Siskiyou County
Behavioral Health Division

Quality Improvement Work Plan
Calendar Year 2025

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Definitions

- ASOC—Adult System of Care
- BHP-Behavioral Health Plan
- CalEQRO—California External Quality Review Organization
- CalMHSA – California Mental Health Services Authority
- 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
- HSAG – Health Services Advisory Group
- LOS—Level of Service Assessment
- MHSA—Mental Health Services Act
- PIP—Performance Improvement Project
- QA- Quality Assurance
- QIC—Quality Improvement Committee
- QoC—Quality of Care
- QM—Quality Management
- SAR—Service Authorization Request
- TAR—Treatment Authorization Request
- UM—Utilization Management

Quality Improvement Work Plan Introduction

The Siskiyou County Behavioral Health Division is an integrated mental health and substance use disorder treatment department. The Behavioral Health Plan (BHP) served 1,102 Medi-Cal members with mental illness and the Drug Medi-Cal Organized Delivery System (DMC-ODS) served 246 members of all ages with substance use disorders in the fiscal year (FY) 23-24. The mission of the BHP 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 make up the BHP's Quality Improvement Work Plan goals for Calendar Year (CY) 2025.

BHP Core Values

The BHP's core values include the following:

- Promotion of wellness and recovery
- The integrity of individual and organizational actions
- Dignity, worth, and diversity of all people
- The intrinsic worth of our clients as human beings
- Importance of human relationships
- Open and honest communication amongst our members
- Contributions of each employee
- Creation of an environment by which all persons can thrive and grow

BHP Services

The mental health services program is comprised of children's services (serving clients 0-18) and adult services (serving clients ages 18 and older), psychiatric/medication services, and Mental Health Services Act (MHSA) funded services. Services are delivered in the community, via county and contracted providers, in the family/community resource centers, at the wellness center, and two clinics located in north and south Siskiyou County. The Children's System of Care (CSOC) utilizes Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medi-Cal services to provide a variety of options for the treatment of children and adolescents such as assessment; individual, group, and collateral therapies; rehabilitation; case management; medication/psychiatric; intensive care coordination and intensive home-based services. Therapeutic behavioral services are available through a contracted provider. For urgent and acute problems, crisis services and mobile crisis are available 24-hours per day, 7-days per week via phone, or walk-in at our two clinic locations, two local hospital emergency rooms, and the jail. Individuals seeking services through the Adult System of Care (ASOC) are assessed and individual and group therapy, rehabilitation, case management, and medical/psychiatric services and the wellness center are available. Peer support is an

essential component of the treatment continuum, and peer providers are available in both the ASOC and CSOC programs. The mental health wellness program operates in Yreka through a contracted service provider and is consumer-run as part of the mental health plan's continuum of care. MHSA funds provide supportive services for full-service partners of all ages.

Quality Management Program

Under the direction of the BHP Director, the quality management (QM) program shall monitor the service delivery system to improve services and meet the needs of beneficiaries. To provide system-wide quality care, every individual within the organization is responsible to ensure that the beneficiary's mental health needs are met and are accountable for providing individualized services that are of high quality, are culturally relevant, language-appropriate, cost-efficient, and tailored to meet the unique needs of each beneficiary. The goal of the QM program is the ongoing development of a system that provides quality design, continuous improvement of services, and efficient use of resources. These goals are accomplished by establishing mechanisms that effectively improve quality, assuring service delivery integration and interagency collaboration, and examining the use of resources within the systems of care. The functions of the QM program include:

- Establish and maintain a systematic process for monitoring and tracking key indicators for client care and administrative support functions;
- Support organizational decision-making; implement and evaluate ongoing quality improvement activities across the BHP;
- Develop communication strategies to share information with providers and other appropriate stakeholders; and
- Create quality improvement capability across programs and services.

Under the Department of Health Care Services (DHCS) BHP contract, the Quality Assurance Manager and Compliance Officer along with the Quality Improvement Committee may review and evaluate any data, reports, performance measures, system utilization, authorizations, policies and procedures, meeting minutes, and any other agency activities.

