KINGS COUNTY
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Mental Health • Prevention and Early Intervention• Substance Use Disorders Prevention and Treatment

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Kings County

Behavioral Health

Quality Assessment & Performance Improvement (QAPI) Work Plan

FY 2024-2025

with

FY 2023-2024

Evaluation

The Quality Assessment & Performance Improvement (QAPI) Work Plan is a required element of the Quality Management Program, as specified by the State Department of Health Care Services (DHCS) Mental Health Plan (MHP) contract with Kings County Behavioral Health (KCBH), and by the California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.440

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INTRODUCTION

In accordance with the California Code of Regulations (CCR), Title 9, Section 1810.440, Kings County Behavioral Health (KCBH) has a Quality Assurance (QA) Team that performs quality assessment and performance improvement (QAPI) activities pursuant to the Department of Health Care Services (DHCS) Mental Health Plan (MHP) Contract. As part of the required activities, KCBH produces an annual QAPI Work Plan via its Quality Improvement Committee (QIC), which is comprised of County and Contracted Mental Health providers and community and county partners.

The goal of the KCBH QAPI activities is to ensure Kings County beneficiaries have appropriate access to timely, quality specialty mental health services as demonstrated through measurable outcomes.

PURPOSE AND STRUCTURE

Within KCBH's Administration Division is the Quality Assurance (QA) Team, which reports to the KCBH Deputy Director. The KCBH QA Team consists of a QA Manager, a QA Licensed Clinician, a Business Applications Specialist, two QA Specialists, and an Office Assistant.

The purpose of the KCBH QA Team is to establish a written description (QAPI Work Plan) by which the specific structure, process, scope and role of this plan is articulated. Beginning with fiscal year (FY) 2019-2020, significant revision took place to the KCBH QAPI Work Plan due to the transition of Managed Care operation and oversight from its previous County contracted provider to the County. Significant changes were also due to the incorporation of the Managed Care regulatory and reporting changes that occurred with DHCS' implementation of the 'Final Rule' that started in FY 2017-2018 continuing through 2018-2019. As such, starting fiscal year 2019-2020, the KCBH QA Team became the oversight for monitoring performance in the following areas, and began baseline development for future trend analysis:

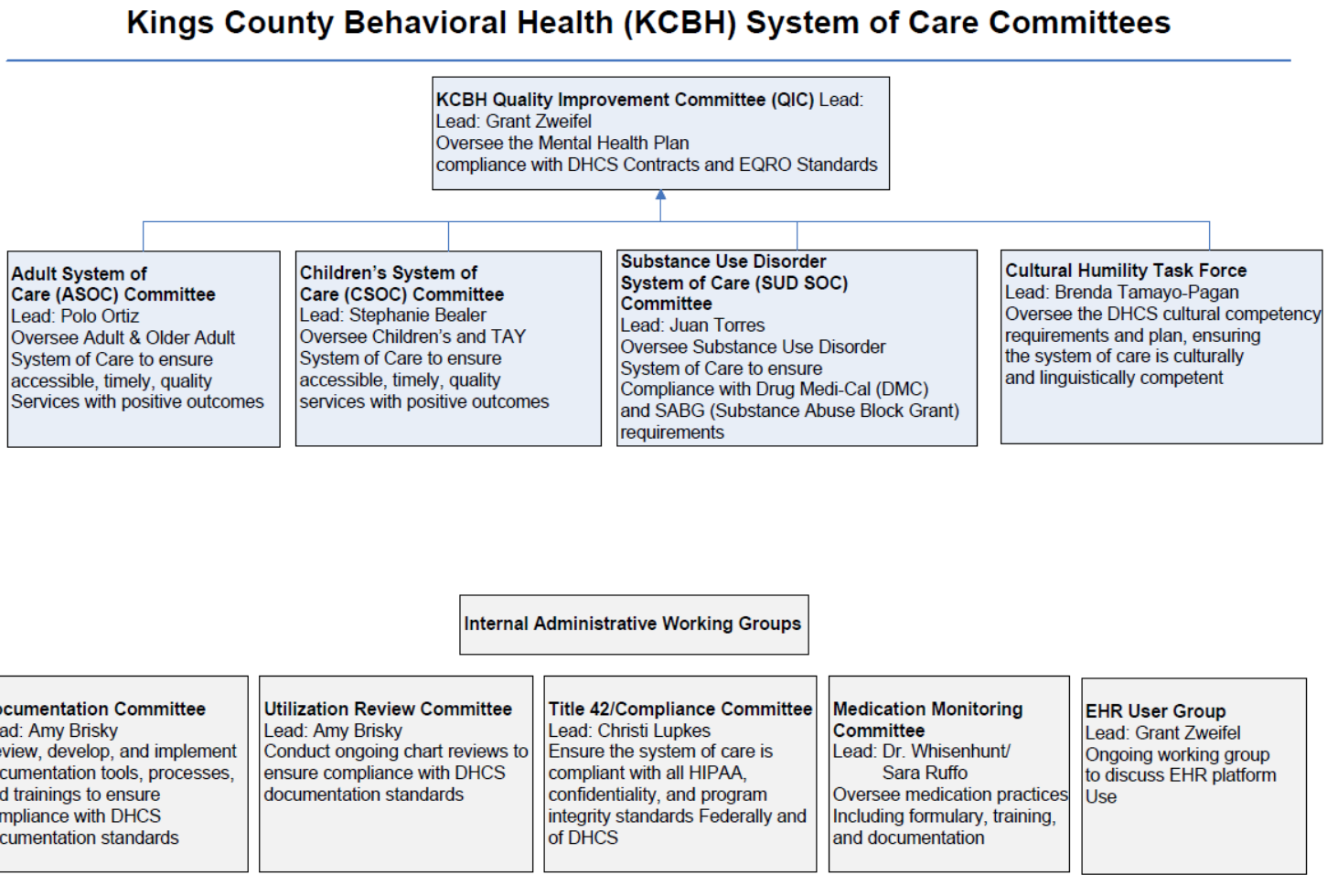
- Beneficiary and System Outcomes
    - Beneficiaries Served and Demographics
    - Timeliness of Services
    - 24/7 Access Line
    - ANSA data
    - CANS/PCS-35 Data
    - Consumer Perception Survey
    - Discharge Disposition
- Utilization Management and Utilization Review
    - Service Utilization (over- and under-utilization)
    - Claims Data
    - Engagement Rates
    - No-Show Rates
    - Chart Review
    - Medication Monitoring
    - Hospitalization Rate

- Provider Network Adequacy, Credentialing, and Monitoring
  - Network Adequacy Provider Counts
  - Time and Distance Standards
  - Provider (Re)Credentialing
- Beneficiary Protections
  - Grievances
  - Appeals
- Cultural and Linguistic Competency
  - Cultural Competency Training
  - Language Access Utilization
  - Community Outreach

Metric development is done on a continuous basis as these measures continue to be designed. Monitoring is conducted quarterly for the metrics developed and are reviewed and discussed at the KCBH Quality Improvement Committee (QIC). The measures are reconciled at fiscal year end into an annual evaluation of the QAPI Work Plan for use in development of the proceeding fiscal year annual QAPI Work Plan update.

COMMITTEES

Kings County Behavioral Health has several committees that comprise the structure of oversight to the Behavioral Health System of Care. While some are specific to the operations of QA Unit, the workflow below depicts the larger oversight of key committees.



PRIOR YEAR EVALUATION AND NEW YEAR FOCUS AREAS

KCBH evaluated the performance of the measures outlined within the fiscal year (FY) 2023-2024 MHP QAPI Work Plan and presented the results at the December 10, 2024 Quality Improvement Committee. Below is the summary of the results of that evaluation, as well as the focus areas identified for the FY 2024-2025 QAPI Work Plan.

FY 2023-2024 EVALUATION SUMMARY

Kings County Behavioral Health Mental Health Plan met the following goals in FY 2023/2024:

- Met and exceeded state's timely access among first access to medication services and follow-up appointments post psychiatric hospitalization.
- Met and exceeded the state's timeliness to first offered SMHS appointment.
- Satisfaction rating of 4.46 (out of 5) among adults clients and 4.12 (out of 5) among child/youth clients and caregivers/parents.
- Hospital 30-day readmission rate remains below 10%.
- Network adequacy certification for provider ratios met state standards.
- Met and exceeded 90% compliance standard for medication monitoring.
- Network adequacy certification for provider ratios met state standards.

Below is a summary of the MHP's goals and outcomes detailed further within this Plan.

- ***Services are Accessible:*** ***Data not available***
    - *Due to changes in the state's external quality review organization and review processes in 2024, Kings County Behavioral Health (KCBH) did not have access to the historical Claims Data reports required to fully populate metrics related to the number served, penetration rates, and related breakdowns by age, race/ethnicity, and service type.*

- ***Services are Timely:*** ***Goal partially met***
  (Timeliness among 1st request and urgent conditions is outside state standards)
    - ***Timeliness among first entry into medication support services and re-entry from post-psychiatric hospitalization remains timely.*** *First entry into medication support services took on average 8.67 business days with 89% of all referrals meeting state standard of 15 business days, and the average length of re-entry post-psychiatric hospitalization took on average 4.29 calendar days with 88% meeting the HEIDIS standard of 7 calendar days.*
    - ***Timeliness from first request for specialty mental health services to first offered appointment*** *remain above the state standard (10 business day/80% met) landing at*

5.19 business days on average with 89% of all requests meeting the 10-business day standard. Timeliness from first request for specialty mental health services to first rendered services land at 9.80 business days on average with only 73% of all requests meeting the 10-business day standard.

- ***Timeliness for entry into services for those experiencing an urgent condition*** *is on average 73.64 hours (3.07 days) with 65.83% meeting the state's 48-hour (2 days) timeliness standard.*

- ***Services are of Quality to Consumers:*** ***Goal partially met***
  (Quality of Life domain in consumer perception survey remains just below 4.0 on the satisfaction scale of 1-5 with 5 being most satisfied)
  - ***For the May 2023 Consumer Perception Survey, satisfaction among caregivers and youth consumers was generally positive, with a total satisfaction rating of 4.12 (out of 5) based on completed responses.*** *This included ratings of 4.18 (83.94%) for service understanding, 4.25 (87.34%) for perceived quality of services, and 3.85 (71.57%) for accessibility. Satisfaction among adult and older adult consumers was also positive, with a total satisfaction rating of 4.46 (86.93%) based on completed responses. This included ratings of 4.10 (79.03%) for service understanding, 4.26 (82.14%) for perceived quality of services, and 3.87 (65.76%) for accessibility.*

- ***Services Produce Measurable Outcomes:*** ***Insufficient data for measuring***
  - ***While in prior year reports, children experienced a 70% reduction in actionable treatment needs*** *per the measurement comparison of the initial Child Adolescent Needs and Strengths (CANS) assessment at time of entry with the CANS completed at discharge, in FY 23/24 the MHP was unable to pull this report due to conversion to a new electronic health records (EHR) system.*
  - ***The Adult Needs and Strengths Assessment (ANSA) dashboard has not yet been developed.***

- ***Services are Appropriately Delivered:*** ***Goal partially met***
  (Number of beneficiaries receiving one SMHS remain well above that of the State, and hospitalizations continue to increase)
  - *Due to changes in the state's external quality review organization and review processes in 2024, Kings County Behavioral Health (KCBH) did not have access to the historical* ***Claims Data*** *reports.*
  - ***Grievances decreased*** *with no identified pattern or trend.*

- ***Appeals experienced an increase.*** *This 23/24 fiscal year saw an 80% increase in appeal requests from FY 22/23 (from 5 appeal requests to 8 requests). However, due to the small sample size, this change is not significant.*
- ***Hospitalizations*** *experienced an increase of 23%, and readmissions within 30-days experienced an increase most notably among children's, although still under 10% readmission rate.*

- ***There is an Adequate Network of Providers:*** ***Goal Met***
  - *As of 2019, the MHP provider network significantly increased, and as such* ***received certification by DHCS during the 2019, 2020, 2021, 2022, and 2023 annual submission as meeting network adequacy*** *for provider ratio. This includes a children's reserve capacity contract.*

- ***Services are Documented in Accordance with State Standards:*** ***Goal Partially Met***
  - ***Chart review*** *compliance fell below the 90% compliance rate goal in total (84.42%), but medication monitoring compliance was (91.86%).*

- ***Services and Workforce are culturally and linguistically competent:*** ***Insufficient data for measuring***
  - *Data limitations have historically made it difficult to create meaningful measurements; however, the MHP will be leveraging the new EHR and Relias platform to improve data collection and develop meaningful metrics for Language Line utilization and cultural competency training in FY 24/25.*

FY 2024-2025 FOCUS AREAS FROM FY 2023-2024 EVALUATION

For FY 2024-2025, Kings County Behavioral Health (KCBH) is building on the progress made during FY 2023-2024. A major milestone achieved was the successful conversion to the CalMHSA-hosted Streamline SmartCare electronic health records (EHR) system, replacing the Kings View-hosted Cerner Anasazi system as of July 1, 2023. To ensure continued access to historical data, the department has also established hosting for its legacy EHR system.

The focus for FY 2024-2025 includes several key initiatives aimed at improving data capabilities and reporting:

- **Enhancing EHR Data Collection Capabilities**:
  - Improve data collection processes within the new EHR system to support robust quality assurance reporting.
  - Ensure key metrics are accurate and readily available to facilitate data-driven decision-making.
- **Developing Alternate Data Sources**:
  - Address the loss of specific data previously provided by Behavioral Health Concepts (BHC), the State's former external quality review organization.
  - Prioritize the development of data sources for key areas, including:
    - Clients served, broken down by demographics.
    - Penetration rates.
    - Claims data related to clients served and services provided.
- **Advancing Reporting and Dashboards**:
  - Collaborate with a data/reports consultant to develop dashboards and reports for:
    - Child and Adolescent Needs and Strengths (CANS).
    - Adult Needs and Strengths Assessment (ANSA).
    - No-show rates.
    - Discharge disposition trends.
    - Network adequacy monitoring.
- **Improving Consumer Perception Surveys**:
  - Implement methods to reduce incomplete or missing responses in consumer perception surveys.
- **Integrating CertifyOS Provider Certification Dashboard**:
  - Leverage the CertifyOS platform to populate the QAPI Work Plan with meaningful metrics for provider certification and recertification processes.

