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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 2022-2023

with

FY 2021-2022

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 of Administrative Services. The KCBH QA Team consists of a QA Manager, two QA Licensed Clinicians, 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 [KCBH]. 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:

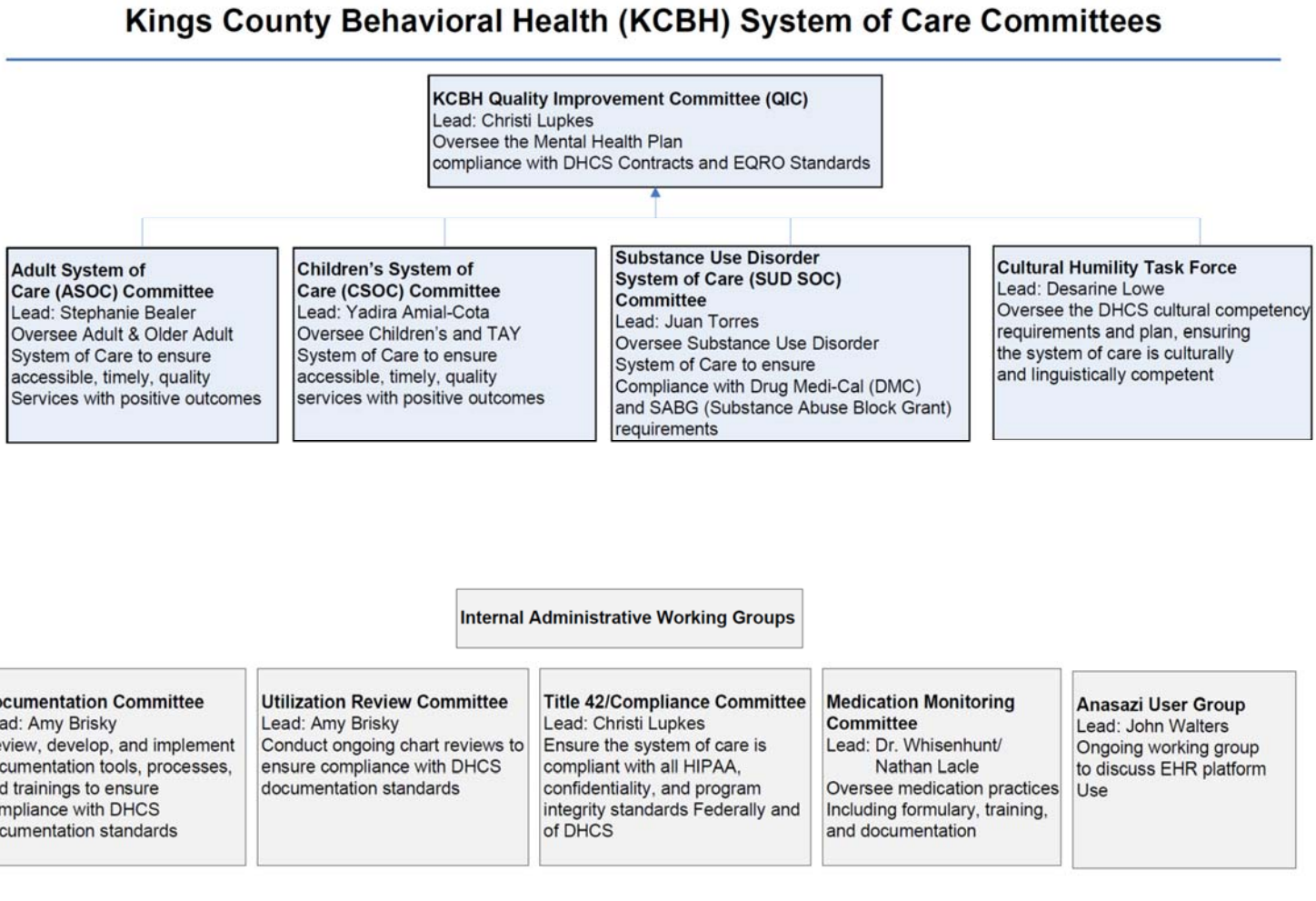
- Beneficiary and System Outcomes
  - Beneficiaries Served and Demographics
  - Timeliness of Services
  - 24/7 Access Line
  - ANSA data
  - CANS/PCS-35 Data
  - Consumer Perception Survey
  - Discharge Disposition
- Utilization Management and Utilization Review
  - Service Utilization (over- and under-utilization)
  - 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/Expedited Appeals
  - State Fair Hearings
- 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) 2021-2022 MHP QAPI Work Plan and presented the results at the August 24, 2022 Quality Improvement Committee. Below is the summary of the results of that evaluation, as well as the focus areas identified for the FY 2022-2023 QAPI Work Plan.

FY 2021-2022 EVALUATION SUMMARY

- ***Services are Accessible:*** ***Goal partially met***
    - ***While the number of individuals with Medi-Cal has increased, those Medi-Cal beneficiaries accessing county mental health services have decreased.*** *The number of individuals served as well as penetration rates steadily increased from 2016 through 2018. In 2019, the number served decreased by approximately 200, but penetration rates increased; and in 2020 and 2021, the number served continued to decrease by approximately 200 each year and penetration rates also decreased. However, the state and other small counties also reflect a similar decrease in the number served and penetration rates. It is suspected this decrease could be influenced by the COVID-19 pandemic which became most prevalent in Nov 2019 and caused national closures starting Mar 2020. Penetration rates among the 6-17 age group was significantly lower than that of the state and other small counties and experienced a steady decline year over year.*

- ***Services are Timely:*** ***Goal partially met***
    - ***First entry into services (10 business days/70% met) and post-psychiatric hospitalization timeliness (7 days/70% met) overall remain timely****. However, timeliness increased in amount of time with first entry and post hospitalization from prior fiscal years, and timeliness among children and foster youth at first entry met the 70% standard but on average took 13 days (3 days above the 10-day standard). Additionally,* ***timeliness for initial access to psychiatry (15 days/70% met) meet standards*** *improving in all age groups from prior fiscal year.*

    - ***The number of urgent conditions identified remain low and the timeliness for rendering services for an urgent condition remain outside of the state's 48-hour timeliness standard****. However, as of October 2021, the Urgent Condition Performance Improvement Project intervention began, and it is anticipated the number of urgent conditions identified will be more reflective of actual need, and the timeliness for which services are rendered for the urgent condition will improve. This intervention will be*

monitored and reported by the QA Unit at the Adult and Child System of Care Committees each month.

- ***Services are of Quality to Consumers:*** ***Goal partially met***
  - ***Satisfaction among caregivers and youth consumers remained generally satisfied; however, the satisfaction among adult and older adult consumers was unable to be appropriately measured*** *as over half of the responses were either missing or selected as not applicable. During this survey period there were significant mitigating factors that caused unreliability in this year's as well as last year's results: (1) The survey was still considered newly accessible online after going live online during the 2020 time period, and while this made it more accessible to consumers and caregivers, the application was still considered new and could have led to challenges in use. (2) The survey was delivered while most services were being provided via telehealth due to pandemic, as such the ability for individuals to complete the survey while at the provider lobby and the ability to best assist in the completion of the survey was impacted.*

  - ***Grievances slightly decreased*** *with no identified pattern or trend.*

- ***Services Produce Measurable Outcomes:*** ***Goal partially met***
  - ***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.*

  - ***The Adult Needs and Strengths Assessment (ANSA) tool is within first year of implementation, as such results are not yet measurable.***

- ***Services are Appropriately Delivered:*** ***Goal partially met***
  - ***The number of claims submitted for each specialty mental health service category decreased in 2021*** *except among TBS, IHBS, and ICC which remained relatively static. However, this decrease would align with the decrease in total number served, and the penetration rate among service categories is similar to the state and other small counties (within a 0.5% range).*

  - ***While the number of beneficiaries who received two to fourteen mental health services by the MHP was comparable to that of the state,*** *the MHP has a higher number who are only receiving one service in total and less beneficiaries than the state who are engaged in 15+ services.*

- ***NOABDs experienced a decrease*** *although timely access NOABD category did have a significant increase.*

- ***Hospitalizations increased but most notably among children*** *which increased by 96%, from 56 in FY 20/21 to 110 in 21/22.* ***Readmissions experienced a decrease*** *overall.*

- ***There is an Adequate Network of Providers:*** ***Goal partially met***
  - *As of 2019, the MHP provider network significantly increased, and as such* ***received certification by DHCS during April 2020 and 2021 annual submission as meeting network adequacy*** *for provider ratio, time and distance, and timely first service (at least 70% of first requests for services are offered an appointment that falls within 10 business days of request).* ***However, in 2022*** *many MHP programs experienced staffing challenges, and as such it is anticipated* ***the MHP will not meet network adequacy among adult psychiatry*** *(short by 1.02 FTE)* ***nor timely access*** *(appts meeting the first offered appt within 10-business days was below the new 80% network adequacy standard). Currently, Kings MHP is awaiting findings from the 2022 Submission.*

- ***Services are Documented in Accordance with State Standards:*** ***Goal Met***
  - ***Chart review compliance remain above the 90% compliance rate goal in total (92.67%), as does medication monitoring compliance (93.33%)****.*

- ***Services and Workforce are culturally and linguistically competent:*** ***Data is not yet captured within this plan*** *but is within the Behavioral Health Department's Cultural Competency Plan which metrics are being identified to carry over into this plan.*

