Siskiyou County Behavioral Health
Specialty Mental Health Services
Implementation Plan Update
FY 21-22

Table of Contents

Definitions

- AAP—Aid to Adoptive Parents
- ABGAR—Annual Beneficiary Grievance and Appeal Report
- CCR—California Code of Regulation
- Cal-MHSA—California Mental Health Services Authority
- CWS—Child Welfare Services
- CSOC—Children's System of Care
- CSEC—Commercially Sexually Exploited Children
- CSE-IT—Committee and CSEC Evaluation Tool
- CRC—Community Resource Centers
- CPM—Core Practice Model
- CCC—Cultural Competency Committee
- CLAS—Culturally and Linguistically Appropriate Services
- DHCS—Department of Health Care Services
- DMC-ODS—Drug Medi-Cal Organized Delivery System
- EPSDT—Early and Periodic Screening, Diagnosis and Treatment
- EHR—Electronic Health Record
- EQRO—External Quality Review Organization
- FFPSA—Family First Prevention Services Act
- FMC—Fairchild Medical Center
- FURS—Family Urgency Response System
- FFS—Fee-for-Service
- FTE—Full-Time Equivalency
- HIPAA—Health Insurance Portability and Accountability Act of 1996
- HMIS—Homeless Management Information System
- ICC—Intensive Care Coordination
- IHBS—Intensive Home-Based Services
- MOU—Memorandum of Understanding
- MHP—Mental Health Plan
- MHSA—Mental Health Services Act
- MHSUDS—Mental Health Substance Use Disorder Services
- NPI—National Provider Identification
- PET—Psychiatric Emergency Team
- PHP—Partnership HealthPlan
- PIP—Performance Improvement Project
- POA—Point of Authorization
- PHCP—Primary Health Care Physicians
- PHI—Protected Health Information
- QAPI—Quality Assessment and Performance Improvement
- QA—Quality Assurance
- QAM—Quality Assurance Manager
- *QI—Quality Improvement*
- QIWP—Quality Improvement Work Plan
- SMHS—Specialty Mental Health Services
- SAMHSA—Substance Abuse and Mental Health Services Administration
- SUD—Substance Use Disorder
- TDD—Telecommunications Device for the Deaf
- TBS—Therapeutic Behavioral Services
- TFC—Therapeutic Foster Care
- TAY—Transitional Age Youth
- UM—Utilization Management
- WPC—Whole Person Care

Mental Health Plan Overview

The Siskiyou County Behavioral Health Division, referred throughout this document as the County Mental Health Plan (MHP), has a Mission to promote the prevention of and recovery from mental illness and substance abuse for Siskiyou County individuals, families, and communities by providing accessible, caring, inclusive, and culturally respectful services.

The MHP's core values include the following:

- Promotion of wellness and recovery
- The integrity of individual and organization 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

The MHP is dedicated to developing, implementing, monitoring, and reviewing the following eight objectives:

1. Maintain accurate and reliable demographic and service-level data to measure and evaluate the impact of services and outcomes. The MHP expects leadership to promote equity of services through culturally responsive policies, practices, and procedures.
2. Expand the behavioral health workforce by recruiting, promoting, training, and supporting culturally and linguistically diverse leadership and expanding the workforce to include consumers and family members to create a better response for the needs of the community.
3. Provide culturally and linguistically appropriate behavioral health services, in an easy to understand written format in our two prominent languages (Spanish and English), as well as the Medi-Cal Manual in audio (English only). If needed, language assistance is available at no cost to the consumer. The MHP contracts with the AT&T Language Line to provide this no- cost service to our non-English speakers.
4. Improve access for all racial, ethnic, and cultural groups, including Hispanic, and Native American populations, TAY, older adults, veterans, LGBTQIA2-S individuals, persons released from jail, homeless individuals, foster care children, and consumer family members.
5. Provide at least four culturally informed trainings per fiscal year for behavioral health staff, contractors, and collaborative community partners.
6. Deliver behavioral health services, including outreach and education, throughout Siskiyou County in collaboration with other community partners

and co-locating services whenever possible, including in diverse community settings known to serve Hispanic and Native populations in the least restrictive environment.

7. Increase the proportion of persons who reflect the diversity of the county by expanding membership for the Quality Improvement Committee (QIC), the Cultural and Linguistic Competence Committee (CLCC), and other committees.
8. Hold personnel and contractors responsible for showing sensitivity to cultural and ethnic differences to ensure that clients and co-workers feel welcome, safe, understood, and respected at the MHP.

Siskiyou County Geography

Siskiyou County is a geographically large, rural frontier county with a population of approximately 44,076 persons, located in the Shasta Cascade region of Northern California. Approximately 6400 square miles in size, Siskiyou County is geographically diverse with lakes, dense forests, desert, and mountainous terrain. The county seat, Yreka, is located on I-5 approximately 20 minutes south of the Oregon border; however, access to the majority of towns and cities is primarily by two-lane road, with minimal public transportation to outlying areas in east county (the Butte Valley area) and west county (down Klamath River toward Happy Camp).

Geography and distance play important roles in determining service delivery. Siskiyou County does not have a central urban area but has a few towns along the main travel corridor of Interstate 5 and multiple small communities dispersed across the remaining 6300 square miles of the county. Only nine cities are incorporated. The county's public transportation system operates buses connecting the more populated areas; however, due to long distances, trips may be limited to once a day and in outlying areas may be limited to once a week. The primary Siskiyou County Behavioral Health clinic is located in Yreka and a smaller satellite clinic is located in Mt. Shasta, the second-largest city in the county.

The current make-up of Siskiyou County differs significantly from that of many California counties in that it is less racially and ethnically diverse with the significant majority of inhabitants identifying as Caucasian (72%) followed by Hispanic (12%), Native American/Alaskan Native (4%), Asian/Pacific Islander (2%), and African American/Black (1%). From the 2010 to 2020 census, the Caucasian group reduced by seven percentage points (79% to 72%) and the Hispanic group increased from 10% to 12%.

The county has a large population of Spanish speakers who reside in the eastern portion of the county, and Spanish is identified as the threshold language. The per capita income for all residents in 19 was $28,615 (U.S. Census 2019 Inflation-Adjusted Dollars) in comparison to a statewide per capita income during that period of $39,393. Eighty-three percent of Siskiyou County residents have earned a high school degree and 34% have obtained a Bachelor's degree or higher. Approximately 11.8% of residents live at or below the poverty line.

Services Provided

The MHP provides or coordinates outpatient mental health services and contracts with outside providers to deliver outpatient and inpatient treatment services. The MHP directly provides the following services:

- Rehabilitative mental health services include assessment, plan development, individual, group, and family therapy, rehabilitation services, individual and group, and collateral services.
- Medication support services include assessment of the need for medication, evaluation of clinical effectiveness and side effects, obtaining informed consent, medication education, collateral services, and plan development.
- Crisis intervention services include assessment, therapy (individual and/or collateral), and referral services.
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health services include assessment, plan development and treatment through mental health services, medication support services, crisis intervention services, Therapeutic Behavioral Services (TBS); Intensive Care Coordination (ICC); and Intensive Home-Based Services (IHBS).

The MHP has designed its intake and authorization process to ensure timely access to the system and appropriate utilization of services. When services are requested, the MHP schedules psychiatric services no later than 15 business days of the request date and non-psychiatric services are scheduled no later than 10 business days of the request date.

Behavioral Health Division Programs

The MHP mental health services program is comprised of Children's and Transitional Age Youth (TAY) Services (serving clients ages 0-20), and Adult Services (serving clients ages 18 and older). Services are delivered in the community through satellite offices staffed by the MHP, via contracted providers, family resource centers, and at two clinics located in north and south Siskiyou County.

Mental Health Services Act (MHSA) provides support services for full-service partners. Clients of all ages can benefit from psychiatric evaluation and medication services, if needed.

Children's and TAY Services

Children's Services utilizes EPSDT Medi-Cal services to provide a variety of options for the treatment of children and adolescents such as assessments, individual/ group/ collateral therapies, rehabilitation, case management, mental health treatment in collaboration with substance use disorder (SUD) services as appropriate, Pathways to Wellbeing, ICC, and IHBS for all children who meet criteria and when medically necessary. Also, intensive therapeutic behavioral services (TBS) are available within the network of providers. The MHP is in the initial collaborative stages toward establishing Therapeutic Foster Care (TFC).

In 2018, the Family First Prevention Services Act (FFPSA), was signed into law. The FFPSA aims to enhance support services for families to help children remain at home and reduce the use of unnecessary congregate care placements by increasing options for prevention services, providing increased oversight and requirements for placements, and by establishing requirements for congregate care placement settings. The essential services assigned to the MHP include the Qualified Individual (QI) Assessment, reporting, and fidelity wraparound aftercare services.

In an effort to ensure appropriate placement of youth into congregate care, FFPSA requires MHPs to designate a “Qualified Individual” (QI) to assist with placement determinations. FFPSA Part IV requires that an assessment by a QI be conducted any time a child is placed in a qualified residential treatment program (e.g., short-term residential therapeutic program) to determine if a child’s needs can instead be met with family members, in a family home or in one of the other approved settings, and to make other specified determinations.

