KERN HEALTH SYSTEMS

EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (EQIHEC) MEETING

Tuesday, March 18, 2025
at 7:15 a.m.

2900 Buck Owens Blvd.
Bakersfield, CA 93308
1st Floor Board Room

For more information, call (661) 664-5000

AGENDA

Executive Quality Improvement Health Equity Committee (EQIHEC) Meeting

Kern Health Systems
2900 Buck Owens Boulevard
Bakersfield, California 93308
1st Floor Board Room

Tuesday, March 18, 2025

7:15 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 2900 Buck Owens Blvd, Bakersfield, CA 93308 during regular business hours, 8:00 a.m.–5:00 p.m., Monday through Friday, following the posting of the agenda. Any supporting documentation that relates to an agenda item for an open session of any regular meeting that is distributed after the agenda is posted and prior to the meeting will also be available for review at the same location.

COMMITTEE MEMBERS: Jennifer Ansolabehere, PHN; Satya Arya, MD; Debra Cox; Danielle C Colayco, PharmD; Todd Jeffries; Allen Kennedy; Philipp Melendez, MD; Chan Park, MD; Martha Tasinga, MD, CMO, Jasmine Ochoa; Rukiyah Polk

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" ARE CONSIDERED TO BE ROUTINE AND NON-CONTROVERSIAL BY KERN HEALTH SYSTEMS STAFF. THE "CA" REPRESENTS THE CONSENT AGENDA. CONSENT ITEMS WILL BE CONSIDERED FIRST AND MAY BE APPROVED BY ONE MOTION IF NO COMMITTEE MEMBER OR AUDIENCE WISHES TO COMMENT OR ASK QUESTIONS. IF COMMENT OR DISCUSSION IS DESIRED BY ANYONE, THE ITEM WILL BE REMOVED FROM THE CONSENT AGENDA AND WILL BE CONSIDERED IN LISTED SEQUENCE WITH AN OPPORTUNITY FOR ANY MEMBER OF THE PUBLIC TO ADDRESS THE COMMITTEE MEMBERS CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Committee Members on any matter not on this agenda but under the jurisdiction of the Committee Members. Committee Members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Committee Members at a later meeting. Also, the Committee Members may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee Members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Gov. Code Sec. 54954.2[a])

CA-3) Executive Quality Improvement Health Equity Committee (EQIHEC) Minutes from December 12, 2024 - APPROVE

CA-4) Behavioral Health Advisory Committee (BHAC) Minutes from January 15, 2025 – APPROVE

CA-5) Health Equity Transformation Steering Committee (HETSC) Minutes from February 11, 2025 – APPROVE

CA-6) Network Advisory Committee (NAC) Minutes from February 27, 2025 - APPROVE

CA-7) Pharmacy Drug Utilization Review (DUR) Minutes from November 25, 2024 – APPROVE

CA-8) Physician Advisory Committee (PAC) Redacted Minutes from October 2, 2024 – APPROVE

CA-9) Physician Advisory Committee (PAC) Redacted Minutes from November 6, 2024 - APPROVE

CA-10) Physician Advisory Committee (PAC) Redacted Minutes from December 4, 2024 – APPROVE

CA-11) Population Health Management Committee (PHMC) Minutes from December 4, 2024 – APPROVE

CA-12) Utilization Management Committee (UMC) Minutes from December 11, 2024 - APPROVE

CA-13) Quality Improvement Workgroup (QIW) Minutes from December 12, 2024 – APPROVE

CA-14) Quality Improvement Workgroup (QIW) Minutes from March 7, 2025 – APPROVE

CA-15) Wellness & Prevention Department (W&P)

a. Q3 2024 Wellness & Prevention Report – APPROVE
b. Q3 2024 Cultural & Linguistics Report – APPROVE
c. Q4 2024 Wellness & Prevention Report – APPROVE
d. Q4 2024 Cultural & Linguistics Report – APPROVE