FY 2022-2023 FOCUS AREAS FROM FY 2021-2022 EVALUATION

As a result of the findings of the evaluation of the FY 21-22 QAPI Work Plan, the Quality Improvement Committee members identified the following focus areas for the FY 22-23 QAPI Work Plan:

- *Low penetration rates among 6-17 year olds – continued focus area from FY 21-22 KCBH QAPI Work Plan*
- *High rates among those receiving only one specialty mental health services – continued focus area from FY 21-22 KCBH QAPI Work Plan*
- *96% Increase in hospitalizations among children and youth*
- *Replicate the CANS metric development for PSC-35 and ANSA*
- *Populate the metrics for cultural and linguistic competence, in alignment with the KCBH Cultural Competency Plan*

In addition to the focus areas identified, the below metrics are still in development within this QAPI Work Plan:

- *Metrics for the 24/7 Access Line*
- *ANSA and PSC-35 Data (noted above as focus area)*
- *Discharge disposition reporting*
- *Service utilization by level of care*
    - *High-utilization of services (appropriately engaged)*
    - *Low utilization of services (unengaged)*
- *Hospitalizations by consumer status (active, former, new) and by payor source (privately insured, publicly insured, uninsured)*
- *Cultural competency metrics (noted above as focus area)*
    - *Cultural Competency training*
    - *Language line utilization*
    - *Community outreach*

Lastly, it is to be noted there are current and coming year initiatives of the MHP such as the DHCS triennial Medi-Cal Review occurring in early 2023, CalAIM occurring January 2022 through July 2023, and conversion to a new electronic health record July 1, 2023, for which these initiatives are also of focus by the same resources that address the above listed focus areas and metric developments.

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

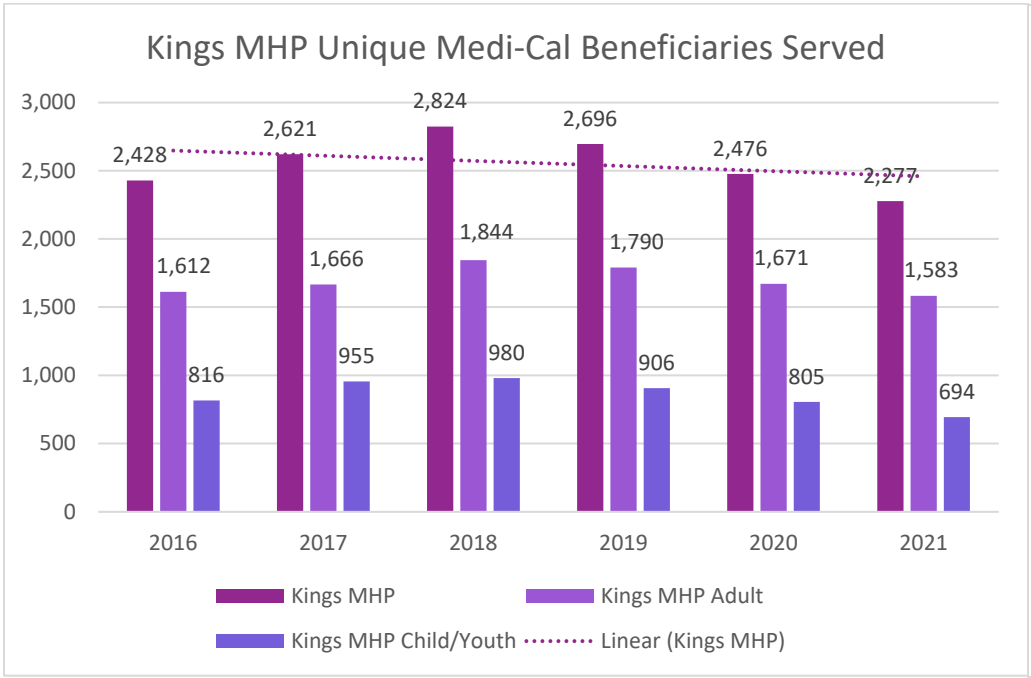
ANALYSIS: Based on the review of the year-by-year approved claims data report disseminated by Behavioral Health Concepts (BHC) each year, the Kings MHP saw a steady increase each year of the number of beneficiaries served and penetration rate from 2016 through 2018 (while the penetration rate increased in 2019 the number served slightly decreased). In 2019, both the number served and penetration rate decreased year over year. The number served decreased by approximately 200 each year and the penetration rate had a percentage decrease of less than 1% each year. In comparison, the state and other small counties also experienced a similar decrease each year as demonstrated by the penetration rate graph on the next page, but Kings MHP penetration rate remains below that of the state and other small counties.

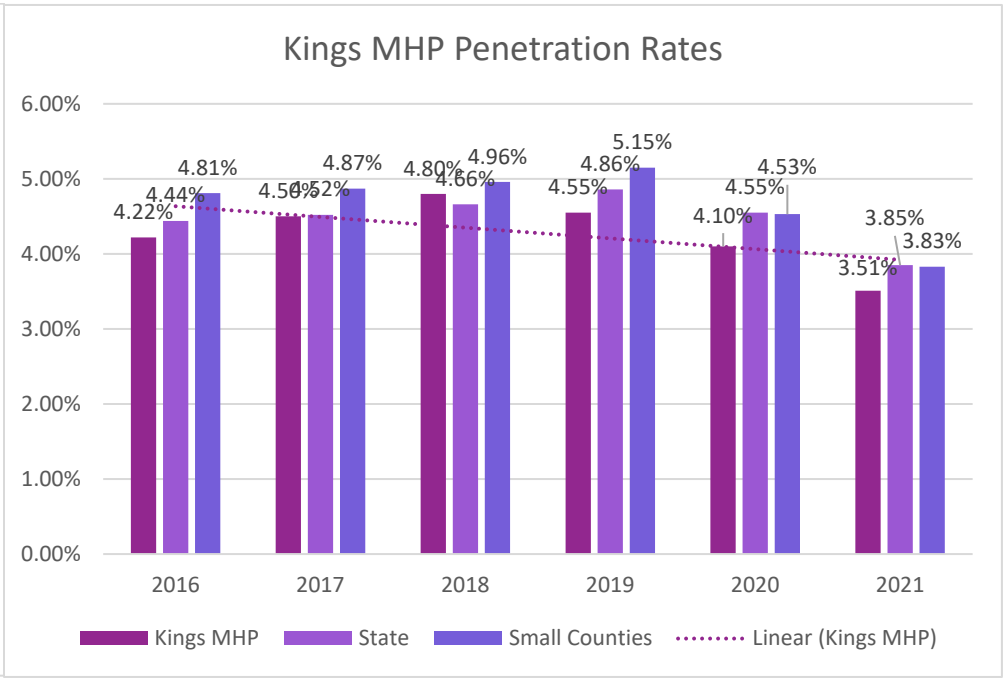
In reviewing the penetration rates by age group, the Kings MHP penetration rate for adults and for children ages 0-5 is comparable to that of the state and other small counties; however, it remains low among child and youth services ages 6-17 and has steadily declined year over year.

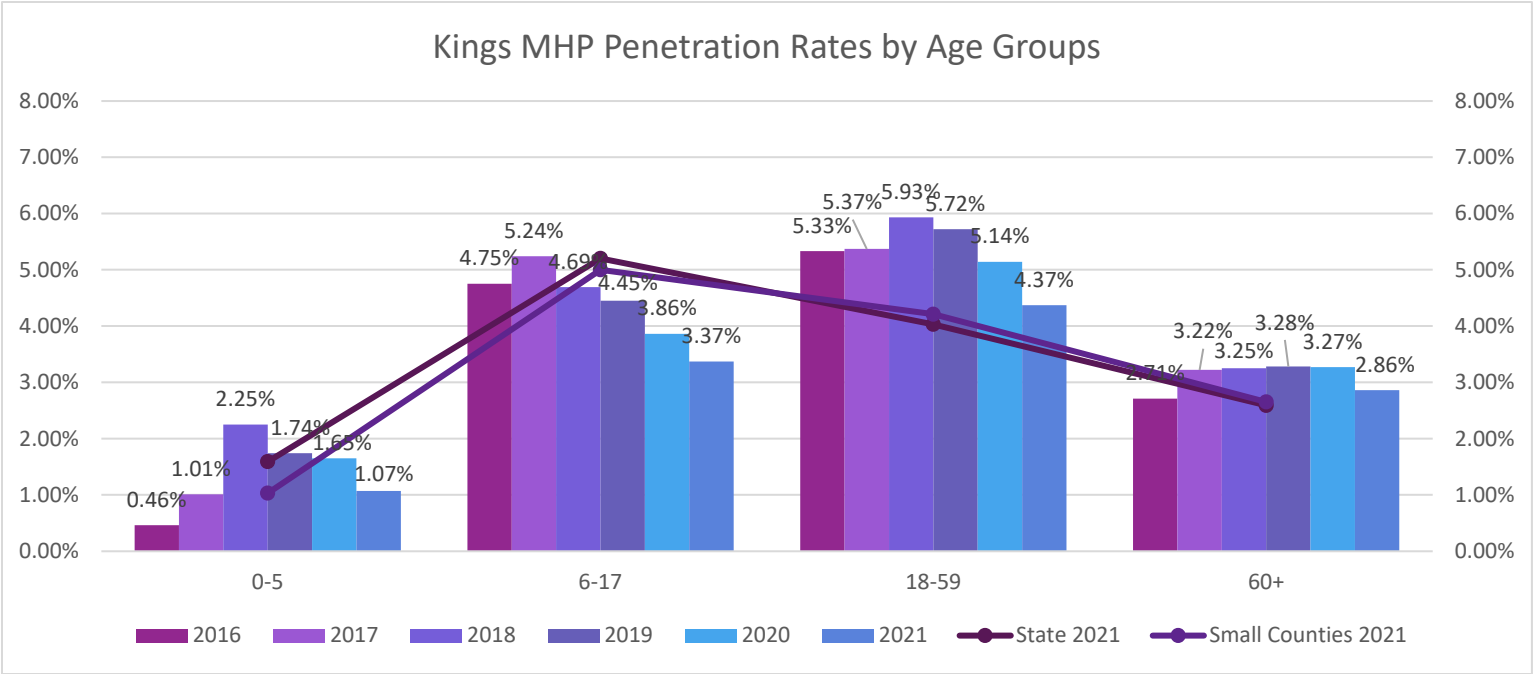
ACTION: The low penetration rate among children ages 6-17 in comparison to the state and other small counties will continue to be a priority action for the Kings County Behavioral Health Children System of Care (CSOC) Committee.

