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FY 2023-24 MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

KINGS FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

October 3, 2023

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EXECUTIVE SUMMARY

Highlights from the fiscal year (FY) 2023-24 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, "Kings" may be used to identify the Kings County MHP.

MHP INFORMATION

Review Type — Virtual

Date of Review — October 3, 2023

MHP Size — Small

MHP Region — Central

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2023-24 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
4	2	2	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	4	0
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**21**	**5**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Clinical	08/2023	Implementation	Low
Urgent Conditions (at Intake)	Non-Clinical	07/2020	Other – Completed	Moderate

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	4

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP's strong collaboration with community partners and managed care plans has a positive impact on access to care.
- The MHP's efforts in the provision of culturally responsive services are noteworthy.
- The MHP's use of dashboards and trending of metrics for performance evaluation and Continuous Quality Improvement (CQI) activities is remarkable.
- The MHP's performance in the areas of post discharge follow up and readmission rates is well above state and national rates.
- The MHP's choice to use qualified outside vendors for their IT needs has proven to be a strength.

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

- The MHP has challenges with timely first offered non urgent appointments for all plan members.
- The MHP's challenges with timely first offered urgent appointments and first offered non-urgent psychiatry appointments for children may have negative outcomes.
- Access to the Oak Wellness Center by "referral only" presents a barrier to access wellness activities.

- The plan members who are key stakeholders of the MHP are not involved in key committees such as QIC and are not aware of results of satisfaction surveys.

Recommendations for improvement based upon this review include:

- Track, trend, and evaluate timeliness metrics for first offered non-urgent appointments for all served and implement strategies to improve timeliness.
- Track, trend, and review first offered urgent appointments and first offered non-urgent psychiatry appointments for children and develop strategies to improve in these areas.
- Remove restrictions for access to the Oak Wellness Center and open access to all plan members.
- Invite plan members to participate in the QIC, Cultural Humility Taskforce (CHTF), and other key committees and share satisfaction survey findings with plan members.

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 mental health 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 foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (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 Kings County MHP by BHC, conducted as a virtual review on October 3, 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 mental health (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; transitional age youth; 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.

Findings in this report include:

- 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, identified by CalEQRO as crucial elements of quality improvement (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 (HIPAA), 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 penetration rate (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

This review took place after the Coronavirus Disease 2019 (COVID-19) pandemic. County Counsel vacancies impacted timely execution of contracts. There was a 33 percent increase in the homeless population compared to the previous year. CalEQRO was able to complete the review without any major challenges. There was no environmental impact during the review.

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.

- Workforce shortages continue and the MHP has engaged in recruiting strategies with vendors such as Indeed to fill the vacancies.
- The MHP implemented the California Advancing and Innovating Medi-Cal (CalAIM) mandates related to Screening and Transition tools in March 2023 and Payment Reform in July 2023.
- The construction for the 72-unit No Place Like Home permanent supportive housing project is in progress and nearing completion.
- The MHP's EHR conversion from Anasazi to SmartCare was on July 1, 2023.
- The MHP completed the mobile crisis services community planning and executed the contract for the first mobile crisis pilot.
- The MHP has made progress in the development and implementation of the new Mental Health Services Act (MHSA) Workforce Education & Training (WET) Central Regional Partnership Program.

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: Track, report and evaluate timeliness of first offered non-urgent service offered by non-English languages and system of care; implement additional strategies if a disparity is observed.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP implemented the new EHR, SmartCare on July 1, 2023. The previous EHR, Anasazi did not have the data analytics capability. Although the new EHR has data analytics capability that will enable tracking and reporting by language, the current focus of the MHP is on ensuring entry functionality, state reporting requirements, and billing capabilities in the implementation phase.
- The MHP has identified a timeline for May 2024 to generate tracking and reporting timeliness by language.
- While there remains work to be done to generate these reports, the MHP has implemented the EHR with this reporting capability and is working in that direction with a timeline.
- Although this item is rated partially addressed, it is not carried over in a recommendation for this year's review due to other priority recommendations identified.

Recommendation 2: Explore the website design as related to non-English language needs and consider strategies for implementation that include embedded bilingual presentation of critical items such as crisis and access contact numbers. Consider

embedding directions in the top of the webpage that direct viewers to the translation function below in multiple non-English languages.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP updated the website to include Spanish translations for the critical items including mental health services, substance use disorder (SUD) services, and crisis line contact information.

- The current design of the website does not allow for relocation of the translation function to elsewhere on the website. The MHP has included a Beneficiary Translation Notice in English and Spanish that states, “please scroll to the bottom of the page beneath the footer if you would like to translate the Kings County Behavioral Health (KCBH) website to one of the available languages.” The MHP has a goal of converting its webpage to the county website in CY 2024 as this does allow the translation function to be at the top of the webpage.

Recommendation 3: Develop an Information Technology (IT) strategic plan to establish priorities for implementing a Personal Health Record (PHR) to increase member access to health records and participate in health information exchange for care coordination.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP implemented the new EHR, SmartCare at the beginning of FY 2023-24. The MHP is working on the records migration and has a plan to work on the reports and the roll out of the patient portal in the next phase.
- While this item is rated partially addressed, it is not carried over in a recommendation for this year’s review due to other priority recommendations identified.

Recommendation 4: Focus on timeliness of children’s services in Quality Improvement Committee (QIC) review to determine if the delays in access reflected in current data have been resolved or continue. If continuing, develop a strategy to address.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- In December 2021, the MHP established a contract with a new provider, KIND Center, that began providing services in January 2022. The number of referrals to this new provider was higher than expected. Since October 2022, KIND Center onboarded six new clinicians to address the increase in referrals. In addition, the center implemented the Access unit in January 2023 with one clinician. Later in May 2023, the center hired two more clinicians. KIND reduced the appointment sessions to 45 minutes to address the need for an increase in assessments and slots for urgent appointments. KIND is in the process of onboarding four additional clinicians.

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 2.33 percent of services were delivered by county-operated/staffed clinics and sites, and 97.67 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 72.87 percent of services provided were claimed to Medi-Cal. This shows an increase from the previous year Medi-Cal claimed services at 55.10 percent.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by the county in partnership with a contract provider for after-hours coverage; members may request services through the Access Line as well as through the following system entry points; walk ins to the clinics. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. Typically, adults are screened and then referred to a contract provider clinic; children are referred to the new provider of children's services.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video/phone to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 883 adults, 139 youth, and 72 older adults across one county-operated site and five contractor-operated sites. There is a decline in the number of youth who received telehealth services compared to the previous fiscal year (301). Among those served, 16 members received telehealth services in a language other than English in the preceding 12 months. This shows a decline compared to the last fiscal year (44).

[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 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 Kings 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: Kings 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: Kings 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
OON Details	
Contracts with OON Providers	
Does the MHP have existing contracts with OON providers?	☐ Yes ☒ No
Contracting status:	☐ The MHP is in the process of establishing contracts with OON providers ☒ The MHP does not have plans to establish contracts with OON providers
OON Access for Members	
The MHP ensures OON access for members in the following manner:	☐ The MHP has existing contracts with OON providers ☒ Other: The County has a policy for OON access for instances where the need may arise but has

	not had to exercise this for provision of required specialty mental health services

- 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:

- The MHP has implemented multiple strategies to reduce stigma and engage the Hispanic/Latino populations and the Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) population. This includes advertisements in Spanish on local busses and bus shelters, radio/social media, and outreach at the local events such as farmers markets, flea markets, and school events. The MHP partnered with a local LGBTQ+ center from a neighboring county to provide access to pop-up support groups that has been well received.
- The MHP identifies specific metrics to assess the success of the outreach campaigns that do not include the 24/7 Access Line metrics. The 24/7 Access Line is an important point of entry for the MHP. The MHP could track the number of calls to the 24/7 line from the Spanish speaking population following an outreach event or consider evaluating the member experience.

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 eligible. 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 a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, Kings demonstrates slightly more challenges to accessing services than seen statewide.

Table 3: Kings 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	68,930	2,623	3.81%	$11,763,969	$4,485
CY 2021	64,788	2,463	3.80%	$16,978,114	$6,893
CY 2020	60,449	2,476	4.10%	$20,598,141	$8,319

Note: 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.

- The number of eligibles has been trending upwards over the past three years, and the number of members served increased in CY 2022 after a slight decrease in CY 2021.
- Total PR increased slightly from the prior year, but is lower than the CY 2020 PR.
- AACM decreased more than $2,000 from CY 2021, and nearly $4,000 from CY 2020.

Table 4: Kings County 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	8,262	80	0.97%	1.31%	1.82%
Ages 6-17	18,525	808	4.36%	5.83%	5.65%
Ages 18-20	3,905	138	3.53%	4.72%	3.97%
Ages 21-64	33,348	1,513	4.54%	4.53%	4.03%
Ages 65+	4,892	84	1.72%	2.25%	1.86%
Total	**68,930**	**2,623**	**3.81%**	**4.30%**	**3.96%**

Note: 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.

- The MHP's total PR is lower than both similar size county and statewide PRs.
- PRs for all age groups in Kings were lower than small counties and statewide PRs, except for 21–64 year-olds.

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

Threshold Language	# of Members Served	% of Members Served
Spanish	331	12.82%
Threshold language source: Open Data per BHIN 20-070		

- The MHP's only threshold language is Spanish, with almost 13 percent of members indicating Spanish is their preferred language.

Table 6: Kings 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	18,918	776	4.10%	$2,836,280	$3,655
Small	218,086	8,382	3.84%	$44,131,230	$5,265
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. Kings has a higher PR than the small counties and statewide.
- For CY 2022, the ACA PR is higher than the total MHP PR and the ACA AACM is lower than the total MHP ACCM.

The racial/ethnic 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.

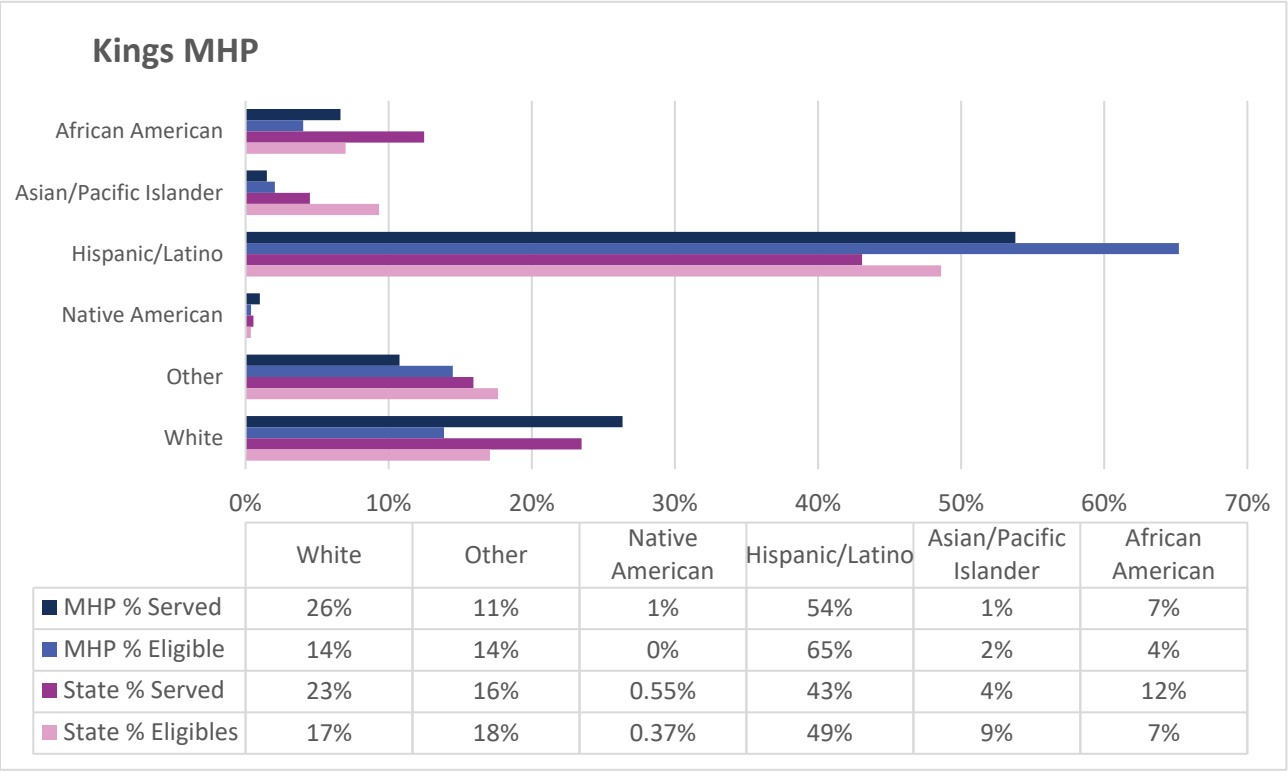
Table 7: Kings MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	2,774	174	6.27%	7.08%
Asian/Pacific Islander	1,409	39	2.77%	1.91%
Hispanic/Latino	44,952	1,411	3.14%	3.51%
Native American	265	26	9.81%	5.94%
Other	9,977	282	2.83%	3.57%
White	9,555	691	7.23%	5.45%
Total	**68,932**	**2,623**	**3.81%**	**3.96%**

Note: 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.

