Siskiyou County
Behavioral Health Division

Quality Improvement Work Plan
Annual Evaluation
Fiscal Year 23-24

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Definitions

- ASOC—Adult System of Care
- CalEQRO—California External Quality Review Organization
- CC—Cultural Competency
- COP—Change of Provider Request
- CSOC—Children's System of Care
- CWS—Child Welfare Services
- DHCS—Department of Health Care Services
- EHR—Electronic Health Record
- FSP—Full-Service Partner
- FTE—Full-Time Equivalency
- FY—Fiscal Year
- HID—Health Information Department
- LOS—Level of Service Assessment
- MHP—Mental Health Plan
- MHSA—Mental Health Services Act
- PIP—Performance Improvement Project
- QAM—Quality Assurance Manager
- QIC—Quality Improvement Committee
- QoC—Quality of Care
- QM—Quality Management
- SAR—Service Authorization Request
- TAR—Treatment Authorization Request
- UM—Utilization Management

Purpose of Evaluation

The Siskiyou County Behavioral Health Division (BHD) is an integrated mental health and substance use disorder treatment department. The Mental Health Plan (MHP) served 1,102 Medi-Cal members with mental illness and the Drug Medi-Cal Organized Delivery System (DMC-ODS) served 246 substance use disorder members of all ages in the fiscal year (FY) 23-24. The mission of the MHP is to promote the prevention of, and recovery from, mental illness and substance abuse of those we serve by providing accessible, caring, and culturally competent services.

The following sections are an evaluation of the MHP's Quality Improvement Work Plan goals that were established for FY 23-24. The Quality Improvement Work Plan Evaluation is an opportunity to objectively review and transparently share the measurable progress towards meeting these goals. The Work Plan Evaluation is the first step in making data-driven decisions for the Quality Improvement Work Plan for FY 24-25.

Section 1: Performance Improvement Projects (PIP)

Goal 1.1 Active Non-Clinical PIP:

The MHP will improve follow-up attendance to specialty mental health services following an emergency department (ED) visit for Medi-Cal members with a mental health diagnosis.

Member Impact: By increasing access to SMHS, members with a mental health diagnosis are more likely to engage in treatment and mitigate higher levels of care and/or crisis episodes.

Monitoring mechanisms: PIP committee meetings, Quality Improvement Committee (QIC) meetings, technical assistance calls with Behavioral Health Concepts.

Baseline & Actions: The non-clinical PIP has been since 2023. From 02/18/2023 to 01/04/2024, crisis workers responded to 82 ED visits with members who had an identified mental illness for which 26% (n=21) attended a mental health service within 7 Calendar Days of ED discharge. The aim was to increase the county baseline data of 62% by 5-percentage points, but the PIP shows the MHP is below half (i.e., 42%) of the county baseline.

The MHP will continue this PIP with a goal of providing follow up 50% of the time.

Timeline: Continue PIP until scheduled completion date on June 30, 2025.

Lead Staff: Project Coordinator, QIC, PIP team, Program Coordinator, and Director of Clinical Services.

Evaluation Findings: During FY 2023-24 (July 1, 2023 – June 30, 2024), 140 members had ED visits and 61 of those members (43.57%) received a mental health service within 7 days of discharge. The goal of 50% has not yet been achieved so we will continue this goal. The QIC will spend two monthly meetings evaluating the workflow and data input processes to find areas that are impacting success in reaching the 50% goal. Findings will be used to determine needs in regard to trainings, documentation and workflow adjustments. QIC will also establish a monthly reporting apparatus to continually evaluate the programs' ability to meet PIP goal of 50%.

Goal 1.2 Active Clinical PIP:

The MHP will utilize a tailored cognitive behavioral therapy group for diversion participants with a dual diagnosis to improve participant outcomes.

Member Impact: By providing treatment groups, these members are more likely to successfully complete mental health diversion and achieve stability with their treatment.

Monitoring mechanisms: PIP committee meetings, QIC meetings, technical assistance calls with Behavioral Health Concepts.

Baseline & Actions:

The clinical PIP has been since 2023. Data was analyzed from 01/2023 to 12/2023 by comparing Q1-Q2 01/2023-06/2023 data to Q2-Q3 07/2023-12/2023 data for improvement. The number of unduplicated members served was similar for both halves of the year (i.e., Q1-Q2 n=15, Q3-Q4 n=14). The number of unduplicated members referred was similar for both halves of the year (i.e., Q1-Q2 n=8, Q3-Q4 n=7). Finally, the number of members who attended at least 6 group services was also similar for both halves of the year (i.e., Q1-Q2 n=12, Q3-Q4 n=10). There was a marginal 0.27-point improvement on average for subjective self-reported survey responses, but each group service is on a different topic. There were no graduates because participants have up to 2 years to complete the program so more time is needed to evaluate improvement.

Timeline: Continue PIP until scheduled completion date on June 30, 2025.

Lead Staff: Project Coordinator, QIC, PIP team, and director of clinical services.

Evaluation Findings: For FY 2023-24, comparison of Q1-2 with Q3-4 yielded the following data:

- The number of unduplicated members referred to the tailored cognitive behavioral group? Q1-2=15, Q3-4=14
- The number of unduplicated members who attended at least 6 groups: Q1-2=12, Q3-4=10
- Self-reported survey response improvement = 8
- Number of program graduates = 6

The number of members referred increased from the baseline and the number of members

who attended at least 6 groups remained the same. This is the first year we had information to report on self-reported survey response improvement (8) and program graduates (6). We will continue this goal until the PIP is completed.

Section 2: Service Delivery Capacity

Goal 2.1 Availability of Services

To maintain an adequate network of mental health providers geographically, culturally, linguistically, and by special population.

Member Impact: Having an adequate network of mental health providers ensures that members that are geographically, culturally, or linguistically diverse have access to quality mental health treatment when, where, and how they need it.

Interventions:

1. Continue monitoring network adequacy and submitting the tool annually until the 274 report replaces it.
2. Submit monthly 274 reports.
3. Engage in quality review process for 274 with a goal of 6 error free submissions.
4. Launch Provider Directory portal via SmartCare, our new Electronic Health Record (EHR) system administered by the California Mental Health Services Authority (CalMHSA).
5. Monitor timely access to services at least once a month.

Monitoring mechanisms: Quarterly network adequacy reports and plans of corrections, monthly 274 expansion reports and quality checks, review of internal provider list and log, data provided by Partnership Health Plan of California and Kings View, the demographics of Medi-Cal members, and access log data.