PRIOR YEAR ACTION AND RESULT: The low penetration rate among children ages 6-17 was presented to the KCBH Children System of Care Committee during fiscal year 2020/2021 for review and discussion for any possible action. From the 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 will be monitored for progress and with positive impact anticipated to be seen in claims in 2022 and beyond.

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

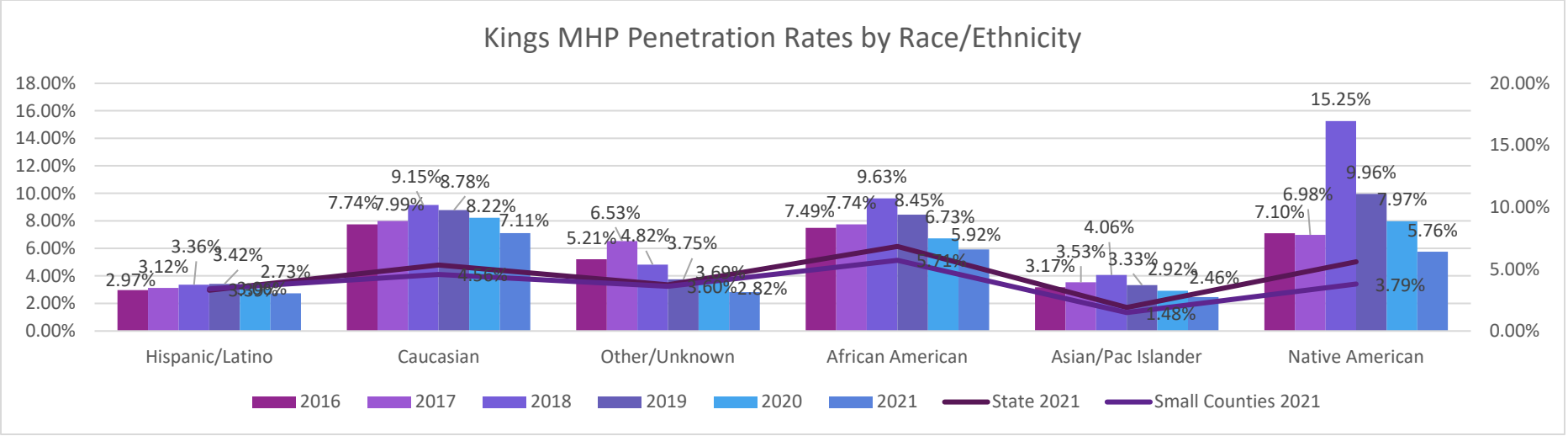
ANALYSIS: Of the beneficiaries served by Kings MHP in 2021, the race and ethnicity composition was 51% Hispanic/Latino, 29% Caucasian, 11% other/unknown, 7% African American, 1% Asian/Pacific Islander, and 1% Native American. The penetration for each were similar to that of the state and other small counties (within approximately 1%+/-) except for Caucasian which was around 2% higher. All penetration rates decreased from 2020 to 2021 in Kings and similarly in the state and other small counties.

ACTION: All penetration rates decreased in 2021 in Kings as well as throughout the state and other small counties most likely because of COVID still creating social distancing and quarantines. However, the MHP will monitor access to ensure no accessibility barriers exist and will continue to run media campaigns and conduct outreach to ensure the public is aware services are open and available to include telehealth options. It is anticipated any increase based on outreach will be seen potentially in 2022 claims data and it is hoped that COVID will have decreased as well and will have less impact to individuals seeking services.

PRIOR YEAR ACTION AND RESULT: The MHP media campaigns and outreach to ensure the public is aware services are open and available to include telehealth options, and it is anticipated any increase based on outreach will be seen potentially in 2022 claims data and it is hoped that COVID will have decreased as well and will have less impact to individuals seeking services.

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%


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%
15.00%
10.00%
5.00%
0.00%
2.97%
3.12%
3.36%
3.42%
2.73%
7.74%
7.99%
9.15%
8.78%
8.22%
7.11%
5.21%
6.53%
4.82%
3.75%
3.69%
3.60%
2.82%
7.49%
7.74%
9.63%
8.45%
6.73%
5.92%
3.17%
3.53%
4.06%
3.33%
2.92%
1.48%
2.46%
7.10%
6.98%
15.25%
9.96%
7.97%
5.76%
3.79%
Hispanic/Latino
Caucasian
Other/Unknown
African American
Asian/Pac Islander
Native American
2016
2017
2018
2019
2020
2021
State 2021
Small Counties 2021

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: The length of time from initial request for mental health services to first offered appointment was an average of 7.52 business days for all ages of which 79% of all first offered appointments met the 10 business day DHCS standard. Last fiscal year it was an average of 1.61 business days with 96% meeting the standard. The length of time increased across all populations; adults, children, and foster youth, for fiscal 20/21 in comparison to 19/20, with all groups' mean maintaining an average below the 10 business day standard.

Additionally, the length of time from initial request for service to first kept appointment (the start of the mental health assessment) was an average of 10.2 business days for all ages of which 71% met the 10 business day DHCS standard. Last fiscal year, it was an average of 6.35 business days with 82% meeting the standard. The length of time increased across all populations; adults, children, and foster youth.

ACTION: Discuss increase in overall access to services timeliness to assess potential reasons and possible actions to remedy.

PRIOR YEAR ACTION AND RESULT: It was determined to monitor timeliness of kept appointments throughout FY 20/21 as the measure was in compliance with timeliness standards but had increased by 3.5 days from FY 18/19 to 19/20. This was monitored and continued to experience an increase as seen in the below table for first request to kept appointment. Therefore, discussions about the reason for increase will be discussed during the November QIC meeting when the FY 20/21 Work Plan Evaluation is presented. However, preliminary discussion have theorized COVID impacts to staffing and access to services may be a primary cause for the increase and as such the timeliness will begin to decrease post-COVID.

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 16/17	*First request was not tracked during this time. Tracking beginning in FY 18/19.*			
FY 17/18				
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

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 16/17	21.63 Mean 17 Median 23.60 Std Dev	19.07 Mean 16 Median 20.02 Std Dev	25.19 Mean 19 Median 27.51 Std Dev	N/A
FY 17/18	1.60 Mean 1.00 Median 2.35 Std Dev.	1.60 Mean 1.00 Median 2.55 Std Dev.	1.59 Mean 1.00 Median 1.88 Std. Dev.	13.51 Mean 9.00 Median 13.79 Std Dev.
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

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

ANALYSIS: In FY 20/21, the length of time from initial request for psychiatry service to first offered psychiatry appointment was an average of 10.9 business days for all ages of which 85.9% met the 15-business day DHCS standard. In FY 19/20, it was an average of 14.78 business days with 64.57% meeting the standard. Timeliness within this measure improved from last fiscal year to this fiscal year, and is now within timeliness standard for both average business days and percent of appointments meeting the standard. When reviewed by age group, Adults and Children met the 15-business day and 70% standard which as mentioned before was an improvement from FY 19/20 bringing the MHP within timeliness standards; however, foster youth still remain outside of the timeliness standard but continue to be a measure of a very low number and as such even one foster youth not meeting the standard could push the total measure outside of compliance.

In FY 20/21, the length of time from initial request for psychiatry service to first rendered psychiatry service was an average of 20.3 business days for all ages of which 54.5% met the 15-business day DHCS standard. There is no prior FY data to compare this too as this is the first year this measure is being requested. When reviewed by age group, adults was an average of 23.9 business days with 44.9% meeting the 15-business day standard, children was an average of 8.4 business days with 84.7% meeting the standard, and there is no data for foster youth to report at this time.

ACTION: The timeliness for first request for psychiatry service (medication service) to first offered appt met the DHCS standards; however, the timeliness to first rendered service did not among adults, it was 9 days outside the 15-day timeframe with the median falling 3 days above the timeframe. Therefore, this measure shall be further reviewed and discussed for possible actions to remedy.

PRIOR YEAR ACTION AND RESULT: In FY 19/20, both the timeliness of offered appointments and kept appointments were in compliance with DHCS standards; therefore, no action was determined as necessary.