Siskiyou County is contracting with the California Mental Health Services Authority (CalMHSA) for Quality Assurance and Quality Improvement measures. The coordination and communication with CalMHSA will be overseen by the Project Coordinator and Compliance Manager. All planned QM, QI, and utilization management (UM) activities comply with the BHP contract, Title 9 regulations, and 42 CFR. Compliance is achieved through continuous oversight, monitoring, tracking, and training; a feedback loop that includes providers, managers, organizational providers, and stakeholders; and ongoing communication.

Quality Improvement Committee

The QIC meetings are held monthly to review data, discuss trends and concerns, and make

recommendations that impact the delivery of services, administrative processes, and performance improvement projects.

The QIC is currently comprised of the Project Coordinator, Compliance Manager, consumers, stakeholders, Behavioral Health Specialists, crisis workers, Licensed Professionals of the Healing Arts, the Patient's Rights Advocate, fiscal staff, management, and representatives from the organizational provider network. The activities of the QIC include, but are not limited to, the following:

- Recommend policy decisions
- Review and evaluate the results of QM activities
- Performance improvement projects (PIPs)
- Institute needed QI actions
- Ensure follow-up of QI processes
- Document QIC meeting minutes regarding decisions and actions

Section 1: Performance Improvement Projects (PIP)

Goal 1.1 Active Non-Clinical PIP:

The BHP will improve follow-up attendance to specialty mental health services following an emergency department visit for 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, QIC meetings, technical assistance calls with Behavioral Health Concepts.

Baseline & Actions: 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 regarding trainings, documentation, and workflow adjustments. QIC will also establish a monthly reporting apparatus to continually evaluate the program's ability to meet PIP goal of 50%.

Timeline: Continue PIP until the scheduled completion date of June 30, 2025. By July 1, 2025, BHD will submit the design phase of the 2025-2027 non-clinical PIP to Health Services Advisory Group (HSAG), which is the new External Quality Review Organization for Behavioral Health Plans (inclusive of BHPs and DMC-ODS plans). The new non-clinical PIP will be to increase the percentage of members who receive at least one Peer Support Service.

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

Contractor: CalMHSA

Goal 1.2 Active Clinical PIP:

The BHP 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:

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.

Timeline: Continue PIP until the scheduled completion date on June 30, 2025. By July 1, 2025, BHD will submit the design phase of the 2025-2027 clinical PIP to HSAG. The new clinical PIP will be to improve the After Emergency Department Visit for Mental Illness (FUM) measure rate.

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

Contractor: CalMHSA

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. Submit monthly 274 reports.
2. Engage in quality review process for 274 with a goal of 6 error free submissions.
3. 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 regarding trainings, documentation and workflow adjustments. QIC will also establish a monthly reporting apparatus to continually evaluate 274 monthly quality checks and NACT reports.

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 SmartCare, the demographics of Medi-Cal members, and access log data.

Baseline:

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

Timeline: Internal provider list updated monthly. Network adequacy tool submitted quarterly. QIC will establish a monthly reporting apparatus to continually evaluate 274 monthly quality checks and NACT reports.

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

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 BHP 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 BHP 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.

3. Interventions from the Cultural and Linguistic Competence Plan:
    a. Meet with culturally diverse groups and agencies to increase/reinforce provider relationships at least two times per fiscal year.
    b. One of the annual mandatory training opportunities to BHP staff will target the specific cultural needs of minority ethnic groups that are in Siskiyou County.
    c. Provide mandatory annual language line training and random testing throughout the year to ensure staff are capable in the use of the language line.
    d. Inform all individuals at first request for services and during intake of the availability of language assistance services and that these services are free.
    e. Seek to recruit staff and contract with bilingual providers for translation and interpretation services. All translation/interpreters shall complete language proficiency testing.

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

Baseline: In future years it is our understanding that the new External Quality Review Organization (EQRO), 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 1 and the narrative below that table.

Table 1: Fiscal Year Data (SmartCare FY 23-24 / Kingsview Previous Years)

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 BHP changed to a new Electronic Health Record (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 rate 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.

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.

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 client 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:

As mentioned above under Goal 2.2, in FY 23-24 the BHP 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 from 15.6%). Please refer to Table 2. 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.

