Behavioral Health Concepts, Inc.
info@bhceqro.com
www.caleqro.com
855-385-3776

FY 2023-24 Medi-Cal Specialty Behavioral Health External Quality Review

KERN FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

August 22-24, 2023

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Kern" may be used to identify the Kern County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — August 22-24, 2023

MHP Size — Large

MHP Region — Southern

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	4	1	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	6	3	1
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**21**	**4**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Cognitive Behavioral Therapy Psychosis (CBTp) for Youth with Early Onset Psychosis (EOP) Symptoms	Clinical	08/2023	Implementation	Low
Quarterly Engagement Self-Care Raffle Basket	Non-Clinical	07/2023	Baseline year	Low

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	5
2	☒Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	8

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

1. The MHP has a robust Quality Improvement (QI) function. (Quality)
2. Identification of service needs among historically underserved cultural communities promotes access to care. (Access, Quality)
3. Strong emphasis on innovative and evidence-based treatment (EBT) models is designed to meet clinical needs. (Quality)
4. The MHP provides timely follow-up post-inpatient discharge and shows low rehospitalization rates. (Access, Timeliness, Quality)
5. Very low claim denial rates demonstrate knowledgeable staff and billing practices. (IS)

The MHP was found to have notable opportunities for improvement in the following areas:

1. Latino/Hispanic and Asian/Pacific Islander penetration rates (PRs) warrant improvement. (Access)
2. Low foster care (FC) PR suggests under-serving this high-risk group. (Access)
3. Legacy data transfer, including timeliness data, to the new Electronic Health Record (EHR) system is needed. (Timeliness, IS)
4. The MHP is not tracking the required Healthcare Effectiveness Data and Information Set (HEDIS) measures for the FC plan members. (Quality)

5. Effective communication to line staff during major systems changes is challenging in a large MHP system. (Quality, IS)

Recommendations for improvement based upon this review include:

1. Continue with the needs assessment and listening sessions with the historically underserved communities, including the Latino/Hispanic and Asian/Pacific Islander groups, to improve access to culturally appropriate mental health (MH) services. (Access)
2. Continue to develop and implement strategies to better identify the FC members and improve access to MH services for them. (Access)
   (This recommendation was continued from FY 2022-23.)
3. QI and IS staff need to develop collaboratively standardized reporting processes that will consistently support the MHP's ability to track follow-up services that occur within 7 and 30 days after psychiatric hospitalizations. Validation protocols need to be created as well to ensure data integrity and accuracy. (Quality, IS)
4. Develop a tracking and reporting mechanism for the required FC HEDIS measures at a minimum, and also examine the feasibility of tracking the other behavioral health related HEDIS measures. (Quality)
5. Develop communication strategies for all ongoing changes related to EHR implementation, California Advancing and Innovating Medi-Cal (CalAIM) implementation, and payment reform for the staff and contract providers. Such a strategy should have a built-in mechanism for feedback and frequently asked questions, as well as take into account how to make such communications timely, efficient, concise, and consistent. (Quality)

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in February 2023.

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs, comprised of 58 counties, to provide specialty MH services (SMHS) to Medi-Cal members under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each Medi-Cal MHP. DHCS contracts with Behavioral Health Concepts, Inc. (BHC), the CalEQRO to review and evaluate the care provided to the Medi-Cal members.

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, member satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in FC as per California Senate Bill 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to NA as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2023-24 findings of the EQR for Kern County MHP by BHC, conducted as a virtual review on August 22-24, 2023.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public MH system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to validate and analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, members, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and the Inpatient Consolidation (IPC) File.

- CalEQRO reviews are retrospective; therefore, data evaluated represent Calendar Year (CY) 2022 and FY 2022-23, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment (EPSDT); FC; TAY; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2022-23 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components (KC), identified by CalEQRO as crucial elements of QI and that impact member outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – summary of the validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5, and also as outlined DHCS's Comprehensive Quality Strategy. Data definitions are included as Attachment E.
- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Validation and analysis of members' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and their families.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, and then "<11" is indicated to protect the confidentiality of MHP members.

Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or its corresponding PR percentages.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2022-23) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

Like many other MHPs across the state, the MHP has encountered challenges with staff recruitment and retention; impact of the implementation of CalAIM and payment reform; and a new EHR implementation.

SIGNIFICANT CHANGES AND INITIATIVES

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services, are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality of care, including those changes that provide context to areas discussed later in this report.

- The transition to inter-governmental transfer for claiming has been challenging for the MHP due to relatively short timelines.
- The rates set under the payment reform were also issued after the county had started its budget planning process. Updated financial analyses delayed the contracting process with the contract providers.
- The MHP transitioned away from the Cerner Corporation's EHR, Anasazi, and was 1 of 24 counties to sign on to the California Mental Health Services Authority (CalMHSA) Semi-Statewide EHR, SmartCare by Streamline. Kern implemented SmartCare in July 2023.
- The MHP reported that the number of youth experiencing behavioral health crisis has been "unprecedented." This has necessitated the MHP to significantly reorganize its service delivery to its youth population, including colocation of staff at the emergency departments (EDs) and providing more wraparound services following step-down from EDs or inpatient settings. Kern Behavioral Health and Recovery Services (BHRS) has been awarded over $17 million in a Behavioral Health Continuum Program Round 5 grant to build a youth crisis stabilization unit and family resource center. The new building will be a ground-up construction expected to be completed in the fall of 2026.
- Kern BHRS also received a $6 million Proposition 47 grant to fund the Kern Transitions Project. This program will employ EBT approaches, including supported employment, with trauma-informed care, and restorative justice principles and practices to reduce recidivism of individuals impacted by the justice system, with the goal of assisting them in transitioning to a constructive, non-criminal lifestyle.

- The MHP reported an average of 24 percent vacancy rate between July 2022 and February 2023. This has necessitated significant recruitment and retention efforts, including an initiative on employee wellness and engagement.
- The MHP has implemented 988 and hosts one of two county-run 988 call centers in the state operating a suicide prevention hotline.
- Homeless outreach and engagement have continued to be a strategic priority for the MHP.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Addressed is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2022-23

Recommendation 1: Investigate the low FC PRs and identify potential barriers to service access. Implement related interventions as identified. At the same time, develop and implement a strategy to correctly report FC timeliness data for psychiatry.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP investigated the low FC PR and has identified three factors that appear to be contributing to this issue: 1) Challenges with updating aid codes in a timely manner to accurately reflect FC status; 2) a lack of outreach and referral mechanisms to increase the engagement of FC youth ages the 0-5; and, 3) a need to improve the connection processes to MHP services for those FC youth who have experienced triggering events that require those services but not connected previously. While the MHP has isolated and defined three potential variables that may be impacting the PR for this population, it has not yet fully identified specific interventions to address these areas of concern.
- The MHP's FY 2021-22 QAPI plan evaluation shows that the MHP served many more FC plan members than CalEQRO's analysis of approved claims indicates.
- To accurately capture FC timeliness data for psychiatry, the MHP added a required "Yes/No" dropdown prompt to its Tracking Log Application in April 2023. End users are now compelled to identify whether individuals scheduled to receive psychiatry appointments are FC youth or not, thus addressing this portion of the prior year's recommendation.

Recommendation 2: Explore funding options to refurbish county outpatient facilities.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP undertook extensive remodeling of the reception and lobby areas of its outpatient clinics, including the contract provider sites, to make them more welcoming and comfortable.
- Because it was a virtual review, the MHP furnished the before and after photos to CalEQRO, which showed significant improvements.
- Parent and family member focus group participants validated by saying, “clinics are remodeled and no longer dark, but bright and pleasant.”

Recommendation 3: Continue efforts to reduce the data analyst vacancy rate through approaches such as salary equity evaluations. If needed, explore options to contract out for the expertise until staff can be hired.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP coordinated with the Kern County Human Resources department to create two new analyst classifications that place an emphasis on data analytics. Following a compensation study, job descriptions that allow for advancement opportunities between two different data analyst levels, were crafted, vetted, and implemented. The MHP is actively recruiting for these new positions.

Recommendation 4: Continue and execute the data sharing agreement with the Managed Care Plans (MCPs) and begin the process of defining the data exchange project(s) that will support operations for both entities.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Kern has executed data sharing agreements with its two MCPs, HealthNet and Kern Health Systems (KHS). In March 2023, the MHP began sharing data via shared file transfer protocol, which is a process that will support the ongoing exchange of information.

Recommendation 5: Investigate virtual training platforms that will support the development of training materials, allow course registration, track attendance, and support the large number of users that will need to access the training shortly before the SmartCare implementation. Implement based on the findings.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- In April 2023, the MHP purchased a subscription to a shareable content object reference model (SCORM) product called the SCORMHero Pro Plan. This virtual training platform will permit the MHP’s Training Services Division to create courses by uploading content, crafting videos, and developing exams to assess for the acquisition of specific information and skills. This tool will function as a

complement to other resources available to the MHP such as Relias and CalMHSA's learning management system.

ACCESS TO CARE

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals (or members) are able to obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, sufficient number of providers and facilities in the areas in which members live, equity, as well as accessibility—the ability to obtain medical care and services when needed.[1] The cornerstone of MHP services must be access, without which members are negatively impacted.

CalEQRO uses a number of indicators of access, including the Key Components and PMs addressed below.

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 42.47 percent of services were delivered by county-operated/staffed clinics and sites, and 57.53 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 67.76 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county staff; members may request services through the Access Line as well as through the following system entry points: Directly operated and contract provider outpatient clinics and urgent care locations. The MHP operates a decentralized access team that is responsible for linking members to appropriate, medically necessary services. The MHP has several walk-in capable clinics where certain days and time slots are reserved for walk-in screening, intake, and assessment. In addition to these, the access and assessment services are located at Mary K Shell Mental Health Center during regular business hours.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 6,379 adult members, 3,145 youth members, and 806 older adult members across 13 county-operated sites and 23 contractor-operated sites. The MHP's previous EHR, Cerner's Anasazi, did not track members receiving telehealth services in a language other than English.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

An adequate network of providers is necessary for members to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

In December 2022, DHCS issued its FY 2022-23 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For Kern County, the time and distance requirements are 45 miles and 75 minutes for outpatient MH and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: Kern MHP Alternative Access Standards, FY 2022-23

Alternative Access Standards	
The MHP was required to submit an AAS request due to time or distance requirements	☐ Yes ☒ No

- The MHP met all time and distance standards and was not required to submit an AAS request.

Table 1B: Kern MHP Out-of-Network Access, FY 2022-23

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No

- Because the MHP can provide necessary services to a member within time and distance standards using a network provider, the MHP was not required to allow members to access services via OON providers.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to members and family members. Examining service accessibility and availability, system capacity and utilization, integration and collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population and monitors access and availability of services form the foundation of access to quality services that ultimately lead to improved member outcomes.

Each access component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Member Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

Strengths and opportunities associated with the access components identified above include:

- Kern MHP has a robust process to ensure access to SMHS for various cultural groups. The Cultural Competency Plan (CCP) is the primary vehicle for identifying needs, priorities, strategies, and evaluation of cultural initiatives. In the past year, the MHP has held "deep listening" sessions with various culture-specific stakeholders to learn what the administration needs to know to improve access and provide culturally appropriate services. The MHP conducted the listening sessions with the presence of at least one behavioral health board member and in partnership with the MCPs.
- The MHP has built a very robust outreach system to improve access and engagement of the homeless and individuals with housing needs. These efforts have required extensive collaboration with external partners including housing agencies, shelters, and law enforcement.
- Kern MHP also has strong partnerships and collaborations with a number of other service partners and agencies including health, social services, MCPs and primary care to enhance access to SMHS.
- The MHP expressed concerns regarding potential changes being contemplated in the Mental Health Services Act (MHSA) funding that could pose fiscal and operational challenges to the services currently funded by MHSA.
- Kern has a rather large Hispanic/Latino population and has placed an emphasis on connecting with this underserved community. UC Davis Health Equity program and Solano County Behavioral Health are providing TA to Kern and other counties to elicit ideas on how to not only increase the PR for this population, but also on helping Hispanic/Latino members navigate the MHP's system of care in ways that will be most beneficial to them.
- Kern's FC and Asian/Pacific Islander PRs have been consistently lower than the corresponding statewide PRs. The MHP identifies the low Asian/Pacific Islander PR as an area needing further attention in its CCP. However, the MHP's own

calculations for FC PR do not recognize it as an issue in the QAPI workplan, which is in contrast to the EQRO's analysis of Kern's approved claims and Medi-Cal eligibility data that identifies low FC PR compared to statewide and other large county averages.

ACCESS PERFORMANCE MEASURES

Members Served, Penetration Rates, and Average Approved Claims per Member Served

The following information provides details on Medi-Cal eligibles, and members served by age, race/ethnicity, and threshold language.

The PR is a measure of the total members served based upon the total Medi-Cal eligibles. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar size county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The Statewide PR is 3.96 percent, with an average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, Kern demonstrates better overall access to care than was seen statewide.

Table 3: Kern MHP Annual Members Served and Total Approved Claims CY 2020-22

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	496,656	20,992	4.23%	$132,186,421	$6,297
CY 2021	462,742	19,991	4.32%	$130,713,369	$6,539
CY 2020	425,012	18,212	4.29%	$113,600,949	$6,238

*Total Annual eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- Between CY 2020 and CY 2022, total members eligible, the number of members served, and total approved claims all steadily trended upward. AACM increased slightly over CY 2020 levels as well.
- During the same period the MHP's overall PR initially increased, though it ultimately fell a bit below the CY 2020 threshold – but with more members served each year.

