Siskiyou County

BEHAVIORAL HEALTH
QUALITY IMPROVEMENT
WORK PLAN

Calendar Year 2026

CA

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Definitions

- ASOC—Adult System of Care
- BHP-Behavioral Health Plan
- CalEQRO—California External Quality Review Organization
- CalMHSA – California Mental Health Services Authority
- CC—Cultural Competency
- COP—Change of Provider Request
- CSOC—Children's System of Care
- CWS—Child Welfare Services
- DHCS—Department of Health Care Services
- EHR—Electronic Health Record
- FSP—Full-Service Partner
- FTE—Full-Time Equivalency
- FUM — Follow-Up After Emergency Department Visit for Mental Illness
- FY—Fiscal Year
- HID—Health Information Department
- HSAG – Health Services Advisory Group
- LOS—Level of Service Assessment
- MHSA—Mental Health Services Act
- PIP—Performance Improvement Project
- QA- Quality Assurance
- 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

Quality Improvement Work Plan Introduction

The Siskiyou County Behavioral Health Division (BHD) is an integrated mental health and substance use disorder treatment department. The Behavioral Health Plan (BHP) served 1,339 Medi-Cal members with mental illness and the Drug Medi-Cal Organized Delivery System (DMC-ODS) served 229 members of all ages with substance use disorders in the fiscal year (FY) 24-25. The mission of the BHP is to promote the prevention of, and recovery from, mental illness and substance abuse of those we serve by providing accessible, caring, and culturally competent services. The following sections make up the BHP's Quality Improvement Work Plan goals for Calendar Year (CY) 2026.

BHP Core Values

The BHP's core values include the following:

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

BHP Services

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

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

Quality Management Program

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

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

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

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

Quality Improvement Committee

The QIC meetings are held monthly to review data, discuss trends and concerns, and make recommendations that impact the delivery of services, administrative processes, and performance improvement projects.

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

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

Section 1: Performance Improvement Projects (PIP)

Goal 1.1 Active Non-Clinical PIP:

The new non-clinical PIP will be to increase the percentage of members who receive at least one Peer Support Service.

Member Impact: By increasing the percentage of members who receive peer support services, members may feel more empowered to build self-directed lives, ultimately improving quality of life, reducing hospitalizations, and mitigating higher levels of care and/or crisis episodes.

Monitoring mechanisms: PIP committee meetings, Quality Improvement Committee (QIC) meetings, CalMHSA PIP Reports, technical assistance calls with Health Services Advisory Group (HSAG).

Baseline & Actions: During FY 2024-2025 the BHP focused on finalizing the Follow-Up After Emergency Department Visit for Mental Illness (FUM) PIP as established prior and evaluated for gaps in data collection and procedures. The prior Follow-Up After Mental Health Hospitalization (FUM) clinical PIP concluded in July 2025. Although the performance target was not achieved, outcomes demonstrated improvement toward the goal. Starting in FY 25-26 the BHP has launched a new non-clinical PIP, under the guidance of HSAG focused on the expansion and standardization of Peer Support Services. This initiative includes development of operational tools and guidance in partnership with CalMHSA to

strengthen consistency, documentation practices, and overall accessibility of peer-delivered services.

Peer Support Services were provided in FY24/25 establishing a baseline measurement of 3.7% of all members receiving a peer service according to CalMHSA data sets. The BHP and CalMHSA collaborated to analyze the data and determined that there were significant data gaps resulting in a higher rate, estimating that (2.9%-3.3%) range is more reflective. A true baseline will be determined in CY 2026.

Next Steps:

- Complete data analysis on previous FUM and utilize the information to guide determinations in the new FUM Clinical PIP.
- Expand Peer Support Services and programming, using CalMHSA-developed tools to standardize processes and workflows.
- Continue alignment of all PIPs with HSAG requirements, including updates to measures and reporting structures.

Timeline: During FY 2024-2025 the BHP focused on finalizing the FUM PIP as established prior and evaluated for gaps in data collection and procedures. The prior Follow-Up After Mental Health Hospitalization (FUM) clinical PIP concluded in July 2025. Although the performance target was not achieved, outcomes demonstrated improvement toward the goal. Starting in FY 25-26 the BHP has launched a new non-clinical PIP, under the guidance of HSAG focused on the expansion and standardization of Peer Support Services. This initiative includes development of operational tools and guidance in partnership with CalMHSA to strengthen consistency, documentation practices, and overall accessibility of peer-delivered services.

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

Contractor: CalMHSA

Goal 1.2 Active Clinical PIP:

The new clinical PIP will be to improve the After Emergency Department Visit for Mental Illness (FUM) measure rate.

Member Impact: By improving the Follow up after Emergency Department Visit measure rate, members are more likely to successfully engage in mental health services and achieve stability with their treatment.

Monitoring mechanisms: PIP committee meetings, QIC meetings, CalMHSA PIP Reports and technical assistance calls with HSAG.