- The largest group of eligibles and members served was Hispanics/Latinos, followed by the "Other" category, and the White category.
- The racial/ethnic groups that were overrepresented were Native American, White, and African American. It should be noted that the Native American population of eligibles is very small, which means over-representation can be achieved with very few being served.
- African American, Hispanics/Latino, and "Other" were underrepresented more in Kings County than statewide.

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

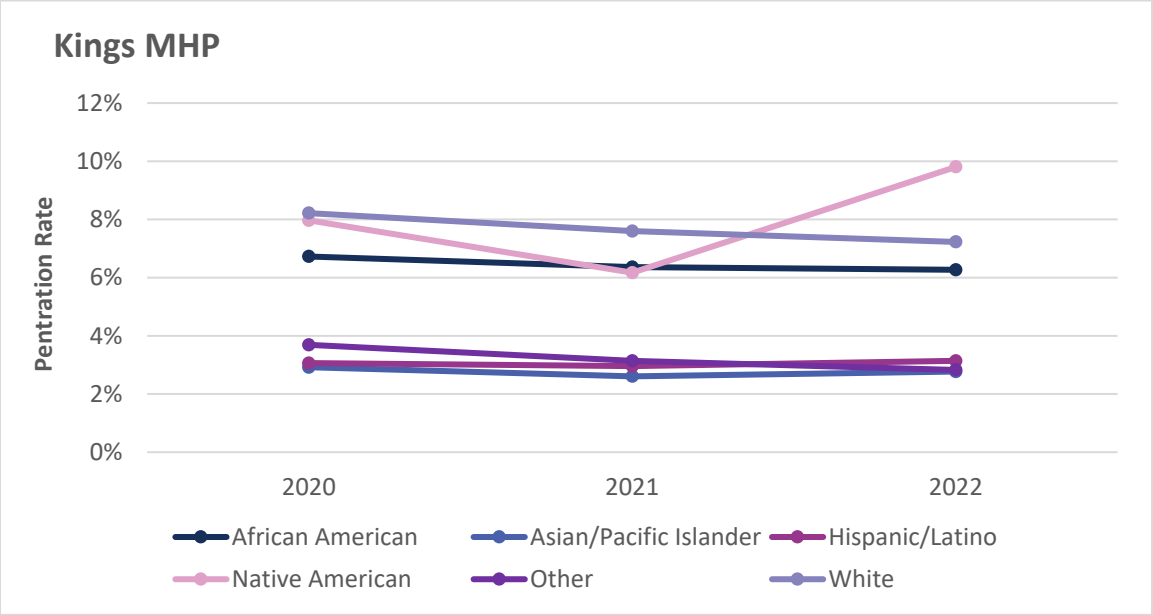


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	26%	11%	1%	54%	1%	7%
MHP % Eligible	14%	14%	0%	65%	2%	4%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- The MHP has a larger proportion of Hispanic/Latino eligibles than the state and smaller proportions of Asian/Pacific Islander, White, Other, and African American eligibles.
- The most proportionally overrepresented racial/ethnic group in the MHP is White, and the most underrepresented is Hispanics/Latino.

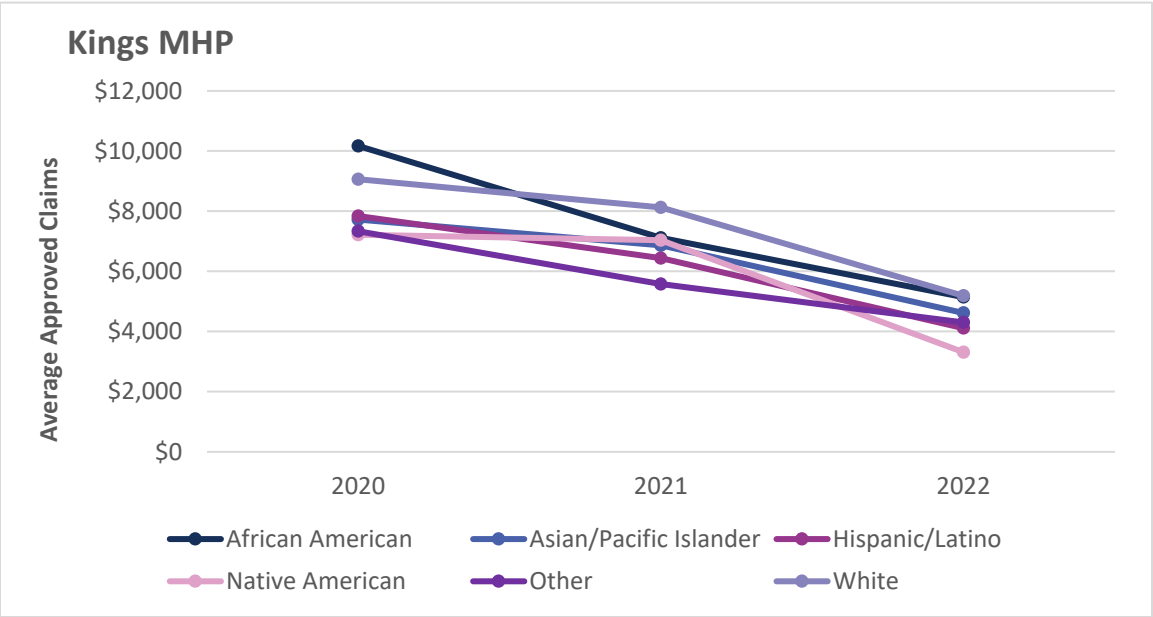
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



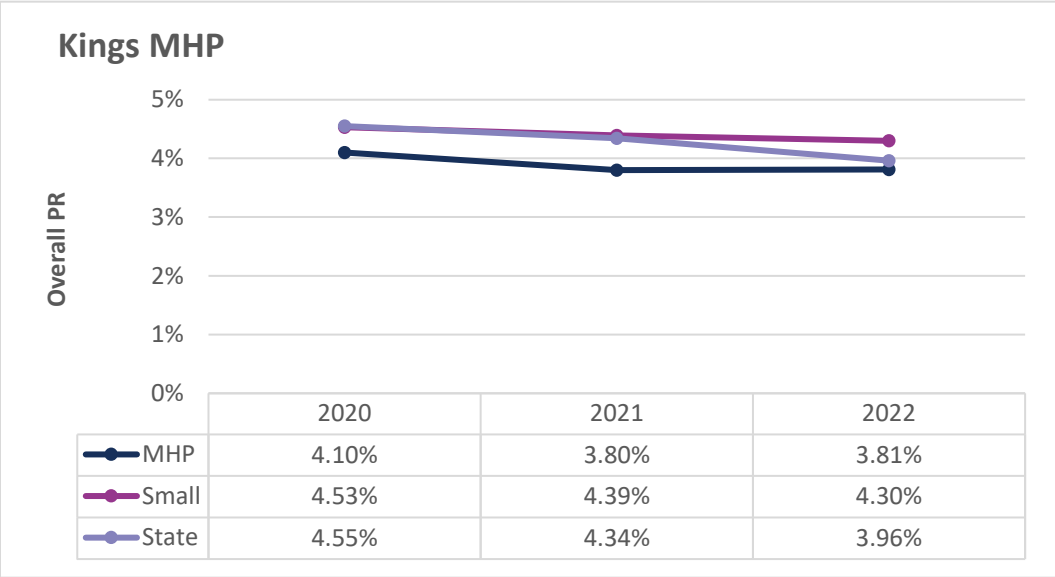
- The PRs for African American, Native American, and White have been consistently higher than other racial/ethnic groups PRs in past three years.
- The PR for Native American decreased in CY 2021, followed by a dramatic increase in CY 2022. Due to the small number of eligibles in this group fluctuations in the handful of members served can create larger shifts in PR than would be seen in a larger population.

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



- AACMs across all racial/ethnic groups decreased each of the past two years.

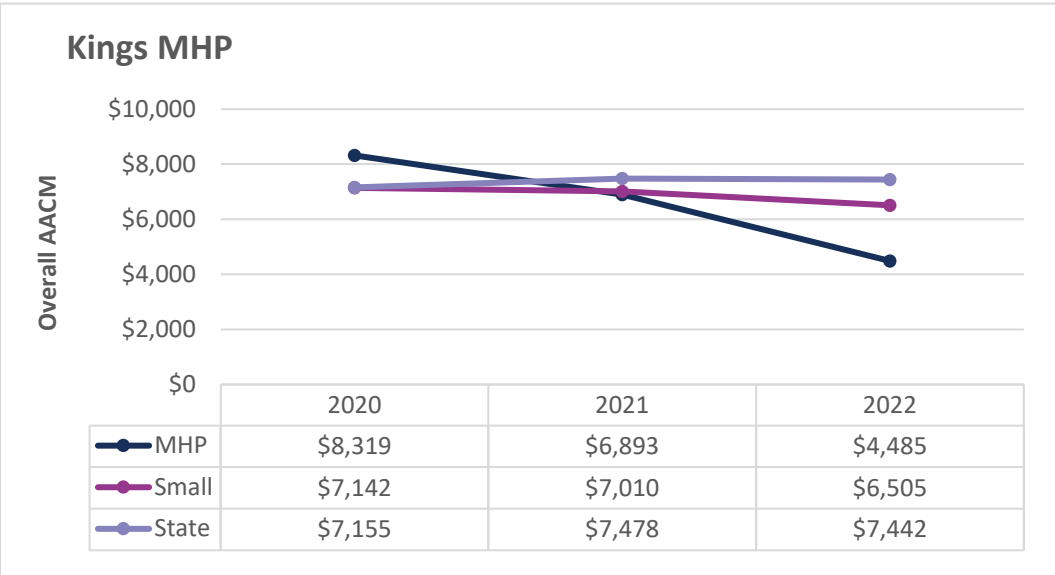
Figure 4: Overall PR CY, 2020-22



	2020	2021	2022
MHP	4.10%	3.80%	3.81%
Small	4.53%	4.39%	4.30%
State	4.55%	4.34%	3.96%

- Over the past three years PRs have been trending downward in the MHP, similar sized counties, and statewide. The MHP did have a slight rise between CY 2021 and 2022.
- The PR for the MHP has been consistently lower than in similar sized counties and statewide.