Table 4: Kern MHP Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	57,904	852	1.47%	1.50%	1.82%
Ages 6-17	131,536	8,511	6.47%	5.01%	5.65%
Ages 18-20	28,285	1,322	4.67%	3.66%	3.97%
Ages 21-64	246,252	9,786	3.97%	3.73%	4.03%
Ages 65+	32,681	521	1.59%	1.64%	1.86%
Total	**496,656**	**20,992**	**4.23%**	**3.60%**	**3.96%**

- The largest eligibility group for Kern was adults ages 21-64, followed by youth ages 6-17. These categories also represented the groups with the largest number of members served.
- The PRs for the 6-17 and 18-20 age groups were higher than both the statewide and county size group PRs. The PR for the 21-64 age group was higher than the county size group and roughly analogous to the statewide numbers. The PRs for the 0-5 and 65+ age groups, however, were lower than either the statewide or county size group.
- The MHP's overall PR was higher than both the statewide and county size group PRs.

Table 5: Threshold Language of Kern MHP Medi-Cal Members Served in CY 2022

Threshold Language	# Members Served	% of Members Served
Spanish	3,559	17.01%
Threshold language source: Open Data per BHIN 20-070		

- Spanish is the only threshold language for Kern, with 17.01 percent of members served reporting Spanish as their primary language in CY 2022. This represents a 5.52 percent increase from CY 2021 (16.12 percent).

Table 6: Kern MHP Medi-Cal Expansion (ACA) PR and AACM CY 2022

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	132,931	5,201	3.91%	$32,345,019	$6,219
Large	2,532,274	76,457	3.02%	$535,657,742	$7,006
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligibles that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. This trend is evidenced by the MHP as well.
- At 3.91 percent, the MHP's ACA PR is higher than both the statewide and county size group levels; however, the ACA AACM is lower than both comparisons.

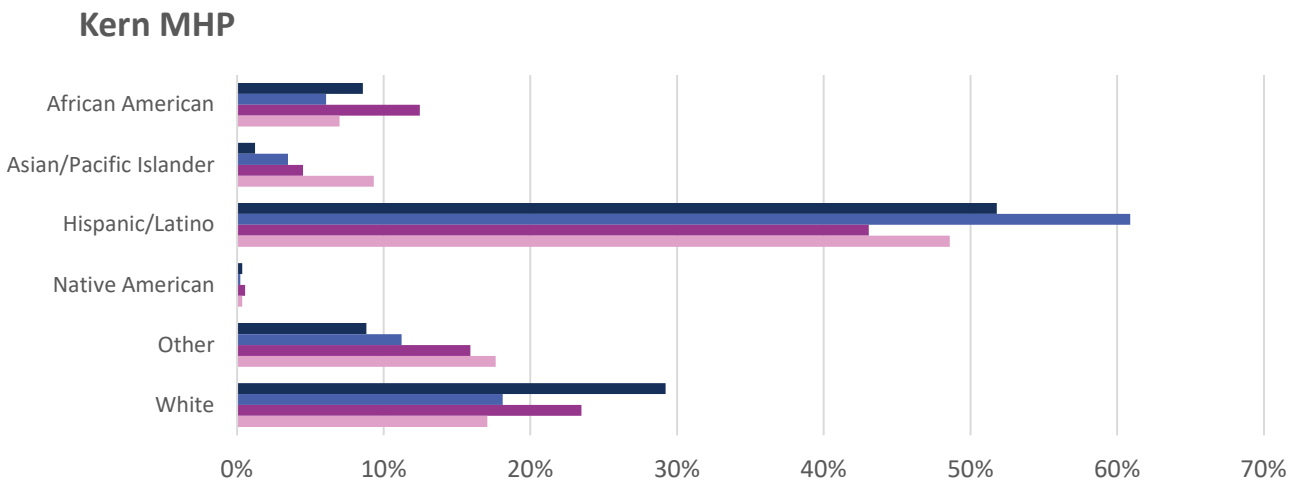
The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total members served. Table 7 and Figures 1-9 compare the MHP's data with MHPs of similar size and the statewide average.

Table 7: Kern MHP PR of Members Served by Race/Ethnicity CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	30,197	1,804	5.97%	7.08%
Asian/Pacific Islander	17,274	257	1.49%	1.91%
Hispanic/Latino	302,434	10,873	3.60%	3.51%
Native American	1,102	75	6.81%	5.94%
Other	55,703	1,851	3.32%	3.57%
White	89,948	6,132	6.82%	5.45%
Total	**496,658**	**20,992**	**4.23%**	**3.96%**

- The largest racial/ethnic group of eligibles was Hispanic/Latino, followed by White. This same pattern was evidenced in the number of members served, with the Hispanic/Latino population constituting the largest group, followed by White.
- The MHP's PRs were higher than statewide levels for the Hispanic/Latino, White, and Native American populations.

Figure 1: Race/Ethnicity for MHP Compared to State CY 2022

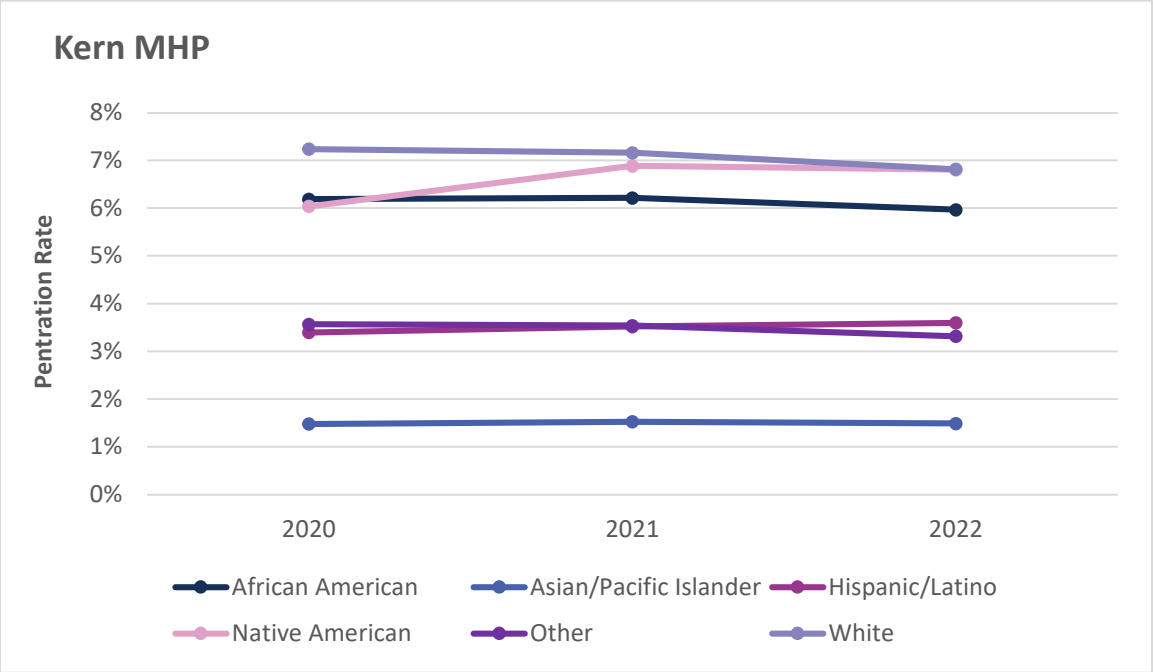


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	29%	9%	0%	52%	1%	9%
MHP % Eligible	18%	11%	0%	61%	3%	6%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- The most proportionately overrepresented racial/ethnic group for both the MHP (18 percent of members eligible vs. 29 percent of members served) and statewide (17 percent vs. 23 percent) was White.
- The most proportionately underrepresented group for both the MHP and the state was Hispanic/Latino, with a 9-percentage point difference between members eligible (61 percent) and members served (52 percent) within the MHP.

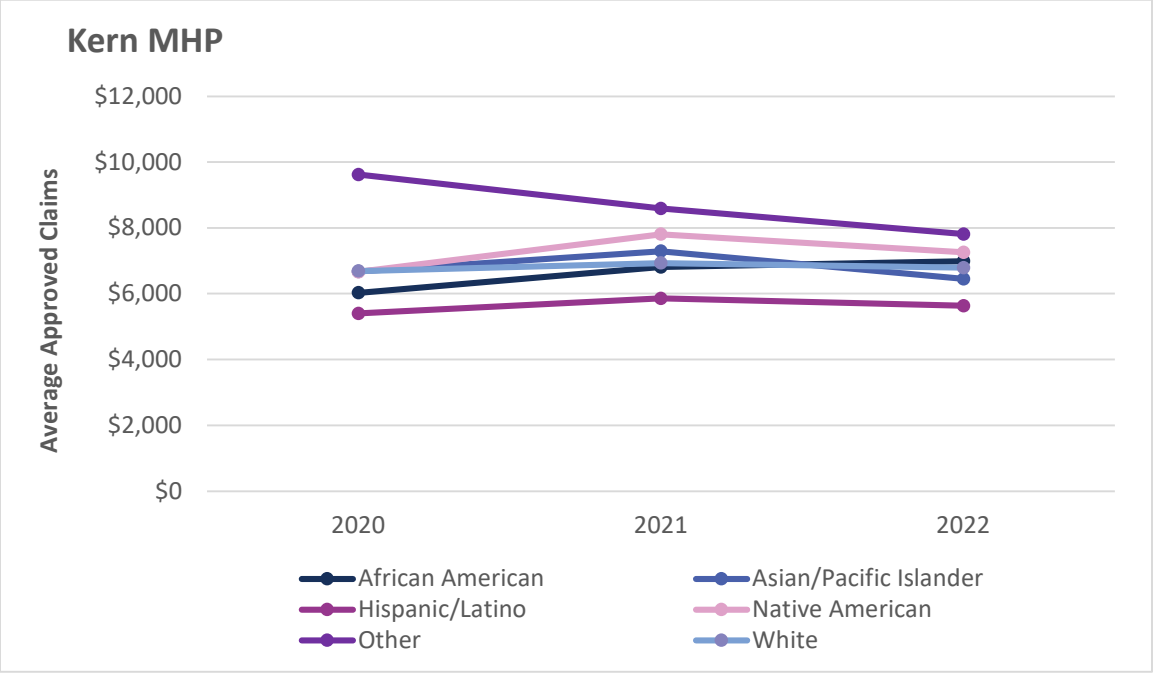
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide for a three-year trend.

Figure 2: MHP PR by Race/Ethnicity CY 2020-22



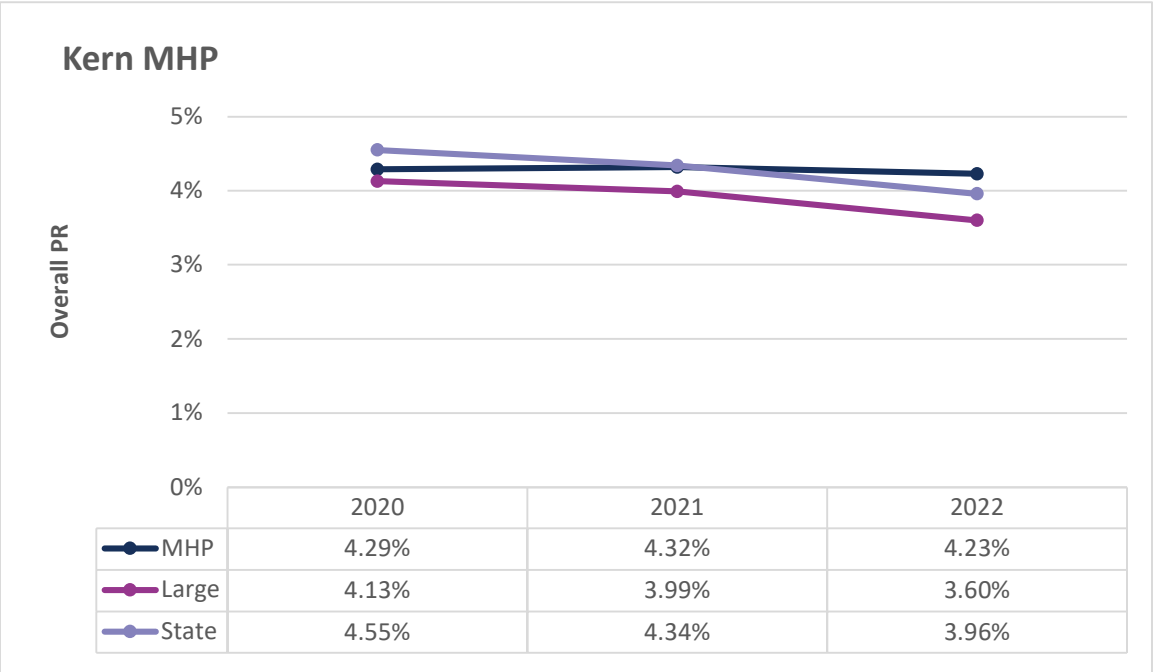
- With the exception of some variability in the Native American group, the PRs for all racial/ethnic groups are either flat or trending slightly downward.
- While White, Native American, and African American populations have consistently had the highest PRs over time, the Asian/Pacific Islander group has consistently had the lowest – this is also evident statewide.

Figure 3: MHP AACM by Race/Ethnicity CY 2020-22



- While members within the Other category have consistently had the highest AACMs over time, Hispanic/Latino members – the largest racial/ethnic group served by the MHP – have invariably had the lowest.

