

Tehama County Mental Health Plan
Quality Assessment and Performance Improvement Workplan
Calendar Year 2026



Quality Assessment and Performance Improvement Plan

The following document describes the quality improvement program structure of the Tehama County Mental Health Plan (MHP), an evaluation of quality improvement goals and to date, and goals and areas of focus for Calendar year 2026.

It is the responsibility of the Tehama County MHP to ensure that all services authorized are delivered with the appropriate standard of care; ongoing quality improvement activities are undertaken with the goal of fulfilling that responsibility. The purpose of this plan is to provide up-to-date information about those ongoing quality improvement activities.

Quality Improvement Program Description

Overview

The Quality Improvement (QI) Program is designed to develop, implement, coordinate, monitor and evaluate performance activities throughout the MHP. The primary concerns of the QI Program include, but are not limited to:

- MHP Medi-Cal member (referred to as “member” in this document) access to services
- Program compliance monitoring
- Collection and evaluation of data or other measures to inform QI activities
- Grievances and appeals
- Member and provider satisfaction
- Gathering and utilizing input from providers, members, and their family members
- Performance improvement projects and identifying opportunities for system and process improvement
- Utilization management and clinical reviews

The QI program is comprised of the Quality Improvement Committee (QIC), Quality Assurance Manager (QAM), and service teams. The QI program is accountable to the Mental Health Director and includes a Quality Assessment and Performance Improvement (QAPI) Workplan which is evaluated annually for effectiveness; QI goals are updated and new goals created based on this evaluation.

Quality Improvement Committee (QIC)

The purpose of the QIC is to improve the quality of mental health care and services provided by Tehama County Health Services Agency – Behavioral Health (TCHSA-BH). It is the aim of TCHSA-BH to provide accessible, timely, culturally competent, professional, and cost-effective services to the community. The QIC monitors and evaluates quality and appropriateness of services at the member, provider, and system levels. The QIC is responsible for recognizing inefficient processes, assessing barriers to quality of care, identifying solutions with measurable objectives and goals, taking actions to meet these objectives and goals, and evaluating the subsequent outcomes.

Integral to the QIC’s success in improving TCHSA-BH services and quality of care is the continued integration of mental health services among TCHSA-BH’s other agency centers and between vendor providers and community health care providers, especially primary care

providers. Collaboration among clinicians, supervisors, outside providers, consumers, patients' rights advocates, and community partners is essential to improve the integration of health care services.

QIC membership includes:

- Quality Assurance Manager (QAM) [CHAIR]
- Mental Health Director
- Contract Provider Representative(s)
- Business Operations Supervisor
- Licensed Clinical Supervisor(s)
- Cultural Competency Committee representative(s)
- Clinician(s)
- Medical Support staff
- Case Resource Specialist(s)
- Patients' Rights Advocate(s)
- Consumer(s)*
- Consumer family members*

* Although we have continued to try to recruit mental health consumers and family members, in 2025 we were unsuccessful in recruiting consumers and family members for direct participation in QIC meetings. This is an active QI work plan goal (see goal A2 below). In 2026 we will also identify TCHSA-BH forums that consumers and family members already attend, such as the Behavioral Health Board, with the goal of taking consumer-specific issues to those forums and bring input back to the QIC meetings. This will address requirements from Title 9, California Code of Regulations and the Contract between TCHSA-BH and the California Department of Health Care Services (DHCS) for participation of consumers and family members in the planning, design and execution of the QI Program.

The QIC functions include (but are not limited to):

- Review new or pending laws, regulations, or policies in mental health.
- Review issues, challenges, improvements, and successes related to quality of care.
- Review and evaluate the results of QI activities including Performance Improvement Projects.
- Initiate necessary QI actions and follow-up of QI processes.
- Review of grievances, appeals, expedited appeals, and state fair hearings to identify trends and areas for improvement as a system.
- Monitor and evaluate the quality and appropriateness of services at the member, provider and system levels and recommend solutions to identified issues.
- Review and evaluate the results of QI activities (internal and external) such as medication monitoring, audits of providers, internal audits, annual reviews by an external quality review organization (EQRO) contracted by DHCS, and Behavioral Health Audits by DHCS.
- Review concerns of substandard care.
- Recommend policies, procedures, and system changes to improve member care and outcomes as a result of QI activities or QIC actions.

- Review and evaluate data to identify strengths, common trends, compliance, and areas for improvement.
- Document all activities through dated and signed minutes of committee meetings that reflect QIC decisions and actions.
- Standard report evaluations quarterly with an annual review.