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 16/17	45 Mean 44 Median 27.89 Std Dev	44 Mean 43 Median 23.22 Std Dev	47 Mean 49 Median 21.61 Std Dev	N/A
FY 17/18	21.99 Mean 21 Median 13.03 Std Dev	21.83 Mean 21 Median 13.21 Std Dev	24.07 Mean 24 Median 12.65 Std Dev	18.55 Mean 18 Median 8.17 Std Dev
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

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 16/17	*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 17/18				
FY 18/19				
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

INDICATOR: TIMELINESS OF FIRST ENTRY FOR URGENT CONDITION

ANALYSIS: In FY 20/21, 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 138 hours (5.75 days) for all ages of which 43% met the 48-hour DHCS standard. In FY 19/20, when the measurement began in quarters 3 & 4, it was an average of 61.20 hours (2.55 days) with 65% meeting the standard. This timeliness measure remains outside of the DHCS standard, and is the MHP's non-clinical PIP for which we anticipate our rollout of a MHP-wide standardized identification, response, and tracking process for Urgent Conditions will improve the identification of and timeliness for urgent conditions.

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

ACTION: A more MHP-wide standardized process for identifying, responding to, and tracking of urgent conditions is the MHP's non-clinical PIP. This process was approved by the Adults System of Care, Children's System of Care, and Documentation Committees' for implementation October 2021. The aim is to better identify those beneficiaries with urgent conditions and serve them in a more timely manner. The tracking will be collected each month from each MHP provider site for analysis, reporting, and discussion at the monthly aforementioned committees to ensure effective implementation and progress towards PIP aim.

PRIOR YEAR ACTION AND RESULT: The MHP was to develop a non-clinical PIP around improving the definition and identification of, process for, and tracking of urgent conditions with the goal of better identifying those with an urgent condition and serving them in a timelier manner. This occurred and the process was implemented October 2021.

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 16/17	1 day Mean 1 day Median N/A Std. Dev.	1 day Mean 1 day Median N/A Std. Dev.	N/A Mean N/A Median N/A Std. Dev.	N/A
FY 17/18	9 days Mean N/A Median N/A Std Dev.	1 day Mean 1 day Median N/A Std Dev.	17 days Mean 17 day Median N/A Std Dev.	N/A Mean N/A Median N/A Std Dev.
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

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				

INDICATOR: TIMELINESS OF POST-PSYCHIATRIC INPATIENT DISCHARGE

ANALYSIS: In FY 21/22, Kings MHP had 231 post-psychiatric hospitalization appointments of which 199 (86%) 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 5.29 days. This was static from the prior year average of 5.27 days and all age groups remain 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 21/22.

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

OBJECTIVE 1.3: SERVICES ARE OF QUALITY TO CONSUMERS

INDICATOR: CONSUMER SATISFACTION SURVEY

ANALYSIS: In 2020, DHCS decreased the number of consumer perception survey periods from the traditional two per year (May and Nov) to one per year, and due to COVID the period was delayed by DHCS from May to June. This continued through 2021.

For the June 2020 Consumer Perception Survey, the ability to assess and compare satisfaction among beneficiaries and caregivers was challenging as the MHP experienced a high percent of questions with "N/A or Missing", as such, while it appears the satisfaction decreased in 2020 overall and in comparison to prior survey periods, it is primarily due to a high percent of missing or incomplete responses. This was also seen in the 2021 Surveys: There were a low number of submitted surveys due to administering primarily online rather than in-person while consumer was in lobby waiting areas, and of those surveys submitted a quarter of the responses among family and child and over half of the responses among adults were marked "missing. In reviewing the results where responses were submitted, all areas were rated predominantly as "shows satisfaction."

ACTION: 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.

PRIOR YEAR ACTION AND RESULT: FY 2020 there was no action as survey were still being administered primarily online due to COVID impact.

CONSUMER PERCEPTION SURVEYS (CPS) RESULTS

Survey Date	# of Surveys	Question Category			
		Satisfaction	Access	Informed Consent/ Participation	Effectiveness/ Well-Being
May 2019 Adult/OA	131	89.6%	87.4%	85.2%	77.0% *(13.9% neutral)*
May 2019 C/Y & Family	274	84.4%	79.6%	84.0%	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	81.9%	87.5%	86.6%	72.7% *(11% neutral)*
Nov 2019 Youth (12-17)	28	78.6%	79.8%	75.8%	65.3% *(20.1% neutral)*
Nov 2019 Adult (18-59)	80	90.4%	79.6%	81.4%	59.0% *(19.3% neutral)*
Nov 2019 Older Adult (60+)	4	91.7%	83.3%	84.1%	59.4% *(15.6& neutral)*
June 2020 Adult/OA	51	56.86% *(38.56% N/A or Missing)*	50.65% *(43.14% N/A or Missing)*	50.45% *(43.85 % N/A or Missing)*	34.19% *(43.63% N/A or Missing)*
June 2020 C/Y & Family	32	71.88% *(23.96% N/A or Missing)*	80.21% *(18.75% N/A or Missing)*	81.25% *(16.32% N/A or Missing)*	61.08% *(32.39% N/A or Missing)*
June 2021 Adult/OA	27	23.46% *(53.09% N/A or Missing)*	23.46% *(53.70% N/A or Missing)*	22.64% *(57.09 % N/A or Missing)*	28.97% *(58.18% N/A or Missing)*
June 2021 C/Y & Family	26	64.10% *(28.21% N/A or Missing)*	65.38% *(28.21% N/A or Missing)*	59.83% *(31.20% N/A or Missing)*	55.94% *(29.37% N/A or Missing)*

OBJECTIVE 1.4: SERVICES PRODUCE MEASURABLE OUTCOMES

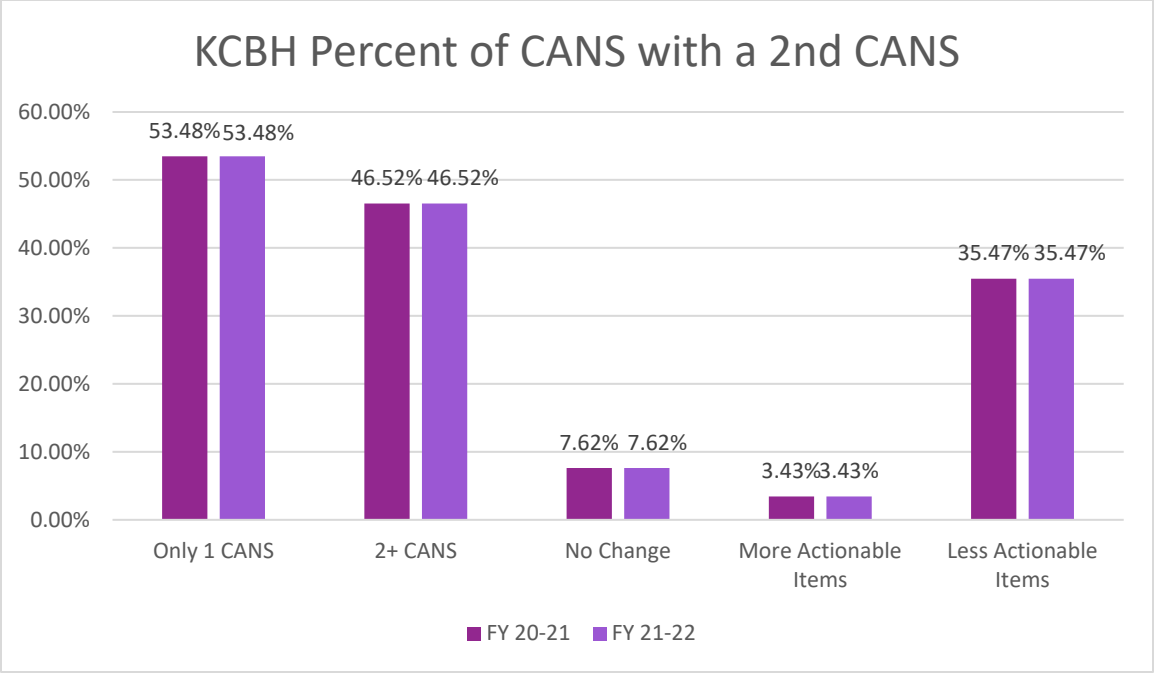
INDICATOR: FUNCTIONAL IMPROVEMENT AMONG CHILD/YOUTH CONSUMERS, PER USE OF CANS/PCS-35

ANALYSIS: The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Kings County Behavioral Health (KCBH) clinicians currently administer CANS 2.0 for children and youth up to 21 years of age at intake, every 6 months throughout treatment or earlier if clinically indicated, and at discharge, as a structured assessment to identify youth and family strengths and needs. Questions on the CANS are scored on a scale from 0-3, with 3 being the highest indicator of needing immediate or intensive action. Questions are grouped into four categories: Child behavioral and emotional needs, Life domain function, Risk behaviors, and Cultural factors. Progress on the CANS is defined as a reduction of at least one need from initial assessment to discharge (i.e., moving from a '2' or '3' at initial assessment to a '0' or '1' on the same item at the discharge assessment). Below is a visual representation of CANS which had an initial and discharge CANS, and the 2s and 3s scored on the initial CANS versus at discharge (2s and 3s being the actionable treatment areas and as such a reduction in 2s and 3s demonstrates progress in treatment).

Upon a more detailed review of FY 20-21 and 21-22 discharge CANS scores among 2s and 3s in comparison to initial CANS 2s and 3s, nearly all scores experienced a reduction of 70% or greater; the area that had a low score but experienced the least percentage of reduction was among 2s in Self-Harm; and the common areas that scored the highest in actionable areas during initial CANS were Depression, Family Functioning, School Functioning, Anger Control, and Decision-making.

