25	1,186	491	8

Chart 1.24 Emergency Services by Diagnosis



	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 22-23	217	135	49	115	36	230
FY 23-24	237	123	39	101	28	574
FY 24-25	347	217	57	175	69	820

**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

b) *Services Provided*

SMHS are provided based on an assessment of whether the client meets access and medical necessity criteria.

ICBHS provides an array of SMHS, which are targeted at addressing the needs of the identified population. Clinical services are organized primarily around the structure of SMHS as outlined in Title 9 of the California Code of Regulations. Additional services are provided based on other sources of funding and interagency collaboration.

The number of unduplicated Medi-Cal clients served by division and the total are included in the table below:

Table 1.1 Medi-Cal Clients Served by Division			
Division	**FY 22-23***	**FY 23-24**	**FY 24-25**
Adults Services	2,097	2,841	2,969
YAYA Services	1,403	1,376	1,464
Children Services	1,874	2,082	2,270
MHTES	685	1,102	1,685
ICBHS Total	**6,059**	**7,401**	**7,239**
***July 1, 2022, through December 31, 2022**			

c) *Utilization of Services for FY 24-25*

The utilization of services for FY 24-25 has been obtained from the monthly Units of Service Summary reports completed by the ICBHS Fiscal Unit. The following is a breakdown of the services that are billed under each type of service.

- Assessment: Assessments completed by a LPHA or MD; Assessment contribution by a non-LPHA; Review of hospital records; Psychological testing; Individual therapy, Family therapy with the client present; Report generation for care coordination; TBS; Psychosocial rehab-individual; Nursing evaluation; and add-on services such as interactive complexity, sign language or oral interpretative services, and prolonged office or other outpatient EM service(s) beyond the maximum time.

- Care Coordination: Targeted Case Management (TCM) and Intensive Care Coordination (ICC).

- Crisis Intervention: Crisis intervention/mobile crisis and psychotherapy for crisis.

- Medication Support Services: Medication training and support; Medication support to an existing client; Oral medication administration; Medication support telephone; Medical team conference with participation by Physician and patient and/or family not present; and Interpretation or explanation of results of psychiatric or other medical results.

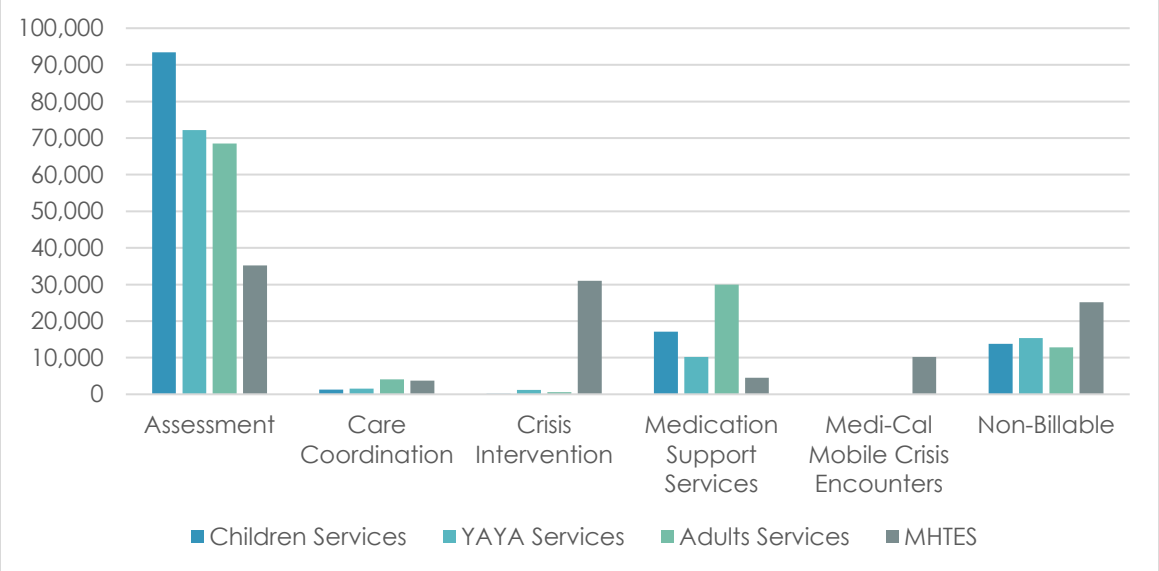
- Medi-Cal Mobile Crisis Encounters: Mobile crisis encounters; Transportation mileage; and Transportation, staff time.

- Non-Billable: Any other non-billable service that must be documented and is not accounted for by other available non-billable procedure codes. Services may include those provided in the Wellness Center, homeless services, school-based socialization programs that are grant funded, and/or Conservatorship Services.

ICBHS SMHS units of service provided by the four service divisions during FY 24-25 are shown below:

Table 1.2 Units of Service					
Type of Service	Children Services	YAYA Services	Adults Services	MHTES	ICBHS - SMHS
Assessment	93,413	72,182	68,548	35,233	**269,376**
Care Coordination	1,255	1,528	4,054	3,694	**10,531**
Crisis Intervention	147	1,206	621	30,993	**32,967**
Medication Support Services	17,078	10,206	29,947	4,502	**61,733**
Medi-Cal Mobile Crisis Encounters	0	0	0	10,220	**10,220**
Non-Billable	**13,795**	**15,402**	**12,851**	**25,163**	**67,211**

Chart 1.25 Units of Service by Division



2) *SMHS Contracted Providers*

a) *Geographic Location of Programs & Population Served*

As part of ICBHS efforts to ensure SMHS are available to Imperial County residents, ICBHS contracts with a variety of local and out-of-county providers:

i. *In-County*

During FY 24-25, ICBHS had three SMHS contracted outpatient providers, one contracted adult crisis residential treatment services provider, and one contracted Short-Term Residential Therapeutic Program (STRTP) provider. The contracted outpatient providers are responsible for providing mental health services, targeted case management, medication support services, intensive care coordination, intensive home-based services, and therapeutic behavioral services.

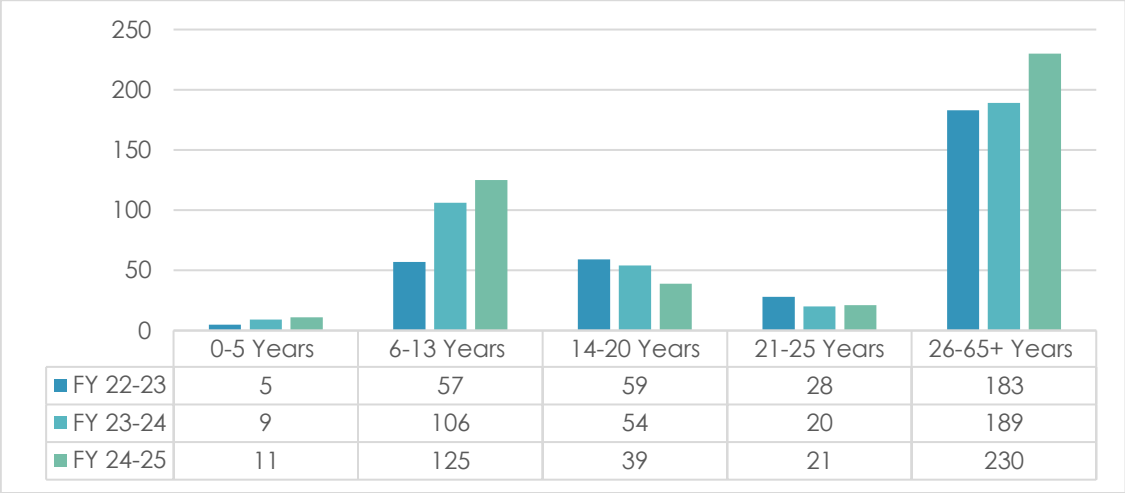
Outpatient services are available to beneficiaries of all ages, while the adult crisis residential treatment services provider only serves adults age 18 and older, and the STRTP provider only serves youth placed in the facility. Contracted SMHS services are available to beneficiaries throughout Imperial County.

ii. *Out-of-County*

During FY 24-25, ICBHS had one contracted provider located outside of the county. This provider provides adult residential treatment services to adult beneficiaries who are referred by ICBHS.

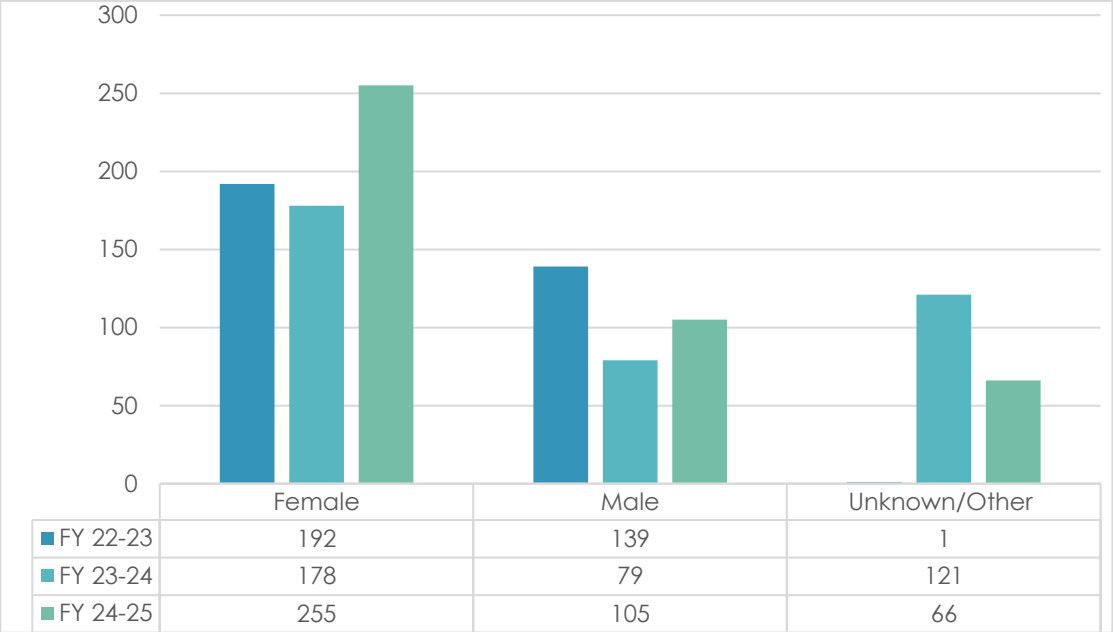
The graphs below indicate demographic information for beneficiaries served by the ICBHS SMHS contracted providers.

Chart 1.26 Beneficiaries Served by Contact Providers - Age Group



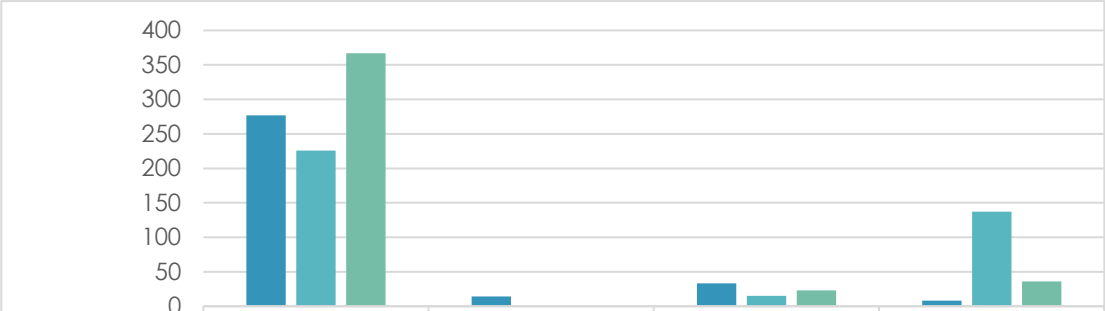
	0-5 Years	6-13 Years	14-20 Years	21-25 Years	26-65+ Years
FY 22-23	5	57	59	28	183
FY 23-24	9	106	54	20	189
FY 24-25	11	125	39	21	230

Chart 1.27 Beneficiaries Served by Contact Providers - Gender



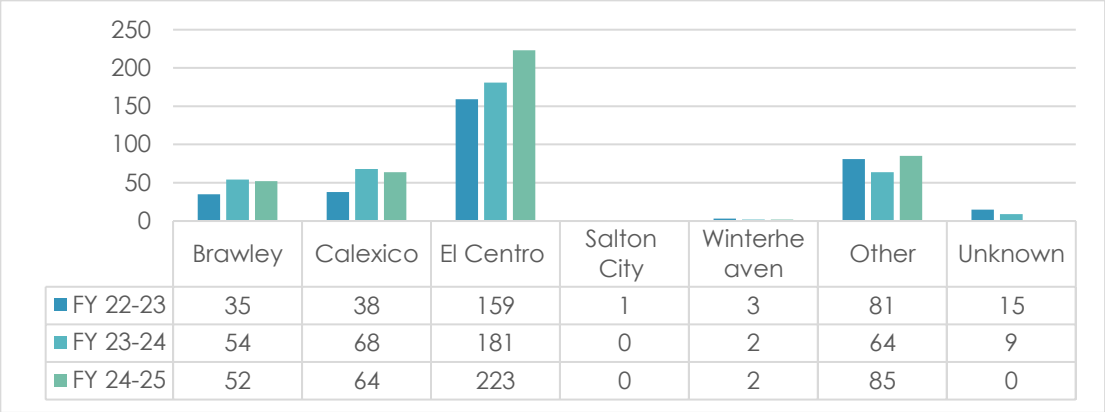
	Female	Male	Unknown/Other
FY 22-23	192	139	1
FY 23-24	178	79	121
FY 24-25	255	105	66

Chart 1.28 Beneficiaries Served by Contact Providers – Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 22-23	277	14	33	8
FY 23-24	226		15	137
FY 24-25	367		23	36

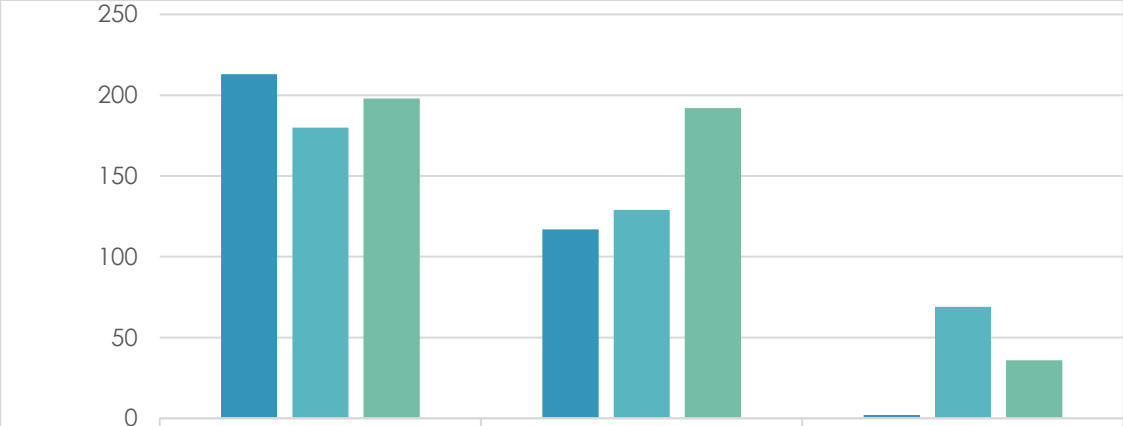
Chart 1.29 Beneficiaries Served by Contact Providers - City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknown
FY 22-23	35	38	159	1	3	81	15
FY 23-24	54	68	181	0	2	64	9
FY 24-25	52	64	223	0	2	85	0

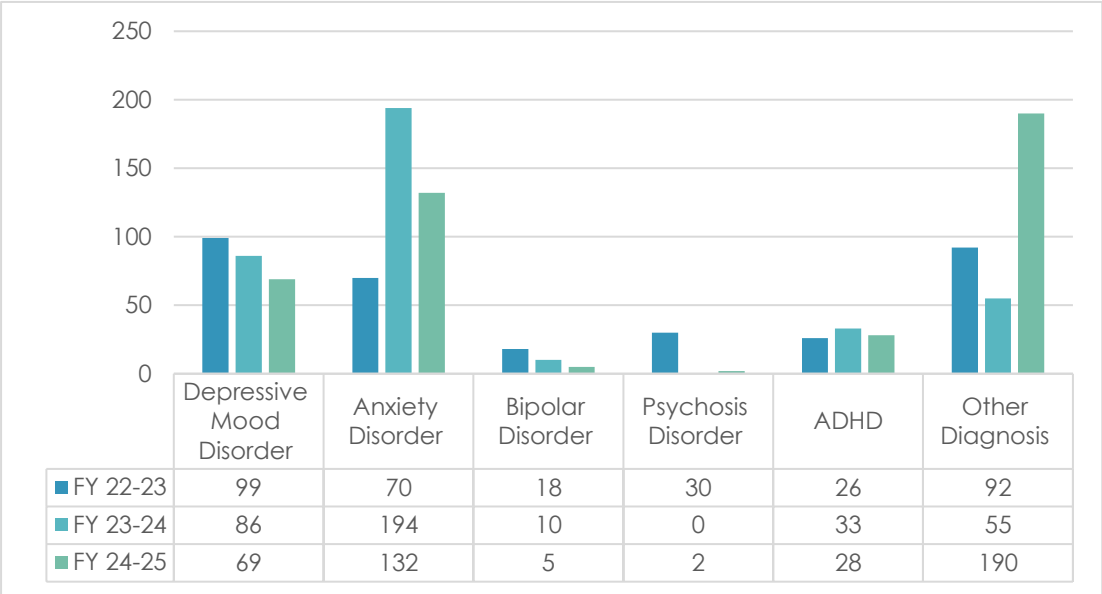
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart 1.30 Beneficiaries Served by Contact Providers – Language



	English	Spanish	Other
FY 22-23	213	117	2
FY 23-24	180	129	69
FY 24-25	198	192	36

Chart 1.31 Beneficiaries Served by Contact Providers – Diagnosis



**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

b) Services Provided

The table below indicates the number of beneficiaries served by contracted providers during FY 24-25, in addition to a comparison for the past three years.

Table 1.3 Beneficiaries Served by Contract Providers

Fiscal Year	Number of Beneficiaries
FY 24-25	426
FY 23-24	378
FY 22-23	332

3) SUDS Direct Service Providers

a) Geographic Location of Programs & Population Served

During FY 24-25, ICBHS provided SUDS at 4 county-operated Medi-Cal certified sites. Each site provides services according to the client's age group and residence.

Adolescents Division

Region	Sites	Address	Provider No.
Central Region	El Centro Adolescent SUDS Treatment Program	315 S. Waterman Ave. El Centro, CA 92243	1303
Southern Region	Adolescent Calexico SUDS Treatment Program	101 Hacienda Dr. Suite B. Calexico, CA 92231	13SN

Charts 1.32 - 1.37 indicate the demographic information for beneficiaries served by adolescent SUDS.