The MHP identified its FFPSA team in October 2021. This team is comprised of a QI, a Wraparound Coordinator, and a FFPSA Supervisor. In addition, the MHP updated bill coding, which will also assist with data reporting, and will add the electronic copy of the QI Assessment and Report into the EHR.

Family Urgent Response System (FURS) services were fully implemented in fiscal year 20-21. FURS services are available to current and former foster youth, and their caregivers, to reduce the potential for placement disruption, family discord, and crisis evaluation/hospitalization. Youth or their caregivers can contact the FURS Hotline and receive an immediate in-person response from provider agencies. The mobile response team is comprised of Siskiyou County staff from Behavioral Health, Child Welfare Services (CWS), and Probation. Each agency provides a lead that rotates responding to after-hours calls, attempts to deescalate situations, and dispatches the team for face-to-face intervention whenever necessary.

Adult Services

Adult clients are provided a behavioral health assessment, wellness and recovery-oriented individual therapy, rehabilitation, and case management services as appropriate. The Adult System of Care Department successfully concluded the Integrated Care Innovation Project, and the MHP embedded a Whole Person Care philosophy throughout the agency. A mental health wellness program is available through a contracted service provider to clients and consumers in the community as part of the mental health plan's continuum of care.

The MHP ensures that other services are available, as needed, through provider contracts and/or referrals, including crisis stabilization, adult residential treatment services, crisis residential treatment services, psychiatric health facility services, psychiatric inpatient hospitalization, and psychiatric nursing facility services.

The MHP fully implemented Mental Health Diversion pursuant to Penal Code Section 1001.36. This is a court-supervised treatment program for mentally ill adult offenders

whose mental illness was a contributing factor in their offense. The program is provided in partnership with the Superior Court, Public Defender, District Attorney, and the Probation Department.

In January 2020, the MHP joined a 4.5-year Multi-County Full Service Partnership (FSP) Innovation Project designed to improve FSP outcomes. In collaboration with cohort counties, the MHP is endeavoring to increase consistency and continuity of care, address the wide variety of needs among FSP participants, and help staff more effectively serve participants with the greatest needs. The MHP trained staff in the evidenced based practice of Strengths-Based Case Management to better address FSP clients' needs, and support them in working toward active graduation to a more stable and independent life. A third-party evaluator will study the impact of these changes on staff, county, and FSP clients over the next 2.5 years.

In 2021, the MHP began working with stakeholders to implement Assisted Outpatient Treatment (AOT). AOT is sustained and intensive court-ordered treatment in the community for those most overcome by the symptoms of severe mental illness. The treatment mechanism is only used until a person is well enough to maintain their own treatment regimen. The program provides a bridge to recovery for those released from inpatient facilities, it can be an alternative to hospitalization, and stops the repeated use of emergency department visits, incarceration, and homelessness.

History & Background

Beginning in 1995, the State consolidated Fee-for-Service (FFS) and Short-Doyle/Medi-Cal programs into a single specialty mental health managed care program. This system allowed specialty mental health services to be carved out of Medi-Cal and thereafter became the responsibility of each county mental health plan. The Siskiyou County Behavioral Health Division (County MHP) was also impacted by the implementation of the Affordable Care Act, which expanded coverage to a large number of individuals. The MHP is now an integrated mental health and substance abuse treatment department, which serves more than 1,300 clients each year across all ages.

In 2011, the MHP initiated a series of major programmatic, structural, and leadership changes in response to a targeted audit by the Department of Health Care Services (DHCS). These changes were necessary to implement the policies, procedures, programs, services, and administrative functions to operate the Behavioral Health Services Department in compliance with state and federal regulations. The Department merged with the Departments of Social Services, Emergency Services, and Public Health to form Siskiyou County Health and Human Services Agency.

In August of 2018, the administrative structure of the MHP changed in an attempt to meet the increased challenges that come from the managed care rule, including hiring both its MHP Clinical Director and Administrative Director. In 2019, the Administrative Director resigned and MHP returned to its previous programmatic structure restored with the hiring of a MHP Deputy Director; however, continued to have a Clinical Director and a MHP Director. Over the last seven years, significant changes were made to the Mental Health Services Act (MHSA) programs, which had originally been implemented through the Family Resource Center network. The County has increased direction and oversight of all programs provided by the eight Family Resource Centers as well as increased oversight of services provided by the organizational provider network. Although the implementation of these changes was a lengthy and challenging process, the relationship with the resource centers over the last several years has improved and allowed the MHP to provide many new and exciting prevention and outreach opportunities.

Through several transitions, the new leadership team has worked diligently to implement quality assurance measures, quality improvement programs, policies, and up-to-date procedures, and a revamped compliance program.

In 2020, the MHP reformatted the Implementation Plan to meet the digital accessibility standards. For the ease of reading this document, Attachment 1 includes a historical outline of the major changes in the agency, programs, and services that have been implemented since 2014. This list includes MHSA and Substance Use Disorder treatment services which are fully integrated into the Siskiyou County Behavioral Health Services Division.

A. Planning, Coordination, Outreach, and Notification

A1. Public Planning Process

A1. Describe the public planning process utilized for the consolidation of MHP services and how members of the local mental health community were involved.

Siskiyou County Behavioral Health developed the initial Implementation Plan in 1997 to meet the requirements of Medi-Cal Specialty Mental Health Services Phase II Consolidation. At that time, Senate Bill 485 directed the State Department of Health Services to expand the implementation of Medi-Cal managed care. In 1994, Assembly Bill 757 established plans for Medi-Cal managed mental health care. The Behavioral Health Department worked with the Behavioral Health Services Board, beneficiaries, providers, family members, the patients' rights advocate, staff, community members, and outside agencies to assist with the development of the original Implementation Plan.

A2. Local Mental Health Board Letter

A2. Include a letter from the local mental health board or commission advising that they have reviewed the Implementation Plan.

After the collaborative planning process was completed to develop the original Implementation Plan for the consolidation of specialty mental health services, the Behavioral Health Board reviewed and approved the final plan. Phase II consolidation took effect in Siskiyou County on January 1, 1998. The Behavioral Health Board letter was included in the original Implementation Plan.

The Behavioral Health Board is provided with the updated annual plans.

A3. Processes for Screening and Referral

A3. Describe the process the MHP will use for screening and when appropriate, referral and coordination with other services.

Screening, referral, and coordination with other services are a critical component to providing excellent care to beneficiaries. The processes for coordinating with other agencies and service providers are as follows:

1. **Substance Use Disorders—**if the assessment determines that there is a substance abuse issue, mental health staff refer the beneficiary to SUD services. As an integrated department, all clinicians are trained in mental health and substance use disorder diagnoses.

2. **Education—**if the assessment determines that the beneficiary could benefit from coordinated care with an educational facility (e.g., schools, community college), MHP staff refer/link the beneficiary with the appropriate education professional. MHP staff work closely with the school system to provide specialty mental health services.

3. **Physical Health—**if the assessment determines that there is a need for health care services, MHP staff refer the beneficiary to Partnership HealthPlan (PHP) for medical care. PHP also provides the mental health benefits for clients with “mild or moderate” mental health issues. Care coordination and effective communication between MHP and PHP including procedures for exchanges of medical information are included in the Memorandum of Understanding (MOU) between MHP and PHP. The MOU is available upon request. If a client is assessed by the MHP as not meeting medical necessity criteria for specialty mental health services due to having a mild to moderate impairment, or having a condition that would be more responsive to appropriate physical health care, a referral is made to PHP and a Notice of Adverse Benefit Determination is issued. If a PHP member is screened by PHP as potentially requiring specialty mental health services, they will be referred to the MHP for an assessment to determine medical necessity.

   MHP staff also coordinates care with hospitals and rural and tribal health clinics.

4. **Housing—**if the assessment determines that the beneficiary requires assistance in obtaining or changing housing, the MHP staff refers the beneficiary to local housing programs, and/or assists the beneficiary and/or family to secure housing through MHSA support activities or other supported housing programs.

   All beneficiaries requiring housing supports are entered into the Homeless Management Information System (HMIS). HMIS is a data system used to record and analyze client, service, and housing data for individuals and families who are experiencing homelessness or at risk of homelessness. HMIS data enables Siskiyou County organizations to work towards their goals as they measure outputs, outcomes, and impacts. Aggregate HMIS data is used to understand the size, characteristics, and needs of the homeless population at multiple levels: project, system, local, state, and national. HMIS is administered at the local level by Continuums of Care (CoC), collaborations for addressing homelessness issues. The MHP is a member of the seven-county NorCal CoC. The NorCal CoC anticipates using HMIS to assist in implementing a region-wide Coordinated Entry System that will refer individuals to housing resources based on a prioritization list. The HMIS software conducts a vulnerability assessment that scores individuals for this list, prioritizing those with the highest service needs and the greatest barriers to accessing services. The MHP has one dedicated staff responsible for entering this data into the HMIS system and connecting homeless individuals to local resources.

5. **Social Services—**if the assessment determines that the beneficiary requires assistance in obtaining the services of Public Assistance, Child Welfare Services (CWS), or Adult Protective Services, the MHP staff help the beneficiary to access these services.

6. **Probation—**if the assessment determines that the beneficiary requires assistance with Probation services, the MHP staff collaborate as appropriate. The MHP has embedded staff in the Probation Day Reporting Center that provide individual and group services for beneficiaries that are criminally involved.