These focus areas will ensure KCBH continues to enhance data collection and reporting capabilities while addressing key quality improvement priorities for FY 2024-2025.

CURRENT YEAR PERFORMANCE MONITORING

KCBH will monitor performance of the aforementioned measures in a meaningful method that includes goals, objectives, indicators/measures, measurement and interpretation. It is the intent that these measures will be tracked over each fiscal year to identify any patterns or trends that reveal areas of success and areas of improvement needed.

GOAL 1: BENEFICIARY AND SYSTEM OUTCOMES

Kings County MHP will provide accessible, timely, quality services that produce measurable results in promoting and sustaining wellness, recovery, and resiliency among individuals with serious emotional disturbances (SED) and severe mental illness (SMI).

OBJECTIVE 1.1: SERVICES ARE ACCESSIBLE

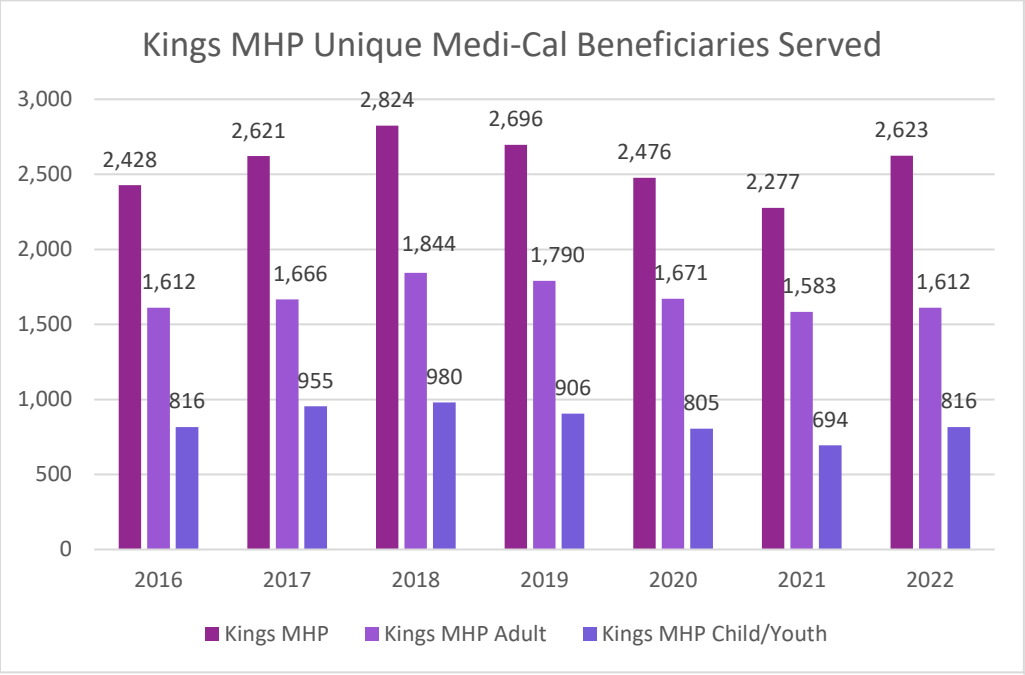
INDICATOR: COUNT AND PENETRATION RATES OF CONSUMERS SERVED, ALL AND BY AGE GROUP

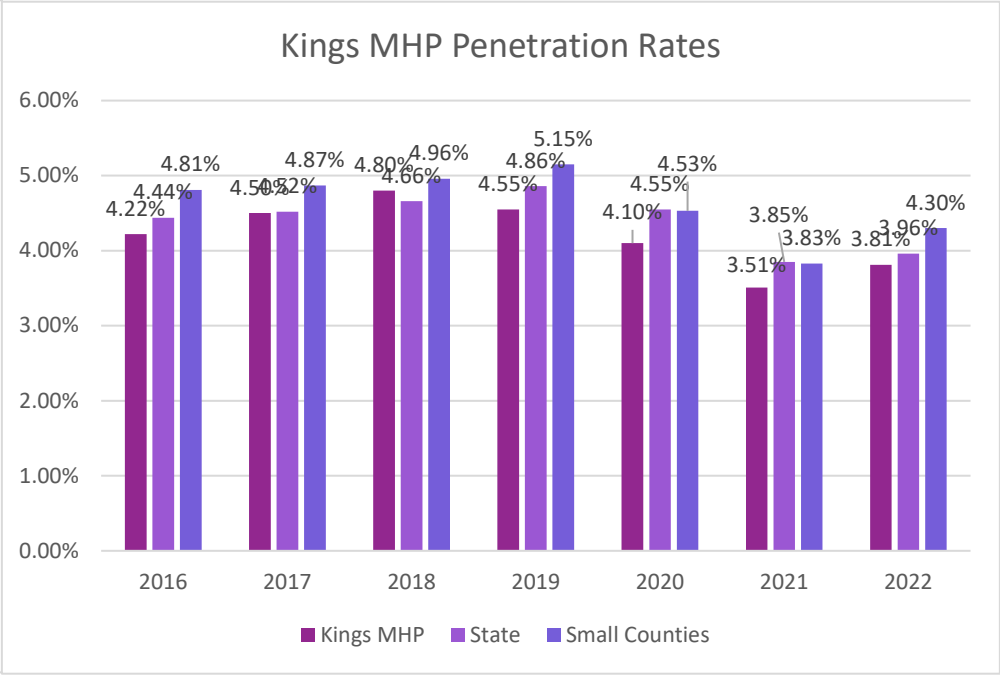
ANALYSIS: Due to changes in the state's external quality review organization and review processes in 2024, Kings County Behavioral Health (KCBH) did not have access to the historical Claims Data reports required to fully populate metrics related to the number served, penetration rates, and related breakdowns by age, race/ethnicity, and service type. KCBH is actively working with the state and the county's electronic health record (EHR) vendor and host to address these data gaps to ensure the timely and accurate reporting of these metrics in future QAPI Work Plans.

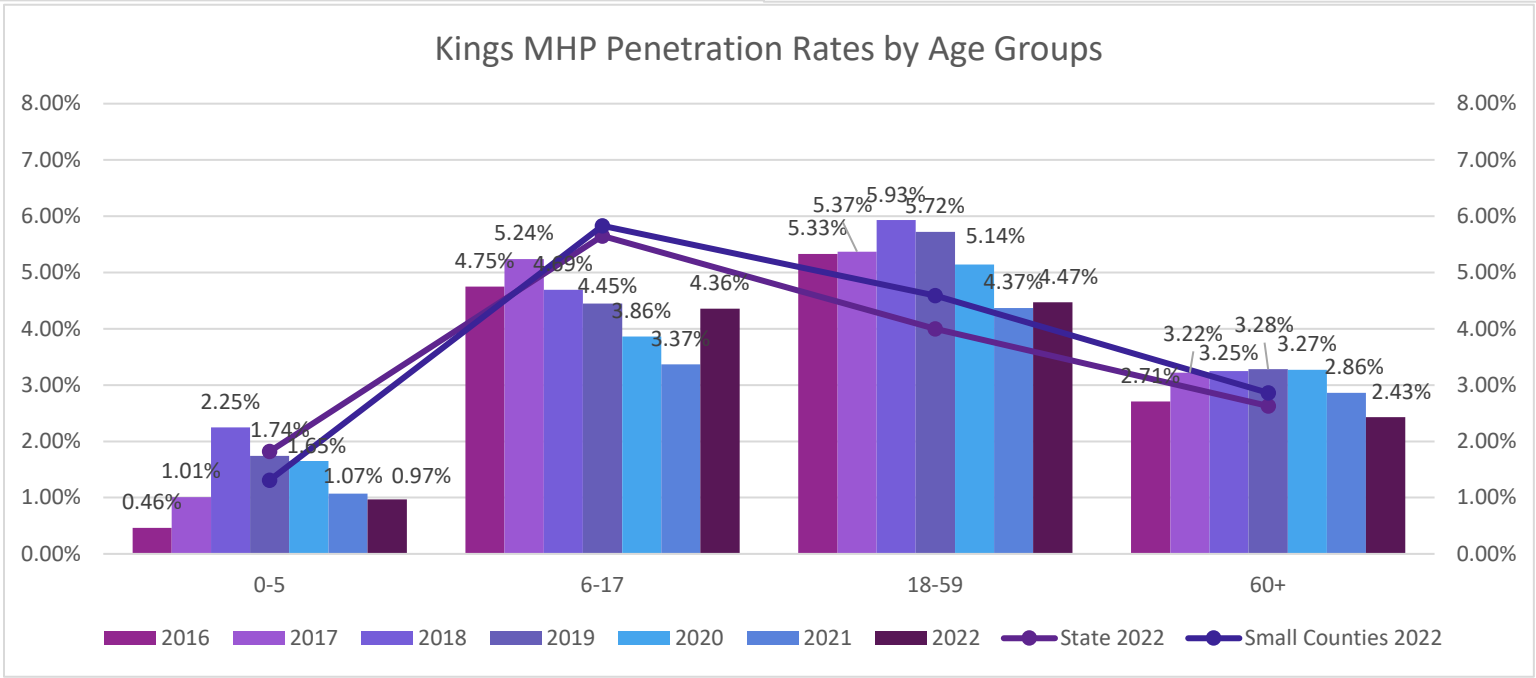
ACTION: Despite current data limitations, KCBH is committed to meeting the accessibility needs of our community and addressing historical disparities. Future QAPI reports will reflect updated metrics and an evaluation of progress once access to the necessary data is restored.

PRIOR YEAR ACTION AND RESULT: The low penetration rate among children ages 6-17 continued to be a focus of the KCBH Children System of Care Committee during fiscal year 2020/21 & 2021/22. During 2020/21 discussion, it was noted that with the reopening of schools post-COVID closure, school-based mental health services and referrals would be reinvigorated, and as such this measure was monitored for progress with impact anticipated in 2022 and beyond which per the 2022 claims data proved true. While data for 2023 was unavailable, the trends observed in 2022 suggested a continued recovery in service accessibility following the initial impacts of COVID-19. The number of individuals served increased by 15% across all ages and by 33% among 6- to 17-year-olds from 2021 to 2022.

Unique Count of Medi-Cal Beneficiaries & Penetration Rates, by Age Group, Receiving SMHS *(with at least one approved claim)*







INDICATOR: CONSUMER SERVED AND PENETRATION RATE BY RACE/ETHNICITY

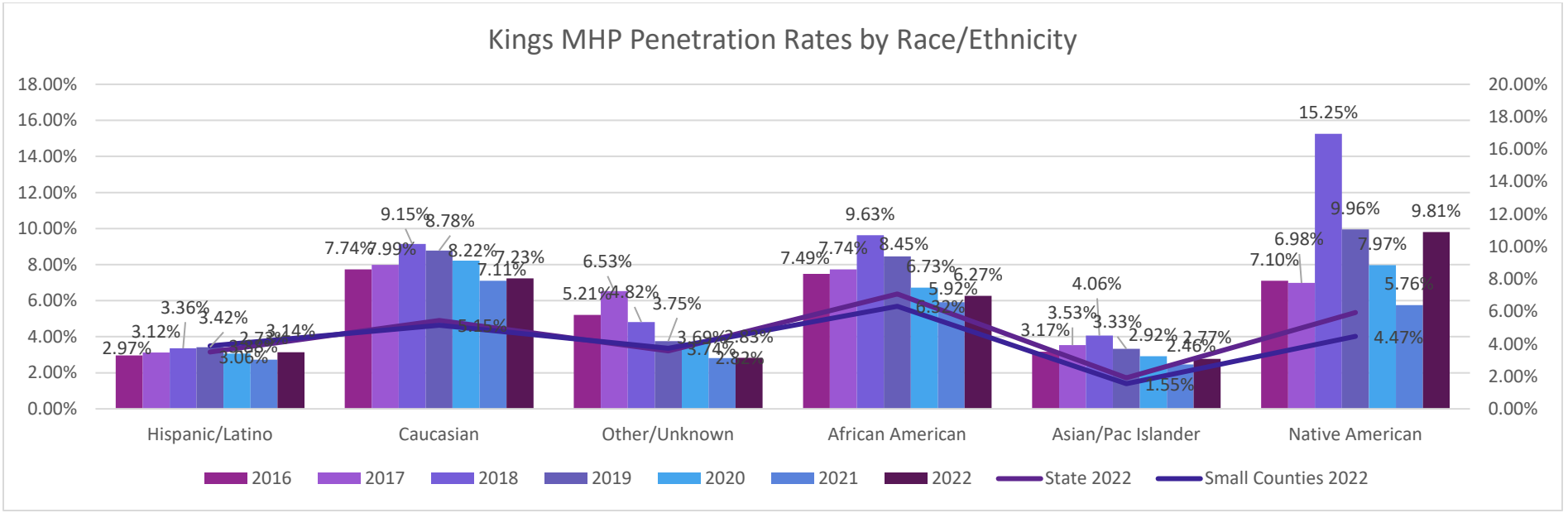
ANALYSIS: Due to changes in the state's external quality review organization and review processes in 2024, Kings County Behavioral Health (KCBH) did not have access to the historical Claims Data reports required to fully populate metrics related to the number served, penetration rates, and related breakdowns by age, race/ethnicity, and service type. KCBH is actively working with the state and the county's electronic health record (EHR) vendor and host to address these data gaps to ensure the timely and accurate reporting of these metrics in future QAPI Work Plans.

ACTION: Despite current data limitations, KCBH is committed to meeting the accessibility needs of our community and addressing historical disparities. Future QAPI reports will reflect updated metrics and an evaluation of progress once access to the necessary data is restored.