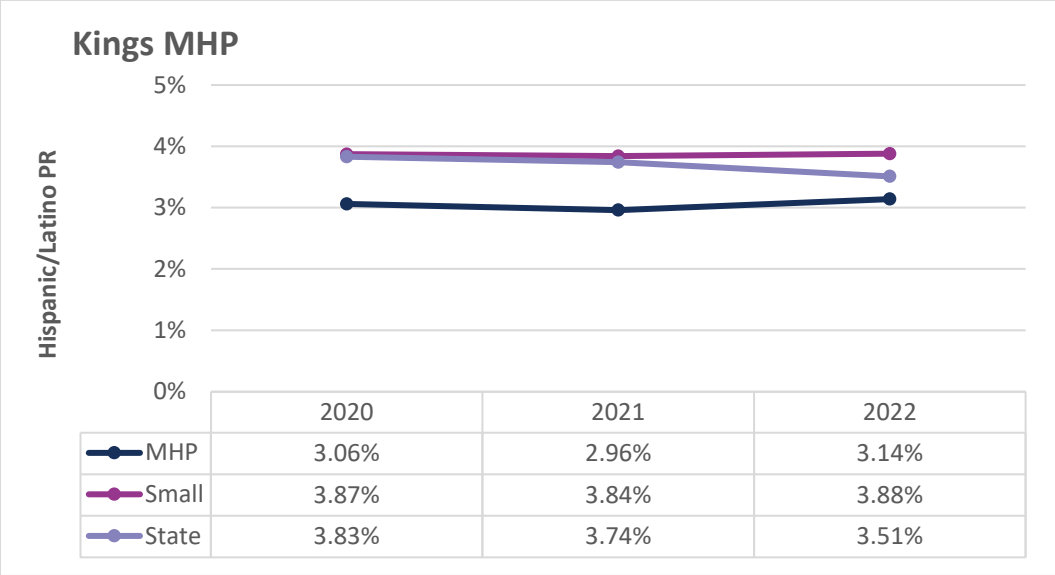
Figure 5: Overall AACM, CY 2020-22



	2020	2021	2022
MHP	$8,319	$6,893	$4,485
Small	$7,142	$7,010	$6,505
State	$7,155	$7,478	$7,442

- AACM had trended downwards over the past three years in the MHP and similar sized counties, whereas statewide there was a rise in 2021 and then a $36 fall in 2022.
- AACM was higher in the MHP than similar sized counties and statewide for CY 2020. For CYs 2021 and 2022 the MHP AACMs were lower than similar sized counties and statewide, with the gap widening in CY 2022.

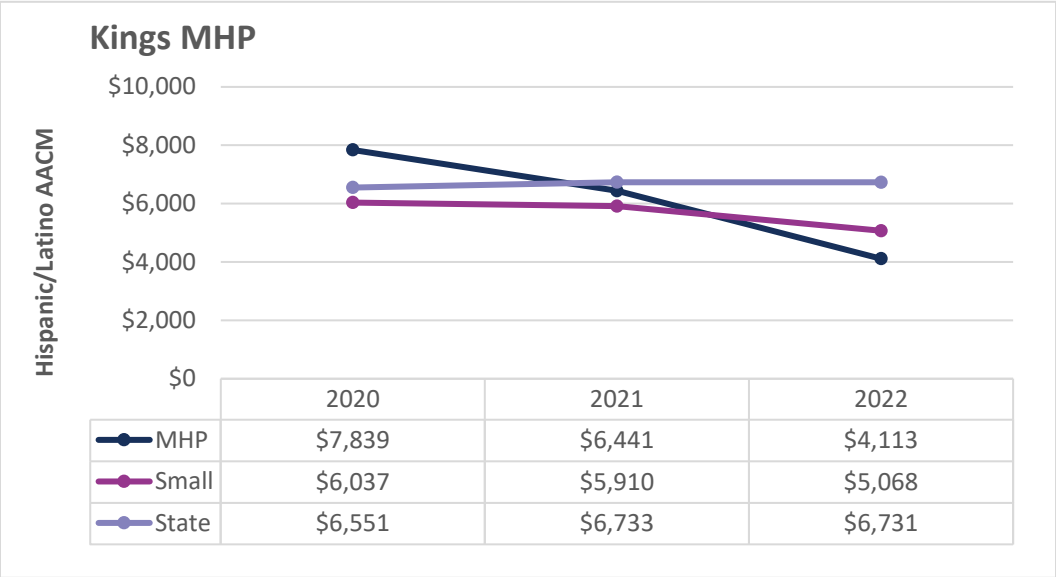
Figure 6: Hispanic/Latino PR, CY 2020-22



	2020	2021	2022
MHP	3.06%	2.96%	3.14%
Small	3.87%	3.84%	3.88%
State	3.83%	3.74%	3.51%

- The Hispanic/Latino PR decreased very slightly from CY 2020 to CY 2021, followed by an increase in CY 2022.
- The MHP Hispanic/Latino PRs were lower than both the similar sized county and statewide PRs over the past three years.

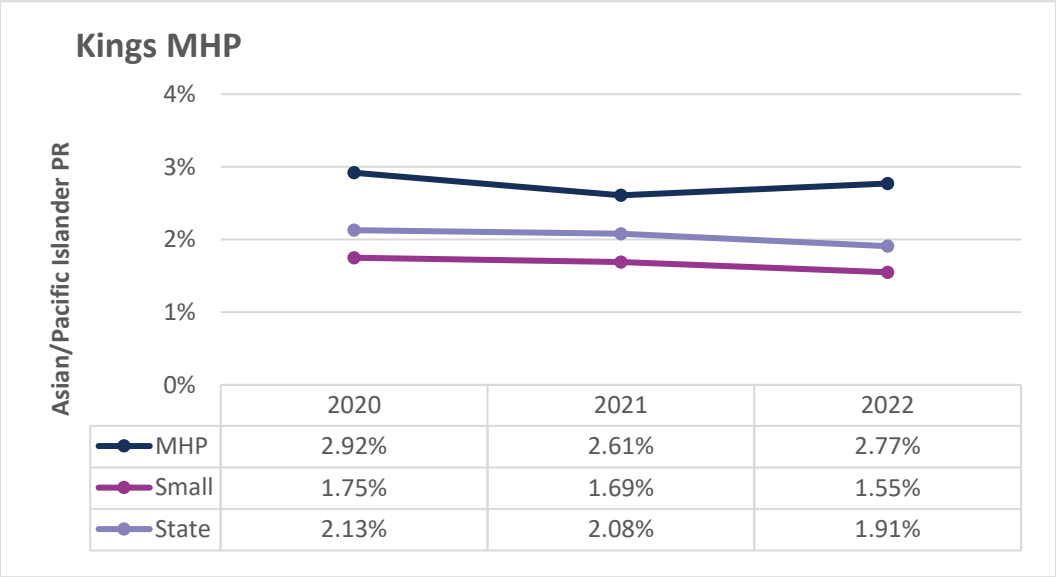
Figure 7: Hispanic/Latino AACM, CY 2020-22



	2020	2021	2022
MHP	$7,839	$6,441	$4,113
Small	$6,037	$5,910	$5,068
State	$6,551	$6,733	$6,731

- AACM for Hispanic/Latino AACM has been decreasing over time in the MHP. This was higher than the AACMs for similar size counties and statewide in CY 2020 but was lower than both in CY 2022.

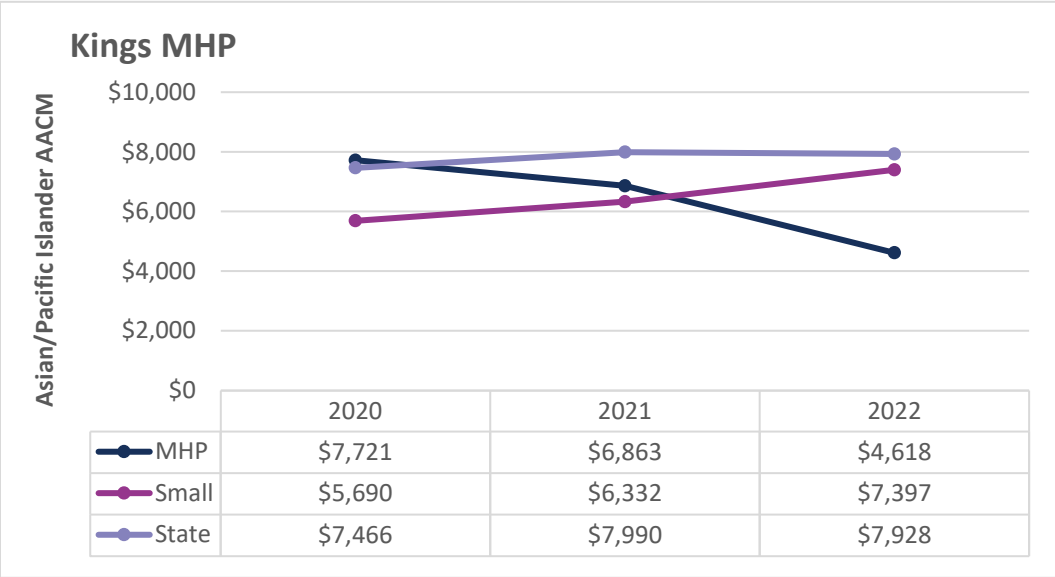
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	2.92%	2.61%	2.77%
Small	1.75%	1.69%	1.55%
State	2.13%	2.08%	1.91%

- The MHP had higher Asian/Pacific Islander PRs than PRs for similar sized counties and statewide for the past three years.

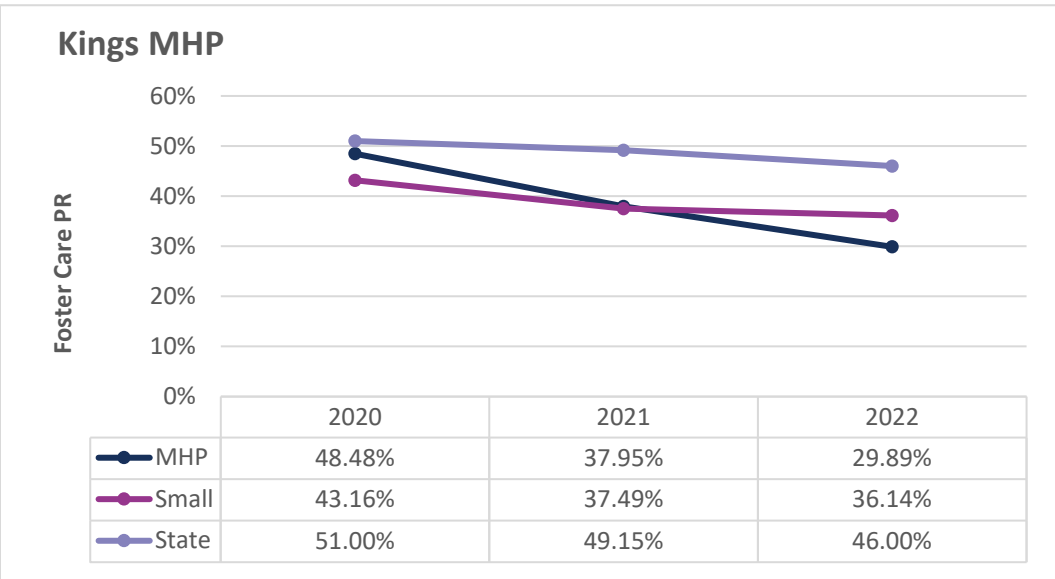
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$7,721	$6,863	$4,618
Small	$5,690	$6,332	$7,397
State	$7,466	$7,990	$7,928

- The MHP's Asian/Pacific Islander AACM was higher than similar sized counties and statewide AACMs in CY 2020, though it has decreased over the past two years and was lower than either comparison in CY 2022.