Quality Assurance Manager (QAM)

The QAM is responsible for coordinating, managing, and reporting on all aspects of the QI processes of the MHP. The QAM chairs the QIC, coordinates or creates standard reports, coordinates annual consumer satisfaction surveys, manages all grievances and appeals, provides liaison services with Department of Health Care Services personnel, audits contracted providers (both individual and organizational), audits TCHSA-BH providers and services, performs site certification reviews for private and organizational providers, and develops Performance Improvement Projects in cooperation with systems of care.

Service Teams

The service teams consist of representatives from Adult Outpatient, Crisis, Medication Support, Case Management, Adult Drop-In Center, Transitional Age Youth, and Behavioral Health Services Act programs (BHSA). The teams work on QI from a clinical perspective in conjunction with and at the direction of the QAM and the QIC.

Data Monitoring

The QI Program monitors and tracks data for the following quality-related quantitative and qualitative reports:

- Service delivery capacity/network adequacy
 - a. Network Adequacy Certification Tool (NACT)
 - b. Medi-Cal penetration rates
- Accessibility of services
 - a. Timeliness of access to services
 - b. Timeliness of authorizations
- Member satisfaction of services provided
 - a. Change of provider requests
 - b. No-show rates
 - c. Trends of member grievances, appeals, and fair hearings
 - d. Results of consumer satisfaction surveys, including comments
- Service delivery system, including meaningful clinical issues and safety/effectiveness of practices
 - a. Results of internal chart reviews
 - b. Results of medication compliance monitoring
 - c. 24/7 Access/Crisis Line test call reports
- Continuity of care with physical health care and other providers
 - a. Inpatient hospitalization follow-up appointments
 - b. Re-hospitalization rates
- Provider appeals and satisfaction

- a. Timeliness of Treatment Authorization Requests (TARs)
- b. Trends of provider grievances and appeals

The QI Program may collect additional data in response to changes in regulations, ongoing QI projects, or as requested by management. Data is analyzed and evaluated at QIC meetings to identify quality issues, establish improvement initiatives, set goals, and document progress toward these quality improvement initiatives quarterly and annually.

Performance Improvement Projects

TCHSA-BH is committed to sustaining improvement gained through performance improvement projects (PIPs). The QI Program will have at least one clinical PIP and one non-clinical PIP every year. A PIP may last more than one year, but once finished, a new PIP will be started. Beginning in 2025, DHCS is requiring each MHP to choose one of the following non-clinical PIP topics:

- Increase the percentage of members with a substance use disorder (SUD) diagnosis who receive at least one Peer Support Service.
- Improve timely access from first contact from any referral source to first offered appointment for any SUD service or specialty mental health service (SMHS).

DHCS is requiring each MHP to select a topic that focuses on improving the rate for one of the following measures:

- Follow-Up After Emergency Department Visit for Mental Illness (FUM)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA).

Evaluation and Goal Setting

The QAPI Workplan will be evaluated annually, demonstrating that QI activities have contributed to meaningful improvement in clinical care and member service, and describing completed and in process QI activities, including performance improvement projects. Upon completion of this evaluation, new goals for the QI Program will be set.

Review of Calendar Year (CY) 2025 Goals and Establishing CY 2026 Goals

A. Quality Improvement Program

1. Quality Improvement Committee

CY 2025 Goal: The new goal for A1 will be to discuss practice guidelines at least quarterly during the QIC. The discussion of practice guidelines will serve the following purposes:

- a. Ensure all QIC members including network providers are aware of the practice guideline requirements.
- b. Meet the requirement in regulations and county policy to adopt specific practice guidelines in consultation with behavioral health care professionals.
- c. Enlist QIC participants, including network providers in the periodic review and update of the practice guidelines.

Coordinate the planning of training for implementing new practice guidelines or updating existing ones.

Background: Staff shortages and leadership changes impacted the QI program and the ability to have full QIC membership or regular meetings in the past, but we have been meeting monthly since March 2023. The Quality Assurance Manager position was vacant until June 2025, as well as many TCHSA-BH direct service positions. Remaining direct care staff, in particular clinicians, have limited time available to participate in QIC. TCHSA-BH hired a new Mental Health Director in September 2024 who is has provided leadership and investment in building QIC membership and participation.

Update for CY 2026: Despite ongoing staffing shortages and a vacant Quality Assurance Manager position for part of the year, QIC was able to meet monthly for all of 2025. Practice guidelines were discussed at some QIC meetings and are now being discussed monthly.

Prior CY 2025 goal: PARTIALLY MET.

CY 2026 Goal: Continue to discuss practice guidelines at least quarterly in the QIC. The discussion of practice guidelines will serve the following purposes:

- a. Ensure all QIC members including network providers are aware of the practice guideline requirements.
- b. Meet the requirement in regulations and county policy to adopt specific practice guidelines in consultation with behavioral health care professionals.
- c. Enlist QIC participants, including network providers in the periodic review and update of the practice guidelines.
- d. Coordinate the planning of training for implementing new practice guidelines or updating existing ones.