Baseline: Internal provider list updated monthly. The Network Adequacy Certification Tool (NACT) was submitted, but DHCS extended the annual report findings, so the MHP is not currently aware of any corrective action items. DHCS is also requiring monthly 274 Expansion reporting that will eventually replace NACT. DHCS also initiated new monthly quality checks that may require resubmission of 274 Expansion reports. FTEs and penetration rates are reported to the QIC and Data Group at least quarterly. The Project Coordinator monitored timely access to services weekly and reported quarterly outcomes to the Data Group.

Timeline: Internal provider list updated monthly. Network adequacy tool submitted

quarterly. FTEs and penetration rates are reported to the QIC quarterly.

Lead Staff: Access Health Assistant, Project Coordinator, Staff Services Analyst.

Evaluation Findings:

- The internal provider list continued to be updated monthly and launched the provider directory portal through SmartCare.
- The MHP did have some corrective actions on the NACT submission.
- The MHP did not have error-free 274 submissions.

Interventions for FY 24-25:

- NACT data is being continually reviewed by the Project Coordinator reported to the Supervisors and QIC monthly.
- The QIC will spend one designated monthly meeting evaluating the workflow and data input processes to find areas that are impacting success. Findings will be used to determine needs in regard to trainings, documentation and workflow adjustments. QIC will also establish a monthly reporting apparatus to continually evaluate 274 monthly quality checks and NACT reports.

Goal 2.2 Penetration Rates:

To increase the penetration rates among underserved minority groups to align with penetration rates of other small-rural counties.

Member Impact: Monitoring penetration rates allows the MHP to identify possible disparities in accessing services. If a disparity is identified and addressed, members have equitable access to mental health treatment.

Interventions:

1. Provide outreach activities, including outreach through The Mobile Crisis Unit and homeless outreach worker, to minority group community members and members in outlying areas.
2. The MHP will assign staff to be available a minimum of one day per week to the outlying areas of the county to engage minority groups in medically necessary services, utilizing interpretation as needed.

Monitoring mechanisms: CalEQRO data. Penetration data. Cultural Competence Plan. Mobile Crisis outreach and utilization data. Homeless Outreach Worker outreach and utilization data. Monthly monitoring via Data Group meetings.

Baseline: Siskiyou MHP continues to use a different methodology than that used by CalEQRO to measure penetration rates.

The overall Kings View penetration rate (5.7%) shows a decline over the past year compared to the last five fiscal years (Table 1). The Hispanic penetration rate has also decreased proportionally to 5.3%.

Table 1: Fiscal Year 22-23 Kings View Data

Penetration Group	FY 17-18	FY 18-19	FY 19-20	FY 20-21	FY 21-22	FY 22-23
Overall Penetration Rate	5.5%	5.9%	6.4%	6.7%	6.8%	5.7%
Hispanic Penetration Rate	4.6%	5.9%	5.9%	6.0%	6.3%	5.3%

The FY 22-23 Kings View language penetration rate for Hmong speakers is the same at 0.9%, the rate for Laotian speakers decreased from 5.6% to 1.9%, and the Spanish rate decreased slightly from 0.9% to 0.5%. The rate for Russian speakers is new category with a penetration rate of 16.7%.

Both the small-rural counties data (Table 2) and Siskiyou County data (Table 3) demonstrated a reduction in the penetration rates for Hispanics and Foster Youth in Calendar Year (CY) 2020, likely as a result of the pandemic.

Table 2: Small-Rural Counties Calendar Year EQRO Data

Penetration Group	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Hispanic Penetration	3.4%	4.5%	4.7%	5.3%	4.6%
Foster Youth Penetration	39.2%	40.9%	40.5%	45.5%	44.9%

Table 3: Siskiyou County Calendar Year EQRO Data

Penetration Group	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Hispanic Penetration	2.4%	2.6%	2.7%	4.2%	3.3%
Foster Youth Penetration	24.1%	39.4%	42.4%	42.5%	38.9%

The MHP provides dedicated clinical and case management services in the outlying East County areas where the majority of Hispanic members reside, as well as the Happy Camp area.

Timeline: Annual evaluation and reporting of penetration rates. Review data quarterly at the data group meeting.

Lead Staff: QIC, Cultural Competence Committee, Project Coordinator, Staff Services Analyst, ASOC System Administrator.

Evaluation Findings

Table 1A: Fiscal Year 23-24 SmartCare Data

Penetration Group	FY 18-19	FY 19-20	FY 20-21	FY 21-22	FY 22-23	FY 23-24
Overall Penetration Rate	5.9%	6.4%	6.7%	6.8%	5.7%	5.47%

Hispanic Penetration Rate	5.9%	5.9%	6.0%	6.3%	5.3%	3.51%

In FY 23-24 the MHP changed to a new EHR system through SmartCare, which is the source for much of the data utilized in this evaluation. (The previous EHR was Kingsview.) The FY 23-24 SmartCare penetration rate for Hispanic members was 3.51% which represents a decrease from 5.3% in FY 22-23, while the overall penetration rat in FY 23-24 was 5.47%, a decrease from 5.7% in FY 22-23. This comparison may or may not be analogous since there could be differences in the calculation methodologies used by the different EHRs. For this reason, we will re-examine the penetration rate next year using FY 2023-24 as a baseline.

Table 2A: Small-Rural Counties Calendar Year EQRO Data

Penetration Group	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Hispanic Penetration	4.7%	5.3%	4.6%	4.8%	4.9%
Foster Youth Penetration	40.5%	45.5%	44.9%	42.5%	39.8%

Table 3A: Siskiyou County Calendar Year EQRO Data

Penetration Group	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Hispanic Penetration	2.7%	4.2%	3.3%	3.7%	3.6%
Foster Youth Penetration	42.4%	42.5%	38.9%	36.7%	27.9%

The most recent penetration rate data from CalEQRO was from the FY 2023-24 Siskiyou Final Report from the EQRO review on April 18, 2024. Since CalEQRO relies on previous years' approved claims data on a Calendar Year, the most recent data was from CY 2022. As shown in Table 3A, the Hispanic penetration rate decreased slightly from CY 2021 to CY 2022 from 3.7% to 3.6%. Similarly, the Foster Youth penetration rate decreased from 36.7% to 27.9%. CalEQRO also provides penetration rates for other similar sized small-rural counties. As shown in Table 2A, Siskiyou County has lower penetration rates for both Hispanic members and Foster Youth than the average for small-rural counties.