Figure 4: Overall PR CY 2020-22



	2020	2021	2022
MHP	4.29%	4.32%	4.23%
Large	4.13%	3.99%	3.60%
State	4.55%	4.34%	3.96%

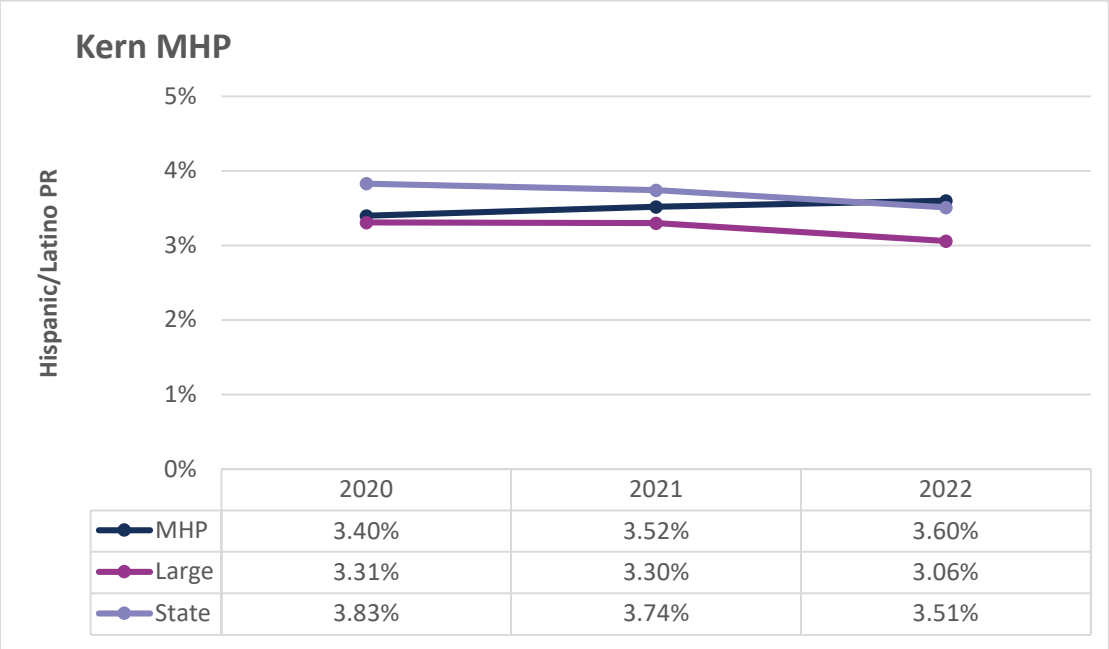
- Although Kern's overall PR slightly increased between CY 2020 and CY 2021, it dropped below CY 2020 levels in CY 2022; however, the state as a whole, including large counties, have experienced a more pronounced decrease in overall PRs over the same time period.

Figure 5: Overall AACM CY 2020-22

	2020	2021	2022
MHP	$6,238	$6,539	$6,297
Large	$7,156	$7,910	$7,838
State	$7,155	$7,478	$7,442

- The MHP's AACM for this three-year period has been consistently lower than those seen statewide and in similar sized counties and is relatively stable.

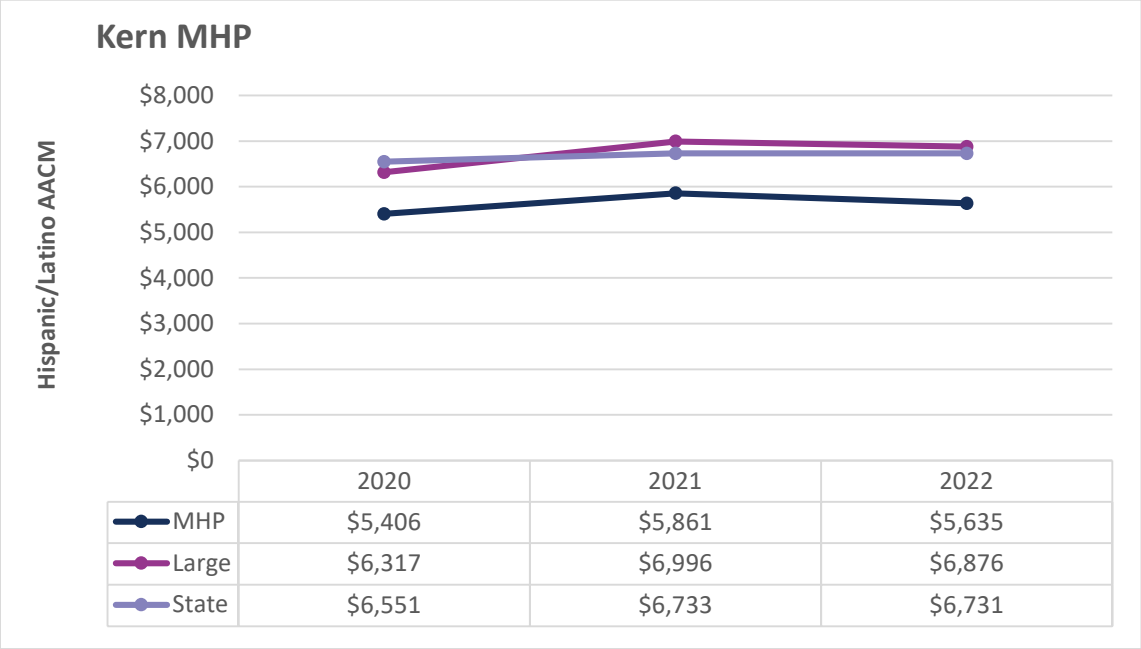
Figure 6: Hispanic/Latino PR CY 2020-22



	2020	2021	2022
MHP	3.40%	3.52%	3.60%
Large	3.31%	3.30%	3.06%
State	3.83%	3.74%	3.51%

- Between CY 2020 and CY 2022, the Hispanic/Latino PRs for the state and large counties have been slowly decreasing. However, the MHP's PR has been exhibiting a modest upward trajectory, with a 5.88 percent increase observed between its PR in CY 2020 and the PR in CY 2022.

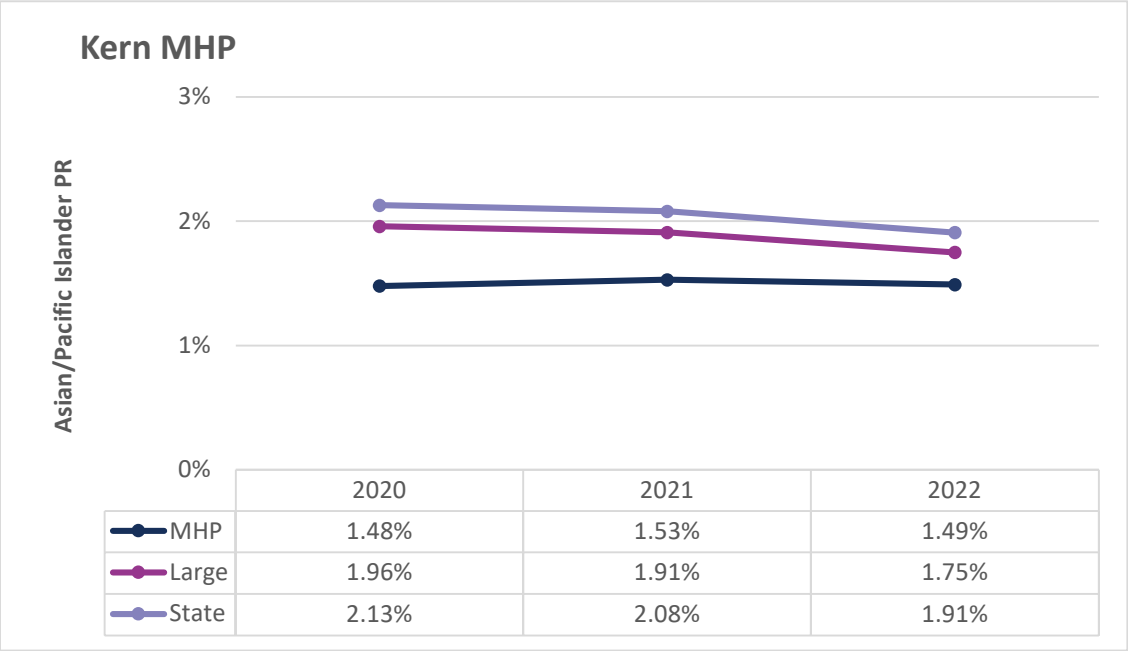
Figure 7: Hispanic/Latino AACM CY 2020-22



	2020	2021	2022
MHP	$5,406	$5,861	$5,635
Large	$6,317	$6,996	$6,876
State	$6,551	$6,733	$6,731

- AACMs among Hispanic/Latino members showed slight increases for the MHP, the state, and large counties between CY 2020 and CY 2022, with the highest percent change occurring between CY 2020 and CY 2021.
- The Hispanic/Latino AACM for the MHP, however, has been consistently lower than AACMs in large counties or statewide.

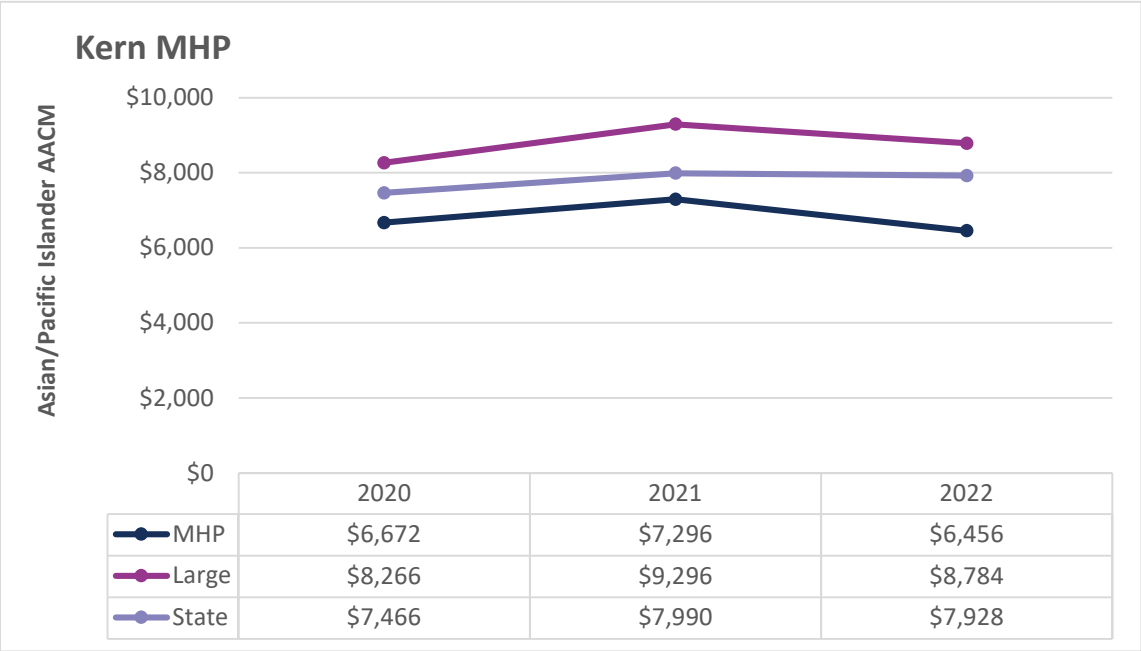
Figure 8: Asian/Pacific Islander PR CY 2020-22



	2020	2021	2022
MHP	1.48%	1.53%	1.49%
Large	1.96%	1.91%	1.75%
State	2.13%	2.08%	1.91%

- Asian/Pacific Islander PRs statewide and in large counties have been showing a rather gradual decline over the past three years. The PR for this group in the MHP has been largely stable, though it has been consistently lower than both statewide and in large counties overall.

Figure 9: Asian/Pacific Islander AACM CY 2020-22



	2020	2021	2022
MHP	$6,672	$7,296	$6,456
Large	$8,266	$9,296	$8,784
State	$7,466	$7,990	$7,928

- The Asian/Pacific Islander AACM in the MHP has been consistently lower across the past three years than statewide and large county AACMs for this group.

Figure 10: Foster Care PR CY 2020-22

	2020	2021	2022
MHP	39.13%	36.18%	34.03%
Large	47.06%	46.53%	44.06%
State	51.00%	49.15%	46.00%

- Between CY 2020 and CY 2022, FC PRs have steadily declined in the MHP, the statewide, and in large counties. PRs in the MHP have been consistently lower than those seen statewide and in large counties across all three years.

Figure 11: Foster Care AACM CY 2020-22

	2020	2021	2022
MHP	$8,803	$10,099	$9,749
Large	$10,129	$11,288	$11,343
State	$10,338	$11,020	$11,542

- Statewide FC AACM has increased each year for the past three years, whereas FC AACM in the MHP fell slightly from CY 2021 to CY 2022.
- The FC AACM for the MHP has been lower than both the statewide and large county AACMs for all three CYs displayed.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the Kern MHP to Adults

Service Category	MHP N = 11,631				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	642	5.5%	11	7	10.3%	14	8
Inpatient Admin	<11	-	13	11	0.4%	26	10
Psychiatric Health Facility	189	1.6%	17	10	1.2%	16	8
Residential	47	0.4%	66	55	0.3%	114	84
Crisis Residential	174	1.5%	15	14	1.9%	23	15
Per Minute Services							
Crisis Stabilization	1,704	14.7%	1,151	1,020	13.4%	1,449	1,200
Crisis Intervention	1,580	13.6%	158	105	12.2%	236	144
Medication Support	5,650	48.6%	242	168	59.7%	298	190
Mental Health Services	8,940	76.9%	705	398	62.7%	832	329
Targeted Case Management	5,362	46.1%	279	138	36.9%	445	135

- The MHP's overall inpatient utilization was lower than statewide.
- The most frequently used service modalities in the MHP were MH services, medication support, and targeted case management (TCM). While the MHP's utilization rates were higher than statewide for MH services and TCM, the MHP's utilization rate for medication support was lower.
- The MHP's utilization rates for crisis services were comparable to statewide.