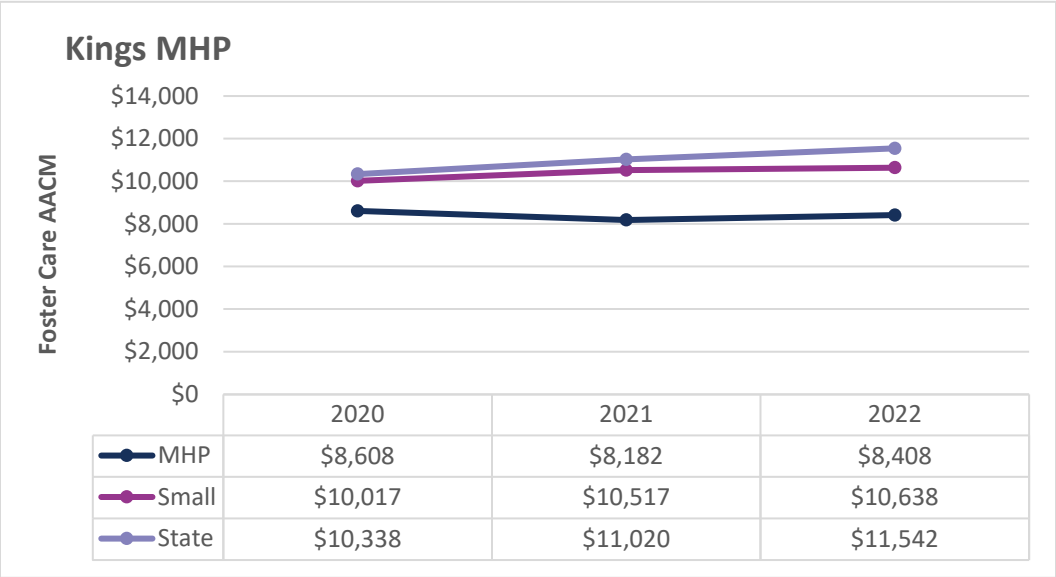
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	48.48%	37.95%	29.89%
Small	43.16%	37.49%	36.14%
State	51.00%	49.15%	46.00%

- The FC PR for the MHP was higher than PRs for similar sized counties and lower than statewide PRs in CY 2020. After decreasing steadily over the past two years, the MHP's CY 2022 FC PR is over six percentage points lower than PRs for similar sized counties, and about 16 percentage points lower than statewide PRs.

Figure 11: Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$8,608	$8,182	$8,408
Small	$10,017	$10,517	$10,638
State	$10,338	$11,020	$11,542

- Statewide FC AACM has increased each year for the past three years, whereas the CY 2022 FC AACM in the MHP is slightly lower than it was in CY 2020.
- The MHP's FC AACM has been consistently lower than FC AACMs for similar sized counties and statewide.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the Kings MHP to Adults, CY 2022

Service Category	MHP N = 1,735				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	61	3.5%	8	6	10.3%	14	8
Inpatient Admin	0	0.0%	0	0	0.4%	26	10
Psychiatric Health Facility	<11	-	46	46	1.2%	16	8
Residential	0	0.0%	0	0	0.3%	114	84
Crisis Residential	<11	-	22	23	1.9%	23	15
Per Minute Services							
Crisis Stabilization	26	1.5%	1,334	1,200	13.4%	1,449	1,200
Crisis Intervention	365	21.0%	218	125	12.2%	236	144
Medication Support	936	53.9%	413	322	59.7%	298	190
Mental Health Services	1,262	72.7%	499	254	62.7%	832	329
Targeted Case Management	635	36.6%	346	101	36.9%	445	135

- Inpatient utilization in the MHP was much lower than statewide.
- Mental health services, medication support, and targeted case management (TCM) were the most used services in the MHP.
- Although mental health services and crisis intervention utilization rates were higher than statewide rates, crisis stabilization and medication support utilization rates were lower.
- All per minute services had fewer average minutes than statewide averages, except for medication support.

Table 9: Services Delivered by the MHP to Kings MHP Youth in Foster Care, CY 2022

Service Category	MHP N = 162				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	12	7.4%	11	9	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	0	0.0%	0	0	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	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	<11	-	1,058	1,125	3.1%	1,166	1,095
Crisis Intervention	34	21.0%	252	117	8.5%	371	182
Medication Support	37	22.8%	263	146	27.6%	364	257
TBS	<11	-	3,984	2,811	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	42	25.9%	558	300	40.8%	1,458	441
Intensive Home-Based Services	29	17.9%	1,356	1,154	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	151	93.2%	1,342	620	95.4%	1,846	1,053
Targeted Case Management	81	50.0%	335	177	35.8%	307	118

- The only per day service with FC utilization was inpatient, which was utilized at a higher rate than statewide – again, the small number of members will have a larger impact on the rates than in a larger population. Average and median billed days were very similar to the state metrics.
- As with statewide, the most-used service for FC youth was mental health services. The second most-used service in the MHP was TCM, which had a higher utilization rate than statewide; crisis intervention had lower utilization than statewide, while therapeutic behavioral services (TBS) had higher utilization.

- Average and median units were comparable (or slightly lower) to statewide for all services except for Intensive Care Coordination, Intensive Home-Based Services, and mental health services that were much lower than the state metrics.

IMPACT OF ACCESS FINDINGS

- The MHP's PRs for children and older adults are lower than the state and similar sized counties PRs which suggests there may be barriers to access that need to be explored. These may include COVID-19 related impact and others such as clinical capacity, transportation issues, and limitations for telehealth access by the plan members.
- Medication support services are provided at a lower rate than statewide rates for both adults and FC youth. However, for adults, the median and average length of service exceeds the statewide averages. This may reflect additional time spent navigating the complexities of telehealth services.
- Within FC services, median units of service remain lower for this population than the statewide metrics, except for TCM and TBS. However, the percentage of FC youth who receive crisis intervention was much higher than the statewide percent. This may reflect a higher number of FC children and youth may end up using crisis intervention services if they did not receive adequate mental health services and intensive care coordination services to abate the crisis. This would require more investigation by the MHP.
- The MHP reports an increase in referrals and caseloads related to CalAIM requirements and capacity issues that impact access to care.

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:

- The MHP has continued the non-clinical PIP on urgent appointments into the second year and the use of an urgent condition triage tool to screen for urgent conditions at intake. PIP findings indicate an increase in the percent of members identified with an urgent condition at 7.2 percent during the review period

(FY 2022-23) compared to the previous measurement (October 2021 to June 2022) at 1.62 percent. This is indicative of the MHP's success in improving the identification of urgent conditions at intake.

- The MHP outpatient follow up rates are reportedly high both for the 7-day at 85 percent and 30-day at 95 percent. Psychiatric rehospitalization rates are low for the 7-day at 3.85 percent and for the 30-day at 9.13 percent.

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. 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 Kings MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	14.68 Business Days	10 Business Days*	46%
First Non-Urgent Service Rendered	18.73 Business Days	10 Business Days**	39%
First Non-Urgent Psychiatry Appointment Offered	8.67 Business Days	15 Business Days*	89.38%
First Non-Urgent Psychiatry Service Rendered	12.15 Business Days	15 Business Days**	75.09%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	89.47 Hours***	48 Hours*	62.59%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	7.11 Calendar Days	7 Calendar Days	84.77%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	7.11 Calendar Days	30 Calendar Days	95.04%
No-Show Rate – Psychiatry	21.15%	25%**	n/a
No-Show Rate – Clinicians	17.73%	25%**	n/a

* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033

** MHP-defined timeliness standards

*** The MHP had no requests that required authorization.

For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-23

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

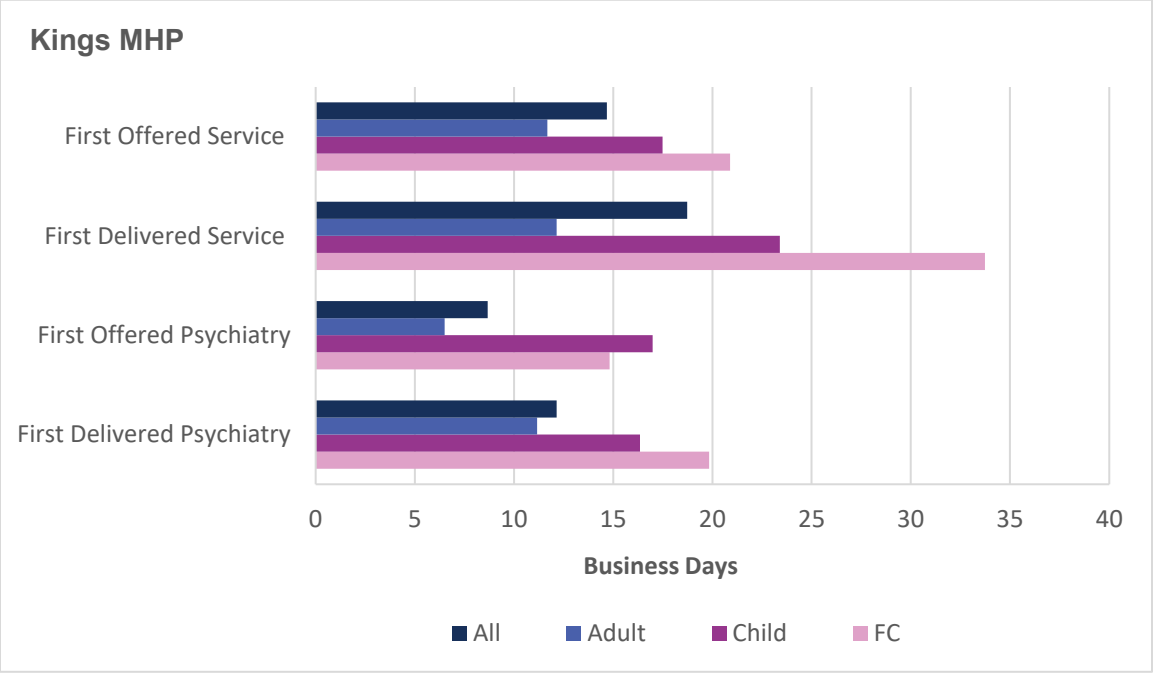


Figure 13: Wait Times for Urgent Services

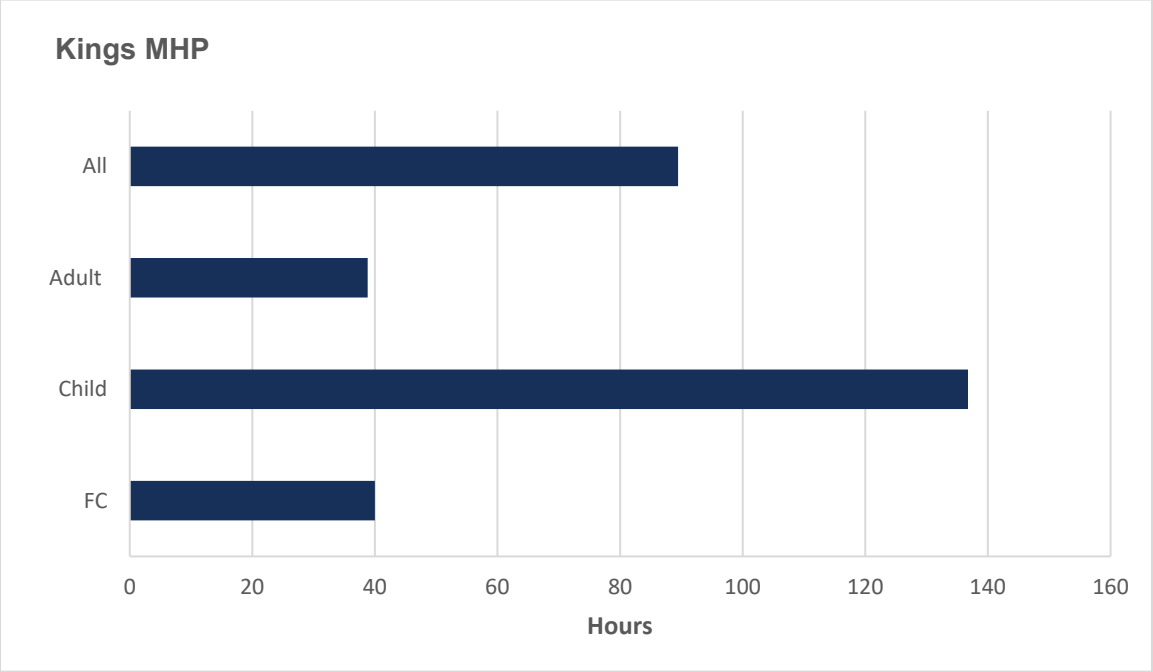
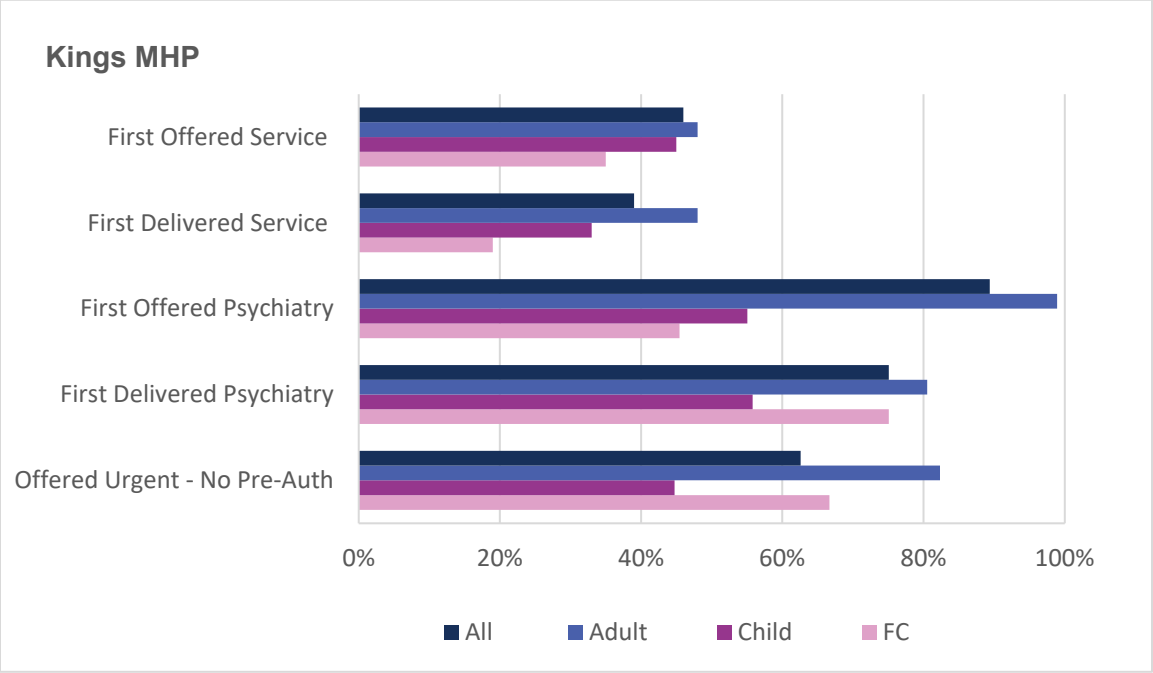