In addition to the strategies listed above under "Interventions" for this goal, the MHP is addressing reduction of disparities related to race and ethnicity in its Cultural and Linguistic Competence Plan, strategies 2.1 and 2.2, as well as reduction of disparities related to spoken language (Spanish is our threshold language) in strategies 4.2, 4.3 and 4.4. These strategies are as follows:

2.1 Meet with culturally diverse groups and agencies to increase/reinforce provider relationships at least two times per fiscal year.

2.2 One of the annual mandatory training opportunities to BHP staff will target the

specific cultural needs of minority ethnic groups that are located in Siskiyou County.

4.2 Provide mandatory annual language line training and random testing throughout the year to ensure staff are capable in the use of the language line.

4.3 Inform all individuals at first request for services and during intake of the availability of language assistance services and that these services are free.

4.4 Seek to recruit staff and contract with bilingual providers for translation and interpretation services. All translation/interpreters shall complete language proficiency testing

In future years it is our understanding that the new EQRO, Health Services Advisory Group, Inc. (HSAG) will not be providing penetration rate data. For this reason, our comparisons going forward will be based on SmartCare penetration rate data, which was provided in Table 1A and the narrative below that table.

Goal 2.3 Clinical Productivity:

To increase the current level of clinical staff productivity to an average of 60% for Clinicians, telepsychiatry, and Behavioral Health Specialists.

Member Impact: Clinical productivity standards ensure that staff have a sufficient amount of time dedicated to serving members and that member care is prioritized over other responsibilities.

Interventions:

1. Develop productivity dashboard for supervisor use.
2. Individual goal setting and follow-up between staff and clinical supervisor when a staff person is not meeting the productivity standard for their server type.

Monitoring mechanisms: QIC and clinical supervisors monitor productivity through Productivity Dashboard.

Baseline: The QAM provided ongoing and new-hire training to clinical staff regarding productivity. Monthly productivity reports were made available to supervisors via a shared folder; staff had access to their current productivity rates through their supervisor.

The average standard productivity rate for MHP clinical providers was 11.4 %. The average productivity by provider type is as follows: Clinicians 26.1%, psychiatry 16.3%, and Behavioral Health Specialists 15.6% (Table 4). Alternative productivity rates by job classification were med support at 5.6%, and the psychiatric emergency team (24/7 crisis response team) at 9.5%.

This stark discrepancy in year-over-year rates is accounted for by several factors. Due to staff turnover, the exact methodology that was used previously is no longer available.

Additionally, the hours worked by providers who do not use county timecards (i.e., telehealth staff) were not available. The low reliability of this year's data will be addressed in the FY 23-24 QIWP.

Table 4: Average Clinical Productivity Rate by Provider Type

Provider Type	FY 17-18	FY 18-19	FY 19-20	FY 20-21	FY 21-22	FY 22-23
Psychiatry	54%	53%	51%	55%	49%	16.3%
Behavioral Health Specialists	33%	37%	32%	33%	36%	15.6%
Clinicians	40%	42%	31%	40%	44%	26.1%

Timeline: Documentation training will be provided for all new employees and targeted training is provided as needed by the QAM. Productivity will be reviewed monthly at the data group meeting.

Lead Staff: QAM, QIC, Clinical Site Supervisors, and Project Coordinator.

Evaluation Findings:

Table 4A: Average Clinical Productivity Rate by Provider Type

Provider Type	FY 18-19	FY 19-20	FY 20-21	FY 21-22	FY 22-23	FY 23-24
Psychiatry	53%	51%	55%	49%	16.3%	52%
Behavioral Health Specialists	37%	32%	33%	36%	15.6%	42%
Clinicians	42%	31%	40%	44%	26.1%	49%

As mentioned above under Goal 2.2, in FY 23-24 the MHP changed to a new EHR system through SmartCare. Based on the FY 23-24 productivity data from SmartCare, clinical productivity increased for all provider types. The average productivity was as follows: Clinicians 49% (increased from 26.1%), psychiatry 52% (increased from 16.3%), and Behavioral Health Specialists 42% (increased from15.6%). Please refer to Table 4A. The productivity rates increased to levels slightly higher than in FY 21-22.

It appears that the interventions for this goal, 1) Develop productivity dashboard for supervisor use, and 2) Individual goal setting and follow-up between staff and clinical supervisor when a staff person is not meeting the productivity standard for their server type have helped to reverse the downward productivity trend noted in FY 22-23. We will continue implementing these interventions and monitor to see if the positive productivity trends continue.

Section 3: Service Accessibility

Goal 3.1 Initial Appointments:

To offer an initial appointment for specialty mental health services (non-urgent) within 10 business days from the request. To offer initial appointments for psychiatric appointments (non-urgent) within 15 business days of the request.

Member Impact: Timeliness standards ensure that members have access to mental health treatment quickly after a need is identified.

Interventions:

1. The quality improvement committee will monitor the access system for trends and performance and strategize solutions if initial appointments are not occurring timely.
2. The MHP will provide ongoing training for processing and capturing timeliness related to urgent requests for initial appointments.
3. Review access data for potential disparities annually and report to QIC.

Monitoring mechanisms: Access reports, behavioral health access logs, and medication access logs.

Baseline: The average number of days until the first offered non-psychiatric appointment for all members was 7 days, which is in alignment with the improvements made in the previous year. Table 5 displays the average timeliness of all members, adults, children, and foster care members based on the Cal-EQRO Assessment of Timely Access report and the compliance rate towards meeting the state standard (81% for all members).

Because of the proximity of go-live of the new EHR, it was determined that modifying the access from to track referrals for homeless individuals and Foster Youth separately from others was not an efficient use of resources. SmartCare has improved functionality related to meta tagging and data categorization, which will increase the MHP's ability to track a variety of special populations in the next fiscal year.

Table 5: Timeliness from Initial Request to First Offered Non-Psychiatric Appointment

Non-Psychiatric Timeliness	All Services	Adult Services	Children's Services	Foster Care
Average days from request to the first offered appointment	7 Days	6 Days	7 Days	8 Days

Non-Psychiatric Timeliness	All Services	Adult Services	Children's Services	Foster Care
Compliance Rate Towards State Standard	81%	83%	77%	84%

The average number of days until the first offered psychiatric appointment for all members was 7 days with a 97% compliance rate to the 15-day standard. Table 6 displays the average timeliness information for all members, adults, children, and foster care.

Table 6: Timeliness from Initial Request to First Offered Psychiatric Appointment

Psychiatric Timeliness	All Services	Adult Services	Children's Services	Foster Care
Average days from request to the first offered appointment	7 Days	7 Days	7 Days	8 Days
Compliance Rate Towards State Standard	97%	97%	98%	92%

Timeline: The MHP publishes timeliness data annually for CalEQRO. Monitor access reports at QIC meetings quarterly.