Table 9: Services Delivered by the Kern MHP to Youth in Foster Care

Service Category	MHP N = 930				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	45	4.8%	9	6	4.5%	12	8
Inpatient Admin	<11	-	15	15	0.0%	5	3
Psychiatric Health Facility	<11	-	9	9	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	<11	-	28	28	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	35	3.8%	1,180	1,080	3.1%	1,166	1,095
Crisis Intervention	46	4.9%	239	161	8.5%	371	182
Medication Support	310	33.3%	278	240	27.6%	364	257
Therapeutic Behavioral Services (TBS)	38	4.1%	1,012	443	3.9%	4,077	2,457
Therapeutic FC (TFC)	<11	-	180	180	0.1%	911	495
Intensive Home Based Services	300	32.3%	377	241	40.8%	1,458	441
Intensive Care Coordination	100	10.8%	568	327	19.5%	2,440	1,334
Katie-A-Like	<11	-	245	233	0.2%	390	158
Mental Health Services	902	97.0%	1,430	733	95.4%	1,846	1,053
Targeted Case Management	385	41.4%	233	94	35.8%	307	118

- Residential and inpatient services utilization in the MHP was comparable to statewide.
- The outpatient services with the highest utilization rates were MH services, TCM, and medication support. The MHP's utilization rates were higher than statewide in all categories.
- The MHP's utilization rate of crisis services for FC youth is lower than statewide.

- The MHP's delivery of Intensive Care Coordination and Intensive Home Based Services (IHBS) services are also below the statewide utilization.

IMPACT OF ACCESS FINDINGS

- The MHP has a robust access system comprising of not only the Access Line, but also several walk-in clinic locations and established referral mechanisms from schools, primary care, and justice-involved sources.
- Even though the MHP's PR for Hispanic/Latinos has been increasing between CY 2020 and CY 2022, disparities in access for them still exists. Considering that Hispanic/Latinos represent 61 percent of Kern's Medi-Cal plan members in CY 2022, perhaps greater outreach and engagement strategies could be identified and implemented. The MHP's health equity efforts in this area are good steps toward it.
- Although FC PRs have been generally declining for the MHP, state, and similar-sized counties between CY 2020 and 2022, the MHP's performance has invariably been the lowest across all three years. Kern has acknowledged its awareness of this area of concern and is presently collaborating with partner agencies to identify strategies and interventions to ameliorate this situation.

TIMELINESS OF CARE

The amount of time it takes for members to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors MHPs' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate MHP timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to members. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved member outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the PMs section.

Each Timeliness Component is comprised of individual subcomponents, which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

Strengths and opportunities associated with the timeliness components identified above include:

- Kern MHP has a robust system in place for tracking, reviewing, and undertaking performance improvement activities related to timeliness metrics. For initial and urgent access measures, it has its own web application that records service requests and initial service encounters. For inpatient follow-up and readmissions,

it relied on two reports from its previous EHR. Reports on the timeliness metrics are presented and examined regularly in the Key Performance Indicators Committee (KPIC).

- The MHP has registered high no-show rates for psychiatry and other clinical appointments for several years and attempted performance improvement activities without significant success. It is currently engaged in a new non-clinical PIP based on plan member incentives to reduce no-shows.
- The MHP was not fully able to accurately record the FC timeliness for all the metrics and those reports may not capture all FC plan members. However, all FC plan members' timeliness data are tracked within the children's timeliness metrics. The MHP updated its web application starting April 2023 and reported that it is now able to fully isolate the FC plan members and provide a complete picture of their timeliness metrics.
- The MHP separates out urgent appointment timeliness by whether prior authorization is required or not. The MHP reports that in implementing BHIN 19-026, it has treated all authorizations for adult crisis residential treatment, IHBS, TBS, and TFC as response to urgent requests requiring prior authorization.
- The clinical line staff and plan members all reported post-inpatient discharge follow-up to be timely and the line staff are instructed to prioritize inpatient follow-up appointments.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across several key timeliness metrics for a specified time period. Counties are also expected to submit the source data used to prepare these calculations. This is particularly relevant to data validation for the additional statewide focused study on timeliness that BHC is conducting.

For the FY 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2022-23 (though June 25, 2023). Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. These data represent the entire system of care.

Claims data for timely access to post-hospital care and readmissions are discussed in the Quality of Care section.

Table 11: FY 2023-24 Kern MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	4.2 Business Days	10 Business Days*	95.7%
First Non-Urgent Service Rendered	6.1 Business Days	10 Business Days**	84.0%
First Non-Urgent Psychiatry Appointment Offered	11.8 Business Days	15 Business Days*	79.3%
First Non-Urgent Psychiatry Service Rendered	12.0 Business Days	15 Business Days**	75.0%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	42.2 Hours	48 Hours*	84.4%
Urgent Services Offered (including all outpatient services) – Prior Authorization Required	6.0 Hours	96 Hours*	99.3%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	11.1 Days	7 Calendar Days	61.7%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	11.1 Days	30 Calendar Days	74.2%
No-Show Rate – Psychiatry	24.0%	18%**	n/a
No-Show Rate – Clinicians	11.3%	15%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards			
For the FY 2023-24 EQR, the MHP reported its performance for the following time period: July 1, 2022 – June 25, 2023			

Figure 12: Wait Times to First Service and First Psychiatry Service

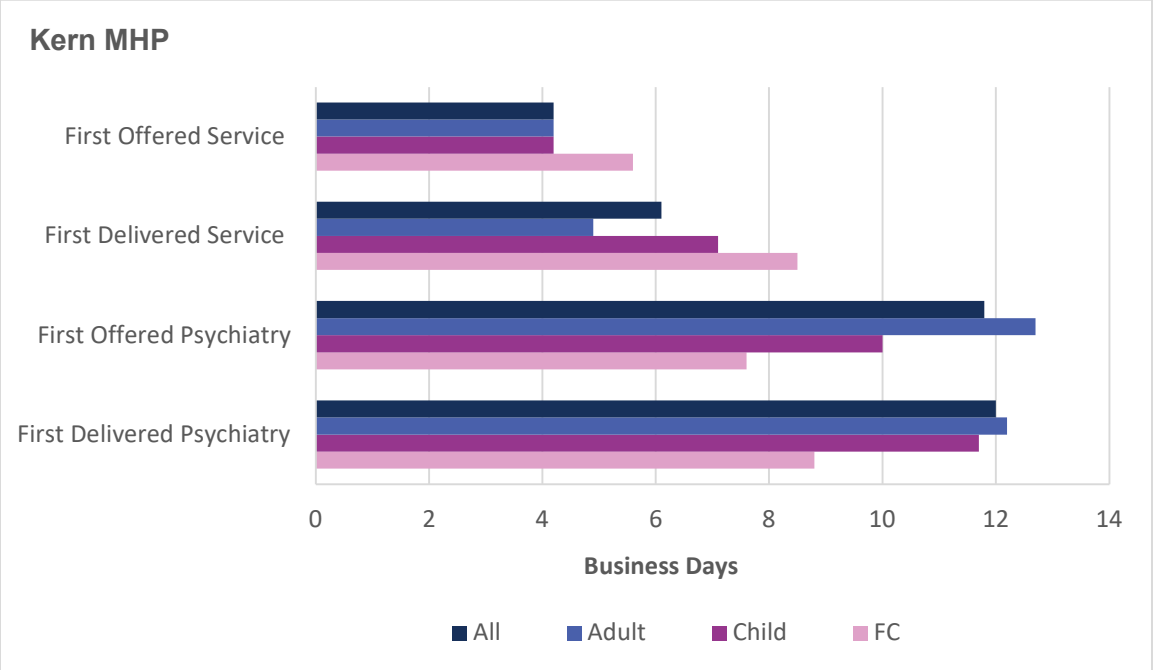


Figure 13: Wait Times for Urgent Services

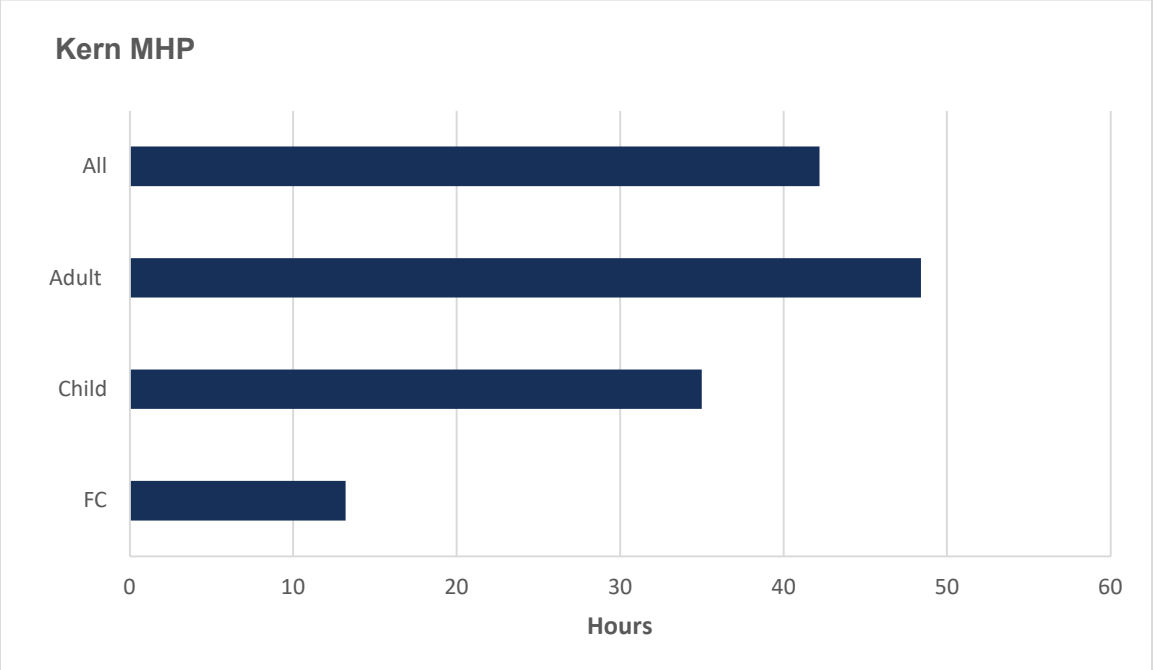
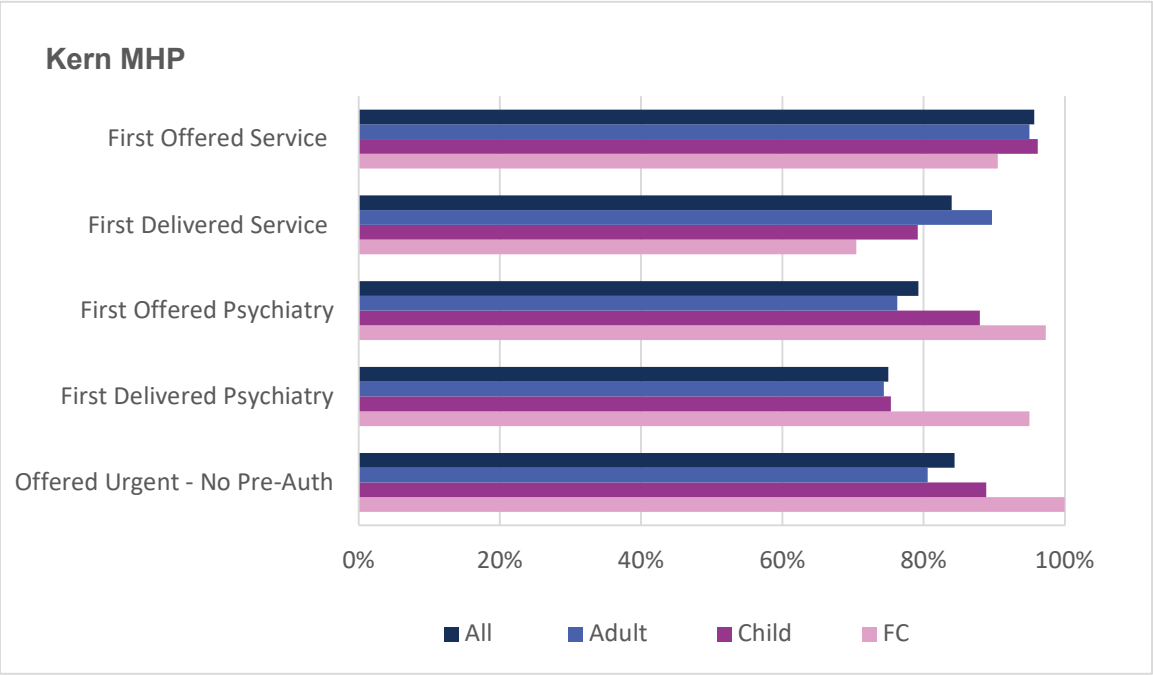


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned MH services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments.
- Although the MHP has not formally articulated an operational definition for "urgent services" for purposes of the ATA, it has created a process for staff to use to ascertain whether a request for services is "urgent." More specifically, the QI Division crafted a memorandum that enumerates ten different factors that staff need to assess to determine if a request for services qualifies as "urgent."
    - There were reportedly 823 urgent service requests with a reported actual wait time to services for the overall population of 42.2 hours. The MHP does track urgent services that require pre-authorization separately. There were reportedly 663 urgent service requests that required prior-authorization with a reported actual wait time to services for the overall population at 6.0 hours, meeting the 96-hour standard 99.3 percent of the time.
- A 15-business day standard is expected for initial access to psychiatry, though the MHP may define when and how this is measured, and often MHP processes, definitions, and tracking may differ for adults and children. The MHP defines timeliness to first delivered/rendered psychiatry services as the time from member's initial request for psychiatry services to the point of the first attended appointment.

- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 24.0 percent for psychiatrists and 11.3 percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

- The KPIC ongoing monitoring of timeliness metrics allows the MHP to promptly address any untoward trend in these metrics as well as to launch more formal performance improvement activities.
- The MHP has successfully created its own web-based timeliness tracking application. It will be important to maintain its functionalities through the transition to a new practice management system.
- Kern's high no-show rates, especially for psychiatry appointments, continue to be a drain on its resources. It will be important to investigate any impact of psychiatrist turnover on the no-show rates, as the family members focus group noted concerns with such turnover.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the members through its structure and operational characteristics, the provision of services that are consistent with current professional, evidenced-based knowledge, and the intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive QAPI Program for the services furnished to members. The contract further requires that the MHP's quality program "clearly defines the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN THE MHP

In the MHP, the responsibility for QI is organized through an integrated behavioral health QI structure that comprises four committees – Executive QI Committee (QIC), System QIC, KPIC, and Regulatory Compliance Committee.

