Siskiyou County
Behavioral Health Division

Quality Improvement Work Plan
Fiscal Year 23-24

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Definitions

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

Purpose of Evaluation

The Siskiyou County Behavioral Health Division is an integrated mental health and substance use disorder treatment department. The Mental Health Plan (MHP) served 1,339 mentally ill clients and 229 substance use clients of all ages in the fiscal year (FY) 22-23. The mission of the MHP is to promote the prevention of, and recovery from, mental illness and substance abuse of those we serve by providing accessible, caring, and culturally competent services.

The following sections are an evaluation of the MHP's Quality Improvement Work Plan goals that were established for FY 22-23. The Quality Improvement Work Plan Evaluation is an opportunity to objectively review and transparently share the measurable progress towards meeting these goals. The Work Plan Evaluation is the first step in making data-driven decisions for the Quality Improvement Work Plan for FY 23-24.

Section 1: Performance Improvement Projects (PIP)

Goal 1.1 Active Non-Clinical PIP:

The MHP will improve follow-up attendance to specialty mental health services following an emergency department visit for beneficiaries with a mental health diagnosis.

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

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

Baseline & Actions: PIP baseline data and planned actions are recorded in the PIP documentation.

Timeline: Continue PIP for 24 months until completed.

Lead Staff: QAM, PIP team, CSOC site supervisor, and Director of Clinical Services.

Evaluation Findings

The non-clinical PIP has been active for 12 months or half the timeline of the PIP. From 02/18/2023 to 01/04/2024, crisis workers responded to 82 ED visits with beneficiaries who had an identified mental illness for which 26% (n=21) attended a mental health service within 7 Calendar Days of ED discharge. The aim was to increase the county baseline data of 62% by 5-percentage points, but the PIP shows the MHP is below half (i.e., 42%) of the county baseline.

Goal 1.2 Active Clinical PIP:

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

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

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

Baseline & Actions: PIP baseline data and planned actions are recorded in the PIP documentation.

Timeline: Continue PIP for 24 months until completed.

Lead Staff: QAM, PIP team, CSOC site supervisor, and director of clinical services.

Evaluation Findings

The clinical PIP has been active for 12 months or half the timeline of the PIP. Data was analyzed from 01/2023 to 12/2023 by comparing Q1-Q2 01/2023-06/2023 data to Q2-Q3 07/2023-12/2023 data for improvement. The number of unduplicated beneficiaries served was similar for both halves of the year (i.e., Q1-Q2 n=15, Q3-Q4 n=14). The number of unduplicated beneficiaries referred was similar for both halves of the year (i.e., Q1-Q2 n=8,

Q3-Q4 n=7). Finally, the number of beneficiaries who attended at least 6 group services was also similar for both halves of the year (i.e., Q1-Q2 n=12, Q3-Q4 n=10). There was a marginal 0.27-point improvement on average for subjective self-reported survey responses, but each group service is on a different topic. There were no graduates because participants have up to 2 years to complete the program so more time is needed to evaluate improvement.

Section 2: Service Delivery Capacity

Goal 2.1 Availability of Services

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

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

Interventions:

1. Continue monitoring network adequacy and submitting the tool annually.
2. Full-Time Equivalents (FTEs) and penetration rates will be reported to the QIC quarterly.
3. Identify staff on the internal provider list that are culturally and/or linguistically proficient.
4. Monitor timely access to services at least once a month.

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

FY 21-22 Baseline: Internal provider list updated monthly. As a result of the pandemic, DHCS extended the Network Adequacy due date; at the time of this report, the MHP had not received the annual findings report, but the MHP is not anticipating any corrective action items. FTEs and penetration rates are reported to the QIC and Data Group at least quarterly. The Project Coordinator monitored timely access to services weekly and reported quarterly outcomes to the Data Group.

Timeline: Internal provider list updated monthly. Network adequacy tool submitted quarterly. FTEs and penetration rates are reported to the QIC quarterly.

Lead Staff: Access Health Assistant and Project Coordinator.

Evaluation Findings

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

Goal 2.2 Penetration Rates:

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

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

Interventions:

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

Monitoring mechanisms: CalEQRO data. Kings View penetration data. Cultural Competence Plan. Public Health Division data.