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide mental health 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 and unscheduled assessments.

  The MHP defined "urgent services" for purposes of the ATA as "Increased symptoms/rapid change from baseline that without intervention within 48 hours would most likely result in a psychiatric crisis; or, medication Issue (not those raised during routine medication services unless subsequent expedient service encounter is needed based on medication issue); or, transition from higher level of care placement (i.e., psychiatric hospital, IMD, Board & Care) or justice system." There were reportedly 152 urgent service requests with a reported actual wait time to services for the overall population of 89.47 hours. The MHP does offer urgent services that require pre-authorization separately. However, for FY 2022-23, the MHP did not have any requests that require authorization. Therefore, no data was reported.

- The MHP defines timeliness to first delivered/rendered psychiatry services as the time from the date the referral was made for psychiatry services to the date service was rendered. The overall wait for the first offered appointment is less than 9 days on average.

- 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 21.64 percent for adult psychiatry services, 17.74 percent for children's psychiatry services, and 25.33 percent for FC psychiatry services. No-show rates for other clinician services are 19.72

percent for adult clinical services, 15.69 percent for children's clinical services, and 12.44 percent for FC clinical services.

IMPACT OF TIMELINESS FINDINGS

- The MHP 7-day and 30-day follow up rates post discharge are positive and are higher than the rates for the state and counties of similar size.
- The MHP has challenges in several areas related to timeliness. For the first offered appointments for adults and children combined, only 46 percent met the standard for 10-business days, with a median of 11 days for adults and 12 for children. Although the MHP presented provider specific data for children for the last two quarters of FY 2022-23 that are indicative of improvement, the MHP would benefit from continued monitoring of timeliness in this area for both adults and children. Identifying related QI activities and strategies to improve timely access to care would be beneficial.
- In the area of first offered non-urgent psychiatry appointments, the MHP met the standard of 15 business days for only 55 percent of the children served. The rates for adults are much higher at 99 percent. Identifying potential barriers to timely non-urgent psychiatry appointments and implementing improvement strategies to address these barriers would be helpful. The MHP's use of telehealth services by youth decreased for this fiscal year compared to the previous year. It would be worth exploring if telepsychiatry appointments can be offered to improve timeliness in this area.
- The MHP has challenges meeting the timeliness standard for first offered urgent appointments for children. Only 45 percent met the standard with a median of 72 hours and an average of 137 hours compared to 82 percent of adults with a median of 24 hours and average of 38 hours.
- The MHP indicates that CalAIM is increasing caseloads, and the capacity issues further impact the timeliness.

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 Quality Improvement (QI) is to oversee quality of care monitoring and improvement of the MHP and its contract providers, which includes Quality Assurance (QA)/Compliance, and with partner agencies also having a QI/compliance function locally. The MHP approaches quality from a continuous point of view, seeking to identify and improve functional areas with rapid cycle activities when possible.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of staff from both the MHP and its contract providers, including clinical directors, clinical supervisors, fiscal staff, psychiatry, peer support specialists, patient rights advocates, and others, is scheduled to meet monthly. Since the previous EQR, the MHP QIC met seven times. Of the eight identified FY 2022-23 QAPI workplan goals, the MHP found one met, six partially met, and one with rating deferred due to lack of data at the point of evaluation.

The MHP utilizes the following level of care (LOC) tools: Child and Adolescent Needs and Strengths tool (CANS), Pediatric Symptom Checklist-35 (PSC-35), and Adult Needs and Strengths Assessment (ANSA).

The MHP utilizes the following outcomes tools: CANS, PSC-35, and ANSA. Only the CANS has a dashboard created for aggregate data tracking purposes; the other two have dashboards under development.

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	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Met
3H	Utilizes Information from Member Satisfaction Surveys	Partially Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Partially 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:

- The MHP has a robust QI process that trends and tracks performance metrics to assess improvement. The QAPI plan includes metrics focusing on access, timeliness, member satisfaction, outcomes, and medication monitoring. The QAPI plan is clearly written, concise, organized, and highlights the impact of the findings and related CQI activities.
- The MHP had challenges with member participation in the consumer perception survey (CPS), which due to COVID-19 required a shift to an electronic submission format. Many members seemed unable to utilize the electronic format and either did not complete or partially completed surveys. The MHP's circulation of the CPS information within the QAPI is posted to the MHP website. However, this information is not available upfront, and the search feature must be used to track the QAPI that presents the CPS findings.
- The Oak Wellness Center, an adult wellness program operated by Kings View, has several activities and utilizes member feedback to improve their activities. However, there is a referral requirement. The MHP's website also lists the wellness center as an adult resource, but does not include address, phone number, or contact person.

- The MHP has seven peer positions and is continuing to expand the utilization of peers and parent partners. Peers feel appreciated and value their role. Peers are involved in helping new members access services and resources, assisting parents in navigating the system and resources, case manager duties, facilitation of support groups, classes at the Oak Wellness Center, homeless outreach, and providing transportation.
- There are no lived experience positions that report directly to the Executive Team. There is one peer supervisory position at the Oak Wellness Center. While there are opportunities for career advancement outside of the lived experience category, currently there are very limited within.
- The MHP set a goal of 90 percent compliance related to medication monitoring. The MHP tracks and trends medication monitoring results and addresses areas for improvement. For FY 2022-23, the MHP reviewed 166 charts and achieved an overall compliance rate of 95.48 percent for the seven areas monitored.
- The MHP tracks the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD): 100 percent compliance.
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): zero percent compliance.
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): zero percent compliance.
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP): 100 percent compliance.

QUALITY PERFORMANCE MEASURES

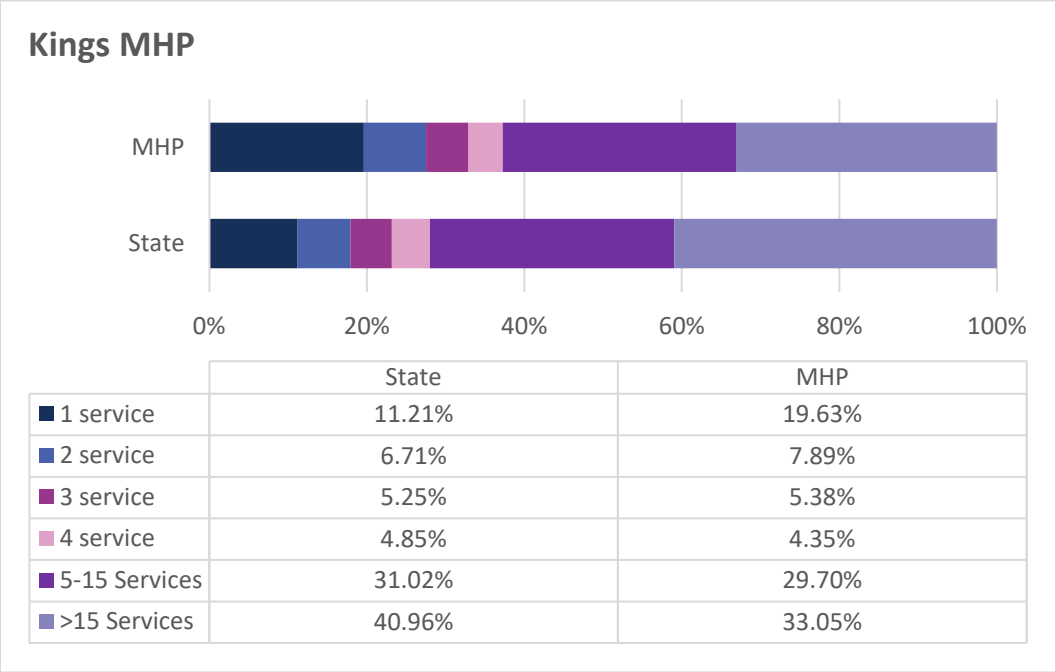
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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 (LOS), as individuals enter and exit care throughout the 12-month period. Additionally, it does not distinguish between types of services.

Figure 15: Retention of Members Served, CY 2022



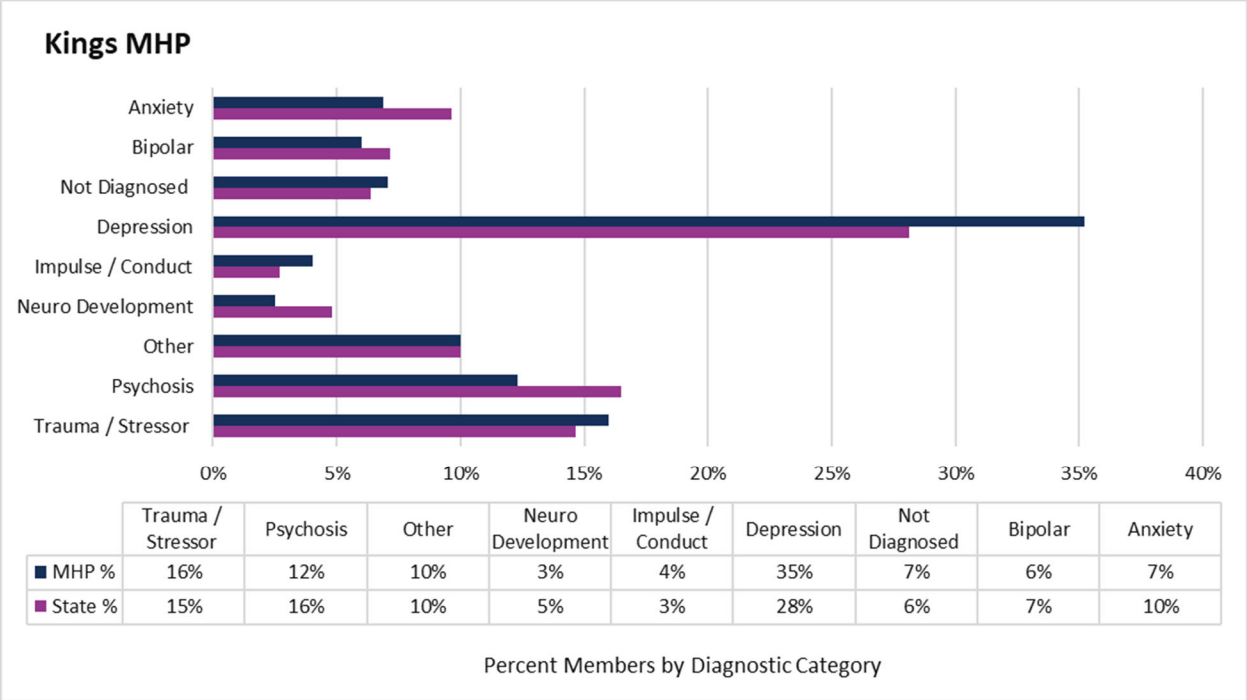
	State	MHP
1 service	11.21%	19.63%
2 service	6.71%	7.89%
3 service	5.25%	5.38%
4 service	4.85%	4.35%
5-15 Services	31.02%	29.70%
>15 Services	40.96%	33.05%

- The MHP has a higher proportion of members receiving only one, two, or three services, and a lower proportion of members retained for four or more services than statewide.