Chart 1.32 Adolescents Served by Age Group

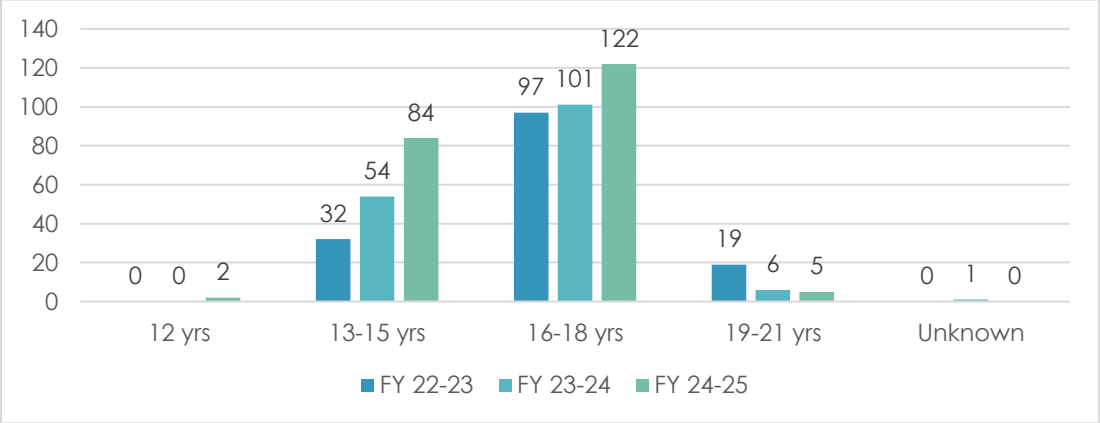


Chart 1.33 Adolescents Served by Gender

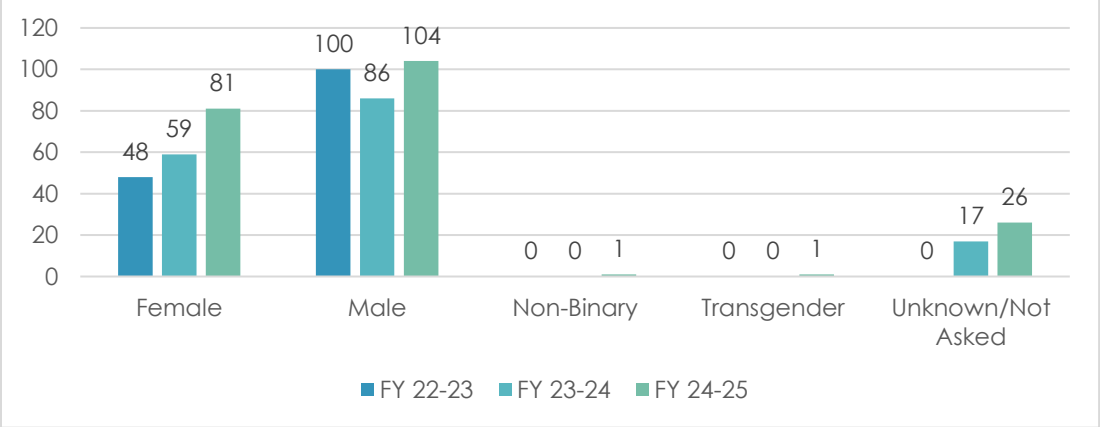


Chart 1.34 Adolescents Served by Ethnicity

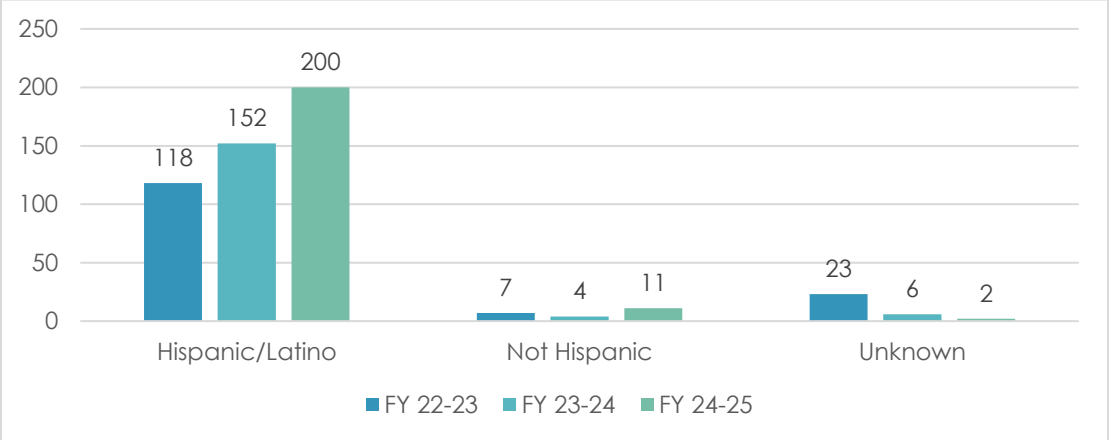


Chart 1.35 Adolescents Served by City of Residence

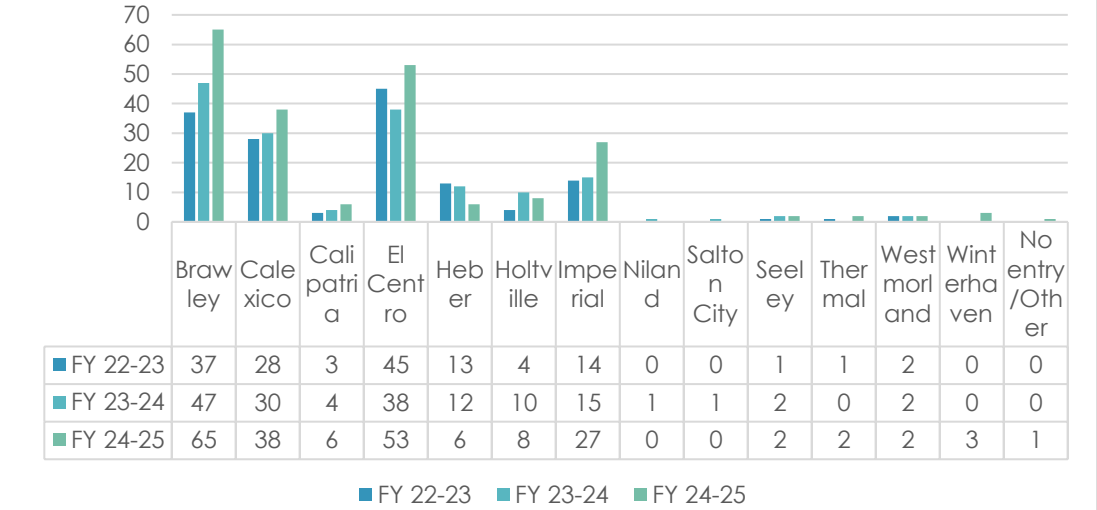


Chart 1.36 Adolescents Served by Language

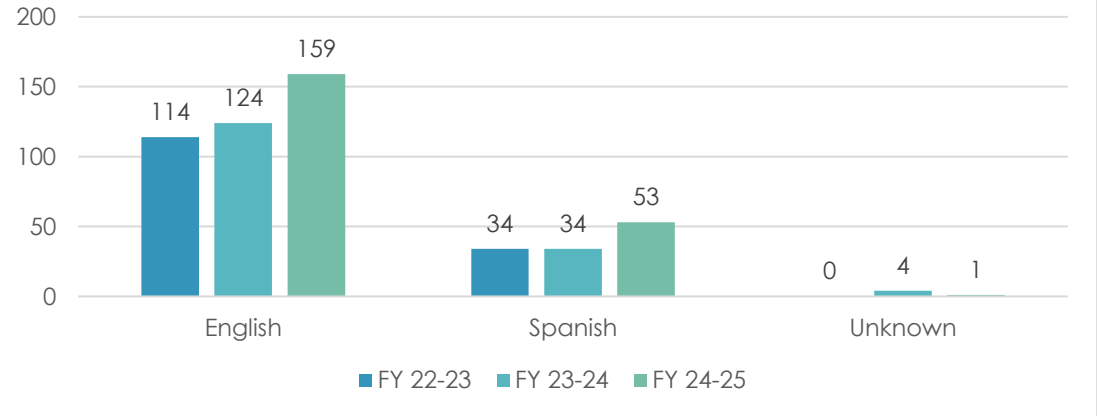
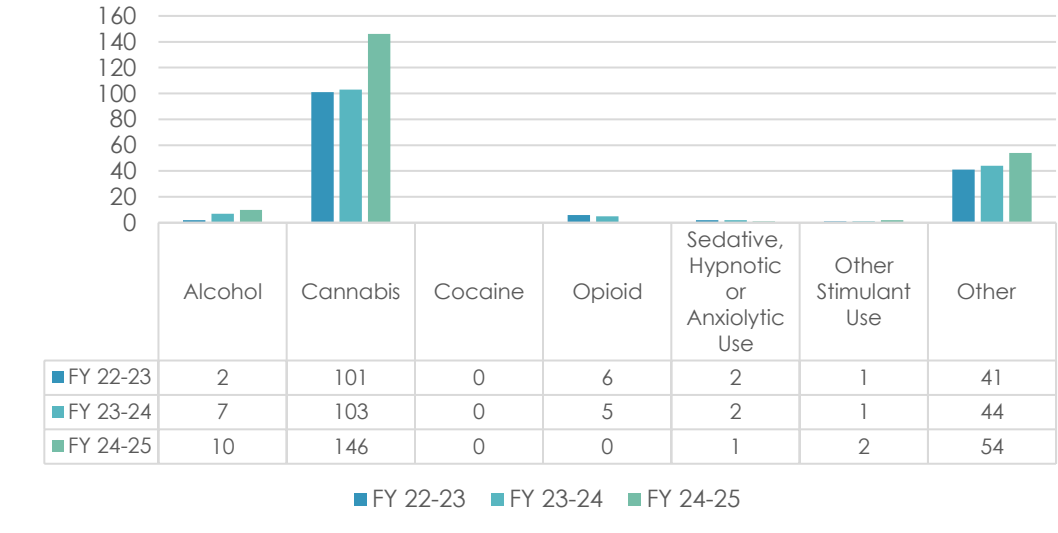


Chart 1.37 Adolescents Served by Diagnosis



**Data may not total the number of beneficiaries served as some have more than one diagnosis.*
**Other- Includes ICD10 Z Codes covering history of other conditions, tobacco, and other social determinants of health.*

Adults Division

Charts 1.38-1.43 indicate the demographic information for beneficiaries served by Adult SUDS.

Region	Sites	Address	Provider No.
Central Region	El Centro Adult SUDS Treatment Program	2695 S. 4th Street El Centro, CA 92243	1309
Southern Region	Calexico Adult SUDS Treatment Program	25 East 3rd Street Calexico, CA 92231	13PH

Chart 1.38 Adults Served by Age Group

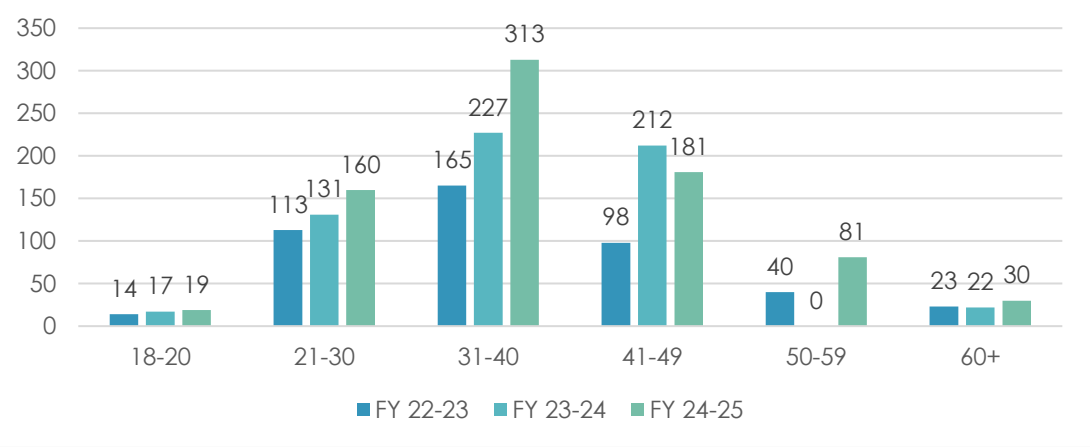


Chart 1.39 Adults Served by Gender

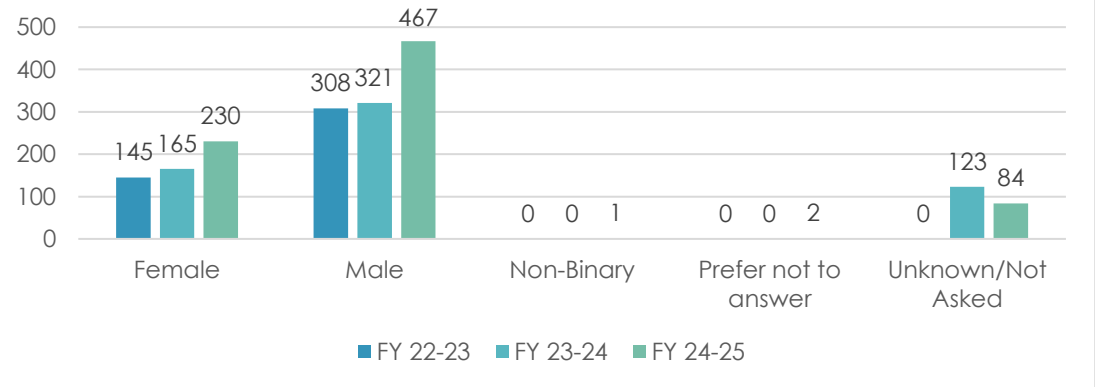


Chart 1.40 Adults Served by Ethnicity

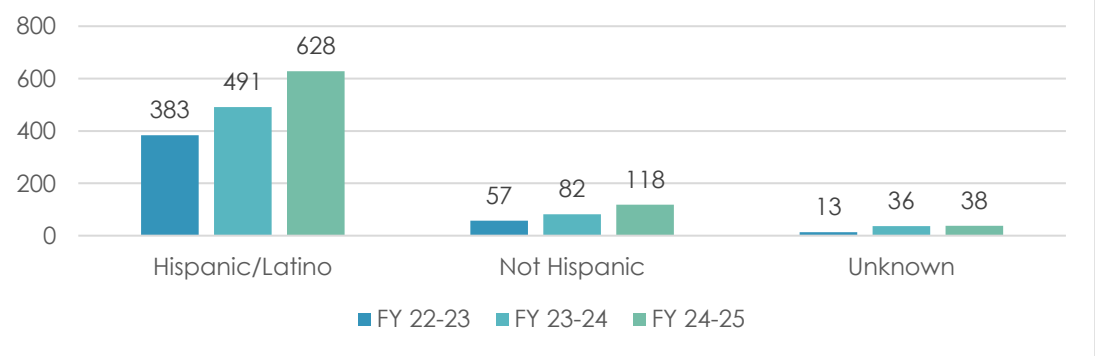


Chart 1.41 Adults Served by City of Residence

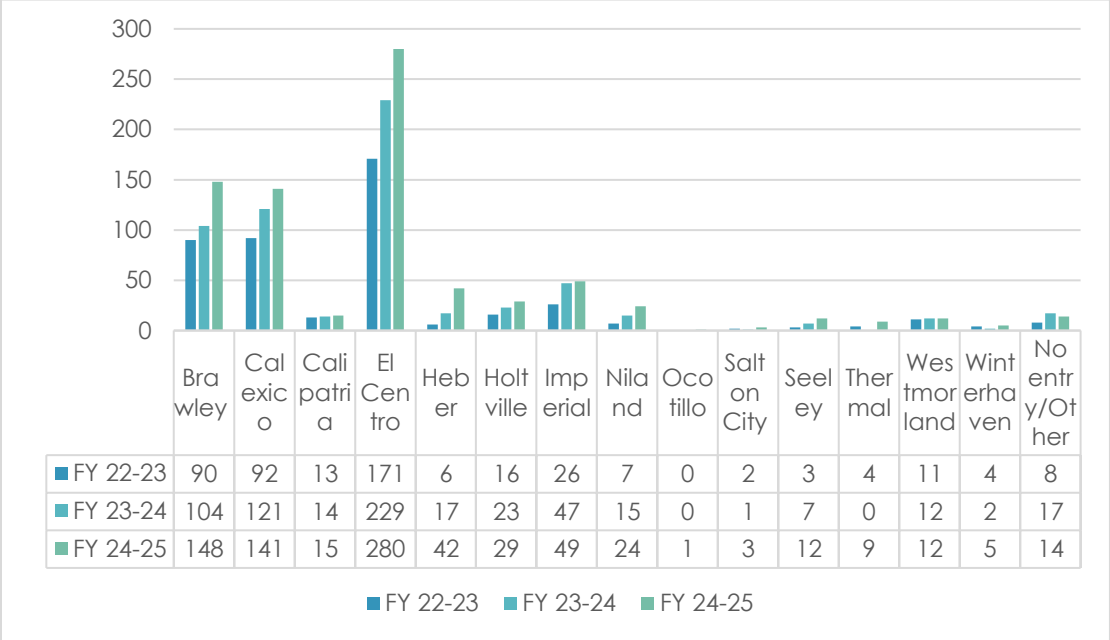


Chart 1.42 Adults Served by Language

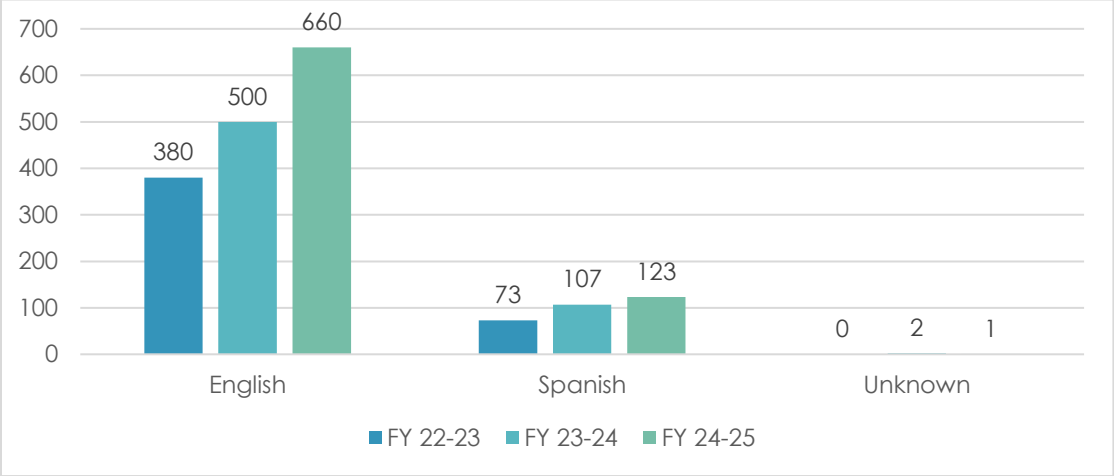
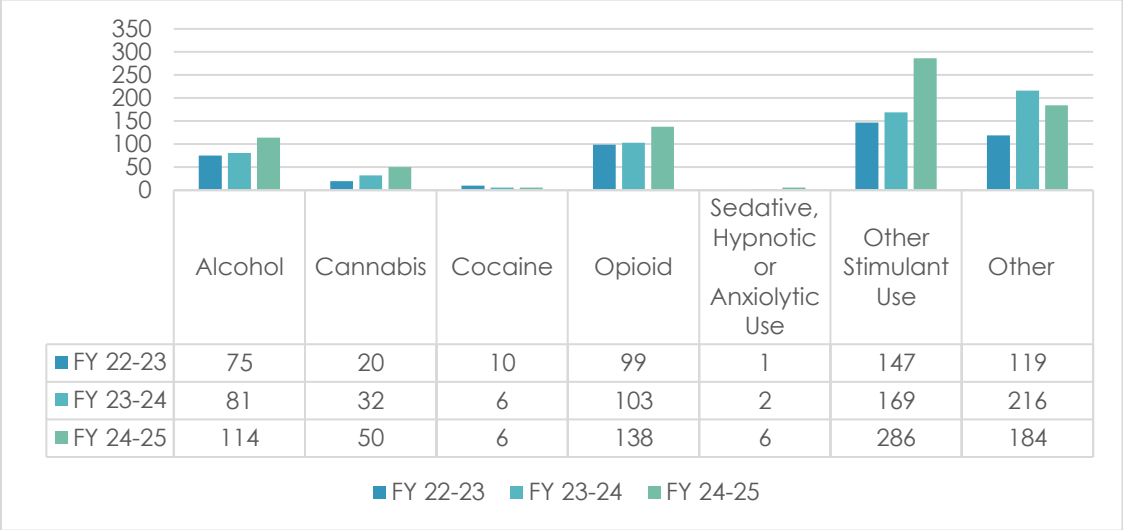


Chart 1.43 Adults Served by Diagnosis



**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

**Other- Includes ICD10 Z Codes covering history of other conditions, tobacco, and other social determinants of health.*

b) Services Provided

ICBHS provides a full continuum of SUDS, including Outpatient Treatment, Intensive Outpatient Treatment, Medications for Addiction Treatment (MAT), Withdrawal Management, Care Coordination, and Recovery Services.

Outpatient Treatment (ASAM Level 1) offers up to nine hours per week for adults and under six hours for adolescents. IOT (ASAM Level 2.1) provides 9–19 hours weekly for adults and 6–19 hours for adolescents, with possible extensions based on medical necessity.

The components of ASAM Level 1 and 2.1 include assessment, care coordination, individual/group counseling, family therapy, medication services, MAT for opioid, alcohol, and other SUDs, recovery education, SUD crisis intervention, and recovery support. Services may be provided in person, via telehealth, or by phone.

MAT is available at the Adult El Centro SUD Clinic and includes a wide range of medications for opioid and alcohol use disorders, overdose prevention, and withdrawal management based on clinical need and client consent. Medications include:

- Opiate overdose prevention- Naloxone (Narcan);
- Opiate use treatment - Buprenorphine- Naloxone (Suboxone) and Naltrexone (oral and extended release);
- Opiate withdrawal management/symptomatic relief-Clonidine for anxiety, Ibuprofen for aches, Dicyclomine for stomach cramping, Loperamide for diarrhea, and Trazodone for insomnia;
- Reduction of alcohol craving - Naltrexone, extended release injectable (Vivitrol), and Acamprosate (Campral);
- Alcohol withdrawal management - Librium (chlordiaxepoxide), Gabapentin, Clonidine (Catapres), Diazepam, Lorazepam, and Trazadone for sleep disturbances; and
- Opioid Use Management - Sublocade (buprenorphine) injection, Brixadi

Ambulatory withdrawal management with extended on-site monitoring is available at the Adult El Centro SUD Clinic, based on clinical need and consent.

Care Coordination supports the integration of SUD, mental health, and medical care to promote whole-person wellness. It is provided alongside all levels of treatment or as a standalone service. Services can be provided in a clinical or non-clinical setting and can be provided in person, by telehealth, or by telephone. Care Coordination includes coordination with medical and mental health providers, discharge planning and transitions between levels of care, and referrals and linkages to community resources (e.g., housing, employment, education, transportation).

Recovery Services support ongoing recovery and relapse prevention, helping clients maintain their highest level of functioning. Services may be provided alone or alongside other DMC-ODS services, including MAT and NTP, and are available post-incarceration for individuals with a prior SUD diagnosis. Eligibility is based on provider or self-assessed relapse risk; a remission diagnosis is not required. Services can be delivered in clinical or community settings, in person, by phone, or via telehealth.