PRIOR YEAR ACTION AND RESULT: The MHP increased media campaigns and outreach in 2021/22 and 2022/23 to ensure the public was aware services were open and available to include telehealth options. It was anticipated any increase based on outreach would be seen potentially in 2022 claims data. The 2022 claims data has shown increased access in services, most notably among the Hispanic/Latino and Native American populations. Although data for 2023 was unavailable, trends observed in 2022 indicated a continued recovery, with service penetration rates improving from 3.51% in 2021 to 3.81% in 2022. The most notable increases were among Hispanic/Latino populations, which saw a 22% rise in individuals served.

Unique Count of Medi-Cal Beneficiaries & Penetration Rates, by Race/Ethnicity, Receiving SMHS *(with at least one approved claim)*

FY	Hispanic/ Latino Count/%	Pene. Rate	Caucasian Count/%	Pene. Rate	Other Count/%	Pene. Rate	African American Count/%	Pene. Rate	Asian/Pac. Islander Count/%	Pene. Rate	Native American Count/%	Pene. Rate
2016	1,133/47%	2.97%	772/32%	7.74%	253/10%	5.21%	204/8%	7.49%	53/2%	3.17%	13/.05%	7.10%
2017	1,205/46%	3.12%	779/30%	7.99%	366/14%	6.53%	212/8%	7.74%	44/2%	3.53%	15/.06%	6.98%
2018	1,316/47%	3.36%	866/31%	9.15%	294/10%	4.82%	262/9%	9.63%	50/2%	4.06%	36/1%	15.25%
2019	1,352/50%	3.42%	816/30%	8.78%	236/9%	3.75%	228/9%	8.45%	40/1%	3.33%	24/.09%	9.96%
2020	1,227/50%	3.06%	752/30%	8.22%	262/11%	3.69%	179/7%	6.73%	36/1%	2.92%	20/0.8%	7.97%
2021	1,161/51%	2.73%	669/29%	7.11%	240/11%	2.82%	160/7%	5.92%	33/1%	2.46%	14/1%	5.76%
2022	1,411/54%	3.14%	691/26%	7.23%	282/11%	2.83%	174/7%	6.27%	39/1%	2.77%	26/1%	9.81%


Kings MHP Penetration Rates by Race/Ethnicity
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
20.00%
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
2.97%
3.12%
3.36%
3.42%
3.06%
3.14%
7.74%
7.99%
9.15%
8.78%
8.22%
7.11%
7.23%
6.53%
5.21%
4.82%
3.75%
7.49%
7.74%
9.63%
8.45%
6.73%
5.92%
6.27%
3.17%
3.53%
4.06%
3.33%
2.92%
1.55%
2.46%
2.77%
7.10%
6.98%
15.25%
9.96%
7.97%
5.76%
9.81%
4.47%
Hispanic/Latino
Caucasian
Other/Unknown
African American
Asian/Pac Islander
Native American
2016
2017
2018
2019
2020
2021
2022
State 2022
Small Counties 2022

INDICATOR: UTILIZATION OF 24/7 ACCESS LINE

Metric to be developed

OBJECTIVE 1.2: SERVICES ARE TIMELY

INDICATOR: TIMELINESS OF FIRST ENTRY FOR CLINICAL SERVICE, NON-URGENT CONDITION

ANALYSIS: For FY 23/24, we were unable to obtain a full year of data due to the Electronic Health Record (EHR) conversion that happened at the beginning of Q1 and into Q2 and the unavailability of certain reports that were typically accessible in prior years. However, even with the data limitation, the length of time from initial request for service first offered service was an average of 5.19 business days for all ages of which 89% met the 10 business day DHCS standard. Additionally, the length of time from initial request for service to first kept appointment was an average of 9.80 business days for all ages of which 73% met the 10-business day DHCS standard.

ACTION: With ongoing updates and changes to the EHR, better data tracking will occur for the coming fiscal year to ensure accurate data reporting.

PRIOR YEAR ACTION AND RESULT: A Performance Improvement Project (PIP) for timeliness was in effect to focus on addressing timeliness for services. Despite the results of a performance improvement project, the lack of comprehensive data for the current period limits our ability to draw direct comparisons or assess trends in the same manner as in prior years. However, for FY 22/23, all areas were in compliance with DHCS standards for timeliness.

1ST REQUEST FOR SERVICE TO 1ST OFFERED APPOINTMENT (IN BUSINESS DAYS)–DHCS Standard: 10 Bus. Days/80% of Appts Must Meet Std

	All Services	Adult Services	Children's Services	Foster Care
FY 18/19	4.68 Mean 1 Median 7.28 Std Dev. 95% Met Std	2.27 Mean 1 Median 8.15 Std Dev. 98% Met Std	2.88 Mean 1 Median 6.20 Std Dev. 90% Met Std	8.91 Mean 7 Median 7.51 Std Dev. 70% Met Std
FY 19/20	1.61 Mean 0 Median 5.30 Std Dev. 96% Met Std	1.15 Mean 0 Median 4.54 Std Dev. 96% Met Std	2.47 Mean 0 Median 6.38 Std Dev. 92% Met Std	8.42 Mean 7.5 Median 8.17 Std Dev. 67% Met Std
FY 20/21	7.5 Mean 6 Median 1-82 Range 79% Met Std	6.3 Mean 5 Median 1-52 Range 83% Met Std	9.5 Mean 8 Median 1-82 Range 71% Met Std	8.7 Mean 8 Median 2-23 Range 75% Met Std
FY 21/22	15.04 Mean 13 Median 11.18 Std Dev 1-114 Range 43% Met Std	12.57 Mean 11 Median 10.89 Std Dev 1-114 Range 50% Met Std	17.26 Mean 17 Median 10.97 Std Dev 1-63 Range 36% Met Std	13.93 Mean 9.50 Median 9.79 Std Dev 1-37 Range 53% Met Std
FY 22/23	14.68 Mean 12 Median 1-78 Range 46% Met Std	11.68 Mean 11 Median 1-76 Range 48% Met Std	17.49 Mean 12 Median 1-78 Range 45% Met Std	20.89 Mean 15 Median 1-77 Range 35% Met Std
FY 23/24	5.19 Mean 4.00 Median 1-19 Range 89% Met Std	2.95 Mean 2.00 Median 1-13 Range 99% Met Std	7.54 Mean 8.00 Median 1-19 Range 77% Met Std	8.22 Mean 10 Median 1-12 Range 78% Met Std

1ST REQUEST FOR SERVICE TO 1ST KEPT APPOINTMENT (IN BUSINESS DAYS)–DHCS STANDARD: 10 BUS. DAYS/80% OF APPTS MUST MEET STD

	All Services	Adult Services	Children's Services	Foster Care
FY 18/19	2.59 Mean 1 Median 8.34 Std Dev. 92% Met Std	2.43 Mean 1 Median 8.97 Std Dev. 97% Met Std	2.99 Mean 1 Median 6.61 Std Dev. 83% Met Std	15.13 Mean 11 Median 13.45 Std Dev. 34% Met Std
FY 19/20	6.35 Mean 2 Median 12.19 Std Dev. 82% Met Std	5.97% Mean 1 Median 13.09 Std Dev. 85% Met Std	7.10 Mean 4 Median 10.14 Std Dev. 77% Met Std	10.05 Mean 9 Median 8.22 Std Dev. 54% Met Std
FY 20/21	10.2 Mean 7 Median 1-275 Range 71% Met Std	7.5 Mean 6 Median 1-61 Range 80% Met Std	13.7 Mean 9 Median 1-275 Range 76% Met Std	13.8 Mean 12 Median 2-54 Range 80% Met Std
FY 21/22	17.25 Mean 14 Median 14.85 Std Dev 1-114 Range 40% Met Std	15.70 Mean 12 Median 15.58 Std Dev 1-114 Range 45% Met Std	18.96 Mean 17 Median 13.79 Std Dev 1-85 Range 34% Met Std	17.54 Mean 14 Median 14.10 Std Dev 2-57 Range 44% Met Std
FY 22/23	18.73 Mean 14 Median 1-144 Range 39% Met Std	12.15 Mean 11 Median 1-76 Range 48% Met Std	23.40 Mean 16 Median 1-120 Range 33% Met Std	33.74 Mean 25 Median 1-144 Range 19% Met Std
FY 23/24	9.80 Mean 5.00 Median 1-115 Range 73% Met Std	3.75 Mean 3.00 Median 1-34 Range 98% Met Std	16.21 Mean 13.00 Median 1-115 Range 43% Met Std	19.33 Mean 14.00 Median 2-64 Range 33% Met Std

INDICATOR: TIMELINESS OF FIRST ENTRY FOR PSYCHIATRIC SERVICE, NON-URGENT CONDITION

ANALYSIS: For FY 23/24, we were unable to obtain a full year of data due to the Electronic Health Record (EHR) conversion that happened at the beginning of Q1 and into Q2 and the unavailability of certain reports that were typically accessible in prior years. Due to this, there is no accurate or sufficient data to report at this time.

ACTION: With ongoing updates and changes to the EHR, better data tracking will occur for the coming fiscal year to ensure accurate data reporting.

PRIOR YEAR ACTION AND RESULT: A Performance Improvement Project (PIP) for timeliness was in effect to focus on addressing timeliness for services. Despite the results of a performance improvement project, the lack of comprehensive data for the current period limits our ability to draw direct comparisons or assess trends in the same manner as in prior years. However, for FY 22/23, all areas were in compliance with DHCS standards for timeliness.

1ST REQUEST TO 1ST OFFERED PSYCHIATRY APPT (IN BUSINESS DAYS)–DHCS
Standard: 15 Bus. Days/80% of Appts Must Meet Std

	All Services	Adult Services	Children's Services	Foster Care
FY 18/19	20.22 Mean 19 Median 12.37 Std Dev. 38% Met Std	20.50 Mean 19 Median 12.85 StdDev 37% Met Std	18.92 Mean 17 Median 9.45 Std Dev. 47% Met Std	13.00 Mean 15 Median 7.07 Std Dev. 50% Met Std
FY 19/20	14.78 Mean 10 Median 13.39 Std Dev 65% Met Std	15.07 Mean 9.5 Median 14.02 StdDev 64% Met Std	13.52 Mean 10.5 Median 9.87 Std Dev 67% Met Std	13.5 Mean 13.5 Median 10.53 StdDev 50% Met Std
FY 20/21	10.9 Mean 6 Median 1-267 Range 86% Met Std	10.5 Mean 6 Median 1-264 Range 87% Met Std	12.3 Mean 6 Median 2-267 Range 83% Met Std	11 Mean 11 Median 3-19 Range 50% Met Std
FY 21/22	7.63 Mean 5 Median 7.15 Std Dev 1-43 Range 90% Met Std	7.14 Mean 5 Median 6.80 Std Dev 1-43 Range 91% Met Std	10.18 Mean 7 Median 8.34 Std Dev 2-40 Range 86% Met Std	15 Mean 14 Median 8.60 Std Dev 5-26 Range 67% Met Std
FY 22/23	8.67 Mean 7 Median 1-61 Range 89% Met Std	6.50 Mean 6 Median 2-54 Range 99% Met Std	16.99 Mean 13 Median 2-61 Range 86% Met Std	14.82 Mean 17 Median 1-28 Range 45% Met Std

1ST REQUEST TO 1ST KEPT PSYCHIATRY APPT (IN BUSINESS DAYS)–DHCS
STANDARD: 15 BUS. DAYS/80% OF APPTS MUST MEET STD

	All Services	Adult Services	Children's Services	Foster Care
FY 18/19	*Length of time from first request to first kept psychiatry appt is a new measure added to EQRO Timeliness Report in FY 20/21; therefore, data began being measured in 20/21.*			
FY 19/20				
FY 20/21	20.3 Mean 13 Median 2-281 Range 55% Met Std	23.9 Mean 18 Median 2-281 Range 45% Met Std	8.4 Mean 6 Median 2-26 Range 85% Met Std	0 Mean 0 Median 0 Range 0% Met Std
FY 21/22	13.49 Mean 7 Median 15.31 Std Dev 1-82 Range 73% Met Std	13.94 Mean 6 Median 16.15 Std Dev 1-82 Range 71% Met Std	11.36 Mean 9 Median 10.11 Std Dev 2-58 Range 85% Met Std	15 Mean 14 Median 8.60 Std Dev 5-26 Range 67% Met Std
FY 22/23	12.15 Mean 10 Median 2-47 Range 75% Met Std	11.16 Mean 9 Median 2-47 Range 81% Met Std	16.35 Mean 14 Median 2-47 Range 56% Met Std	19.83 Mean 18.50 Median 6-33 Range 75% Met Std

INDICATOR: TIMELINESS OF FIRST ENTRY FOR URGENT CONDITION

ANALYSIS: For FY 23/24, we were unable to obtain a full year of data due to the Electronic Health Record (EHR) conversion that happened at the beginning of Q1 and into Q2 and the unavailability of certain reports that were typically accessible in prior years. This created an issue with reporting for Q1 only. However, even with the data limitation, the length of time from initial request for service for an urgent condition to rendered service where prior authorization was not required was an average of 73.64 hours (3.07 days) for all ages of which 65.83% met the 48-hour DHCS standard.

There is also an area where the MHP is to report on urgent conditions that require prior authorization for service; however, there were none meeting this requirement therefore no data to report.

ACTION: The non-clinical Performance Improvement Project (PIP) aimed at improving the definition, identification, process, and tracking of urgent conditions was successfully completed in October 2023. The intervention focused on standardizing the process for identifying and responding to urgent conditions across the MHP, which was implemented and approved by the Adults System of Care, Children's System of Care, and Documentation committees in October 2021. As a result of the project, a more consistent and timely approach for identifying beneficiaries with urgent conditions was established.