Lead Staff: Intake coordinator, intake Clinicians, clinical supervisors, and Project Coordinator.

Evaluation Findings

Table 5A: Timeliness from Initial Request to First Offered Non-Psychiatric Appointment

Non-Psychiatric Timeliness	All Services	Adult Services	Children's Services	Foster Care
Average days from request to the first offered appointment	6 Days	5 Days	7 Days	7 Days
Non-Psychiatric Timeliness	All Services	Adult Services	Children's Services	Foster Care
Compliance Rate Towards State Standard	89%	93%	88%	90%

Table 6A: Timeliness from Initial Request to First Offered Psychiatric Appointment

Psychiatric Timeliness	All Services	Adult Services	Children's Services	Foster Care
Average days from request to the first offered appointment	9 Days	8 Days	9 Days	8 days
Compliance Rate Towards State Standard	87%	90%	85%	88%

As shown in Table 5A (compared to Table 5) above, the average number of days until the first offered non-psychiatric appointment decreased in all age grouping except for children, where it remained the same at 7 days. The compliance rate towards meeting the state standard of 10 business days improved for all age groups, ranging from 88% to 93% compliance.

For psychiatric appointments, as shown in Table 6A (compared to Table 6), the average number of days until the first offered psychiatric appointment increased for all groups analyzed, except for foster care where it remained the same at 8 days. All average number of days was still easily within the 15-business day state standard. The compliance rate towards meeting the state standard shows a decrease for all groupings, but still ranges from 85% to 90% compliance. We will address this change in timeliness in the FY 24-25 QI work plan interventions for Goal 3.1.

Goal 3.2 Access to Urgent and Emergent Conditions:

To assure that members are receiving timely access to urgent and emergent services 24/7. For urgent services that do not require prior authorization, services are offered within 48 hours of a request, and services that require prior authorization are offered within 96 hours of a request.

Member Impact: Timeliness standards for urgent and emergent conditions ensure that members experiencing a mental health crisis or have an urgent need for an appointment have priority access to services.

Intervention:

1. The crisis line is answered by a live person 24/7 100% of the time.
2. Work with CalMHSA and Streamline to calculate latency of response and include in EHR reports.
3. Crisis workers and Mobile Crisis workers respond timely to 90% of requests, with any request requiring a delayed response including a documented reason.
4. Review response time annually at the QIC to assure it is within state standards.

Monitoring mechanisms: QIC review of crisis data, Electronic Health Record (EHR) data, and CalEQRO timeliness data submitted annually by MHP.

Baseline: The MHP continues to contract with the Alameda 24-hour crisis line to ensure that crisis calls are answered by a live person. The average response time was 38 minutes, with a 100% compliance rate to the two-hour MHP standard. Urgent services did not require prior authorization.

Table 7: Timeliness to Urgent Services – Prior Authorization not Required

Urgent Appointment	All Services	Adult Services	Children's Services	Foster Care
Average Hours from Urgent Request to First Urgent Appointment	0.63 hrs	0.63 hrs	0 hrs	0 hrs
Compliance Rate Towards State Standard	100%	100%	100%	100%

Timeline: Annual review by QIC. Response time will be reported semi-annually to the management team and the Clinical Site Supervisor for crisis services.

Lead Staff: Crisis workers, Mobile Crisis Workers, ASOC System Administrator, Program Coordinator, and Project Coordinator.

Evaluation Findings

- Average response time is 38 minutes, 94.2% compliance of 2-hour standard
- There were 5 urgent request appointments.

The average response time remained the same and the compliance with the 2-hour standard decreased slightly from 100% to 94.2%. This goal will be continued in FY 2024-25.

Goal 3.3 Test Calls:

To monitor and make improvements to the 24-hour crisis/access line (including business line) including responses, the information given to the caller, and ensure that calls are being conducted in the callers' preferred language.

Member Impact: Test calls ensure that members are provided accurate information when they call the MHP and that staff can effectively utilize the translation services in the member's preferred language.

Interventions:

1. Results of the test calls will be recorded in the test call log, communicated to relevant staff or contractor; and concerns will be addressed by the Compliance Officer.

2. Results will be reviewed in the QIC annually for trends.
3. Review test calls in quarterly data group meetings.
4. Complete at least 20% of test calls in a language other than English.

Monitoring mechanisms: Test call log and call sheets

Baseline: There were 15 test calls completed: 9 test calls to the 24-hour crisis line and 6 test calls to the in-house business line. Zero test calls were conducted in Spanish. There was a 7% decrease in test calls and no alternate language testing.

Timeline: Compliance reports to DHCS quarterly; annual review by QIC.

Lead Staff: Compliance Officer.

Evaluation Findings

There were 12 test calls completed: 8 test calls to the 24-hour crisis line and 4 test calls to the in-house business line. One test call was conducted in Spanish. There were 4 fewer test calls than during the last evaluation period and BHD did conduct alternate language testing.

The QIC will spend two monthly meetings evaluating the workflow and data input processes to find areas that are impacting success in reaching the 50% goal. Findings will be used to determine needs in regard to trainings, documentation and workflow adjustments. QIC will also establish a monthly reporting apparatus to continually evaluate trends to provide any suggestions to improve effectiveness.

Section 4: Member Satisfaction

Goal 4.1 Member Satisfaction:

Diversify data collection to better gauge member satisfaction and identify areas that need improvement.

Member Impact: Member satisfaction surveys ensure that the MHP has a system in place for the voice of each member to be heard.

Interventions:

1. Administer Consumer Perception Survey to members twice per year.
2. Utilize brief consumer surveys to obtain data regarding satisfaction and improvement opportunities on topics determined by the QIC.
3. Review the results of the Consumer Perception Surveys at the QIC.

Monitoring mechanisms: Review survey data and focus group data.

Baseline: The MHP provided the Member Satisfaction survey once last year in May. For the May 2024 survey period, there were 78 surveys, an increase from 63 in May 2023. The majority of the surveys (73.1%) were completed by adults, with 19.2% submitted by youth, 5.1% submitted by family, and 2.5% by older adults. The number of surveys offered increased by 52% from last year (i.e., n=117 surveys offered May 2024 vs. n=77 surveys offered May 2023). Due to low numbers, adults were the only group compared to statewide (SW) responses. Table 8 shows the mean scores and percent agree improved for Siskiyou in May 2024 compared to May 2023.Table 9 shows that for the current May 2024 survey, in nearly all the domains Siskiyou has higher mean scores and percent agreement with survey statements than statewide responses.