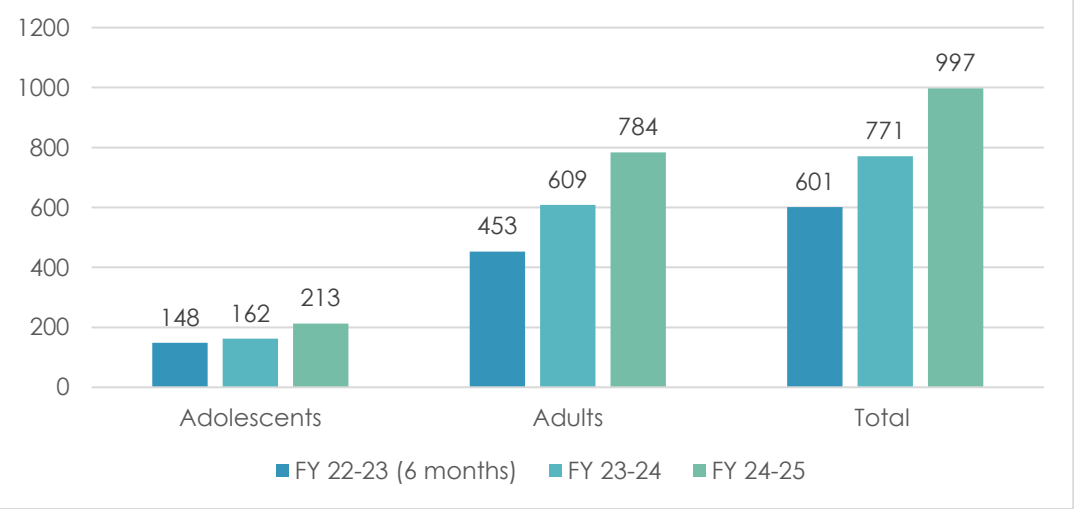
The number of unduplicated beneficiaries is included in the table and chart below:

Table 1.4 Unduplicated Medi-Cal Clients Served

SUD Programs	FY 22-23*	FY 23-24	FY 24-25
Adolescent SUD Services	148	162	213
Adult SUD Services	453	609	784
Total	**601**	**771**	**997**

**July 1, 2022, through December 31, 2022*

Chart 1.44 Beneficiaries Served by SUD Programs



c) Utilization of Services for FY 24-25

The utilization of services for FY 24-25 has been obtained from the monthly Units of Service Summary reports completed by the ICBHS Fiscal Unit. The following is a breakdown of the services that are billed under each type of service.

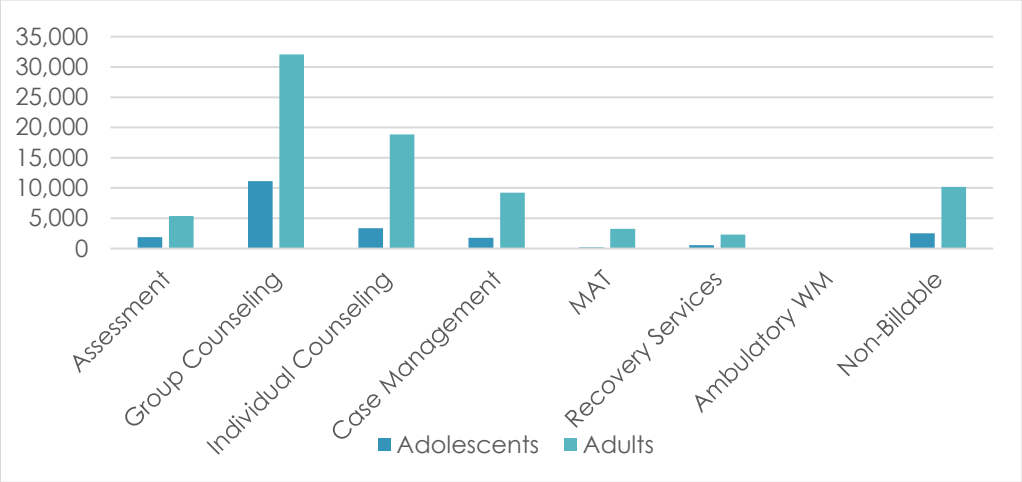
- Assessment: Assessments completed by a LPHA or MD; ASAM assessment or other structured SUD assessment; and SUD screening.
- Group Counseling: Group counseling services.
- Individual Counseling: Individual counseling services; Contingency Management; and any SUD crisis interventions.
- Case Management: Targeted Case Management/Intensive Care Coordination; Medical team conference with participation by the physician, patient and/or family not present.
- Medication Assisted Treatment: Medication training and support and/or oral medication administration.
- Recovery Services: Psychosocial rehabilitation individual; Psychosocial rehabilitation group; and comprehensive community support services.
- Ambulatory Withdrawal Management: Ambulatory withdrawal management services delivered in an office setting with the frequency to be determined by the severity of withdrawal symptoms.
- Non-Billable: Any other non-billable service that must be documented and is not better accounted for by other available non-billable procedure codes.

SUDS units of service provided by the Adolescent SUD Program and the Adult SUD Program during FY 24-25 are shown below:

Table 1.5 SUDS Units of Service

Type of Service	Adolescents	Adults
Assessment	1,871	5,389
Group Counseling	11,151	32,040
Individual Counseling	3,372	18,860
Case Management	1,765	9,250
Medication Assisted Treatment	175	3,271
Recovery Services	544	2,332
Ambulatory Withdrawal Management	0	0
Non-Billable	**2,536**	**10,207**

Chart 1.45 Units of Service by SUD Programs



4) *SUDS Contracted Providers*

a) *Geographic Location of Programs & Population Served*

To ensure the appropriate levels of care are available to Imperial County residents, ICBHS contracts with local and out-of-county providers to SUDS services:

i. *In-County*
During FY 24-25, ICBHS had one contracted provider for NTP services. NTP services were provided in NTP-licensed clinics located in Calexico and in El Centro. This provider has services available for all individuals that reside in all geographic areas of the county; however, it has primarily served the 18+ age group due to beneficiaries between the ages of 0-17 not seeking these services.

ii. *Out-of-County*
During FY 24-25, ICBHS had three DMC certified contracted providers for residential treatment services. The residential programs provided adolescent and adult residential treatment services, which are limited to 14-day detox services. ABC Recovery provided levels of care 3.2 and 3.5; Tarzana Treatment Centers 3.1, 3.2, 3.3, 3.5, 3.7, 4.0 & OTP Level 1; and Clare Matrix 3.1, 3.2, and 3.5. The providers are designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.

b) Services Provided

Narcotic treatment and residential treatment services are available, based on medical necessity and the individualized treatment plan, to all beneficiaries residing in Imperial County who meet the established medical necessity criteria and pertinent ASAM level of care designation.

The NTP contracted provider offers narcotic treatment in various forms of services that are based on the individuals' needs and assessment. The components of NTP services include Intake; Individual and Group Counseling; Patient Education; Medication Services; Collateral Services; Crisis Intervention Services; Treatment Planning; Medical Psychotherapy; Recovery Services; and Discharge Services. NTP is also required to provide other non-controlled medications approved by the FDA, such as buprenorphine, disulfiram, and naloxone for providing medication assisted treatment to patients with substance use disorder.

During Fiscal Year 2024-2025, a total of 279 clients received counseling services as a part of NTP services. It is important to note that this total reflects unique individuals and not the number of counseling sessions provided. As such, the count may differ from the number of counseling services provided throughout the year.

From FY 2023-2024 to FY 2024-2025, there was a notable increase in the number of total clients and clients receiving individual counseling, while a slight decrease was observed in the number of clients receiving group counseling.

The residential treatment providers offer residential treatment in a non-institutional, 24-hour, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis. Residential treatment services are provided to both non-perinatal and perinatal beneficiaries. This includes both adults and adolescents. The components of Residential treatment services include: Intake; Individual and Group counseling; Patient Education; Family Therapy; Safeguarding Medications; Collateral Services; Crisis Intervention Services; Treatment Planning; Transportation Services; Case Management; and Discharge Services.

During Fiscal Year 2024-2025, a total of 105 clients received residential treatment admissions. It is important to note that this total reflects unique individuals and not the number of residential admissions completed. As such, the count may differ from the number of residential services throughout the year.

From FY 2023-2024 to FY 2024-2025, there was a notable increase in the number of total clients and clients who received each ASAM level of care. There were no reported admissions to ASAM level 4.0 or OTP level 1 during this reporting period.

The services provided by contracted providers to Imperial County residents on FY 24-25 are displayed below:

Table 1.6 NTP Utilization of Services			
Type of Service	FY 22-23	FY 23-24	FY 24-25
Individual Counseling	217	229	**279**
Group Counseling	203	211	**210**
Total		240	**279**

Table 1.7 Residential Admissions by Level of Care			
Type of Service	FY 22-23 Admissions	FY 23-24 Admissions	FY 24-25 Admissions
ASAM Level 3.1	27	30	**40**
ASAM Level 3.2	12	6	**13**
ASAM Level 3.3	0	0	**2**
ASAM Level 3.5	62	55	**64**
ASAM Level 3.7	0	0	**1**
ASAM Level 4.0	0	0	**0**
OTP – Level 1	0	0	**0**
Total	**88**	**79**	**105**

5) Federal Network Adequacy Standards

Network adequacy standards were developed pursuant to Title 42 of the Code of Federal Regulations. Network adequacy standards include time, distance, and timely access requirements with which ICBHS must comply, taking into consideration the urgency of the need for services and the assurance of adequate capacity of services on the number and type of providers, age groups served by each provider, as well as the language capabilities of each. Imperial County must meet the distances standard of up to 60 miles or 90 minutes from the client's place of residence.

Reporting requirements include accessibility analyses confirming compliance with the time and distance standards for both children/youth and adults. Provider data that includes provider counts by type, licensure, National Provider Identification numbers, site locations, ages served, cultural competence, and language capabilities are also included in the reporting, as is the expected utilization of services, language line utilization, and grievances and appeals regarding access to services.

During FY 2024–25, ICBHS submitted monthly 274 files to DHCS for both SMHS and SUDS. These files included data on provider capacity, mandatory provider types, provider service validation, contract validation, and time/distance standards. Each submission identified which network providers delivered specific covered services and was submitted by the 10th of each month. For the FY 2025–26 Annual Network Adequacy Certification, DHCS used the July 2025 274 file to validate ICBHS's compliance with network capacity and composition requirements, including mandatory provider types and time/distance standards.

b. Overview of the objectives and planned activities for FY 25-26:

- The QM Unit will monitor the number, type, and geographic distribution of SMHS and SUDS in order to verify that timely and appropriate services are available to all Medi-Cal beneficiaries within Imperial County.

- ICBHS will ensure service delivery capacity to meet the needs of beneficiaries.

- ICBHS will monitor its network adequacy and submit data through the monthly submissions of the 274 standard files.

QUALITY IMPROVEMENT MONITORING

IMPERIAL COUNTY
Behavioral Health Services
MENTAL HEALTH & SUBSTANCE USE RECOVERY

Quality Improvement Monitoring

I. Timeliness of Services

The QM Unit monitors ICBHS ability to meet the following timeliness standards as established by DHCS:

Table 2.1 Timely Access Standards for SMHS

Service Type	Timely Access
Outpatient Non-Urgent Non-Psychiatric Specialty Mental Health Services	Offered an appointment within 15 business days of request for services.
Non-urgent follow-up appointments	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.
All Urgent SMHS Appointments	Urgent Appointments 48 hours without prior authorization. 96 hours with prior authorization
Psychiatric Services	Offered an appointment within 15 business days of request for services.

Table 2.2 Timely Access Standards for SUDS

Service Type	Timely Access
Outpatient Services – Outpatient Substance Use Disorder Services	Offered an appointment within 10 business days of request for services.
Non-urgent follow-up appointments with a Non-Physician	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.
All Urgent SUD Appointments	Urgent Appointments 48 hours without prior authorization. 96 hours with prior authorization
Opioid Treatment Program	Within three business days of request

The QM Unit collects data through the EHR, Timeliness of Services report, monthly to verify that beneficiaries can access services timely without delay. Individual instances of access delays may result in the QM Unit conducting a more in-depth review to identify any potential quality of care issues. A corrective action plan is issued when the SMHS or SUDS overall compliance rate with timeliness standards falls below 80 percent. Timeliness findings are reported to clinical management and/or the QIC, on a quarterly basis.

a. Update on the objectives and activities for FY 24-25:

1) SMHS Outpatient Non-Urgent Non-Psychiatric Specialty Mental Health Services

The DHCS standard for timelines to first non-urgent services is 10 business days. The current intake process for SMHS allows clients to be scheduled an appointment with a mental health professional if at the time of the request the client requests a non-urgent service. The first offered

non-urgent service is an intake assessment scheduled with a licensed/registered clinician. Requests for non-urgent services are recorded by the Access Unit.

The QM Unit evaluates timeliness to first non-urgent services by reviewing the date of the request and determining the length of time to the first offered appointment. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes timeliness to first non-urgent services data for FY 24-25

Table 2.3 Timeliness to First Non-Urgent Services				
Review Period	Medi-Cal Requests	Appointments Offered Within 10 Business Days	Appointments Offered Over 10 Business Days	Compliance Rate
FY 24-25	4,985	4,887	98	98%
FY 23-24	2,728	2,592	136	95%
FY 22-23	2,902	2,761	141	95%

2) *SMHS Non-Urgent Follow-Up Appointments*

The DHCS standard for timeliness to non-urgent follow-up appointments with a non-physician provider is 10 business days from the date of the first non-urgent service rendered. The non-urgent follow-up service is a clinically appropriate outpatient service scheduled with a licensed/registered clinician.

The QM Unit evaluates timeliness to non-urgent follow-up appointments by reviewing the date of the first non-urgent service rendered and determining the length of time to the offered follow-up appointment. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes timeliness to non-urgent follow-up appointment data for FY 24-25:

Table 2.4 Timeliness to Non-Urgent First Followed Up Offered Non-Urgent Services				
Review Period	Non-Urgent Follow-Up Offered Appointments	Appointments Offered Within 10 Business Days	Appointments Offered Over 10 Business Days	Compliance Rate
FY 24-25	3,083	2,674	409	87%

3) *SMHS All Urgent Appointments*

The DHCS standard for timeliness to urgent services not requiring prior authorization is 48 hours. For urgent services requiring prior authorization, the DHCS timeliness standard is 96 hours. Requests for urgent services not requiring prior authorization are recorded by the Access Unit, while requests for urgent services requiring prior authorization are recorded by the Payment Authorization Unit.

ICBHS provides urgent services upon request or when it is determined that a client's "condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for [a non-urgent appointment] … would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function …." (28 CCR § 1300.67.2.2, subd. (b)(7); Health & Safety Code § 1367.01, subd. (h)(2))

The QM Unit evaluates timeliness to urgent services not requiring prior authorization by reviewing the date of the request and determining the length of time to the first offered service. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes the FY 24-25 data related to timeliness to urgent services not requiring prior authorization:

Table 2.5 Timeliness to Urgent Services Not Requiring Authorization				
Review Period	Requests	Services Offered Within 48 Hours	Services Offered Over 48 Hours	Compliance Rate
FY 24-25	352	337	15	96%
FY 23-24	152	134	18	88%
FY 22-23	17	15	2	88%

The QM Unit evaluates timeliness to urgent services requiring prior authorization by reviewing the date of the request and determining the length of time to the first offered service following authorization. The monitoring process involves gathering data from the Payment Authorization Unit's treatment authorization log. The table below summarizes the FY 24-25 data related to timeliness to urgent services requiring prior authorization:

Table 2.6 Timeliness to Urgent Services Requiring Authorization				
Review Period	# of TARs Submitted	Requests for Urgent Services	Services Offered Within 96 Hours	Compliance Rate
FY 24-25	214	0	N/A	N/A
FY 23-24	218	0	N/A	N/A
FY 22-23	196	0	**N/A**	**N/A**

4) SMHS Psychiatric Services

The DHCS standard for timeliness to first non-urgent psychiatry service is 15 business days. The first offered non-urgent psychiatry service is an Initial Psychiatry Assessment (IPA) scheduled with a psychiatrist. Beneficiaries may request non-urgent psychiatry services by calling the ICBHS 24/7 Line and requesting an appointment with a psychiatrist. Requests for non-urgent psychiatry services are recorded by the Access Unit.

The QM Unit evaluates timeliness to first non-urgent psychiatry services by reviewing the date of the request and determining the length of time to the first offered psychiatry appointment. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes timeliness to first non-urgent psychiatry services data for FY 24-25:

Table 2.7 Timeliness to First Non-Urgent Psychiatric Services				
Review Period	Requests	Appointments Offered Within 15 Business Days	Appointments Offered Over 15 Business Days	Compliance Rate
FY 24-25	24	19	5	79%
FY 23-24	0	N/A	N/A	N/A
FY 22-23	8	7	1	88%

5) *SUDS Outpatient Services*

The DHCS standard for timelines to first non-urgent services is 10 business days. The current intake process for SUDS services allows for clients to be scheduled an appointment with a SUD professional if at the time of the request the client requests a non-urgent service. The first offered non-urgent service is a clinically appropriate outpatient service scheduled with a SUD counselor or a licensed/registered clinician, which can include prevention, screening, assessment, individual counseling, group counseling, targeted case management, or recovery service. Requests for non-urgent services are recorded by the Access Unit.

The QM Unit evaluates timeliness to first non-urgent services by reviewing the date of the request and determining the length of time to the first offered appointment. During FY 23-24, the absence of a dedicated tracking mechanism in the EHR prevented reliable reporting of first non-urgent timeliness data. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes timeliness to first non-urgent services data for FY 24-25:

Table 2.8 Timeliness to First Non-Urgent Services

Review Period	Requests	Appointments Offered Within 10 Business Days	Appointments Offered Over 10 Business Days	Compliance Rate
FY 24-25	1,489	1,478	11	99%
FY 23-24	N/A	N/A	N/A	N/A
FY 22-23	525	519	6	99%

6) *SUDS Non-Urgent Follow-Up Appointments with a Non-Physician*

The DHCS standard for timeliness to non-urgent follow-up appointments with a non-physician SUD provider is 10 business days from the date of the first non-urgent service rendered. The non-urgent follow-up service is a clinically appropriate outpatient service scheduled with a counselor or registered/licensed clinician, which can include individual counseling, group counseling, targeted case management, or recovery services. Requests for non-urgent follow-up appointments are recorded by the SUD programs.

The QM Unit evaluates timeliness to non-urgent follow-up appointments by reviewing the date of the first non-urgent service rendered and determining the length of time to the offered follow-up appointment. During FY 23-24, the absence of a dedicated tracking mechanism in the EHR prevented reliable reporting of non-urgent follow-up timeliness data. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes timeliness to non-urgent follow-up appointment data for FY 24-25:

Table 2.9 Timeliness to Non-Urgent Follow-Up Appointments with a Non-Physician

Review Period	Requests	Appointments Offered Within 10 Business Days	Appointments Offered Over 10 Business Days	Compliance Rate
FY 24-25	1,000	985	15	99%
FY 23-24	N/A	N/A	N/A	N/A

7) *SUDS All Urgent Appointments*

The DHCS standard for timeliness to urgent services not requiring prior authorization is 48 hours. For urgent services requiring prior authorization, the DHCS timeliness standard is 96 hours. All requests for urgent services not requiring prior authorization are recorded by the Access Unit.

ICBHS provides urgent SUDS services upon request or when it is determined that a client's "condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for [a non-urgent appointment] … would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function …." (28 CCR § 1300.67.2.2, subd. (b)(7); Health & Safety Code § 1367.01, subd. (h)(2))

The QM Unit evaluates timeliness to urgent services not requiring prior authorization by reviewing the date of the request and determining the length of time to the first offered service. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes the FY 24-25 data related to timeliness to urgent services not requiring prior authorization:

Table 2.10 Timeliness to Urgent Services Not Requiring Authorization

Review Period	Requests	Services Offered Within 48 Hours	Services Offered Over 48 Hours	Compliance Rate
FY 24-25	11	11	0	100%
FY 23-24	11	10	1	91%
FY 22-23	4	2	2	50%

The QM Unit also evaluates timeliness to urgent services requiring prior authorization by reviewing the information collected in the EHR Inquiry Log. To date no client requests have been made for urgent services requiring prior authorization.

8) *SUDS Opioid Treatment Program*

The DHCS standard for timeliness to first opioid treatment services is 3 business days. Beneficiaries request services directly from ICBHS' contracted NTP provider, although they may also request opioid treatment services by contacting the 24-hour access line or through a referral from another provider. The first non-urgent opioid treatment service is an initial assessment.

The QM Unit evaluates timeliness to first opioid treatment services by reviewing the date of the request and determining the length of time to the first offered appointment. This data is gathered and reported by the NTP provider monthly using an Excel spreadsheet. The table below summarizes the timeliness to opioid treatment services data for FY 24-25:

Table 2.11 Timeliness to First NTP/OTP Services				
Review Period	Medi-Cal Requests	Appointments Offered Within 3 Business Days	Appointments Offered Over 3 Business Days	Compliance Rate
FY 24-25	190	190	0	100%
FY 23-24	182	182	0	100%
FY 22-23	200	200	0	100%

b. Overview of the objectives and planned activities for FY 25-26:

- The QM Unit will monitor SMHS and SUDS Timely Access Standards monthly to verify beneficiaries can access services without delay.

- The QM Unit will issue corrective action plans to SMHS and SUDS if less than 80 percent of Medi-Cal client requests were not offered a service within the required timeframe.

- SMHS and SUDS divisions will ensure a complete protocol is developed and maintained that outlines the necessary steps for accurately completing the SMHS and SUDS Timeliness Record in SmartCare, supporting consistent processes and timely access to services for beneficiaries.

II. Accessibility of Services

The QM Unit monitors accessibility of SMHS and SUDS by evaluating the responsiveness of the 24/7 Access Line and the Mental Health Triage Unit.

a. Update on the objectives and activities for FY 24-25:

1) Responsiveness of the 24/7 Access Line

The QM Unit monitors the responsiveness of ICBHS 24/7 Access Line monthly by conducting random test calls, during business hours and after hours, in English and Spanish, Imperial County's threshold language. Monitoring is conducted to verify that the 24/7 Access Line is available to beneficiaries 24 hours a day, seven days a week.