ACTION: The Children's System of Care (CSOC) Committee will continue to review and discuss the CANS data to determine if any action is warranted during 22/23. Additionally, the Quality Assurance Unit is working on presenting the PSC-35 data in a similar fashion to the CSOC Committee in the fall of 2022 for which it will be incorporated into the QAPI Work Plan moving forward with any actions determined by the CSOC Committee.

PRIOR YEAR ACTION AND RESULT: There was no prior year action; metric developed as of FY 21/22 QAPI Work Plan.


KCBH Percent of CANS with a 2nd CANS
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
53.48% 53.48%
46.52% 46.52%
7.62% 7.62%
3.43% 3.43%
35.47% 35.47%
Only 1 CANS
2+ CANS
No Change
More Actionable Items
Less Actionable Items
FY 20-21
FY 21-22

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

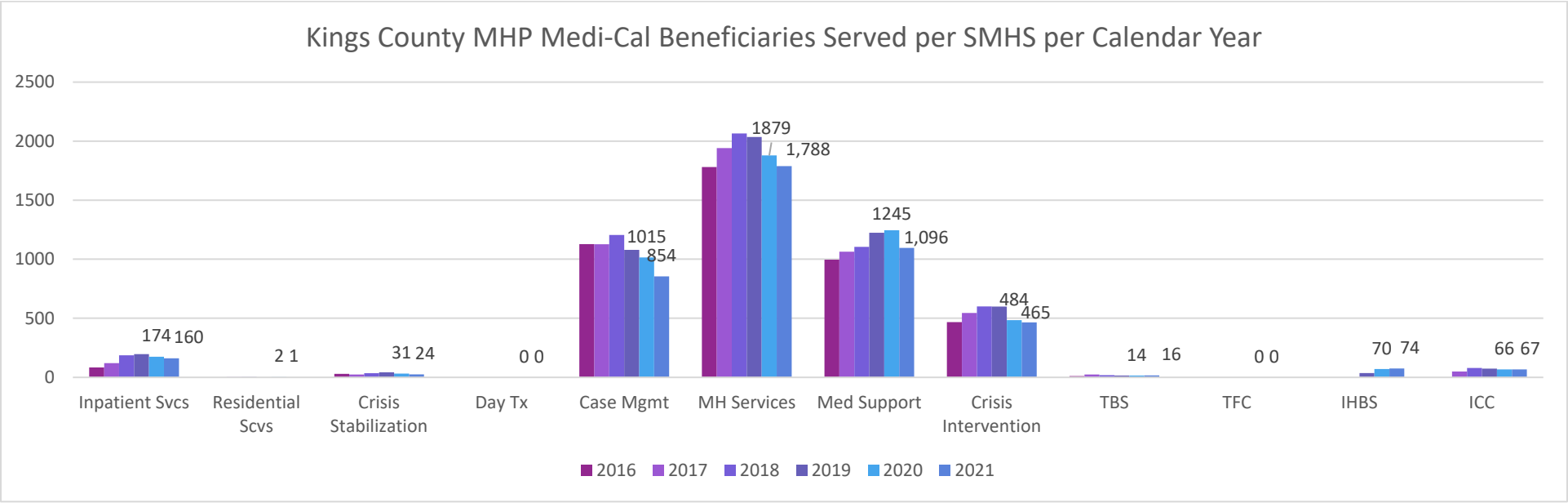
Placeholder for Metric: Count consumer with no contact for more than 30 days

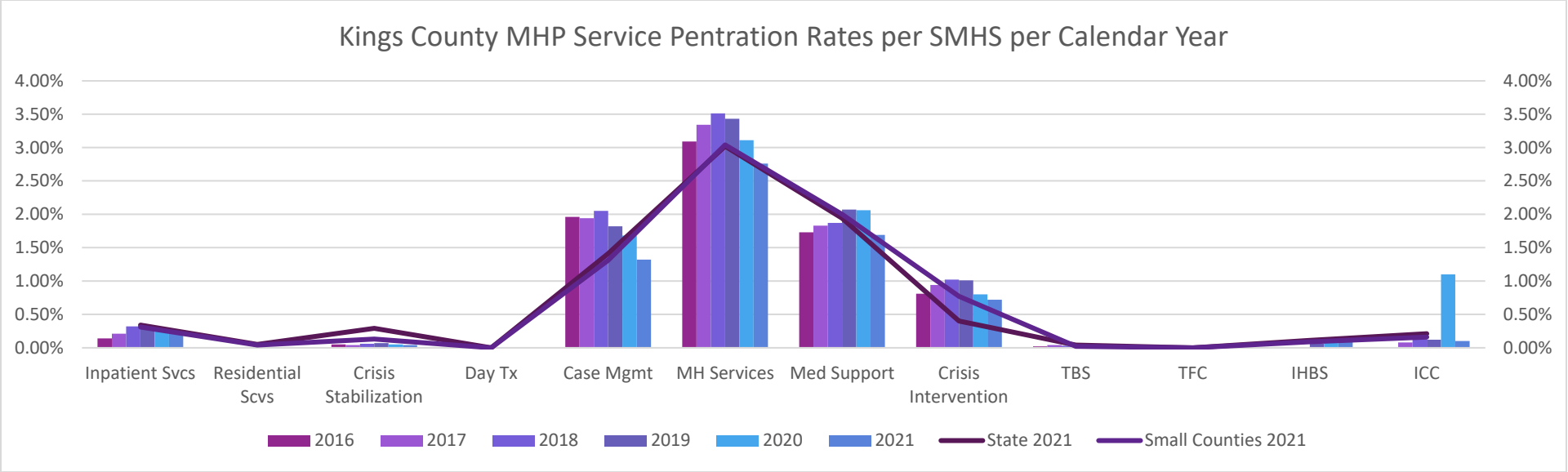
INDICATOR: SERVICES PROVIDED AS DEMONSTRATED THROUGH APPROVED CLAIMS

ANALYSIS: In FY 21/22, the number of beneficiaries with claims decreased among all SMHS categories except among TBS, IHBS, and ICC which remained relatively static; however, the decrease appears similar to that of the decrease in total population served (approx. decrease of 200). When reviewing the penetration rate among all service categories though, most of the rates decreased which is expected with the decrease of number served, but the rates are similar to that of the state and other small counties (within less than a 0.5% range).

ACTION: No action is needed as penetration rates are similar to that of the state and other small counties.

PRIOR YEAR ACTION AND RESULT: No action was identified for FY 20/21.



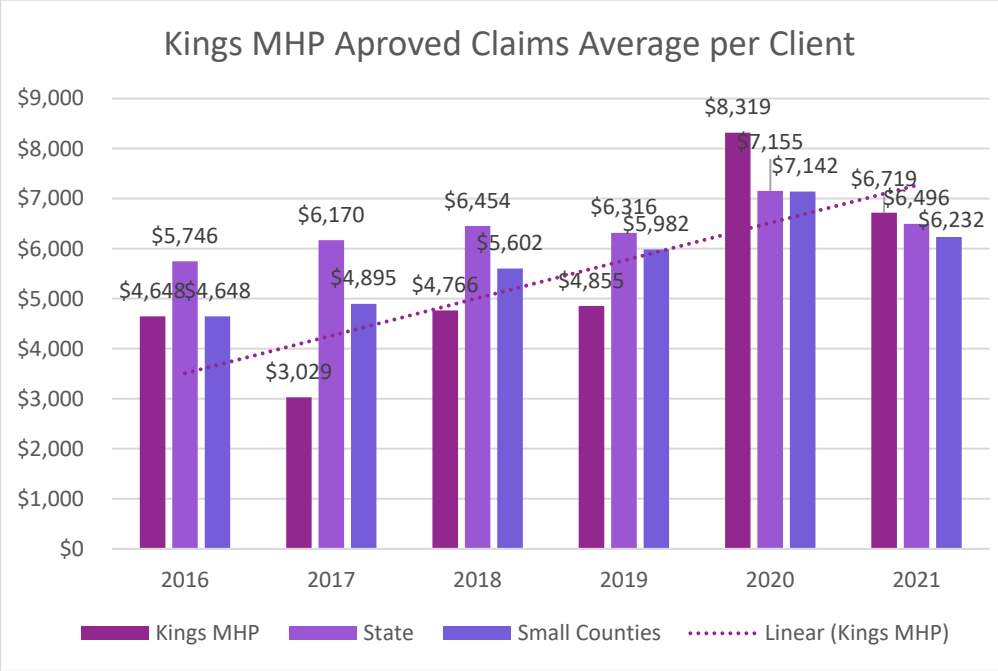

Kings County MHP Service Pentration Rates per SMHS per Calendar Year
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
Inpatient Svcs
Residential Scvs
Crisis Stabilization
Day Tx
Case Mgmt
MH Services
Med Support
Crisis Intervention
TBS
TFC
IHBS
ICC
2016
2017
2018
2019
2020
2021
State 2021
Small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