Table 8: Satisfaction Score by Adult – Siskiyou County May 2024 Compared to May 2023

	Mean Score May 2024	Percent Agree May 2024	Mean Score May 2023	Percent Agree May 2023
Access	4.44	95.2%	4.28	90%
General Satisfaction	4.67	100.0%	4.4	93%
Outcome	4.17	88.2%	3.94	75%
Participation in Treatment Planning	4.40	90.0%	4.27	86%
Quality	4.50	95.1%	4.31	91%
Social Connectedness	4.11	79.7%	3.99	77%
Functioning	4.07	77.0%	3.98	74%

Table 9: Satisfaction Score by Adult – Siskiyou County Compared to Statewide May 2024

	Siskiyou Mean Score	Siskiyou Percent Agree	Statewide Mean Score	Statewide Percent Agree
Access	4.44	95.2%	4.35	91.4%
General Satisfaction	4.67	100.0%	4.45	91.7%
Outcome	4.17	88.2%	4.04	78.8%

Participation in Treatment Planning	4.40	90.0%	4.33	91.8%
Quality	4.50	95.1%	4.36	91.4%
Social Connectedness	4.11	79.7%	4.04	78.9%
Functioning	4.07	77.0%	4.03	76.2%

Timeline: Surveys conducted annually. Brief consumer surveys are conducted as directed by the QIC. Report at least annually to the Data Group.

Lead Staff: Compliance Officer, Project Coordinator, QIC, and QAM.

Evaluation Findings: RISR (Redwood Institute of Social Research) is developing cards for satisfaction survey QR code; new satisfaction survey approved by the Cultural Competence Committee (CCC).

The QIC will spend one designated month meeting evaluating the effectiveness of survey questions and data input processes. The Cultural Competency Committee will review responses to the member satisfaction surveys quarterly to determine trends. Findings will be used to determine needs in regard to trainings, documentation and workflow adjustments.

Goal 4.2 Grievances, Appeals, Expedited Appeals, and Fair Hearings:

To evaluate member grievances, appeals, and fair hearings for timeliness, care concerns, and trends.

Member Impact: Evaluating the grievances and appeals allows the MHP to monitor for areas that require quality improvement in order to ensure that all members have access to appropriate care and that the grievance and appeal system is responsive to member needs.

Interventions:

1. The Compliance Officer or designee will present data to QIC annually.
2. Compliance Officer will notify QAM, as needed, if trends or potential quality of care issues are identified.
3. QAM will review all grievances and appeals yearly for trends and quality of care issues.

Monitoring mechanisms: Review the member log and completed documentation.

Baseline: There were seven grievances filled during FY 22-23. Of the seven, one resulted in a change of provider. Two of the seven members were unable to be reached for phone

follow- up. There were no repeated issues noted.

There were also six exempt grievances logged for the FY, most related to misunderstanding or lack of communication.

There were no appeals, expedited appeals, state fair hearings, or second opinion requests during FY 22-23.

Timeline: Compliance Officer will present data to the QIC twice a year.

Lead Staff: Compliance Officer, QIC, and QAM.

Evaluation Findings

Twelve total grievances were reported. Three Quality of Care grievances occurred, one was unable to be reached for phone follow up, and one was unwilling to discuss further. There were no repeated issues.

Five total exempt grievances were logged (two no contact or unwilling to discuss further, two misunderstandings, and one resolved through management & QA review).

There were no appeals, expedited appeals, state fair hearings, or second opinion requests during FY 23-24.

This goal will be continued.

Goal 4.3 Change of Provider (COP) Requests:

To evaluate member requests to change persons providing services for timeliness, care concerns, and trends.

Member Impact: Monitoring the change of provider requests ensures that a seamless process is in place for members to change providers, as appropriate, and monitor for training opportunities to improve service delivery.

Interventions:

1. Change of provider requests are completed for any member that requests a change. Agency staff will complete the form in the event of verbal requests.
2. QAM will review annually for trends and quality of care issues.
3. QAM will report any identified trends or patterns to the QIC.

Monitoring mechanisms: Change of provider log and completed documentation.

Baseline: There were 62 total COPs, four of which were withdrawn. Of the 58 COPs, 43 (74%) were approved and 15 (26%) were denied, most due to not having an alternate provider available. Four members submitted more than one COP. Gender breakdown is as follows: 72% were female and 29% were male, 3% were not reported. Nine (26%) were

regarding children.

Department and provider type breakdowns: Meds: 12 (21%), CSOC: 13 (22%), ASOC: 33 (57%), Telehealth: 29 (50%), Clinicians: 72%, Behavioral Health Specialists: 21%, Peers: 0%, Nurses/Psych Aids: 0%.

Three providers had elevated COPs of five or more, and three had four, together making up 55% of the total change of providers.

Timeline: Compliance Officer presents data to the QI committee semi-annually. COP requests are processed within 10 days of request.

Lead Staff: Compliance Officer, QIC, and QAM.

Evaluation Findings: There were 98 total COPs, 11 of which were withdrawn. Of the 87 COPs, 61 (70%) were approved and 26 (30%) were denied, most due to not having an alternate provider available. Ten members submitted more than one COP. Gender breakdown is as follows: 65% were female and 35% were male. Thirteen (13%) were regarding children.

Department and provider type breakdowns: Clinicians 39 (40%), Medical providers 35 (36%), Behavioral Health Specialists 24 (21%).

There were eight providers who had more than 3 COPs. five providers had more than 5 COPs, three providers had more than 7 COPs, and two providers had more than 10 COPs.

We will be shifting to have this reported to the QIC annually with a trigger of deeper review when a provider has more than two in the same quarter or more than five for the year. 57 out of 87 were from those eight providers.

Goal 4.4 Consumer and Family Member Involvement:

To increase consumer and family member involvement in the quality improvement process through QI events, the QIC, and through the creation of peer-employee positions.

Member Impact: All services are improved when members and/or their families have a voice in all stages of the quality improvement process.

Interventions:

1. Incentives will be offered to consumers and family members for participation on the committees.
2. Provide training and support to peer employees, including to attain peer certification.
3. Provide outreach to increase consumer and family member participation.

Monitoring mechanisms: Committee and event sign-in sheets.

Baseline: Peer employees had a combined total of 2,370 hours. QIC had seven consumers participating, however, attendance was inconsistent. The Behavioral Health Advisory Board had two family members and two consumers. Cultural Competence Committee had participation from two consumers, and the committee collaborated with consumer-members from Six Stones Wellness Center.