7. **Vocational Services / Employment—**if the assessment determines the beneficiary is interested in obtaining or changing employment, the MHP staff refer the client to an appropriate agency. Referrals are made to the Siskiyou County CalWORKs program and Siskiyou Works.

A4. Interagency Agreements

A4. For clients who require a system of care approach, provide a list of agencies with which the MHP has interagency agreements. Briefly describe the nature of those agreements. As an alternative, the MHP may include copies of any existing interagency.

The MHP has multiple interagency agreements for clients and beneficiaries who require a system of care approach. These agencies include Public Health, Social

Services, Child Welfare System, Probation, County Jail, Public Defender, the District Attorney, Office of Education, and Fairchild Medical Center.

Public Health— the MHP relies on the assistance of the Public Health Mobile Outreach Van to provide mental health service brochures, referrals, and outreach information to the east and west county areas. Additionally, the Director of Public Health provides administrative oversight for the MHP nurses.

Social Services— the MHP works with Social Services to provide CalWORKS group and individual services to clients who meet CalWORKS criteria. Additionally, the MHP and Social Services both participate in providing homeless services including the homeless multidisciplinary teams.

Child Welfare System (CWS) — the MHP and CWS have a longstanding relationship ensuring that foster youth are provided with mental health assessments and on-going care when medical necessity is met. The MHP manages the Family Partner Peer program through a SAMHSA Mental Health Block Grant which assists in providing supportive services to families and caregivers of children involved in the MHP and CWS systems. Additionally, CWS monitors the use of psychotropic medications, the use of antipsychotic medications, and the use of multiple concurrent psychotropic medications for foster youth through SafeMeasures. Quarterly, the MHP attends meetings with CWS to review SB 1291 HEDIS measures for medication monitoring for foster youth. The MHP, in collaboration with CWS, are working toward an implementation plan for Therapeutic Foster Care.

Probation — the MHP works closely with probation and has embedded a clinician and two behavioral health specialists into the day reporting center. Upon release from jail or prison, the MHP assists in the coordination of medication services and receives referrals for mental health assessments. The embedded clinician is responsible for all Mental Health Diversion assessments. Additionally, the Probation Department is a collaborative partner with the Siskiyou Revive program, which is funded through the Board of State and Community Corrections and managed by the MHP.

County Jail and Public Defender—the MHP assisted in the development of the County Mental Health Diversion program by embedding a part-time behavioral health specialist with the Public Defender to coordinate the diversion participants. This program was funded through a SAMHSA Mental Health Block Grant, which also allowed the MHP to place tablets in the booking area of the Siskiyou County Jail for officers to complete a Brief Jail-Based Mental Health Screening form on each individual that is housed at the jail; referrals from this screening tool are shared with the diversion team for further review of fitness for the diversion program.

Fairchild Medical Center (FMC) — The MHP collaborated with FMC through the duration of the MHSA Integrated Care Innovation Project, a pilot program integrating services to meet clients' physical and mental health care needs. This Innovation project ended in October of 2020. The MHP transitioned out of the pilot program and incorporated project learnings agency-wide. Beginning in December 2020, the MHP

stationed Psychiatric Emergency Team (PET) workers at Fairchild Hospital to improve response time, increase support and collaboration with hospital staff.

A5. Member Services Handbook Brochure

A5. Provide statement assuring that at least thirty (30) days prior to implementation, the MHP will provide a copy of proposed draft of the MHP's Member Services Handbook/Brochure.

In standard access procedures, MHP beneficiaries are offered the Member Services Handbook and brochure. Beneficiaries are educated about how they can access services, what services are available, and the steps in the beneficiary problem resolution process.

A6. Provider Handbook

A6. Provide a statement assuring that at least thirty (30) days prior to implementation, the MHP will provide a copy or proposed draft of the MHP's Provider Handbook/Brochure.

The MHP provider handbook includes the required components of procedures for requesting authorization of services, procedures for submitting claims for payments, the beneficiary problem resolution process, and the provider problem resolution process.

MHP staff providers are given access to the provider handbook during the onboarding process, and the handbook is available electronically along with all of the agency policies and procedures.

Contract providers are given the provider handbook upon new contract agreements or if any updates have been made to the handbook.

A7. 24-Hour Access and Crisis Line

A7. Describe how the MHP will provide for 24-hour phone access, including a statewide, toll-free phone line with linguistic capacity.

The MHP contracts with Crisis Support Services of Alameda County for the 24/7 Access and Crisis line. Translation is available in more than 140 languages including teletype (TDD) services for deaf and hearing-impaired individuals.

B. Continuity of Care

B1. Procedures for Transition of Services

B1. For beneficiaries receiving Fee-for-Service/Medi-Cal (FFS/MC) outpatient professional MHP services prior to Phase II consolidation, describe the procedures the MHP will use for the transition of services to protect the continuity of care for beneficiaries.

The MHP is fully operational and provides a range of specialty mental health services to Medi-Cal beneficiaries to assure continuity of care for all persons needing medically-necessary mental health services.

Medi-Cal beneficiaries who meet medical necessity criteria for specialty mental health services (SMHS) have the right to request continuity of care. Beneficiaries with pre-existing provider relationships who make a continuity of care request to the MHP will be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or a terminated network provider (i.e., an employee of the MHP or a contracted organizational or network provider). SMHS will continue to be provided, at the request of the beneficiary, for a period not to exceed 12 months, necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined by the MHP in consultation with the beneficiary and the provider, and consistent with good professional practice

For more information, see policy 14 CLIN 307, Continuity of Care.

C. Interface with Physical Health Care

C1. How MHP will Interface

C1. Describe how the MHP will interface with physical health care providers and provide clinical consultation and training when a beneficiary belongs to a physical health managed care plan and/or when the beneficiary has an FFS/MC primary health care provider.

The MHP psychiatrist is available to Primary Health Care Physicians (PHCP) for consultation and distribution of educational materials related to medications or other mental health care issues. During regular clinic hours and days, consultation with the psychiatrist is available at the MHP clinic site or by phone.

During non-business hours, urgent psychiatric issues are evaluated by the Psychiatric Emergency Team (PET) in conjunction with medical providers at the two

local emergency departments. PET workers are also stationed at Fairchild Hospital to improve response time and increase support for hospital staff.

As required by Title 9 Section 1810.370(a), there is an MOU between MHP and PHP. Following Section 1810.370(a) (2), the MHP provides the availability of clinical consultation, including consultation on medications, to PHCP for clients whose mental health conditions are being treated by PHCP.

Regulations regarding the management of confidential information and records, as per mental health laws and regulations and Welfare and Institutions Code, Section 5328, are adhered to when a specific MHP client is involved.

The MHP also provides intensive services to clients that have both Severe Mental Illness (SMI) and co-occurring physical health conditions. The client's physical health problems include conditions such as diabetes, chronic pain, stroke, lung disease, liver disease, traumatic brain injuries, and memory care issues. These medical conditions require the care of multiple specialists, such as cardiologists, neurologists, pulmonologists, urologists, nephrologists, and others to ensure their medical needs are addressed properly. The MHP offers these clients case management and peer services to assist them in navigating through complex coordination of the medical and mental health care systems. The MHP also advocates for clients to access services as needed that support their medical and mental health treatment goals.

For more information, see policies: Referral to Psychiatrist or Primary Care Physician MED 12-02; Clinical Consultation and Training MEDS 16-02; Crisis Intervention CLIN 12-29; MOU with Partnership HealthPlan of California.

D. Access, Cultural Competence, & Age Appropriateness

Under a 1915(b) waiver from the Health Care Financing Administration, access to Medi-Cal MHP services must be maintained or enhanced under the waivered program. Section 14684 W&I Code requires the delivery of culturally competent and age-appropriate services to the extent feasible.

D1. Level of Access

D1. Describe the level of access to Phase II FFS/MC MHP services.

The MHP does not currently use the same health record system that was utilized prior to consolidation and is unable to compare pre and post-consolidation levels of access data. As of November of 2012, the MHP began utilizing the Anasazi Electronic Health Record (EHR), which allows for more consistent and accurate data collection and reporting than was previously possible. In 2020, the MHP began

utilizing a level of service tool within the EHR to ensure that clients are accessing the appropriate levels of care. The tool assists in identifying areas of need and allows for more relevant and targeted program planning and service delivery throughout the county.

D2. Geographic Access, Special Populations, Under 21 Years

D2. Describe: a) How access to Medi-Cal MHP services will be maintained under Phase II consolidation, including a geographical access to services; b) How the MHP will maintain access for special populations; and c) How the MHP will assure adequate service capacity for full-scope Medi-Cal beneficiaries under age 21.

1. Geographical Access

The MHP maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of its beneficiaries by ensuring compliance with the State's Network Adequacy Standards.

The majority of specialty mental health services are delivered by the MHP because there are a limited number of providers available in Siskiyou County. On-going data demonstrates that MHP serves a large number of people and the proportion of persons served analyzed by age, gender, and race/ethnicity closely resembles the proportion of persons served by rural MHP's across California.