16) Quality Improvement Workgroup (QIW)

a. QI Trilogy Overview – PRESENTATION
b. 2024 QP Evaluation - APPROVE
c. 2025 Quality/Health Equity Program Description - APPROVE
d. 2025 QI Work Plan – APPROVE

17) Quality Performance (QP)

a. Q1 2025 Report - APPROVE
b. Q1 2025 – PRESENTATION

18) Health Equity Transformation Steering Committee (HETSC)

a. 2025 Workplan – APPROVE
b. JEDI Charter – APPROVE
c. HEO Updates – PRESENTATION

19) Behavioral Health Advisory Committee (BHAC)

a. Q1 2025 Report - APPROVE

20) Member Services

a. Q4 2024 Operational Board Report – APPROVE
b. Q4 2024 Grievance Summary Report - APPROVE
c. Member Services Email Audit Summary Report – APPROVE

21) Utilization Management (UM)

a. Q4 2024 Report – APPROVE

b. 2024 Workplan Evaluation – APPROVE

c. 2025 Workplan – APPROVE

d. UM Management Criteria – APPROVE

22) Network Adequacy Committee (NAC)

a. Q1 2025 Report – APPROVE

23) Population Health Management (PHM)

a. Improving Maternal Healthcare Access in East Kern County Report – APPROVE

24) Wellness & Prevention Department (W&P)

a. 2024 Annual Report - APPROVE

ADJOURN MEETING TO TUESDAY, JUNE 17, 2025 @ 7:15 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the Board of Directors may request assistance at the Kern Health Systems office, 2900 Buck Owens Blvd. Bakersfield, California or by calling (661) 664-5000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

KERN HEALTH SYSTEMS

EQIHEC Table of Contents

March 18, 2025

COMMITTEE: ***EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (EQIHEC)***
DATE OF MEETING: ***DECEMBER 12, 2024***
CALL TO ORDER: ***7:17 AM BY TRACO MATTHEWS, CHAIR***

Members Present On-Site:	Jennifer Ansolabehere, KC Public Health Satya Arya, MD - ENT. Danielle Colayco, PharmD – Komoto	Allen Kennedy – Quality Team DME Michael Komin, MD – Komin Medical Group Chan Park, MD – Vanguard Family Medicine	Rukiyah Polk - CAC Chair Traco Matthews – KHS Chief Health Equity Officer
Members Virtual Remote:			
Members Excused=E Absent=A	Debra Cox – Omni Family Health (A) Jasmine Ochoa - Health Equity Manager of Public Health (E)	Todd Jeffries – Bakersfield Community Healthcare (E) Philipp Melendez, MD – OB/GYN (A)	
Staff Present:	Michelle Curioso - Director of Pop Health Management Pawan Gill - Health Equity Manager Sukhpreet Sidhu, MD – Pop Health Medical Director Anastasia Lester – Sr. Health Equity Analyst Devin Brown – Chief Human Resources Officer John Miller – Quality Improvement Medical Doctor Martha Tasinga, MD – KHS Chief Medical Officer	Magdee Hugais – Director of Quality Improvement Kailey Collier - Director of Quality Performance Maninder Khalsa – Medical Director Christine Pence, Senior Director of Health Services Adriana Salinas – Director of CSS Nate Scott – Member Services Director	Vanessa Nevarez - Health Equity Coordinator Greg Panero – Provider Network Analytics Abdolreza Saadabadi, MD – BH Medical Director Isabel Silva - Senior Director of Wellness & Prevention Melinda Santiago – Director of Behavioral Health Aurora De La Torre – MCAS Supervisor

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Quorum	8 of 12 committee members present; Debra Cox, Jasmine Ochoa, Todd Jeffries, and Philipp Melendez were absent.	Committee quorum requirements met.	N/A
Call to Order	Traco Matthews, Chair, called meeting to order at 7:17 am.	N/A	N/A
Public Presentation	There were no public presentations.	N/A	N/A