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

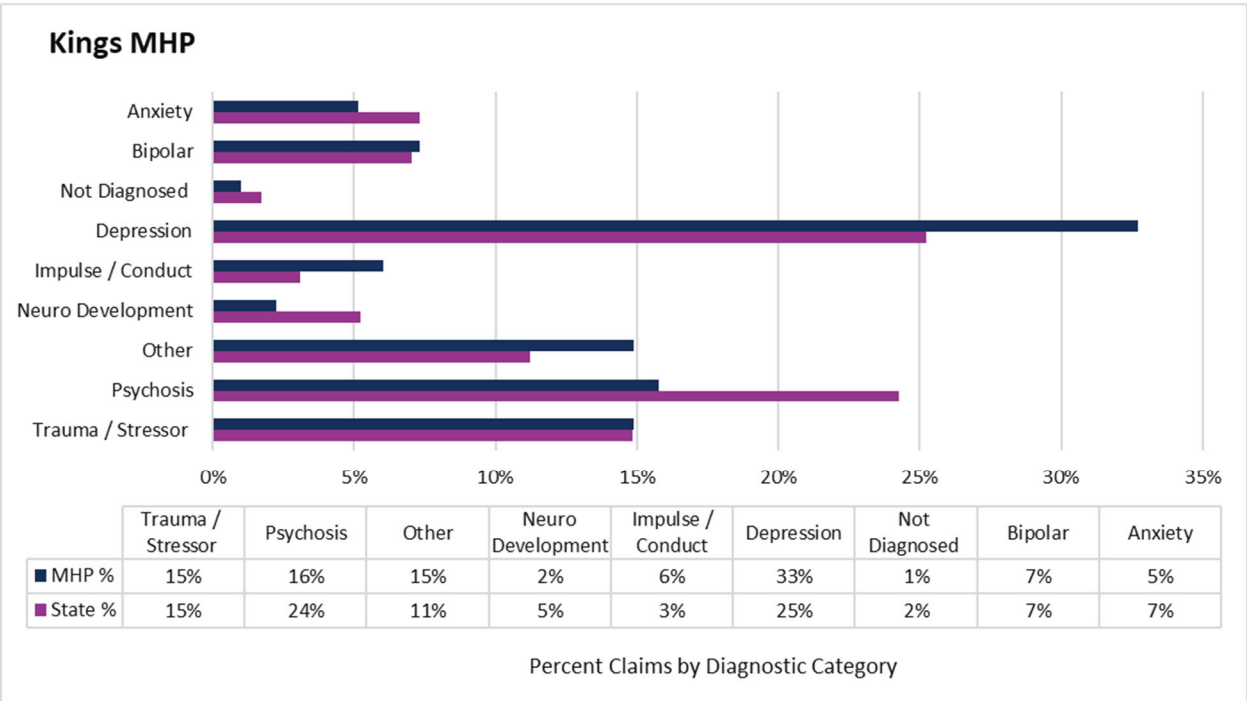


	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	16%	12%	10%	3%	4%	35%	7%	6%	7%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

Percent Members by Diagnostic Category

- Depression was the most common diagnostic category and had the biggest proportional difference between the MHP and statewide prevalence.

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 %	15%	16%	15%	2%	6%	33%	1%	7%	5%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

Percent Claims by Diagnostic Category

- Approved claims by diagnostic categories were comparable to diagnostic patterns in the MHP.
- The percent of Approved claims was eight percent higher for the state than the MHP for Psychosis diagnosis and four percent lower for Other.

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 length of stay (LOS).

Table 13: Kings MHP Psychiatric Inpatient Utilization, CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	116	134	8.01	8.45	$11,411	$12,763	$1,323,650
CY 2021	164	212	9.80	8.86	$14,466	$12,696	$2,372,440
CY 2020	174	206	9.16	8.68	$11,123	$11,814	$1,935,435

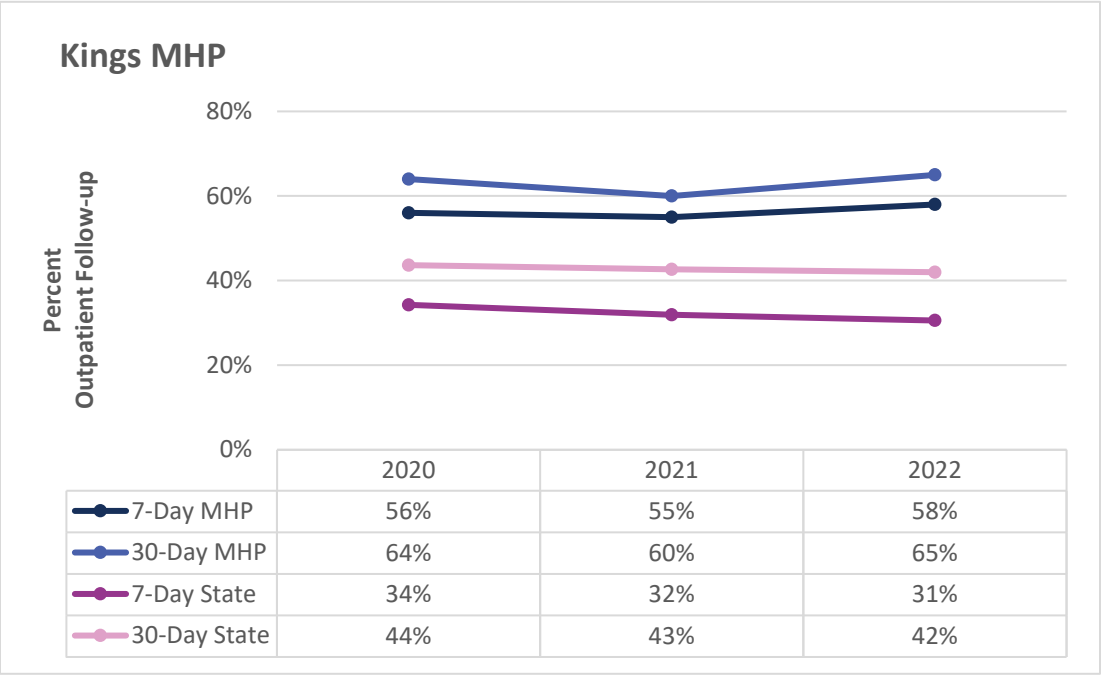
- The MHP showed a significant decrease in inpatient utilization in CY 2022 compared to the prior years, and also at a shorter ALOS – previously longer than the statewide average and now shorter.

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 are 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.

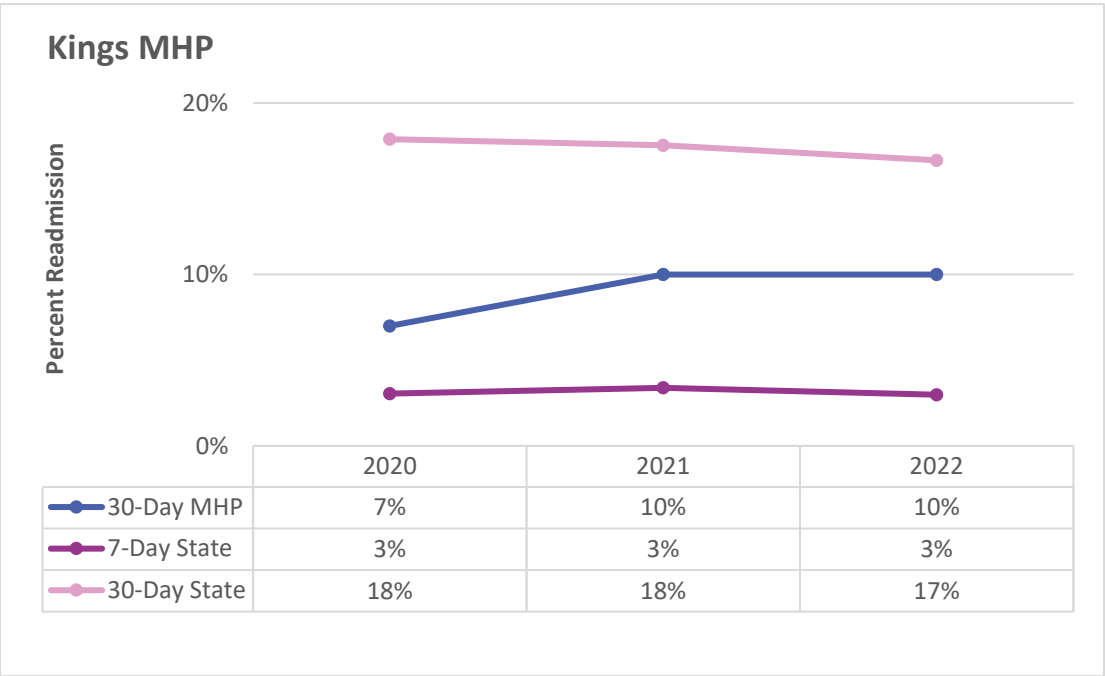
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	56%	55%	58%
30-Day MHP	64%	60%	65%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- The MHP's 7- and 30-day follow-up rates were higher than statewide rates, increasing in 2022, whereas the statewide rates decreased slightly.

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



	2020	2021	2022
30-Day MHP	7%	10%	10%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The psychiatric readmission rates for the MHP was fewer than 11 people and therefore not displayed under HIPAA regulations.
- The state 30-day readmission rates have followed the same pattern as the 7-day rates and are between 7 and 9 percentage points higher.

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 level of care 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. HCBs 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.

Tables 14 and 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: Kings 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	46	1.75%	18.22%	$2,142,999	$46,587	$41,300
	CY 2021	105	4.26%	34.11%	$5,791,204	$55,154	$45,408
	CY 2020	129	5.21%	32.88%	$6,772,824	$52,503	$41,925

- The percentage of members in the HCM category has decreased dramatically over the past three years. The HCM count decreased by 64 percent between CYs 2020 and 2022.
- The average claims per HCM also decreased substantially (by more than $8,500) between CYs 2021 and 2022, and total approved claims for this group decreased

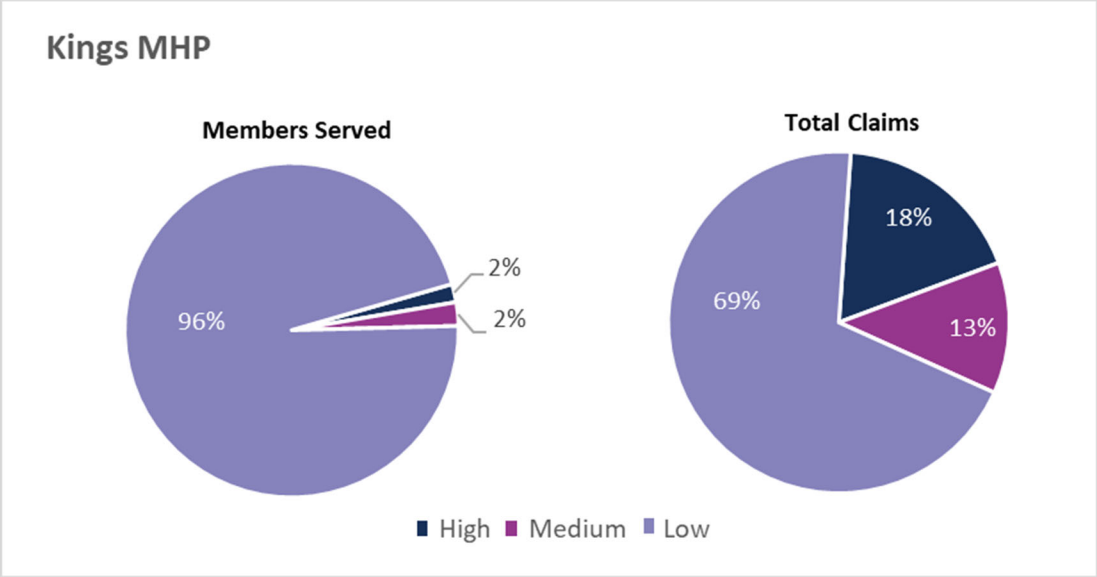
by 68 percent between CYs 2020 and 2022.This is consistent with decreased hospital utilization.