2. [Consumer Involvement in the Quality Improvement Program](#)

CY 2025 Goal: Continue to try to recruit mental health consumers and family members for direct participation in QIC meetings. Also identify TCHSA-BH forums that consumers and family members already attend, with the goal of taking consumer-specific issues to those forums and bring input back to the QIC meetings.

Background: Staffing and leadership vacancies have significantly impacted TCHSA-BH's ability to recruit and retain members and/or their family members as QIC members who can share valuable insights and perspectives from their lived experience coping with mental health disorder symptoms and of being a TCHSA-BH Mental Health Services consumer.

Update for CY 2026: In 2025 we continued to be unsuccessful in recruiting consumers and family members with lived experience to directly participate in the QIC meeting.

Prior CY 2025 goal was NOT MET.

CY 2026 Goal: TCHSA-BH will continue to try to recruit consumers and family members to attend QIC meetings. As an alternative way to ensure that consumers and family members are actively involved in the planning, design and execution of the QI Program, one or more QIC members will attend Behavioral Health Advisory Board (BHAB) meetings, which include consumer and family representation. QIC members will solicit input at the BHAB on QIC agenda items of particular interest to consumers and family members. QIC members will also take information from the BHAB and share pertinent input during QIC meetings.

3. Quality Improvement Work Plan and Evaluation

CY 2025 Goal: Continue to keep the QAPI Work Plan current and completed by March 31 of each year. Use project management tools and begin work on the updated plan at the beginning of each year.

Background: Completion of workplans, including appropriate follow up, has been a challenge in past years due to staffing shortages and the lack of a consistent Quality Assurance Manager to spearhead QIC initiatives.

Update for CY 2026: The Quality Assurance Manager position was filled in June 2025 and was able to begin updating the QAPI Work Plan in a timely manner in early 2026. The CY 2026 work plan will be completed within a year of the completion date of the CY 2025 work plan.

Prior CY 2025 goal: MET.

CY 2026 Goal: Continue to keep the QAPI Work Plan current with annual evaluations and documented revisions as needed. Use project management tools and begin work on the updated plan at the beginning of each year.

B. Monitoring Service Delivery Capacity

1. Network Adequacy

CY 2025 Goal: This ongoing goal continues to be to increase the number of filled positions, particularly for direct service staff, in order to meet network certification standards for provider capacity.

Background: Contracts are in place with Victor Community Support Services and Remi Vista for youth services, and Children First for adult and youth services. We have also contracted with Iris Telehealth and Community Behavioral Health for seven clinicians, one of whom is bilingual. We are continuing our recruitment efforts to fill direct care positions. TCHSA-BH has had previous Network Adequacy Certification Tool (NACT) plans of correction to increase staffing and has increased contracts with network providers and developed contracts with staffing agencies as a means to improve network adequacy. TCHSA-BH's ability to meet network adequacy standards has been

impacted both by shortages in mental health professionals statewide and by Tehama's status as a small rural county.

Update for CY 2026: TCHSA-BH currently has a NACT CAP and needs to submit one month of current data with no errors. We are tracking language line encounter usage and need to pull phone records. TCHSA-BH expects to close out the CAP in April 2026. **Prior CY 2025 goal:** PARTIALLY MET.

CY 2026 Goal: This ongoing goal continues to increase the number of filled positions, particularly for direct service staff, in order to meet network certification standards for provider capacity. TCHSA-BH will also resolve any current NACT CAPs.

2. Penetration Rates for the Latino/Hispanic Population

CY 2025 Goal: Re-invigorate services in Corning by increasing hours of services provided after staffing issues are addressed. We anticipate this will improve penetration rates in following years.

Background: TCHSA-BH continues to have a lower penetration rate for the county's threshold population (Latino/Hispanic) compared to other small counties. We have a clinic in Corning that serves a predominately Latino/Hispanic population.

Update for CY 2026: TCHSA-BH was unable to obtain current penetration rates for the Latino/Hispanic population from its Electronic Health Record (EHR) vendor Netsmart/Avatar. In the future, we will have a service provider that will be able to provide us with this information. However, TCHCA Information Technology is still working on obtaining that service provider. In previous years, penetration rates were provided annually by the EQRO, but since DHCS transitioned the EQRO to Health Services Advisory Group, Inc. (HSAG), they haven't provided us with that information. In order to improve penetration rates for the Latino/Hispanic population, TCHSA-BH has continued to expand Latino outreach by providing services in Corning. We currently have one bilingual telehealth therapist that is working in Corning. Providers from our contract provider Victor works at the Corning site two days per week.