Baseline & Actions:

FUM Baseline data showed an 80% completion of follow up after mental health episode in

the Emergency Department according to CalMHSA data sets. The BHP and CalMHSA collaborated to analyze the data and determined that there were significant data gaps resulting in a higher number, estimating that (63%-67%) range is more reflective. A true baseline will be determined in CY 2026.

Next Steps:

- Implement enhanced FUM interventions and monitor performance against baseline HEDIS data.
- Finalize CalMHSA-supported tools and integrate them into routine workflows.
- Conduct ongoing data review to identify trends, opportunities, and potential adjustments to interventions.

Timeline: BHD submitted the design phase of the 2025-2027 clinical PIP to HSAG. The new clinical PIP will be to improve the After Emergency Department Visit for Mental Illness (FUM) measure rate. Data measurement for the new Clinical PIP will begin January 1, 2026.

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

Contractor: CalMHSA

Section 2: Service Delivery Capacity

Goal 2.1 Availability of Services

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

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

Interventions:

1. Submit monthly 274 reports.
2. Engage in outreach with other counties and contracting agencies to innovate and collaborate on filling service availability gaps in the Superior Region. .
3. The QIC will spend one designated monthly meeting evaluating the workflow and data input processes to find areas that are impacting success. Findings will be used to determine needs regarding trainings, documentation and workflow adjustments. QIC will also establish a monthly reporting apparatus to continually evaluate 274 monthly quality checks and NACT reports.

Next Steps**:**

- Continue monthly monitoring and updates of provider network through the CONNEX platform.
- Identify and collaborate to address service gaps based on QIC and Data Committee reviews.
- Enhance reporting to support trend analysis and targeted service expansion planning.

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

Baseline:

FY 2023-24 (baseline):

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

FY 2024-25 (update):

In FY 2024–2025, the County enhanced reporting and monitoring of service availability, with 274 updates reviewed through both the QIC and Data Committee. These reviews support continuous assessment of network capacity and identification of gaps in service access.

In response to the implementation of the CONNEX platform, the agency revised the provider update process, enabling monthly reviews and updates of providers in network. These improvements strengthen the County's ability to maintain an accurate, timely, and comprehensive provider directory for members.

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

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

Goal 2.2 Penetration Rates:

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

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

Interventions:

1. Provide outreach activities, including outreach through The Mobile Crisis Unit and homeless outreach worker, to minority group community members and members in outlying areas.
2. The BHP will assign staff to be available a minimum of one day per week to the outlying areas of the county to engage minority groups in medically necessary services, utilizing interpretation as needed.
3. Interventions from the Cultural and Linguistic Competence Plan:
    a. Meet with culturally diverse groups and agencies to increase/reinforce provider relationships at least two times per fiscal year.
    b. One of the annual mandatory training opportunities to BHP staff will target the specific cultural needs of minority ethnic groups that are in Siskiyou County.
    c. Provide mandatory annual language line training and random testing throughout the year to ensure staff are capable in the use of the language line.
    d. Inform all individuals at first request for services and during intake of the availability of language assistance services and that these services are free.
    e. Seek to recruit staff and contract with bilingual providers for translation and interpretation services. All translation/interpreters shall complete language proficiency testing.

<u>Next Steps</u>:

- Continue monitoring penetration rates with the updated ethnicity and race data structure.
- Analyze trends in FY 25-26 to distinguish between data collection impacts and intervention outcomes.
- Develop targeted strategies to address identified disparities once consistent baseline data are established.

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

Baseline: In future years it is our understanding that the new External Quality Review Organization (EQRO), HSAG will not be providing penetration rate data. For this reason, our comparisons going forward will be based on SmartCare penetration rate data, which was provided in Table 1 and the narrative below that table.

Table 1: Fiscal Year Data (SmartCare FY 23-24 and FY 24-25 / Kingsview Previous Years)

Penetration Group	FY 19-20	FY 20-21	FY 21-22	FY 22-23	FY 23-24	FY24-25
Overall Penetration Rate	6.4%	6.7%	6.8%	5.7%	5.47%	9.16%
Hispanic Penetration Rate	5.9%	6.0%	6.3%	5.3%	3.51%	5.98%

In FY 24-25 the County realigned the collection and categorization of ethnicity and race data to improve accuracy and better reflect the demographic composition of the served population. With the data collection adjustment, the FY 24-25 data will serve as the new baseline going forward with the idea that race and ethnicity data and collection practices are consistently evolving.

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

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

Goal 2.3 Clinical Productivity:

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

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

Interventions:

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

Next Steps:

- Continue implementation of productivity trainings and monitor provider performance.
- Utilize the structured review process to address productivity gaps in collaboration with management, the Project Coordinator and QAM.

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

Baseline:

As mentioned above under Goal 2.2, in FY 23-24 the BHP changed to a new EHR system through SmartCare. Based on the FY 24-25 productivity data from SmartCare, clinical

productivity decreased for all provider types. The average productivity was as follows: Clinicians 38% (decreased from 49%), psychiatry 38% (decreased from 52%), and Behavioral Health Specialists 26% (decreased from 42%). Please refer to Table 2. The productivity rates are more closely aligned with previous years prior to the shift to SmartCare.