As required by DHCS MHSUDS Information Notice No. 18-011 and 20-012 regarding Network Adequacy, Siskiyou County's time and distance standards are 60 miles and 90 minutes for psychiatric services for Mental Health Services, Targeted Case Management, Crisis Intervention, and Medication Support Services. Time means the number of minutes it takes a beneficiary to travel from the beneficiary's residence to the nearest provider site. Distance means the number of miles a beneficiary must travel from the beneficiary's residence to the nearest provider site. The mental health services must either be within 60 miles from the beneficiary's residence or be within a 90-minute drive from the beneficiary's residence to meet the standards, unless the MHP is approved for a time and distance waiver.

Information Notice no. 20-012 requires MHPs to submit documentation to DHCS reported on a Network Adequacy Certification Tool on an annual basis that it complies with the following requirements:

- Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the county; and,
- Maintains a network of providers, operating within the scope of practice under State law, which is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the county.

The following map shows the beneficiary population density of the county by zip code in September 2018. This representation of the density remains stable from year to year; a majority of the beneficiaries reside along the I-5 corridor that runs

north/south through the center of the county. For beneficiaries living in the west and east regions, the MHP ensures timely access by offering transportation into the Yreka or Mount Shasta clinics and by sending clinicians and behavioral health specialists into the rural communities to provide direct services.

The MHP is approved for a time and distance waiver through DHCS for the areas of Happy Camp, Forks of Salmon, Somes Bar, and Tulelake. The MHP provides evidence to DHCS annually to demonstrate that the MHP is the closest specialty mental health provider to these areas and that the MHP is able to provide telehealth services to these areas, when appropriate.

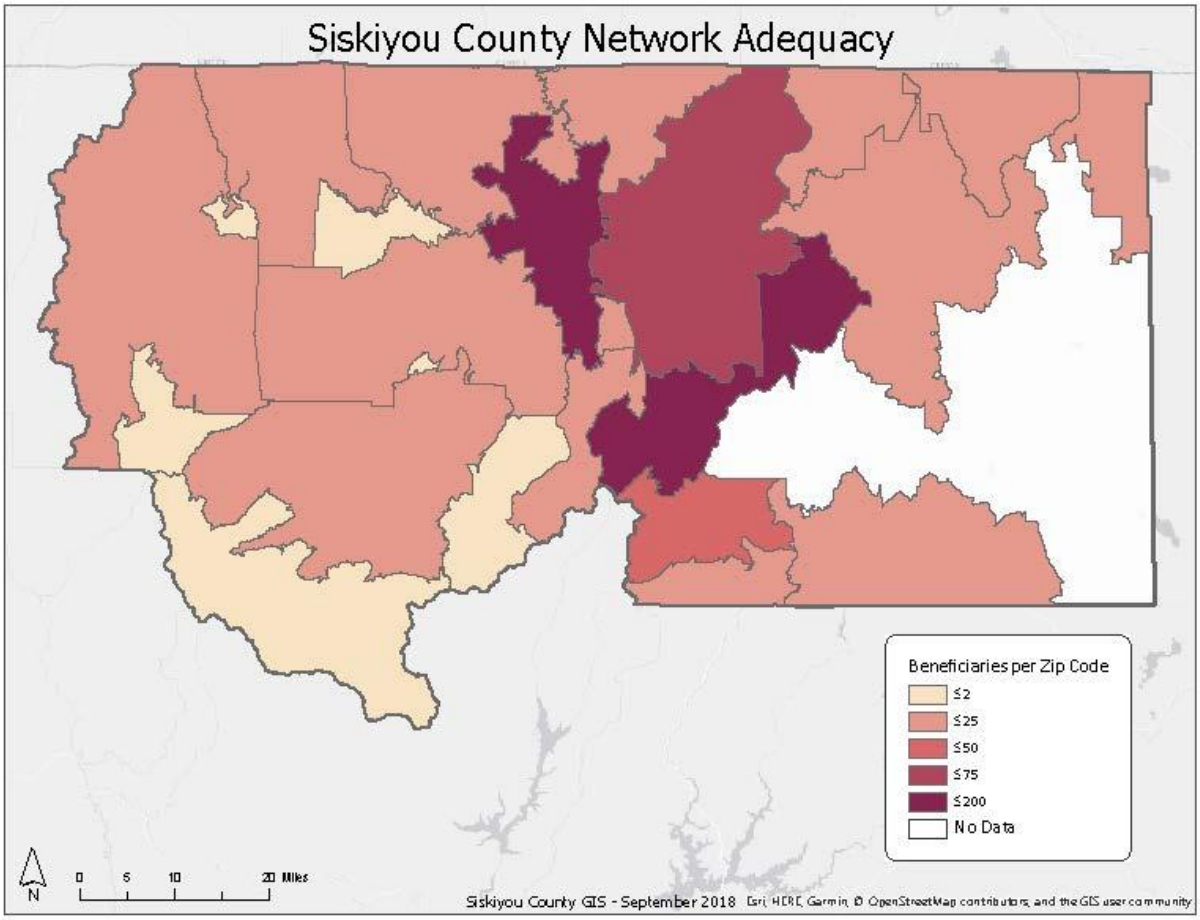

Figure 1 Siskiyou County Network Adequacy Heat Map 2019

2. Special Populations

The MHP is committed to providing specialty mental health services to the diverse populations in the county, including the Native American community, Hmong community, monolingual Spanish speaking community, homeless individuals, the criminally involved, and hard-to-reach individuals who may need behavioral health services, but who have not accessed them. Other unserved or

underserved special populations and ethnic minorities are identified annually through the Community Partnership Planning process and penetration reports.

The MHP provides informational presentations and exhibits during community events throughout the year. Examples of these events include community health fairs, the county fair, veterans' events, and focus groups. These presentations are focused on the Native American and homeless communities and offer educational information for the general public about mental illness, reducing stigma, and inform the community about the availability of services and treatment options.

To reach homeless and other hard-to-reach individuals, the MHP distributes informational materials through the eight Community Resource Centers (CRC) and the mobile Public Health Outreach Van. CRC staff are available to assist unserved and under-served individuals in accessing specialty mental health services and provide a variety of prevention services on site. The MHP collaborates with other county and community resources to hold multi-disciplinary team meetings for individuals experiencing homelessness and plans to reach additional unserved and under-served populations through the collaboration of community Faith-based organizations. The MHP has also initiated the utilization of an outreach van for mental health and alcohol and other drug access services, as well as COVID related information.

For beneficiaries who are criminally involved, the MHP collaborates with Siskiyou County Probation to ensure that MHP staff are embedded in the Day Reporting Center, evidence-based treatment options are offered onsite, and to ensure the transition of medication services for those exiting the jail or prison systems. The MHP also provides clinical assessments, case management, and specialty mental health services for individuals who are involved with Mental Health Diversion under Penal Code Section 1001.36.

In January 2022, the MHP will implement the Assisted Outpatient Treatment program in collaboration with the Courts, Public Defender, County Counsel, local law enforcement, and other local stakeholders to address the needs of severely mentally ill individuals who are not engaged in mental health treatment.

3. Beneficiaries Under Age 21

The MHP ensures that the needs of each age category are addressed. Age-appropriate services are available, including individual/family therapy, group therapy, medication support, rehabilitation services, and case management services. The MHP staff work closely with the schools and offer a range of services to meet the needs of children and their families by age, gender, race/ethnicity, and primary language.

The MHP ensures that each child/youth in the foster care system receives appropriate mental health services depending on the child's needs. This population includes children (ages 0-15) and Transition Age Youth (ages 16-25). The MHP maintains at least the minimum full-time equivalency (FTE) Network

Adequacy standards set by the state to ensure that the agency can provide adequate services to this population.

MHP clinicians are recruited with a focus on being a general practitioner prepared to work with individuals of all ages. The MHP provides each beneficiary with services guided by behaviors, attitudes, and policies that enable effective service provision in cross-cultural and age-appropriate settings to the fullest extent within the medical necessity criteria. If there is a specialized service needed for a beneficiary that the MHP cannot meet, the MHP oversees the provision of the service through referral. The goal of the MHP is for all clinicians of the Children's System of Care (CSOC) Department to be certified in Trauma-Focused Cognitive Behavioral Therapy; CSOC has also initiated training to expand current services and treatment for the 0-5 population. The MHP has initiated planning for the coordination of TFC services.

In 2017, the Commercially Sexually Exploited Children (CSEC) MOU was established. In collaboration with Child Welfare Services (CWS), Social Services, Probation and the Superior Court of Siskiyou, the MOU is currently being updated. In 2020, Siskiyou County was one of the few counties that had completed an AB2083 Interagency MOU between CWS, the MHP, Probation, County Office of Education and the Far Northern Regional Center for children/youth at risk of moving to a higher level of care. The MOU also addresses exchange of information and coordination details related to CSEC.

West Coast's Commercial Sexual Exploitation-Identification Tool (CSE-IT, pronounced "see it"), is designed to improve early identification of children who are commercially sexually exploited. The CSE-IT is appropriate for use by any provider serving youth, including child welfare workers, probation officers, mental health clinicians, and first responders. The MHP began using this tool in April of 2019, and runs monthly reports to identity missed opportunities for administration of the CSE-IT tool. Monthly reporting also helps identify training needs and increase compliance with assessment procedures. Full CSE-IT trainings are provided to onboarding staff. Refresher trainings occur every 6 months or more frequently, when necessary.

Katie A/Pathways to Wellbeing Process and Services

As a result of the Settlement Agreement in Katie A. v. Bonita, the State of California agreed to take a series of actions that transformed the way California children and youth who are in foster care, or who are at imminent risk of foster care placement, receive access to mental health services.