PRIOR YEAR ACTION AND RESULT: Although the intervention itself has been successfully completed, data tracking continues monthly across all MHP provider sites. Data is analyzed and reported quarterly to all relevant stakeholders, ensuring ongoing monitoring and evaluation to assess the effectiveness of the intervention and continued progress toward the PIP's goals.

AVERAGE LENGTH OF TIME FOR URGENT APPOINTMENT THAT DO NOT REQUIRE PRIOR AUTHORIZATION (IN HOURS)–DHCS Standard: 48 HOURS/80% of Appts Must Meet Std

	All Services	Adult Services	Children's Services	Foster Care
FY 18/19	4.26 Mean 8 Median 3.43 Std Dev. 35% Met Std	4.50 Mean 6 Median 3.59 Std Dev. 25% Met Std	3.85 Mean 9 Median 3.91 Std Dev. 50% Met Std	8 Mean 8 Median 0 Std Dev. 0% Met Std
Reported in hours as of FY 19/20				
FY 19/20	61.20 Mean 36 Median 85.82 Std Dev. 65% Met Std	79.38 Mean 48 Median 98.17 StdDev 54% Met Std	27.43 Mean 0 Median 44.75 Std Dev. 86% Met Std	0 Mean 0 Median 0 Std Dev. 0% Met Std
FY 20/21	138 Mean 96 Median 0-840 Range 43% Met Std	123.75 Mean 84 Median 0-672 Range 44% Met Std	96 Mean 60 Median 0-312 Range 50% Met Std	576 Mean 576 Median 312-840 Rg. 0% Met Std
FY 21/22	98.93 Mean 48 Median 175.50 Std Dev 0-840 Range 71% Met Std	98.53 Mean 24 Median 191.98 Std Dev 0-840 Range 79% Met Std	104 Mean 48 Median 162.16 Std Dev 0-696 Range 50% Met Std	0 Mean 0 Median 0 Std Dev 0-0 Range 0% Met Std
FY 22/23	89.47 Mean 24 Median 0-1200 Range 63% Met Std	38.82 Mean 24 Median 0-504 Range 82% Met Std	136.74 Mean 72 Median 0-1200 Range 45% Met Std	40 Mean 24 Median 24-72 Range 67% Met Std
FY 23/24	73.64 Mean 24 Median 0-624 Range 65.8% Met Std	35.80 Mean 24 Median 0-264 Range 79.6% Met Std	141.42 Mean 72 Median 0-624 Range 40.8% Met Std	384 Mean 384 Median 288-480 Range 0% Met Std

AVERAGE LENGTH OF TIME FOR URGENT APPOINTMENT THAT REQUIRES PRIOR AUTHORIZATION (IN HOURS)–DHCS STANDARD: 96 HOURS/80% OF APPTS MUST MEET STD

	All Services	Adult Services	Children's Services	Foster Care
FY 16/17	*No appts that require prior authorizations*			
FY 17/18				
FY 18/19				
FY 19/20				
FY 20/21				
FY 21/22				
FY 22/23				
FY 23/24				

INDICATOR: TIMELINESS OF POST-PSYCHIATRIC INPATIENT DISCHARGE

ANALYSIS: In FY 23/24, Kings MHP had 355 post-psychiatric hospitalization appointments of which 312 (88%) of the follow-up appointments fell within the 7-calendar day HEIDIS standard, with the average number of calendar days for all follow-up appointments at 4.29 days. This decreased from 22/23 7.11 mean and remains within the 7-day HEIDIS standard.

ACTION: Measures are within HEIDIS standard therefore no action is necessary.

PRIOR YEAR ACTION AND RESULT: There was no action identified in 23/24.

AVERAGE LENGTH OF TIME FOR A FOLLOW-UP APPOINTMENT AFTER HOSPITAL DISCHARGE (IN DAYS)

	All Services	Adult Services	Children's Services	Foster Care
FY 16/17	6.32 Mean 4 Median 8.04 Std Dev.	6.17 Mean 4 Median 7.41 Std Dev.	7.41 Mean 3 Median 11.77 Std Dev.	N/A
FY 17/18	3.48 Mean 1 Median 7.24 Std Dev.	3.18 Mean 1 Median 7.07 Std Dev.	7.89 Mean 4 Median 10.36 Std Dev.	3.83 Mean 4 Median 3.97 Std Dev.
FY 18/19	7.18 Mean 5 Median 73% Met Std	7.17 Mean 5 Median 73% Met Std	7.46 Mean 5 Median 69% Met Std	5.33 Mean 5 Median 100% Met Std
FY 19/20	2.97 Mean 2 Median 94% Met Std	2.95 Mean 2 Median 93% Met Std	3.14 Mean 3 Median 97% Met Std	2.86 Mean 2 Median 86% Met Std
FY 20/21	5.27 Mean 3 Median 84% Met Std	4.94 Mean 3 Median 86% Met Std	5.97 Mean 4 Median 79% Met Std	7.11 Mean 3 Median 72% Met Std
FY 21/22	5.29 Mean 3 Median 86% Met Std	5.34 Mean 3 Median 87% Met Std	5.14 Mean 3.5 Median 83% Met Std	5.40 Mean 3.5 Median 70% Met Std
FY 22/23	7.11 Mean 3 Median 84.77% Met Std	7.93 Mean 3 Median 82.45% Met Std	4.31 Mean 2 Median 97.73% Met Std	2 Mean 2 Median 100% Met Std
FY 23/24	4.29 Mean 2 Median 7.02 Std Dev. 87.89% Met Std	4.27 Mean 2 Median 7.42 Std Dev. 89.58% Met Std	4.31 Mean 2 Median 5.02 Std Dev. 81.36% Met Std	4.63 Mean 4 Median 4.50 Std Dev. 75% Met Std

OBJECTIVE 1.3: SERVICES ARE OF QUALITY TO CONSUMERS

INDICATOR: CONSUMER SATISFACTION SURVEY

ANALYSIS: For the May 2023 Consumer Perception Survey, assessing and comparing satisfaction among beneficiaries and caregivers was challenging due to a high percentage of consumers and family members not completing certain questions, marked as "N/A or Missing". The "# of Surveys" column shows the total number of surveys collected, while the percentages reflect only those who responded to each question. This provides a more accurate representation of respondents' perceptions of the services received.

ACTION: Continue with administering the survey in paper form for all those who have in-person services while in the lobby for their appointment and only offering online surveys to those who receive their service through telehealth, but ask clinics to have staff check in with survey takers to encourage completion of survey.

PRIOR YEAR ACTION AND RESULT: Increase number of individuals completing a survey by administering the survey in paper form for all those who have in-person services while in the lobby for their appointment and only offering online surveys to those who receive their service through telehealth. This was shown to significantly increase the number of individuals starting a survey, but did not reduce the number not completing a survey among adults.

CONSUMER PERCEPTION SURVEYS (CPS) RESULTS

Survey Date	# of Surveys	Question Category *(Likert scale 1 to 5, with 5 most satisfied)*			
		Satisfaction	Access	Informed Consent/ Participation	Effectiveness/ Well-Being
May 2019 Adult/OA	274	4.48 (89.6%)	4.28 (87.4%)	4.40 (85.2%)	3.96 (77.0%) *(13.9% neutral)*
May 2019 C/Y & Family	131	4.4 (84.4%)	4.37 (79.6%)	4.34 (84.0%)	4.01 (65.1%) *(20.6% neutral)*

Survey Date	# of Surveys	Question Category			
		Satisfaction	Access	Informed Consent/ Participation	Effectiveness/ Well-Being
Nov 2019 Caregiver (0-11)	24	4.17 (81.9%)	4.14 (87.5%)	4.24 (86.6%)	3.9 (72.7%) *(11% neutral)*
Nov 2019 Youth (12-17)	28	4.22 (78.6%)	4.15 (79.8%)	4.26 (75.8%)	3.89 (65.3%) *(20.1% neutral)*
Nov 2019 Adult (18-59)	80	4.49 (90.4%)	4.24 (79.6%)	4.31 (81.4%)	3.91 (59.0%) *(19.3% neutral)*
Nov 2019 Older Adult (60+)	4	4.72 (91.7%)	4.33 (83.3%)	4.39 (84.1%)	3.71 (59.4%) *(15.6& neutral)*
June 2020 Adult/OA	51	4.20 (56.86%) *(38.56% N/A or Missing)*	4.01 (50.65%) *(43.14% N/A or Missing)*	4.24 (50.45%) *(43.85 % N/A or Missing)*	3.62 (34.19%) *(43.63% N/A or Missing)*
June 2020 C/Y & Family	32	4.32 (71.88%) *(23.96% N/A or Missing)*	4.37 (80.21%) *(18.75% N/A or Missing)*	4.39 (81.25%) *(16.32% N/A or Missing)*	4.05 (61.08%) *(32.39% N/A or Missing)*
June 2021 Adult/OA	27	4.89 (23.46%) *(53.09% N/A or Missing)*	4.82 (23.46%) *(53.70% N/A or Missing)*	4.79 (22.64%) *(57.09 % N/A or Missing)*	4.67 (28.97%) *(58.18% N/A or Missing)*
June 2021 C/Y & Family	26	4.23 (64.10%) *(28.21% N/A or Missing)*	4.21 (65.38%) *(28.21% N/A or Missing)*	4.10 (59.83%) *(31.20% N/A or Missing)*	3.82 (55.94%) *(29.37% N/A or Missing)*

Survey Date	# of Surveys	Question Category *(Likert scale 1 to 5, with 5 most satisfied)*			
		Satisfaction	Access	Informed Consent/ Participation	Effectiveness/ Well-Being
June 2022 Adult/OA	120	4.18 (24.76%) *(71.11% N/A or Missing)*	4.10 (23.89%) *(71.25% N/A or Missing)*	4.11 (23.97%) *(71.30% N/A or Missing)*	3.83 (20.48%) *(71.65% N/A or Missing)*
June 2022 C/Y & Family	139	4.16 (59.71%) *(27.58% N/A or Missing)*	4.22 (64.03%) *(26.62% N/A or Missing)*	4.23 (61.31%) *(29.74% N/A or Missing)*	3.90 (52.58%) *(29.37% N/A or Missing)*
May 2023 Adult/OA	106	4.46 (86.93%)	4.10 (79.03%)*)*	4.26 (82.14%)*)*	3.87 (65.76%)
May 2023 C/Y & Family	180	4.12 (78.43%)	4.18 (83.94%)	4.25 (87.34%)	3.85 (71.57%)

OBJECTIVE 1.4: SERVICES PRODUCE MEASURABLE OUTCOMES

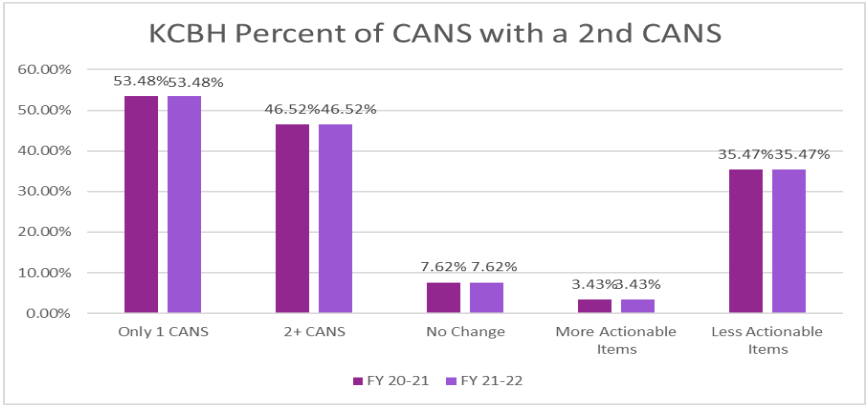
INDICATOR: FUNCTIONAL IMPROVEMENT AMONG CHILD/YOUTH CONSUMERS, PER USE OF CANS/PCS-35

ANALYSIS: In FY 23/24, Kings County Behavioral Health (KCBH) has maintained its commitment to utilizing the Child and Adolescent Needs and Strengths (CANS) tool to assess and address the needs of children and youth up to 21 years of age. CANS assessments are administered at intake, every six months, and at discharge to evaluate actionable areas across key domains, including Child Behavioral and Emotional Needs, Life Domain Function, Risk Behaviors, and Cultural Factors. Progress continues to be measured by reductions in actionable areas (scores of 2 or 3) from intake to discharge.

Despite these ongoing efforts, the department has not yet achieved its goal of implementing a fully operational CANS dashboard within the new EHR system. While this remains a top priority, progress has been delayed due to resource constraints and the complexity of the EHR transition. Without a dashboard, the ability to efficiently track and analyze CANS data in real time is limited, and reporting relies heavily on manual processes and legacy data retrieval.

ACTION: Efforts will focus on securing necessary resources and collaborating to expedite the dashboard's completion.

PRIOR YEAR ACTION AND RESULT: In FY 22/23, the department-initiated plans to create a CANS dashboard as part of the EHR transition. However, due to delays, this goal was not realized. The absence of a dashboard continues to impact data reporting and analysis, emphasizing the importance of making this a priority in FY 23/24.