The MHP monitors its quality processes through the latter three committees that bring all its findings and reports to the Executive QIC, which is ultimately responsible for the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of executives, managers, and the QI staff, is scheduled to meet quarterly. The System QIC consists of a wide range of stakeholders including staff and plan members. In between the Executive QIC meetings, the other three committees meet to discuss their findings. Since the previous EQR, the MHP QIC met three times. Of the 11 identified FY 2021-22 QAPI workplan goals, the MHP met 10 goals. The only goal that it did not meet was the reporting of unusual occurrences due to the staff not meeting the reporting timeframes.

The MHP does not utilize a standardized level of care (LOC) tool; however, it does perform LOC tracking and employs Clinical Practice Guidelines (CPG) to inform the LOC decisions.

The MHP utilizes the following outcomes tools: Child and Adolescent Needs and Strengths (CANS), the Columbia-Suicide Severity Rating Scale (C-SSRS), the General Anxiety Disorder-7, the 35-item Pediatric Symptom Checklist, and the Patient Health Questionnaire.

The MHP places an emphasis on data analytics and uses platforms such as Microsoft Power BI to generate dashboards and data visualization reporting tools. These reports can be crafted with a member-level, provider-level, program-level, or system-level focus, and are distributed to end users ranging from leadership and KPIC to clinical and clerical staff, as well as contractors. For example, there are dashboards that contain longitudinal output from the CANS that illustrate the extent to which members are improving over time by evaluating changes in CANS domain scores.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SMHS healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for members. These key components include an organizational culture that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

Each Quality Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Met
3H	Utilizes Information from Member Satisfaction Surveys	Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Member and Member Employment in Key Roles throughout the System	Partially Met

Strengths and opportunities associated with the quality components identified above include:

- All four different QICs meet regularly, and the structure allows for rapid performance improvement actions and evaluation while ensuring stakeholder participation.
- The MHP relies on data-driven decision making. The KPIC is instrumental in producing and reporting on performance indicators that focus on plan member care quality, processes, and outcomes.
- The MHP's implementation of the Transition to Independence Process (TIP), an EBT model, and the creation of TAY dyads consisting of a therapist and a recovery specialist have the potential to better identify the treatment and other needs of youth aged 18-23 years, and thereby improve their progress and outcomes.

- In general, the MHP has good communication practices with all stakeholders. The MHP has expanded its community engagement efforts to improve service quality and appropriateness.
- Although Kern has developed a robust CPG to inform its LOC decisions in the adult system of care, it does not have an LOC measurement tool.
- Since the implementation of the new EHR on July 1, 2023, the line staff reported being overwhelmed by the volume of emails that they received outlining the changes.
- The line staff also appeared to lack clarity on productivity standards, use of interns, and related billing issues.
- The MHP has peer employees in various positions and locations. However, they continue to remain an underutilized resource in that many plan members are unaware of their existence and roles.
- The MHP does not track and does not trend the HEDIS measures as required by WIC Section 14717.5.

QUALITY PERFORMANCE MEASURES

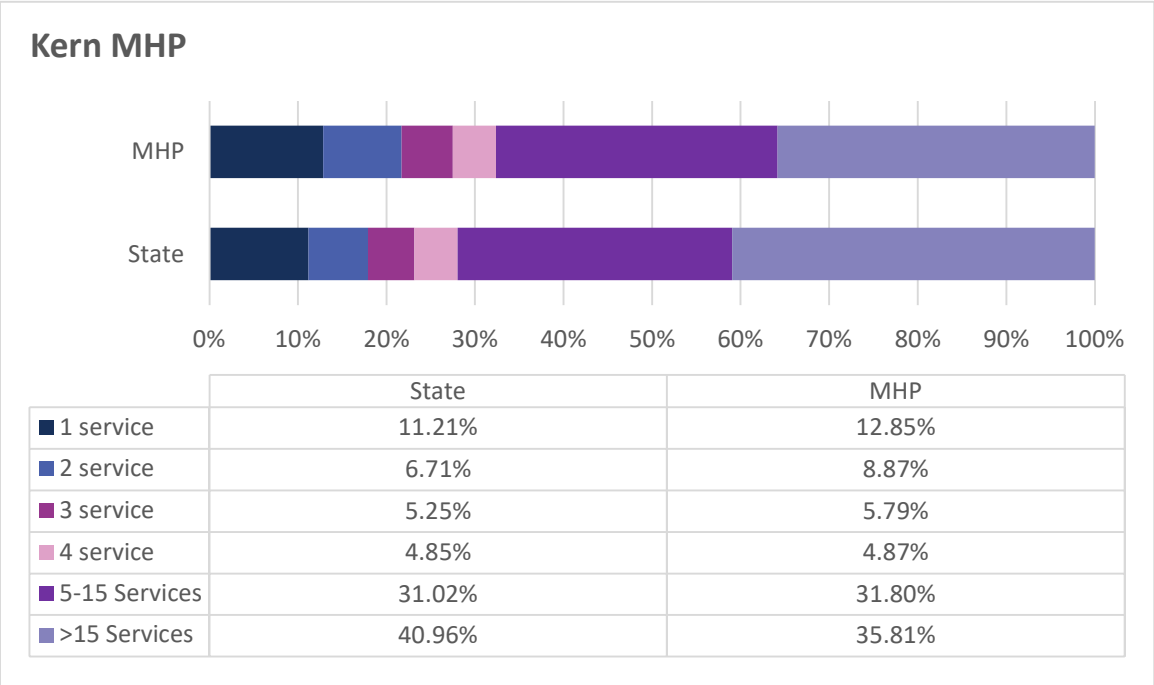
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented in the approved claims:

- Retention in Services
- Diagnosis of Members Served
- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- High-Cost Members (HCM)

Retention in Services

Retention in services is an important measure of member engagement in order to receive appropriate care and intended outcomes. One would expect most members served by the MHP to require 5 or more services during a 12-month period. However, this table does not account for the length of stay, as individuals enter and exit care throughout the 12-month period.

Figure 15: Retention of Members Served CY 2022



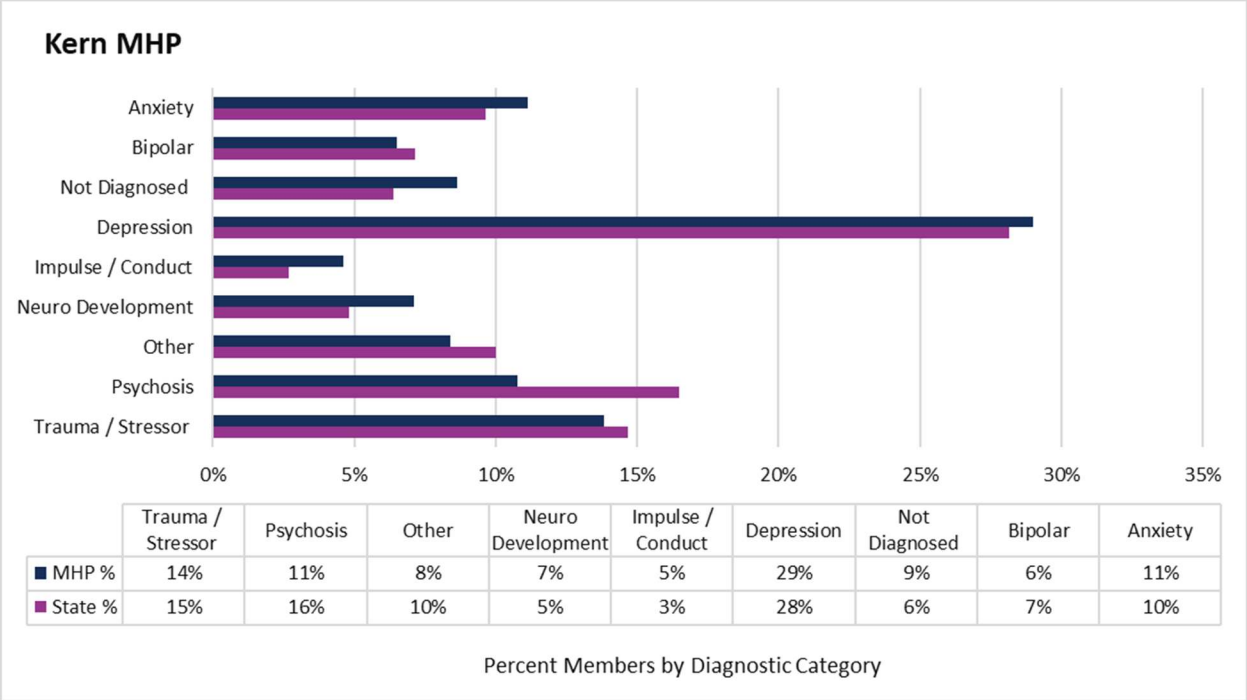
	State	MHP
1 service	11.21%	12.85%
2 service	6.71%	8.87%
3 service	5.25%	5.79%
4 service	4.85%	4.87%
5-15 Services	31.02%	31.80%
>15 Services	40.96%	35.81%

- Statewide, the percentage of plan members who received five or more services is higher than the MHP (71.98 percent vs. 67.61 percent). Conversely, the percentage of members who received between one or two services is higher for the MHP. This may indicate challenges to engaging some members in services.

Diagnosis of Members Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP members in a diagnostic category compared to statewide. This is not an unduplicated count as a member may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

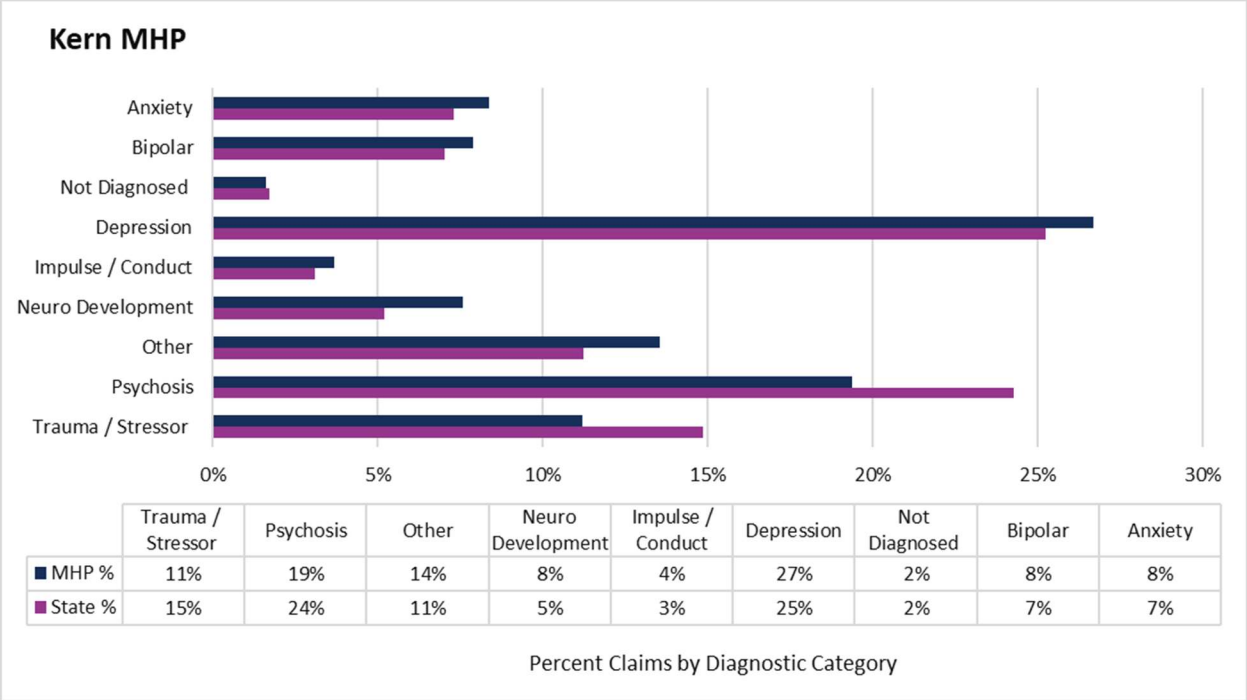
Figure 16: Diagnostic Categories by Percentage of Members Served CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	14%	11%	8%	7%	5%	29%	9%	6%	11%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- The most prevalent diagnostic category for the MHP – and statewide – for CY 2022 was Depression. Diagnostic rates were generally comparable between the MHP and statewide, with the greatest difference being in Psychosis (11 percent in the MHP vs. 16 percent statewide).

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	11%	19%	14%	8%	4%	27%	2%	8%	8%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- Consistent with the MHP's diagnostic patterns, the largest diagnostic category for approved claims in CY 2022 was Depression, followed by Psychosis. These three diagnostic categories account for 60 percent of the MHP's total claims.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average LOS.

Table 13: Kern MHP Psychiatric Inpatient Utilization CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	MHP ALOS in Days	Statewide ALOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	1,189	1,506	9.90	8.45	$15,247	$12,763	$18,128,543
CY 2021	1,214	1,622	10.64	8.86	$16,944	$12,696	$20,569,743
CY 2020	1,205	1,581	11.02	8.68	$16,785	$11,814	$20,226,430

- There was a slight increase in the total number of admissions and the count of unique members served who received inpatient treatment between CY 2020 and CY 2021, followed by a decrease in total admissions in CY 2022. Inpatient AACMs and total approved claims followed the same pattern. For CY 2022, the

MHP's AACM is almost $2,500 higher than the statewide AACM, representing a slight narrowing of the gap seen in the previous two years.