Table 2: Average Clinical Productivity Rate by Provider Type (SmartCare FY 23-24 and FY 24-25 / Kingsview Previous Years)

Provider Type	FY 19-20	FY 20-21	FY 21-22	FY 22-23	FY 23-24	FY 24-25
Psychiatry	51%	55%	49%	16.3%	52%	38%
Behavioral Health Specialists	32%	33%	36%	15.6%	42%	26%
Clinicians	31%	40%	44%	26.1%	49%	38%

This decrease may be attributable to the initiation of several new programs, where time spent on administration, planning, and implementation was not included in provider productivity calculations.

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

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

Section 3: Service Accessibility

Goal 3.1 Initial Appointments:

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

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

Interventions:

1. The quality improvement committee will monitor the access system for trends and performance and strategize solutions if initial appointments are not occurring timely.
2. The BHP will provide ongoing training for processing and capturing timeliness.
    a. The BHP provided timeliness training for the Health Assistants to review data input and appropriate processes. Continual trainings will occur based

off evidence of errors in documentation errors.

b. The BHP will provide training to clinical staff on timeliness standards and data elements in the EHR to optimize timeliness data collection.

3. Project Coordinator will review all timeliness documentation as a co-signer. Any out of compliance issues are then reported to the supervisor in the responsible department.
4. Review access data for potential disparities annually and report to QIC.

Next Steps:

- Continue monitoring timeliness data for patterns and emerging bottlenecks.
- Analyze the impact of new programs on staff capacity and initial appointment timeliness.
- Implement targeted interventions to mitigate delays and maintain compliance with established standards.
- Maintain collaboration between the Project Coordinator, clinical teams, and management to ensure continuous improvement in initial engagement pathways.

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

Baseline:

The average number of days until the first offered non-psychiatric appointment (shown in Table 3 below) decreased from FY 23-24 to FY 24-25 in all age grouping except for foster care, where it remained the same at 7 days. The compliance rate towards meeting the state standard of 10 business days improved for all age groups, ranging from 90% to 98% compliance.

For psychiatric appointments, (shown in Table 4 below), the average number of days until the first offered psychiatric appointment decreased for all groups analyzed, except for foster care where it remained the same at 8 days. All average number of days was still easily within the 15-business day state standard. The compliance rate towards meeting the state standard shows an increase for all groupings, with ranges from 93% to 98% compliance.

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

Non-Psychiatric Timeliness	All Services	Adult Services	Children's Services	Foster Care
FY 24-25 Average days from request to the first offered appointment	5.5 Days	4.5 Days	5 Days	7 Days
FY 23-24 Average days from request to the first offered appointment	6 Days	5 Days	7 Days	7 Days
FY 24-25 Compliance Rate Towards State Standard	93%	98%	97%	90%
FY 23-24 Compliance Rate Towards State Standard	89%	93%	88%	90%

The average number of days until the first offered psychiatric appointment for all members was 7 days with a 96% compliance rate to the 15-day standard. Table 4 displays the average timeliness information for all members, adults, children, and foster care.

Table 4: Timeliness from Initial Request to First Offered Psychiatric Appointment

Psychiatric Timeliness	All Services	Adult Services	Children's Services	Foster Care
FY 24-25 Average days from request to the first offered appointment	7 Days	7 Days	6 Days	8 Days
FY 23-24 Average days from request to the first offered appointment	9 Days	8 Days	9 Days	8 days
FY 24-25 Compliance Rate Towards State Standard	96%	96%	98%	93%
FY 23-24 Compliance Rate Towards State Standard	87%	90%	85%	88%

During FY 2024–2025, the County implemented improved pathways to support timely access to initial appointments, resulting in higher compliance rates. Increased monitoring and standardization of data entry for timeliness enhanced the agency's ability to identify bottlenecks and inefficiencies in the appointment process.

However, FY 2025–2026 may see challenges due to the initiation of new programs and services, which could temporarily reduce staff availability and capacity, potentially impacting timeliness.

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

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

Goal 3.2 Access to Urgent and Emergent Conditions:

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

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

Interventions:

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

Next Steps:

- Prioritize integration of urgent and emergent service data into the EHR to enable timely analysis and reporting.
- Continue ongoing monitoring of response times to identify patterns and potential service gaps.
- Implement targeted staff training or process adjustments as needed based on data insights.
- Maintain collaboration with contracted partners to ensure compliance with access standards and continuous improvement in response timeliness.

Monitoring mechanisms: QIC review of crisis data, EHR data, and EQRO timeliness data verification completed annually between the BHP and HSAG..