The MHP has implemented the Pathways to Wellbeing (Katie A Settlement Agreement) to serve children and youth who are eligible for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) services, including those who have been identified as Katie A subclass members. The MHP provides ICC and IHBS under the Core Practice Model (CPM) for clients under the age of 21 who are eligible for full-scope Medi-

Cal, when medically necessary. The MHP is in collaboration with the County Department of Social Services as they seek a provider for TFC.

The CPM is a set of practices and principles that promotes a set of values shared by all who seek to support children, youth, and families involved in child-serving agencies including, but not limited to, the child welfare system, special education, probation, drug and alcohol, and other health and human services agencies or legal systems with which the child or youth is involved. To effectively provide ICC and IHBS, the MHP utilizes the principles of the CPM, in which the services are provided in conjunction with a Child and Family Team.

It is the policy of the MHP that children and youth are screened to determine their mental health needs and whether Katie A eligibility criteria have been met during the assessment process. ICC and IHBS may be provided to children and youth as EPSDT services, regardless of whether the child/youth is a Katie A subclass member, consistent with DHCS guidance in Information Notice No. 16-004.

For more information, see policies: Intensive Services for Children & Youth Service Referral CLIN 16-00, Intensive Services for Children & Youth Service Assessment CLIN 16-01, and Intensive Services for Children & Youth Service Delivery CLIN 16-02.

D3. Procedures for 24-hour availability of Services

D3. Describe procedures the MHP will use to provide for 24-hour availability of services to address urgent conditions for beneficiaries who need services.

For urgent conditions, services are available 24-hours per day, 7 days per week via phone and walk-in at Ream Ave and Campus Drive sites, our two hospital emergency rooms, and at the county jail. The MHP contracts with a 24-hour crisis hotline to ensure that calls are answered and accurate information is provided to the beneficiaries. The MHP also has a Psychiatric Emergency Team that is available to respond to urgent and emergent services outside of standard business hours.

Previously, the MHP treated all emergent and urgent requests as a crisis and offered immediate crisis service within two hours. In an effort to better meet the needs of beneficiaries, new procedure were developed in 2021 to allow for urgent requests for services to be reviewed by a clinical supervisor and provided within 48 hours for services that do not require prior authorization and 96 hours for those that do.

For foster involved youth and families, FURS is also available 24-hours per day, 7 days per week.

D4. Out-of-County Access

D4. Describe how access will be ensured for beneficiaries living out of County when there may or may not be an in-plan provider available. This includes children in foster care placements and adults in residential placements, as well as other individuals who may seek mental health services in another county.

If the MHP is unable to provide the necessary services to a particular beneficiary, the MHP will adequately and timely cover the services out-of-network, for as long as the MHP is unable to provide them. The cost to beneficiaries for services provided out-of-network pursuant to an authorization will not be greater than the cost would be if the services were provided by the MHP directly. Requests for out-of-network services require a completed Service Authorization Request form, which requires approval by the Behavioral Health Director, a licensed clinical supervisor, or the Quality Assurance Manager. Standard timely access requirements apply to out-of-network services unless an out-of-network provider's standards are more stringent, in which case the timeliness standard will follow the more stringent guidelines.

Services for out-of-county youth

The MHP is responsible for authorizing or providing medically necessary specialty mental health services to children/youth who receive Aid to Adoptive Parents (AAP) or Kin-GAP funding/services. The MHP will provide medically necessary specialty mental health services to a child in an AAP or Kin-Gap aid code residing outside his or her county of origin in the same way that it would provide services to any other child for whom the MHP is listed as the county of responsibility on the Medi-Cal Eligibility Data System.

A service authorization request is submitted by the provider within three working days following the date of receipt of the request for services for children/youth in an Aid to Adoptive Parents (AAP) or Kin-GAP placement. The MHP will make an authorization decision (approve or deny services) within three working days following the date of receipt of the request for services. The QA manager notifies the MHP in the child's county of residence host county, the MHP in the child's adoptive parents' county of residence (if applicable), and the requesting provider of the approval decision within three working days or less following the date of receipt of the request for services.

Inpatient Services out-of-county

The MHP authorizes psychiatric inpatient services, as needed, from out-of-county providers. Beneficiaries who require inpatient care are referred to an inpatient facility that best meets their unique needs. Inpatient services for both adults and children are provided through contracts with approved hospitals and psychiatric health facilities, whenever possible. The quality assurance manager is responsible for the inpatient authorizations.

For more information, refer to policies: CLIN 304, CLIN 305, and CLIN 310.

D5. Languages, Visual/Hearing Information

D5. Describe the languages in which MHP information will be available and the standards for making these determinations, and (c) how the MHP will provide information for persons with visual and hearing impairments.

The MHP does not currently meet criteria for a threshold language but can provide informing materials in Spanish upon request. The MHP also has large-print Medi-Cal

Beneficiary handbooks available and is ensuring that all documents put on the MHP website are accessible for electronic readers.

The MHP strives to deliver culturally and linguistically appropriate services to clients and their families. This approach is reflected in the Division's mission statement, informing materials, and client plans. Cultural discussions are an integrated component of the child, youth, adult, and older adult service delivery systems. The MHP has adopted specific standards and processes for providing and monitoring culturally and linguistically competent services, including a Cultural Competency Committee (CCC); annual cultural and linguistic competence plan updates; promotion of the national standards on Culturally and Linguistically Appropriate Services (CLAS); and staff and interpreter training.

The MHP CCC is a cross-agency committee that is comprised of mental health and substance use disorder providers, administration, and consumer representatives. The CCC members work closely together to review data, organize cultural activities, promote culture and healing to help balance the lives of the persons served by the MHP, and the committee contributes to the overall planning and implementation of services in the county.

At least annually, the MHP provides cultural competence training to staff, including administrative and management staff, direct service providers, clerical/front office staff, and organizational providers. Covered topics include cultural diversity and sensitivity; CLAS standards and implementation; using culture-specific approaches to treatment and recovery; understanding client culture; and other subjects.

For more information, refer to policy: Cultural Competence Plan and Linguistic Requirements ADMIN 13-23; current Agency Cultural Competence (CC) Plan; Cultural Competency Work Plan.

D6. Provider Choice, Second Opinions

D6. Describe the process for ensuring that the beneficiary will: (a) have a choice of practitioner whenever feasible, and (b) availability of second opinions when there is a dispute regarding medical necessity and the MHP denies services.

1. Provider Choice

Whenever feasible and requested, clients of the MHP shall have an initial choice of provider from the list of individuals who have been identified by MHP as qualified providers for services authorized by the MHP, including the right to use culturally-specific providers.

Also, whenever feasible and requested, enrolled clients of the MHP shall have the opportunity to change to another individual provider who has been identified by MHP as a qualified provider for services authorized by the MHP.

Cases may be transferred from one provider to another either due to client request or clinical indication. All MHP clients may request a change of provider, including the right to use culturally-specific providers. Change of provider forms, in both English and Spanish, are available in the lobby at each MHP site.

2. Second Opinions

If services are denied or modified due to medical necessity or other allowable reasons, the MHP shall arrange for the client to obtain a second opinion about his/her mental health condition, if requested by the client. The second opinion is provided at no cost to the client, and is provided by specific licensed mental health professionals who are either employed by the MHP or under contract with the MHP.

D7. Written Log of Initial Contact

D7. Describe procedures the MHP will use to maintain a written log of initial contact (telephone, written, or in-person) by beneficiaries requesting MHP services from the MHP.

The MHP maintains written logs of initial requests for specialty mental health services that are made via phone, in person, or in writing (CCR. Title 9, chapter 11, section 1810.405(f)). The written logs contain the name of the beneficiary, date of the request, and the initial disposition of the request.

When services are requested for mental health or medication services, an electronic access form is completed for each beneficiary to monitor the timeliness of the request. The access form in the EHR includes the beneficiary's name, date of birth, request date, contact information and mailing address, Medi-Cal information, contact attempts/outcomes, first date offered, scheduled date, date of attended assessment, and post-assessment referral information.

E. Confidentiality

E1. Policies and Procedures Regarding Confidentiality

E1. Describe any changes in current or planned policies and procedures to continue to assure compliance with all applicable state and federal laws and regulations to protect beneficiary confidentiality.

All staff hired by, or volunteering with the MHP must review and sign an acknowledgment of understanding of all HIPAA policies and procedures before they make any contact with beneficiaries or their confidential information. The policies encompass all state and federal laws and regulations pertaining to the confidentiality of protected health information (PHI), including Title 42 Part II. These policies and procedures not only inform MHP staff about appropriate regulations regarding beneficiary confidentiality but also include how to report breaches in confidentiality and sanctions for these types of breaches.

All MHP staff are required upon hire, and annually thereafter, to take a course in HIPAA policy. This course reviews regulations for the protection of PHI. Staff must complete and pass an examination indicating their comprehension of covered materials.

All MHP staff are required upon hire, and annually thereafter to complete a compliance training of which confidentiality standards are a major component. Each MHP staff member must pass an exam on the compliance program and must sign an agreement to adhere to compliance and ethical standards while maintaining employment with the MHP.