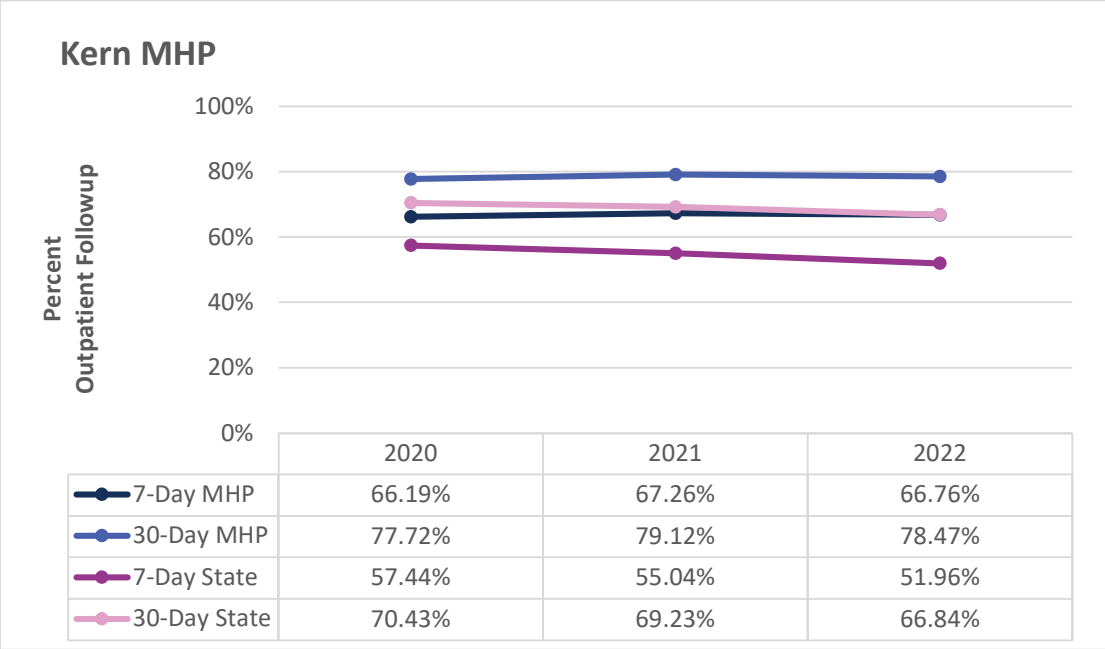
- Although the MHP's average LOS in days was consistently higher than the state, it has steadily declined over this three-year timeframe.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2022 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the member outcomes and is reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis.

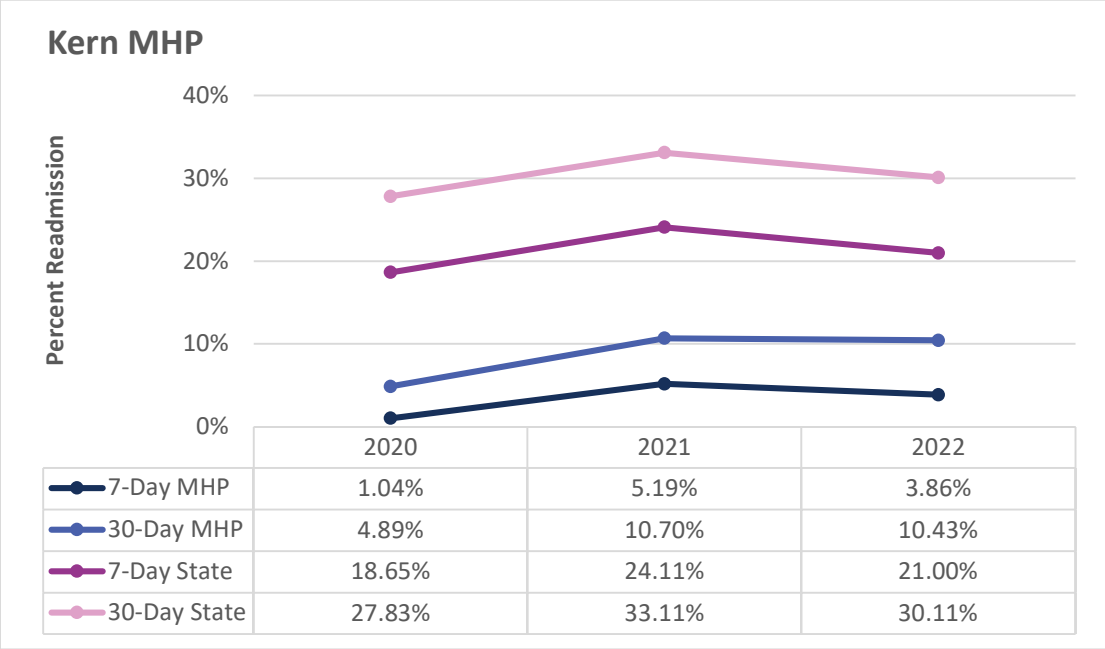
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2020-22



	2020	2021	2022
7-Day MHP	66.19%	67.26%	66.76%
30-Day MHP	77.72%	79.12%	78.47%
7-Day State	57.44%	55.04%	51.96%
30-Day State	70.43%	69.23%	66.84%

- While statewide post-psychiatric inpatient follow-up rates have decreased over the past three years, the MHP has maintained stable 7- and 30-day follow-up rates that have been consistently higher than those seen statewide. The MHP's self-reported data on these metrics closely matched CalEQRO's calculations.

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2020-22



	2020	2021	2022
7-Day MHP	1.04%	5.19%	3.86%
30-Day MHP	4.89%	10.70%	10.43%
7-Day State	18.65%	24.11%	21.00%
30-Day State	27.83%	33.11%	30.11%

- The MHP's 7-day and 30-day psychiatric readmission rates have been consistently lower than statewide.
- The MHP's self-reported data on these metrics closely matched CalEQRO's calculations.
- The MHP's high rates of 7- and 30-day follow-up and low rates of rehospitalizations reflect the heavy emphasis it places on prioritizing and ensuring follow-ups and medication management post inpatient discharge.

High-Cost Members

Tracking the HCMs provides another indicator of quality of care. High cost of care represents a small population's use of higher cost and/or higher frequency of services. For some clients, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. Further, HCMs may disproportionately occupy treatment slots that may prevent access to levels of care by other members. HCB percentage of total claims, when compared with the HCM count percentage, provides a subset of the member population that warrants close utilization review, both for appropriateness of LOC and expected outcomes.

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACM is $7,442, the median amount is just $3,200.

Table 15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of the statewide members are "low-cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACM of $4,364 and median of $2,761 for members in that cost category.

Table 14: Kern MHP High-Cost Members (Greater than $30,000) CY 2020-22

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	619	2.95%	25.25%	$33,381,879	$53,929	$44,284
	CY 2021	623	3.12%	25.81%	$33,739,412	$54,156	$44,095
	CY 2020	460	2.53%	23.13%	$26,270,742	$57,110	$43,042

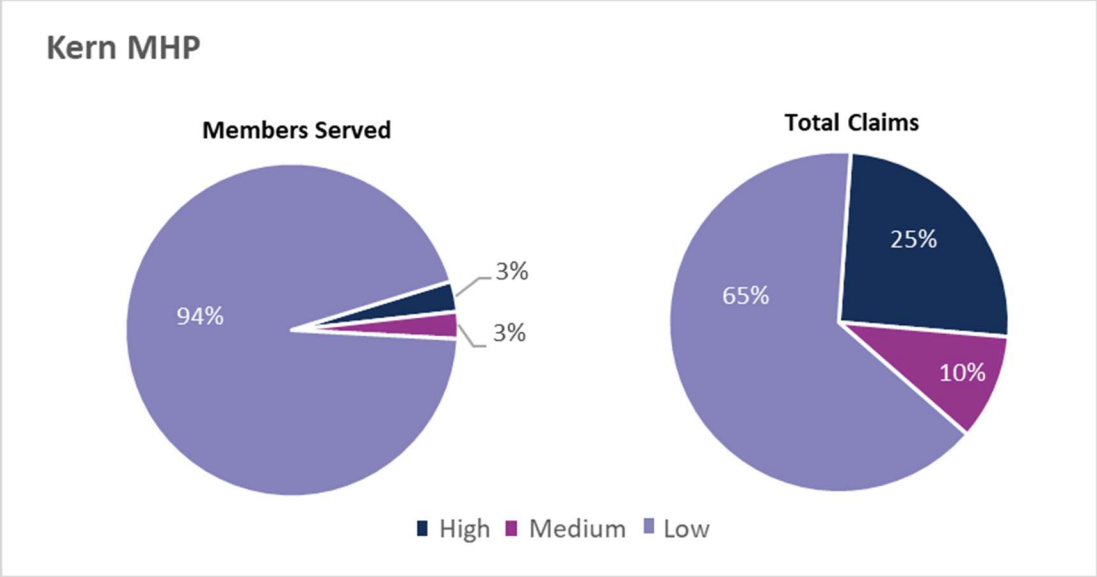
- Compared to CY 2020, the count of HCMs, the percent of members in the high-cost category, and the percent of total claims billed for services provided to HCMs have increased; however, there were slight decreases from CY 2021 to CY 2022 for all of those variables. Further, the proportion of members considered to be HCMs, and the percentage of claims attributed to them, were lower in the MHP than statewide.
- Average approved claims for these members have decreased over the past three years; however, median approved claims for HCMs during this same period have increased slightly. Both HCM average approved claims and median approved claims for CY 2022 are slightly lower than statewide.
- While HCMs represented almost 3 percent (1.59 percentage points lower than statewide) of all Medi-Cal individuals who were served in CY 2022, this same group produced slightly more than 25 percent of the total claims.

Table 15: Kern MHP Medium- and Low-Cost Members CY 2022

Claims Range	# of Members Served	% of Members Served	Category Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	551	2.62%	10.05%	$13,289,118	$24,118	$23,616
Low-Cost (Less than $20K)	19,822	94.43%	64.69%	$85,515,424	$4,314	$2,909

- Almost 95 percent of the members served are low-cost members, having generated total costs of less than $20,000. Collectively, 65 percent of total claims were ascribed to services received by low-cost members.

Figure 20: MHP Members and Approved Claims by Claim Category CY 2022



IMPACT OF QUALITY FINDINGS

- The MHP's innovative QIC structure optimizes quick identification of issues and remedial action while ensuring stakeholder participation.
- One of the QICs, the KPIC, tracks key indicators on a regular basis that enables the MHP to foster data-driven decision-making in its management and operations.
- The MHP has been very active in planning and implementing innovative and EBT models.
- Implementation of CalAIM and Payment Reform has created a lack of clarity among the line staff, at least temporarily, while the administration sorts through various changes.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested by individual MHPs, hosts quarterly webinars, and maintains a PIP library at www.caleqro.com.

A summary of the validation tools for each PIP are located in Attachment C of this report. Validation rating refers to the EQRO's overall confidence that the MHP (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: CBTp for Youth with EOP Symptoms

Date Started: Phase I – 08/2022; Phase II – 08/2023

Date Completed: Phase I – 07/2023; Phase II – 07/2024 (estimated)

Aim Statement:

Phase 1: The goal of this intervention is that Oswell I and III staff are able to increase symptom recognition in youth by at least 0.93 percentage point on average. Staff will work with youth up to the age of 18. This PIP will be completed between 8/2022 to 7/2023.

Phase 2: Providing psycho-education skill building training related to CBTp to the child and family will allow for those clients who were identified with "Psychosis (Thought Disorder)" as a "Need" on the initial CANS assessment to make clinical progress during treatment. This intervention will increase the current average "clinical progress" rating

[2] https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec438-330.pdf

[3] https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-sec457-1260.pdf

from 29 percent to 32 percent over the next eight to ten months. “Clinical Progress” will be measured by the Psychosis (Thought Disorder) Needs rating improving between the Initial CANS Assessment to the 6-month assessment(s) for those clients who had Psychosis (Thought Disorder) identified as a Need initially.

Target Population: Plan members from Children’s Oswell I and III clinics, who have Psychosis (Thought Disorder) identified as a need on the initial CANS Assessments.

Status of PIP: The MHP’s clinical PIP is in the implementation phase.

Summary

The MHP has started Phase II of its clinical PIP on detection of EOP and providing early intervention. Phase I of this PIP focused primarily on training of clinicians and early detection of EOP. In Phase II, the MHP has added the CBTp treatment component in addition to continuing with the early detection efforts. Through this intervention, the MHP will provide psycho-education skills to both the youth and their families in two larger clinics serving children and youth. The MHP is measuring meaningful clinical progress as a result of the intervention as the outcome.

At the time of the review, the MHP was facing challenges in its data tabulation and report production due to the implementation of a new EHR on July 1, 2023. Additionally, since the Phase II of the PIP also started at the same time and the first quarter data tracking was not completed at the time of the review, CalEQRO was not able to determine the effectiveness of CBTp with the target population in producing the intended outcomes. The MHP was able to track the data for Phase I and presented the findings on its identification of EOP. All three post-intervention data points showed better results than the target percentage. However, the MHP was not able to conduct any significance testing due to the low number of plan members with identified EOP.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because of the lack of data from Phase II and the low counts from Phase I. It is possible that as the count goes up and longer-term findings are tabulated, the MHP will be able to better determine how robust its findings are.

The MHP requested TA sessions prior to the review. In these sessions, the following recommendations were made:

- Create percentages rather than whole numbers for the measures.
- Create two tables to capture diagnosis and age distribution of the cohorts to show some evidence of clinical need for youth as indicated in the CANS.
- It is important to note other barriers including general lack of psychotic symptoms and diagnoses for the age group receiving the intervention.

.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this clinical PIP including:

- Consider examining past data to assess the correlation between the CANS psychosis item and later psychosis diagnosis in order to improve the understanding of one of the stated goals of reducing the onset of psychosis.
- Change the PMs from simple counts to percentages. The MHP completed this in its revised PIP documentation submitted after the review.
- Clearly define "meaningful clinical progress." The MHP clarified this in its revised PIP documentation.
- Consider tabulating the results by age group and diagnoses to refine understanding of the findings.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Quarterly Engagement Self-Care Raffle Basket

Date Started: 07/2023

Date Completed: 06/2024 (estimated)

Aim Statement: Within the next 6-9 months, the no-show rates for Southeast Bakersfield Recovery and Wellness Center (SERAWC) team will decrease by a rate of 5 percent each:

- Psychiatry: 23.57 percent to 22.39 percent
- Other Clinician: 16.54 percent to 15.71 percent

Target Population: Adult plan members from the SERAWC.