Test calls determine the ability of the 24/7 Access Line to provide information related to 1) available SMHS and/or SUDS, 2) referrals for urgent services and medical emergencies, 3) information regarding problem resolution and fair hearing process, and 4) interpreter and translation service information. Test callers also assess whether or not the 24/7 Access Line appropriately determines the urgency of callers' requests; answers call within five rings; provides information related to TTY/TDY services; and providers with written SMHS and/or SUDS materials upon request.

During FY 24-25, the QM Unit conducted 52 test calls, 30 during business hours and 22 after hours. Below are the findings related to the test calls conducted by the QM Unit:

Table 3.1 24/7 Access Line			
Test Call Criteria	Percentage of Test Calls Where Requirement Was Met		
	Business Hours	After Hours	All Calls
Language Capability	100%	100%	100%
SMHS Access Information	100%	87%	93%
Urgency Assessment	100%	85%	92%
Resolution and Fair Hearing Process	95%	100%	97%
Access Log Criteria	Percentage of Test Calls Where Requirement Was Met		
	Business Hours	After Hours	All Calls
Name of the caller	82%	82%	81%
Date of the request	82%	95%	88%
Initial disposition of the request	77%	90%	83%

2) Access to After-Hours Care

ICBHS is responsible for ensuring beneficiaries have access to after-hours care. After-hours care is provided through the 24/7 Access Line, where callers are assessed for safety and urgency of need and referred to the ICBHS Triage Unit for immediate attention. ICBHS has established a one-hour standard from the time of the request to provide after-hours care.

The QM Unit compares the After-Hours Access Log call times from the EHR, which identifies the client's request for after-hours care (requests made after-hours, weekends, and holidays) to the times contacts are made to the client by After-Hours Triage staff, to determine whether after-hours care was provided within one hour.

In review of the data for FY 24-25, the QM Unit determined that access to after-hours care was provided within one hour for only 49 percent of requests. This is a slight increase when compared to last fiscal year; however, the compliance rate continues to be low and could be attributed to staff failing to log their after-hours encounters with beneficiaries.

Table 3.2 SMHS Access to After-Hours Care			
Review Period	Requests	Within Standard	Compliance Rate
FY 24-25	464	225	**49%**
FY 23-24	440	206	**47%**
*FY 22-23	164	161	**98%**

Inclusive of July-December 2022 data only due to EHR transition.

During FY 24-25, the QM Unit determined that access to after-hours care was provided within one hour for 100% of requests for SUDS services.

Table 3.3 SUDS Access to After-Hours Care			
Review Period	Requests	Verified	Compliance Rate
FY 24-25	1	1	100%
FY 23-24	0	0	N/A
FY 22-23	5	2	40%

b. Overview of the objectives and planned activities for FY 25-26:

- The QM Unit will continue to monitor the 24/7 Access Line to verify that SMHS and/or SUDS services and information are available to beneficiaries at all hours through the 24/7 Access Line and the Mental Health Triage Unit.

- The QM Unit will monitor beneficiaries' access to after-hours services through multiple established support channels. After-hours care is provided through telephone-based assistance available 24 hours a day, 7 days a week via the Beneficiary Access Line and the Suicide and Crisis Hotline. In-person after-hours support is provided at Casa Serena, Monday through Friday from 5:00 p.m. to 10:00 p.m. Furthermore, Mobile Crisis Response Teams are deployed to ensure timely access to urgent mental health and substance use services when clinically indicated.

III. Client/Family Satisfaction

The QM Unit monitors client/family satisfaction with the SMHS and SUDS through the consumer/family satisfaction survey; grievances, appeals, and fair-hearings process; and requests to change persons providing services.

a. Update to the objectives and activities for FY 24-25:

1) Consumer/Family Satisfaction Survey

In Calendar Year (CY) 2024, ICBHS administered two statewide satisfaction surveys: the Consumer Perception Survey (CPS) for beneficiaries receiving SMHS and the Treatment Perception Survey (TPS) for those receiving SUDS. Both surveys, developed by the state, were provided in English and Spanish—the threshold languages for the county.

CPS - SMHS

The CPS, conducted annually, uses a point-in-time method to gather input from beneficiaries receiving face-to-face mental health services, case management, or medication support during a designated one-week sampling period. In CY 2024, ICBHS collected a total of 293 CPS surveys, a decrease of 104 compared to the previous year.

Among these, 59 youth clients completed the CPS. Youth survey results showed notable improvement in Cultural Sensitivity and General Satisfaction. There was a slight decline in Perception of Access. Overall, the data reflects a positive trend in satisfaction and culturally responsive care for youth beneficiaries.

In contrast, 104 youth family members completed the CPS and reported mixed results. While there was a slight increase in Outcome of Services and Perception of Functioning, there were

notable decreases in Social Connectedness, Cultural Sensitivity, and Participation in Treatment Planning. These findings indicate areas requiring further attention to strengthen family engagement and support.

Survey findings for youth and youth families are summarized below, including a side-by-side comparison with CY 2023 findings:

Table 4.1 Youth CPS Results				
Survey Area	CY 2022 (n=82)	CY 2023 (n=67)	CY 2024 (n=59)	Difference in % (2023 to 2024)
General Satisfaction	86%	81%	88%	+7
Perception of Access	95%	87%	86%	-1
Participation in Treatment Planning	94%	77%	78%	+1
Outcome of Services	94%	73%	76%	+3
Social Connectedness	69%	80%	86%	+6
Cultural Sensitivity	82%	85%	93%	+8
Perception of Functioning	66%	78%	78%	0

Table 4.2 Youth Families CPS Results				
Survey Area	CY 2022 (n=138)	CY 2023 (n=156)	CY 2024 (n=104)	Difference in % (2023 to 2024)
General Satisfaction	90%	89%	88%	-1
Perception of Access	93%	93%	88%	-5
Participation in Treatment Planning	90%	90%	84%	-6
Outcome of Services	70%	75%	78%	+3
Social Connectedness	87%	96%	84%	-12
Cultural Sensitivity	96%	98%	92%	-6
Perception of Functioning	68%	72%	78%	+6

Adult beneficiaries completed 115 CPS surveys in 2024, continuing a pattern of generally high satisfaction. Significant increases were observed in Perception of Access and Perception of Functioning, with other areas such as General Satisfaction and Quality and Appropriateness also showing improvement. The only area with a slight decline was Participation in Treatment Planning.

Survey findings for adults are summarized below, including a side-by-side comparison with CY 2023 findings:

Table 4.3 Adult CPS Results				
Survey Area	CY 2022 (n=93)	CY 2023 (n=128)	CY 2024 (n=115)	Difference in % (2023 to 2024)
General Satisfaction	81%	90%	93%	+3
Perception of Access	94%	90%	97%	+7
Quality and Appropriateness	90%	88%	93%	+5
Participation in Treatment Planning	95%	92%	91%	-1
Outcome of Services	72%	74%	77%	+3
Social Connectedness	83%	80%	80%	0.0
Perception of Functioning	71%	71%	77%	+6

A smaller group of 15 older adult beneficiaries participated in the CPS. Despite the smaller sample size, results were overwhelmingly positive. General Satisfaction, Perception of Access, *and* Quality and Appropriateness all improved, with Perception of Access showing the most significant gain. Participation in Treatment Planning was the only area that declined. This data highlights continued satisfaction among older adults, alongside a need to better engage them in shared decision-making.

Survey findings for older adults are summarized below, including a side-by-side comparison with CY 2023 findings:

Table 4.4 Older Adult CPS Results

Survey Area	CY 2022 (n=45)	CY 2023 (n=46)	CY 2024 (n=15)	Difference in % (2023 to 2024)
General Satisfaction	92%	96%	100%	+4
Perception of Access	92%	88%	100%	+12
Quality and Appropriateness	83%	88%	93%	+5
Participation in Treatment Planning	91%	96%	87%	-9
Outcome of Services	70%	83%	85%	+2
Social Connectedness	67%	77%	77%	0.0
Perception of Functioning	80%	74%	85%	+11

All CPS results were reviewed by ICBHS management and shared with both internal teams and contract providers to support continuous improvement efforts.

TPS - SUDS

TPS follows a semi-annual, point-in-time methodology and targets all SUDS clients receiving face-to-face services during a two-week sampling window.

In CY 2024, 52 youth clients receiving outpatient services from the county's two adolescent SUD clinics completed the TPS. Participation significantly increased from previous years. However, the data revealed a downward trend in many areas. Notable declines included Staff Sensitivity to Cultural Background, Feel Less Cravings for Drugs and Alcohol, and Good Enrollment Experience. While most areas showed a decrease, a few areas, such as Feeling Better Able to Do Things and Willingness to Recommend Services, showed improvement, indicating positive treatment impact for some participants.

Among adult SUDS clients, 369 surveys were completed—a significant increase of 124 surveys from CY 2023, although participation by beneficiaries receiving outpatient and residential services continues to be low. Most adult respondents reported consistently high satisfaction, particularly in areas such as Treated with Respect, Feeling Welcomed, and Overall Satisfaction with Services. While there were slight declines in Staff Helped Connect with Services, Staff Giving Enough Time, and Coordination with Physical and Mental Health Providers, the overall feedback remained favorable. Encouragingly, 94.1 percent of respondents said they would recommend the program to a friend.

Survey findings for youths and adults are summarized below, including a side-by-side comparison with CY 2023 findings:

Table 4.5 Youth TPS Results				
Survey Area	CY 2022 % (n=21)	CY 2023 % (n=14)	CY 2024 % (n=52)	Difference in % (2023 to 2024)
Convenient location	81.0	92.9	82.4	-10.5
Services available at a convenient time	90.5	92.9	82.0	-10.9
Good enrollment experience	81.0	92.9	68.6	-24.3
Received services right for me	90.5	85.7	80.4	-5.3
Staff treated me with respect	100	92.9	82.0	-10.9
Staff sensitive to cultural background	68.4	85.7	60.0	-25.7
Counselor provided necessary services	80.0	71.4	62.8	-8.6
Worked with counselor on treatment goals	95.2	92.9	79.6	-13.3
Counselor took the time to listen	95.2	92.9	83.7	-9.2
Developed positive trusting relationship with counselor	80.0	85.7	71.4	-14.3
Counselor was sincerely interested	90.5	78.6	79.6	+1.0
Liked my counselor here	90.5	85.7	83.7	-2.0
Counselor is capable of helping me	100	85.7	79.6	-6.1
Staff helped with health and emotional needs	100	92.9	83.3	-9.6
Staff helped with other issues	90.0	92.3	83.3	-9.0
Better able to do things	85.7	71.4	77.6	+6.2
Feel less craving for drugs and alcohol	N/A	64.3	58.3	-27.4
Satisfied with services I received	100	85.7	74.0	+2.6
Would recommend the services to a friend	81.0	71.4	80.4	+16.1

Table 4.6 Adult TPS Results				
Survey Area	CY 2022 % (n=192)	CY 2023 % (n=245)	CY 2024 % (n=369)	Difference in % (2023 to 2024)
Convenient location	85.3%	90.4%	91.4	+1.0
Convenient time	90.5%	95.0%	93.5	-1.5
I chose my treatment goals	88.7%	91.9%	90.9	-1.0
Staff gave me enough time	93.7%	95.8%	90.3	-5.5
Treated with respect	91.0%	95.0%	95.5	+0.5
Understood communication	90.5%	97.1%	96.6	-0.5
Cultural sensitivity	90.5%	95.3%	92.7	-2.6
Work with physical health care providers	88.2%	92.9%	88.5	-7.3
Work with mental health providers	87.2%	91.1%	89.3	-5.3
Staff helped connect with services	N/A	87.3%	86.3	-6.9
Better able to do things	89.9%	93.8%	90.6	-0.5
Feel less cravings for drugs and alcohol	N/A	94.6%	90.2	-3.6
Felt welcomed	92.6%	95.8%	95.7	+2.8
Overall satisfied with services	94.2%	94.6%	93.0	-0.7
Got the help I needed	91.1%	93.2%	90.2	-4.4
Recommend agency	92.3%	93.7%	94.1	+6.8

TPS results were reviewed by SUDS leadership and shared with staff and contracted providers to guide ongoing quality improvement initiatives.

Supplemental Quality Monitoring Activities

In addition to the CPS and TPS, the Quality Management (QM) Unit conducted several follow-up efforts to further assess client experiences and inform system improvements. These included targeted surveys with older adults receiving SMHS, with 50 total responses collected, 20 via phone and 30 through focus groups. Results showed that 84 percent of participants received services in their preferred setting, indicating generally positive perceptions of access.

Similarly, follow-up surveys with youth clients were conducted to evaluate satisfaction with access, treatment planning, and outcomes. Of the 40-youth surveyed (39 by phone and one in a focus group), 92 percent reported satisfaction with services, 98 percent were satisfied with access, 88 percent felt involved in treatment planning, and 92 percent believed they were making progress.

Finally, the QM Unit implemented monthly phone surveys throughout FY 2024–2025. A total of 132 clients, parents, and guardians participated. Over 94 percent reported satisfaction with their services and expressed that treatment had positive impact on their overall quality of life. Notably, no participants receiving SMHS reported dissatisfaction or raised any concerns during the survey process.

These various data collection efforts continue to inform the department's commitment to person-centered, culturally responsive, and outcome-driven care.

2) Grievances and Appeals

The Quality Management (QM) Unit is responsible for monitoring the grievances and appeals system to ensure compliance with federal requirements. This includes oversight of all grievance and appeal logs submitted by both county-operated and contracted providers. The QM Unit ensures that all concerns are reviewed and addressed appropriately and that beneficiaries are fully informed of their rights throughout the process.

During Fiscal Year 2024–2025, ICBHS received a total of 72 grievances, 10 standard appeals, and 11 expedited appeals related to SMHS. While this reflects a decrease in the number of grievances compared to the previous year, the number of appeals—both standard and expedited—increased. In contrast, SUDS received 4 grievances and no appeals during the same reporting period. The numbers include both Medi-Cal and non-Medi-Cal beneficiaries.

The table below summarizes the grievances and appeals by category:

Table 4.7 Grievances & Appeals by Category						
Grievance Category	FY 22-23		FY 23-24		FY 24-25	
	SMHS	SUDS	SMHS	SUDS	SMHS	SUDS
Related to Customer Service	0	0	0	0	4	2
Related to Case Management	0	0	0	0	0	0
Access to Care	20	0	20	1	0	0
Quality of Care	97	7	97	7	38	2
County (Plan) Communication	0	0	0	0	0	0
Confidentiality	0	0	0	0	3	0
Payment/Billing Issues	0	0	0	0	0	0
Suspected Fraud	0	0	0	0	0	0
Abuse, Neglect or Exploitation	0	0	0	0	0	0
Lack of Timely Response	0	0	0	0	2	0
Denial of Expedited Appeal	0	0	0	0	0	0
Filed for other reasons	4	0	5	2	25	0
Appeal Category	FY 22-23		FY 23-24		FY 24-25	
	SMHS	SUDS	SMHS	SUDS	SMHS	SUDS
Denial or Limited Authorized or Service (s)	1	0	0	0	0	0
Reduction, Suspension, or Termination of a Previously Authorized Service	28	0	11	1	21	0
Payment Denial	0	0	0	0	0	0
Service Timeliness	0	0	0	0	0	0
Untimely Response to Appeal or Grievance	0	0	0	0	0	0
Denial of Client Request to Dispute Financial Liability	0	0	0	0	0	0

Among the SMHS grievances filed during FY 24–25, two exempt grievances were not logged within the required one working day. However, all other grievances and appeals were resolved in accordance with federal guidelines and to the satisfaction of the beneficiaries involved. No significant trends or systemic issues were identified from the SMHS grievances and appeals data.

Similarly, all SUDS grievances received during the fiscal year were addressed in compliance with regulatory requirements, and there were no appeals submitted. The issues raised were resolved to beneficiaries' satisfaction, and no recurring patterns or concerns were identified in the grievances filed.

3) Requests to Change Persons Providing Services

The Quality Management (QM) Unit actively monitors all client requests to change their assigned service providers in order to identify potential trends related to specific programs or staff, and to ensure that any concerns related to the therapeutic relationship or treatment approach are addressed appropriately.

SMHS

During Fiscal Year 2024–2025, ICBHS received a total of 238 requests from Medi-Cal beneficiaries seeking to change their SMHS provider—a slight decrease from the 253 requests received in FY 2023–2024. An additional 25 requests were submitted by non-Medi-Cal clients.

Of the total requests received across both Medi-Cal and non-Medi-Cal populations, 253 (96 percent) were approved, 4 (1 percent) were denied, and 4 requests were withdrawn by the client. Each request was reviewed and processed in accordance with established procedures.

The table below outlines the reasons cited for requesting a provider change during the past three fiscal years:

Table 4.8 Reason for Requests for Change of Provider			
Reason	FY 22-23	FY 23-24	FY 24-25
Quality of Care Treatment Concerns	57	70	31
Quality of Care-Staff Behavioral Concerns	20	24	10
Service Not Available	18	21	22
Request Transfer to Another Clinic	2	8	6
Language Barrier	10	15	21
Not Feeling Comfortable with Provider	10	85	78
In-Person Provider	N/A	36	28
No Therapeutic Alliance with Provider	5	8	17
Dissatisfaction with Provider	22	4	29
Disagreement with Course of Treatment	1	3	20
Confidentiality	0	1	1

Notably, the most common reasons in FY 2024–2025 included Not Feeling Comfortable with Provider (78 requests), Dissatisfaction with Provider (29 requests), and Quality of Care – Treatment Concerns (31 requests). While the overall volume of requests decreased slightly, certain categories—such as Disagreement with Course of Treatment and No Therapeutic Alliance—saw notable increases, signaling potential areas for continued provider training and engagement.

SUDS

For SUDS, ICBHS received 26 requests from Medi-Cal beneficiaries and 7 requests from non-Medi-Cal clients seeking a provider change, reflecting a slight decrease from the previous fiscal year's total of 28 Medi-Cal requests.

The table below outlines the reasons cited for requesting a provider change during the past three fiscal years:

Table 4.9 Reason for Requests for Change of Provider			
Reason	FY 22-23	FY 23-24	FY 24-25
Quality of Care Treatment Concerns	N/A	2	12
Prefer a Spanish Speaking Provider	1	0	0
Not feeling comfortable with Male/Female Provider	3	4	12
No therapeutic Alliance with Provider	5	2	3
Dissatisfaction with Provider	N/A	0	4
Disagreement with Course of Treatment	1	0	0
Uncomfortable with Provider	4	20	2

In FY 2024–2025, the most frequently cited reasons included *Quality of Care – Treatment Concerns* and *Not Feeling Comfortable with Male/Female Provider* (12 requests each). These trends suggest an increased sensitivity among clients to provider fit and perceived quality of care.

All requests were reviewed by clinical managers and evaluated in the context of the client's clinical needs and service history. When possible, clinical managers discussed the concerns directly with the client or their authorized representative. In cases where contact could not be established, the request was processed based on the available information.

When appropriate, clinical managers encouraged clients or their authorized representatives to communicate directly with their provider to resolve concerns. Regardless of the outcome, all clients or their representatives were notified of the decision by telephone, mail, or in person within the required 14 business days.

b. Overview of the objectives and planned activities for FY 25-26:

- The QM Unit will continue to conduct monitoring activities to determine client/family satisfaction with SMHS and SUDS.

- The QM Unit will conduct monthly phone surveys on an as-needed basis to assess client satisfaction with ICBHS, their treatment provider and/or care team, and their overall experience with services.

- ICBHS will implement corrective action to ensure the grievance and appeal system requirements are implemented appropriately to ensure the protection of client rights when filing grievances and appeals.

- QM will assume full responsibility for receiving, acknowledging, investigating, and resolving all grievances, appeals, and complaints submitted to ICBHS, ensuring compliance with DHCS requirements and adherence to internal policies and procedures. Patients' Rights advocate and the QM Unit will assist with communication between clients and providers ensuring client's receive quality of care treatment.

IV. Service Delivery System and Meaningful Clinical Issues Affective Beneficiaries, Including the Safety and Effectiveness of Medication Practices

The QM Unit monitors the service delivery system and meaningful clinical issues affecting SMHS and SUDS beneficiaries, including the safety and effectiveness of medication practices. This is accomplished through medication monitoring, chart reviews, oversight of triage services, and evaluation of NTP utilization of Methadone and non-Methadone Medication-Assisted Treatment (MAT), as well as assessing the provision of services at certain levels of care and/or follow-up treatment.

i. Update on the objectives and activities for FY 24-25:

1) Medication Monitoring

The medication monitoring reviews for SMHS are conducted monthly by seven adult and child psychiatrists, a pharmacist, and the Medical Director while the SUDS reviews are conducted quarterly by the Medical Director and two medical doctors focusing on the programs delivering Medication Assisted Treatment (MAT). The Medical Director conducts monthly medication monitoring reviews for the NTP provider.

Utilizing a review tool, the Medication Monitoring Committee monitors the SMHS delivery system, including telepsychiatry, to review the safety and effectiveness of medication practices; identify meaningful clinical issues affecting beneficiaries' system-wide; review medication practices for children, youth and young adults, and adults receiving medication support services; and address any quality-of-care concerns or outliers identified related to medication use. On the other hand, the reviews tools used for monitoring MAT and NTP service delivery are used to review the safety and effectiveness of medication practices; identify meaningful clinical issues affecting beneficiaries' system-wide; medication practices for MAT; and address any quality-of-care concerns or outliers identified related to medication use.