Baseline: The BHP continues to contract with the Alameda 24-hour crisis line to ensure that crisis calls are answered by a live person. The average response time was 41 minutes, with a 89.6 % compliance rate to the two-hour BHP standard. There were 5 urgent request

appointments. The average response time increased slightly from 38 to 41 minutes and the compliance with the 2-hour standard increased from 94.2% to 89.6 from FY 23-24 to FY 24-25. Urgent services did not require prior authorization.

During FY 2024-2025, County Behavioral Health agency continued to maintain contracts to ensure access to urgent and emergent services, including ongoing collaboration with Alameda. Response times are being continuously evaluated to identify bottlenecks and determine whether additional staff training is required.

Currently, data analysis for urgent and emergent service response times cannot be fully integrated into the EHR, limiting the ability to track trends and identify areas for improvement in real time.

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

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

Goal 3.3 Test Calls:

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

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

Interventions:

1. Results of the test calls will be recorded in the test call log, communicated to relevant staff or contractor; and concerns will be addressed by the Compliance Officer.
2. Complete at least 20% of test calls in a language other than English.
3. The QIC will spend two monthly meetings evaluating the workflow and data input processes to find areas that are impacting success in reaching the 50% goal. Findings will be used to determine needs in regard to trainings, documentation and workflow adjustments. QIC will also establish a monthly reporting apparatus to continually evaluate trends to provide any suggestions to improve effectiveness.

<u>Next Steps</u>:

- The Compliance Committee will prioritize test call performance as a key focus area for FY 2025–2026.

- Implement targeted training and support strategies to increase staff proficiency and confidence in completing test calls.
- Monitor test call outcomes and integrate findings into ongoing quality improvement activities to strengthen initial engagement processes.
- Identify process improvements and workflow adjustments to mitigate the impact of staff turnover on test call completion and accuracy.

Monitoring mechanisms: Test call log and call sheets

Baseline:

Table 5: 24/7 Crisis and Access Line Test Calls, FY 22-23 to FY 24-25

	24-hour crisis line	In-house (BHP)	Alternative language	Total calls
FY 22-23	9 (60%)	6 (40%)	0	15
FY 23-24	8 (67%)	4 (33%)	1 (8.3%)	12
FY 24-25	11 (44%)	14 (56%)	6 (24%)	25

During FY 2024-25, test calls were a challenge for the County Behavioral Health agency, largely due to ongoing staff turnover among personnel responsible for initial engagement. But the BHP was able to increase the number of total calls and has exponentially increased the calls in-house and in alternative languages. The increase in number of calls has also highlighted the quality issues with test calls. The QIC dedicated multiple meetings to discussing strategies to enhance staff confidence and effectiveness in conducting test calls.

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

Lead Staff: Compliance Officer and Project Coordinator

Contractor: CalMHSA

Section 4: Member Satisfaction

Goal 4.1 Member Satisfaction:

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

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

Interventions:

1. Administer Member Perception Survey to members once per year.
2. Utilize brief member surveys to obtain data regarding satisfaction and improvement opportunities on topics determined by the QIC. New satisfaction survey approved by the Cultural Competence Committee (CCC) to engage members on a rolling basis and reviewed for trends twice a year.
3. The QIC will spend one designated month meeting evaluating the effectiveness of survey questions and data input processes. The Cultural Competency Committee will review responses to the member satisfaction surveys quarterly to determine trends. Findings will be used to determine needs regarding trainings, documentation and workflow adjustments.

Next Steps:

- Develop and implement strategies to increase survey participation to obtain more representative member feedback.
- Continue monitoring survey results through the CCC and QIC to identify trends, strengths, and areas for improvement.
- Use survey findings to inform quality improvement initiatives and enhance member-centered services.
- Explore additional methods for engaging members in feedback collection, including digital tools or targeted outreach initiatives.
- Exponentially expand Peer Support Services and develop peer-focused programs to further enhance member engagement, recovery-oriented services, and peer-driven initiatives.

Monitoring mechanisms: Review survey data and focus group data.

Baseline: The BHP provided the Member Satisfaction survey once last year using the survey instrument provided by UCLA.

Table 6: Satisfaction Score by Adult – Siskiyou County May 2025 Compared to Previous Years

	Mean Score May 2025	Mean Score May 2024	Mean Score May 2023
Access	4.41	4.44	4.28
General Satisfaction	4.5	4.67	4.4

Outcome	3.98	4.17	3.94
Participation in Treatment Planning	4.32	4.40	4.27
Cultural Appropriateness	4.22		
Social Connectedness	3.92	4.11	3.99
Functioning	3.96	4.07	3.98

Table 7: Satisfaction Score by Adult – Siskiyou County Compared to Statewide May 2025

	Siskiyou Mean Score 2025	Statewide Mean Score 2025
Access	4.41	4.38
General Satisfaction	4.5	4.49
Outcome	3.98	4.06
Participation in Treatment Planning	4.32	4.37
Cultural Appropriateness	4.22	4.49
Social Connectedness	3.92	4.06
Functioning	3.96	4.05

During FY 2024-25, the County Behavioral Health agency collects member satisfaction data through the Consumer Perception Survey (CPS) administered by UCLA, as well as a rolling in-house survey reviewed by the CCC and QIC. Data indicates overall positive satisfaction among respondents; however, the total number of survey responses remains limited, reducing the representativeness of the findings. The data shows consistency across years within the county. In comparison to the statewide mean score the county is aligned within a small range from the statewide mean.