Status of PIP: The MHP's non-clinical PIP is in the baseline year.

Summary

Kern MHP has historically reported high no-show rates despite its various efforts to mitigate this issue, including through past PIPs, without much success. This new non-clinical PIP is another iteration with a new incentive-based intervention. At this time the PIP is being conducted at only one of the clinics based on some one-time success with this intervention at the same clinic earlier in 2023.

The intervention comprises of a quarterly raffle with a self-care basket as the prize. All adult SERAWC members are eligible to be entered into the raffle draw if they have kept three successive appointments with their treatment teams within a month without a single no-show. At the time of the review, the MHP had not completed the first quarter of the PIP and, therefore, was able to provide only the baseline data with a target of 5 percent reduction in no-shows.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence, because:

- The PIP lacks any remeasurement data.
- While the MHP had identified multiple factors that can contribute to no-shows, this particular intervention is based on very slim internal evidence and a single cited study of adolescent and youth no-show rates.
- There is no clear connection to actual individual needs or challenges that contribute to no-shows. For instance, a one-time no-show in a month due to other extraneous factors such as transportation will disqualify an individual from that quarter's raffle draw, and therefore, will not affect the root cause of that no-show.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this non-clinical PIP including:

- Provide a root cause analysis, data, and other justification to support the chosen intervention and the service location. The MHP revised its PIP write-up in the review submission that partially addressed this concern.
- Consider increasing the frequency of the raffle draw, or, at least, make the entire quarter's cohort eligible rather than narrowing the pool by drawing only one month out of the three each quarter – so that the main aspect of the intervention occurs more frequently.

INFORMATION SYSTEMS

Using the Information Systems Capabilities Assessment protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for HIS, as identified in 42 CFR §438.242. This evaluation included a review of the MHP's EHR, Information Technology (IT), claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs.

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is the CalMHSA semi-statewide EHR SmartCare by Streamline, which was implemented in July 2023. Currently, the MHP is actively implementing this new system which requires heavy staff involvement to fully develop.

Approximately 3 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency. With the accelerating demand for IS support in connection with the MHP's ongoing efforts to fully implement and develop SmartCare functionality and reporting, Kern has seen a 29 percent increase in IS staffing over last year; however, the total IS budget for the same period has slightly dropped from 3.83 percent to 3 percent.

The MHP has 1,683 named users with log-on authority to the EHR, including approximately 815 county staff and 868 contractor staff. Support for the users is provided by 40 full-time equivalent (FTE) IS technology positions. Currently, all positions are filled.

As of the FY 2023-24 EQR, all contract providers have access to directly enter clinical data into the MHP's EHR.

Contract providers directly enter member practice management and service data into the MHP IS as reported in the following table:

Table 16: Contract Provider Transmission of Information to the Kern MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	100%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. Kern does not currently offer a PHR; however, it intends to address this need within the next year.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. The MHP engages in electronic exchange of information with HealthNet and KHS, the two MCPs.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive member outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

Each IS Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 17: IS Infrastructure Key Components

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Partially Met
4C	Integrity of Medi-Cal Claims Process	Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Met

Strengths and opportunities associated with the IS components identified above include:

- The MHP has a robust IS staff of 40 FTEs, which represents a 29 percent increase over staffing levels last year.
- There is a vibrant and ongoing dialogue that exists between Kern's executive leadership team and the IS department to collaboratively identify and develop viable strategies to address IS-related needs in a timely fashion.
- For CY 2022, Kern had consistent monthly claim lines with timely submissions. Moreover, its overall denied claims rate for this period was less than one-fifth of the state's rate.
- The MHP was one of 24 counties that elected to implement the CalMHSA semi-statewide EHR SmartCare by Streamline. Kern implemented SmartCare in July 2023. The IS staff provided excellent support to the MHP's internal and contracted staff during the agency's EHR transition. More specifically, the IS department not only expanded its hours of operation for a limited period of time to a 24/7 model, but it has also demonstrated a commitment to providing necessary training to all end users to ensure their ability to successfully use the new EHR.
- During and immediately following the transition to SmartCare, the MHP discovered that much of the embedded data and reporting functionality that was intended to be integrated into the new EHR is still in development and is not yet available for use. Consequently, many staff have had to temporarily revert to manual reporting processes to satisfy data-analytics needs.
- While the IS staff endeavored to help and support end users during the EHR transition, some individuals expressed feelings of being overwhelmed by the number of IS-related emails they received.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either approved or denied. This may also indicate if the MHP is behind in submitting its

claims, which would result in the claims data presented in this report being incomplete for CY 2022.

Table 18 appears to reflect a largely complete or very substantially complete claims data set for the time frame represented.

Table 18: Kern MHP Summary of Short-Doyle/Medi-Cal Claims CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	27,131	$9,501,234	$128,352	1.35%	$9,372,882
Feb	27,362	$9,640,167	$86,781	0.90%	$9,553,386
Mar	32,968	$11,633,270	$108,019	0.93%	$11,525,251
April	28,643	$10,200,644	$88,684	0.87%	$10,111,960
May	28,647	$10,344,395	$126,377	1.22%	$10,218,018
June	28,852	$9,997,626	$119,763	1.20%	$9,877,863
July	26,663	$9,182,638	$84,471	0.92%	$9,098,167
Aug	31,272	$10,482,110	$135,211	1.29%	$10,346,899
Sept	30,148	$10,043,962	$95,024	0.95%	$9,948,938
Oct	30,845	$10,286,109	$126,291	1.23%	$10,159,818
Nov	27,677	$9,052,531	$74,805	0.83%	$8,977,726
Dec	26,030	$8,358,051	$60,815	0.73%	$8,297,236
Total	**346,238**	**$118,722,737**	**$1,234,593**	**1.04%**	**$117,488,144**

- The MHP generated consistent monthly claim lines and made timely submissions throughout CY 2022.

Table 19: Kern MHP Summary of Denied Claims by Reason Code CY 2022

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B must be billed before submission of claim	1,651	$639,994	51.84%
Beneficiary is not eligible or non-covered charges	405	$245,567	19.89%
Other healthcare coverage must be billed first	486	$206,901	16.76%
Deactivated NPI	169	$49,698	4.03%
Service line is a duplicate and repeat service modifier is not present	158	$42,680	3.46%
Service location NPI issue	98	$36,296	2.94%
Other	16	$9,349	0.76%
Place of service incomplete or invalid	3	$3,178	0.26%
Late claim submission	3	$930	0.08%
Total Denied Claims	**2,989**	**$1,234,593**	**100.00%**
Overall Denied Claims Rate	**1.04%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The MHP's overall denied claims rate was 1.04 percent, which is less than a fifth of the statewide denial rate.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Kern's IS staff is at full capacity, with 40 FTEs currently available to provide IS support to end users. This staffing level represents a 29.03 percent increase over the 31 FTEs that were dedicated to IS activity last year. During the EQR, many staff expressed their overall satisfaction with the ongoing technical support that is being provided by the MHP's IS department. In particular, they were impressed with the way the IS department facilitated the EHR transition to SmartCare, as well as efforts to train and equip end users with the skills and knowledge that will allow them to meaningfully engage with the new system.
- Kern's overall denied claims rate for CY 2022 of 1.04 percent is 4.88 percentage points lower that the state's rate, thereby suggesting that the MHP has a fiscal team that employs effective strategies in the process of addressing billing needs in a timely fashion.
- The MHP's IS staff may want to consider developing new communication strategies to manage the dissemination of emails relating to SmartCare.
- Although confronted with the challenge of SmartCare's data and reporting functionality either being inoperative or completely missing, the IS department has been actively working to address this issue by participating in regular

dialogues with CalMHSA's TA team. As a result, Kern's IS department announced during the review that it had been able to secure and install an ad-hoc reporting tool supplied by CalMHSA. This mechanism will help to mitigate the MHP's need to rely on SmartCare's reporting functions, which remain limited for the time being, and will grant them increased abilities to craft reports that contain user-defined parameters, scopes, and content. This will help the MHP to remain a data-driven agency during the new EHR implementation.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) consists of four different surveys that are used statewide for collecting members' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of members: adult, older adult, youth, and family members. MHPs administer these surveys to members receiving outpatient services during two prespecified one-week periods. CalEQRO receives CPS data from DHCS and provides a comprehensive analysis in the annual statewide aggregate report.

The MHP extensively uses the CPS findings in its QAPI activities and its KPIC for evaluation and follow-up actions. The results are summarized by programs and publicly posted in clinic lobbies. The MHP's website is undergoing extensive revisions. At the time of the review, there was a placeholder for further information on CPS.

In addition, the MHP utilizes a Local Recovery Survey (LRS) for each of the MH service teams and shares the results with the clinics and the supervisors. Providers not meeting the threshold scores on LRS are required to take actions such as increased staff training or implement new strategies.

PLAN MEMBER/FAMILY FOCUS GROUPS

Plan member and family member (PMF) focus groups are an important component of the CalEQRO review process; feedback from those who receive services provides important information regarding quality, access, timeliness, and outcomes. Focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and PMF involvement. CalEQRO provides gift cards to thank focus group participants.

As part of the pre-review planning process, CalEQRO requested two 90-minute focus groups with PMFs containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested A group of 8-10 English and Spanish-Speaking adult plan members who began services within the past 12-18 months. The focus group was held via Zoom and included five participants; one monolingual individual, whose attendance was confirmed at the last minute, was not able to participate as no interpreter was arranged for ahead of time. All plan members participating receive clinical services from the MHP.

The focus group participants all receive wraparound services and started in the past 12 months. Adult wraparound is a higher intensity service offered to inpatient-discharged plan members or those with other co-occurring needs. The participants were unsure as to how long they will be in that program and what kind of outpatient care they will be

receiving post-wraparound. They were also not clear as to whether they are benefiting from the services. A common concern was that the staff were more concerned about billable hours (a concern voiced by the clinical line staff as well who reported that payment reform has made them more concerned about billable hours). The participants were also not aware of any peer services, echoing a similar finding from last year's EQRO-run focus group.

Recommendations from focus group participants included:

- Service is good but rushed. The participants would like not to feel rushed in their treatment program.
- More structured goals.
- Help with getting a job and disability benefits.

Consumer Family Member Focus Group Two

CalEQRO requested A group of 8-10 English and Spanish-Speaking family members of child and youth members who began services within the past 12-18 months. The focus group was held via Zoom and included eight participants; a Spanish language interpreter was used for this focus group. All participants have a child or youth family member who receives clinical services from the MHP. The focus group consisted of both FC and biological parents and caregivers.

For those who entered services in the past year, the access experience was different, but positive for both FC and biological parents. FC children already had their services lined up when the FC parents received the children. For the biological parents, the school suggested getting help and the primary care physicians made the referrals.

The focus group participants appeared to have similar experiences in terms of the services their children received. Cultural and diversity issues are managed well, and translation services are readily available. Services are in-person and provided at home, school, or clinics. Most participants reported feeling supported by staff and being involved in their children's plan of care. The participants voiced some concern about the psychiatrist turnover.

Recommendations from focus group participants included:

- More education and training for youth who are aging out of the system on self-care and how to access other services. This is particularly important for FC youth.
- Strategies to have a stable psychiatrist workforce so turnover is not an issue.

SUMMARY OF MEMBER FEEDBACK FINDINGS

The experiences and impressions shared by the focus group participants varied between the adult plan members and the parents and caregivers of children and youth. The adult focus group captured feedback from a narrow slice of the overall MHP members, namely those who are relatively new to the system and receiving high-intensity services. They lacked information on their own program's duration and what follow-up options would be available to them upon completing the program. On the children's side, the parents and caregivers appeared to have more information about the treatment their children were receiving. However, they also felt that the youth aging out of the system need more information on their future care and services.

The adult beneficiaries' perception of the staff was also different from the children's side and more negative. The parents and caregivers were very complimentary of the staff who work with their children.

CONCLUSIONS

During the FY 2023-24 annual EQR, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on member outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP's unique QI structure ensures data-driven decision making, prompt identification of needs for performance improvement, and participation by various stakeholders including the plan members and the line staff. (Quality)
2. In the past year, Kern BHRS has undertaken efforts to identify the service needs for historically underserved cultural communities. It has held in-depth listening sessions with some of the groups already and plans to continue these in the coming year. (Quality, Access)
3. Kern MHP is always looking for and implementing innovative and EBT models. After implementing CPG and EOP last year, the MHP is now implementing the TIP model for the TAY population to improve their recovery and path to independence as they transition to adulthood. (Quality)
4. Between CY 2020 and 2022, Kern performed well in terms of orchestrating the connection of members to timely outpatient follow-up services post-inpatient discharge. The MHP's percentages of members who successfully attended an outpatient follow-up service within both 7 and 30 days were higher than the state's corresponding rates and the rehospitalization rates were well below the state. (Access, Timeliness, Quality)
5. For CY 2022, the MHP maintained consistent and effective monthly claiming and timely submissions, which yielded an overall denied claims rate of 1.04 percent. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The largest racial/ethnic group that Kern serves is the Hispanic/Latino population, which, in CY 2022, constituted 61 percent of total eligibles. Although the MHP's PR for this group was higher than the state and similar-sized counties, more work is needed to reach out to and engage this community. While Kern is currently participating with four other counties in a statewide equity project to increase their overall PR to Hispanic/Latinos, no data have yet been captured that have provided evidence that improvement is indeed occurring. (Access)
2. Despite efforts to assess and remediate low FC PRs within the system of care, the MHP has only been able to identify three factors that appear to be

contributing to this area of concern. The MHP needs to develop strategies more fully and/or interventions that will specifically address low FC PRs. (Access)

3. Due to the transition to SmartCare, and the fact that some of the legacy data in Anasazi could not be converted and imported into the new system, the MHP was unable to accurately report on the timeliness of post-inpatient follow-up services for FY 2022-23. Therefore, it is important to develop a sound process to support the extraction, assessment, and reporting of timeliness data to ensure accuracy and data integrity. (Timeliness, IS)
4. The MHP is not able to track the HEDIS measures for the FC population or for the broader children's system of care. (Quality)
5. During the past year, the communication to line staff regarding the new EHR implementation, payment reform, and CalAIM implementation has been overwhelming at times, and at others, lacked clarity. (Quality, IS)

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the EQR and are intended as TA to support the MHP in its QI efforts and ultimately to improve member outcomes:

1. Continue with the needs assessment and listening sessions with the historically underserved communities including the Latino/Hispanic and Asian/Pacific Islander groups to improve access to culturally appropriate MH services. (Access)
2. Continue to develop and implement strategies to better identify the FC beneficiaries and improve access to MH services for them. (Access)

   (This recommendation was continued from FY 2022-23.)