Charts are randomly selected from the EHR or through quality-of-care referrals when an identified concern requires further review. The QM Unit compiles the data, identifying opportunities for improvement and areas of concern. All reports are submitted to the Medical Director, and the QM Unit ensures that management receives copies of the reports and completed tools, as appropriate. Findings from the SMHS report, including areas of concern and improvement opportunities, are discussed with the SMHS psychiatrists, while the SUDS findings are reviewed by the Medical Director with the two medical doctors.

During FY 24-25, the Medication Monitoring Committee reviewed 239 charts: 126 from Adult Services, 32 from Children Services, and 81 from Youth and Young Adult Services. Areas with compliance at 85 percent or below were identified as opportunities for improvement. SMHS was compliant at 86 to 100 percent in all 18 areas evaluated. This represents a decrease from 92 to 100 percent in FY 23-24. No significant findings were identified, suggesting that SMHS prescribers are largely adhering to best practices in the implementation of medication support services.

In FY 24-25, the Medical Director and two medical doctors reviewed 42 charts from the SUDS county-operated programs providing MAT, achieving an average of 97 percent compliance across the nine areas evaluated. The committee identified one finding related to: ensuring documentation indicates that laboratory panels were ordered and reviewed when necessary. This marked a decrease in identified findings compared to the prior fiscal year, which reported three issues.

Meanwhile, in FY 24-25, the Medical Director reviewed 24 charts from the NTP provider, with 100 percent compliance in all 18 areas, maintaining consistency with the previous fiscal year.

2) Chart Reviews

a) Quality of Care Reviews

ICBHS has the responsibility to detect and address concerns related to poor quality of care, including, but not limited to inaccurate diagnosis, medication malpractice, treatment that is

not medically necessary, clinical interventions that are outside the scope of the provider, underuse and overuse of treatment services, services that are unethical or culturally inappropriate, and treatment that jeopardizes the safety and well-being of the client. When quality of care concerns is identified by ICBHS staff or contracted providers, the QM Unit is notified by submitting a Quality-of-Care Referral Form. The QM Unit will assign the case for a second level review by the Medication Monitoring Committee or to an individual reviewer such as a Quality Improvement Specialist, Program Supervisor, Program Manager, licensed clinician, registered nurse, or the Medical Director. Findings are presented to the program supervisor and manager, as appropriate.

Additionally, ICBHS has established the Quality-of-Care Review Committees (QOC) that reviews documentation requirements and the quality of services provided, identifying opportunities for improvement and training needs, as appropriate. This committee is comprised of ICBHS staff across all the divisions within ICBHS and the QM Unit. When findings are identified, these are also presented to the program supervisor and manager, as appropriate.

During FY 24-25, the QM Unit reviewed a total of twenty-six clinical charts to assess the quality of services provided by ICBHS providers. The QM Unit received thirteen referrals submitted by the ICBHS Patients' Rights Advocate, the MHP QI Coordinator, QM staff, and the Compliance Unit and thirteen were discussed within the Quality-of-Care Committee. There were no quality-of-care concerns identified; however, recommendations for improvements were made to the treatment team(s) assigned to each case. Three corrective action plans were also issued. A summary of findings was presented to the QIC.
The QM Unit made the following recommendations to the QIC as a result of the quality of care reviews conducted during FY 24-25:

- Ensure meaningful care coordination occurs between mental health providers, significant supports, and/or community agencies to support the client towards improving their overall mental health condition. *(Repeat finding from FY 23-24).*
- Ensure the problem list is being updated on an ongoing basis to reflect the current presentation of the beneficiary and/or significant changes in their mental health condition or life events. Ensure that the beneficiaries are included in the development of the problem list.
- For Service providers to evaluate the effectiveness of interventions provided towards achieving treatment goals and/or reducing identified problems. Ensure that services provided to the beneficiary are medically necessary, according to the presenting program and/or given diagnosis.
- Ensure that safety plans are developed or reinforced when applicable.

b) ICBHS Quality Management Chart Reviews

The QM Unit conducts routine chart reviews to verify the overall quality of services provided by the ICBHS. Chart reviews were conducted for each SMHS service division using a chart review tool that evaluated the following areas: Access to Specialty Mental Health Services, Assessment/Reassessment, Problem List, Treatment Interventions, Care Coordination, and Other Areas of Review. The QM Unit compiled reports that identified opportunities for improvement and areas of concern, as appropriate. Division reports were provided to management, with each division receiving a corrective action plan. The QM Unit approved

corrective action plans, prior to implementation, and followed up with each division to ensure all corrective actions were completed, as appropriate. Compliance referrals were submitted to the Compliance Unit when instances of potential fraud, waste, or abuse were identified.

During FY 24-25, the QM Unit reviewed 128 charts, of which 29 were from Children Services, 17 were from Youth and Young Adults Services, 23 were from Adults Services, 25 were from Mental Health Triage and Engagement Services, 20 from SUD Services, and 13 from Narcotic Treatment Program (NTP). The summary of findings below were areas identified as needing correction:

Assessment /Re-Assessment

- No ongoing or thorough assessments, including but not limited to client's presenting problem (changes), risks factors, and strengths, impacting the treatment process *(Repeat finding from FY 23-24).*
- No exploration and/or updating of the client's diagnosis when client reports additional or new symptoms and behaviors that when not previously documented or assessed.
- Not completing outcome measurement tools, as required, to determine progress or lack of progress.
- A safety plan is not being developed when appropriate *(Repeated finding from FY 23-24).*

Problem List

- Problem List does not include a list of symptoms, conditions, diagnosis and/or risk factors identified through assessment, psychiatric diagnostic evaluation and/or crisis encounters *(Repeated finding from FY 23-24*).
- Providers are not updating or completing the Problem List according to the clients' current problems/needs and are not educating or involving the client in the development of Problem List *(Repeated finding from FY 23-24).*

Treatment Interventions

- No meaningful interventions provided in accordance with the client's presenting problems (interventions are not being linked to the problems list or what the client is reporting, no description of how interventions will benefit the client, vague care plan focus).
- Interventions do not focus on the identified client's needs and/or reported symptoms and behaviors.
- No timely access to services in accordance with the clients' mental health needs/presenting problem (no attempts to facilitate home and/or school visits, as appropriate, gaps in treatment) *(Repeated finding from FY 23-24).*
- No documentation of the follow up plan for future encounters for the provider and/or client and to evaluate effectiveness of the interventions and/or progress with mental health conditions *(Repeated finding from FY 23-24).*
- No timely documentation of the services provided to maintain the integrity of the service (late documentation, exceeding three working days) *(Repeated finding from FY 23-24).*

Care Coordination

- No meaningful (*something that provides a clinical value to the treatment)* coordination of care with other care providers within mental health and/or SUD treatment, and/or family support that will assist the client in making progress towards treatment and to assess barriers hindering progress, when appropriate *(Repeated finding from FY 23-24).*
- Cases are not taken to team as needed to discuss lack of progress, significant events/changes, appropriateness of diagnosis, need for additional interventions or higher level of services.

Other Areas of Review

- No valid Release of Information (missing required elements) *(Repeated finding from FY 23-24).*

The QM Unit also conducted a review of clients receiving residential treatment services to identify quality of care issues in both the pre-admission and post-discharge process. During FY 24-25, the QM Unit reviewed a total of 40 clinical charts for clients referred to the three contracted residential treatment providers; 5 from Adult Residential, 15 from Crisis Residential, and 20 from substance use disorder treatment. The summary of findings below were areas identified as needing correction:

Pre-Residential Treatment

- Client was not admitted into residential treatment within 14 days from the authorization date *(Repeated finding for FY 23-24).*
- No documented evidence to support the reason for referral to residential treatment (how residential treatment will assist client in alleviation symptoms).
- No evidence that the referring service coordinator contacted residential treatment providers to monitor the referral and/or treatment changes/outcomes or significant changes, as appropriate *(Repeated finding for FY 23-24).*

Post-Residential Treatment

- No evidence of meaningful coordination of care between ICBHS providers and residential treatment staff (not just merely providing updates, no documentation of how information provided/received will assist in making changes to treatment and regain stability, as appropriate) *(Repeated finding for FY 23-24).*
- No evidence the assigned service coordinator reviewed the residential treatment discharge summary/plan to follow recommendations, as appropriate. *(Repeated finding for FY 23-24).*
- Service coordinator did not schedule the client's next appointment within an appropriate amount of time, based on the client presenting problem and medical need. *(Repeated finding for FY 23-24).*
- No evidence the assigned service coordinator followed up with the client to ensure a smooth transition from residential treatment to the outpatient clinic and processed the appropriate referrals to support client treatment.
- No evidence of SUD staff updated the ASAM, after the residential discharge.

In addition to the regularly scheduled chart reviews conducted, the QM Unit also conducted ad hoc focus reviews. Focus reviews are assigned as a follow-up from any type of prior case review, as referred by management or supervisors, or as requested by individual providers.

During FY 24-25, the QM Unit conducted six focus reviews: two requested by the Compliance Unit, and four conducted as follow-up reviews. The following findings were identified during these focus reviews:

- No meaningful interventions provided to address the reported symptoms and behaviors.
- No care coordination amongst treatment team.
- No timely contact and/or follow up to provide treatment services.

Findings were reported to the individual(s) requesting each focus review, as well as the affected supervisor(s) and management.

Beginning FY 24-25, a targeted training initiative was launched to address documentation and billing related findings identified through ongoing chart reviews. The purpose of this initiative was to strengthen documentation and billing practices across direct treatment staff, supervisors, and program managers, thereby improving clinical record accuracy, compliance with standards, and overall service quality.

The training sessions provided comprehensive guidance on documentation standards, including claiming requirements, procedure codes, progress note documentation, Problem List, Care Coordination and Care Planning. These sessions focused on areas where chart reviews had previously revealed inconsistencies, non-compliance and areas identified as needing improvement. Each training included practical examples and clarified expectations in alignment with regulatory and internal quality.

To further support staff, regular office hours were implemented as an open forum for direct treatment staff, supervisors, and managers. These sessions offered opportunities to ask questions, clarify documentation requirements, delivery of services, and receive guidance on specific documentation challenges. This ongoing support mechanism encouraged a culture of continuous learning, accountability, and collaboration.

Based on positive staff feedback and observed improvements in documentation quality, both the training sessions and office hours will continue as needed throughout FY 25-26. This continued effort will ensure that staff remain informed and supported by maintaining high standards of clinical documentation, and that quality improvement efforts remain responsive to emerging needs identified through ongoing chart review and staff input.

3) Triage Services

The QM Unit tracks and monitors the admissions and re-admissions of the individuals who are admitted to the MHTU (5150). The Mental Health Triage Unit (MHTU) provides immediate crisis intervention services 24 hours a day, 7 days a week for individuals of all ages. The MHTU includes psychiatrists, nurses, clinicians, mental health rehabilitation technicians, and mental health workers who provide crisis interventions to individuals that are a danger to self, danger to others, or gravely disabled.

The monitoring process consists of reviewing the crisis log, removing entries for clients that remain on a voluntary hold or pre-screening. The MHTU tracks data relevant to age, city of origin, gender, admission and discharge dates, placement if applicable, type of hold, individuals

with high re-admission rates. Other areas tracked by QM include but are not limited to the following: foster youth, minors, unhoused individuals, active or inactive with the ICBHS SMHS, number of episodes, hospitalizations, conservatorships, care –coordination and aftercare from the MHTU.

During FY 24-25, there were 519 clients admitted to the MHTES Triage Unit, for a total of 722 admissions, which is an increase of 84 admissions from the previous fiscal year. A comparison of prior fiscal years is included below:

Table 5.1 MHTE Triage Unit Admissions		
Review Period	# of Clients	# of Admissions
FY 24-25	519	722
FY 23-24	456	638
FY 22-23	380	498

A comparison of the prior fiscal years is included below for age and gender demographics:

Table 5.2 MHTE Triage Unit				
Demographics		FY 22-23	FY 23-24	FY 24-25
Age	Minors	143	151	249
	Adults	355	487	473
Gender	Female	237	261	321
	Male	261	342	391
	Other	-	35	10

Of the 722 admissions during FY 24-25, 440 (61%) were actively receiving services from ICBHS at the time of Triage (5150) admission. The status by division is as follows:

- Children Services- 83 (11%) active clients at the time of Triage admission
- Youth & Young Adults Services- 117 (16%) active clients at the time of Triage admission
- Adults Services: 171 (24%) active clients at the time of Triage admission
- Mental Health Triage Engagement Services: 69 (10%) active clients and 282 (39%) inactive clients that were referred to ICBHS SMHS.

Triage Readmissions

Of the 722 admissions during FY 24-25, 203 were readmissions, which is an increase from FY 23-24. ICBHS' overall readmission rate is 28 percent. This remains the same from FY 23-24. There were 42 readmissions that occurred within 30 days of discharge, resulting in a 6 percent 30-day readmission rate. This is an increase from FY 23-24 when the 30-day readmission rate was 5 percent. The table below summarizes ICBHS Triage readmissions:

Table MHTU 5150 Triage Readmissions			
Table 5.3			
Review Period	FY 22-23	FY 23-24	FY 24-25
Total Readmissions	118	182	203
Total Admissions	498	638	722
Readmission Rate	**24%**	**28%**	**28%**
Readmissions Within 30 Days	31	31	42
Total Admissions	498	638	722
30-Day Readmission Rate	**6%**	**5%**	**6%**

Additional FY 24-25 Insights:

- For FY 24-25, there were a total of 537 Danger to Self, 134 Danger to Others and 57 Gravely Disabled individuals that were placed on an involuntary hold due to mental health concerns.
- At the time of the Triage admissions, 61 clients were actively receiving services with Substance Use Disorder Division.
- 78 (11%) clients were unhoused at the time of Triage admission for FY 24-25.
- Of those admitted to the Mental Health Triage Unit under 5150 hold, 159 (22%) were admitted to an inpatient psychiatric hospital.

4) NTP Utilization of Methadone and Non-Methadone MAT

The Quality Management (QM) Unit monitors the utilization of methadone and non-methadone medications within the Narcotic Treatment Program (NTP) to ensure that all approved and medically necessary treatments are accessible to beneficiaries. This oversight involves collecting and reviewing medication data extracted from the Electronic Health Record (EHR) via the "Services Report," which captures the types of medications prescribed within the NTP during a given review period.

During Fiscal Year 2024–2025, a total of 289 unduplicated clients received medication as part of NTP services. It is important to note that this total reflects unique individuals and not the number of doses administered. As such, the count may differ from the number of medication instances or doses provided throughout the year.

Most clients continued to receive Methadone, consistent with prior years. Utilization data for both methadone and non-methadone MAT options are summarized below:

Table 5.4 NTP Utilization of Methadone and non-Methadone MAT		
NTP - Medications	FY 23-24	FY 24-25
Methadone	224	275
Buprenorphine-Mono	3	2
Buprenorphine-Naloxone Combination	5	15
Disulfiram	0	0
Naloxone- Nasal Spray	0	0
Total	**232**	**289**

From FY 2023–2024 to FY 2024–2025, there was a notable increase in the number of clients receiving Methadone and Buprenorphine-Naloxone Combination, while slight decreases were observed in the number of clients receiving Buprenorphine-Mono. There was no reported utilization of Disulfiram or Naloxone Nasal Spray during this reporting period.

Methadone remains the primary medication utilized within the NTP setting. However, the gradual rise in the number of clients receiving Buprenorphine-Naloxone Combination suggests a growing application of alternative MAT options where clinically appropriate. According to feedback from the NTP program, all non-methadone MAT medications continue to be made available and are offered when medically necessary, although Methadone remains the preferred and most commonly prescribed treatment.

b. Overview of the objectives and planned activities for FY 25-26:

- The QM Unit will continue conducting chart reviews and other monitoring activities to identify relevant clinical issues affecting beneficiaries, including safety and effectiveness of medication practices and quality of care concerns.
- The QM Unit will develop and deliver focused documentation training as needed basis, as determined by the nature and scope of the chart review findings.
- The QM Unit will conduct routine chart reviews to assess compliance with established documentation requirements. The QM Unit will provide focused documentation training to ICBHS providers every six months.
- The QM Unit will continue to monitor and analyze Triage (5150) admission and readmission trends, with a focus on identifying high-utilizer populations and systemic barriers to stabilization.
- The Mental Health Triage Unit (MHTU) and program divisions will develop targeted interventions aimed at reducing the 30-day readmission rates, while enhancing care coordination, aftercare follow-up, and linkage to ongoing services for individuals admitted on involuntary holds.
- The QM Unit will continue to conduct a quarterly review of prescribing trends for non-methadone MAT (e.g., Buprenorphine-Naloxone) and provide feedback to NTP to support informed treatment planning and improve access to the full range of medically necessary MAT options.

V. Continuity and Coordination of Care with Medi-Cal Managed Care Plans

ICBHS is responsible for providing SMHS to Medi-Cal clients who meet both access and medical necessity criteria. ICBHS is expected to coordinate with local Medi-Cal Managed Care Plans (MCPs) to arrange services for clients who do not meet the criteria for SMHS. As of the beginning of FY 24-25, MOUs with both MCPs are pending execution, though agreements have been made regarding the language and scope of each MOU. Additionally, the QM Unit monitors the continuity and coordination of care with Physical Care Providers (PCPs) and other human services agencies used by its clients. This is achieved through providing information, training, and consultation to PCPs and other human services agencies, as well as through memorandums of understanding.

a. Update on the objectives and planned activities for FY 24-25:

1) Adult and Youth Screening Tools for Medi-Cal Mental Health Services

DHCS requires the use of the adult and youth screening tools to ensure Medi-Cal clients are guided to the appropriate Medi-Cal mental health system (i.e. MCP or ICBHS SMHS). The screening tools identify initial indicators of client's needs in order to make a determination for referral to either the client's MCP for a clinical assessment and medically necessary non-SMHS or to ICBHS for a clinical assessment and medically necessary SMHS.

The table below summarizes the screening tools implemented by ICBHS during FY 24-25:

Table 6.1 Adult and Youth Screening Tools

FY 24-25

Category	MCP Score (0-5)	ICBHS Score (6+)	Total Screenings	MCP %	ICBHS %	Urgent	Referred to SUD
Adult	1,830	319	2,149	85%	15%	270	408
Youth	2,268	290	2,558	89%	11%	127	90
Total	**4,098**	**609**	**4,707**	**87%**	**13%**	**397**	**498**

FY 23-24

Category	MCP Score (0-5)	ICBHS Score (6+)	Total Screenings	MCP %	ICBHS %	Urgent	Referred to SUD
Adult	1,828	337	2,165	84%	16%	209	317
Youth	2,234	321	2,555	87%	13%	104	73
Total	**4,062**	**658**	**4,720**	**86%**	**14%**	**313**	**390**

ICBHS implements the screening tool to all clients regardless of payor source.

The adult and youth screening tools have assisted ICBHS in the process of assessing the client's immediate needs to provide the needed care, especially when it is an urgent situation; however, they have not been effective in identifying the client's appropriate level of care. The implementation of the screening tools is facing significant challenges, which include lack of cultural competence and the stigma associated with behavioral health services within the Imperial County population. This results in individuals not feeling comfortable disclosing all of their symptoms and life-functioning impairments with the screening staff, the process which takes place over the phone in the majority of cases. Consequently, lower screening tool scores are typically reported, which do not accurately convey a measurement that will assist screening staff in identifying the proper level of care for the individual requesting services. As a result, all clients are referred for a full intake assessment, regardless of the outcome of the screening tool.

During FY 24-25, ICBHS determined that 2,240 Medi-Cal beneficiaries met access criteria and medical necessity for SMHS, illustrating that the adult and youth screening tools do not fully support their intended purpose.

2) Transition of Care Tool for Medi-Cal Mental Health Services

DHCS requires the use of the transition of care tool to ensure that Medi-Cal clients who are receiving mental health services from one delivery system (i.e. MCP or ICBHS) receive timely and coordinated care when either 1) their existing services need to be transitioned to the other delivery system; or 2) services need to be added to their existing mental health treatment from the other delivery system consistent with the No Wrong Door policies.

During FY 24-25, ICBHS completed a total of forty-one (41) transition of care tools; 40 from Adult Services and 1 from Children services.

3) Care Coordination and Continuity of Care

a. Outreach and Engagement

ICBHS has expanded its outreach efforts in the city of Winterhaven, serving both tribal and non-tribal residents. In collaboration with Indian Health Services, ICBHS conducted community education presentations to improve service accessibility, clarify the referral process, and identify treatment needs.

Community Service Workers continue to participate in a variety of activities, including outreach events and educational presentations, a kiosk at the Imperial Valley Mall, regular social media postings, hosting recurring web-based events, wellness radio shows, and participating in back-to-school events and health fairs. ICBHS remains committed to conducting outreach and engagement activities throughout Imperial County to ensure equitable access to substance use disorder (SUD) services, increase awareness of treatment options, and support recovery for individuals and families affected by substance use.

Additionally, SUD enhanced its outreach to Tribal communities through a combination of community events, educational sessions, and interagency partnerships. Presentations and resource dissemination took place at Tribal community sites, such as Fort Yuma Health Services. The SUD program also worked alongside school officials serving Tribal youth to develop referral pathways and support networks. SUD program supervisors and managers participated in outreach events to raise awareness about available services. Outreach efforts also aimed to engage elected Tribal officials or their designated representatives.