FY 21-22 Baseline: Overall penetration rate of 6.8% and 6.3% rate for Hispanics (published by Kings View for FY 21-22). The Hispanic penetration rate is 3.3% compared to the small-rural counties' rate of 4.6% (data is from EQRO CY 2020). The language penetration rate for minority group members includes Hmong 1%, Laotian 6%, and Spanish 0.9%. The Siskiyou MHP uses a different methodology than that used by CalEQRO. The MHP monitors the Kings View penetration data monthly and annually reviews the EQRO data for the small-rural counties comparison. The Healthy Siskiyou Mobile Unit served 927 county residents, 46% of

which were in primarily Hispanic areas of the county. Mobile unit services are provided by bilingual (Spanish/English) staff.

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

Lead Staff: QIC, Cultural Competence Committee, and Project Coordinator.

Evaluation Findings

Siskiyou MHP continues to use a different methodology than that used by CalEQRO to measure penetration rates for the purpose of monthly monitoring the Data Group meetings.

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

Table 1: Fiscal Year Kings View Data

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

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

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

Table 2: Small-Rural Counties Calendar Year EQRO Data

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

Table 3: Siskiyou County Calendar Year EQRO Data

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

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

Goal 2.3 Clinical Productivity:

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

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

Interventions:

1. Monitor productivity rates and report to supervisors monthly.
2. Individual goal setting and follow-up between staff and clinical supervisor when a staff person is not meeting the productivity standard for their server type.
3. Monitor alternative productivity standards for non-clinical job classifications including nurses, the psychiatric emergency team, peers, and program coordinators.

Monitoring mechanisms: QIC and clinical supervisors monitor productivity through monthly reports.

FY 21-22 Baseline: Average clinical productivity rate is 43%. The average clinical productivity by provider type includes clinicians 44%, psychiatry 49%, and Behavioral Health Specialists 36%. Alternative productivity rates by job classification were nurses at 10%, and the psychiatric emergency team (24/7 crisis response team) at 19%.

Annual staff-wide documentation training and documentation training for all new employees by QAM.

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

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

Evaluation Findings

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

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

This stark discrepancy in year-over-year rates is accounted for by several factors. Due to staff turnover, the exact methodology that was used previously is no longer available. Additionally, the hours worked by providers who do not use county timecards (i.e., telehealth staff) were not available. The low reliability of this year's data will be addressed in the FY 23-24 QIWP.

Table 4: Average Clinical Productivity Rate by Provider Type

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

Section 3: Service Accessibility

Goal 3.1 Initial Appointments:

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

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

Interventions:

1. The quality improvement committee will monitor the access system for trends and performance and strategize solutions if initial appointments are not occurring timely.
2. The MHP will provide ongoing training for processing and capturing timeliness related to urgent requests for initial appointments.
3. Track homeless and foster youth access to services independently of other referrals.

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

FY 21-22 Baseline: The average number of days until the first offered non-psychiatric appointment was 5 days (93% compliance rate) and 9 days for psychiatric appointments (95% compliance rate). For CSOC non-urgent, non-psychiatric services, the average number of days until the first offered appointment was 7 days with a compliance rate of 92%. The CSOC average for foster youth is 6 days with 92% compliance.

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

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

Evaluation Findings

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

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

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

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

Non-Psychiatric Timeliness	All Services	Adult Services	Children's Services	Foster Care
	7 Days	6 Days	7 Days	8 Days
Compliance Rate Towards State Standard	81%	83%	77%	84%

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

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

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

Goal 3.2 Access to Urgent and Emergent Conditions:

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

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

Intervention:

1. The crisis line is answered by a live person 24/7 100% of the time.
2. Crisis workers enter the time of call and time of response in the electronic assessment.
3. Review response time semi-annually at the QIC to assure it is under the two-hour standard.

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

FY 21-22 Baseline: Average of 35 minutes for response time with a 94% compliance rate to the 2-hour standard. The Access to Services Standards policy was updated to include urgent appointments. The MHP received 3 urgent appointment requests that did not require prior authorization and none that required prior authorization for ICC, IHBS, or TBS.

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

Lead Staff: Crisis workers, crisis Site Supervisor, and Project Coordinator.