Timeline: QIC will monitor semi-annually.

Lead Staff: QIC, Clinical Director, and MHSA Coordinator.

Evaluation Findings: Peer employees had a combined total of 704.25 hours. QIC had six unique consumers participating, however, attendance was inconsistent. The Behavioral Health Advisory Board had four unique consumers, including family members, who participated. Cultural Competence Committee had participation from six consumers, and the committee collaborated with consumer members from Six Stones Wellness Center.

We are actively recruiting for the CCC to get more community partners and members involved. We have developed a form and recruitment materials.

Section 5: Clinical Issues

Goal 5.1 Performance Outcomes:

Collect baseline measures for MHP priority outcome measures as outlined in BHIN 24-004

Member Impact: Monitoring member outcomes ensures that members are improving as a result of receiving services from the MHP.

Interventions:

1. Implement data collection for the following priority outcome measures:
    a. Follow-up After Emergency Department Visit for Mental Illness
    b. Follow-up After Hospitalization Visit for Mental Illness
    c. Antidepressant Medication Management
    d. Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics
    e. Adherence to Antipsychotic Medications for Individuals with schizophrenia
    f. Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
    g. Pharmacotherapy of Opioid Use Disorder

h. Use of Pharmacotherapy for Opioid Use Disorder

i. Initiation and Engagement of Substance use Disorder Treatment

Monitoring mechanisms: EHR data.

Baseline: CalMHSA did not allow individual counties to add forms into SmartCare. Because of the level of care/service not having a specified tool required by the state, there is no LOC/LOS available in SmartCare. Due to this barrier, these interventions were discontinued during the conversion process. A new Baseline will be established during FY 23-24.

Performance outcomes related to HEDIS measures including, FUM, FUA, and POD were monitored with tailored interventions to improve performance outcomes.

Timeline: CalMHSA has committed to developing reports for required quality measures, publication of these reports is to be determined.

Lead Staff: QAM, Clinical Director, System Administrators, Clinical supervisors, and Project Coordinator.

Evaluation Findings: CalMHSA is still working to develop proper data collection forms on the SmartCare EHR system. We are currently using alternate tools to continue monitoring these data collection measures. We are working with CalMHSA and HSAG to examine quality data collection practices for these data collection measures while unavailable through our EHR system. Program Directors, Project Coordinator and QAM continually review these materials to identify gaps. The QIC will be reviewing these data collection practices for their effectiveness and accuracy from an inter-programmatic perspective.

Goal 5.2 Utilization Management:

To perform documentation reviews to monitor utilization of services and timely and appropriate documentation for 100% of Service Authorization Requests (SARS), 100% of Treatment Authorization Requests (TARS), 10% of organizational and contractor documentation (non-hospital), and 10% of the active caseload for utilization.

Member Impact: Utilization management provides the evaluation of all services to ensure efficiency and appropriateness of care for members.

Interventions:

1. All new clinical staff will receive documentation training and documentation review.
2. Provide documentation training to all clinical staff to increase the quality of care, compliance, accurate billing, and timely completion of documentation.
3. Random utilization review by QI or peers will be provided to ensure regulatory compliance.
4. Utilization review of targeted cases will occur when trends or quality of care

concerns are identified.

5. Utilization review of documentation by contracted or organizational providers will be provided by the QAM or designee. Appeals follow the process identified in the provider manual.
6. Concurrent review of inpatient hospitalization will be provided by contractor, Kepro, and recorded on the Kepro platform and reported to the MHP via completed TAR forms.
7. Health Information Department (HID) staff review documentation for completeness and timeliness within 60 days after member admission and upon staff notice of termination.

Monitoring mechanisms: Inpatient census, Kepro platform, TAR log and TARs; HID chart review log; completed utilization; and provider denials and appeals.

Baseline: There was a total of 731 reviews completed, which represents a decline from the previous year because of the health information department shifting in focus to conversion from Anasazi to SmartCare, the new electronic medical record system. This includes 436 sixty-day reviews and 295 targeted clinician reviews. Additionally, during conversion, HID other team members performed a brief review of every open chart to ensure assessment and other essential documents were complete and up to date in preparation for conversion. 1058 of these reviews were completed.

Iris Telehealth, one of the MHP's contracted providers, reviewed clinical and medication providers' notes with 11 total reviews completed.

TAR and inpatient stay concurrent reviews were contracted out to Kepro. During the fiscal year, 100% of inpatient stays (57) were reviewed by Kepro, with a total of 402 days approved and 2 days rejected. The QAM continues to oversee the process and provides review of 10% of contract provider notes.

Timeline: Utilization: outcomes are presented annually to the QIC; quality of care concerns are communicated to the management team and appropriate supervisor within 24 hours of discovery; TARs are completed within 14 days of receipt; HID reviews within 60 days of initial service; and training provided as trends are identified and at least yearly.

Lead Staff: HID, System Administrators, Clinical Site Supervisors, Project Coordinator, and QAM.

Evaluation Findings

Health Information Department (HID) staff review documentation for completeness and timeliness within 60 days after member admission and upon staff notice of termination = 430

Number of Treatment Authorization Requests (TARS) approved by Kepro = 113

Number of contracted provider denials and appeals (Returned claims are appeals) = 34

Number of Service Authorization Requests (SARS) = 20

Number of Chart Reviews = 218

Goal 5.3 Quality Care:

To establish corrective action for 100% of occurrences that raise quality of care concerns.

Member Impact: implementing and completing corrective action plans ensures that members have access to high-quality and effective treatment and that the MHP has a mechanism to identify and address any potential disparities in care.

Interventions:

1. The QAM will assure timely corrective action for all quality of care issues.
2. Quality of care issues, corrective actions, training needs, and recommendations will be logged.
3. A representative from the MHP will participate in the Siskiyou County child death review team.

Monitoring mechanisms: Incident reports, after-hours call log, access reports, compliance hotline calls, member log, chart reviews, medication monitoring worksheets.

Baseline: Although there were no Quality of Care (QoC) issues logged during FY 22-23, seven have been logged since the beginning of FY 23-24, indicating, that whatever the reason for the lack of reported concerns, reports have returned to an expected frequency. The QAM continues to provide direct training to every service provider regarding documentation regulations and the QI program. New staff are encouraged to attend, at minimum, one QIC meeting, to gain a working understanding of the committee.

The MHP evaluates suspicious deaths, suicides, and homicides of members and member-related deaths. There is a clear process for sequestering involved charts and providing quality review related to services rendered. Any concerns are then annotated in the QoC log and followed up on as needed.