In fiscal Year 2024-2025, ICBHS served 29,204 individuals were served, an increase from 27,288 in the previous fiscal year. This growth was largely driven by increased school engagement, resulting in schools requesting educational presentations for students and staff. Interventions included harm reduction strategies, participation in community coalitions, and delivering community-based, culturally competent education. By tailoring evidence-based prevention strategies Imperial County’s demographic needs, SUD has been able to extend its reach and enhance participation, and maintained its focus on reducing stigma, building rapport, and removing barriers to care.

b. Harm Reduction

As part of its harm reduction efforts, ICBHS assembles and distributes personal hygiene kits tailored for both men and women, containing essential items such as feminine hygiene products, socks, hair ties, toothbrushes, toothpaste, condoms, deodorant, bar soap, hairbrushes, non-alcoholic mouthwash, shampoo, and conditioner. Designed for individuals experiencing homelessness, each kit also contains information about ICBHS services. Hygiene kits are available at all four county operated SUD clinics and are distributed during outreach and engagement activities. ICBHS remains committed to preventing overdoses and continues to lead proactive education and outreach initiatives in schools and communities, recognizing that prevention through education is one of the most effective strategies. These efforts are carried out in collaboration with schools, law enforcement, hospitals, and other community agencies. Additionally, ICBHS provides naloxone, a life-saving medication that reverses opioid overdoses involving substances such as heroin, fentanyl, and prescription opioids to clients and community members. The agency also distributes fentanyl and xylazine test strips to detect the presence of these substances in other drugs, further supporting harm reduction and overdose prevention efforts.

c. SUD Bridge Collaboration

ICBHS and El Centro Regional Medical Center (ECRMC) are collaborating to develop and implement strategic initiatives aimed at improving buprenorphine adherence among patients who initiate Medication for Addiction Treatment (MAT) in the emergency department. This partnership will focus on monitoring and evaluating a telehealth-based approach to enhance care coordination between the emergency department and SUD outpatient clinics. Through this collaborative effort, ICBHS and ECRMC strive to establish integrated care that not only supports patient retention in MAT programs but also strengthens the overall continuum of care for vulnerable populations affected by substance use.

ICBHS and Pioneers Memorial Hospital (PMH) have established a quarterly *SUD Champions Meeting* aimed at strengthening care coordination and communication between the hospital's emergency department and the SUD treatment programs. These meetings focus specifically on patients who receive MAT inductions in the emergency room, with the goal of streamlining patient transitions from emergency care to ongoing outpatient treatment.

The mission of ICBHS is to enhance the existing referral systems by incorporating a whole-person care approach with local hospitals. This approach emphasizes addressing the physical, mental, and social needs of patients to support sustained recovery. Through these efforts, ICBHS ensures that all patients who initiate MAT in the emergency department are successfully linked to comprehensive SUD treatment programs. These programs provide essential MAT follow-up services, counseling, behavioral health support, and other outpatient resources designed to promote long-term recovery and reduce the risk of relapse. By fostering collaboration between emergency departments and outpatient clinics, ICBHS and its partners aim to improve patient outcomes, reduce hospital readmissions, and ultimately strengthen the continuum of care.

d. School Partnerships

Minimal staffing continues to be a barrier, especially as the demand for substance use disorder (SUD) treatment services has increased compared to previous fiscal years. This growing need is largely due to ICBHS's continued collaboration with local school officials. Regular meetings, held before the end and beginning of each school year, have helped promote and offer SUD treatment and prevention services across school districts.

e. Health Management Associates – Systems of Care Learning Collaborative – Optimizing Programs and Systems to Meet the Needs of Populations with Opioid and Other Substance Use Disorder (OUD/SUD)

ICBHS continues its close collaboration with Health Management Associates (HMA) to implement targeted and approved strategies aimed at expanding access to Medication-Addiction Treatment (MAT), residential treatment, and enhanced care for individuals with co-occurring mental health and substance use disorders. Through this partnership, ICBHS seeks to improve and broaden substance use disorder (SUD) and mental health services, increase provider knowledge and awareness of co-occurring disorders, and strengthen community partnerships to support harm reduction efforts focused on preventing overdose deaths and reducing stigma associated with SUD and treatment.

HMA facilitated an intensive three-day Motivational Interviewing (MI) training for clinical staff specializing in the treatment of co-occurring disorders. The training included one full day of refresher courses, offered in both morning and afternoon sessions followed by two comprehensive days dedicated to advanced MI instruction. MI refresher sessions are intended to reinforce participants' existing MI skills and understanding. The following two days provided an in-depth exploration of MI's core principles and techniques, emphasizing essential conversational skills such as open-ended questions, affirmations, reflective listening, and summarization. This training was highly successful, with participants actively participating, equipping clinical teams to better engage and motivate individuals toward active participation in treatment and ultimately improve outcomes for clients with co-occurring disorders.

In addition to MI training, HMA conducted in-person MAT workshops aimed at improving the quality of patient care across Imperial County. These workshops attracted strong participation from key stakeholders, including government and community agencies, law enforcement, primary care providers, and ICBHS staff. Furthermore, ICBHS and HMA facilitated two in-person train-the-trainer sessions for ICBHS direct service staff, correctional officers, and probation officers. These sessions focused on the conceptualization and treatment of substance use and co-occurring disorders, MAT, stigma reduction, and harm reduction strategies.

Funding for these training events and ongoing consultations provided by HMA have been supported through the California Department of Health Care Services (DHCS) via State Opioid Response Grants awarded by Substance Abuse and Mental Health Services Administration (SAMHSA).

f. Youth Opioid Response Grant 3

ICBHS has actively participated in the California Youth Opioid Response (YOR) grant program, receiving consecutive funding through Rounds 3 and 4 under the State Opioid Response (SOR III) initiative to address the rising prevalence of opioid and stimulant use disorders among youth and young adults.

From April 2023 through September 2024, ICBHS implemented YOR Round 3, which provided an initial award of $500,000, along with an additional $142,000 to support expanded outreach and engagement activities in Imperial County. This funding focused on youth and young adults aged 12 to 24 and supported a wide range of services, including outreach, education, community engagement, harm reduction, early intervention, and youth-specific services related to opioid and stimulant use. During this period, ICBHS exceeded its target goals in multiple service delivery areas. These achievements were made possible through strong community partnerships and formalized Memoranda of Understanding (MOUs) with local school districts, which increased access to services in school settings. Additionally, ICBHS made significant efforts to reach the unhoused population by distributing hygiene kits and providing vital mental health and SUD resources.

Building on the success of Round 3, ICBHS was awarded $734,152 on May 1, 2025, by the California Institute for Behavioral Health Solutions (CIBHS) through YOR Round 4. This fourth round of SOR III funding expands the target population to include youth, transitional age youth (TAY), and young adults aged 16 to 25. YOR Round 4 emphasizes a comprehensive, youth-centered approach to addressing the opioid and stimulant crisis. The focus is on expanding access to life-saving medications for opioid use disorder and strengthening all stages of care from prevention and harm reduction to treatment and recovery support for young people affected by opioid and stimulant use disorders.

Together, YOR Rounds 3 and 4 reflect ICBHS’s continued commitment to combating the opioid and stimulant crisis through innovative, collaborative, and culturally responsive strategies aimed at improving the health and well-being of youth and young adults throughout Imperial County.

g. California Opioid Settlement Funds

Imperial County, as a participating California subdivision, will continue to receive opioid settlement funds managed by ICBHS. These funds will be dedicated to opioid care, treatment, and programs addressing misuse, related disorders, and the epidemic’s impacts. ICBHS will prioritize High Impact Abatement Activities (HIAA) to reduce and ultimately end the opioid crisis through care, treatment, outreach, and support services.

On February 25, 2025, Imperial County Behavioral Health Services (ICBHS) entered into an agreement with Health Management Associates (HMA) to support efforts in addressing substance use and mental health needs, enhancing stakeholder engagement and collaboration, and identifying and overcoming resource barriers within Imperial County. As part of this agreement, HMA will provide facilitation services to prioritize the allocation of opioid abatement settlement funds through an impartial and equitable community engagement process. To prepare for upcoming in-person collaborative meetings, ICBHS and

HMA have established a steering committee composed of community agency stakeholders tasked with facilitating discussions and guiding the allocation process.

Together, ICBHS and HMA will host four Community Conversations. These sessions are designed to encourage open dialogue among residents, local leaders, healthcare providers, and other stakeholders, ensuring diverse voices and perspectives are included. The primary goal is to identify the most pressing community needs and to develop effective strategies to address the impact of opioid use and misuse. Through this collaborative and inclusive approach, ICBHS and HMA aim to build a stronger, healthier community by addressing the root causes of opioid use and supporting individuals and families affected by this crisis.

h. PATH Justice-Involved Round 3

ICBHS will provide pre-release behavioral health services to justice-involved individuals beginning 90 days prior to release and continuing post-release from correctional facilities. Pre-release services will include comprehensive assessments and intensive care coordination to ensure continuity of care for individuals identified with mental health or substance use disorders.

In partnership with the Imperial County Sheriff's Office, ICBHS continues to develop an implementation plan to enable the secure seamless data exchange for individuals with a history of mental health and substance use treatment. This plan will streamline referrals, assessments, and care coordination, ensuring incarcerated individuals are effectively linked to appropriate services both before and after release.

Additionally, PATH funds will be utilized to support investments in personnel, infrastructure, and IT systems necessary to facilitate collaborative planning and successful implementation of these pre-release services.

i. BHCIP Round 5: Crisis and Behavioral Health Continuum

On February 19, 2024, ICBHS and DHCS executed a Program Funding Agreement (PFA) for the Behavioral Health Continuum Infrastructure Program (BHCIP) Round 5: Crisis and Behavioral Health Program, providing up to $17,285,302 in grant funding. The funds will be used to establish a 16-bed Adult Residential SUD Treatment Facility with Incidental Medical Services (IMS), designated by DHCS/ASAM as Level of Care 3.5 and Level of Care 3.2 for Withdrawal Management. This facility will address barriers to care and significantly expand local treatment access.

ICBHS meets monthly with Advocates for Human Potential (AHP), contracted by DHCS to provide consulting and oversight, ensuring compliance with construction milestones and project phases. The facility is scheduled for completion by June 30, 2027.

To support project delivery, ICBHS has contracted with Vanir Construction Management, Inc. for project management oversight and assistance in securing a highly qualified construction management entity to execute the project under a progressive design-build model. ICBHS anticipates selecting the construction entity by November 2025, with a groundbreaking ceremony planned for February 2025.

j. Recovery Incentives Program: California's Contingency Management (CM) Benefit

The Recovery Incentives Program is part of California's Contingency Management (CM) Benefit, implemented by ICBHS to support individuals with stimulant use disorders. The program provides financial incentives, in the form of gift cards, to reinforce abstinence from stimulant use, as verified by twice-weekly drug testing over a 24-week period. Participants receive incentives for each drug test that returns a negative result, with increasing rewards for continued abstinence.

ICBHS places strong emphasis on individualized support through consistent counseling that validates participants' progress. Program outcomes are closely monitored, and data is actively used to inform ongoing improvements. The success of the program is further reinforced by counselors who provide continuous encouragement and behavioral support. Through regular affirmations and personalized guidance, counselors play a vital role in sustaining participant motivation and creating a recovery-focused environment.

k. Bond Behavioral Health Continuum Infrastructure Program (BHCIP) Round 1 Launch Ready – Northern Horizons Campus Behavioral Health Expansion:

On May 6, 2025, ICBHS was conditionally awarded the Bond BHCIP Round 1: Launch Ready grant in the amount of $22,405,797.58 to support the Northern Horizons Campus Behavioral Health Expansion Project. The funding from this grant will allow both ICBHS to expand its mental health and SUD services in the north-end area of Imperial County to address the urgent needs in the care continuum for people with mental health and substance use conditions including unhoused individuals, veterans, older adults and adults with disabilities. By addressing these needs, ICBHS will foster a healthier environment, reduce stigma, and promote recovery and resilience among those individuals living with both mental health and SUDs.

Through this project, ICBHS plans to renovate a county owned site at 220 E. Main Street, Brawley, California 92227 by constructing and utilizing a campus-type model that will provide multiple levels of care on the continuum by providing accessible, community-based, and client-centered behavioral health services that offer both immediate support and long-term care. By co-locating SUD and mental health treatments within a one site. The Northern Horizons Campus will deliver integrated, whole-person care through intensive outpatient programs, effectively addressing significant behavioral health service gaps in this underserved community.

l. Recovery Residence for women and parenting women:

On January 7, 2025, ICBHS executed an agreement with Open Door Ministry for the Broken (ODM), an organization that provides recovery residences for women and parenting women aged 18 and older, undergoing medically necessary treatment for SUD or recovery services. The ministry offers a stable, safe, and drug and abstinent living environment essential for supporting clients' recovery journeys.

ODM maintains a safe clean setting that helps reduce relapse risk, supports recovery and treatment maintenance, and assists clients in fulfilling probation or child protective service

requirements. The ODM also aids women in achieving reliable income and successfully reintegrating them into the community.

In addition to housing and supportive services, ODM offers guidance on accessing community resources for both women and their children. Counseling and mental, emotional, and spiritual support services are available to clients and their families. Furthermore, ODM connects women with external resources, including job training, educational programs, trade schools, health and wellness services, and childcare assistance as needed.

4) Memorandum of Understanding with Manage Care Plans

As the designated SUDS Plan for Imperial County, ICBHS is responsible for delivering SMHS and SUDS to Medi-Cal clients who meet both access and medical necessity criteria. ICBHS is also expected to collaborate with local Medi-Cal Managed Care Plans (MCPs) to coordinate care for Medi-Cal clients who do not meet criteria for SMHS and/or SUDS. In FY 2022–2023, Imperial County transitioned from its previous MCPs—Molina Healthcare and California Health & Wellness—to Kaiser Permanente and the Community Health Plan of Imperial Valley (CHPIV). In FY 2024–2025, Memoranda of Understanding (MOUs) were executed with both new MCPs.

b. Overview of the objectives and planned activities for FY 25-26:

- ICBHS will provide training, as needed to ensure Access Unit complies with requirements for member access, continuity and coordination of care as indicated in BHIN 25-020.
- ICBHS Access Unit will be responsible for implementing Medi-Cal screening and transition of care tools to ensure timely access, appropriate referrals, and coordinated behavioral health services in collaboration with Medi-Cal Managed Care Plans.
- ICBHS Access Unit will ensure consistent implementation of the Transition of Care Tool, including efforts to initiate appropriate transitions from and to MCPs, supported by finalized MOUs and clear referral pathways.
- QM will continue monitoring the implementation and effectiveness of the adult/youth screening and TOC tool for Medi-Cal SMHS to assess consistent implementation and assess whether clients are receiving timely access to medically necessary care.
- ICBHS will update its Policies and Procedures to align with the requirements of BHIN 25-020.
- ICBHS will actively collaborate with local Tribal officials through regular meetings to identify and address service delivery barriers and will implement targeted outreach and culturally responsive presentations to educate the community, enhance service accessibility, streamline referral pathways, and assess treatment needs within Imperial County’s Native American population.
- Partnership with Imperial County Sheriff’s Office, ICBHS will deliver comprehensive pre-release and post-release behavioral health services for justice-involved individuals, initiating care coordination 90 days prior to release and continuing through post-release, in alignment with the CalAIM Justice-Involved Initiative, to support successful community reintegration, reduce recidivism, and improve overall health outcomes.

- ICBHS will continue collaborating with El Centro Regional Medical Center and Pioneer Memorial Hospital to implement a streamlined referral system that ensures timely, efficient access to services and expedites care coordination for clients receiving MAT in emergency departments and urgent outpatient care centers.

- ICBHS will expand countywide outreach and engagement initiatives and strengthen collaborations with key community agencies to increase awareness, promote prevention, and reduce stigma associated with Opioid Use Disorder (OUD), Stimulant Use Disorder (StUD), and other SUDS among youth and adults, fostering earlier intervention and greater access to treatment and recovery supports.

- ICBHS will explore and pursue opportunities to expand recovery housing options in Imperial County to better serve clients with SUD and co-occurring conditions to support clients' recovery, stability, and successful reintegration into the community.

- ICBHS will enhance education, expand resource availability, and strengthen support systems to prevent and address substance use among youth and young adults, with the goal of reducing high-risk behaviors, promoting healthy decision-making, and ensuring timely connection to evidence-based interventions throughout the next academic year.

VI. Provider Complaints and Appeals

The QM Unit monitors provider disputes with ICBHS concerning the request for authorization or payment for SMHS or SUDS. The QM Unit also monitors provider appeals through the written appeals submitted to ICBHS by providers for denial of authorization or payment, or modification of requests for authorization.

a. Update on the objectives and planned activities for FY 24-25:

During FY 24-25, the QM Unit fulfilled SMHS and SUDS provider relations responsibilities, as needed. All providers are encouraged, as outlined in the Provider Handbook, to present complaints to the Provider Relations staff by telephone, in person, or in writing. Provider Relations staff makes every effort to resolve complaints quickly and at the lowest possible level. If providers are not satisfied with the outcome of the complaint process, they are provided information on the appeals process.

In FY 24-25, no complaints were reported to the QM Unit. Similarly, no appeals were submitted. The lack of submission of both complaints and appeals is consistent with previous years. All requests for services requiring prior or concurrent authorization were processed as requested, except for 6 inpatient authorization requests; however, the inpatient providers did not appeal the decision by ICBHS to deny payment.

Meanwhile, in FY 24-25, the current process for providing services that require prior authorization (residential and inpatient) involve the client first being assessed by ICBHS. If it is identified that a client meets the ASAM level of care for residential or inpatient service, ICBHS coordinates referral and admission to an appropriate provider. Therefore, during FY 24-25, there were no requests for authorization of service by a SUDS provider, and subsequently no need for a provider appeal. Likewise, no requests were made by beneficiaries for a service that requires prior authorization. This is a consistent finding over time.

b. Overview of the objectives and planned activities for FY 25-26:

- The Provider Relations staff will provide technical assistance to providers and/or SMHS and/or SUDS staff as needed to resolve complaints at the lowest possible level.

VII. Hospitalization Monitoring

The QM Unit tracks and monitors the admission and readmission of the SMHS inpatient psychiatric hospitalizations to identify any potential quality of care issues. Additionally, the QM Unit also conducts chart reviews for all hospitalizations to ensure SMHS complies with the care coordination standards outlined in Procedure 01-115, Hospitalization Discharge/Placement Coordination. The QM Unit also tracks and monitors the admission and readmission of beneficiaries hospitalized for SUD-related issues to identify any potential quality of care concerns or emerging trends.

a. Update on the objectives and planned activities for FY 24-25:

1) Inpatient Psychiatric Admissions

During FY 24-25, there were 162 Medi-Cal beneficiaries, and 60 non-Medi-Cal clients hospitalized, for a total of 292 admissions, which is a decrease from the previous fiscal year. A comparison of prior fiscal years is included below:

Table 8.1 Inpatient Psychiatric Admissions

Review Period	# of Clients Hospitalized			# of Admissions		
	Medi-Cal	Non Medi-Cal	Total	Medi-Cal	Non Medi-Cal	Total
FY 24-25	162	60	222	227	65	292
FY 23-24	177	63	240	232	72	304
FY 22-23	80	77	157	112	93	205

Of the 292 admissions during FY 24-25, 169 (58%) were active clients receiving services from ICBHS at the time of the hospitalization. The status by division is as follows:

- Children Services – 12 (4%) active clients at time of hospitalization.
- Youth & Young Adults Services – 27 (9%) active clients at time of hospitalization.
- Adults Services – 77 (26%) active clients at time of hospitalization.
- Mental Health Triage & Engagement Services – 53 (18%) active clients at time of hospitalization, 123 (43%) were inactive with ICBHS and assigned for follow-up.

2) *Inpatient Psychiatric Readmissions*

Of the 292 admissions during FY 24-25, 70 were readmissions. ICHBS overall readmission rate is 24 percent. This is an increase from FY 23-24 when the readmission rate was 15 percent.

There were 19 readmissions that occurred within 30 days of discharge, resulting in a 7 percent 30-day readmission rate. This is a decrease from FY 23-24 when the 30-day readmission rate was 15 percent. The table below summarizes the ICBHS inpatient psychiatric readmissions:

Table 8.2 Inpatient Psychiatric Readmissions			
Review Period	**FY 22-23**	**FY 23-24**	**FY 24-25**
Total Readmissions	48	47	70
Total Admissions	205	304	292
Readmission Rate	**23%**	**15%**	**24%**
Readmissions Within 30 Days	33	26	19
Total Admissions	205	304	292
30-Day Readmission Rate	**16%**	**15%**	**7%**

3) *Hospital Chart Reviews*

The QM Unit is responsible for conducting hospitalization chart reviews to monitor if the ICBHS is following established policies and procedures regarding hospitalization discharge planning and placement coordination. This allows the QM Unit to determine whether or not clients are receiving the appropriate follow up care after a psychiatric hospitalization and implement corrective interventions if necessary.

During FY 24-25, the QM Unit reviewed 126 hospitalizations: 61 for Adults Services, 24 for YAYA Services, 14 for Children Services, and 27 for Mental Health Triage and Engagement Services. A review tool with the following three categories was utilized: 1) Hospitalization Monitoring; 2) Hospitalization Discharge Planning; and 3) After Hospitalization Discharge Summary. The QM Unit identified the following as areas for improvement:

<u>Hospitalization Monitoring</u>

- Present case during treatment team meetings to care coordinate and receive treatment recommendations and/or changes after the inpatient psychiatric treatment. *(Repeat finding from FY 23-24)*

<u>Hospitalization Discharge Planning</u>

- Contact the hospital staff to ensure the client is discharged with sufficient medication supply. *(Repeat finding from FY 23-24)*
- Complete the Hospital Discharge Summary to ensure discharge instructions and/or recommendations are followed by other service providers to coordinate treatment. *(Repeat finding from FY 23-24)*
- Contact client and/or support person (s) the same day of discharge (via phone or face-to-face) to verify a smooth transition between levels of care.
- Inform client /support person of scheduled appointments to ensure continuity of care and avoid a readmission.