Evaluation Findings

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

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

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

Goal 3.3 Test Calls:

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

Beneficiary Impact: Test calls ensure that beneficiaries are provided accurate information when they call the MHP and that staff can effectively utilize the translation services in the beneficiaries preferred language.

Interventions:

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

3. Review test calls in quarterly data group meetings.
4. Complete at least 20% of test calls in a language other than English.

Monitoring mechanisms: Test call log and call sheets

FY 21-22 Baseline: 18 test calls were completed. Ten were to the 24-hour crisis line. Eight of the calls were to the in-house business line, (4 were conducted in Spanish).

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

Lead Staff: Compliance Officer.

Evaluation Findings

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

Section 4: Beneficiary Satisfaction

Goal 4.1 Beneficiary Satisfaction:

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

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

Interventions:

1. Administer Consumer Perception Survey to beneficiaries twice per year.
2. In response to Consumer Perception Survey outcomes, utilize brief consumer surveys to obtain data regarding satisfaction on topics determined by the QIC.
3. Review the results of the Consumer Perception Surveys at the QIC to develop brief consumer surveys.

Monitoring mechanisms: Review survey data and focus group data.

FY 21-22 Baseline: Due to the COVID-19 pandemic, one round of surveys was conducted, but the data was not available for analysis.

Timeline: Surveys conducted biannually. Brief consumer surveys are conducted as directed by the QIC. Report annually to the all-staff meeting.

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

Evaluation Findings

FY 22-23: The MHP provided the Beneficiary Satisfaction survey once last year and not bi-annually as planned. For the May 2023 survey period, there were 63 surveys completed mostly by adults with 14% submitted by youth, 8% submitted by family, and 8% submitted by older adults. The surveys done by families increased from zero to 8% from last year. Also, the amount of surveys offered increased by 26% from last year (i.e., n=77 surveys offered May 2023 vs. n=61 surveys offered May 2022). Due to low numbers, adults were the only group compared to statewide (SW) responses. Table 9 shows Siskiyou is in line with statewide responses.

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

	Mean Score	Percent Agree	SW Mean Score	SW Percent Agree
Access	4.28	90%	4.33	91%
General Satisfaction	4.4	93%	4.42	91%
Outcome	3.94	75%	4.00	77%
Participation in Treatment Planning	4.27	86%	4.33	92%
Quality	4.31	91%	4.34	91%
Social Connectedness	3.99	77%	3.98	77%
Functioning	3.98	74%	3.98	75%

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

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

Beneficiary Impact: Evaluating the grievances and appeals allows the MHP to monitor for areas that require quality improvement in order to ensure that all beneficiaries have access

to appropriate care and that the grievance and appeal system is responsive to beneficiary needs.

Interventions:

1. The Compliance Officer will present data to QIC semi-annually.
2. QAM will review all grievances and appeals yearly for trends and quality of care issues.

Monitoring mechanisms: Review the beneficiary log and completed documentation.

FY 21-22 Baseline: Eighteen grievances and four exempt grievances were received. It took the MHP an average of 22 business days from the date of the grievance to determine a disposition (Median= 12; standard deviation= 26; Range = 88). 100% of the grievances were completed within the 90 days timeliness standard. There were zero State Fair Hearings or appeals.

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

Lead Staff: Compliance Officer, QIC, and QAM.

Evaluation Findings

There were seven grievances filled during FY 22-23. Of the seven, one resulted in a change of provider. Two of the seven clients were unable to be reached for phone follow-up. There were no repeated issues noted.

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

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

Goal 4.3 Change of Provider (COP) Requests:

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

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

Interventions:

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

Monitoring mechanisms: Change of provider log and completed documentation.

FY 21-22 Baseline: The MHP received 69 change of provider (COP) requests; 20% were requested by six individual clients. For the COP requests, 93% were for adults and 7% were for children/youth; 52% were female requestors and 48% were male. For the provider types, 38% of the requests were to change Clinicians, 28% were to change Behavioral Health Specialists, and 35% were to change a medical provider. On average, it took the MHP 15 business days to process COP requests, as compared to the 10-day standard.

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

Lead Staff: Compliance Officer, QIC, and QAM.