Table 2: Average Clinical Productivity Rate by Provider Type (SmartCare FY 23-24 / Kingsview Previous Years)

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%

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

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

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 BHP will provide ongoing training for processing and capturing timeliness related to urgent requests for initial appointments. The BHP will provide timeliness training for the Health Assistants to review data input and appropriate processes.
3. Project Coordinator will review all timeliness documentation as a co-signer. Any out of compliance issues are then reported to the supervisor in the responsible department.
4. Review access data for potential disparities annually and report to QIC.
5. QIC will be working to find if there are still any gaps that need interventions. QIC will identify additional interventions that may address the decrease in psychiatry timeliness from FY 22-23 to FY 23-24.

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 (shown in Table 3 below) decreased from FY 22-23 to FY 23-24 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, (shown in Table 4 below), 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.

Table 3: Timeliness from Initial Request to First Offered Non-Psychiatric Appointment

Non-Psychiatric Timeliness	All Services	Adult Services	Children's Services	Foster Care
FY 22-23 Average days from request to the first offered appointment	7 Days	6 Days	7 Days	8 Days
FY 23-24 Average days from request to the first offered appointment	6 Days	5 Days	7 Days	7 Days
FY 22-23 Compliance Rate Towards State Standard	81%	83%	77%	84%
FY 22-23 Compliance Rate Towards State Standard	89%	93%	88%	90%

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 4: Timeliness from Initial Request to First Offered Psychiatric Appointment

Psychiatric Timeliness	All Services	Adult Services	Children's Services	Foster Care
FY 22-23 Average days from request to the first offered appointment	7 Days	7 Days	7 Days	8 Days
FY 23-24 Average days from request to the first offered appointment	9 Days	8 Days	9 Days	8 days

FY 22-23 Compliance Rate Towards State Standard	97%	97%	98%	92%
FY 23-24 Compliance Rate Towards State Standard	87%	90%	85%	88%

Timeline: The BHP publishes timeliness data annually for the EQRO. Monitor access reports at QIC meetings quarterly.

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

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, EHR data, and EQRO timeliness data submitted annually by BHP.

Baseline: The BHP 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 94.2% compliance rate to the two-hour BHP 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%. from FY 22-23 to FY 23-24. Urgent services did not require prior authorization.

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.

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 BHP, and that staff can effectively utilize the translation services in the members' 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. Complete at least 20% of test calls in a language other than English.
3. 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.

Monitoring mechanisms: Test call log and call sheets

Baseline: In FY 22-23, 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.

In FY 23-24, there were 12 test calls completed: Eight test calls to the 24-hour crisis line and four test calls to the in-house business line. One test call was conducted in Spanish. There were three fewer test calls than during the last evaluation period and BHD did conduct alternate language testing.

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

Lead Staff: Compliance Officer and Project Coordinator

Contractor: CalMHSA

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 BHP has a system in place for the voice of each member to be heard.

Interventions:

1. Administer Member Perception Survey to members once per year.
2. Utilize brief member surveys to obtain data regarding satisfaction and improvement opportunities on topics determined by the QIC. RISR (Redwood Institute of Social Research) is developing cards for satisfaction survey QR code; new satisfaction survey approved by the Cultural Competence Committee (CCC).
3. 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 regarding trainings, documentation and workflow adjustments.

Monitoring mechanisms: Review survey data and focus group data.

Baseline: The BHP provided the Member Satisfaction survey once last year using the survey instrument provided by UCLA. 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% submitted 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 5 shows the mean scores, and percent agree improved for Siskiyou in May 2024 compared to May 2023. Table 6 shows Siskiyou has higher mean scores and percent agreement with survey statements than statewide responses.

Table 5: 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 6: 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 biannually. Brief member surveys are conducted as directed by the QIC. Report at least annually to the Data Group.

Lead Staff: Project Coordinator, QIC, and Compliance Manager

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 BHP to monitor for areas that require quality improvement 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 Project Coordinator and CalMHSA QA Representative, as needed, if trends or potential quality of care issues are identified.
3. Compliance Manager and Project Coordinator will review all grievances and appeals yearly for trends and quality of care issues.

Monitoring mechanisms: Review the member log and completed documentation.

Baseline: Twelve total grievances were reported during FY 23-24. 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.

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

Lead Staff: Compliance Officer, QIC and Project Coordinator.

Contractor: CalMHSA

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. Compliance Manager and Project Coordinator will review annually for trends and quality of care issues.
3. Compliance Manager and Project Coordinator will report any identified trends or patterns to the QIC.
4. 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.

Monitoring mechanisms: Change of provider log and completed documentation.