Prior CY 2025 goal: PARTIALLY MET.

CY 2026 Goal: Continue to expand the availability of services in Corning. Identify a contractor who can provide penetration rates by race/ethnicity, including for Latino/Hispanic members.

C. Monitoring Member Satisfaction

1. No Shows

CY 2025 Goal: Continue to monitor no show rates and, where applicable, implement projects or policies identified by TCHSA-BH management that may reduce no show rates. Discuss possible reasons for differences in no show rates for psychiatry and for TCHSA-BH and vendor providers, which may be related to the mix of services provided.

Background: This data was regularly reviewed in QIC since CY 2023, is reported on for EQRO and is made easier to track and report with the implementation of the Electronic Health Record (EHR) in June 2022. The average no-show rate for psychiatry appointments in CY 2023 was 24%, which is well above the set standard of 10%.

Update for CY 2026: We continue to track the percentages of no-shows in monthly QIC meetings and informally discuss trends and strategies for improving appointment attendance. For both 2024 and 2025, our EHR was able to provide us with data to analyze missed visits, by separating out member no shows from appointments that were cancelled by either members or staff. In this QAPI work plan we are able to include two tables below: Table 3, which displays no shows and cancelled visits for TCHSA-BH providers only, and for TCHSA-BH including vendors; and Table 4, comparing the total percentages for each category across two years. Agency-wide, the percentage of member no shows (not cancelled) was 10.34%, including 17.44% for psychiatric appointments and 7.54% for non-psychiatric appointments (a decrease from 9.03% in 2024). The overall percentage of missed visits decreased in most categories of scheduled visits from 2024 to 2025. TCHSA-BH recognizes that many factors contribute to lack of appointment attendance; our agency standard for no-shows continues to be 10%. TCHSA-BH management will discuss use of strategies such as reminder calls and texts, as well as no show groups for members who missing multiple appointments including medication management.

Prior CY 2025 Goal: MET.

Table 3: Missed Visit Summary Table – CY 2025

		TOTAL - TCHSA-BH only		TOTAL - TCHSA-BH including Vendors	
Scheduled Psychiatry Visits (based on staff above who provide med support services)	Percentage of Client No Shows	17.87%	TOTAL MISSED % 29.58%	17.44%	TOTAL MISSED % 29.32%
	Percentage Client Cancellation	5.11%		5.41%	
	Percentage of Staff Cancellations	6.56%		6.43%	
Scheduled Non-Psychiatry Visits	Percentage of Client No Shows	15.54%	TOTAL MISSED % 24.18%	7.54%	TOTAL MISSED % 18.78%
	Percentage Client Cancellation	4.30%		7.54%	
	Percentage of Staff Cancellations	4.32%		3.70%	
Total - All Scheduled Visits	Percentage of Client No Shows	16.81%	TOTAL MISSED % 27.13%	10.34%	TOTAL MISSED % 21.77%
	Percentage Client Cancellation	4.74%		6.93%	
	Percentage of Staff Cancellations	5.55%		4.48%	

Trends from CY 2025 Missed Visit Summary Table for review by the TCHSA-BH management team and QIC to identify potential causes and interventions:

- Percentage of client no shows continues to be significantly higher for psychiatry visits (17.44%) than for non-psychiatry clinic visits (7.54%).
- Percentage of client no shows is significantly higher for TCHSA-BH non-psychiatry clinic visits (15.54%) than for vendors (vendor no show rate was 3.97% and total TCHSA-BH including vendors was 7.54%).
- Percentage of client cancellation of appointment (within 24 hours of the appointment) was lower for TCHSA-BH (4.3%) than vendors (8.98% for vendors and 7.54% TCHSA-BH including vendors). The higher client cancellation rate for vendors means clients are cancelling more often rather than being no shows to appointments.

Table 4: Missed Visit Summary Table - CYs 2024 and 2025

		CY 2024		CY 2025	
Scheduled Psychiatry Visits (based on staff who provide med support services)	Percentage of Client No Shows	17.24%	TOTAL MISSED % 32.15%	17.44%	TOTAL MISSED % 29.32%
	Percentage Client Cancellation	7.02%		5.41%	
	Percentage of Staff Cancellations	7.89%		6.43%	
Scheduled Non-Psychiatry Visits	Percentage of Client No Shows	9.03%	TOTAL MISSED % 20.31%	7.54%	TOTAL MISSED % 18.78%
	Percentage Client Cancellation	9.09%		7.54%	
	Percentage of Staff Cancellations	2.19%		3.70%	
Total - All Scheduled Visits	Percentage of Client No Shows	10.81%	TOTAL MISSED % 23.00%	10.34%	TOTAL MISSED % 21.77%
	Percentage Client Cancellation	8.61%		6.93%	
	Percentage of Staff Cancellations	3.59%		4.48%	