INDICATOR: FUNCTIONAL IMPROVEMENT AMONG ADULT CONSUMERS, PER USE OF ANSA

Metric to be developed

INDICATOR: DISCHARGE DISPOSITION

Metric to be developed

GOAL 2: UTILIZATION MANAGEMENT AND UTILIZATION REVIEW

Services are delivered in a manner that is appropriate to meet the level of care needs of each consumer

OBJECTIVE 2.1: SERVICES ARE APPROPRIATELY DELIVERED

INDICATOR: SERVICE UTILIZATION BY LEVEL OF CARE BASED ON PROGRAM'S LEVEL OF CARE DELIVERY

Placeholder for Metric: Number of services by service code within each level of care program (ROS, FSP, ACT) in comparison with number of consumers served by program

INDICATOR: HIGH-UTILIZATION OF SERVICES

Placeholder for Metric: Count of consumers receiving high-use of crisis intervention or more than 5 services per month, who are not in an ACT, FSP, TBS, or IHBS program

INDICATOR: UNDER-UTILIZATION OF SERVICES

Placeholder for Metric: Count consumer with no contact for more than 30 days

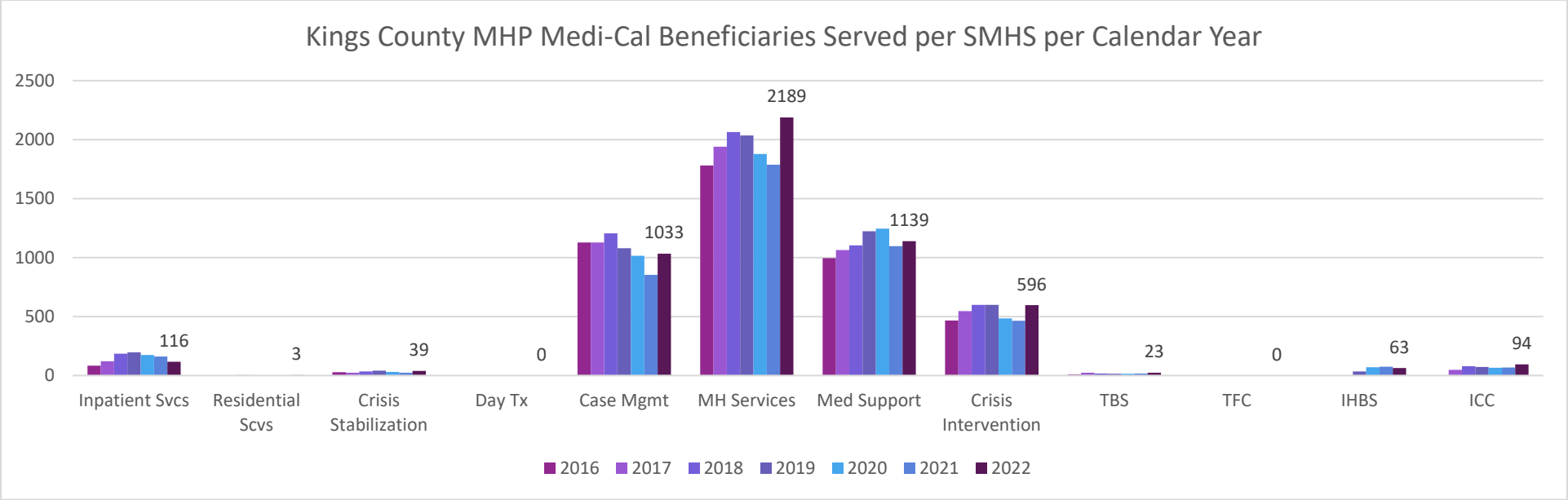
INDICATOR: SERVICES PROVIDED AS DEMONSTRATED THROUGH APPROVED CLAIMS

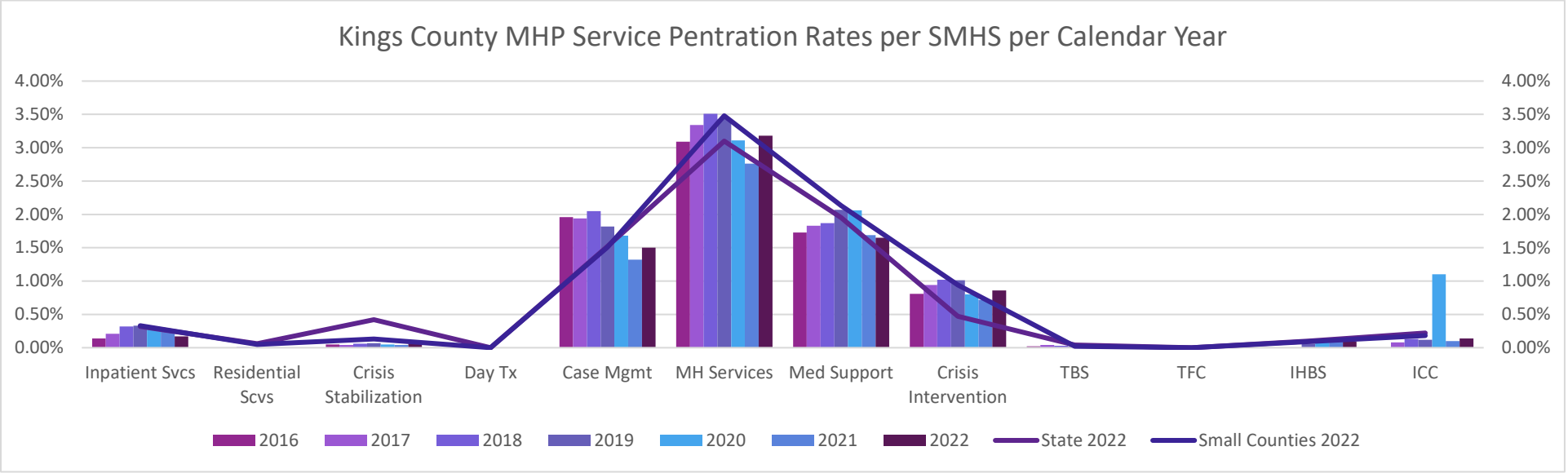
ANALYSIS: Due to the unavailability of claims data for FY 2023/24, a direct analysis of service provision trends for this period could not be conducted. However, the trends observed in calendar year 2022 provide valuable context. In 2022, the number of beneficiaries with claims increased across most Specialty Mental Health Services (SMHS) categories, with notable increases in crisis intervention services (+28%) and mental health services (+22%). These increases were consistent with an overall 16% rise in the number served across SMHS categories, aligning with the 15% increase in the total population served from 2021 to 2022.

While inpatient services saw a 27.5% decrease and Intensive Home-Based Services (IHBS) experienced a 15% decrease in 2022, these trends may reflect shifts in service utilization patterns, particularly the increased use of crisis intervention services, which could have mitigated inpatient service needs. Penetration rates across all service categories remained consistent with those of the state and other small counties, within a 0.5% range.

ACTION: No specific action is required at this time, as penetration rates remain aligned with state and small county averages. Moving forward, Kings County Behavioral Health is prioritizing enhancements to its data collection and reporting systems to ensure the timely availability of claims data for future analysis and reporting.

PRIOR YEAR ACTION AND RESULT: No action was identified for FY 22/23.


Kings County MHP Medi-Cal Beneficiaries Served per SMHS per Calendar Year
2500
2000
1500
1000
500
0
116
3
39
0
1033
2189
1139
596
23
0
63
94
Inpatient Svcs
Residential Scvs
Crisis Stabilization
Day Tx
Case Mgmt
MH Services
Med Support
Crisis Intervention
TBS
TFC
IHBS
ICC
2016
2017
2018
2019
2020
2021
2022


Kings County MHP Service Pentration Rates per SMHS per Calendar Year
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
Inpatient Svcs
Residential Scvs
Crisis Stabilization
Day Tx
Case Mgmt
MH Services
Med Support
Crisis Intervention
TBS
TFC
IHBS
ICC
2016
2017
2018
2019
2020
2021
2022
State 2022
Small Counties 2022

INDICATOR: MEDI-CAL APPROVED CLAIMS AND SERVICES

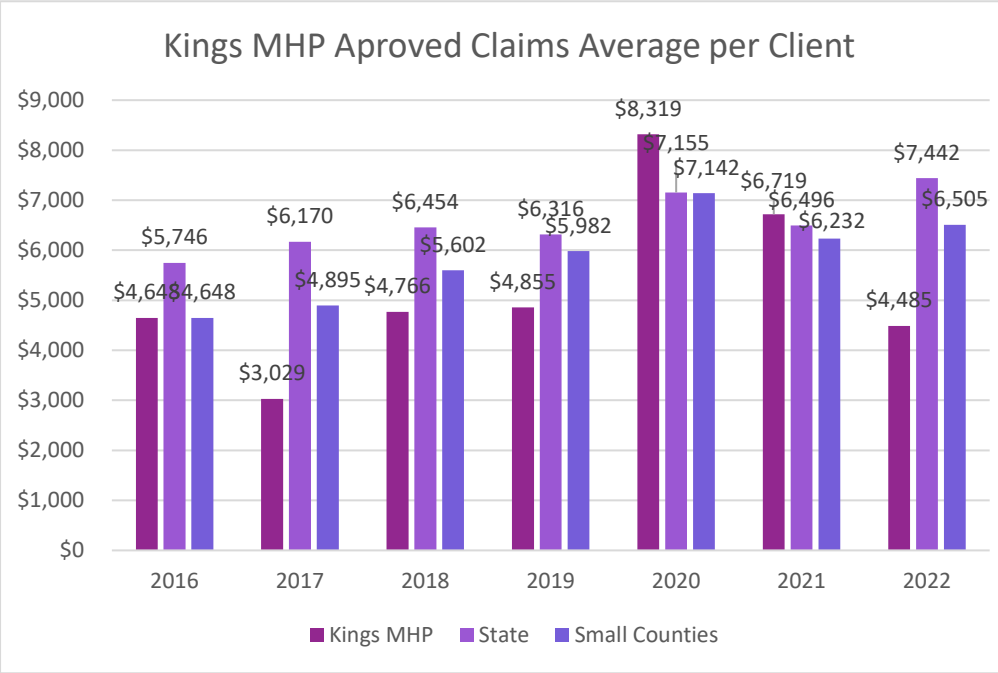
ANALYSIS: For FY 2023/24, claims data was unavailable due to the lack of access to historical reports following the state's transition to a new external quality review organization. As such, the trends from calendar year 2022 provide the most recent reference point.

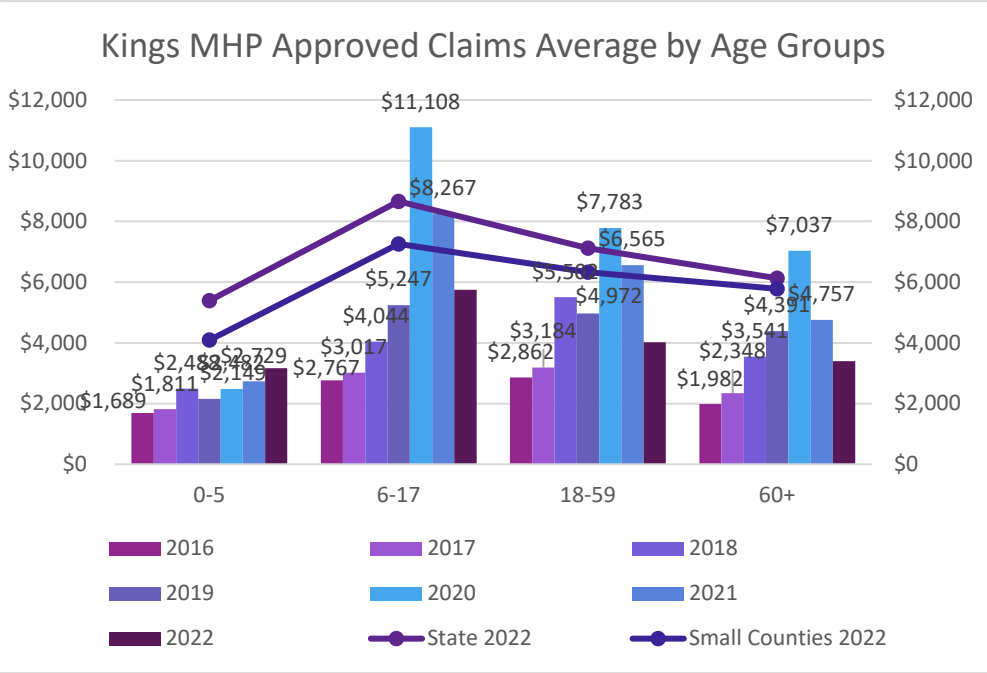
In 2022, the average approved claim for Kings County Behavioral Health (KCBH) returned to $4,485 per beneficiary, aligning closely with the historical average of approximately $4,500, except for the significant but temporary increase observed during FY 2020-2021 due to the adoption of COVID-adjusted rates. These inflated rates, which were intended to support MHPs in managing pandemic-related costs, cannot be used for accurate year-to-year or cross-county comparisons, as not all counties opted to apply these adjusted rates.

Kings County's average approved claim remains significantly below that of the state and other small counties. However, this difference largely reflects the absence of certain service categories in Kings County that have higher costs, such as Day Treatment (state average $11,927, small county average $28,504) and Therapeutic Foster Care (state average $22,796, small county average $5,487). Therefore, direct comparisons to state and small county averages should be interpreted with caution, as Kings County's service mix differs substantially.

ACTION: No action is recommended, as the average approved claims are consistent with historical patterns and reflect the specific service availability in Kings County.

PRIOR YEAR ACTION AND RESULTS: No action was identified in FY 2022/23, and no further action is proposed for FY 2023/24.