The MHP Director, or designee, continues to participate in the Siskiyou County child death review team.

Timeline: Specific timeframes will be issued with each quality of care plan of correction, and annual evaluation reported to the QIC.

Lead Staff: QIC, Compliance Officer, and QAM.

Evaluation Findings: In FY 23-24 there were 13 quality of care issues logged and resolved, based on data provided by SmartCare.

Goal 5.4 Medication Monitoring:

To provide safe and effective medication practices through a review of 10% of active medical members.

Member Impact: Medication monitoring is critical to ensuring that all members receive safe and effective medications that are compliant with the Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Interventions:

1. Monitor 10% of active medical member charts.
2. Ensure that the medication monitoring process is completed, and forms are submitted to HID.
3. Collaborate with Child Welfare Services (CWS) and review SB 1291 HEDIS measures for foster care youth.
4. QAM will identify and report trends to management team and QIC, as well as coordinate needed follow-up.

Monitoring mechanisms: Medication monitoring logs and review sheets.

Baseline: A total of 38 charts were reviewed by the contracted pharmacist for contra-indications and potential safety concerns. The MHP continues to struggle with finding a consistently available contractor to perform medication monitoring.

HEDIS measures for children and foster youth were tracked throughout the year. The Medication Monitoring committee review children and foster measures with QAM and Project Coordinator for quality checks and proper documentation compliance. Compliance with metabolic monitoring is a challenge with this age group, even with continued intervention and support from CSOC to get labs completed. CWS sends a representative to quarterly scheduled meetings.

Timeline: QIC review annually. Quarterly Medication Monitoring meeting for youth.

Lead Staff: QAM, HID, medical services staff, Compliance Officer, CWS, and medication-monitoring consultant.

Evaluation Findings: A total of 76 charts were reviewed for contraindications and potential safety concerns, including 57 internal reviews by QAM and 19 conducted by one contracted pharmacist. The Medication Monitoring Committee continues to meet quarterly with a representative for Child Welfare Services present coordinating to meet requests by the local court systems in regards to medication procedures.

Goal 5.5 Cultural and Linguistic Competence:

To increase the cultural and linguistic competence of the agency and contracted staff.

Additional goals are established by the committee in the cultural competence (CC) work plan.

Member Impact: Increasing the cultural and linguistic competence of the agency ensures that all MHP staff can understand, communicate with, and effectively interact with members across different cultural and/or language differences.

Interventions:

1. Revise the cultural competence plan annually.
2. Provide a minimum of two cultural competence training courses annually.
3. Provide alternative formats for all member informing materials as required.
4. Continue integration of cultural competence and quality improvement.

Monitoring mechanisms: MHP cultural competence plan, QIC/CCC meeting minutes, training log, training agendas, and sign-in sheets.

Baseline: The cultural competence plan for FY 22-23 was updated and posted to the county website. Three required cultural competence training courses were completed by all staff including: Cultural Competence, Understanding Unconscious Bias, and The Role of the Behavioral Health Interpreter. The MHP did not meet its goal for 4 training courses due to the extensive hours of training required to transition to the new electronic health record. The MHP continues to provide alternative formats to ensure member access to informing materials and has a designated staff training in running accessibility reports for documents that will be published on the website.

In order to ensure maximum participation and integration of the Cultural Competence Committee and Quality Improvement Committee, the two meetings were integrated into one monthly meeting. This occurred at the end of FY 22-23.

Timeline: Annual update of cultural competence plan, due to DHCS by end of quarter two. Minimum of quarterly reporting to the QI committee.

Lead Staff: CCC chairperson, Compliance Officer and QIC.

Evaluation Findings: The cultural competence plan for FY 23-24 was updated and posted to the county website. Four cultural competence training courses were completed by staff including: Recognizing Implicit Bias, Utilizing the Behavioral Health Interpreter, Working with Justice-Involved Individuals and Building a Multicultural Care Environment. The MHP continues to provide alternative formats to ensure member access to informing materials and has a designated staff training in running accessibility reports for documents that will be published on the website.

A subcommittee is also being developed for 18 months in collaboration with Queer Humboldt to focus on organizational cultural humility practices. This subcommittee will serve

under the CCC with representatives from multiple programs and community partners.

Goal 5.6 Full-Service Partnerships:

Improve the outcomes of Full-Service Partners (FSP).

Member Impact: Improving the FSP outcomes is critical to reducing member inpatient psychiatric hospitalizations, incarcerations, and episodes of homelessness, as well as increasing attendance in school, work, and outpatient treatment.

Interventions:

1. Provide a continuous quality review of MHSA policies and procedures and report findings and/or changes to the QIC.
2. Continue to work with Third Sector to improve FSP outcomes through Strength-Based Case Management.
3. Track and monitor the number of FSPs who receive housing and other services through the MHP.

Monitoring mechanisms: Flexible spending forms, Smart Care, and FSP registration data.

Baseline: The MHP provided housing for 30 FSP members. The MHP recorded 199 unduplicated FSP members. The MHP recorded 73 FSP members who received medication services. New MHSA Coordinator to provide oversight. Behavioral Health continues to train in and utilize the tools within the Strength-Based Case Management Model. This year, we expanded our clientele to include all members and FSP. We also implemented a fidelity review process to assess the integration of the model's tools and benefits to the members and staff, aiming for future self-efficiency.

Timeline: Annually.

Lead Staff: Project Coordinator, MHSA Coordinator, and QAM.

Evaluation Findings: In FY 23-24 there were 172 FSP members, 121 of whom were provided with housing and 148 received medication services.

BHD is working to integrate FSP members with the new programs that have started or will be starting soon such as Care Court and Justice Involved Reentry.

Section 6: Physical Health Care

Goal 6.1 Coordination between Managed Care Plan and MHP:

To improve coordination between Partnership Health/Carelon Network and the MHP through communication, monitoring referrals, and ensuring that members are served at the

appropriate level of care. To track 100% of referrals made to Carelon to improve continuous care.

Member Impact: Coordination of care ensures that members experience no delay in being referred to the appropriate level of care, regardless of if the care is through Partnership Health or the MHP.

Interventions:

1. Quarterly meetings between Partnership HealthPlan/Carelon and the MHP.
2. Monitor referrals through Carelon and MHP closed-loop referral tracker.
3. Monitor screening and transition of care tools for appropriate screening outcomes and transitions between the MHP and MCP.

Monitoring mechanisms: MOUs, access reports, screening forms, Carelon closed-loop referral tracker, and Screening and transition of care tracker.