After Hospitalization Discharge Care

- Conduct a home visit/Zoom appointment within 3 business days of discharge and complete a thorough assessment (mental status, adherence to medication, coordination of care and/or needed referrals). *(Repeat finding from FY 23-24)*
- Present case during treatment team meetings to care coordinate and receive treatment recommendations and/or changes after the inpatient psychiatric treatment.
- Is there evidence the treatment plan was updated or at least reviewed as a result of the client's hospitalization

Opportunities for improvement were also identified at the division level. The deputy directors were provided with individual reports by division to implement appropriate interventions to address areas of concern.

4) Follow-Up After Hospitalization for Mental Illness (FUH)

Follow-up after hospitalization for mental illness is a HEDIS measure that assesses the percentage of inpatient discharges for diagnosis of mental illness or intentional self-harm among patients age 6 years and older that resulted in follow-up care with a mental health provider within 7 days and 30 days. Monitoring for timeliness of follow-up after hospitalization is essential as individuals hospitalized for mental health disorders often do not receive adequate follow-up care. By receiving appropriate and timely follow-up care, clients are more likely to have positive outcomes and have a reduced risk for readmission to a hospital.

During FY 24-25 the QM Unit monitored the timeliness to first service appointment after a hospitalization, after hospitalization, as ICBHS has established a standard of providing a first service SMHS appointment within 7 business days of discharge for all clients who are hospitalized.

The monitoring process entailed collecting data for all clients who are discharged from a psychiatric hospital. The data sources utilized are the Payment Authorization Unit Hospitalization Log, which identifies the clients who were hospitalized, their date of admission, and their date of discharge, and the EHR, which includes documentation regarding clients' treatment history, claims, and the date of the first psychiatric appointment and other appointments scheduled.

During FY 24-25, there were 292 hospitalizations. Of those, 97 clients did not receive a SMHS follow-up appointment with ICHBS due to the clients non-adhering toward services (45%); re-admitted back to inpatient psychiatric hospital (18%); residing out of county (19%); refusing services (5%); or other reasons (13%).

Of the 195 clients that received follow-up appointments, 126 (65%) were actively receiving SMHS services from ICBHS and 69 (35%) were not. The average waiting time to receive an appointment was 3 days for active clients and inactive clients.

During FY 24-25, ICBHS was 63 percent compliant in meeting the standard for scheduling a follow-up appointment within 7 business days after a hospitalization, which is a slight increase from the previous year.

Of the 195 clients that received a follow-up appointment during FY 24-25, 6 percent received an appointment within 8 to 30 days after hospitalization.

A comparison of prior years is included below:

Table 7.3 Timeliness of First Service Appointment After a Hospitalization					
Active Clients					
Review Period	**Clients Hospitalized**	**Received F/U Appt. in 7 Days**	**Received F/U Appt. in 8-30 Days**	**Avg. Wait Time For Appt.**	**Compliance Rate**
FY 24-25	170	121	5	3 days	71%
FY 23-24	185	126	8	3 days	68%
FY 22-23	86	70	85	5 days	84%
Inactive Clients					
Review Period	**Clients Hospitalized**	**Received F/U Appt. in 7 Days**	**Received F/U Appt. in 8-30 Days**	**Avg. Wait Time For Appt.**	**Compliance Rate**
FY 24-25	122	62	7	3 days	51%
FY 23-24	119	60	5	3 days	50%
FY 22-23	32	22	30	10 days	69%

5) SUD Related Hospitalizations

The QM Unit monitoring process consisted of collecting data related to hospitalizations from the ICBHS SUD Hospitalizations Log. The log records the number of hospitalizations, the client' status (active/inactive) at ICBHS at time of hospital admission, the number of days the client was hospitalized, the number of ICBHS program episodes prior to the hospitalization as well as ASAM level of care, and the timeliness of follow-up care after hospital discharge. If any hospitalizations are reported, the QM Unit will investigate the efforts made to prevent the hospitalization.

During FY 24-25, there were 5 hospitalizations made by SUD treatment programs, which is a decrease from prior years, as indicated below:

Table 7.4 Hospital Admissions & Readmissions						
Review Period FY	**Adolescent SUD Program**		**Adult SUD Program**		**Total**	
	Admissions	**Readmissions**	**Admissions**	**Readmissions**	**Admissions**	**Readmissions**
24-25	0	0	5	0	5	0
23-24	1	0	5	0	6	0
22-23	4	1	11	0	14	1

The average hospitalization timeframe for the Adult SUD programs was 1 day. After hospitalization, the average timeframe for follow-up care was within 2 days.

Current efforts being implemented by the county-operated SUD treatment programs to prevent hospitalization involve assessing clients in a consistent and timely manner upon admission and throughout the course of treatment as needed. For those individuals engaging in high-risk behaviors, clinical staff provide additional support, such as care coordination, to reduce the risk of emergencies and hospitalizations. Additionally, ICBHS continues to collaborate with local hospitals to effectively coordinate treatment for clients requiring SUD and MAT services.

b. Overview of the objectives and planned activities for FY 25-26:

- The QM Unit will investigate why the number of inpatient psychiatric hospital admissions increased by nearly 50 percent from FY 22-23 to FY 23-24.
- SMHS will provide training to providers to ensure a home visit or Zoom appointment is provided to clients within 3 business days of discharge from an inpatient psychiatric hospital.
- The QM Unit will calculate timeliness of first follow-up after hospitalization for mental illness by measuring against the first service provided to the client, regardless of the service type.
- SUDS will continue to assess clients throughout the course of treatment and provide timely interventions to prevent avoidable hospitalizations.
- The QM Unit will continue conducting chart reviews and other monitoring activities to identify relevant clinical issues affecting beneficiaries, including safety and effectiveness of medication practices and quality of care concerns.
- The ICBHS SUD programs will implement interventions to ensure service coordinators collaborate with residential staff throughout treatment, schedule follow-up appointments within 7 days of discharge, and utilize discharge summaries to support beneficiaries in maintaining sobriety.

VIII. No Show Rates

To maximize service delivery capacity and expand service delivery, the QM Unit monitors, tracks, and analyzes the no-show rates for SMHS services delivered by psychiatrists, clinicians, and nurses, as well as for SUDS services including ASAM assessments, MAT, and individual counseling appointments. Data related to these services was collected from the EHR to evaluate client engagement in services and identify possible barriers to treatment or causes of non-adherence.

As part of this effort, the QM Unit presented no-show data to the QIC, highlighting key reasons for considering the adoption of a lower no-show benchmark across all appointment types. The proposal included an approach targeting incremental improvements of 5% until the new benchmark was achieved; however, the QIC decided to place this initiative on hold, and no changes to the existing no-show benchmarks will be implemented at this time. In addition, the QM Unit conducted an analysis to identify the causes of high no-show rates in youth services, which involved administering 80 surveys via mail and phone to gather insight into reasons behind youth clients missing scheduled appointments, though only minimal responses were received.

a. Update on the objectives and planned activities for FY 24-25:

1) Psychiatric No Show Rates

a) No Show Rates to Initial Psychiatric Assessments (IPA)

ICBHS no show rate to IPA was 23 percent during FY 24-25, which is a decrease from 25 percent in FY 23-24. The Children, Adults, and Mental Health Triage & Engagement Services divisions exceed their no-show benchmarks. Trends for the divisions were identified

at the program level and were shared with management. The current benchmarks by division are as follows:

- Children Services – 18 percent
- YAYA Services – 25 percent
- Adults Services – 23 percent
- Mental Health Triage & Engagement Services – 16 percent

The results by division are summarized below:

Table 8.1 No Show Rates - Initial Psychiatric Assessment

Review Period	Children Services		Youth & Young Adults Services		Adults Services		MHTES		ICBHS Total	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rates	No Show Appts.	No Show Rate
FY 24-25	86	21%	126	24%	223	25%	139	19%	574	23%
FY 23-24	105	19%	129	24%	355	33%	121	19%	710	25%
FY 22-23	63	23%	63	24%	71	19%	13	7%	210	19%

b) No Show Rates to Medication Support Appointments

The no show rate to psychiatrist medication support appointments was 21 percent during FY 24-25, which is a decrease from 22 percent in FY 23-24. The Youth & Young Adults Division exceeded its no-show benchmark. Trends for the divisions were identified at the program level and were shared with management. The current benchmarks by division are as follows:

- Children Services – 18 percent
- YAYA Services – 22 percent
- Adults Services – 23 percent

The results by division are summarized below:

Table 8.2 No Show Rates - Psychiatrist Medication Support Appointments

Review Period	Children Services		Youth & Young Adults Services		Adults Services		ICBHS Total	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	589	17%	690	24%	1,709	22%	2,988	21%
FY 23-24	861	18%	895	24%	2,575	23%	4,331	22%
FY 22-23	399	14%	380	18%	742	15%	1,521	15%

2) Clinician No Show Rates

a) No Show Rates to Intake Assessments

ICBHS no show rate to SMHS initial intake assessment was 28 percent during FY 24-25, which is a slight increase from 27 percent in FY 23-24. The Children's, Adults and Mental Health Triage & Engagement Services divisions exceeded their no-show benchmark. Trends

for the Children's, Adults and Mental Health Triage & Engagement Services divisions were identified at the program-level and were shared with management. The current benchmarks by division are as follows:

- Children Services – 20 percent
- YAYA Services – 30 percent
- Adults Services – 30 percent
- Mental Health Triage & Engagement Services – 26 percent

The results by division are summarized below:

Table 8.3 No Show Rates – Intake Assessment

Review Period	Children Services		Youth & Young Adults Services		Adults Services		Mental Health Triage Engagement Services		ICBHS Total	
	No Show Appts	No Show Rate	No Show Appts	No Show Rate	No Show Appts	No Show Rate	No Show Appts	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	352	22%	242	23%	549	31%	441	35%	1,584	28%
FY 23-24	345	20%	322	25%	544	33%	327	34%	1,538	27%
FY 22-23	170	20%	157	27%	230	29%	152	31%	709	26%

b) *No Show Rates to Psychotherapy Appointments*

ICBHS no show rate for SMHS psychotherapy appointments was 20 percent during FY 24-25, which is an increase from 19 percent in FY 23-24. All divisions met their benchmarks for FY 24-25. The current benchmarks by division are as follows:

- Children Services – 20 percent
- YAYA Services – 25 percent
- Adults Services – 18 percent

The results by division are summarized below:

Table 8.4 No Show Rates – Psychotherapy Appointments

Review Period	Children Services		Youth & Young Adults Services		Adults Services		ICBHS Total	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	1,524	18%	1,452	23%	639	18%	3,633	20%
FY 23-24	1,426	17%	1,186	22%	579	19%	3,191	19%
FY 22-23	365	13%	282	24%	108	9%	755	15%

3) *Nurse No Show Rates*

a) *No Show Rates to Nursing Evaluations*

ICBHS no show rate to SMHS nursing evaluations was 20 percent during FY 24-25. The Children's division exceeded their no-show benchmark. Trends were identified at program level and were shared with management. The current benchmarks by division are as follows:

- Children Services – 15 percent
- YAYA Services – 22 percent
- Adults Services – 25 percent
- Mental Health Triage & Engagement Services – 17 percent

Effective FY 24-25, the no-show rate for nursing evaluations only included initial nursing assessments. The annual nursing assessments were not included, as they are no longer tracked by ICBHS.

The results by division are below:

Table 8.5 No Show Rates – Initial Nursing Evaluations

Review Period	Children Services		Youth & Young Adults Services		Adults Services		Mental Health Triage Unit		ICBHS Total	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	126	18%	125	20%	273	25%	131	16%	655	20%
FY 23-24	424	14%	590	26%	669	17%	188	20%	1,871	18%

b) *No Show Rates to Medication Support Appointments*

ICBHS no show rate to SMHS nurse medication support appointments was 13 percent during FY 24-25, which is a decrease from 17 percent in FY 23-24. All divisions met their benchmark and no trends were identified. The current benchmarks by division are as follows:

- Children Services – 22 percent
- YAYA Services – 25 percent
- Adults Services – 25 percent
- Mental Health Triage & Engagement Services – 25 percent

The results by division are summarized below:

Table 8.6 No Show Rates – Nurse Medication Support Appointments

Review Period	Children Services		Youth & Young Adults Services		Adults Services		ICBHS Total	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	1,009	13%	1,007	20%	1,705	11%	3,721	13%
FY 23-24	918	18%	1,091	25%	991	12%	3,000	17%
FY 22-23	58	12%	76	27%	208	10%	342	12%

4) *ASAM Assessment No Show Rates*

The overall no show rate for ASAM assessment appointments was 34 percent during FY 24-25, which is a decrease from the previous FY, and neither the Adolescent SUD nor the Adult SUD program exceeded their benchmarks. Any trends identified at the program level were shared with management. The current benchmarks for ASAM assessment appointments are as follows:

- Adolescent SUD Program – 40 percent
- Adult SUD Program – 55 percent

The results by program are summarized in the table below:

Table 8.7 No Show Rates – ASAM Assessment

Review Period	Adolescent SUD		Adult SUD		SUD Division	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	62	21%	441	37%	503	34%
FY 23-24	133	38%	545	45%	678	43%
FY 22-23	76	33%	267	40%	343	38%

5) *Individual Counseling No Show Rates*

The overall no show rate for individual counseling appointments was 29 percent during FY 24-25, which is a decrease from the previous FY, neither the Adolescent SUD nor the Adult SUD program exceeded their benchmarks. Any trends identified at the program level were shared with management. The current benchmarks for individual counseling appointments are as follows:

- Adolescent SUD Program – 41 percent
- Adult SUD Program – 50 percent

The results by program are summarized in the table below:

Table 8.8 No Show Rates – Individual Counseling

Review Period	Adolescent SUD		Adult SUD		SUD Division	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	273	25%	1,968	30%	2,241	29%
FY 23-24	373	31%	1,645	35%	2,018	34%
FY 22-23	610	41%	2,325	48%	2,935	46%

6) *MAT No Show Rates*

The overall no show rate for MAT appointments was 40 percent during FY 24-25, which is an increase from the previous FY. While the Adolescent SUD Program did not exceed its benchmark, the Adult SUD Program did with a 40 percent no show rate. Any trends identified at the program level were shared with management. The current benchmarks for individual counseling appointments are as follows:

- Adolescent SUD Program – 50 percent
- Adult SUD Program – 30 percent

The results by program are summarized in the table below:

Table 8.9 No Show Rates – MAT						
Review Period	Adolescent SUD		Adult SUD		SUD Division	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	14	27%	541	40%	555	40%
FY 23-24	18	33%	774	37%	792	37%
FY 22-23	14	31%	539	34%	553	34%

While the SUD programs have generally demonstrated improvement in appointment show rates during FY 24–25, the established benchmarks remain high, and in some cases—such as with MAT—no-show rates continue to be significantly elevated. This suggests that, despite progress, challenges with client engagement persist and warrant further analysis and targeted interventions.

b. Overview of the objectives and planned activities for FY 25-26:

- QM Unit will continue to monitor and analyze no-show rates for SMHS and SUDS and will report findings to QIC.

- SMHS and SUDS will implement targeted interventions with the goal of increasing client engagement and decreasing no show rates.

PERFORMANCE IMPROVEMENT PROJECTS

IMPERIAL COUNTY
Behavioral Health Services
MENTAL HEALTH & SUBSTANCE USE RECOVERY

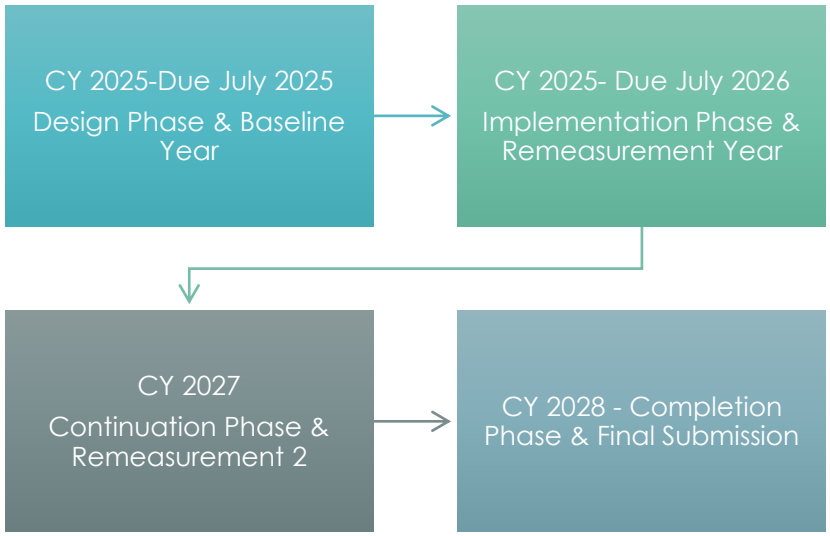
Performance Improvement Projects

I. Service Delivery Capacity

QIC oversees the development of clinical and non-clinical Performance Improvement Projects (PIPs). The QIC reviews data indicating the need for quality improvement activities, taking into consideration recommendations made by the QM Unit, and selects the PIPs and the individuals assigned to participate in a PIP taskforce. Members of the PIP taskforce are responsible for developing the PIPs, collecting and analyzing data, developing goals and key performance indicators, implementing interventions, and measuring outcomes. Progress on each PIP is presented during the monthly QIC meetings and to the Health Services Advisory Group (HSAG) who serve as the External Quality Review Organization (EQRO) during the annual external quality review.

The California Department of Health Care Services (DHCS) requires ICBHS SMHS and SUDS to implement two performance improvement projects (PIPs) per contract—one clinical and one nonclinical. Additionally, DHCS has instructed the County to discontinue any previously mandated PIPs. The new PIPs will commence in 2025, with the first annual submission due in July 2025, and conclude in 2027, with the final annual submission due in July 2028. ICBHS has been provided with two nonclinical and two clinical PIP topics to choose from for the next three years.

The QIC selected to focus on a Nonclinical PIP focusing on increasing the percentage of clients who receive at least one Peer Support Service and on al Clinical PIP focusing on improving the rate of Follow-Up After Emergency Department Visit for Mental Illness and/or Substance Use. The table below is the PIP timeline overview for the next three years:



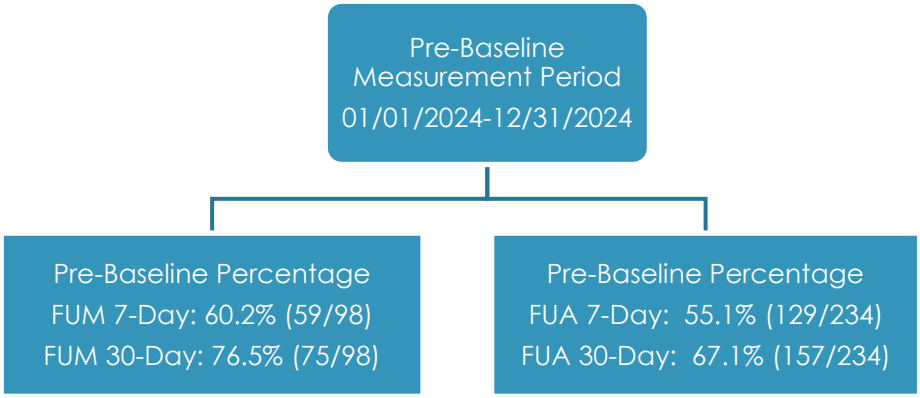
a. Update on the objectives and planned activities for FY 24-25:

1) SMHS & SUDS Clinical PIP: Follow-Up After Emergency Department Visit for Mental Illness (FUM) & Follow-Up After Emergency Department Visit for Substance Use (FUA)

The aim of the Clinical PIP is to determine whether targeted interventions increase the percentage of emergency department (ED) visits for clients 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm and clients 13 years and older with a principal diagnosis of substance use disorder or any diagnosis of drug overdose who receive a follow-up visit within 7 and 30 days of the ED visit. These follow-up measures are formally known as Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA).

The FUM and FUA are apart from the Behavioral Health Accountability Sets (BHAS) designated by the Department of Health Care Services (DHCS) for annual reporting by County Behavioral Health Plans. These measures aim to promote post-ED coordinated care; improve engagement in outpatient services; and reduce readmissions by addressing the needs of clients most at risk of disengagement from care. The target for these measures is set at the 50th percentile national performance rate or a 5% improvement over baseline if the current rate already exceeds the 50th percentile.

In July 2025, ICBHS submitted the required design phase and baseline year template to HSAG. The table below reflects the Pre-Baseline Measurement Period and Percentage for 1/1/2024 through 12/31/2024 for ICBHS



To lead the 3-year Clinical PIP initiative, ICBHS established a PIP Workgroup Committee, which convenes monthly to monitor progress, review performance data, and address implementation challenges. The QIC met on July 10, 2025, and agreed to implement an intervention centered around developing a mental health and substance use educational video to guide patients discharged from the ED toward a pathway for continuous care with ICBHS. The video is intended to make information more accessible, engaging, and easier to understand, while increasing motivation among individuals to follow up with aftercare services post ED.