Trends from Missed Visit Summary Table – CYs 2024 and 2025 for review by the TCHSA-BH management team and QIC to identify potential causes and interventions:

- For scheduled psychiatry visits the percentage of client cancellation and staff cancellation decreased from CY 2024 to CY 2025.
- For scheduled non-psychiatry clinic visits the percentage of client no shows and percentage of client cancellation both decreased from CY 2024 to CY 2025.
- Total missed visit percentages decreased for all categories of scheduled visits (psychiatry, non-psychiatry and all scheduled visits) from CY 2024 to CY 2025.

CY 2026 Goal: Continue to track and show improvement in the percentage of no shows and missed visits for clinic and psychiatry visits, and for all scheduled visits. Discuss in

QIC how to implement effective strategies for decreasing the percentage of cancelled visits and no shows by sharing practices between vendors and TCHSA-BH that have been effective. Discuss use of strategies such as reminder calls and texts, as well as no show groups for members who missing multiple appointments including medication management.

2. **Consumer Satisfaction Surveys**

CY 2025 Goal: Improve numbers of submitted and completed Consumer Satisfaction Surveys by improving support for consumers or their family members to complete the Consumer Satisfaction Surveys during the specified time. TCHSA-BH hopes to use this more robust data to identify trends that may inform QI projects, to decrease the number of surveys given to members and not completed, and to improve on the mean scores from year to year.

Background: Consumer Perception Surveys provide invaluable insight into the experiences of consumers and their family members and help to guide system improvements.

Update for CY 2026: TCHSA-BH successfully obtained 122 completed Consumer Perception Surveys in 2025, out of 170 surveys that were submitted (72%). The number and percentage of surveys completed increased significantly from 2024 (66 surveys completed – 35% those submitted). Of the 122 surveys completed, 20 were from family members, 32 from youth, 55 from adults and 15 from older adults. Please see the notes under each table for trends identified from the comparison of Tehama County with statewide data and Tehama County mean scores from 2024 to 2025. The QIC will discuss these trends in one of our upcoming meetings to identify if any changes can be made that might impact any of the domains where Tehama’s 2025 mean scores are lower than the statewide scores or Tehama’s 2024 scores.

Prior CY 2025 Goal: MET (Improve numbers of completed Consumer Satisfaction Surveys by improving support for consumers or their family members to complete the surveys during the specified time). The following tables (4 through 7) summarize the mean satisfaction score (on a scale of 1 to 5) by survey domain area for families of children and youth (ages 0-17), youth (ages 13-17), adults, and older adults compared to statewide data, as well as Tehama data comparing mean scores from 2024 and 2025:

Table 5: Satisfaction Score by Domain: Families of Children and Youth – Tehama County and Statewide May 2024 and May 2025

Domain	2024 Tehama Mean Score	2024 Statewide Mean Score	2025 Tehama Mean Score	2025 Statewide Mean Score
Access	4.46	4.43	4.53	4.46
General Satisfaction	4.50	4.38	4.29	4.40

Outcome	3.55	3.98	3.96	4.01
Participation in Treatment Planning	4.67	4.31	4.39	4.33
Cultural Appropriateness	4.75	4.57	4.70	4.59
Social Connectedness	4.02	4.27	4.26	4.30
Functioning	3.51	3.99	3.95	4.02

In 2024 the mean scores for Tehama County families were higher than the statewide mean scores in four of seven of the domains. The Tehama 2025 mean scores were also higher than the Tehama 2024 mean scores in four of the seven domains.

Table 6: Satisfaction Score by Domain: Youth - Tehama County and Statewide May 2024 and May 2025

Domain	2024 Tehama Mean Score	2024 Statewide Mean Score	2025 Tehama Mean Score	2025 Statewide Mean Score
Access	4.34	4.23	4.42	4.26
General Satisfaction	4.37	4.24	4.42	4.28
Outcome	4.16	3.86	4.07	3.92
Participation in Treatment Planning	4.18	4.09	4.47	4.10
Cultural Appropriateness	4.61	4.39	4.47	4.40
Social Connectedness	4.32	4.12	4.39	4.15
Functioning	4.20	3.91	4.07	3.94

For all seven domains the mean satisfaction score for youth in Tehama County was higher than the statewide mean scores. The Tehama 2025 mean scores were also higher than the Tehama 2024 mean scores in four of the seven domains.