Baseline: There were 98 total COPs, eleven 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, 3% were not reported. Thirteen (15%) were regarding children.

Department and provider type breakdowns: Clinicians 39 (40%), Medical providers 35 (36%), Behavioral Health Specialists 24 (25%).

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. 57 out of 87 were from those eight providers.

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

Lead Staff: QIC, Compliance Manager and Project Coordinator.

Contractor: CalMHSA

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

Monitoring mechanisms: Committee and event sign-in sheets.

Baseline: Peer employees had a combined total of 704.25 hours. QIC had six unique members 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.

Timeline: QIC will monitor semi-annually.

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

Section 5: Clinical Issues

Goal 5.1 Performance Outcomes:

Collect baseline measures for BHP 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 BHP.

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
2. These measurement tools are being actively built and reviewed currently between BHD and CalMHSA. For the interventions we are working with HSAG to develop and verify that we have the tools to accurately measure. The interventions have yet to be fully established but once they are approved by HSAG we will be reviewing data measurement in the QIC regularly.

Monitoring mechanisms: EHR data.

Baseline: 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 Compliance Manager 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.

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

Lead Staff: Clinical Director, System Administrators, Clinical supervisors, Compliance Manager and Project Coordinator

Contractor: CalMHSA

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 in collaboration by the CalMHSA QA Representative, Compliance Manager and Project Coordinator 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 BHP 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:

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

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, Compliance Manager and Project Coordinator

Contractor: CalMHSA

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 BHP has a mechanism to identify and address any potential disparities in care.

Interventions:

1. The Compliance Manager and Project Coordinator 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 BHP 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: In FY 23-24 there were 13 quality of care issues logged and resolved, based on data provided by SmartCare. The Compliance Manager and Project Coordinator continue 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 BHP evaluates suspicious deaths, suicides, and homicides of member 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 BHP 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 Manager and Project Coordinator

Contractor: CalMHSA

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. Compliance Manager and Project Coordinator 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 76 charts were reviewed for contraindications and potential safety concerns, including 57 internal reviews by Quality Assurance Manager 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.

HEDIS measures for children and foster youth were tracked throughout the year. The Medication Monitoring committee review children and foster measures with 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: Project Coordinator, HID, medical services staff, Compliance Officer, CWS, and medication- monitoring consultant.

Contractor: CalMHSA

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

Baseline: The cultural competence plan for FY 23-24 was updated and posted to the county website. Four cultural competence training courses were completed by all staff including: Recognizing Unconscious Bias, Utilizing the Behavioral Health Interpreter, Working with Justice-Involved Individuals and Building a Multicultural Care Environment. The BHP 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.

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.

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 BHP.

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

Baseline:

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.

Timeline: Annually.

Lead Staff: Project Coordinator, MHSA Coordinator, and Compliance Manager.

Section 6: Physical Health Care

Goal 6.1 Coordination between Managed Care Plan and BHP:

To improve coordination between Partnership Health/Carelon Network and the BHP 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 BHP.

Interventions:

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

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

Baseline: In FY 2023 -2024 the BHP 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 BHP and Partnership continued to have designated meetings alongside programmatic specific meetings. The BHP seeks to develop MCSP involvement in FY 2024 -2025 in committees such as CCC and QIC.

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

Lead Staff: QIC, intake coordinator, Project Coordinator, and Compliance Manager.

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 holds 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: 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 234-245, as many of the BHP 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 BHP collaborated with SacValley MedShare throughout the fiscal year for the health care exchange, and the BHP provided contract evidence to DHCS to demonstrate progress towards meeting the CalAIM data-exchange initiatives. The BHP'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.

Timeline: Annual QIC review.

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

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 BHP is both efficient and effective in maintaining provider relationships and avoiding disruptions in member care.

Interventions:

1. Provider appeals are processed following the BHP'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: In FY 23-24 there were no appeals. The BHP 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 Project Coordinator and organization provider leadership.

Timeline: Provider meetings scheduled at least quarterly.

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

Goal 7.2 Community-Based Services:

Through collaboration and formal agreements, the BHP 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 BHP 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: In FY 22, Six Stones Wellness Center served 145 returning members and added 72 new members. The BHP 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 BHP 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.

In FY 23-23, expanded into the schools and community resource centers in Siskiyou County meeting with County level and local level administration.

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.