3. QI and IS need to develop collaboratively standardized reporting processes that will consistently support the MHP's ability to track follow-up services that occur within 7 and 30 days after psychiatric hospitalizations. Validation protocols need to be created as well to ensure data integrity and accuracy. (Quality, IS)
4. Develop a tracking and reporting mechanism for the required FC HEDIS measures at a minimum, and also examine the feasibility of tracking the other behavioral health related HEDIS measures. (Quality)
5. Develop communication strategies for all ongoing changes related to EHR implementation, CalAIM implementation, and payment reform for the staff and contract providers. Such a strategy should have a built-in mechanism for feedback and frequently asked questions, as well as take into account how to make such communications timely, efficient, concise, and consistent. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

The following conditions significantly affected CalEQRO's ability to prepare for and/or conduct a comprehensive review:

Although the MHP encountered challenges throughout the 12 months preceding EQR, no significant barriers to conducting the EQR were identified.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from the MHP Director

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Kern MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Groups
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Specialized Service Systems: Crisis, Law Enforcement
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Contract Provider Group Interview – Operations and Quality Management
Community-Based Services Agencies Group Interview
Information Systems Billing and Fiscal Interview
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Saumitra SenGupta, Lead Quality Reviewer
Lynda Hutchens, Quality Reviewer
Rick Jackson, Information Systems Reviewer
Pamela Roach, Consumer/Family Member Reviewer

Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-review and the post-review meetings and in preparing the recommendations within this report.

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Acevedo	Aida	Unit Supervisor II	Kern BHRS
Alcarez	Felicia	Supervisor	Kern BHRS
Aleman	Maria		Kern BHRS
Amaro	Estrella	Supervisor	Kern BHRS
Arellano	Sandra	Workforce Development Coordinator	Kern BHRS
Armstrong	Jessica	Deputy Director	Kern BHRS
Atilano	Brooke	Peer Specialist	College Community Services (Lake Isabella)
Austin-Townsend	Alicia	Vice President	Mental Health System
Ayon	Claudia	case manager	Clinica Sierra Vista
Bailey	Liz	Administrator	Kern BHRS
Barboza	Crystal	Planning Analyst	Kern BHRS
Barrientos	Celeste	Recovery Specialist	Kern BHRS
Brown	Liz	Compliance Officer	Kern BHRS
Bulley	Sheri	Supervisor	Kern BHRS
Burdick	Jeff	Captain	Bakersfield Police Department
Burris-Garofalo	Debra	Northern Regional Director	Childnet
Burrowes	Allison	Deputy Director	Kern BHRS
Butler	Patricia	Recovery Specialist	Kern BHRS

Last Name	First Name	Position	County or Contracted Agency
Calvillo	Sonja	Peer Specialist	College Community Services (Tehachapi)
Carlson	Julia	CAO Fiscal and Policy Analyst	County Administrative Office
Carrasco	Ivan	Supervisor	Kern BHRS
Castro	Cristina	Recovery Specialist	Kern BHRS
Clawson	Erica	Therapist II	Child Guidance Clinic
Corse	Lynn	Administrator	Kern BHRS
Culy	Michelle	Administrator	Kern BHRS
Curiel	Jeorgina	Associate Social Worker	College Community college
Davis	Lesleigh	Administrator	Kern BHRS
Del Rio	Candee	Sr. Administrative & Fiscal Officer	Kern BHRS
Dhillon	Myeisha	Coord of Administrative & Legislative Analysis	Kern BHRS
Doucette	Michelle	LMFT (in place of Barbara Paradise)	College Community Services
Duke	Chloe	Recovery Specialist	Kern BHRS
Duran	Bianca	Recovery Specialist	Kern BHRS
Fuentes	Francisco	BH Unit Supervisor	Kern BHRS
Galindo	Timothy	Recovery Specialist	Kern BHRS
Galvez	Angel		Bakersfield American Indian Health Project
Garcia	Christopher	Technology Services Supervisor	Kern BHRS
Garcia-Trebizo	Marisa	Specialty Behavioral Health Director	Clinica Sierra Vista

Last Name	First Name	Position	County or Contracted Agency
Giffard	Jason	Unit Supervisor	Kern BHRS
Gonzalez	Gregory	Supervisor	Kern BHRS
Gonzalez	Selma	Administrative Coordinator	Kern BHRS
Gonzalez Quiroz	Oladis	Peer Specialist	Kern BHRS
Grewal	Shaundeep	Clinic Supervisor	Clinical Sierra Vista (Delano)
Groce	Louis	Public Information Officer	Kern BHRS
Gutierrez	Sarah	HR Manager	Kern BHRS
Hailemichael	Saba	CAO Fiscal & Policy Analyst	County Administrative Office
Harris	Emmetta	Social Services Worker	Kern Dept Public Health
Herrera	Cynthia	Pre-Licensed Therapist	College Community College (Wasco)
Hornibrook	Heather	Administrator	Kern BHRS
Hoyle	Linda	Executive Director	Child Guidance
Hughes-Malara	Jennifer		Telecare
Hunt	Rachelle	Technology Manager	Kern BHRS
Jenkins	David	Planning Analyst	Kern BHRS
Jimenez-Puente	Sarah	Unit Supervisor II	Kern BHRS
Jones	Ashley	Supervisor	Kern BHRS
Kaur	Amandeep	Nurse	Kern BHRS
Kaya	Jeffery	Supervisor	Kern BHRS
Kimsey	Brian	Technology Services Supervisor	Kern BHRS

Last Name	First Name	Position	County or Contracted Agency
Kuwahara	Stacy	**MHP Director**	Kern BHRS
Lara	Tracy	Program Specialist	Kern BHRS
Leonzo-Castillo	Karina	Supervisor	Kern BHRS
Lesser	Marcie	Program Manager	Child Guidance Clinic
Lopez	Allissa	Administrator	Kern BHRS
Lopez	Amber	Supervisor	Kern BHRS
Luna	Cesar	Planning Analyst	Kern BHRS
Lyles	Emily	Administrator	Kern BHRS
Madhanagopal	Dr. Nandhini	Psychiatrist	Kern BHRS
Mann	Tonya	Administrator	Kern BHRS
Marinas	Theresa	Program Manager	Mental Health Systems
Matthew	Traco	Chief Health Equity officer	KHS
Mcintyre	Melanie	Supervisor	Kern BHRS
Medina	Edward	Recovery Specialist III	Kern BHRS
Mena	Ana	Behavioral Health Unit Supervisor II	Kern BHRS
Mendoza	Luz	Planning Analyst	Kern BHRS
Molla	Mohammed	Joint Chair of Psychiatry I	Kern BHRS
Moniz-Smith	Karen	Program Manager	Child Guidance Clinic
Olango	Dr. Garth	Medical Director	Kern BHRS
Olgin	Breanna	Clinical Supervisor	Kern BHRS

Last Name	First Name	Position	County or Contracted Agency
Olvera	Ana	Administrator	Kern BHRS
Padilla	Estela	Department Analyst	Kern BHRS
Perez	Rose	Clinical Supervisor	College Community Services
Perez	Tony	Coord of Administrative & Legislative Analysis	Kern BHRS
Perkins	Kenneth	Chief Deputy	Kern Sherriff
Petitt	Sylvia	Supervisor	Kern BHRS
Puente-Jimenez	Sarah	Unit Supervisor II	Kern BHRS
Ramirez	Fernanda	BH Unit Supervisor	Kern BHRS
Richards	Brian	Sr. System Analyst	Kern BHRS
Rivas	Alondra	case manager	Clinica Sierra Vista
Robinson	Donna	Supervisor	Kern BHRS
Rodriguez	Aida	Case Manager	Clinica Sierra Vista
Roney	Alan	Supervisor	Kern BHRS
Ross	Chelcy	Program Specialist	Kern BHRS
Sanchez	Karina	BH Therapist	Clinica Sierra Vista
Spain	Maysee	Peer Specialist	Kern BHRS
Stalvo	Julia	Pre-Licensed Therapist	Pathways
Steinke	Christi	SUD Counselor	Mental Health Systems
Taylor	Robin	Deputy Director	Kern BHRS

Last Name	First Name	Position	County or Contracted Agency
Tovar	Mayra	Recovery Specialist	Kern BHRS
Walker-Scott	Calissa	Intervention Specialist II	Child Guidance Clinic
Wheeler	Jim	Executive Director	Flood Ministries
Whitlock	Jamie	Supervisor	Kern BHRS
Williams	Heather	Supervisor	Kern BHRS
Witt	Amanda	Peer Specialist	College Community Services BKS
Ybarra	Julianne	Supervisor	Kern BHRS
Zaragoza	Jeanette	Supervisor	Kern BHRS

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY
Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The MHP lacks data from Phase II at this time and Phase I data is not conclusive yet. It is possible that as the count goes up and longer-term findings are tabulated, the MHP will be able to better determine how robust its findings are.

General PIP Information
MHP/DMC-ODS Name: Kern MHP
PIP Title: CBTp for Youth with EOP Symptoms
PIP Aim Statement: Phase 2: Providing psycho-education skill building training related to CBTp to the child and family will allow for those clients who were identified with "Psychosis (Thought Disorder)" as a "Need" on the initial CANS Assessment to make clinical progress during treatment. This intervention will increase the current average "clinical progress" rating from 29% to 32% over the next 8-10 months. "Clinical Progress" will be measured by the Psychosis (Thought Disorder) Needs rating improving between the Initial CANS Assessment to the 6-month assessment(s) for those clients who had Psychosis (Thought Disorder) identified as a Need initially.
Date Started: Phase I – 08/2022; Phase II – 08/2023
Date Completed: Phase I – 07/2023; Phase II – 07/2024 (estimated)
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:

General PIP Information
Target population description, such as specific diagnosis (please specify): Plan members from Children's Oswell I and III clinics, who have Psychosis (Thought Disorder) identified as a need on the initial CANS Assessments.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Phase 1: 1) Assess plan members for symptoms of psychosis; 2} Phase 2: Provide CBTp Psycho-Education Skills to the plan member and family.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Clinician training on CBTp assessment and intervention.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): N/A

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Phase 1 continue to Phase 2: Percentage of plan member with a CANS Needs Rating on the psychosis question	8/22-11/22	N=239 2.47%	☐ Not applicable—PIP is in planning or implementation phase, results not available	N = 297 3.7%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Phase 1: Percentage of plan members with a diagnosis related to psychosis	8/22-11/22	0%	☒ Not applicable—PIP is in planning or implementation phase, results not available	The MHP has not completed any remeasurement on this PM.	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Phase 2: Percentage of plan members with "Clinical Progress" on the Psychosis (Thought Disorder) Need between the Initial CANS Assessment to the 6-month assessment.	FY 2022-23	29%	☒ Not applicable—PIP is in planning or implementation phase, results not available	The MHP plans to do the first quarterly measurement in October, 2023.	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☒ Baseline year

☒ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

- Consider examining past data to assess the correlation between the Child and Adolescent Needs and Strengths' (CANS) psychosis item and later psychosis diagnosis in order to improve the understanding of one of the stated goals of reducing the onset of psychosis.
- Change the PMs from simple counts to percentages. The MHP completed this in its revised PIP documentation.
- Clearly define meaningful clinical progress. The MHP clarified this in its revised PIP documentation.
- Consider tabulating the results by age group and diagnoses to refine understanding of the findings.

Non-Clinical PIP

Table C2: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	Lack of remeasurement data at the time of the review. Improvement strategy is based on limited prior success or other evidence.
General PIP Information	
MHP/DMC-ODS Name: Kern MHP	
PIP Title: Quarterly Engagement Self-Care Raffle Basket	
PIP Aim Statement: Within the next 6-9 months, the no-show rates for SERAWC team will decrease by a rate of 5 percent each, • Psychiatry: 23.57 percent to 22.39 percent • Other Clinician: 16.54 percent to 15.71 percent	
Date Started: 07/2023	
Date Completed: 06/2024 (estimated)	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information
Target population description, such as specific diagnosis (please specify): Adult plan members from the SERAWC clinic who keep three successive scheduled appointments with the treatment team within a month without a single no-show.

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Provide self-care raffle basket drawings each quarter.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): N/A
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): N/A

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Decrease the no-show rates for Psychiatry by rate of 5%	05/2023	N=280 23.57%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Decrease the no-show rates for Other Clinician by rate of 5%	05/2023	N=913 16.54%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☒ Baseline year

☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

Address the identified root causes in addition to providing an incentive.

Identify fiscal strategies to sustain and expand the intervention to other locations if proven successful.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, PIP Validation Tool, and Approved Claims Definitions are available on the CalEQRO website.

ATTACHMENT E: LETTER FROM THE MHP DIRECTOR

A letter from the MHP director was not required to be included in this report.