Evaluation Findings

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

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

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

Goal 4.4 Consumer and Family Member Involvement:

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

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

Interventions:

1. Incentives will be offered to consumers and family members for participation on the committees.
2. Provide training and support to peer employees.
3. Provide outreach to increase consumer and family member participation.
4. Develop informing material on how consumers and family members can be involved in various committees and volunteer opportunities. Ensure the materials are available online and at MHP site locations.

Monitoring mechanisms: Committee and event sign-in sheets.

FY 21-22 Baseline: Peer employees had a combined total of 1,747 hours. QIC has six consumers participating. Behavioral Health Advisory Board had two family members and one consumer. Cultural Competence Committee had participation from two consumers, and the committee collaborated with consumer-members from Six Stones Wellness Center.

Timeline: QIC will monitor semi-annually.

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

Evaluation Findings

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

Section 5: Clinical Issues

Goal 5.1 Performance Outcomes:

To provide the Level of Service (LOS) Assessment as an outcome measurement system-wide by administering it to all clients open to adult and children's services.

Beneficiary Impact: Monitoring client outcomes ensures that beneficiaries are improving as a result of receiving services from the MHP.

Interventions:

1. Clinicians will administer the LOS at the time of assessment, as indicated in changes in clinical presentation, and at the time of closing.
2. LOS Outcome data is reported annually to the QIC and other stakeholders.
3. Project Coordinator will report ongoing outcome measurements to the Data Group semi-annually.

Monitoring mechanisms: Anasazi data.

FY 21-22 Baseline: 1,081 Level of Service (LOS) Assessments were completed. For clients with more than one completed LOS, 19% had a decrease in their score and 9% had an increase.

Timeline: Training certifications of agency and contracted clinicians within 30 days of hire date.

Lead Staff: Clinical supervisors and Project Coordinator.

Evaluation Findings

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

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

Goal 5.2 Utilization Management:

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

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

Interventions:

1. QAM will provide new clinical staff documentation training and documentation review.
2. Provide documentation training to all clinical staff to increase the quality of care, compliance, accurate billing, and timely completion of documentation.

3. Utilization review: the quality department will identify cases through random sampling and distribute them for review. Targeted reviews occur when trends are identified.
4. Utilization review of documentation by contracted or organizational providers is done by the QAM or designee. Appeals follow the process in the provider manual.
5. TARs are reviewed by the QAM or designee and recorded on the inpatient census log and TAR forms.
6. Health Information Department (HID) staff review documentation for completeness and timeliness within 60 days after client admission.
7. Crisis supervisors provide a concurrent review for all Medi-Cal inpatient psychiatric hospitalizations. The QAM reviews all concurrent review documentation associated with TAR submissions and 10% of concurrent review documentation associated with psychiatric health facility invoices.

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

FY 21-22 Baseline: In FY 21-22, 1,358 reviews were completed. This included 893 sixty-day reviews, targeted clinical reviews, 166 chart reviews, 47 treatment authorization requests (TAR), 21 service authorization requests (SAR), and 231 organization chart reviews (10% of all organization provider services). The QAM reviews the Psychiatric Health Facility stay records and concurrent review information. The training was available as needed for MHP staff by the QAM, and the QAM reports review trends to the QIC annually. The MHP did not identify any specific trends in FY 21-22 utilization review period.

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

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

Evaluation Findings

FY 22-23: There was a total of 731 reviews completed, which represents a decline from the previous year because of the health information department shifting in focus to conversion from Anasazi to SmartCare, the new electronic medical record system. This includes 436 sixty-day reviews and 295 targeted clinician reviews. Additionally, during conversion, HID

other team members performed a brief review of every open chart to ensure assessment and other essential documents were complete and up to date in preparation for conversion. 1058 of these reviews were completed.

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

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

Goal 5.3 Quality Care:

To establish corrective action of 100% of occurrences that raise the quality of care concerns and are identified through the quality improvement process.

Beneficiary Impact: Following through with corrective action plans that arise from quality of care concerns ensures that beneficiaries have access to high-quality and effective treatment.