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

Lead Staff: Project Coordinator, QIC, and Compliance Manager

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

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

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

Interventions:

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

Next Steps:

- Leverage the newly hired QAM to conduct comprehensive reviews of grievances, appeals, expedited appeals, and fair hearings.
- Analyze data for patterns or trends to identify potential areas for targeted quality improvement interventions.
- Develop protocols to flag programs or providers requiring additional evaluation or corrective action.
- Integrate findings into broader QI initiatives to enhance service quality, member satisfaction, and compliance with regulatory standards.

Monitoring mechanisms: Review the member log and completed documentation.

Baseline:

Table 8: Grievances and Appeals

	FY 23-24	FY24-25
Grievances (total)	**12**	**16**
-Related to Customer Service	1	1
-Quality of Care	8	13
-Related to Case Management	3	0

-Other	0	2
Resolved	**12**	**16**
Appeals	0	1
Resolved	**0**	1

Twelve total grievances were reported during FY 23-24 and 16 during FY 24-25.
In FY 23-24, eight Quality of Care grievances occurred, one was unable to be reached for phone follow-up and one was unwilling to discuss further. There were no repeated issues. There were three grievances Related to Case Management and one Related to Customer Service. Five total exempt grievances were logged (two no contact or unwilling to discuss further, two misunderstandings, and one resolved through management & QA review). There were no appeals, expedited appeals, state fair hearings, or second opinion requests during FY 23-24.

In FY 24-25, 13 Quality of Care grievances were submitted, as well as one Related to Customer Service and two fell into the "Other" category as they did not fit into any of the categories listed here. Four exempt grievances were logged (3 were no contact or unwilling to discuss and one was a misunderstanding). There was one appeal in FY 2024, which was resolved.

During FY 2024–25, the County Behavioral Health agency experienced a limited capacity for advanced evaluation of grievances, appeals, expedited appeals, and fair hearings due to the vacancy of a QAM. While the Compliance Manager ensured that all required processes and timelines were followed, the absence of a dedicated QAM constrained the agency's ability to analyze patterns, identify recurring issues, or evaluate program- or provider-specific trends.

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

Lead Staff: Compliance Officer, QIC and Project Coordinator.

Contractor: CalMHSA

Goal 4.3 Change of Provider (COP) Requests:

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

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

Interventions:

1. Change of provider requests are completed for any member that requests a change. Agency staff will complete the form in the event of verbal requests.
2. Compliance Manager and Project Coordinator will review annually for trends and quality of care issues.
3. Compliance Manager and Project Coordinator will report any identified trends or patterns to the QIC.
4. Change of Provider requests will be reported to the QIC annually with a trigger of deeper review when a provider has more than two in the same quarter or more than five for the year.

Next Steps:

- Utilize the newly hired QAM to conduct detailed analysis of change of provider requests.
- Identify patterns or trends that may indicate systemic issues or areas for targeted quality improvement.
- Monitor programs or providers with higher request volumes and implement interventions as appropriate.
- Incorporate findings into broader quality improvement initiatives to enhance service access, member satisfaction, and compliance with regulatory requirements.

Monitoring mechanisms: Change of provider log and completed documentation.

Baseline:

Table 9: Change of Provider Requests

	FY 23-24	**FY 24-25**
Total COP requests	**98**	**73**
-Withdrawn	11	3
-Denied	26	17
-Approved	61	53
	FY 23-24	**FY 24-25**
Total COP requests	**98**	**73**
-Female	64 *(65%)*	48 *(66%)*
-Male	31 *(35%)*	25 *(34%)*
-Not reported	3 *(3%)*	0

	FY 23-24	FY 24-25
-Adult	85 *(86%)*	64 *(88%)*
-Child	13 *(14%)*	9 *(12%)*
	FY 23-24	**FY 24-25**
More than 3 COPs	8	7
More than 5 COPs	5	3
More than 7 COPs	3	3
More than 10 COPs	2	1

See Table 9 above for the breakdown of Change of Provider Requests by gender, age group, number withdrawn, denied and approved, as well as the number of providers having more than two change of provider requests.

During FY 2024–25, the County Behavioral Health agency had limited capacity for advanced evaluation of change of provider requests due to the previous vacancy of a Quality Assurance Manager. While the Compliance Manager ensured that all requests were processed according to policy and timelines, the absence of a dedicated QAM limited the ability to analyze trends, identify recurring issues, or determine if specific programs or providers were associated with higher request rates.

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

Lead Staff: QIC, Compliance Manager and Project Coordinator.