Table 7: Satisfaction Score by Domain: Adult – Tehama County and Statewide May 2024 and May 2025

Domain	2024 Tehama Mean Score	2024 Statewide Mean Score	2025 Tehama Mean Score	2025 Statewide Mean Score
Access	4.29	4.35	4.41	4.37
General Satisfaction	4.24	4.45	4.53	4.48
Outcome	3.92	4.04	3.97	4.06
Participation in Treatment Planning	4.11	4.33	4.27	4.36
Quality	4.37	4.36	4.35	4.39
Social Connectedness	4.11	4.04	3.87	4.06
Functioning	3.96	4.03	3.91	4.05

For Tehama adults the mean satisfaction scores in 2025 tended to be lower than the statewide mean satisfaction scores, except for in the domains of access and general satisfaction, where they were slightly higher than in the statewide scores. The Tehama 2025 mean scores were higher than the Tehama 2024 mean scores in four of the seven domains.

Table 8: Satisfaction Score by Domain: Older Adult – Tehama County and Statewide May 2024 and May 2025

Domain	2024 Tehama Mean Score	2024 Statewide Mean Score	2025 Tehama Mean Score	2025 Statewide Mean Score
Access	4.70	4.31	4.60	4.38
General Satisfaction	4.50	4.46	4.62	4.49
Outcome	4.29	4.02	4.28	4.08
Participation in Treatment Planning	4.36	4.30	4.46	4.37
Quality	4.58	4.31	4.43	4.37
Social Connectedness	4.22	4.02	4.08	4.02
Functioning	4.20	3.99	4.19	4.04

In 2025 for all seven domains the mean satisfaction score for older adults in Tehama County was higher than the statewide mean scores. The Tehama 2025 mean scores were lower than the Tehama 2024 mean scores in five of the seven domains (all domains except for general satisfaction and participation in treatment planning).

CY 2026 Goal: Continue to increase numbers of submitted and completed Consumer Satisfaction Surveys by improving support for consumers or their family members to complete the Consumer Satisfaction Surveys during the specified time. TCHSA-BH hopes to use this more robust data to identify trends that may inform QI projects, to decrease the number of surveys given to members and not completed, and to improve on the mean scores from year to year.

D. Monitoring the service delivery system regarding clinical issues

1. Chart Reviews

CY 2025 Goal: Implement a chart review program for internal TCHSA-BH charts and contract providers using a CalAIM-compliant chart review tool. This program shall include regular monthly chart audits of both TCHSA-BH and vendor charts to ensure compliance with CalAIM service provision and documentation requirements, including but not limited to those from BHIN 21-073 (Access Requirements), 22-011, BHIN 23-068 (Documentation Requirements, and BHIN 22-065 (Transition of Care Tools) and subsequent BHINs that supersede this guidance.

Background: TCHSA-BH has had challenges with fully implementing California Advancing and Innovating Medi-Cal (CalAIM) service and chart documentation requirements due to critical vacant positions. During FY 24-25, monthly chart reviews continued for our contract providers, though using an out-of-date chart review tool.

Update for CY 2026: In CY 2025, TCHSA-BH conducted chart audits of contract providers using a new chart audit tool consistent with CalAIM documentation requirements from BHIN 23-068. In CY 2026 our goal is to begin using the new audit tool for chart reviews of internal county providers. All staff have been trained with the new updated forms in AVATAR. The Assessment and Targeted Case Management Care Plan have been implemented in AVATAR.

Prior CY 2025 Goal: MET

CY 2026 Goal: Continue to conduct the required chart reviews using the updated chart audit tool for contract providers and begin utilizing the new tool for internal county providers. Establish a baseline on the percentage of chart reviews with results meeting documentation requirements. .

2. Medication Compliance/Medication Monitoring

CY 2025 Goal: TCHSA-BH will continue to monitor Medication Compliance and Medication Monitoring consistent with state requirements. TCHSA-BH will establish a baseline for percentage of medication monitoring reports that reveal compliance

issues. Following the establishment of a baseline, future goals will address specific improvements needed.

Background: For several years, TCHSA-BH has been working to hire a contractor to provide this service for our agency. TCHSA-BH experienced challenges finding a psychiatrist or pharmacist who was interested in providing this oversight for our agency despite multiple attempts including reaching out through staffing agencies and reaching out to known providers. TCHSA-BH has now contracted a pharmacist to complete the required medication compliance and monitoring reviews.

Update for CY 2026: We have contracted with a pharmacist this year. The contractor is reviewing 10 charts randomly monthly.

Prior CY 2025 Goal: MET. Please see Table 9 for specific monitoring compliance results.