The MHP staff are required to obtain informed consent from beneficiaries prior to the onset of services. Informed consent includes the limits of confidentiality.

All group services provided by the MHP require sign-in sheets that contain an agreement for the confidentiality of information shared during group be kept private amongst group members. This agreement is to inform group members of the importance of confidentiality.

For more information, refer to MHP's Compliance Plan and policies: Compliance Program ADMIN 13-05; Implementation of Compliance Program COMP 14-01; Compliance Trainings COMP 14-03; and the MHP Code of Conduct policy, Code of Conduct and Ethics ADMIN 14-05; HIPAA policies; Breach Notification and Mandatory Reporting ADMIN 14-01; Confidentiality of Client Records ADMIN 14-04; Confidentiality Agreement and Acknowledgement ADMIN 17-01; and Confidentiality Agreement and Acknowledgement ADMIN 17-01; Exhibit A

F. Quality Improvement, Utilization Management Programs

F1. Quality Improvement Program

F1. Describe the MHP's Quality Improvement (QI) Program.

The MHP has implemented a quality improvement (QI) program in accordance with federal regulations and the MHP Contract for evaluating the appropriateness and quality of services, including over-utilization and under-utilization of services. The QI program meets these requirements through the following processes:

1. **Quality Assessment and Performance Improvement**

   The MHP has implemented an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for the services it provides to

beneficiaries. The MHP QAPI Program strives to improve the MHP's established outcomes through structural and operational processes and activities that are consistent with current standards of practice.

The MHP maintains a written description of the QAPI Program that clearly defines the QAPI Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. The MHP evaluates the impact and effectiveness of its QAPI Program annually and updates the Program as necessary.

The QAPI program includes the collection and submission of performance measurement data required by DHCS, which may include performance measures specified by the federal Center for Medicare and Medicaid Services. The MHP measures and annually reports to DHCS its performance, using the standard measures identified by DHCS.

The MHP conducts performance monitoring activities throughout the MHPs' operations. These activities include, but are not limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances. The MHP has mechanisms to detect both underutilization of services and overutilization of services.

The MHP implements mechanisms to assess beneficiary/family satisfaction. The MHP assesses beneficiary/family satisfaction by:

a. Surveying beneficiary/family satisfaction with the MHP's services at least annually;
b. Evaluating beneficiary grievances, appeals, and fair hearings at least annually; and
c. Evaluating requests to change persons providing services at least annually.
d. The MHP informs providers of the results of beneficiary/family satisfaction activities.

The MHP implements mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism is under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring occurs at least annually.

The MHP has implemented mechanisms to address meaningful clinical issues affecting beneficiaries system-wide.

The MHP has implemented mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The MHP takes appropriate follow-up action when such an occurrence is identified. The results of these interventions are evaluated by MHP at least annually.

The MHP's QAPI Program will include Performance Improvement Projects.

2. QI Committee and Program

The MHP QI program monitors the service delivery system to improve the processes of providing care and better meeting the needs of its beneficiaries.

The MHP has established a QI Committee to review the quality of specialty mental health services provided to beneficiaries. The QI Committee recommends policy decisions; reviews and evaluates the results of QI activities, including performance improvement projects; institutes needed QI actions; ensures the follow-up of QI processes; and documents QI Committee meeting minutes regarding decisions and actions taken.

The QI Program is accountable to the MHP Director. The operation of the QI program includes substantial involvement by licensed mental health professionals. The QI Program includes active participation by MHP practitioners and providers, as well as beneficiaries and family members, in the planning, design, and execution of the QI Program.

QI activities will include:

a. Collecting and analyzing data to measure against the goals or prioritized areas of improvement that have been identified;
b. Identifying opportunities for improvement and deciding which opportunities to pursue;
c. Identifying relevant committees internal or external to the MHP to ensure appropriate exchange of information with the QI Committee;
d. Obtaining input from providers, beneficiaries, and family members in identifying barriers to the delivery of clinical care and administrative services;
e. Designing and implementing interventions to improve performance (including required performance improvement projects [PIPs]);
f. Measuring the effectiveness of the interventions;
g. Incorporating successful interventions in the system, as appropriate; and
h. Reviewing client grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required.

It is the goal of the MHP to build a structure that ensures the overall quality of services. This goal is accomplished by meaningful, realistic, and effective quality improvement activities and data-driven decision making; collaboration amongst staff, including consumer/family QI committee members; and utilization of technology for data analysis. Through data collection and analysis, significant trends are identified and policy and system-level changes are implemented, when appropriate.

The QIC assures that QI activities are completed and utilizes a continuous feedback loop to evaluate on-going quality improvement activities, including the PIPs. This feedback loop helps to monitor previously identified issues and provides an opportunity to track issues over time. The QIC continuously conducts planning and initiates new activities for sustaining improvement.

3. Utilization Review

The quality assurance department is responsible for all utilization management (UM) activities. Assessments will be provided to children and adults to determine medical necessity, level of care, and appropriateness of services by either the MHP or contracted providers. Additionally, utilization review activities are conducted retrospectively by the quality assurance and health information departments. Any problems or issues identified throughout the quality management system will be reviewed in the QIC. Charts may also be referred to the QA department by the QIC and by any other staff when there are concerns about the quality of care; specifically the authorization, provision, or documentation of specialty mental health services to a particular client.

4. QI Work Plan

The MHP maintains an annual QI work plan that includes the following:

1. An annual evaluation of the overall effectiveness of the QI program covering the current contract cycle with documented revisions as needed, utilizing data to demonstrate that QI activities have contributed to meaningful improvement in clinical care and beneficiary service;
2. Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review;
3. Evidence that QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service;
4. A description of completed and in-process QI activities, including performance improvement projects. The description will include:
5. Objectives and activities for the coming year;
6. Monitoring previously identified issues, including tracking issues over time; and
7. Targeted areas of improvement or change in service delivery or program design.
8. A description of mechanisms the MHP has implemented to assess the accessibility of services within its service delivery area. This will include goals for responsiveness for the MHP’s 24-hour toll-free telephone number, timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, and access to after-hours care; and

9. Evidence of compliance with the requirements for cultural competence and linguistic competence.

The QI work plan is provided to the External Quality Review Organization (EQRO) during its annual review of the MHP system. It is also provided to DHCS at yearly updates and updated on the agency website.

F2. Annual Work Plan

F2. Provide an assurance that within ninety (90) days after implementation, the MHP will have completed an annual work plan to include the requirements in Attachment 2, Section 2.

The Quality Improvement Work Plan (QIWP) and QIWP Evaluation are revised annually and are available online at https://www.co.siskiyou.ca.us/behavioralhealth.

F3. Utilization Management Program

F3. Describe the MHP's Utilization Management (UM) Program. MHPs may attach supportive documentation such as organizational charts, process descriptions, and policies and procedures to satisfy any of the following required elements of this section. The description must include the UM program description of structure and process, including the following:

a) The authorization process used by the MHP, including the process by which the MHP obtains relevant information to support its authorization decisions.

b) If the MHP delegates any UM activities to a separate entity, the MHP will describe how the relationship meets Department of Mental Health standards.

The MHP performs documentation reviews to monitor the utilization of services and timely and appropriate documentation for 100% of Service Authorization Requests, 100% of Treatment Authorization Requests, 10% of organizational and contractor documentation (non-hospital), and 10% of the active caseload for utilization and peer reviews combined.

The Quality Assurance Manager (QAM) provides new clinical staff documentation training and documentation review. Documentation training is also provided to all clinical staff to increase the quality of care, compliance, accurate billing, and timely completion of documentation.

For utilization review, cases are selected through random sampling by the quality department and forwarded to the clinical supervisor or consultant for review. Targeted reviews occur when trends are identified. Utilization review of documentation by contract or organizational providers is conducted by the QAM or designee and all appeals follow the process outlined in the provider manual.

G. Problem Resolution Process

G1. Beneficiary Problem Resolution Process

G1. Beneficiary Problem Resolution Processes: Describe how the MHP will respond to beneficiary concerns regarding service-related issues in compliance with statewide requirements specified in Attachment 4.

The MHP works to resolve any problem identified by clients in a sensitive and timely manner, utilizing the beneficiary problem resolution process. The resolution process includes procedures for addressing grievances, standard appeals, and expedited appeals. Clients and the MHP have rights and responsibilities specific to each type of process. These rights and responsibilities relate to how a problem is filed, regulatory notification and documentation requirements, and timeframes for filing and responding to grievances and appeals.

The MHP will follow all the requirements and procedures from the Code of Federal Regulations, Chapter 42, Section 438, Subpart F; the MHP Contract, Exhibit A, Attachment 12; and DHCS MHSUDS Information Notice No. 18-010E.

Grievance Timetable:

Within one business day of receipt, the Behavioral Health Director (or designee) will log the grievance and send written notice of receipt to the client. Upon disposition of the grievance, the Behavioral Health Director (or designee) will log the disposition and send written notice of the disposition within 90 to the client.

Standard Appeal Timetable:

Within one business day of receipt, the Behavioral Health Director (or designee) will log the standard appeal and send written notice of receipt to the client. Upon disposition of the appeal, the Behavioral Health Director (or designee) will log the disposition and send written notice of the disposition to the client within 30 days of receipt. This timeframe may be extended by up to 14 calendar days if the client requests and extension, or the MHP determines that there is a need for additional information and that they delay is in the client’s interest. If the extension is due to the MHP's request for a delay, the client is given written notice of the reason for the delay.