Interventions:

1. The QAM will assure timely corrective action for all quality of care issues.
2. Quality of care issues, corrective actions, training needs, and recommendations will be logged.
3. Finalize and implement the psychological autopsy process for suspicious deaths, suicides, and homicides of client and client-related deaths.
4. Participate in the Siskiyou County child death review team.

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

FY 21-22 Baseline: Fifteen quality of care issues were logged and resolved. Participation in the Siskiyou County Child Death Review Team.

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

Lead Staff: QIC, Compliance Officer and QAM.

Evaluation Findings

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

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

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

Goal 5.4 Medication Monitoring:

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

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

Interventions:

1. Revise and update current policy MEDS 602 to include a peer review process for ensuring minimum psychiatric service frequency and follow-up standards.
2. Monitor 10% of active medical client charts.
3. Ensure that the medical monitoring process is completed and submitted to HID.
4. To provide training to increase awareness and compliance with the policy and process for medication monitoring.
5. Monitor SB 1291 HEDIS measures for medication monitoring of foster care youth.
6. Collaborate with Child Welfare Services (CWS) and review Safe Measures data quarterly.
7. QAM will identify and report trends to QIC and coordinate needed follow-up.

Monitoring mechanisms: Medication monitoring log and review sheets.

FY 21-22 Baseline: 55 reviews were completed. Eight percent of the active medical charts were reviewed. 15 additional reviews were completed by the contracted psychiatrist. In August of 2021, the MHP implemented the MEDS 605 Controlled Substance Subscribing and Contract policy; all beneficiaries were informed of the policy change and all medication prescribers were trained in the new procedures.

Timeline: QIC review annually.

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

Evaluation Findings

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

HEDIS measures for children and foster youth were tracked throughout the year. Compliance with metabolic monitoring is a challenge with this age group, even with continued intervention and support from CSOC to get labs completed. CWS sends a representative to quarterly scheduled meetings.

Goal 5.5 Cultural and Linguistic Competence:

To increase the cultural and linguistic competence of the agency and contracted staff. Additional goals are established by the committee in the cultural competence (CC) work plan.

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

Interventions:

1. Revise the cultural competence plan and work plan annually.
2. Provide a minimum of four cultural competence trainings per fiscal year.
3. Provide alternative formats for all beneficiary informing materials as required.
4. The QI committee will receive updates from the cultural competence committee semi-annually.

Monitoring mechanisms: MHP cultural competence plan and work plan, training log, training agendas, and sign-in sheets.

FY 21-22 Baseline: Staff were assigned three mandatory cultural competency trainings through Relias, which included The Role of the Behavioral Health Interpreter, Understanding Unconscious Bias, and Your Rose in Workplace Diversity. Mandatory in-person training was provided to clinical staff in collaboration with Probation on how to work with justice-involved individuals. All MHP staff also have access to elective courses throughout the year.

Timeline: Annual update of cultural competence plan due to DHCS by end of quarter two. Semi-annual reporting to the QI committee.

Lead Staff: Cultural competence committee chairperson and QIC.

Evaluation Findings

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

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

Goal 5.6 Full-Service Partnerships:

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

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

Interventions:

1. Provide a continuous quality review of MHSA policies and procedures and report findings and/or changes to the QIC.
2. Continue to work with Third Sector to improve FSP outcomes through Strength-Based Case Management.

3. Track and monitor the number of FSPs who receive housing and other services through the MHP.

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

FY 21-22 Baseline: The MHP provided housing for 102 FSP clients**.** The MHP recorded 198 unduplicated FPS clients—120 of which received medication services. The MHP created three new MHSA policies and procedures and modified several others.

Timeline: Annually.

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

Evaluation Findings

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

Section 6: Physical Health Care

Goal 6.1 Coordination between Managed Care Plan and MHP:

To improve coordination between Partnership Health/Beacon Network and the MHP through communication, monitoring referrals, and ensuring that clients are served at the appropriate level of care. To track 100% of referrals made to Beacon to improve continuous care.

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

Interventions:

1. Quarterly meetings between Partnership HealthPlan/Beacon Health Options and the MHP.

2. Monitor referrals through Beacon Health Options log and Behavioral Health access forms.
3. Level of Service (LOS) assessment will be utilized at the time of initial assessment and regular intervals to ensure clients are being served at the appropriate level of care.
4. Monitor access screenings and transition of care tools for appropriate screening outcomes and transitions between the MHP and MCP.