Kings MHP Aproved Claims Average per Client
$9,000
$8,000
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
$4,648
$5,746
$4,648
$3,029
$6,170
$4,895
$4,766
$6,454
$5,602
$4,855
$6,316
$5,982
$8,319
$7,155
$7,142
$6,719
$6,496
$6,232
$4,485
$7,442
$6,505
2016
2017
2018
2019
2020
2021
2022
Kings MHP
State
Small Counties


Kings MHP Approved Claims Average by Age Groups
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0
$1,689
$1,811
$2,729
$2,767
$3,017
$4,044
$5,247
$11,108
$8,267
$2,862
$3,184
$4,972
$6,565
$7,783
$1,982
$2,348
$3,541
$4,391
$4,757
$7,037
0-5
6-17
18-59
60+
2016
2017
2018
2019
2020
2021
2022
State 2022
Small Counties 2022

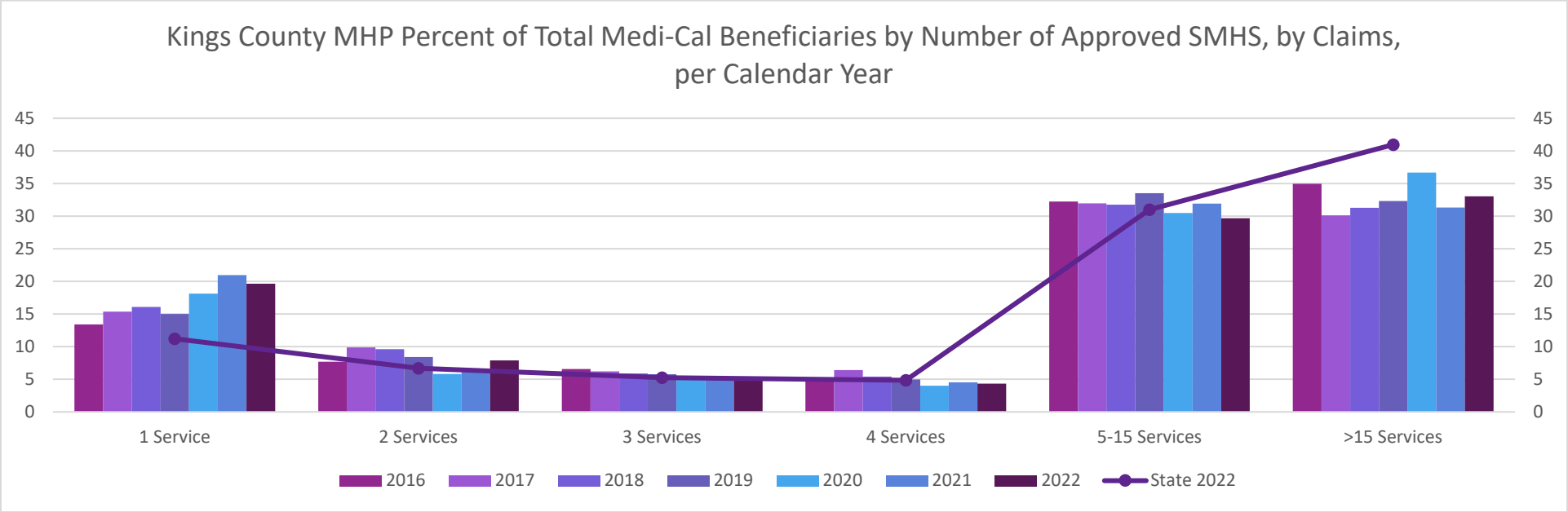
INDICATOR: ENGAGEMENT RATES OF CONSUMERS

ANALYSIS: Due to the lack of available claims data for FY 2023/24, current trends could not be analyzed. However, previous data indicates that Kings County MHP continues to have more beneficiaries receiving only one Specialty Mental Health Service (SMHS) compared to the state rate, and fewer beneficiaries receiving more than 15 SMHS than the state rate. Beneficiaries receiving between 2 and 15 SMHS remain consistent with the state rate.

ACTION: The MHP will continue exploring methods to analyze this trend through available data, while also engaging providers in discussions to better understand the factors contributing to the higher proportion of beneficiaries receiving only one SMHS and the lower proportion receiving 15 or more.

PRIOR YEAR ACTION AND REMAINS THIS YEAR'S ACTION: In FY 2022/23, the MHP committed to developing reports to assess whether beneficiaries are engaging in the most appropriate level of care and successfully discharging after sufficient program engagement. This action has not yet been completed and remains a priority for FY 2024/25.

Additionally, the MHP intended to review other counties' QAPI Work Plans to compare rates of Notices of Adverse Benefit Determination (NOABD) related to medical necessity denials at assessment. This review would help determine if the higher rate of beneficiaries receiving only one SMHS is linked to a higher rate of beneficiaries not meeting medical necessity at assessment. This review also remains an ongoing priority.



INDICATOR: NO-SHOW RATE FOR CLINICAL AND PSYCHIATRY SERVICES

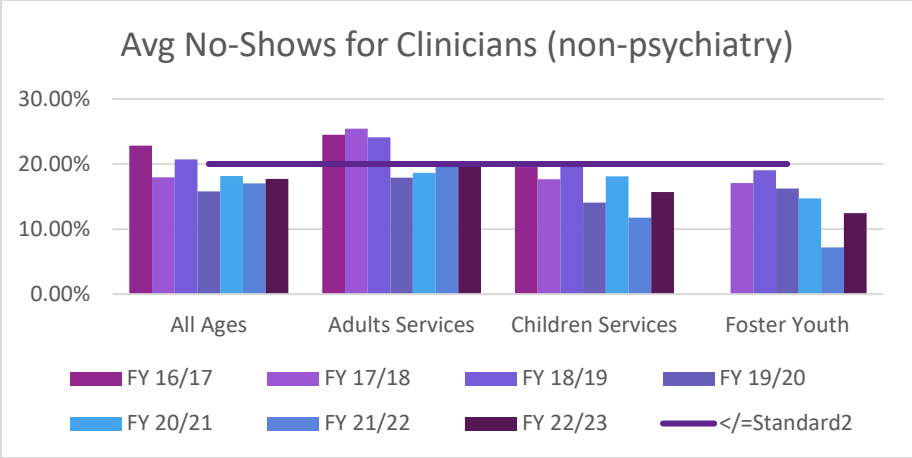
ANALYSIS: During FY 23/24, the transition to our new EHR system and the associated challenges with the calendar functionality prevented us from accurately tracking no-show rates for both clinical and psychiatry services. Providers' use of the calendar feature did not align with the system's intended data capture methods, making it impossible to compile reliable no-show data. However, the workflow issues have since been identified and addressed. With these improvements in place, the plan is to develop a direct reporting mechanism within the EHR that can pull no-show data directly from providers' calendars, ensuring comprehensive and accurate reporting in the future.

ACTION: Collaborate with EHR vendor and internal IT staff to develop a report that captures no-show rates directly from provider calendars. Provide training and guidance to providers on calendar usage to ensure consistency and accuracy of data. Once the reporting tool is finalized, begin regular data collection and analysis to re-establish a baseline no-show rate and identify areas for improvement.

PRIOR YEAR ACTION AND RESULT: In FY 22/23, the MHP successfully tracked no-show rates and identified areas requiring improvement for psychiatry services. The data informed targeted action items, including forwarding the psychiatry no-show rate to the Medical Director for review. However, with the EHR conversion, these established data-tracking processes were disrupted, prompting the current focus on restoring and improving no-show data collection methods for FY 23/24 and beyond.

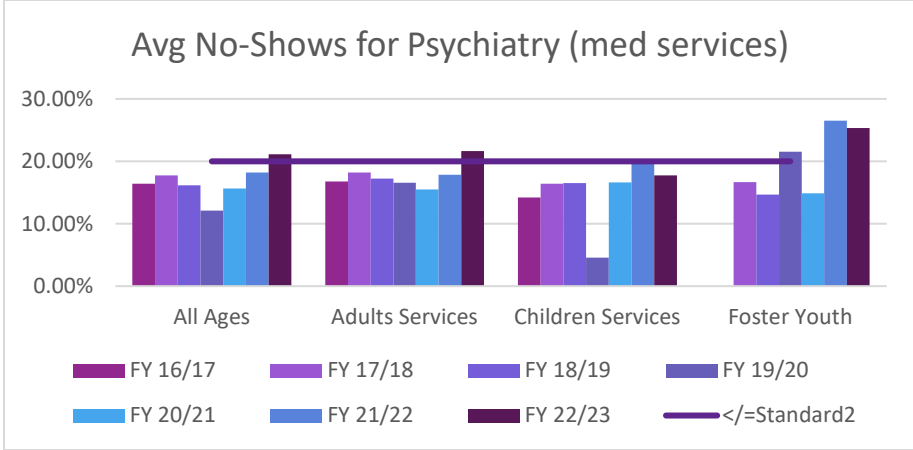
AVERAGE NO-SHOWS FOR CLINICIANS OTHER THAN PSYCHIATRISTS

MHP Standard: </=20%



AVERAGE NO-SHOWS FOR PSYCHIATRISTS

MHP Standard: </=20%



OBJECTIVE 2.2: SERVICES ARE DOCUMENTED ACCORDING TO STATE STANDARDS OF CARE

INDICATOR: CHART REVIEW/UTILIZATION REVIEW

ANALYSIS: In FY 23/24, Kings County MHP had a 84.42% utilization review (UR) compliance rate after reviewing 104 charts. This is a significant decrease from FY 22/23 total compliance of 93.7%, and is below the compliance goal of 90%. In July 2023, the MHP transitioned from our former Electronic Health Record, Cerner Anasazi to the new Semi-Statewide E.H.R. SmartCare. Utilization Review was suspended from July until December 2023 to allow providers to complete E.H.R. training and become familiar with the new system. The MHP UR audit tool was revised in November 2023 to better align with CalAIM Documentation Redesign standards, reduce question redundancy, and streamline the tool. This tool went live in December 2023.

UR is broken out into 6 categories seen in the graph below wherein all but one category fell below the MHP goal of 90% compliance. The only area above 90% compliance was Billing. The MHP UR audit tool was revised in November 2022 to align with CalAIM Documentation Redesign making comparison of data across fiscal year 22/23 to be difficult as many UR categories, including Assessment, Access Criteria, and Problem List were changed significantly. For this reason, there is an unavoidable data limitation which should be considered.

Throughout the fiscal year, the MHP has implemented various initiatives with the goal of addressing documentation challenges, improving operational procedures, and providing ongoing E.H.R. support for all users. Some of these initiatives have included virtual training on Screening and Transition of Care Tools (9/20/23) and CalAIM Documentation Standards (1/31/24), email blasts addressing documentation of chart review time (2/23/24) and Certified Peer Support service codes (2/23/24), as well as a series of five optional in-person clinics focusing on topics identified through UR findings (6/4 (Assessment, 6/11 Care Planning, 6/18 Certified Peer Support Specialist, 6/24 Screening/Transition of Care Tools, 7/9 NOABDs).

Despite these efforts, the MHP saw a drop in the compliance rate of many Utilization Review Categories throughout the fiscal year including Assessment, Problem List, Other Documentation (Informing Materials), and Billing.

While the UR audit tool has changed from the previous fiscal year, we can generally compare compliance rates in some categories. Assessment compliance rate decreased from 93.47% in FY 22/23 to 87.62% (5.85% decrease). Problem List compliance dropped from 91.6% in FY 22/23 to 86.76% in FY 23/24 (a 4.84% decrease). Progress Notes decreased 7.48% from 95.2% in FY 22/23 to

87.72% in FY 23/24. Finally, the Other Documentation category which monitors compliance with service timeliness standards as well as informing materials and consent forms decreased from 75.39% in FY 22/23 to 62.48% in FY 23/24 (a 12.91% drop).

ACTION: Other Documentation and Specialized Services categories will remain areas of focus for improvement at the UR Committee in FY 24/25.

PRIOR YEAR'S ACTION AND RESULTS:

The MHP UR audit tool was revised in November 2022 to align with CalAIM Documentation Redesign making comparison of data across fiscal year 22/23 to be difficult as many UR categories, including Assessment, Access Criteria, and Problem List were changed significantly. For this reason, there is an unavoidable data limitation which should be considered when reviewing the following analysis.

The MHP saw significant changes in the compliance percentages of many categories throughout FY 22/23 which are trending in a positive direction. In Q3, it was discovered that due to an E.H.R. limitation, providers were not able to edit/ correct the Problem List fields (specifically the area in which a diagnosis is "identified by") completed by another MHP program. This issue had persisted since the implementation of Documentation Redesign in August 2022. This resulted in findings of Problem Lists being out of compliance with little/ no opportunity for correction. The MHP attempted to ameliorate this in Q4 by only recording Problem List deficiencies if the error was made by the current treating provider who had opportunity to enter/correct the diagnosis/problem. This issue is likely the reason for the 5.55% compliance decrease in the Problem List category as no other question in this category yielded significant or persistent findings.

Although the Consent category is under the compliance percentage goal of 90% and continues to be an area of focus for the MHP, there has been a 8.72% increase in compliance throughout the fiscal year.