Expedited Appeal Timetable:

Within one business day of receipt, the Behavioral Health Director (or designee) will log the expedited appeal and send written notice of receipt to the client. Within two calendar days of receipt the Behavioral Health Director (or designee) will notify the client orally and in writing if the MHP denies a request for an expedited resolution of an appeal, at which point it would convert to the standard appeal process. The Behavioral Health Director (or designee) will log the disposition and then notify the client orally and in writing of the disposition within 72 hours of receipt.

The MHP has designated the Patient's Rights Advocate and Compliance Officer or a designated supervisor to aid clients in the problem resolution process. This individual also provides the status of a client's grievance or appeal, upon request.

The MHP has authorized the Quality Assurance Manager or designee to make decisions regarding appeals. These individuals have not been involved in any previous level of review or decision making. If the situation is clinical, the person(s) making the decision must be a licensed mental health professional with the appropriate clinical expertise in treating the beneficiary's condition. Such situations requiring clinical expertise include appeals based on lack of medical necessity; grievances regarding denial of expedited resolution of an appeal; and/or grievances/appeals that involve clinical issues.

The Compliance Officer or designee confidentially maintains a grievance and appeal log for tracking purposes. The log entry includes the client's name; the date of receipt; the nature of the problem; and the final disposition of the grievance or appeal (e.g., the date the decision is sent to the client, or documentation explaining the reason for lack of a final disposition).

Clients have the right to request a state fair hearing after completing the MHP problem resolution process.

For more information, see policy: Beneficiary Problem Resolution Process ADMIN 13-17.

G2. Provider Problem Resolution Process

G2. Provider Resolution Process: Describe how the MHP will respond to concerns from providers on any issue, including denial of payment authorization and claims processing delays, in compliance with statewide requirements specified in Attachment 5.

A provider may appeal a denied or modified request for the MHP payment authorization or a dispute with the MHP concerning the processing or payment of a provider's claim to the MHP. The written appeal must be submitted to the MHP within 90 calendar days of the date of receipt of the non-approval of payment or within 90 calendar days of the MHP's failure to act on the request in accordance with the regulatory time frames.

The MHP will have 60 calendar days from its receipt of the appeal to inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.

If the appeal concerns the denial or modification of an MHP payment authorization request, the MHP will utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.

If the appeal is not granted in full, the provider will be notified of any right to submit an appeal to DHCS pursuant to Section 1850.320.

If applicable, the provider shall submit a revised request for the MHP payment authorization within 30 calendar days from receipt of the MHP's decision to approve the MHP payment authorization request.

If applicable, the MHP will have 14 calendar days from the date of receipt of the provider's revised request for MHP payment authorization to submit the documentation to the Medi-Cal fiscal intermediary that is required to process the MHP payment authorization.

H. Administration

H1. Provider Selection Criteria

H1. Specify any practitioner provider and organizational provider selection criteria the MHP will utilize that exceed minimum state and federal criteria specified in Attachment 6.

1. Provision of Specialty Mental Health Care

Mental health services are provided by Medi-Cal certified mental health organizations or agencies and by mental health professionals who are licensed according to state requirements; or by non-licensed providers who agree to abide by the definitions, rules, and requirements for rehabilitative mental health services established by the Department of Health Care Services (DHCS), to the extent authorized under state law. All specialty mental health services are delivered from Medi-Cal certified mental health sites. The MHP implemented a process of ensuring all applicable network providers enroll through DHCS’s Provider Applications and Validation Enrollment (PAVE) portal. All required providers were enrolled by July 1, 2021.

For more information, see policies: Medical Service Provision Standard CLIN 305.

2. Provider Selection Criteria

To ensure delivery of the highest quality mental health services, the MHP is committed to selecting and retaining qualified providers that meet strict standards and regulations surrounding client care, availability of services, cultural competence, and client rights. The MHP reviews potential providers for acceptable licensing and compliance with state and federal regulations. In addition, providers are routinely reviewed for licensing and compliance with standards.

The MHP requires that providers are licensed, or registered/waivered per the State of California standards related to their practice or scope of work. The following information must be verified by the MHP unless the required information has been previously verified by the applicable licensing, certification, and/or registration board:

- The appropriate license and/or board certification or registration, as required for the particular provider type;
- Evidence of graduation or completion of any required education, as required for the particular provider type;
- Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
- Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

In addition to licensing standards, all contract providers must maintain a safe facility, store and dispense medications in compliance with all applicable state and federal laws and regulations, maintain client records in a manner that meets state and federal standards, meet the standards and requirements of the MHP Quality Improvement Program, and meet any additional requirements that are established by the MHP as part of a credentialing or evaluation process.

Organizational providers must also provide for appropriate supervision of staff, have as Head of Service a licensed mental health professional or another appropriate individual as described in state regulations, possess appropriate liability insurance, have accounting and fiscal practices that are sufficient to comply with its obligations pursuant to state code, and permit an on-site review at least every three years.

The MHP will verify and document the following information from each network provider, as applicable, but need not verify this information through a primary source:

- Work history;
- Hospital and clinic privileges in good standing;
- History of any suspension or curtailment of hospital and clinic privileges;
- Current Drug Enforcement Administration identification number;
- National Provider Identifier number;
- Current malpractice insurance in an adequate amount, as required for the particular provider type;
- History of liability claims against the provider;
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/;

- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal or on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network. This list is available at http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp; and
- History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

The MHP routinely verifies provider information through:

- Online verification of licenses to determine that they are current and clear of any formal actions, negative reports, or limitations monthly and at the time of hiring;
- Online verification that providers are not on the Medi-Cal List of Suspended and Ineligible Providers, and the Federal OIG List of Excluded Individuals/Entities and Excluded Parties List System on the System Award Management database.
- Checks of the National Plan and Provider Enumeration System to confirm that ordering, rendering, and referring providers have a current National Provider Identification (NPI) number; and
- Checks of the Social Security Death Master File at the time of hiring.

The MHP does not discriminate against particular providers who service high-risk populations or specialize in conditions that require costly treatment. A provider is not excluded from eligibility solely based on the type of license or certification that the provider possesses.

For more information, see policies: Provider Selection & Certification ADMIN 16-05; Agency Certification- Medi-Cal ADMIN 16-04.

3. Hospital Selection Criteria

The MHP requires that each hospital complies with federal Medicaid laws, regulations, guidelines, State statutes, regulations, and not violate the terms of the MHP contract between the MHP and DHCS. The Hospitals must sign a provider agreement with DHCS, provide psychiatric inpatient hospital services (within its scope of licensure) to all clients who are referred by the MHP, refer clients for other services when necessary, and not refuse an admission solely based on age, sex, race, religion, physical or mental disability, or national origin.

The MHP may also consider (but is not limited to) any or all of the following in selecting hospitals:

- History of Medi-Cal certification, licensure, and accreditation.
- Circumstances and outcomes of any current or previous litigation against the hospital.
- The geographic location(s) that would maximize client participation.

- The ability of the hospital to:
    - Offer services at competitive rates.
    - Demonstrate positive outcomes and cost-effectiveness.
    - Address the needs of clients based on factors including age, language, culture, physical disability, and specified clinical interventions.
    - Serve clients with severe mental illness and serious emotional disturbances.
    - Meet the quality improvement, authorization, clinical and administrative requirements of the MHP.
    - Work with clients, their families, and other providers in a collaborative and supportive manner.

If the MHP decides not to contract with a Traditional Hospital or Disproportionate Share Hospital, during the appropriate time of year when hospital contracts are negotiated, the MHP will submit a Request for Exemption from Contracting to DHCS including the information required by CCR, Title 9, § 1810.430(c).

H2. Sample Boilerplate

H2. Provide a statement assuring that at least thirty (30) days prior to *implementation, the MHP will submit a sample boilerplate contract for each type of provider with whom the MHP intends to contract--organizational and practitioner provider(s).*

The MHP submitted the sample boilerplate contract with the initial implementation plan. The MHP continues to submit the boilerplate contract with each annual Network Adequacy submission to the state.

H3. Claims Method and Timeframes

H3. Describe the method and time frames to be used by the MHP to process claims and payments for practitioners and organizational providers.

All services are documented in the EHR within five days of the date of service and contract providers are expected to follow the same guidelines. The Behavioral Health fiscal department submits Medi-Cal claims monthly.

H4. Inpatient services

The Quality Assurance Manager is responsible for the authorization for payment of inpatient services and is the designated “Point of Authorization” for Siskiyou County MHP. Hospitals have 10 days to notify the MHP of an inpatient admission unless otherwise specified in the contract. In 2019, the MHP initiated concurrent review policies and procedures for psychiatric inpatient hospital services and psychiatric health facility services as outlined in BHIN 19-026. The MHP ensures that all medically necessary covered SMHS are sufficient in amount, duration and scope to achieve the purpose for which the services are rendered. The MHP does not require

prior authorization for emergency admission to a psychiatric inpatient hospital or PHF. Following the date of admission, hospitals must request authorization for continued stay. Determinations will be made based on the criteria for acute or administrative day placements.