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Committee Announcements	Traco Matthews gave the opportunity for member updates. • There were no committee announcements.		
Committee Minutes	**<u>Approval of Minutes</u>** CA-3) The Committee's Chairperson, Traco Matthews, presented the EQIHEC Minutes for approval.	**Action:** • Satya A. first, Chan P. second. All aye's. Motion carried.	12/12/24
Old Business	There was no old business to present.	N/A	N/A
New Business	**<u>Consent Agenda Items</u>** • CA-4) Behavioral Health Advisory Committee (BHAC) Minutes from October 16, 2024 • CA-5) Health Equity Transformation Steering Committee (HETSC) Minutes from September 12, 2024 • CA-6) Network Advisory Committee (NAC) Minutes from October 18, 2024 • CA-7) Pharmacy Drug Utilization Review (DUR) Minutes from September 30, 2024 • CA-8) Physician Advisory Committee (PAC) August 7, 2024, Redacted Summary of Proceedings • CA-9) Physician Advisory Committee (PAC) September 4, 2024, Redacted Summary of Proceedings • CA-10) Population Health Management (PHMC) Minutes from September 4, 2024 • CA-11) Utilization Management Committee (UMC) Minutes from September 11, 2024 • CA-12) Quality Improvement Workgroup (QIW) Minutes from September 26, 2024 • A motion to approve Consent Agenda Items was requested.	**Action:** • Satya A. first, Chan P. second. All aye's. Motion carried.	12/12/24

	13) Behavioral Health Advisory Committee Report • Melinda S. gave a presentation that covered the Q3 and Q4 reports of the Behavioral Health Department and posed a question to the committee regarding how the current KHS provider information is being promoted. • Chan P. replied to Melinda S. that he would like a more hands-on approach that includes more communication and follow-up. He recommended having more staff and resources for internal provider staff. • A motion to approve the Behavioral Health Advisory Committee Report was requested.	**Action:** • Michael K. first, Satya A. second. All aye's. Motion carried.	12/12/24
	14) Quality Performance Report • Kailey C. presented the Quality Performance Summary Report that covered Q3 2024 data. Kailey C. concluded by asking the group if site reviews have been helpful and for specifics within their practice that are working with their patients. • Danielle C. asked if the HPV rate is bringing down compliance rates. • Kailey C. responded that yes, the second dose is bringing down rates and that Care Data is required to report vaccines. The oversight and monitoring can be improved by KHS and KHS will work better with providers to report the data. • Kailey C. asked the committee how KHS can better educate our members. • Danielle C. identified an opportunity to start HPV vaccinations at age 9. • A motion to approve the Quality Performance Report was requested.	• No response was given from the committee. • No response was given from the committee. • Kailey C. will follow up on HPV age requirements. • Chan P. first, Satya A. second. All aye's. Motion carried.	12/12/24 12/12/24 12/12/24 12/12/24

	15) Quality Improvement Workgroup Report • Magdee H. presented the Quality Improvement Report that covered Q3 2024 data. • Quality of Care (QOC) Grievances for Q2 2024 was presented: 490 grievances were classified as Quality of Care (QOC) concerns and closed. 2,543 grievances were classified as non-QOCs and closed. 3,033 total grievances were closed. • A summary of PQI activity for Q2 2024 was presented: 162 PQIs were reviewed. 85 were classified as "No Quality Concern." 75 were classified as "Potential Harm." 2 were classified as "Actual Harm." • The results of the 2024 KHS Provider Satisfaction Survey showed significant improvements compared to 2023: Overall Satisfaction: 90%. Would Recommend: 98.8% (up from 98.3% in 2023). Coordination of Care: increased to 53.1%. • Magdee H. concluded by asking the group for any recommendations for QIW. • A motion to approve the Quality Improvement Workgroup Report was requested. **16) Grievance Summary Report** • Nate S. presented the 2023 Grievance Analysis, the Q3 2024 Grievance Operational Board Update, and the Q3 2024 Summary Report. • Michael K. asked if the 10 grievances KHS currently has is per provider. • Nate S. responded that the grievances are not per provider, they are overall. He then began to define what a grievance is. He explained that KHS is required to accept a member's dissatisfaction as a grievance, even though the member did not want to formally file a grievance. Nate S. added that per our member satisfaction survey, our members are very happy, however, there is always room for improvement as NCQA continues to raise the bar for quality assurance.	• No response was given from the committee. • Satya A. first, Michael K. second. All aye's. Motion carried.	12/12/24 12/12/24