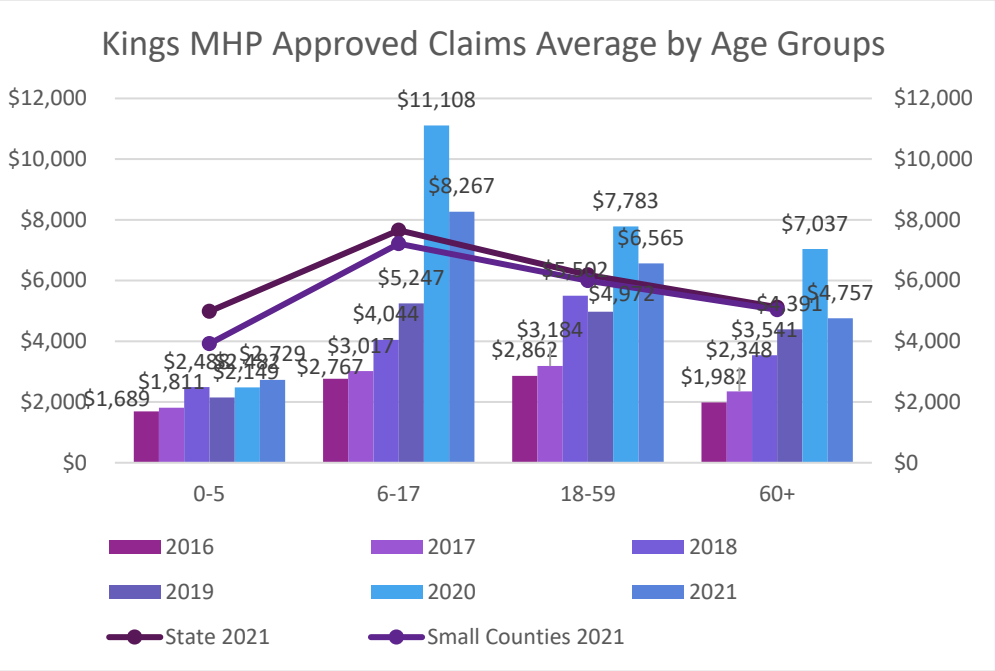
INDICATOR: MEDI-CAL APPROVED CLAIMS AND SERVICES

ANALYSIS: Kings MHP average approved claims per beneficiary was steadily increasing in 2018 and 2019 from 2017. However, in 2020 the average claim per beneficiary significantly increased nearly doubling, but that is not an accurate reflection of a true increase because during 2020 MHPs were able to adjust their rates to COVID rates which were rates above the typical SMHS rates to assist MHPs in covering costs during the unpredictable pandemic. This COVID rate continued into a portion of 2021. Therefore, any data related to claim amounts that cover FY 20/21 should be reviewed with caution as they reflect an atypical inflated amount that cannot be compared to other years nor to the State and other counties, as it was optional for MHPs to adjust to COVID rates and as such State and other small county claims encompass some adjusted rates and other non-COVID adjusted rates.

ACTION: No action recommended.

PRIOR YEAR ACTION AND RESULTS: No identified action from FY 20/21.



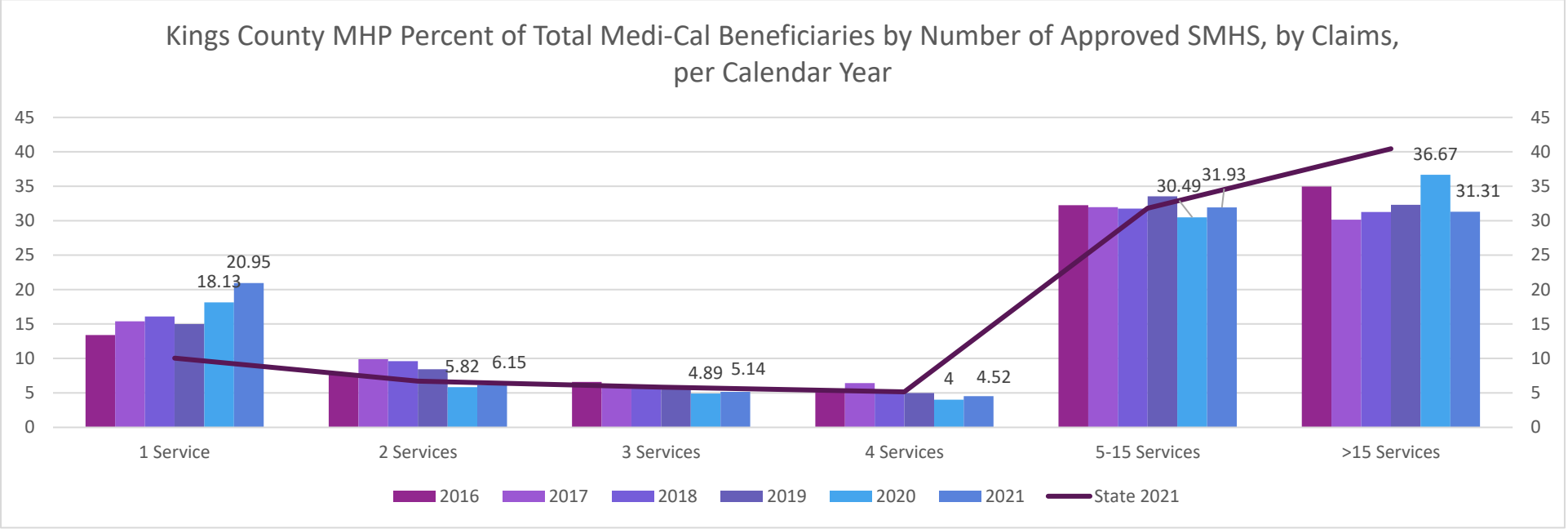


INDICATOR: ENGAGEMENT RATES OF CONSUMERS

ANALYSIS: Kings MHP appears to continue to have more beneficiaries receiving only one SMHS (i.e. presumably more being found not meeting medical necessity, or after assessment not returning for treatment) than the state rate, and less receiving more than 15 SMHS than the state rate. Beneficiaries receiving 2 to 15 SMHS from Kings MHP is similar to or slightly higher than that of the state.

ACTION: The MHP will explore methods in which this may be able to be examined through data and will also discuss among providers to try to glean an understanding of potential reasons for the more having just 1 SMHS and less having 15 or more.

PRIOR YEAR ACTION AND REMAINS THIS YEAR'S ACTION: The MHP was to develop reports to assist in assessing if beneficiaries are engaging in services at the most appropriate level of care and thus discharging successfully after a sufficient length of program engagement. However, that has not yet occurred. Additionally, the MHP was to review other County QAPI Work Plans to assess their NOABD rate for medical necessity denial at assessment in an effort to gauge if the higher rate of beneficiaries receiving one SMHS is indicative of a higher rate of beneficiaries not meeting medical necessity at assessment, but this has not yet occurred.



INDICATOR: NO-SHOW RATE FOR CLINICAL AND PSYCHIATRY SERVICES

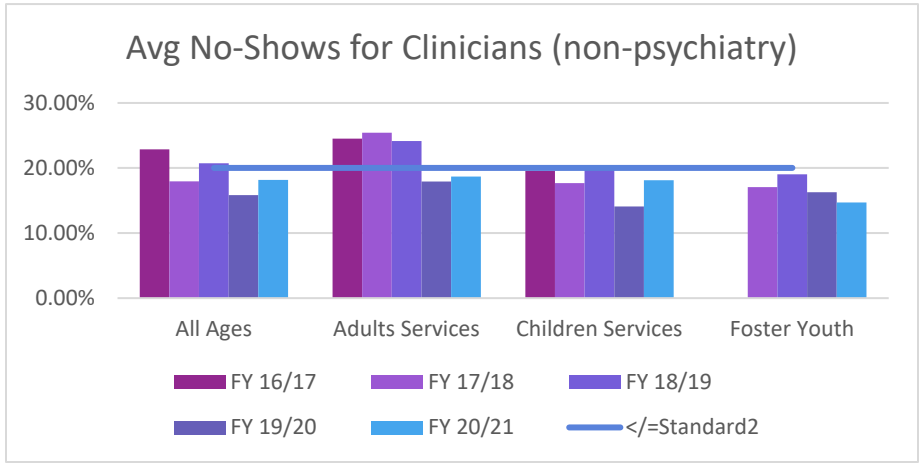
ANALYSIS: In FY 20/21, the no-show rates for psychiatry (med services) among all ages was 15.65%, among adults was 15.48%, among children and youth was 16.62%, and among foster youth was 14.86%. In comparison, for fiscal year 2019/2020, the no-show rates for psychiatry (med services) among all ages was 12.11%, among adults was 16.55%, among children and youth was 4.55%, and among foster youth was 21.54%. For clinical services (non-med services), for fiscal year 2020/2021, the no-show rates among all ages was 18.15%, among adults was 18.66%, among children and youth was 18.11%, and among foster youth was 14.69%. In comparison, for fiscal year 2019/2020, the no-show rates among all ages was 15.81%, among adults was 17.91%, among children and youth was 14.08%, and among foster youth was 16.25%. The MHP goal is to have a no-show rate of 20% or less among med services and clinical services. All age groups met at or below this rate for fiscal year 2020/2021.

ACTION: No action needed.

PRIOR YEAR ACTION AND RESULT: The children's no-show rate for psychiatry in FY 19/20 decreased substantially from 16.53 in FY 18/19 to 4.55 in FY 19/20, so with such a significant change, the data was to be reviewed for accuracy as well as for potential causes. The data was found to be accurate, and in FY 20/21 returned to typical time frames as seen in prior FYs.