Monitoring mechanisms: MOUs, access reports, screening forms, Beacon Health Options log, and LOS assessment.

FY 21-22 Baseline: The MHP received referrals for three children/youth from Beacon Health Options and referred out 35 adults and 13 children to the Beacon system. The MHP Director attended five meetings with Partnership HealthPlan. Level of Service Assessment completed for 876 unduplicated clients. Whole Person Care services were provided to 17 participants.

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

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

Evaluation Findings

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

Goal 6.2 Exchange of Information:

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

Beneficiary Impact: Exchanging information with physical health care providers and other agencies ensures that beneficiaries have their physical health care needs met and that they are provided linkage to other supportive services.

Interventions:

1. Provide outreach to increase consultation with Fairchild Medical Clinic, Fairchild Hospital, and Mercy Medical Center.
2. Provide consultations for beneficiaries under 5150 hold with emergency room staff and hospitalists when requested.
3. Track consultations through the consultation log.
4. Continue training on the consultation form to document and track psychiatric consultations, including after-hours consultations.
5. Finalize contract and develop policies and procedures for participation in the health care exchange.
6. Encourage psychiatric providers to utilize consultation as a tool to successfully step clients down to a lower level of care.

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

FY 21-22 Baseline: The MHP attended three outreach meetings for the Healthcare Collaborative, which is attended by the MHP, Fairchild Medical Center, Mercy Medical Center, and other local providers; the collaborative disbanded in FY 21-22 as a result of meeting the primary goals of the group. The MHP increased internal trainings, prescriber communications, and external consultation through expanded telehealth contracts. The intake coordinator continues to obtain authorizations for the release of information for children and adult clients for their primary care providers and human service agencies, as appropriate. For the reporting period, five consultations were recorded in the consultation log; four were external consultations, one was internal, and one was for a non-MHP client. The Healthcare Exchange is expected to be operational in the next fiscal year.

Timeline: Annual QIC review.

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

Evaluation Findings

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

The implementation of the Health Information Exchange (HIE) is ongoing. Contracted with CalMHSA, the MHP will be entering CONNEX through SmartCare. The MHP continues to

contract with SacValley Med share as well and plans to expand access to key staff in the behavioral health departments.

Section 7: Provider Relations

Goal 7.1 Provider Appeals:

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

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

Interventions:

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

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

FY 21-22 Baseline: The MHP reduced the frequency of the organizational provider meetings as a result of Remi Vista's diminished staff capacity. In the fiscal year, seven organizational provider meetings were held with Remi Vista. The MHP reported one provider appeal and 84 contract and organizational provider services denied; all appeals and denials occurred timely.

Timeline: Provider meetings scheduled at least quarterly.

Lead Staff: QAM, Deputy Director, CSOC Clinical Site Supervisor, CSOC Health Assistant, and fiscal staff.

Evaluation Findings

The MHP continues to contract with one SMHS provider, Remi Vista. Meetings to collaborate and support this partnership occur monthly. Clinical staff collaborate on shared cases through case consultation, CFT, and TBS meetings, depending on the case. Remi Vista continues to experience staffing shortage, so the number of overall services was low. The

MHP reported all appeals and denials occurred timely. There was a total of 34 services denied.

Goal 7.2 Community-Based Services:

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

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

Interventions:

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

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

FY 21-22 Baseline: Six Stones Wellness Center served 172 returning members and added 27 new members. The MHP executed MHSA contracts with nine community/family resource centers, Dunamis, First Five, Directing Change, Etna PAL, Siskiyou Health Care Collaborative, Karuk Tribal Housing Authority, and Remi Visa Inc. In addition to Dunamis providing school-based trainings, the MHP collaborated with the Siskiyou County Office of Education to implement the Mental Health Student Services Act (MHSSA) school-based services. Informal agreements were established with Probation, the Sheriff's Department, and the Siskiyou County Court.

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

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

Evaluation Findings

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

community providers in the outlying areas of the county such as the Happy Camp area, the Butte Valley/Tulelake area, and the Scott Valley area.