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

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	60	2.29%	12.42%	$1,460,940	$24,349	$23,819
Low-Cost (Less than $20K)	2,517	95.96%	69.36%	$8,160,030	$3,242	$1,809

- Almost 96 percent of members fall into the low-cost category, and the average approved claims per member in that category is $3,242. Only 60 members were served in the medium-cost category, just over two percent. The average claims per member in the medium-cost category was $24,349.

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



- Most of the members served fall into the low-cost category, representing about 69 percent of claims and 96 percent of members served.

IMPACT OF QUALITY FINDINGS

- In the area of beneficiary retention, the MHP is about eight percentage points higher than the statewide average with individuals that receive one service, and similarly lower than the statewide average for those who receive more than 15 services. This may indicate easier initial access and potential barriers to retention that may be worth further exploration.
- Inpatient utilization trends indicate fewer hospitalizations and a decrease in the LOS compared to the prior two years. The length of stay for CY 2022 was lower than the statewide average. The AACM is directly related to length of stay but is also impacted by facility rates. This MHP does not have a local psychiatric inpatient unit and must send its members to regional hospitals.

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.

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: Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Date Started: 08/2023

Date Completed: Planned for 08/2025

Aim Statement: Will implemented interventions increase the percentage of follow-up mental health services for Medi-Cal beneficiaries with ED visits for MH conditions within 7 and 30 days by 5% by June 30, 2024?

Target Population: The target population for this PIP is both adults and children served by the MHP. The MHP serves children between the ages of 6-17 that comprise 27.1 percent of the ED visits and adults 18-64 that comprise 73 percent of ED visits. Regarding preferred language of the members, about 89 percent of the ED visits were from members that spoke English, 11percent Spanish, and for 0.3 percent language was Unknown. The Hispanic population were 46.1percent of the ED visits, 33 percent

[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

were White, 9.2 percent Unknown, 6.9 percent African American, and Asian/Pacific Islanders and Other were about 2.3 percent.

Status of PIP: The MHP's Clinical PIP is in the implementation phase and is developing strategies to implement that include data exchange with the hospital and developing a referral management process.

Summary

The MHP reviewed the post discharge 7-day (66%) and 30-day (74%) follow up rates for CY 2021 and noted that their metrics in this area are above the national and state benchmarks demonstrating success in accessing services following a hospital discharge. However, the MHP notes the lack of knowledge and understanding of the processes including referral management that may have yielded positive findings. The MHP is interested in identifying those processes and replicating these to ensure success. The MHP's ATA for FY 2022-23 shows further improvement with the 7-day (85%) and 30-day (95%) rates. However, the MHP analyzed the data provided by DHCS for this PIP.

The MHP will focus on beneficiaries with a qualifying event as defined in the Follow up for Mental Health (FUM) metric. The MHP defines a qualifying event as an ED visit with a principal diagnosis of mental illness or intentional self-harm, also referred to as "MH" or "MH conditions." The MHP's executive team conducted a root cause analysis (RCA) and developed some hypotheses regarding potential barriers to follow up discharge. The MHP plans to explore further in this area through robust stakeholder engagement. The three interventions for this PIP include implementing a post-discharge follow-up system by utilizing the plan data feed and developing infrastructure for direct data exchange with the hospital, creating a referral management system, and establishing a better working relationship with the local emergency departments. The MHP has identified tools to track the metrics such as the screen logs (September 2023) but has not yet clearly structured and developed their interventions at this time.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence because the MHP has demonstrated high post discharge follow up and low readmission rates for the past fiscal year (FY 2022-23) that exceeds the national and state rates. Although the MHP submitted the BHQIP as a clinical PIP, given the very high performance, this area does not indicate a problem area that allows for improvement activity.

CalEQRO recommendations for improvement of this clinical PIP:

- The MHP has challenges with timely first offered non-urgent appointments for all populations. In addition, the MHP has struggles providing timely first offered non-urgent appointments for psychiatry and first offered urgent appointments for children. The MHP would benefit greatly from identifying one of these areas, (especially urgent appointments for children) as the problem area for the PIP.

Implementing strategies to improve timely access to clinical care may prevent a potential crisis and address high risk areas. These recommendations were provided to the MHP during the review.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Urgent Conditions (at Intake)

Date Started: 07/2020

Date Completed:12/2023

Aim Statement: Will the implementation of a standardized process for identifying, responding to, and tracking urgent conditions among all new beneficiaries requesting specialty mental health services lead to timelier access to appropriate services over a twelve-month timeframe during FY 2022-23?

Target Population: All new members experiencing an urgent condition who are requesting services from the MHP.

Status of PIP: The MHP's non-clinical PIP is in the completed phase and will end in December 2023.

Summary

The MHP review of timeliness data for urgent conditions (limited to initial requests) indicated a low number of identified urgent conditions and problems with timely first appointments for urgent conditions for all populations. The MHP developed an Urgent Care Triage tool to ensure a standardized process to define criteria for urgent conditions and to identify members who have urgent conditions. The MHP implemented the tool in year two and the first remeasurement demonstrated an improvement in the average time from identification of an urgent condition to first service (61.2 hours to 50.18 hours). However, the other two measures (number of new members and percent identified as urgent and the number of new members who had a crisis visit within three months of the service request but were not identified as urgent) did not result in improvement.

The MHP continued use of this tool and the final remeasurement results were indicative of improvement in the number and percent of new members identified as having an urgent condition (2.73 percent at baseline to 7.11 percent at final remeasurement). However, the other two measures did not indicate any improvement.

TA and Recommendations

As submitted, this non-clinical PIP was found to have Moderate confidence because although the PIP demonstrated improvement on one measure (related to the number of

new members identified with urgent conditions) on the final measurement, there was no improvement reflected in the other two measures.

CalEQRO recommended the MHP to follow up with a TA call for the next PIP because this PIP has been completed.

CalEQRO recommendations for improvement of this non-clinical PIP:

- The MHP's addition of an Urgent Condition Triage Tool, and the enhanced structure has demonstrated an increase in the number of urgent conditions identified. As this PIP is concluding following this review (December 2023), recommendations for improvement would not be executable within the framework of a PIP. The MHP will benefit from continuing the use of this tool and working on strategies to improve timely access for those with urgent conditions seeking services as no improvement was noted in timely access for urgent conditions.

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 Electronic Health Records (EHR), 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 semi-statewide EHR, Streamline/SmartCare administered by CalMHSA, which has been in use for less than one year. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop.

Approximately 2.63 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.

The MHP has 153 named users with log-on authority to the EHR, including approximately 32 county staff and 121 contractor staff. Support for the users is provided by one 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. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

Contract providers submit member practice management and service data to the MHP IS as reported in the following table:

Table 16: Contract Provider Transmission of Information to Kings 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	95%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	5%
		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 PHR enhances members' and their families' engagement and participation in treatment. With a new vendor for the EHR as of July 2023, the PHR capability is likely a year away, moving into 2024.

Interoperability Support

The MHP is not a member or participant in a HIE. The MHP engages in electronic exchange of information with its contract providers and SUD contract providers.

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 rates continue to be below the state metrics related to Medi-Cal claims that are denied.
- The MHP first tried to use their system of 15 years, Cerner, to provide its EHR ongoing but changed course and prepared to use SmartCare. SmartCare was implemented in July 2023. Once the MHP has fully incorporated SmartCare, better data access is expected and within a year the MHP will start to incorporate a PHR.

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 reflects a largely complete or substantially complete claims data set for the time frame represented.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	3,495	$772,166	$11,592	1.50%	$760,574
Feb	3,476	$808,592	$13,603	1.68%	$794,989
Mar	4,538	$1,070,479	$20,943	1.96%	$1,049,536
April	4,072	$961,762	$16,673	1.73%	$945,089
May	4,054	$949,015	$15,985	1.68%	$933,030
June	3,895	$873,848	$20,894	2.39%	$852,954
July	3,644	$829,115	$17,470	2.11%	$811,645
Aug	4,516	$1,048,086	$17,521	1.67%	$1,030,565
Sept	4,320	$986,800	$30,774	3.12%	$956,026
Oct	4,262	$977,108	$11,141	1.14%	$965,967
Nov	3,730	$829,283	$22,031	2.66%	$807,252
Dec	2,511	$565,414	$18,128	3.21%	$547,286
Total	**46,513**	**$10,671,668**	**$216,755**	**2.03%**	**$10,454,913**

- Claims volume was generally stable across CY 2022, with a smaller number of claims in December. December had the highest rate of denied claims and October the lowest, the difference being just above two percent.

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

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Medicare Part B must be billed before submission of claim	610	$144,817	66.81%
Other healthcare coverage must be billed first	193	$43,628	20.13%
Beneficiary is not eligible or non-covered charges	40	$11,618	5.36%
Deactivated NPI	13	$10,282	4.74%
Other	17	$3,222	1.49%
Service line is a duplicate and repeat service modifier is not present	9	$2,056	0.95%
Service location NPI issue	2	$567	0.26%
Late claim submission	1	$567	0.26%
Total Denied Claims	**885**	**$216,757**	**100.00%**
Overall Denied Claims Rate	**2.03%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- Almost 87 percent of the denied claims needed to bill either Medicare Part B or other healthcare coverage. Many of those dollars should be retrievable once that is done. The MHP's denied claims rate, 2.03 percent, less than half the statewide rate.

IMPACT OF INFORMATION SYSTEMS FINDINGSI

- The MHP has met four out of five IS Key Components despite going through a change in the EHR.
- Throughout the review, participating staff stated they were receiving helpful training and experiencing open communication with CalMHSA surrounding the implementation of SmartCare. There is confidence that CalMHSA will continue to work with them to meet CalAIM requirements.
- The MHP continues to rely on vendors to provide the IT services necessary for compliance and to provide and improve the care to their members. This strategy seems to work well for them to rely on vendor management for the IT detail work, leaving county management the time to manage the changes and improvements needed.
- The denial claims number and percent related to Medicare Part B billing for CY 2022 has increased compared to last year. The number for this denial code is twice as high and ten percentage points higher compared to last year. This finding indicates an opportunity to address lost revenue in this area.

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 includes CPS data results in the QAPI document that is posted on the website. However, this information is not easily located by a search and not available upfront on the website.

PLAN MEMBER/FAMILY FOCUS GROUP

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 one 90-minute focus group with MHP members containing 10 to 12 Spanish speaking participants.

The focus group was held virtually and included four participants; a language interpreter was used for this focus group. All consumers participating receive clinical services from the MHP. All received services within the past 12 months.