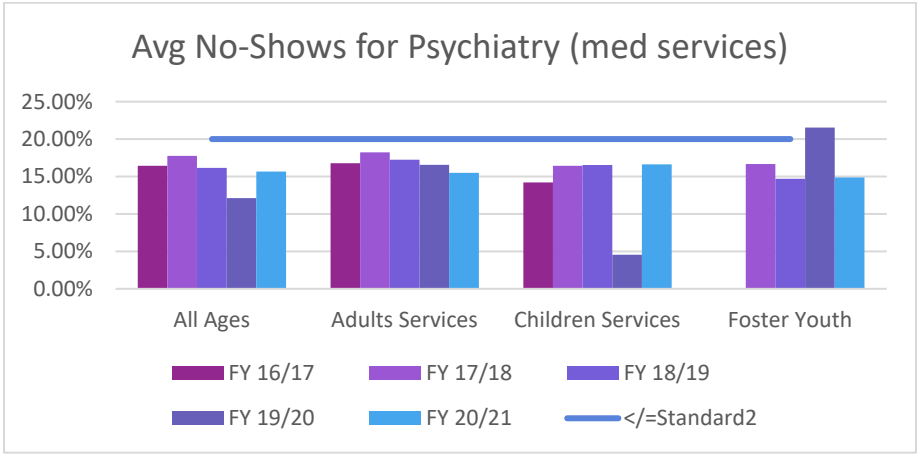
AVERAGE NO-SHOWS FOR CLINICIANS OTHER THAN PSYCHIATRISTS

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

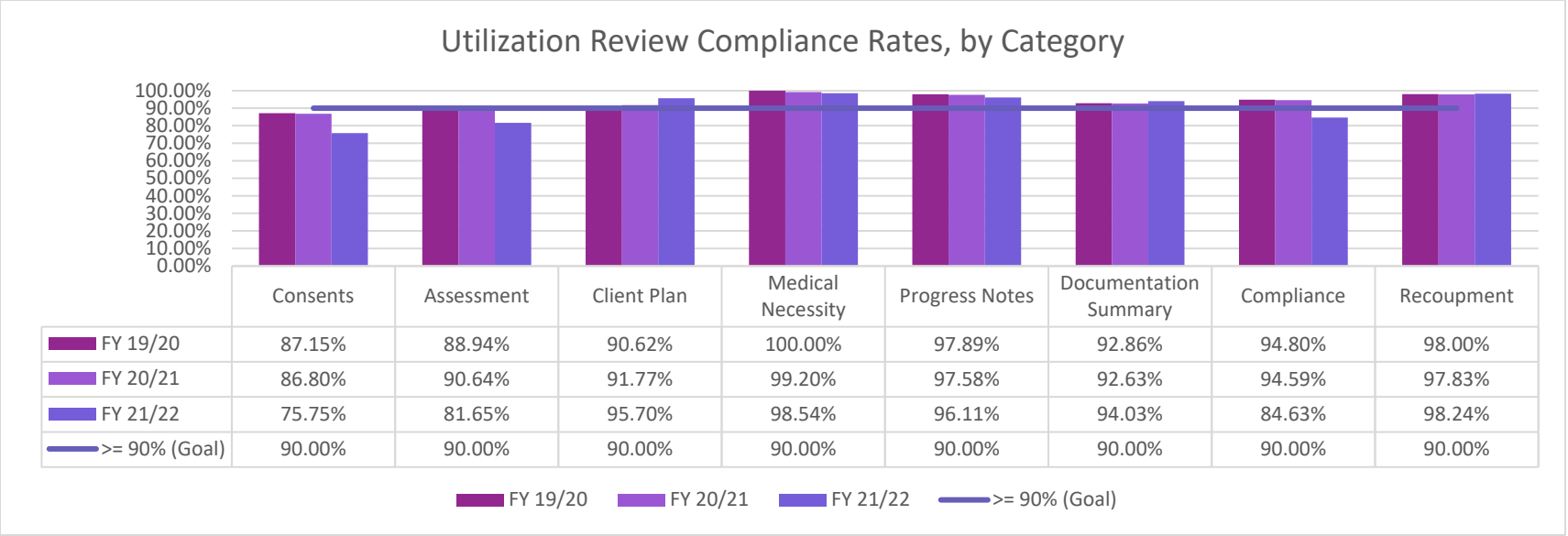
ANALYSIS: In FY 21/22, Kings County MHP had a 92.67% utilization review (UR) compliance rate after reviewing 201 charts totaling 11,550 chart items. This is a slight decrease from FY 20/21 total compliance of 95.17%; however, is over the compliance goal of 90%. UR is broken out into 8 categories seen in the graph below wherein all but three met or exceeded the MHP goal of 90% compliance. The three below 90% compliance were: Consents, Assessments, and Compliance items.

ACTION: Consents will remain an area of focus for improvement in UR in FY 21/22 using the feedback gathered by the May 2022 activities outlined below, as well as changing the UR Tool to capture any and all relevant CalAIM impacts to documentation.

PRIOR YEAR'S ACTION AND RESULTS: Consent was the primary focus in FY 20/21 of which the QA Clinician: (1) recirculated the AB630 Memo and form to be completed by clinicians prior to initiating therapy services as this was a particularly low compliance area (68%); (2) Hosted an optional training on the UR audit tool for all current and new UR chart reviewers; and (3) In May 2022, met with clinic leads and managers from each provider site to discuss Consent Category Compliance including provider identified challenges with meeting compliance, strategies employed that are currently working, and to gather feedback about future MHP interventions.

CHART REVIEW RESULTS

FY	Total Charts Reviewed	Items Compliant	Items Not-Compliant	Total % Compliant
FY 19/20	233	13,838	1,311	91.35%
FY 20/21	215	19,673	950	95.17%
FY 21/22	201	11,550	913	92.67%



	Consents	Assessment	Client Plan	Medical Necessity	Progress Notes	Documentation Summary	Compliance	Recoupment
FY 19/20	87.15%	88.94%	90.62%	100.00%	97.89%	92.86%	94.80%	98.00%
FY 20/21	86.80%	90.64%	91.77%	99.20%	97.58%	92.63%	94.59%	97.83%
FY 21/22	75.75%	81.65%	95.70%	98.54%	96.11%	94.03%	84.63%	98.24%
>= 90% (Goal)	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

INDICATOR: MEDICATION PRACTICES

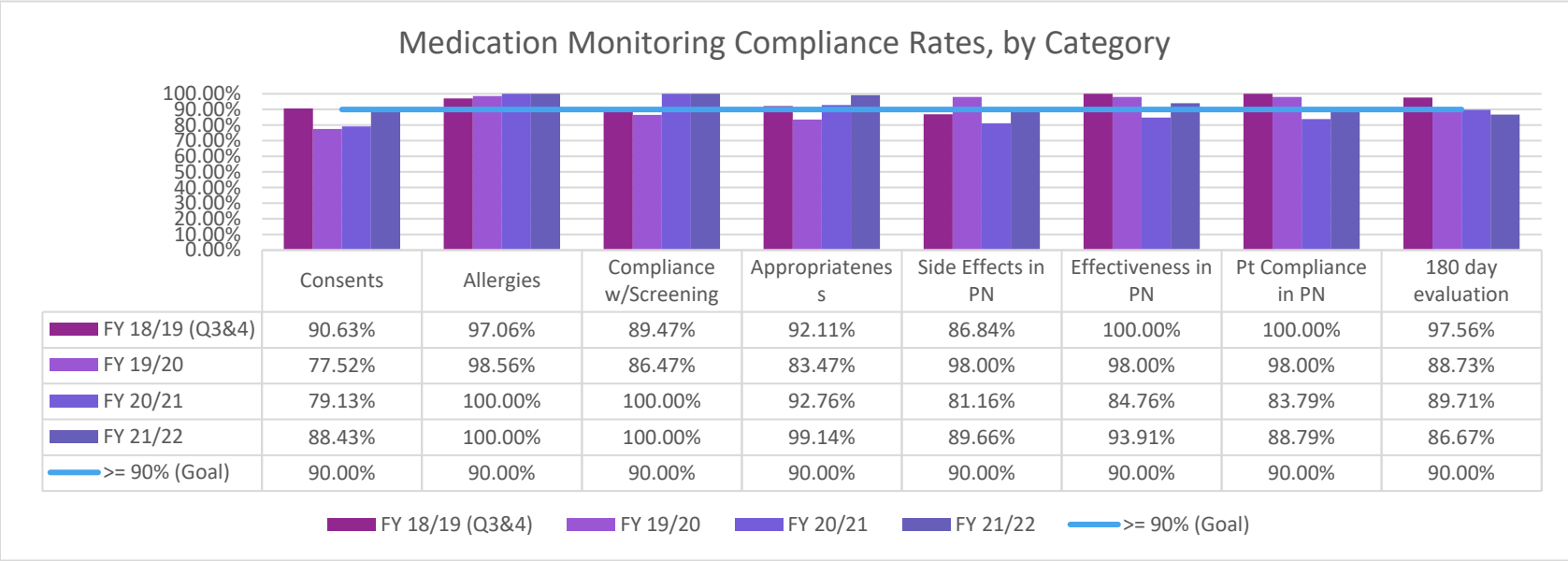
MEDICATION MONITORING CHART REVIEW RESULTS

ANALYSIS: In FY 21/22, Kings MHP had a 93.33% medication monitoring compliance rate after reviewing 149 charts totaling 974 chart items. The medication monitoring review is broken out into 8 categories seen in the graph below. Four of the eight categories met or exceeded the MHP goal of 90% compliance. The other four categories that did not meet the 90% standard were: Med Consent and Progress Notes (Side Effects, Patient evaluated every 180 days, and Patient Compliance).