	• Michael K. asked if providers ask to dismiss their grievances. • Dr. Martha T. responded no. She added that when providers ask to no longer have members as patients it is usually due to their relationship being broken. Also, if a member wants to change their doctor at any time, KHS will do that for them. • A motion to approve the Grievance Summary Report was requested. **<u>17) Utilization Management Program Report</u>** • Dr. Maninder K. presented the UM Program report that contains a synopsis of analytics that reflect the performance of the Utilization Management Department's in the 3rd quarter of 2024 including Utilization Management Metrics, and Internal Audit Results. • On October 1, 2024, KHS revised the codes required for Prior Authorization. Although a small number of codes were added, a significantly larger number of codes were removed to result in an overall reduction in authorizations throughout the Provider Network. The UM team is monitoring the impact of these changes and addressing Provider questions and concerns. • The Utilization Management Team audits performance to ensure regulatory and industry standards are met or exceeded. In addition, available data is analyzed using a Health Equity lens and identifying areas where additional effort will benefit the population we serve. • Dr. Martha T. added that KHS has 72 hours for urgent referrals and routine referrals are 5 days. • Satya A. left the meeting at 8:30am. • A motion to approve the Utilization Management Program Report was requested.	• Jennifer A. first, Satya A. second. All aye's. Motion carried. • Allen K. first, Chan P. second. All aye's. Motion carried.	12/12/24 12/12/24

	18) Network Adequacy Committee Report • Greg P. presented the Network Adequacy Report that covered Q4 2024 data. • Greg P. addressed a follow-up from a previous concern that Jennifer A. had regarding lack of birthing centers at the 9-12-24 EQIHEC meeting. KHS is currently trying to be contracted with the Antelope Valley Hospital which has OBGYN access and that the Ridgecrest Regional Hospital should be opening their labor and delivery hospital soon. Dr. Sukhpreet S. added that KHS has recently credentialed a provider for OB services in Ridgecrest. • A motion to approve the Network Adequacy Committee Report was requested. **19) Pop Health Management Report** • Michelle C. presented the Pop Health Management Report that covered Q4 2024 data. She also addressed a concern that Jennifer A. had regarding lack of access of maternal healthcare in East Kern at the 9-12-24 EQIHEC meeting. • Michelle C. presented the problem of access to maternal healthcare in East Kern and sets the stage for understanding the issues surrounding this gap in care. The presentation evaluates healthcare access for pregnant women in East Kern, presenting population demographics, healthcare utilization data, and analyzing disparities related to age, ethnicity, and socioeconomic factors. The data on pregnancy care utilization (54% of pregnant women received care from a provider) provides insights into how well the current system is serving the community. The recommendation for action—improving access to healthcare for pregnant women in the region.	• Chan P. first, Allen K. second. All aye's. Motion carried.	12/12/24

	• A call to action by the PHM Committee has resulted in a workgroup that was developed to tackle the issue of limited access to healthcare services for pregnant women in East Kern. • These actions are: Following up on the reopening of the Ridgecrest Hospital, increasing access to healthcare providers – new provider was added per PNM, offering mobile health clinics or improving telemedicine availability. Providing community outreach and education to increase utilization of available services. Partnering with CBOs. • Ongoing monitoring and assessment to ensure that improvements are being made include Tracking maternal health outcomes over time to see if access to care improves, conducting follow-up surveys with pregnant women in East Kern to assess whether access to care and the quality of care have improved, Monitoring changes in maternal and fetal health outcomes, such as rates of complications or preterm births, following the proposed interventions. • Jennifer A. questioned the data in Michelle C's. presentation that stated 46% of pregnant members were not seen by their providers. • Dr. Martha T. responded that some of the possibilities for such a high percentage is because some women may not keep their baby, or their cultural norm is to not see a doctor in the first trimester. Michelle C. added that KHS is participating in groups that are trying to find resolutions to address education and health literacy issues. • A motion to approve the Population Health Management Report was requested.	• Jennifer A. first, Chan P. second. All aye's. Motion carried.	12/12/24