Baseline: Communication and collaboration between the MHP and MCP partner continues to expand. Quarterly meetings with leadership continue. Additionally, Beacon (now Carelon) participated in piloting the DHCS screening tool, which allowed for increased communication between the two plans. The MHP also continues to have a unique relationship with the MCP through the SUD program, As Siskiyou County Substance Use Disorder program is part of the Partnership regional Model. SUD participates in quarterly quality improvement meetings with Partnership.

Timeline: Meetings with Partnership HealthPlan will occur quarterly, and referral reports will be generated monthly.

Lead Staff: QIC, intake coordinator, Project Coordinator, and QAM.

Evaluation Findings:

In FY 2023 -2024 the MHP and Partnership continued to develop their relationship as more programs developed that involved integral communication between the agencies such as Providing Access and Transforming Health Initiative Justice-Involved (PATH JI). The MHP and Partnership continued to have designated meetings alongside programmatic specific meetings. The MHP seeks to develop MCP involvement in FY 2024 -2025 in committees such as CCC and QIC.

Goal 6.2 Exchange of Information:

Provide consultation to physical health care providers and human service agencies and participate in health care exchange through SacValley MedShare.

Member Impact: Exchanging information with physical health care providers and other agencies ensures that members have their physical health care needs met and that they are

provided linkage to other supportive services.

Interventions:

1. Provide outreach to increase consultation with Fairchild Medical Clinic, Fairchild Hospital, and Mercy Medical Center.
2. Provide consultations for members under 5150 hold with emergency room staff and hospitalists when requested.
3. Track consultations through the consultation log.
4. Encourage psychiatric providers to utilize consultation as a tool to successfully step members down to a lower level of care.

Monitoring mechanisms: Policy and procedure, outreach log, consultation log, consultation form, and SacValley MedShare data.

Baseline: Seven consultations were provided in FY 22-23, one of which was identified as a crisis consultation. Six of the seven were members and two were internal consultations. Review and training on the consultation process in a variety of situations, including crisis and step-downs, were provided at the Drs Summit meeting, available to all contracted prescribers.

The implementation of the Health Care Exchange is ongoing. Contracted with CalMHSA, the MHP will be entering the CONNEX EHR through SmartCare. The MHP continues to contract with SacValley Med share as well and plans to expand access to key staff in the behavioral health departments.

Timeline: Annual QIC review.

Lead Staff: Medical services staff, intake coordinator, Compliance Officer, Project Coordinator, medical Health Assistant, and Clinical Director.

Evaluation Findings:

For the FY 23 -24 reporting period, seven consultations were recorded in the consultation log; five were external consultations, two were internal, and one was identified as a crisis. To improve the consultation documentation, clinical meetings occur monthly for providers both in-person and virtually; these meetings will continue in FY 24-25, as many of the MHP prescribers are telehealth.

The intake coordinator continues to obtain authorizations for the release of information for children and adult clients for their primary care providers and human service agencies, as appropriate. This process will remain the same for FY 24-25.

The MHP collaborated with SacValley MedShare throughout the fiscal year for the health care exchange, and the MHP provided contract evidence to DHCS to demonstrate progress towards meeting the CalAIM data-exchange initiatives. The MHP's current Electronic Health

Record is compatible with data exchange and is reportedly moving into the CONNEX program in FY 24-25 although dates are not finalized for this program.

Section 7: Provider Relations

Goal 7.1 Provider Appeals:

Maintain the provider appeal process so that 100% of appeals are processed timely.

Member Impact: Monitoring the provider appeal process ensures that the MHP is both efficient and effective in maintaining provider relationships and avoiding disruptions in member care.

Interventions:

1. Provider appeals are processed following the MHP's guidelines for timeliness and the levels of appeal as described in the provider manual.
2. Conduct regular meetings with organizational providers to improve communication and processes.

Monitoring mechanisms: Inpatient census log, provider appeal log, and denial letters.

Baseline: The MHP continues to work with one SMHS provider, Remi Vista. Meetings to collaborate and support this partnership occur monthly. Clinical staff collaborate on shared cases through case consultation, CFT, and TBS meetings, depending on the case. Remi Vista continues to have a staffing shortage, so the number of overall services was low. The MHP reported all appeals and denials occurred timely. There was a total of 34 services denied.

Timeline: Provider meetings scheduled at least quarterly.

Lead Staff: QAM, Deputy Director, CSOC System Administrator, CSOC Health Assistant, and fiscal staff.

Evaluation Findings: In FY 23-24 there were no appeals. The MHP denied 98 contract and organizational provider services. All denials occurred timely.

Due to the reduced staffing issues meetings continued to be a struggle. Collaborative meetings were able to occur quarterly with limited attendance by Remi Vista. For FY 2024 - 2025 alternative collaborative communication methods will be examined to supplement reduced meetings if staffing shortages continue. Documentation is a standing agenda item in all meetings, targeted training is offered as needed, and a direct line of communication has been established between the QAM and organization provider leadership.

Goal 7.2 Community-Based Services:

Through collaboration and formal agreements, the MHP will support community-based services and natural supports for members.

Member Impact: Supporting community-based services ensures that members have access to supportive services regardless of where they live in the county.

Interventions:

1. Partner with Six Stones Wellness Center to offer peer-run supportive services.
2. Partner with other qualified providers to extend the MHP network, with an emphasis on outlying areas of the county.
3. Expand services through school-based counseling.

Monitoring mechanisms: Executed contracts with service providers, network adequacy outcomes, and MHSA Annual Plan data.

Baseline: Six Stones Wellness Center served 145 returning members and added 72 new members. The MHP executed MHSA contracts the Siskiyou Community Resource Collaborative, which includes community resource centers throughout Siskiyou County, Dunamis Wellness, First-5, Happy Camp Community Action, Hellikon, Karuk Tribe, Lotus Educational, Quartz Valley Indian Reservation, T.E.A.C.H., Tiny Mighty Strong, Youth Empowerment Siskiyou, Yreka High School District. School-based counseling was supported Dunamis and Yreka High School District. The MHP strengthened its relationship with community providers in the outlying areas of the county such as the Happy Camp area, the Butte Valley/Tulelake area, and the Scott Valley area.

Timeline: Community-based service agreements are reported to QIC annually through the MHSA Coordinator.

Lead Staff: MHSA Coordinator, Project Coordinator, and Clinical Director or designee.

Evaluation Findings: Expanded into the schools and community resource centers in Siskiyou County meeting with County level and local level administration.