Contractor: CalMHSA

Goal 4.4 Consumer and Family Member Involvement:

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

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

Interventions:

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

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

Next Steps:

- Continue to foster increased participation from members and community partners in the QIC, CCC, and other local advisory meetings.
- Leverage the Community Program Planning (CPP) process for Behavioral Health Services Act (BHSA) programs to further enhance stakeholder involvement.
- Develop structured opportunities for members and families to provide feedback on policies, programs, and quality improvement initiatives.
- Monitor engagement trends and implement strategies to sustain and expand active involvement in quality and service planning activities.
- Develop peer programming and monitor peer engagement.

Monitoring mechanisms: Committee and event sign-in sheets.

Baseline: In FY 2024-25 peer employees had a combined total of 1,102 hours, which was an increase from 704.25 hours in FY 2023-24. QIC had eight unique members participating consistently. The Behavioral Health Advisory Board had three unique consumers, including family members, who participated. Cultural Competence Committee had participation from eight consumers, and the committee collaborated with consumer members from Six Stones Wellness Center.

During FY 2024–25, the vacancy of the QAM led to significant shifts in the operations of the QIC. Following the re-establishment of the QIC and CCC, there has been a substantial increase in participation by members and community partners. Engagement levels have improved, providing broader input into quality improvement activities and decision-making processes.

Peer services will undergo substantial expansion in FY 2025–26 through the addition of several new peer positions and the development of structured peer-driven programming aimed at enhancing utilization and improving member engagement.

Timeline: QIC will monitor semi-annually.

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

Section 5: Clinical Issues

Goal 5.1 Performance Outcomes:

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

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

Interventions:

1. Implement data collection for the following priority outcome measures:
    a. Follow-up After Emergency Department Visit for Mental Illness
    b. Follow-up After Hospitalization Visit for Mental Illness
    c. Antidepressant Medication Management
    d. Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics
    e. Adherence to Antipsychotic Medications for Individuals with schizophrenia
    f. Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
    g. Pharmacotherapy of Opioid Use Disorder
    h. Use of Pharmacotherapy for Opioid Use Disorder
    i. Initiation and Engagement of Substance use Disorder Treatment
2. These measurement tools are being actively built and reviewed currently between BHD and CalMHSA. For the interventions we are working with HSAG to develop and verify that we have the tools to accurately measure. The interventions have yet to be fully established but once they are approved by HSAG we will be reviewing data measurement in the QIC regularly.

Next Steps:

- Implement staff training and monitoring processes to ensure accurate and complete submission of Plan Data Feed data.
- Collaborate with CalMHSA and HSAG to identify and integrate required data elements for full fidelity.
- Continue reviewing performance outcomes data to validate compliance with standards and identify any gaps in measurement.
- Use improved data quality to inform targeted quality improvement initiatives and enhance service delivery.

Monitoring mechanisms: EHR data.

Baseline: CalMHSA is still working to develop proper data collection forms on the SmartCare EHR system. We are currently using alternate tools to continue monitoring these data collection measures. We are working with CalMHSA and HSAG to examine quality data

collection practices for these data collection measures while unavailable through our EHR system. Program Directors, Project Coordinator and Compliance Manager continually review these materials to identify gaps. The QIC will be reviewing these data collection practices for their effectiveness and accuracy from an inter-programmatic perspective.

During FY 2024–25, turnover of key staff resulted in incomplete or incorrectly uploaded data to both DHCS and CalMHSA. While the agency met multiple performance standards, the available data may not fully reflect actual outcomes due to these gaps.

Towards the end of FY 2024–25 and continuing into FY 2025–26, the agency has developed training materials and monitoring processes to ensure accurate submission of Plan Data Feed data, a primary source for performance measurement. Additionally, CalMHSA is collaborating with HSAG to determine required data elements to ensure fidelity of CalMHSA reporting.

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

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

Contractor: CalMHSA

Goal 5.2 Utilization Management:

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

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

Interventions:

1. All new clinical staff will receive documentation training and documentation review.
2. Provide documentation training to all clinical staff to increase the quality of care, compliance, accurate billing, and timely completion of documentation.
3. Random utilization review by QI or peers will be provided to ensure regulatory compliance.
4. Utilization review of targeted cases will occur when trends or quality of care concerns are identified.
5. Utilization review of documentation by contracted or organizational providers will be provided in collaboration by the CalMHSA QA Representative, Compliance

Manager and Project Coordinator or designee. Appeals follow the process identified in the provider manual.

6. Concurrent review of inpatient hospitalization will be provided by contractor, Kepro, and recorded on the Kepro platform and reported to the BHP via completed TAR forms.
7. Health Information Department (HID) staff review documentation for completeness and timeliness within 60 days after member admission and upon staff notice of termination.