	20) Health Equity Transformation Steering Committee • Pawan G. presented policy 22.08-I Collection of SOGI (Sexual Orientation & Gender Identity) Data 2024-140. • Danielle C. asked if unisex is an option under the category 'sex assigned at birth' and stated she would like to get with Pawan offline to answer additional questions due to time constraints. • Pawan G. responded that she welcomes feedback. • The committee was asked to approve and adopt policy 22.08-I Collection of SOGI (Sexual Orientation & Gender Identity) Data. **21) EQIHEC Report Templates** • Traco M. presented the new EQIHEC report template which includes a written summary that will be published on the KHS website for approval.	• Chan P. first, Danielle C. second. All aye's. Motion carried. • Danielle C. first, Chan P. second. All aye's. Motion carried.	12/12/24 12/12/24

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Open Forum	N/A	Informational only.	N/A
Next Meeting	The next meeting will be held Tuesday, March 18, 2024, at 7:15am.	Informational only.	N/A
Adjournment	The Committee adjourned at 9:17am. ***Respectfully Submitted:*** ***Vanessa Nevarez, Health Equity Project Coordinator***	• Danielle C. first, Chan P. second. All aye's. Motion carried.	N/A

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: **BEHAVIORAL HEALTH ADVISORY COMMITTEE**
DATE OF MEETING: **JANUARY 15, 2025**

Members Present On-Site:	Marisa Garcia-Trebizo, LMFT - Director at CSV Heather Hornibrook, LMFT – Deputy Dir. KBHRS	Mesha Muwanga, LMFT – Rhema Therapy Inc. Melinda Santiago, KHS Director of Behavioral Health	Martha Tasinga MD, KHS Chief Medical Officer
Members Virtual Remote:	Matthew Beare, MD – Clinica Sierra Vista Anuradha Rao, MD - Omni	Franco Song, MD – Psychiatric Wellness Center	
Members Excused=E Absent=A	Cherilyn Haworth, CSUB (A)		
Staff Present:	Amy Daniel, KHS Executive Health Services Coordinator Vanessa Hernandez, KHS Senior Support Clerk Yolanda Herrera, KHS Credentialing Manager	John Miller, MD - KHS QI Medical Director Courtney Morris, KHS Behavioral Health Supervisor Steve Pocasongre, KHS NCQA Accreditation Specialist	Abdolreza Saadabadi, MD PhD Pam Thomsen, KHS NCQA Program Manager Julie Ybarrra, KHS Supervisor BH