ICBHS is working collaboratively with CalMHSA who have been providing technical assistance for the Clinical PIP. SMHS and SUDS will continue to move forward with increasing the percentage of emergency department (ED) visits for clients 6 years of age and older with a

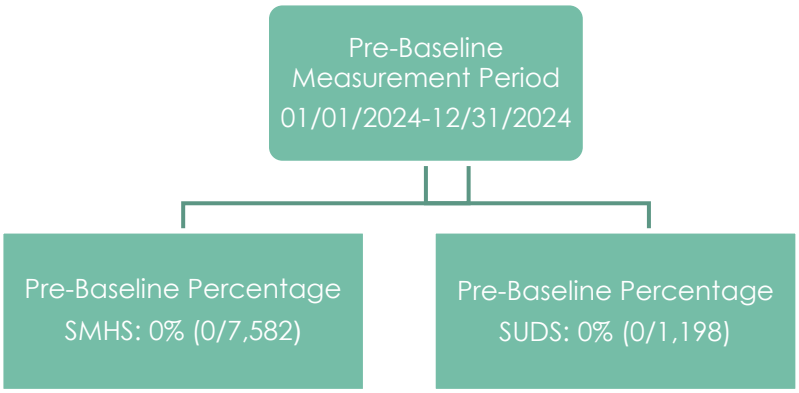
principal diagnosis of mental illness or intentional self-harm and 13 years and older with a principal diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose, for which the client received a follow-up visit within 7 and 30 days of the ED for FY 25-26.

2) ***SMHS & SUDS Nonclinical PIP: Increase the percentage of clients who receive at least one Peer Support Service***

The aim of the Nonclinical PIP is to determine whether targeted interventions increase the percentage of clients accessing SMHS and SUDS who also receive at least one peer support service provided by a certified peer support specialist during the reported remeasurement period.

Peer Support Services are culturally competent, strength-based individual and group interventions that promote recovery, resilience, engagement, and self-advocacy. These services include structured coaching to help set and achieve recovery goals, prevent relapse, enhance community and family support, and link clients and their families to community resources. Services can be delivered in both clinical and non-clinical settings and may involve family or support people, even in the client's absence, if clinically appropriate and centered on the client's recovery. Peer Support Specialists must pass an exam covering 17 Core Competencies, with certification administered by CalMHSA. Certified specialists are recognized under the Medi-Cal Peer Benefit by participating counties in agreement with DHCS.

In July 2025, ICBHS submitted the required design phase and baseline year template to HSAG. The table below reflects the Pre-Baseline Measurement Period and Percentage for 1/1/2024 through 12/31/2024 for ICBHS



SMHS and SUDS baseline is zero as there are no Peer Support Services being offered at this

To lead the 3-year Nonclinical PIP initiative, ICBHS established a PIP Workgroup Committee, which convenes monthly to monitor progress, review performance data, and address implementation challenges. This PIP aims to strengthen engagement and retention in behavioral health services through the integration of Peer Support Services.

On March 24, 2025, ICBHS submitted its Peer Support Services Opt-In letter to DHCS. Approval was granted, allowing ICBHS to begin rendering and billing for Peer Support Services effective July 1, 2025.

As of July 2025, the following staff have successfully completed Peer Support Specialist certification: three direct service providers and one administrative staff member from the Mental Health Triage & Engagement Services Division, two administrative staff from the Youth and Young Adult Division, and one direct service provider and one administrative staff member from SUDS.

The QIC met on July 10, 2025, the Quality Improvement and agreed to implement an intervention centered in having the Peer Support Specialists focus on engaging clients prior to appointments for the purpose of reducing missed appointments.

ICBHS is working collaboratively with CalMHSA who have been providing technical assistance for the Nonclinical PIP. ICBHS will continue to move forward with increasing the percentage of clients who receive at least one Peer Support Service for FY 25-26.

b. Overview of the objectives and planned activities for FY 25-26:

- SMHS and SUDS will implement targeted interventions to increase the percentage of eligible emergency department (ED) discharges that receive a follow-up visit within 7 and 30 days of the ED encounter.
- SMHS and SUDS will continue to work with the local MCPs to establish data exchange processes to better coordinate care for Imperial County Medi-Cal beneficiaries who are accessing the local EDs for a mental illness and substance use disorders.
- ICBHS and SUDS will implement intervention focused on pre-appointment client engagement**,** led by certified Peer Support Specialists**,** with the goal of increasing the percentage of clients who receive at least one Peer Support Service during FY 2025–2026.
- QM will continue to produce quarterly No-Show reports for targeted programs. Trends will be analyzed to compare no-show rates pre- and post-intervention to evaluate the effectiveness of Peer Support Services.
- QM will continue to work with the Clinical and Nonclinical PIP workgroup committees, contributing to discussions on data trends, barriers to success, intervention strategies, and quality findings.
- QM will continue to collaborate with CalMHSA to ensure PIP interventions are consistent with statewide standards and BHAS metric requirements, providing technical input to maintain fidelity and compliance.
- QM will ensure that all PIP narratives, data summaries, performance analyses, and evaluation components are completed accurately and submitted according to DHCS timelines and format specifications.

- QM will work with the Information Systems (IS) team to design and implement tracking mechanisms within the Electronic Health Record (EHR) system, supporting accurate and automated data pulls for FUM, FUA, and Peer Services.

CULTURAL & LINGUISTIC COMPETENCE

IMPERIAL COUNTY
Behavioral Health Services
MENTAL HEALTH & SUBSTANCE USE RECOVERY

Cultural and Linguistic Competence

ICBHS utilizes the Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards as the framework for its Cultural Competence Plan. The Cultural Competence Plan outlines the department's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, and gender identity. As part of the Cultural Competence Plan, ICBHS will select specific training courses to increase the knowledge and proficiency of staff and evaluate the cultural and linguistic competence of services and staff through continuous QI activities.

a. Overview of the ICBHS objectives and activities for FY 24-25:

I. Continuous Quality Improvement Plan

The QM Unit monitored the existing state mandated cultural and linguistic competence requirement under the QI Program. The process for monitoring entailed: 1) ensuring proficiency of staff and interpreters; 2) reviewing and assisting with updating ICBHS Cultural Competence Plan; and 3) monitoring the process for incorporating relevant cultural competence standards, such as access, quality of care, and quality management, into the QI Work Plan for FY 24-25. These QM monitoring activities support and foster a philosophy that attaining cultural and linguistic competence is an ongoing developmental process, which was designed around the framework of the CLAS Standard, as indicated in the Cultural Competence Plan.

a) Proficiency of Staff

Cultural Competence Training Plan

The QM Unit produced an annual Cultural Competence Training Plan, which includes all training activities planned for the fiscal year for mental health and SUD program staff. The training plan includes a description of each training, audience, and proposed schedule. The plan is used by management to deliver effective training as well as meet the requirements of the Cultural Competence Plan.

Cultural Competence Training Report

The QM Unit produced an annual Cultural Competence Training Report summarizing training activities for the fiscal year for mental health and SUD program staff. The data is used by management to assess the department's attempt to deliver effective training as well as monitor the progress towards meeting requirements of the Cultural Competence Plan.

During FY 2024–2025, the Quality Management (QM) Unit monitored ICBHS's compliance with the annual requirement for all staff to attend at least one cultural competence training. Of the 586 ICBHS employees, 94.54% (554 staff) successfully completed the training. An additional 4.95% (29 staff) did not fulfill the requirement, while 0.51% (3 staff) were either on medical leave or

recently hired. The QM Unit will continue to monitor these individuals to ensure that all employees complete the required cultural competence training.

Client Culture Training

ICBHS provided the Client Culture Training and the Client Culture Refresher Course to ~~221~~ 88 SMHS and SUDS program staff during FY 24-25. These trainings provide staff with an understanding that consumers of behavioral health services have a set of values, beliefs, and lifestyles that are developed as a result of their own personal experiences with mental illness, the mental health system, and their own ethnic culture. The trainings covered areas such as definitions of client culture, three levels of staff cultural competence, stigma and anti-stigma facts, discrimination and social distance, early steps in the recovery movement, recovery definitions and SAMHSA is guiding principles of recovery, among other topics.

Language Assistance Services Training

During FY 24-25, the Access Unit supervisor provided two training courses to approximately 16 staff from the Access Unit and after-hours staff. The Access Unit supervisor provided training to SUD program and mental health staff on the use of language assistance services, policies, and procedures in order to improve staff knowledge of how to utilize language assistance services.

Transgender, Gender-Diverse, and Intersex (TGI) Cultural Competency Training

California law (SB 923, 2022) requires behavioral health providers to complete mandatory cultural competency training focused on serving Transgender, Gender-Diverse, and Intersex (TGI) individuals. The training equips providers with the knowledge and skills to deliver inclusive, respectful, and affirming care by covering topics such as gender diversity, appropriate use of names and pronouns, reducing stigma and discrimination, and addressing the unique behavioral health needs of TGI communities. This requirement helps ensure compliance with state law while also supporting equitable, high-quality behavioral health services that improve engagement, trust, and outcomes for TGI clients.

During FY 24-25, the identification of a TGI training called The TGI Affirming Care & Equity Training offered by OutCare commenced with only 2 staff passing. The training requirement for all affiliated service providers is to be completed by July 31, 2025, with renewals required every 2 years.

b) Proficiency of Interpreters

Interpreter Training for Staff and Interpreters

In an effort to ensure that staff have the proper skills and knowledge to provide accurate interpretation from one language to another, the ICBHS contracted with the National Latino Behavioral Health Association (NLBHA) to provide the Behavioral Health Interpreter Training. During FY 24-25, one interpreter training course took place via Zoom on May 12-15, 2025, for 27 staff.

The interpreter training focused on many areas, including the complexity of language and how there are different communication styles within each cultural group. The training covered the verbal and non-verbal communication styles used by some cultural groups and how important it is to understand each communication styles in order to convey the right message, as well as how many cultures reflect either a high context (telling the whole story, indirect) or low context (straight forward, direct) style of communication. Understanding the high and low context styles is crucial to the interpreter as it presents challenges for an interpreter who works with both.

In addition, the training covered the important roles of an interpreter: as a clarifier, the interpreter helps simplify technical terms; as a cultural broker, the interpreter provides cultural information to improve communication; as an advocate, the interpreter works on behalf of the client when their needs are not being met; and as a conduit, the interpreter provides verbatim or word for word interpreting and, as much as possible, not changing the message.

New Employee Orientation (Cultural Competence Training Course)

The ICBHS Center for Clinical Training continued to implement an eLearning cultural competence training course for new hires during FY 24-25. This training course allows newly hired staff to understand what cultural competence is and how ICBHS implements the National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards in the department and our community. During FY 24-25, 147 staff received the new employee orientation eLearning course.

County Formal Testing Process

In an effort to ensure bilingual staff are proficient in the Spanish language, the County of Imperial has a formal testing process in place. The County's Department of Human Resources and Risk Management provides a written literacy test, which must be passed in order to be deemed bilingual and receive bilingual differential pay. As of June 30, 2025 a total of 258 ICBHS employees who utilize a language other than English when performing work duties through the mental health, substance use disorders, and administrative programs have passed the written literacy test.

c) *Cultural Competence Taskforce*

ICBHS has a Cultural Competence Taskforce (CCTF) committed to promoting the delivery of services and provision of information to residents of Imperial County in a manner that is responsive to and respectful of the individual attitudes, beliefs, customs, and practices of the various cultural and ethnic groups we serve.

In FY 24-25, CCTF continued its work toward achieving its CY 2025 goals, which are based on the Culturally and Linguistically Appropriate Services (CLAS) Standards of Care. The CLAS Standards are intended to advance health equity, improve quality of care, and eliminate health disparities by establishing a blueprint for health and healthcare organizations. A complete report of activities is included in the 2025 Annual Cultural Competence Plan. Some of the CCTF achievements include:

- The QM Unit conducted random test calls, during business and after hours, in both English and Spanish, the County's threshold language. During FY 24-25 the QM Unit followed the DHCS Protocol when conducting random test calls. The Access Logs were also reviewed to verify the test calls were logged, as required.

  Test callers assessed Access Unit Staff's knowledge in the following areas: 1) language capability, 2) material alternative format, 3) request for TTY/TDY services 4) request for Interpreters Services, 5) Provider Directory and/or Beneficiaries Handbook was available upon request. The test calls are made at random times of the day and days of the week, verified that the 24-hour-toll-free telephone line was in operation 24 hours a day, seven-days a week.

  During FY 24-25, the QM Unit conducted a total of 52 test calls, 30 during business hours and 22 after-hours. The Access Unit was 100 percent compliant when providing services, including language capabilities.

- During FY 24-25, the translation subcommittee reviewed four documents to ensure the accuracy of translation and cultural appropriateness. The following documents were reviewed and approved: SmartCare Forms (Consent for email, Service Notes, Coordinated Care Consent, and Mental Health Exam). The CCTF subcommittee reviewed the forms and recommendations were provided to the appropriate program.

d) *Cultural Competence Plan Update*

In an effort to ensure that quality assurance activities were incorporated into the Cultural Competence Plan (CCP), the QM Unit participated in the revision of the CCP Plan. During FY 24-25, the QM Unit prepared a CCP Update, which included the activities conducted by ICBHS CCTF. The CCP is updated annually as required.

e) *Other Activities*

<u>Informing Clients of Their Right to Language Assistance Services</u>
In order to inform clients of the availability of language assistance services, ICBHS displays posters that provide information on the interpreter services available through Language Line

Solutions at all mental health and SUD clinics. Additionally, upon admission for treatment, all clients enrolling in a mental health or SUD clinic are informed by staff of the availability of interpreter services. Services are also offered by bilingual staff, as 89 percent of the workforce is bilingual, and 88 percent is proficient in the Spanish language.

During FY 24-25, the Access and Benefits Workers continued to identify clients' primary language when scheduling appointments and logging if interpreter services were needed in languages other than the established threshold language, Spanish. To monitor if services are offered to clients, the Access Unit supervisor reviews the Access Log to ensure that language assistance services are offered to clients requesting them. The QM Unit conducts random test calls to assess if the Access Unit staff offers interpreter services.

Interpreter Services Contracts

In order to facilitate timely access to services, ICBHS contracts interpreter services for in-person and over the phone interpreter services. ICBHS contracts with Deaf Communities of San Diego and Hanna Interpreting Services, independent contractors, for sign language translation and interpretation. In addition, the ICBHS allocates funds for the Language Line Solutions annually to provide interpreters services in languages not spoken by ICBHS staff.

Quality Improvement Committee

The CCTF chairperson participates in the QIC and attends on a monthly basis. The CCTF chairperson reports on activities, any issues/concerns, and progress towards meeting objectives under CLAS Standards on behalf of the CCTF and makes recommendations, as appropriate.

Mental Health Service Act Steering Committee

The CCTF chairperson and other members of the CCTF are members of the Mental Health Services Act (MHSA) Steering Committee. The members actively participate in the planning of MHSA services, ensuring the inclusion of cultural competencies, and provide input and make recommendations, as appropriate. With the passage of Proposition 1 on March 1, 2024, California began transforming the behavioral health system, including transitioning MHSA into the Behavioral Health Services Act (BHSA). The CCTF chairperson will continue to be part of any BHSA committee that is established because of this transformation in support of culturally competent activity planning.

II. Capacity of Service

A profile of the County of Imperial reflects that Hispanics account for 86 percent of the population and 75 percent speak a language other than English at home. The most recent DHCS data indicates Spanish is Imperial County's primary threshold language.

ICBHS ensures that SMHS and SUD services are rendered by staff that are culturally competent and linguistically proficient to meet the needs of the population(s) served. This is measured by an analysis of the Medi-Cal beneficiaries served compared with the data collected annually that evaluates staff's cultural competency.

a) *Number of Clients by Team and Region*

In FY 24-25, the MHP and SUD Divisions provided services to 9,385 (8,388 MHP Division, 997 SUD Division) unduplicated beneficiaries per division. Of these, 86 percent were Hispanic, and 31 percent were Spanish speaking. The distribution by division is included below:

Table 9.1 MHP & SUD Distribution of Beneficiaries and Staff by Division

MHP Division	Number of **Beneficiaries** FY 24/25	Number of ***Staff** FY 24/25	Ethnicity **Beneficiaries** FY 24/25		Ethnicity ***Staff** FY 24/25		Language **Beneficiaries** FY 24/25		Language ***Staff** FY 24/25	
Children Services	2270 (27%)	68 (20%)	89%	Hispanic	90%	Hispanic	47%	Spanish	88%	Spanish
Youth and Young Adult Services	1464 (18%)	47 (14%)	89%		94%		32%		89%	
Adult Services	2969 (35%)	73 (22%)	82%		78%		34%		78%	
Mental Health Triage & Engagement	1685 (20%)	86 (26%)	81%		93%		29%		95%	
SUD Division	Number of **Beneficiaries** FY 24/25	Number of ***Staff** FY 24/25	Ethnicity **Beneficiaries**		Ethnicity ***Staff**		Language **Beneficiaries**		Language ***Staff**	
Adolescent SUD	213 (21%)	29 (9%)	94%	Hispanic	93%	Hispanic	25%	Spanish	83%	Spanish
Adult SUD	784 (79%)	49 (15%)	80%		88%		16%		92%	

Staff data was collected for comparison from the Staff Cultural Competency Survey 2025, excluding "Administration and Network " staff.

Children Services: 90 percent of Children Services division staff were Hispanic with 88 percent fluent in Spanish. In addition, 66 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Youth and Young Adults Services: 94 percent of Youth and Young Adults Services division staff were Hispanic with 89 percent fluent in Spanish. In addition, 72 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Adults Services: 78 percent of Adults Services division staff were Hispanic with 78 percent fluent in Spanish. In addition, 62 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Mental Health Triage & Engagement Services: 93 percent of MHTES Services division staff were Hispanic with 95 percent fluent in Spanish. In addition, 72 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Adolescent SUD Services: 93 percent of division staff were Hispanic with 83 percent fluent in Spanish. In addition, 28 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Adult SUD Services: 88 percent of Adult Services direct services staff were Hispanic with 92 percent fluent in Spanish. In addition, 65 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

ICBHS ensures that beneficiaries have access to SMHS and SUDS treatment services that are culturally and linguistically competent by providing information and services in the client's preferred language. ICBHS also ensures that language assistance and interpretive services are available to all beneficiaries upon request. Interpretive services for Spanish speaking beneficiaries are provided by bilingual staff (English and Spanish) and Language Line Services in all programs and clinics. Interpretive services in other languages are also available through Language Line Services. ICBHS also has American Sign Language Interpretive Services available for beneficiaries with speech and/or hearing impairments.

III. Staff Cultural Competence and Linguistic Capabilities

In FY 24-25 the QM Unit assessed the cultural competence and linguistic capabilities of staff by conducting a staff survey. The survey elements included: 1) staff identifying information; 2) ethnicity; 3) language capabilities; 4) interpretation; 5) cultural awareness; and 6) cultural training needs. In an effort to ensure that staff complete and return the survey, ICBHS director has made this a mandatory survey. The survey was conducted during April 2025 for all ICBHS staff and contract providers.

444 surveys were completed by staff, which represents a 70 percent response rate. The total number of surveys includes:

- 82 in administrative services
- 99 in direct services-licensed (includes licensed/registered interns)
- 138 in direct services-unlicensed, and;
- 125 in support services.

A Staff Cultural Competence Survey Report was prepared and included findings for ethnicity, linguistic capabilities, interpretation, cultural awareness, cultural training needs, and self-identified client/family member. The report was presented in two sections: results by function and results by division and function.

The survey results indicate that of the completed surveys, Hispanic/Latino population continues to be the largest portion of the department's population representing 84 percent of the population, while the second highest race, White, accounted for 13 percent. When addressing the language that the staff is competent enough to provide services to clients beside English, Spanish (88%) continues to be the most fluent language among the staff. Staff were also asked to identify if they had provided interpretation services in the last year, 14 percent of the staff reported that they provided interpretation services for clients in the last year.

The survey results also reported staff feeling quite a bit knowledgeable to very knowledgeable of the population staff work with; Hispanic/Latino (236), Mental Health Clients (192), and White (145). Staff

that provide services were also asked if they felt they have received the training(s) they need to be culturally knowledgeable of the population you regular work with to which 59 percent responded agreed or strongly agreed. However, for the remaining staff who expressed a need for training, American Indian/Alaskan Native, Asian/Pacific Islander, Physical Disabilities and Mental Health, and LGBTQ.

28 surveys were completed by contract providers, which represents a 6.3 percent response rate.

The total number of surveys includes:

- 43 percent in direct services-licensed (includes licensed/registered interns), and;
- 57 percent in support services.

The survey results indicate that 84% of staff identified as Hispanic/Latino and 13% as White, with Spanish (88%) being the most fluent non-English language among staff. Fourteen percent reported providing interpretation services in the past year. Staff felt most knowledgeable about Hispanic/Latino, mental health, and White populations, and 59% agreed they had received sufficient cultural training. However, staff also expressed the need for more training related to American Indian/Alaskan Native, Asian/Pacific Islander, individuals with physical disabilities, mental health, and LGBTQ populations. Contract provider participation was low, with only a 6.3% response rate.

b. Overview of the ICBHS objectives and planned activities for FY 25-26:

- ICBHS will ensure the Cultural Competence Plan is updated annually and contains an assessment of the department's overall cultural competence and ability to meet the cultural needs of beneficiaries, including goals for improving cultural competence and access to care.

- ICBHS will ensure to evaluate training needs to enhance the ability to meet the cultural needs of beneficiaries.

- The QM Unit will monitor the cultural and linguistic activities of the Department to ensure the cultural and linguistic needs of beneficiaries are met.