In accordance with the California Code of Regulation (CCR), Title 9, Section 1820.220, Siskiyou County MHP has designated a Point of Authorization (POA) where psychiatric inpatient hospitals submit written requests for MHP payment authorizations for Medi-Cal psychiatric inpatient hospital services provided to Siskiyou County clients. The contact information for the MHP POA is:

Siskiyou County Behavioral Health Division
2060 Campus Drive
Yreka, CA 96097-3321
(530) 841-4100

Procedures and timeframes for payment authorization are in accordance with CCR, Title 9, Section 1820.220. A written request for MHP payment authorization will be in the form of a Treatment Authorization Request. The POA staff who approve or deny payment will be licensed mental health or waivered/registered professionals of the MHP. All adverse decisions regarding hospital requests for payment authorization are reviewed and approved by a physician.

For additional information, refer to policies: Inpatient Treatment Authorization CLIN 16-05; Service Authorization requests Organization/Contracted Providers CLIN 302; Authorization of Specialty Mental Health Services CLIN 310.

H5. Out-of-county youth

The MHP maintains financial responsibility for all foster children/youth placed out of the county who receive specialty mental health services under Presumptive Transfer. Payments to host counties will be made in accordance with agreed-upon policies and procedures.*

The MHP will provide Specialty Mental Health Services to foster children upon presumptive transfer to the MHP from the MHP in the county of original jurisdiction without any delay in timeliness. Upon presumptive transfer, the MHP will assume responsibility for the authorization and provision of Medi-Cal Specialty Mental Health Services (SMHS) and the payment for services within 48 hours of placement of the foster child or youth outside of the county of original jurisdiction, unless a waiver based on an exception to presumptive transfer exists, based on DHCS Mental Health and Substance Use Disorder Services (MHSUDS) Information Notices No. 17-032 and 18-027.

Presumptive transfer means a prompt transfer of the responsibility for providing or arranging and paying for SMHS from the county of original jurisdiction to the county in which the foster child or youth resides. A presumptive transfer is intended to provide children and youth in foster care who are placed outside their

counties of original jurisdiction timely access to SMHS, consistent with their individual strengths and needs, and Medicaid Early and Periodic Screening Diagnostic and Treatment (EPSDT) requirements. In 2019, the MHP initiated the utilization of the California Mental Health Services Authority (Cal-MHSA) Presumptive Transfer Portal.

For more information, see policy: Service Authorization Requests Organizational/ Contracted Providers CLIN 302.

** Siskiyou County MHP will follow payment guidelines as appropriate for services provided to children and youth under Presumptive Transfer, as directed in MHSUDS Information Notice No. 17-032.*

H6. Contact Person

H4. Identify a contact person who can be reached regarding any questions with this Implementation Plan.

Tracie Lima, LCSW
Clinical Director
Siskiyou County Behavioral Health Division
2060 Campus Drive
Yreka, CA 96097-3321
(530) 841-2230

Attachment 1: Implementation Plan Overview of Revisions

Significant Developments in Mental Health Plan (MHP) System (Since 1997)

In 2011, in response to a targeted audit by the Department of Health Care Services, Behavioral Health initiated a series of major programmatic, structural and leadership changes. These changes were necessary to implement the policies, procedures, programs, services and administrative functions to operate the Behavioral Health Services Department in compliance with state and federal regulations. The Department merged with the Departments of Social Services, Emergency Services and Public Health to form Siskiyou County Health and Human Services Agency.

Several changes in leadership significantly impacted the Department's process with regard to implementing necessary changes, as well as difficulty recruiting and retaining an Agency Director. In April of 2018, the department hired its fourth Agency Director and in August of 2018, the administrative structure of the MHP changed in an attempt to meet the increased challenges that come from the managed care rule, including hiring both its Clinical Director and Administrative Director. In 2019, the Administrative Director resigned and the MHP returned to its previous programmatic structure restored with the hiring of a Deputy Director.

Over the last several years, significant changes were made to Mental Health Services Act (MHSA) programs, which had originally been implemented through the Family Resource Center network. The County has increased direction and oversight of all programs provided by the eight Family Resource Centers as well as increasing oversight of services provided by the organizational provider network. Although, implementation of these changes was a lengthy and challenging process the relationship with the resource centers over the last several years has improved and allowed us to provide many new and exciting prevention programs and outreach.

Below is a year-to-year description of the MHP changes from 2012 to the current reporting year.

2021 Changes and Updates

1. Full implementation of the Family Urgent Response System (FURS) services.
2. Addition of the Family First Prevention Services Act (FFPSA) services.
3. Changes to the MHP Innovation Projects include the conclusion of the Integrated Care Project, which transitioned to agency-wide integration these services, and the implementation of the new 4.5 year multi-county Full Service Partnership Innovation Project.
4. Changes to the services available for the criminally involved populations include the implementation planning for Assisted Outpatient Treatment program. A narrative description of the Mental Health Diversion program, implemented in 2020, was also added to the implementation plan.
5. Updates to the processes for screenings and referrals include the Homeless Management information System (HMIS) and Coordinated Entry System for

housing, embedded staff in the day reporting center for Probation, and Siskiyou Works for vocational/employment resources.

6. Interagency agreements updated for Fairchild Medical Center include stationing Psychiatric Emergency Team workers at the hospital during non-business hours.
7. Access to services updated to include time and distance waivers for network adequacy, updated special populations, procedures for 24-hour availability of services to include urgent requests for services, and the addition of Commercially Sexually Exploited Children (CSEC) assessments for beneficiaries under the age of 21.

2020 Changes and Updates

1. The Implementation Plan was reformatted to improve digital accessibility standards. Some sections of the original report have been moved to different section or subheadings to ensure that digital readers can accurately read the information. Many of the previous tables and images have been removed, but the content is still available in the narrative.
2. Addition of current programs, including Siskiyou Revive (Prop-47), Mental Health Diversion, integrated care, and Relias Training opportunities for new and existing staff.
3. Addition of section A6 Provider Handbook, D1 Level of Access, D4 Out of County Access, D6 Provider Choice and Second Opinions, D7 Written Log of Initial Contact, F3 Utilization Management Program, and H4 Contact Person.
4. Completion of Homeless Mentally Ill Outreach and Treatment program.
5. Initiation of California Emergency Solutions for Housing and the Health Information exchange.
6. Initiation of the Family Urgent Response System (FURS) SB80 and formulized the MOU for the Interagency Placement Committee, utilization of the Presumptive Transfer Portal, and Full-Service Partner Innovation Project and Individual Services and Supports Plan.
7. Full implementation of Drug Medi-Cal Organized Delivery System (DMC-ODS) programs and services and, in collaboration with Partnership Health Plan and other Superior Region counties, developed Regional Model Implementation Plan for Drug Medi-Cal Delivery System.

2019 Changes and Updates

1. Addition of current programs including Family Partner Peer, Homeless Mentally Ill Outreach and Treatment, Homeless Multidisciplinary Team Meetings, and Feedback Informed Treatment.
2. Addition of current system changes for DMC-ODS programs and services.
3. Notice of successful Triennial audit in May 2019.

4. Formulated Interagency Commercially Sexually Exploited Children (CSEC) Committee and CSEC Evaluation Tool (CSE-IT) as well as an in-house trainer for interagency trainings and collaborative CSI-IT data.
5. Resignation of the Administrative Director and hiring of Deputy Director.

2018 Changes and Updates

1. New partnership with Public Health Mobile Outreach Van.
2. Clinical Director and Administrative Director hired.
3. Development of the CSEC committee.

2017 Changes and Updates

1. Fully implemented the MHSA 3-year plan with annual updates through a stakeholder process.

2016 Changes and Updates

1. Notice of successful Triennial audit in May 2016.
2. Substance Use Disorder (SUD) program is certified to provide Drug Medi-Cal services effective December 2016 in Yreka and Mount Shasta.
3. Implementation of the Psychiatric Emergency Team, a dedicated after-hours crisis response team.

2015 Changes and Updates

1. International Statistical Classification of Diseases and Related Health Problems (ICD) 10 conversion completed.
2. Wellness Center in Yreka opened and served 224 unduplicated individuals.
3. Access system improved, intake coordinator position created, and dedicated staff to provide screenings and assessment.
4. Five-year Substance Abuse Strategic Prevention Plan was approved by DHCS and implemented.

2014 Changes and Updates

1. A new compliance officer was hired. Compliance Work Plan is completed annually, the submission of the Annual Beneficiary Grievance and Appeal Report (ABGAR) began, policies and procedures updated to conform to regulations, the access line test and verification calls established, and compliance training conducted annually for MHP staff and organizational providers. The Compliance Committee meets quarterly.
2. A new Quality Assurance Manager hired to oversee quality improvement, quality assurance, and utilization review. Quality Improvement Committee meetings are held quarterly and subcommittees for performance improvement projects meet more frequently. A variety of utilization review activities for the MHP and contract medical records were conducted. The provider manual was updated, and the Performance Improvement Projects were developed and implemented.

3. Recruitment and retention activities, including salary increases which resulted in clinicians recruited for open positions, becoming licensed, or being trained.

2013 Changes and Updates

1. Deputy Director hired; supervisor and management meetings held weekly.
2. Memorandum of Understanding (MOU) with Partnership HealthPlan and Continuum of Care. This additionally allowed the transportation services to expand through the MOU.

2012 Changes and Updates

1. Anasazi Electronic Health Record implemented.