Table 9: Medication Monitoring Results Summary

10 charts were reviewed each month

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
No of charts with compliance issues	6	8	9	3	5	3	3	3	3	2	7	7	59
Total compliance issues	12	20	22	7	9	3	4	3	4	2	11	7	104

We will be using 2025 medication monitoring results as a baseline to compare with future medication monitoring compliance results. A total of 59 charts of 120 charts (49%) reviewed were found to have one or more compliance issues, as summarized in Table 9. 104 total compliance issues were identified. Some of the compliance findings included missing lab work, informed consent, medication consent forms, and documentation of response to medications.

CY 2026 Goal: TCHSA-BH will continue to monitor Medication Compliance/Medication Monitoring consistent with state requirements and decrease the number and percentage of charts with compliance issues, as well as total compliance issues. TCHSA-BH management will review medication monitoring reports and focused follow up with specific providers or with training, depending on trends identified in the monitoring results.

3. [Access/Crisis line test calls](#)

CY 2025 Goal: Conduct at least three test calls per quarter and at least one test call in a language other than English at least once per quarter. Improve test call results, including for logging compliance. All TCHSA-BH staff will receive updated training for call handling; Mobile Crisis staff will receive updated training for call handling, including

the provision of work aids, work flows, etc., to improve staff's ability to handle calls efficiently and appropriately, direct calls correctly, and meet state and federal requirements for information and service provision. Call logging will be tracked quarterly. Focused and individual training provided when compliance issues arise.

Background: In CY 2024, 21 of 27 test calls (78%) provided the information requested (access to SMHS, urgent condition need, or problem resolution information) and only 5 of the 18 calls (28%) required to be logged met all the requirements for information to be included in the log (name of member, date of the request and initial disposition). Each quarter, calls were made in a non-English language and after hours. The calls that did not log the required information were for both business hours and after hours. All staff who answer the Access line were provided mandatory training, and additional resource materials, including a decision tree, were provided to staff.

Update for CY 2026: In the last year, 35 of 36 test calls (97%) provided the information requested (access to SMHS, urgent condition need, or problem resolution information), which is an increase from 78% in CY 2024. 23 of the 27 calls (82%) required to be logged met all the requirements for information to be included in the log (name of member, date of the request and initial disposition). This is an increase from 27% in CY 2024. Four of the 36 test calls were in Spanish and 6 calls were made after hours. The calls that did not log the required information were all made during business hours. The one call that did not provide the required information (about the problem resolution process) was also made during business hours. All staff who answer the Access line, including Mobile Crisis staff, were provided mandatory training, and additional resource materials, including a decision tree, were provided to staff.

Prior FY 24-25 Goal: MET.

CY 2026 Goal: Conduct at least three test calls per quarter and at least one test call in a language other than English at least once per quarter. Improve test call results, including for logging compliance. All TCHSA-BH staff will receive updated training for call handling; Mobile Crisis staff will receive updated training for call handling, including the provision of work aids, work flows, etc., to improve staff's ability to handle calls efficiently and appropriately, direct calls correctly, and meet state and federal requirements for information and service provision. Call logging will be tracked quarterly. Focused and individual training provided when compliance issues arise. In 2026 focused training will be provided to staff who answer calls during business hours, in particular for logging all required information and providing information about the problem resolution process when this is requested.

E. Continuity of Care with Physical Healthcare and Other Agencies

1. Inpatient Hospitalization Follow-Up and Re-Hospitalization Rates

CY 2025 Goal: Continue to show improvement in meeting required standards for follow-up appointments after psychiatric hospitalization. TCHSA-BH will be opting into

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) and will be working with the National Committee for Quality Assurance (NCQA) on Healthcare Effectiveness Data and Information Set (HEDIS) measures including the 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge as part of their assessment.

Background: According to data from the FY 2023-24 EQRO report, 49% of members received follow-up appointments after psychiatric hospitalization within 7 days and 47% received follow-up appointments after psychiatric hospitalization within 30 days.

Update for CY 2026: The inpatient follow-up data is coming out of Xferal at this time. TCHSA-BH has contracted with CalMHSA to get HEDIS measures for Tehama County going forward. The inpatient hospitalization follow-up rates and re-hospitalization rates will be reported on quarterly at QIC meetings.

Prior CY 2025 goal was PARTIALLY MET. Please refer to Table 10 for inpatient hospitalization follow-up and re-hospitalization rates for CY 2025.