Summary of focus group findings

- Time to first service for most participants was one week except for one where this was a month. The majority received appointment reminders for therapy. None of the participants currently see a psychiatrist. One member is prescribed medication by their primary care provider.
- All participants mentioned that staff understand their cultural needs, and they receive services from a bilingual therapist. Information brochures are available in Spanish. Regarding transportation services, transportation information was given to the members at the start of services. The participants receive transportation for their appointments by van or bus tokens. None of the participants reported having transportation issues.
- Participants were aware of how to request a change of psychiatrist or therapist if they had a concern or problem. This information was offered by the therapist.

- All participants shared that their family could talk to the provider and be involved in their treatment. Members are given a choice of appointments either by phone, video or in person. All preferred in-person and expressed this was more personal.
- Members receive reminder calls. If an appointment is missed, the provider calls to reschedule. Participants mentioned they call on their own as well when they miss an appointment.
- All participants were given information about the warmline and crisis numbers, including the 24/7 access line. They are aware of these resources. Members completed satisfaction surveys but did not hear about the results. However, they mentioned that they saw positive changes following the surveys.
- Participants utilize the Oak Wellness Center and appreciate the activities. They are made aware of the wellness activities by their therapist.
- One member received housing support when they had the need. None of the participants were aware of any opportunity to be on any committees and did not receive invitations to participate and share their input. However, all felt they could share their input with their treatment team. SUD services were not a part of the discussion as none of the members had any substance use issues.
- All participants report that they are happy with the services they receive and have a sense of hope and recovery.

Recommendations from focus group participants included:

- Participants were pleased with the service they received. The only recommendation given was to publicize the services offered so that more members who need these services can access and benefit.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Overall, the adult plan members who participated found services to be culturally responsive, accessible, and helpful. They appreciated the opportunities for wellness activities and support from their treatment team.

They recommended that more members could benefit from the services offered by MHP if the MHP could publicize their services. They noted that not all members have access to the website and using other ways to outreach would be helpful to connect and engage those in need of the services.

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 has a strong collaboration with managed care plans, contractors, and community partners that includes schools, community-based organizations, and other stakeholders. Examples include the input of 960 voices for the Mobile Crisis Community Planning and the Community Solutions workgroup for the homeless collaborative.
2. Translated information materials and interpreter services are easily available for plan members with no barriers. The MHP has the capacity for bilingual staff that meets the needs of the Spanish speaking members. The cultural humility survey results indicate high satisfaction rates in this area and overall cultural responsiveness of the MHP.
3. The MHP has a robust QI process that focuses on CQI in several areas. The QAPI trends critical timeliness and quality metrics including medication monitoring and outcome measures. The CANS dashboards presentation is impressive and the MHP uses data for important decision making.
4. The MHP's post-discharge follow-up rates for the 7-day and 30-day are higher than the rates for the state and similar sized counties demonstrating a streamlined coordination of care compared to other MHPs which may be struggling in this area.
5. The MHP choice to use qualified outside vendors for their IT needs has proven to be a strength. It has freed up county employees' time to research what is working and not working to make the necessary changes to have low claim denials, outreach to the community, and to have bilingual front-line providers. They are working with these vendors to find ways to get timely critical data to improve their services.

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP's timeliness metrics related to first offered non-urgent appointments for adults and children are reflective of delays to access to care. While the MHP shared provider-specific data related to children during the last two quarters of FY 2022-23 that was positive, it is yet to be determined if the improvement is sustained.

2. The MHP has struggles with timely first offered non-urgent psychiatry appointments and first offered urgent appointments for children.
3. The Oak Wellness center offers multiple wellness activities to members. However, there is a requirement for referral that limits members' access to the wellness activities which could be very beneficial.
4. The MHP does not share the results of the CPS and other surveys such as the cultural humility survey with the members. The CPS results are presented in the QAPI plan that is posted on the website. However, this information is not available upfront and not easy to access. Results are presented to the taskforce members and QIC, but neither of these committees include members.

RECOMMENDATIONS

1. Track, report, and evaluate timeliness of first offered non-urgent appointments for adults and children and implement strategies to improve timeliness. (Timeliness)
2. Track, report, and evaluate timely access to care for children in two areas – timeliness of first offered non-urgent appointments for psychiatry and first offered urgent appointments. Implement strategies to address the challenges with timely access to care for children in these two areas. (Timeliness)
3. Improve access to the Oak Wellness Center for all members and remove current restrictions that require a referral. (Access)
4. Share findings from CPS and other satisfaction surveys conducted to plan members in a format that is easy to access and understand and include plan members in committees such as QIC and CHTF to receive their input. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers to this FY 2023-24 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: CalEQRO Claims Data Definitions

ATTACHMENT F: Letter from 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 – Kings 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
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 Well-Being (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Clinical Line Staff Group Interview
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
Information Systems Capabilities Assessment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Naga Kasarabada, Quality Reviewer
Christy Horman, Quality Reviewer
Pamela Springer, IS Reviewer
Gloria Marin, Senior 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 videoconference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Amial-Cota, LMFT	Yadira	Children's System of Care Clinical Program Manager	Kings County Behavioral Health
Bernal	Diane	Adults System of Care Unit Supervisor	Kings County Behavioral Health
Brisky, LMFT	Amy	Quality Assurance Clinician	Kings County Behavioral Health
Campbell	Ryan	Business Applications Specialist	Kings County Behavioral Health
Casillas, LMFT	Tracey	TURN BHS KIND Center Program Manager	TURN Behavioral Health Services (BHS)/Mental Health Services (MHS)
Garcia	Hilda	Patient Rights Advocate	Kings County Behavioral Health
Lewis, PhD, LMFT	Lisa	Director	Kings County Behavioral Health
Lowe	Desarine	Community Outreach Specialist/Cultural Competency	Kings County Behavioral Health
Lupkes	Christi	Deputy Director of Administrative Services	Kings County Behavioral Health
Lynn, LMFT, LPCC	Nora	Assistant Regional Clinical Director	Kings View
Moreno	Rose	Fiscal Specialist	Kings County Behavioral Health
O'Brien, APCC	Herschel	Children's FSP Program Clinical Supervisor	Aspiranet
Ortiz, LMFT, LPCC	Polo	Adult System of Care Manager	Kings County Behavioral Health
Rangel	Monica	Quality Assurance Specialist	Kings County Behavioral Health
Rivas, LMFT	Christee	Children's Core Program Director	Aspiranet
Rogers	Lisa	Regional Clinical Director	Kings View
Ruffo	Sara	Unit Supervisor, MOST Medical Suite	Kings County Behavioral Health
Stack, MFT	Samantha	TURN/MHS ACT Program Manager	TURN Behavioral Health Services (BHS)/Mental Health Services (MHS)

Last Name	First Name	Position	County or Contracted Agency
Tafolla	Laura	Fiscal Analyst	Kings County Behavioral Health
Verhaege	Amanda	Contracts Manager	Kings County Behavioral Health
Verhaege	Chris	IT Office Systems Analyst	Kings County IT
Williams	Kaile	Quality Assurance Specialist	Kings County Behavioral Health
Woolman	Brett	FURS Program Manager	Aspiranet

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	Currently, the validation of this PIP is based on the structure and not on the data analysis and evaluation. While the PIP focuses on the FUM rates which are critical areas for PIP development, the FUM rates for this MHP are higher than the state and national benchmarks. The data analysis and review indicate no barriers identified to post discharge follow up. The current topic chosen for the PIP does not indicate a problem and is thus rated low confidence. There are other critical areas such as first offered urgent appointments for children and first offered non-urgent psychiatry appointments for children that indicate challenges with timely access to care for children and warrant performance improvement.

General PIP Information
MHP/DMC-ODS Name: Kings
PIP Title: Follow-Up After Emergency Department Visit for Mental Illness (FUM)
PIP Aim Statement: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5% by June 30, 2024.
Date Started: 08/2023
Date Completed: 08/2025
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): Members between the ages of 6-17 made up 27.1% of the ED visits and those in the age range of 18-64 made up 72.9% of ED visits. About 89% of the ED visits had beneficiaries that spoke English with 11.1% of them speaking Spanish, and 0.3% being Unknown. The Hispanic population were 46.1% of the ED visits with 33% being White, 9.2% Unknown, and 6.9% were African American. Asian/Pacific Islanders and Other made of 2.3% or less each.
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): Implement a post-discharge follow-up system to ensure beneficiaries are scheduled for appointments within specified time frames.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Establish a better working relationship with Adventist to increase awareness of outliers that are hospitalized and discharged
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): Create a referral log to keep track of beneficiaries to ensure linkage to MH services.

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
		☒ Not applicable—PIP is in Planning or implementation phase, results not available	J		☐ 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: Currently, the validation of this PIP is based on the structure and not on the data analysis and evaluation. While the PIP focuses on the FUM rates which are critical areas for PIP development, the FUM rates for this MHP are higher than the state and national benchmarks, and the data analysis and review indicate no barriers identified to post discharge follow up. The ATA report for FY 2022-23 indicates higher rates compared to CY 2021. In the area of timeliness for first offered urgent appointments for children, only 45% meet the standard for timeliness (48 hours) compared to 83% for adults. The first offered non-urgent psychiatry appointment for children is at 55% (15 business days) standard compared to 99% for adults. These indicate potential areas for improvement related to timely access for children and indicate a greater need than the current PIP topic that indicates much higher rates of performance. The current topic chosen for the PIP does not indicate a problem and the recommendation is to focus on the areas suggested that indicate a problem. EQR discussed these areas during the review and suggested the MHP to follow up with a TA call for the new PIP.

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	The PIP has improved the percent urgent conditions identified from 2.7 percent for the baseline measurement to 7.1 percent at the second remeasurement that resulted from the consistent implementation of a standardized Urgent Condition Triage tool. The MHP did not conduct statistical analysis to determine the significance. Thus, moderate confidence is selected. The other measures that did not demonstrate improvement and will likely be responsive to other interventions that target barriers to timely access such as improving capacity and ensuring member compliance with showing up for appointments.

General PIP Information
MHP/DMC-ODS Name: Kings
PIP Title: Urgent Conditions (at Intake)
PIP Aim Statement: Will the implementation of a standardized process for identifying, responding to, and tracking urgent conditions among all new beneficiaries requesting specialty mental health services lead to timelier access to appropriate services over a twelve-month time period during FY 2022-23?
Date Started: 07/2020
Date Completed: 12/2023
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): All members at intake, who request services and present with an urgent condition.
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): Click or tap here to enter text.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Training of staff to urgent care operational criteria and the use of an urgent care triage tool which provides greater structure to the process.
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): Implement a Standardized process (definition) for identifying urgent conditions through MHP calls and walk-ins by using a triage tool for urgent conditions

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
1. # of new beneficiaries identified with urgent condition	December 2019-May 2020	Of 732 new beneficiaries, 20 (2.73%) were identified as an urgent	July 2022-June 2023	Of 2139 new beneficiaries, 152 (7.11%) were identified as an urgent condition	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Statistical analysis was not conducted.

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
2. # of new beneficiaries who received crisis services w/in 3 months prior to but were not identified as urgent condition upon initial access	December 2019-May 2020	13 members who accessed services had previous crisis contact but were not identified as urgent condition upon initial access.	July 2022-June 2023	136 beneficiaries who accessed services had previous crisis contact but were not identified as urgent condition upon initial access.	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):Statistical analysis was not conducted.
3. Time (Hours) from identification to initial treatment/service	December 2019-May 2020	Mean: 61.20 Median: 36 Std. Dev: 83.65 Standard Met: 65% Range: 0-360	July 2022-June 2023	Mean: 156.13 Median: 48.00 Std. Dev: 239.99 Standard Met: 52.69% Range: 0-1656	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Statistical analysis was not conducted.

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.

PIP Validation Information
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: The MHP's addition of an Urgent Condition Triage Tool, and the enhanced structure has demonstrated an increase in the number of urgent conditions identified. As this PIP is concluding following this review (December 2023), recommendations for improvement would not be executable within the framework of a PIP. The MHP will benefit from continuing the use of this tool and working on strategies to improve timely access for those with urgent conditions seeking services as no improvement was noted in timely access for urgent conditions. The EQR team suggested the MHP to review problem areas for a new PIP and to schedule a TA call.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required as part of this report.