Next Steps:

- Finalize utilization management policy and procedures.
- Implement robust monitoring and tracking processes for subcontractors.
- Conduct ongoing reviews to ensure timely identification and resolution of issues.
- Integrate findings into broader quality improvement initiatives

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

Baseline:

Table 10: Utilization Management Metrics

Utilization Management Metrics	FY 23-24	FY 24-25
Number of TARs approved	113	265
Number of contracted provider Denials and Appeals	34	2
Number of SARs	20	12
Number of Chart Reviews	218	152

As shown in Table 10 above, the number of TARs approved has more than doubled between FY 2023-24 and 2024-25, with the number of contractor denials and appeals, SARs and chart reviews decreasing significantly. Both were significantly impacted by BHD not having a QAM for most of this timeline. It is a direct QAM duty and requires a clinical person to do it. BHD only has a handful of licensed staff in the entirety of the agency so this was directly impacted.

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

Lead Staff: HID, System Administrators, Clinical Site Supervisors, Compliance Manager and

Project Coordinator

Contractor: CalMHSA

Goal 5.3 Quality Care:

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

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

Interventions:

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

Next Steps:

- Transition oversight of the Quality-of-Care log to the QAM.
- Conduct comprehensive reviews of both clinical and non-clinical areas.
- Implement ongoing monitoring and follow-up.
- Integrate findings into broader quality improvement initiatives.

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

Baseline: In FY 2024-25 there were three quality of care issues logged and resolved, based on data provided by SmartCare. The Compliance Manager and Project Coordinator continue to provide direct training to every service provider regarding documentation regulations and the QI program. New staff are encouraged to attend, at minimum, one QIC meeting, to gain a working understanding of the committee.

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

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

During FY 2024–2025, the Compliance Manager and Project Coordinator managed the

Quality-of-Care log, providing oversight for one non-clinical issue and routing the two clinical issues to site supervisors to resolve due to the QAM vacancy.

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

Lead Staff: QIC, Compliance Manager and Project Coordinator

Contractor: CalMHSA

Goal 5.4 Medication Monitoring:

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

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

Interventions:

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

Next Steps:

- Ensure QAM attends all meetings for oversight.
- Strengthen review processes for clinical and procedural issues.
- Monitor trends and integrate findings into quality improvement initiatives.
- Enhance documentation and follow-up procedures.

Monitoring mechanisms: Medication monitoring logs and review sheets.

Baseline:

Table 11: Medication Monitoring Reviews

	FY 23-24	FY 24-25
Total Chart Review	75	50
Internal Reviews	57 (76%)	41 (82%)
Reviewed by Contracted Pharmacist	19 (24%)	9 (18%)

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

During FY 2024-2025, Medication Monitoring meetings were conducted quarterly; however, oversight was limited due to the QAM vacancy. Clinical site supervisors attended meetings to provide guidance. Shortages in medication providers and reduced capacity of external auditor impacted the total chart review reflected in the increased portion of chart reviews having to be completed internally and an overall reduced number of total reviews.

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

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

Contractor: CalMHSA

Goal 5.5 Cultural and Linguistic Competence:

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

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

Interventions:

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

Next Steps:

- Continue culturally responsive trainings.
- Maintain and expand the Cultural Competence subcommittee.
- Monitor engagement to evaluate effectiveness.
- Integrate findings into staff development and quality initiatives

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

Baseline: The cultural competence plan for FY 2024-25 was updated and posted to the county website. Four cultural competence training courses were completed by all staff including: Recognizing Unconscious Bias, Utilizing the Behavioral Health Interpreter, Working with Justice-Involved Individuals and Building a Multicultural Care Environment. The BHP continues to provide alternative formats to ensure member access to informing materials and has a designated staff training in running accessibility reports for documents that will be published on the website.

A subcommittee was developed in FY 2024-25 for 18 months in collaboration with Queer Humboldt to focus on organizational cultural humility practices. This subcommittee will serve under the CCC with representatives from multiple programs and community partners.

During FY 2024-25, oversight of Cultural Competence shifted from the QAM to the Project Coordinator. A subcommittee with Queer Humboldt focused on organizational cultural humility practices, increasing member and community partner engagement.

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

Lead Staff: CCC chairperson, Compliance Officer and QIC.

Goal 5.6 Full-Service Partnerships:

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

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

Interventions:

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

Next Steps:

- Review FSP client data to identify barriers.
- Collect extended data on FSP members to evaluate care coordination and resource

allocation.

- Implement targeted interventions to improve service access.
- Integrate findings into BHSA planning and quality improvement initiatives.

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

Baseline:

Table 12: Full Service Partnership Clients

	Overall FSP clients	FSP Clients who received housing services	FSP Clients who received medication services
FY 23-24	172	121 (70.3%)	148 (86.0%)
FY 24 -25	157	98 (62.4%)	125 (79.6%)

During FY 2024-2025, a significant decrease in FSP clients accessing housing and medication services was observed. This may be influenced by staff capacity and turnover. The agency is reviewing barriers to access while in preparation for BHSA shift.

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

Timeline: Annually.

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

Section 6: Physical Health Care

Goal 6.1 Coordination between Managed Care Plan and BHP:

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

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

Interventions:

1. Quarterly meetings between Partnership HealthPlan/Carelon and the BHP.

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

Next Steps:

- Develop enhanced EHR monitoring tools.
- Track communications and referrals to identify breakdowns.
- Strengthen collaborative processes using data from monitoring tools.
- Continue regular meetings to improve joint service delivery.