Table 10: Inpatient Hospitalization Follow-Up and Re-Hospitalization Rates – CY 2025

	Q1 Jan-Mar		Q2 Apr-June		Q3 July-Sept		Q4 Oct-Dec		TOTAL CY	
Hospital Admissions										
• Total	85		89		109		67		350	
• Adult	66		72		87		41		266	
• Child	19		17		22		26		84	
Hospital Discharges										
• Total	82		98		110		63		353	
• Adult	63		79		88		37		267	
• Child	19		19		22		26		86	
Follow Up Appointments Scheduled	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
• Total	40	49%	59	60%	64	58%	33	52%	196	56%
• Adult	32	51%	48	61%	49	56%	20	54%	149	56%
• Child	8	42%	11	58%	15	68%	13	50%	58	67%
Follow Up Appointments Within 7 days	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
• Total	21	25%	50	51%	51	46%	31	49%	153	43%
• Adult	16	25%	40	51%	40	45%	18	49%	114	43%
• Child	5	26%	10	53%	11	50%	13	50%	39	45%
Readmissions	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
• Total	4	4.9%	6	6.1%	5	4.5%	4	6.3%	19	5.4%

• Adult	3	4.8%	5	6.3%	3	3.4%	2	5.4%	13	4.9%
• Child	1	5.3%	1	5.3%	2	9.1%	2	7.7%	6	7.0%

Percentage is calculated by number of follow up visits (or readmissions) divided by number of hospital discharges.

In 2025, 43% of members received a follow up visit within 7 days after hospital discharge (43% for adults, 45% for children). For the last three quarters of 2025 (April-December), 49% received a follow up visit within 7 days after hospital discharge (48% for adults, 51% for children). 5.4% of members had a hospital readmission (4.9% for adults and 7% for children). TCHSA-BH management team will discuss potential strategies for increasing the percentage of follow up appointments and decrease the percentage of readmissions and bring discussion points to the QIC for recommendations.

CY 2026 Goal: Continue to track and improve percentages of outpatient follow-up rates and rehospitalization rates after a psychiatric inpatient discharge. Continue to share this information at QIC meetings.

F. Significant Changes and Current Initiatives

1. Outcome Measures

CY 2025 Goal: TCHSA-BH will continue the use of the CANS-50, PSC-35, and PQB, and implement ANSA once staff are trained in its use. This goal may be discontinued once all outcome measure tools are implemented and being used regularly.

Background: TCHSA-BH will continue the use of CANS and PCS-35 and implement ANSA and PQB. We will be implementing ANSA (just waiting to pay for the trainings) and the PQ-16 has been replaced already and implemented the PQB instead.

Update for CY 2026: TCHSA-BH has been using the CANS and PCS-35 and implement implemented the ANSA and PQB. Staff have been fully trained in the use of these outcome measurement tools.

Prior CY 2025 Goal: MET.

CY 2026 Goal: Since the outcome measure tools have been fully implemented, this will be discontinued as a QAPI work plan goal.

2. Performance Improvement Projects (PIPs)

CY 2025 Goal: DHCS is requiring all MHPs to conduct new clinical and non-clinical PIPs to begin in 2025 (with the first annual submissions due in July 2025) and conclude in 2027 (with the final annual submission due in July 2028). TCHSA-BH's PIP selections will be as follows:

1. **Non-Clinical PIP:** Improve timely access from first contact from any referral source to first offered appointment for any SUD service or SMHS.

- Timeliness Standard: First contact/appointment offered from any referral within 10-days.
 - Most Recent 12 Month Data Measurement Period: 12/12/2023-12/12/2024
 - Numerator: 110
 - Denominator: 180
 - Rate: 61%
2. Clinical PIP: Follow-Up After Emergency Department Visit for Mental Illness (FUM) - Improving the FUM measure rate
- Most Recent 12 Month Data Measurement Period: This not something that we were currently tracking, and we will need to establish a baseline.
 - Numerator: N/A
 - Denominator: N/A
 - Rate: N/A

Background: In 2025 TCHSA-BH was in the process of implementing the two new clinical and non-clinical PIPS as described above in the CY 2025 Goal. The previous PIPs are no longer active.

Update for CY 2026: We do not have any data available to establish baseline information for these two PIPs at the time this QAPI work plan is being updated. Currently we have no vessel to track this information. We do have a contract in place with a vendor, but due to 42 CFR regulations there were significant delays in implementing the appropriate safeguards in order to make sure member privacy was protected appropriately within our EHR. In March of 2026, we were able to publish member facing materials regarding their rights for opting out to the Health Information Exchange, and have a scheduled training this month with the EHR vendor to fully go live. Due to these technological barriers, we have no information regarding follow up after emergency visits or referral timeliness data.

Prior CY 2025 Goal: NOT MET.

CY 2026 Goal: Begin implementation of the new clinical and non-clinical PIPs, beginning with establishing baseline data:

1. Non-Clinical PIP: Improve timely access from first contact from any referral source to first offered appointment for any SUD service or SMHS.
 - Timeliness Standard: First contact/appointment offered from any referral within 10-days.
2. Clinical PIP: Follow-Up After Emergency Department Visit for Mental Illness (FUM) - Improving the FUM measure rate