CHART REVIEW RESULTS

FY	Total Charts Reviewed	Items Compliant	Items Not-Compliant	Total % Compliant
FY 22/23	187	8,7,57	589	93.7%
FY 23/24	106	4,504	831	84.42%

Categories	**Total Yes**	**Total No**	**FY 22/23 YTD Compliance Percentage**
Consents	386	126	75.39%
Assessment	2,076	145	93.47%
SMHS Access Criteria	322	0	100.00%
Problem List	1,177	108	91.60%
Progress Notes	1,667	84	95.20%
Documentation Summary	307	14	95.64%
Compliance	1,771	88	95.27%
Recoupment	1,051	24	97.77%
Total (Overall)	**8,757**	**589**	**93.70%**
Categories	**Total Yes**	**Total No**	**FY 23/24 YTD Compliance Percentage**
Assessment	1,231	174	87.62%
Problem List	367	56	86.76%
Progress Notes	1,000	140	87.72%
Other Documentation (Consents)	353	212	62.48%
Specialized Services	303	227	57.17%
Billing	1,250	22	98.27%
Total (Overall)	**4,504**	**831**	**84.42%**

INDICATOR: MEDICATION PRACTICES

MEDICATION MONITORING CHART REVIEW RESULTS

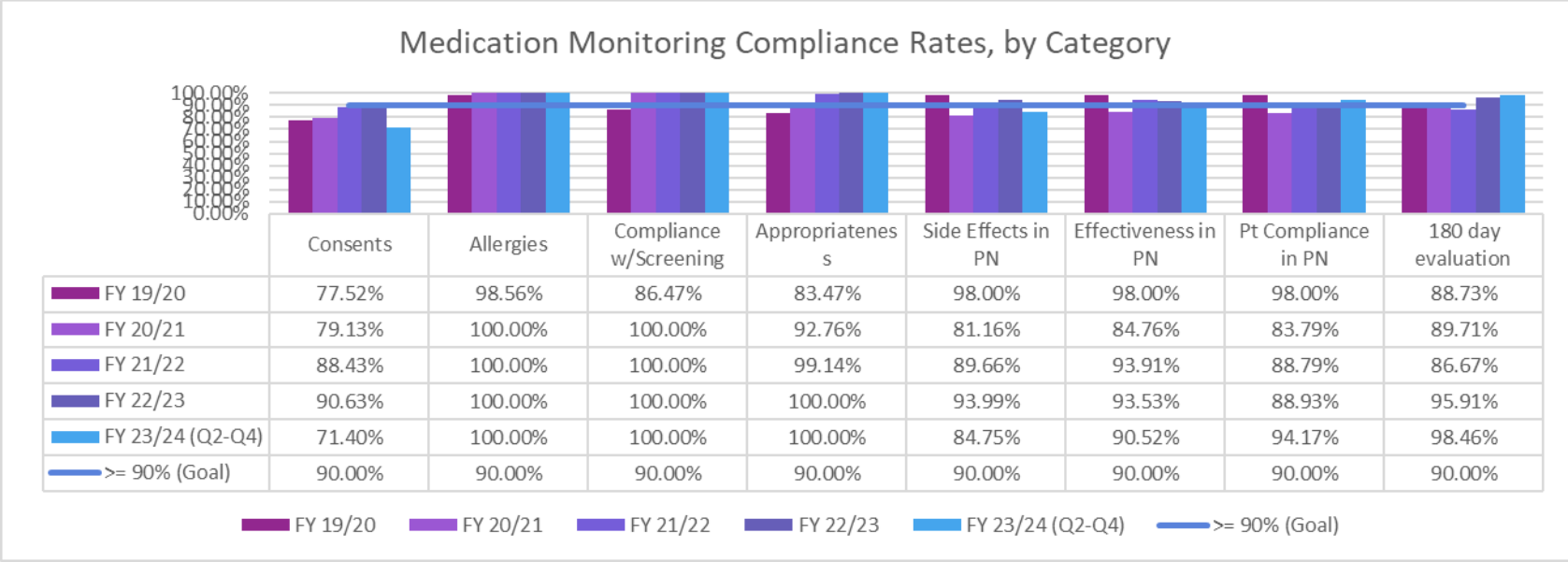
ANALYSIS: In FY 23/24, Kings MHP achieved a 91.86% medication monitoring compliance rate after reviewing 114 charts totaling 884 chart items. The medication monitoring review was divided into 8 compliance categories, as depicted in the graph below. Notably, six of the eight categories met or exceeded the MHP goal of 90% compliance. However, compliance for *consents present in chart* (71.40%) and *noting the presence/absence of side effects* (84.91%) fell below this target, highlighting areas for improvement in these critical aspects of medication management. Through medication monitoring reviews and committee meetings, it was discovered that changes resulting from the adoption of a new Electronic Health Record (EHR) system played a significant role in the decreased compliance rates. Specifically: 1. The new EHR system introduced changes to how medication consent forms are documented and scanned, leading to inconsistencies in workflow and errors in tracking consent documentation. 2. The documentation for allergic reactions or side effect presence/absence was affected due to differences in how the new system handles these fields, creating confusion among prescribers and support staff. These workflow challenges appear to have directly contributed to the lower compliance rates compared to prior years.

ACTION: To address these gaps, the MHP shall continue monitoring compliance of prescribers' documentation regarding medication consent and side effect status. The following targeted actions will be implemented: Continue to conduct focused training sessions as needed for prescribers and support staff on the EHR workflows related to consent documentation and allergic reaction/side effect charting. Medication Monitoring reviews will continue to deliver prescriber-specific feedback, ensuring timely identification and resolution of workflow issues.

PRIOR YEAR ACTION AND RESULTS: In FY 22/23, the MHP convened monthly medication monitoring committee meetings with all psychiatrists and med support staff to discuss and review compliance metrics. These meetings were instrumental in maintaining high compliance rates in most categories. However, the transition to a new EHR system introduced unanticipated workflow challenges that negatively impacted compliance in documenting medication consents and allergic reactions. While the meetings helped address some of these challenges, the data highlights the need for ongoing focused training sessions and prescriber-specific feedback through Medication Monitoring reviews to further refine EHR workflows and resolve these issues in the upcoming year.

MEDICATION MONITORING RESULTS

FY/Qtr	Total Charts Reviewed	Items Compliant	Items Not-Compliant	Total % Compliant
FY 18/19 (Q3&4)	47	283	17	94.33%
FY 19/20	159	955	113	89.42%
FY 20/21	156	990	92	90.71%
FY 21/22	149	909	65	93.33%
FY 22/23	166	1,131	54	95.23%
FY 23/24	114	802	82	91.86%



	Consents	Allergies	Compliance w/Screening	Appropriateness	Side Effects in PN	Effectiveness in PN	Pt Compliance in PN	180 day evaluation
FY 19/20	77.52%	98.56%	86.47%	83.47%	98.00%	98.00%	98.00%	88.73%
FY 20/21	79.13%	100.00%	100.00%	92.76%	81.16%	84.76%	83.79%	89.71%
FY 21/22	88.43%	100.00%	100.00%	99.14%	89.66%	93.91%	88.79%	86.67%
FY 22/23	90.63%	100.00%	100.00%	100.00%	93.99%	93.53%	88.93%	95.91%
FY 23/24 (Q2-Q4)	71.40%	100.00%	100.00%	100.00%	84.75%	90.52%	94.17%	98.46%
>= 90% (Goal)	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

INDICATOR: HOSPITALIZATION AND RE-HOSPITALIZATION RATES

ANALYSIS: In FY 23/24, there were 606 total psychiatric hospitalizations (includes all involuntary psychiatric hospitalizations in Kings County regardless of insurance type). This is an increase from 493 in FY 22/23. In reviewing the number of hospitalizations (606) against the total County population (152,682), the County had less than a 1% (0.4%) Hospitalization Rate. Among readmission rates within 30-days of hospital discharge, there was an increase in beneficiaries hospitalized but a decrease in percentage rate from 9.13% (45) in FY 22/23 to 8.91% (54) in FY 23/24. The primary increase in readmissions remains among adults.

ACTION: Data will continue to be monitored through FY 24/25 at the quarterly reporting meetings at QIC to identify trends and determine if the increase stabilizes or aligns with the average across prior fiscal years.

PRIOR YEAR ACTION AND RESULT: In FY 22/23, data was monitored, and no significant interventions were implemented. Monitoring revealed an increase in readmissions with a decrease in the readmission rate.

HOSPITALIZATION RATES

	All Services	Adult Services	Children's Services	Foster Care
FY 16/17	210	11	28	N/A
FY 17/18	203	180	13	10
FY 18/19	308	259	44	5
FY 19/20	463	378	72	13
FY 20/21	434	354	56	24
FY 21/22	477	367	110	18
FY 22/23	493	399	88	6
FY 23/24	606	500	98	8

Data Limitation: Although there appears to be a significant increase from prior fiscal years (16/17, 17/18 and 18/19), it was noted that the methodology for which hospitalizations were captured changed in FY 19/20 and as a result it accounted for the increase in hospitalization. As such, the increase was not attributed to an increase in individuals being hospitalized, rather an administrative change in reporting.

RE-HOSPITALIZATION WITHIN 30-DAYS OF HOSPITAL DISCHARGE

	All Services	Adult Services	Children's Services	Foster Care
FY 16/17	15/14%	14/12.93%	1/29%%	N/A
FY 17/18	27/13.30%	24/13.33%	2/15.38%	1/10%%
FY 18/19	43/13.96%	35/13.51	5/11.36	3/60.00%
FY 19/20	35/7.56%	30/7.94%	3/4.17%	2/15.38%
FY 20/21	34/7.83%	29/8.19%	2/3.57%	3/12.50%
FY 21/22	24/5.03%	16/4.36%	8/7.27%	0/0%
FY 22/23	45/9.13%	41/10.28%	4/4.55%	0/0%
FY 23/24	54/8.91%	44/8.80%	8/8.16%	2/25%

HOSPITALIZATION BY CONSUMER STATUS: ACTIVE, FORMER, NEW

Metric to be developed

HOSPITALIZATION BY CONSUMER PAYOR SOURCE: MEDI-CAL, MEDICARE, UNINSURED, PRIVATE INSURANCE

Metric to be developed

GOAL 3: PROVIDER NETWORK ADEQUACY, CREDENTIALING, AND MONITORING

The MHP will ensure all provider and provider sites are enrolled, credentialed, and/or certified in compliance with Medi-Cal requirements.

OBJECTIVE 3.1: THERE IS AN ADEQUATE NETWORK OF PROVIDERS

INDICATOR: PROVIDER STAFFING

ANALYSIS: During FY 23/24, the conversion to our new EHR and the adoption of the DAT file format for state reporting presented challenges in tracking compiled provider Full-Time Equivalencies (FTEs). While we can confirm data accuracy as it enters our EHR, we do not currently have a method to review the aggregated FTE totals post-compilation. Our reliance on the EHR's DAT output means we cannot isolate final provider type totals at this time. Despite this limitation, the state has continued to accept our quarterly reports, and we remain in compliance with required provider FTE measures. We are actively working with our EHR vendor and a report developer to create a functional reporting mechanism, and we will backfill these FTE totals once the necessary capability is established.

ACTION: Collaborate with the EHR vendor and a report developer to establish a reliable reporting method that allows for the extraction and review of compiled FTE totals. Maintain ongoing verification of provider data inputs to ensure ongoing compliance, even as we work toward generating final FTE compilations. Once the reporting tool is available, backfill FY 23/24 FTE data and update all relevant documentation accordingly.

PRIOR YEAR ACTION AND RESULT: In FY 22/23, the MHP successfully tracked and reported provider FTE data as outlined previously. The established processes allowed for accurate monitoring of direct and reserve provider FTEs, resulting in the timely submission of quarterly reports that met DHCS standards. During that period, the MHP could easily verify compiled data, ensuring a smooth and compliant reporting cycle. These past achievements provide a baseline for current efforts to restore full data oversight and reporting accuracy within the new EHR environment.

FULL-TIME EQUIVALENCY (FTE) BY PROVIDER TYPE

Time Period	Child/Youth Psychiatry *(includes NP)*	Adult Psychiatry *(includes NP)*	Child/Youth Medical Personnel *(i.e. RN, PT)*	Adult Medical Personnel *(i.e. RN, PT)*	Child/Youth Therapists	Adult Therapists	Child/Youth Other Qual. Prov. *(Rehab Spc, Case Mgr, PSS)*	Adult Other Other Qual. Prov. *(Rehab Spc, Case Mgr PSS)*	TOTAL
Jan 2019	5.0		5.0		43.0		16.0		69.0
April 2019	1.0	2.7	1.0	6.0	16.1	25.2	14.7	20.7	87.4
July 2019	0.9	4.0	0.7	4.3	19.8	24.1	19.5	19.7	93.0
Oct 2019	0.9	4.1	0.9	6.1	21.1	24.5	24.2	18.1	99.9
Jan 2020	2.5	5.1	0.9	6.1	27.1	22.5	40.1	19.2	123.5
April 2020	2.9	6.1	0.9	7.1	25.1	22.5	39.1	18.3	122
April 2021	2.29	4.36	0.9	8.10	18.55	21.00	21.70	13.65	89.65
July 2022	2.94 *(excludes NP & Reserve)*	1.91 *(excludes NP)*	1.25 *(includes NP)*	6.40 *(includes NP)*	27.95 *(excludes Reserve)*	16.00	27.65	11.80	94.90 *(excludes Reserve)*
Nov 2023	1.04 *(excludes NP & Reserve)*	3.96 *(excludes NP)*	0.00 *(includes NP)*	6.90 *(includes NP)*	27.50 *(excludes Reserve)*	24.75	22.20	17.10	103.45 *(excludes Reserve)*

DHCS NETWORK ADEQUACY PROVIDER RATIO FINDINGS						
Provider Category	**Date**	**DHCS Standard**	**DHCS Estimated Need Population** *(Medi-Cal Eligible X Prevalence)*	**# of FTE Providers Needed to Meet the Ratio Standard**	**# of FTE Providers Reported by the MHP**	**DHCS Findings (Pass/ Conditional Pass)**
Psychiatry Provider Capacity - Adults	**Nov 2023**	1:457	1697.11	3.71	4.96	Met
	July 2022	1:524	1535	2.93	4.46	Pass
	Apr 2021	1:524	1414	2.70	3.31	Pass
	Apr 2020	1:524	1272	2.43	5.09	Pass
	Apr 2019	1:524	1,272	2.43	3.25	Pass
Psychiatry Provider Capacity -Children/ Youth	**Nov 2023**	1:267	705.28	2.64	2.64	Met
	July 2022	1:323	684	2.12	2.54 *(includes 1 FTE Reserve)*	Pass
	Apr 2021	1:323	665	2.06	2.19	Pass
	Apr 2020	1:323	572	1.77	2.82	Pass
	Apr 2019	1:323	572	1.77	1.10	Conditional Pass

Outpatient SMHS Provider Capacity - Adults	**Nov 2023**	1:85	2533	29.8	49.45	Met
	July 2022	1:85	2292	26.96	29.45	Pass
	Apr 2021	1:85	2110	24.82	41.70	Pass
	Apr 2020	1:85	1898	22.33	47.75	Pass
	Apr 2019	1:50	1,898	37.96	44.37	Pass
Outpatient SMHS Provider Capacity -Children/ Youth	**Nov 2023**	1:49	2432	49.63	53.75	Met
	July 2022	1:43	2357	54.82	55.55 *(includes 21 FTE Reserve)*	Pass
	Apr 2021	1:43	2292	53.30	39.35	Pass
	Apr 2020	1:43	1972	45.87	61.34	Pass
	Apr 2019	1:30	1,972	65.74	28.04	Conditional Pass

INDICATOR: GEOGRAPHIC DISTRIBUTION OF PROVIDERS

TIME AND DISTANCE STANDARDS

ANALYSIS: All beneficiaries within Kings County are within the DHCS time and distance standards of 75 minutes and 45 miles to the nearest MHP provider, as the county as a whole geographically is no larger from any given point to another than that of the time and distance standards. As such, DHCS found the Kings MHP to be in compliance in prior network adequacy certifications and it is anticipated that this will continue to be found in compliance as the time and distance standards have not changed nor has the county jurisdictional area.