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

Baseline: In FY 2024 -25 the BHP and Partnership continued to develop their relationship as more programs developed that involved integral communication between the agencies such as Providing Access and Transforming Health Initiative Justice-Involved (PATH JI). The BHP and Partnership continued to have designated meetings alongside programmatic specific meetings.

During FY 2024-2025, the BHP and MCP developed collaboration through meetings and Closed Loop Referral processes. A DHCS audit highlighted areas needing improvement.

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

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

Goal 6.2 Exchange of Information:

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

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

Interventions:

1. Provide outreach to increase consultation with Fairchild Medical Clinic, Fairchild Hospital, and Mercy Medical Center.
2. Provide consultations for members under 5150 holds with emergency room staff and hospitalists when requested.
3. Track consultations through the consultation log.

4. Encourage psychiatric providers to utilize consultation as a tool to successfully step members down to a lower level of care.

Next Steps:

- Input and track physical health data through EHR inquiries and HIE platforms (CONNEX, SacValley).
- Enable real-time updates for providers.
- Monitor data exchange to identify gaps and improve coordination.
- Strengthen integration of behavioral and physical health services.

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

Baseline: For the FY 23-24 reporting period, seven consultations were recorded in the consultation log; five were external consultations, two were internal, and one was identified as a crisis. To improve the consultation documentation, clinical meetings occur monthly for providers both in-person and virtually; these meetings will continue in FY 2025-26, as many of the BHP prescribers are telehealth.

Table 13: Consultations with Physical Health Care Providers and Human Service Agencies

	FY 23-24	FY 24-25
Total Consultations	**7**	**0**
External Consultations	5	0
Internal Consultations	2	0
Crisis	1	0

The intake coordinator continues to obtain authorizations for the release of information for children and adult clients for their primary care providers and human service agencies, as appropriate. This process will remain the same for FY 2025-26.

The BHP collaborated with SacValley MedShare throughout the fiscal year for the health care exchange, and the BHP provided contract evidence to DHCS to demonstrate progress towards meeting the CalAIM data-exchange initiatives. The BHP's current Electronic Health Record is compatible with data exchange and is reportedly moving into the CONNEX program where provider lists are updated monthly by the Project Coordinator.

During FY 2024-25, monitoring and logging member engagement with physical health providers was challenging, limiting evaluation of whether physical health needs were met. Multiple factors contributed to there being not consultations during the FY 2024-25 period. One is that many of the hospitals have access to telehealth providers internally and Siskiyou County Behavioral Health lost their in-house psychiatrist, so the agency is also using a

telehealth psychiatrist. The expansion of the Health Information Exchange is set to provide more real time engagement with client's health records across agencies and counties.

Timeline: Annual QIC review.

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

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Section 7: Provider Relations

Goal 7.1 Provider Appeals:

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

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

Interventions:

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

Next Steps:

- QAM to collaborate with CalMHSA to develop a monitoring tool.
- Implement updated documentation guidelines and staff training.
- Monitor appeal processes to identify trends.
- Integrate findings into quality improvement initiatives

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

Baseline:

Table 14: Provider Appeals

	FY 23-24	FY 24-25
Appeals	0	1 (resolved)
Denials	98	65

In FY 2023-24 there were no appeals. The BHP denied 98 contract and organizational provider services. All denials occurred timely. In FY 2024-25 there was one resolved appeal and 65 denials, as illustrated above in Table 14.

During FY 2024-25, meetings with Remi Vista continued. In the absence of the QAM, Clinical Site Supervisors and Program Managers oversaw documentation practices.

Due to ongoing staffing shortages, regular meetings continued to be challenging. Collaborative meetings were held on a quarterly basis. During FY 2024–2025, alternative collaborative communication methods will be examined to supplement reduced meeting frequency if staffing shortages persist. Communication efforts were improved by engaging appropriate staff from both agencies in targeted discussions prior to meetings, allowing for more efficient use of time and more focused dialogue during quarterly meetings. The agency will continue to strengthen working relationships between key staff and Remi Vista personnel through email communication, which has improved meeting efficiency by reducing administrative tasks and ensuring that discussions involve staff with the appropriate expertise.

Timeline: Provider meetings scheduled at least quarterly.

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

Goal 7.2 Community-Based Services:

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

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

Interventions:

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

Next Steps:

- Evaluate community-based service contracts in light of funding shifts.
- Identify gaps and develop strategies to maintain or expand access.
- Monitor changes in contracted providers.
- Ensure continuity of member access to essential services

Monitoring mechanisms: Executed contracts with service providers, network adequacy

outcomes, and MHSA Annual Plan data.

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

During FY 2024-2025, MHSA Program Coordinator continued developing community resource engagement. Funding shifts due to BHSA and Public Health reallocation may affect contracted providers.

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.