ACTION: The MHP shall monitor medication consent compliance for new electronic medication consents. The MHP shall continue to provide education and reminder at the monthly medication monitoring committee meeting regarding expectations of medication consent compliance. The MHP will provide a refresher training with acknowledgment of expectation if medication consents continue to fall below goal of 90%. The MHP shall continue to provide education and reminder at the monthly medication monitoring committee meeting regarding expectations of documentation and adhering to compliance of all areas of documentation (such as Side Effects, Patient evaluated every 180 days and Patient Compliance). The MHP shall be working on standardizing a documentation template and documentation requirements Policy and Procedure during FY 22/23. The MHP shall analyze trends that may be hindering item compliance and will work towards improving noncompliant items.

PRIOR YEAR ACTION AND RESULTS: The action from the FY 20/21 QAPI Work Plan were for Med Monitoring categories to be discussed in the medication monitoring committee for decision with action to assist in increasing compliance in the three areas that did not meet the 90% standard. These areas were discussed monthly when compliance was under the goal of 90%. There was an increase in the mediation consents compliance; however, it still fell short of the 90% compliance goal. Requirements for documentation did see a slight increase, however, fell short of the 90% compliance goal except for effectiveness of medication prescribed, which saw an increase to 93.91% in FY21/22.

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%



	Consents	Allergies	Compliance w/Screening	Appropriateness	Side Effects in PN	Effectiveness in PN	Pt Compliance in PN	180 day evaluation
FY 18/19 (Q3&4)	90.63%	97.06%	89.47%	92.11%	86.84%	100.00%	100.00%	97.56%
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%
>= 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 21/22, there were 477 total psychiatric hospitalizations, an increase from 434 in FY 20/21. In reviewing the number of hospitalization (477) against the number of beneficiaries served per 2020 Claims Data (2277), the MHP had a 21% Hospitalization Rate which is above that of the estimated 15% benchmark. However, among readmission rates within 30-days of hospital discharge, there was a decrease from 7.83% (34) in FY 20/21 to 5.03% (24) in FY 21/22. The primary increase in hospitalizations was among children which saw a 96% increase from 56 in FY 20/21 to 110 in 21/22.

ACTION: The children's hospitalizations will be discussed within the Children's System of Care (CSOC) Committee for review for action.

PRIOR YEAR ACTION AND RESULT: There were no actions identified for FY 21/22.

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

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%

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: For the FY 22/23 Network Adequacy Certification, the Kings MHP reported the availability of 94.90 direct provider full-time equivalencies (FTE), not including any reserve capacity FTEs. The MHP has a reserve capacity contract for children's psychiatry and SMHS providers to expand available providers if the need should arise. With the reserve, the available FTEs are 116.90. This composition of providers, along with the reserve capacity FTEs, meets the DHCS provider ratio standards for the 2022 annual network adequacy certification for child psychiatry providers, child non-psychiatry providers, and adult no-psychiatry providers, but is under the ratio for adult psychiatry (need 2.93 FTE, reported 1.91 FTE which was a 1.40 FTE reduction (by 4 providers) in adult psychiatry from April 2021 to July 2022).

ACTION: Assess FTE reduction in adult psychiatry to assess if these are vacancies that have since been filled, etc. Corrective action by the MHP for any unmet provider ratio will be required by March 2023.

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)*

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	**July 2022**	1:524	1536	2.93	1.91	Awaiting Finding Report
	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	**July 2022**	1:323	636	1.97	2.94 *(includes 1 FTE Reserve)*	Awaiting Finding Report
	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	**July 2022**	1:85	2292	26.96	34.20	Awaiting Finding Report
	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	**July 2022**	1:43	2357	54.81	77.85 *(includes 21 FTE Reserve)*	Awaiting Finding Report
	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

Metric to be developed

GOAL 4: BENEFICIARY PROTECTIONS

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

INDICATOR: COUNT AND TYPE OF GRIEVANCES, APPEALS, EXPEDITED APPEALS, AND STATE FAIR HEARINGS

ANALYSIS: In FY 21/22, Kings MHP processed 63 Patient Rights Advocate-processed grievances and Exempt grievances (exempt are grievances completed same day), which is a slight decrease from FY 20/21 (66). No trend or pattern arose during the FY among grievances. Additionally, Kings MHP issued 772 Notice of Adverse Benefit Determinations (NOABDs) for which 19 were appealed resulting in 13 decisions upheld and 6 decisions overturned. The number of NOABDs issued in FY 21/22 by the MHP was a slight decrease from 20/21. The MHP implemented the use of NOABDs in January 2020 making it difficult to compare FY 18/19 & 19/20 to future years. Prior to January 2020, providers would have used a NOA-B form to indicate that a beneficiary did not meet medical necessity criteria for SMHS and this would have been logged as a Denial. Terminations were completed by issuing a 10-day letter to the beneficiary and were not logged/tracked as formally as have been since the implementation of NOABDs. With this in mind, the MHP compares NOABD categories for 20/21 and 21/22. In this comparison, it was found that there was a pattern and trend emerging among timely access NOABDs as there were 89 issued in 21/22 but none in 20/21. In reviewing this, it was identified that a reminder of the use of timely access NOABDs was necessary to ensure those not offered an appt within the timely access standard (i.e. 10-business days for first offered appt or 15-business days for first offered psychiatry appt, etc.) are to be issued a timely access NOABD.

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 21/22.

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 18/19	7	0	59	10	1	0	1	0	35	0	**113**
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**

APPEALS RESULTING FROM NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD)

		Process			Appeal Decision			Expedited Appeal Disposition		
Category	**FY**	**# of all NOABDs Issued**	**Appeal**	**Expedited Appeal**	**Appeals Pending or unresolved** *as of reporting time*	**Decision Upheld**	**Decision Overturned**	**Expedited Appeals Pending or unresolved** *as of reporting time*	**Decision Upheld**	**Decision Overturned**
Denial Notice	**18/19**	464	0	0	0	0	0	0	0	0
	19/20	312	3	0	0	0	3	0	0	0
	20/21	6	0	0	0	0	0	0	0	0
	21/22	8	0	0	0	0	0	0	0	0

Payment Denial	**18/19**	0	0	0	0	0	0	0	0	0
	19/20	0	0	0	0	0	0	0	0	0
	20/21	37	5	0	0	1	5	0	0	0
	21/22	22	8	0	0	5	3	0	0	0
Delivery System	**18/19**	0	0	0	0	0	0	0	0	0
	19/20	254	1	3	0	1	0	0	0	3
	20/21	253	6	0	0	1	0	0	0	0
	21/22	215	1	0	0	0	1	0	0	0
Modification	**18/19**	0	0	0	0	0	0	0	0	0
	19/20	1	1	0	0	1	0	0	0	0
	20/21	0	0	0	0	0	0	0	0	0
	21/22	1	0	0	0	0	0	0	0	0
Termination	**18/19**	0	0	0	0	0	0	0	0	0
	19/20	245	3	1	0	3	0	0	0	1
	20/21	485	8	0	0	5	3	0	0	0
	21/22	436	10	0	0	8	2	0	0	0
Authorization Delay	**18/19**	0	0	0	0	0	0	0	0	0
	19/20	0	0	0	0	0	0	0	0	0
	20/21	0	0	0	0	0	0	0	0	0
	21/22	0	0	0	0	0	0	0	0	0
Timely Access	**18/19**	0	0	0	0	0	0	0	0	0
	19/20	0	0	0	0	0	0	0	0	0

	20/21	0	0	0	0	0	0	0	0	0
	21/22	89	0	0	0	0	0	0	0	0
Financial Liability	**18/19**	0	0	0	0	0	0	0	0	0
	19/20	0	0	0	0	0	0	0	0	0
	20/21	0	0	0	0	0	0	0	0	0
	21/22	0	0	0	0	0	0	0	0	0
Grievance and Appeal Timely Resolution	**18/19**	0	0	0	0	0	0	0	0	0
	19/20	0	0	0	0	0	0	0	0	0
	20/21	1	0	0	0	0	0	0	0	0
	21/22	1	0	0	0	0	0	0	0	0
TOTALS	**18/19**	**464**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	19/20	**812**	**8**	**4**	**0**	**5**	**3**	**0**	**0**	**4**
	20/21	**782**	**19**	**0**	**0**	**7**	**12**	**0**	**0**	**0**
	21/22	**772**	**19**	**0**	**0**	**13**	**6**	**0**	**0**	**0**

STATE FAIR HEARINGS

Time Period	Total # of State Fair Hearing	SFH Pending, unresolved as of reporting time	Decision Upheld	Decision Overturned
FY 18/19				
FY 19/20	1	0	1	0
FY 20/21	1	0	1	0
FY 21/22	0	0	0	0

GOAL 5: CULTURAL AND LINGUISTIC COMPETENCE

OBJECTIVE 5.1: CULTURALLY AND LINGUISTICALLY COMPETENT WORKFORCE

INDICATOR: TYPE OF CULTURAL COMPETENCY TRAINING AND NUMBER OF ATTENDANCE

Metric to be pulled from Cultural Competency Plan and Network Adequacy Certification with regards to provider training hours and language line usage.

INDICATOR: LANGUAGE LINE UTILIZATION

Metric to be pulled from Cultural Competency Plan and Network Adequacy Certification with regards to provider training hours and language line usage.

INDICATOR: COMMUNITY OUTREACH

Metric to be pulled from Cultural Competency Plan and Network Adequacy Certification with regards to provider training hours and language line usage.