ACTION: No action to be taken.

INDICATOR: PROVIDER CREDENTIALING/RE-CREDENTIALING

ANALYSIS: During FY 23/24, the MHP faced challenges maintaining the fidelity required for consistent credentialing and re-credentialing processes due to the EHR conversion and additional state reporting responsibilities. As a result, prior methods of tracking and verifying credentialing timelines and compliance were disrupted. In September of FY 23/24, the MHP implemented a new contracted third-party credentialing solution, CertifyOS. This platform is expected to streamline credentialing workflows and provide a centralized dashboard for data monitoring. Moving forward, the MHP will leverage the CertifyOS dashboard to develop standardized metrics, ensuring comprehensive and accurate oversight of provider credentialing activities.

ACTION: Collaborate with CertifyOS representatives to establish a clear metric that can be monitored via the dashboard. Provide training to administrative and QA staff on navigating and extracting data from CertifyOS tools. Begin regular data collection and analysis by Q3 FY 23/24, using the dashboard metrics to evaluate performance and identify areas needing improvement.

PRIOR YEAR ACTION AND RESULT: In FY 22/23, the MHP acknowledged the need for a reliable credentialing and re-credentialing metric but did not finalize one due to competing priorities and system conversions. Although no formal data were collected, this experience highlighted the importance of a streamlined process and contributed to the decision to contract with CertifyOS. With this partnership now in place, the MHP is positioned to implement effective tracking measures and improve the fidelity of its credentialing activities.

GOAL 4: BENEFICIARY PROTECTIONS

OBJECTIVE 4.1: THE MHP WILL PROVIDE A GRIEVANCE SYSTEM FOR CONSUMERS

INDICATOR: COUNT AND TYPE OF GRIEVANCES AND APPEALS

ANALYSIS: In FY 23/24, Kings MHP Patient Rights Advocate processed 58 grievances, a decrease from FY 22/23 (87); and the Kings MHP Quality Assurance Clinician processed 8 appeals, an increase from FY 22/23 (5). However, due to the small sample size, this change is not significant. No trend or pattern arose during the FY among grievances nor appeals.

ACTION: The Patient Rights Advocate and Quality Assurance Clinician continue to assess grievances and appeals on a quarterly basis to identify any trends or patterns that may need to be addressed. No further action is required at this time, but the continued use of timely access NOABDs will be closely monitored.

PRIOR YEAR ACTION AND RESULT: There was no identified action for FY 23/24.

GRIEVANCES

Time Period	Grievance Categories										TOTAL
	Access		Quality of Care		Change of Provider		Confidentiality Concern		Other		
	PRA	Exempt	PRA	Exempt	PRA	Exempt	PRA	Exempt	PRA	Exempt	
FY 19/20	11	2	21	17	0	0	0	0	16	6	**73**
FY 20/21	2	1	3	23	0	1	0	1	11	24	**66**
FY 21/22	3	5	8	17	0	0	1	1	8	20	**63**

ABGAR Changed to MCPAR 22/23												
	Cust Service	Case Mgmt	Access to Care	Quality of Care	Cunty Communication	Payment/ Billing	Suspected Fraud	Abuse/ Neglect/ Exploitation	Untimely Response	Denial of Exp. Appeal	Other	Total
FY 22/23	3	3	7	14	0	3	0	0	0	0	6	**36**
FY 23/24	3	14	8	18	0	0	0	0	0	0	15	**58**

APPEALS RESULTING FROM NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD)

FY	Categories							TOTALS
	Denial or Limited Service	Modif. or Term of Services	Payment Denial	Service Timeliness	Untimely Response to Appeal of Griev.	Denial of Bene Request to Dispute Financial Liab.	Delivery System*(ABGAR only, ended in 22/23)*	
18/19	0	0	0	0	0	0	0	**0**
19/20	3	5	0	0	0	0	4	**12**
20/21	0	8	5	0	0	0	6	**19**
21/22	0	10	8	0	0	0	1	**19**
22/23	3	2	0	0	0	0	N/A	**5**
23/24	0	4	0	0	0	0	4	**8**

GOAL 5: CULTURAL AND LINGUISTIC COMPETENCE

OBJECTIVE 5.1: CULTURALLY AND LINGUISTICALLY COMPETENT WORKFORCE

INDICATOR: TYPE OF CULTURAL COMPETENCY TRAINING AND ATTENDANCE

ANALYSIS: In FY 23/24, the MHP began offering the "Improving Cultural Competency for Behavioral Health Professionals" online training to all Kings County Behavioral Health providers, including contracted staff, as of July 24, 2023. This 5-hour course meets the current state requirement for enhancing cultural competency. While the training remains continuously available to accommodate new hires, the MHP initially had no mechanism to verify and track completion rates across its provider network. However, the recent implementation of the Relias online training platform will now enable systematic tracking of training participation. With this tool, the MHP can begin collecting and analyzing data on attendance and completion, paving the way for the development of meaningful metrics to measure cultural competency training compliance and its impact on service delivery.

ACTION: The MHP will fully integrate the cultural competency training into the Relias platform's tracking system, enabling the collection of attendance and completion data for all providers. Through this integration, the MHP can begin systematically monitoring and verifying that new hires, as well as existing staff, complete the required training. With these data in hand, the MHP will develop a standardized metric by Q3 FY 24/25 to measure compliance and guide ongoing efforts to ensure a culturally and linguistically competent workforce.

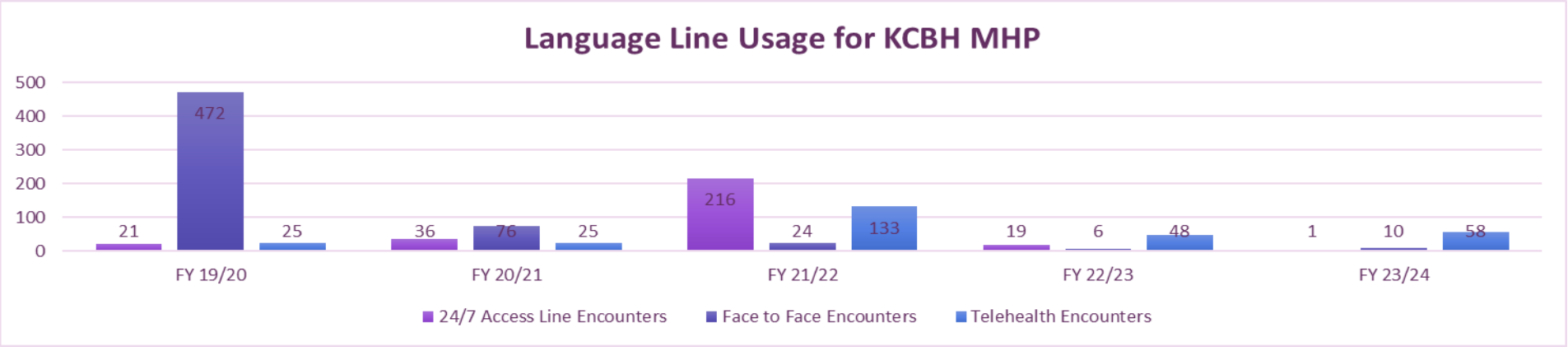
PRIOR YEAR ACTION AND RESULT: In FY 22/23, no formal metric existed for tracking cultural competency training. The MHP recognized the need for a measurable indicator but did not finalize or implement one. These lessons have informed the current strategy, resulting in the adoption of an online training platform capable of providing the necessary data to establish and monitor meaningful measures moving forward.

INDICATOR: LANGUAGE LINE UTILIZATION

ANALYSIS: Over the past five fiscal years, reported Language Line usage across the 24/7 Access Line, face-to-face, and telehealth encounters has fluctuated. FY 21/22 saw a spike in Access Line and telehealth usage, while face-to-face encounters declined steadily since FY 19/20. However, this data relied solely on self-reported provider numbers, likely underestimating true usage due to cumbersome tracking methods and a lack of integrated tools in the legacy EHR.

ACTION: The new EHR includes a dedicated field in both access logs and progress notes to capture Language Line usage, enabling the MHP to begin accurately tracking this data. To support this effort, the EHR and Quality Assurance teams will collaborate closely with providers, offering training and guidance to ensure proper documentation practices are understood and followed. In parallel, a new report is being developed to compile and interpret the collected data. Combined, these initiatives aim to unveil meaningful trends, highlight service gaps, and inform data-driven improvements moving forward.

PRIOR YEAR ACTION AND RESULT: In FY 22/23, the MHP recognized the need for a reliable metric but could not establish one due to reliance on self-reported data and the limitations of the legacy EHR. While the issues were acknowledged, no concrete action was taken ahead of the planned EHR transition. These challenges directly influenced the current year's strategy, leading to the EHR's new tracking capabilities and a clearer path toward meaningful data collection and analysis.

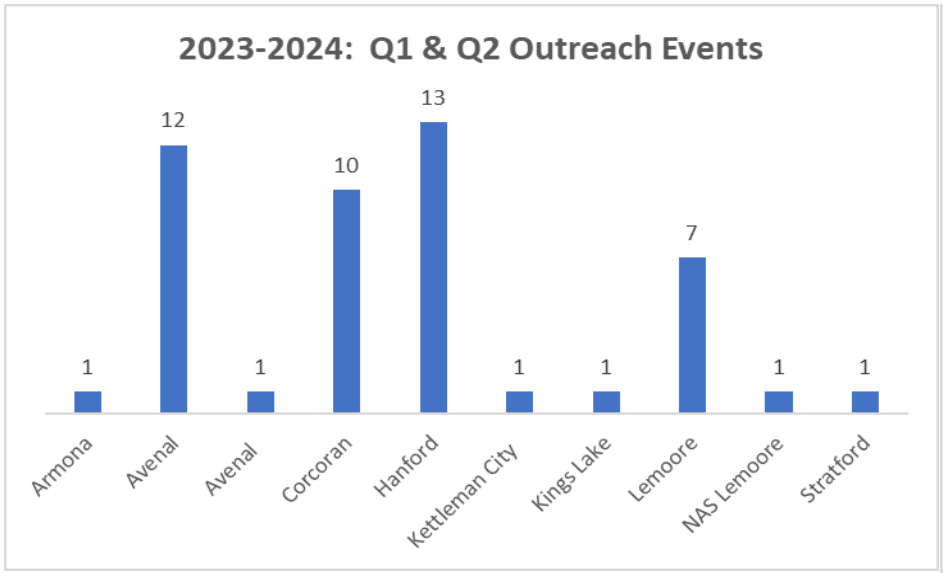


INDICATOR: COMMUNITY OUTREACH

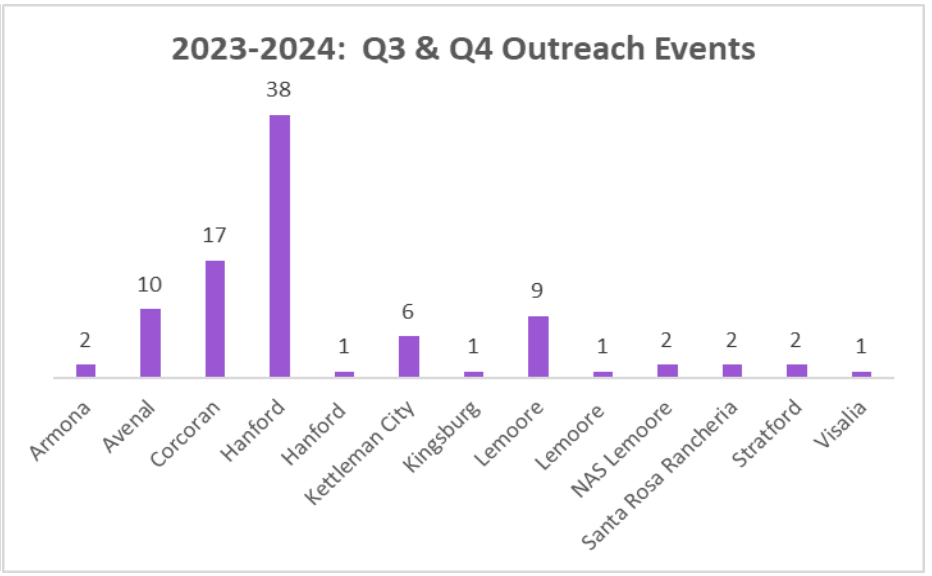
ANALYSIS: During FY 2023-2024 KCBH participated in a total of **140 OUTREACH EVENTS** throughout Kings County. The charts below show the number of events that were attended in Q1/Q2 & Q3/Q4 by city/community. Most of the outreach events occurred in the communities of Avenal, Corcoran, Hanford, and Lemoore. In Q3/Q4, there was an increase of outreach events attended in the target area of Kettleman City, as well as 2 outreach events at the Santa Rosa Rancheria.

ACTION: A metric for community outreach is still being determined, however the goal of the outreach team is to attend events targeting the most underserved and vulnerable populations, specifically where there is limited access to care, such as Avenal, Kettleman City, and Corcoran. Also, populations such as the Santa Rosa Rancheria and NAS Lemoore.

PRIOR YEAR ACTION AND RESULT: There was a significant increase in our participation at Community Outreach events, with 63 total events attended in FY 22-23 and 140 total events in FY 23-24.



TOTAL OF **48 OUTREACH EVENTS** ATTENDED IN Q1/Q2.



TOTAL OF **92 OUTREACH EVENTS** ATTENDED IN Q3/Q4.