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga, CMO and Melinda Santiago, KHS Director of Behavioral Health called the meeting to order at 12:05 PM.		N/A
Committee Minutes	**Approval of Minutes** Approval of Minutes from October 16, 2024 meeting.	☑ **APPROVED**: A motion was made by A.Saadabadi MD and seconded by M.Garcia-Trebizo LMFT, to approve the minutes of October 16, 2024. Motion carried.	1/15/25
OLD BUSINESS	**NCQA Standards** **NCQA QI 4 A-B Continuity and Coordination Between Medical and Behavioral Health Care**	☑ **CLOSED**: Informational discussion only	1/15/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Melinda Santiago, Dir. Of Behavioral Health informed the members that this standard has been finalized and submitted for feedback which was accepted and submitted the key indicators for AMM, ADD and SSD which was voted and agreed at the last meeting. The identified barriers and interventions will be a focus for 2025. **ME 7E (BH) Grievance and Appeal – Review qualitative and quantitative analysis** Melinda Santiago, Dir. Of Behavioral Health reported that we have met our goal regarding complaints for Behavioral Health as we are u under 10 complaints per 1,000 members. Area of focus appears to be mainly regarding access to care, attitude and services and improving quality of care. Melinda informed the members that although we met our goal these areas of concern will be addressed and attention on how we can improve communication, office training, and overall member education in virtual formats. **ME 7E – Annual Assessment of Behavioral Healthcare and Services – Review (BH) Member Experience Surveys** Melinda Santiago, Dir. Of Behavioral Health informed the members that KHS is participating in the Regional Advisory Committees that have identified areas of opportunity to improve telehealth access including education to members on the benefits available through virtual formats. Also, the Regional Advisory Committee has identified training opportunities for offices and will present some best practices for offices and providers to adopt. Members asked for additional information as to what provider support will be offered. Melinda informed the committee that there will be conversations on training needs, on-line trainings available and the plan to start focusing on low penetration rates such as non-specialty mental health services to better understand the barriers, cultural sensitivities and how best can we support and provide additional training. Melinda provided an executive summary of the 2024 ECHO Member Satisfaction Survey. Item specific attributes such as Office Wait time and Medication Side effects are slightly lower in comparison	☑ **CLOSED**: Informational discussion only ☑ **CLOSED**: Informational discussion only ☑ **CLOSED**: Informational discussion only	1/15/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	with benchmarks. Members discussed this may be part of the patient's perception as well as some patients may get confused during the intake process specific to medication management.		
	Eating Disorders Follow-up Melinda reported that KHS anticipates aligning our Policy and Procedures with Kern Behavioral Heath & Recovery Services due to the shared responsibilities and will begin to streamline this process and will bring back to this committee when it is ready. No additional follow-up is necessary at this time.	☑ **CLOSED**: Informational discussion only and will be brought back to committee once P&P is finalized.	1/15/25
NEW BUSINESS	**Welcome New Member -Tribal Liaison** The new Tribal Liaison is Tara Grey, who unfortunately was not able to be here today. Ms. Grey will be the liaison between the health plan and Tribal Clinics to help KHS engage in the Tribal Community. Ms. Grey will be present at our April meeting.	☑ **CLOSED**: Informational discussion only	1/15/25
	NSMHS Outreach & Education Plan Melinda reported that KHS has submitted their NSMHS Outreach and Education Plan to the State (DHCS) who will then submit their feedback on our plan. KHS will be revamping our Mental Health website page to include resource links and platforms that will be free to our members to access. There will also be provider trainings for our primary care providers.	☑ **CLOSED**: Informational discussion only	1/15/25
OPEN FORUM	**Open Forum** Committee Dates were provided for 2025 and consensus was that Wednesdays were better than Mondays.	☑ **CLOSED**: Informational discussion only.	1/15/25
NEXT MEETING	Next meeting will be held April 9, 2025.	☑ **CLOSED**: Informational only.	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
ADJOURNMENT	The Committee adjourned at 1:10 pm. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Behavioral Health Advisory Committee Minutes 01/15/2025

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

COMMITTEE: ***HEALTH EQUITY TRANSFORMATION STEERING COMMITTEE (HETSC)***
DATE OF MEETING: ***February 11, 2025***
CALL TO ORDER: ***2:00pm - Pawan Gill, Health Equity Manager – CHAIR***

Staff Present:	• Jackie Byrd, Senior Marketing and Communications Specialist • Lela Criswell, Member Engagement Manager • Pawan Gill, Health Equity Manager • Anastasia Lester, Senior Health Equity Analyst • Finster Paul III, Manager of Community Health and Wellness • Cesar Chavez, HRIS and Analytics Manager • Magdee Hugais, Director of QI	• Marilu Rodriguez, Senior Health Equity Analyst • Melinda Santiago, Director of Behavioral Health • Adriana Salinas, Director of Community and Social Services • Nate Scott, Director of Member Services • Tiffany Chatman, Wellness & Prevention Manager	• Frankie Gonzalez, Employee Relations Manager • Vanessa Nevarez, Health Equity Coordinator • Amy Sanders, Member Services Manager • Maritza Jimenez, Community Engagement Supervisor • Jake Hall, Senior Director of Contracting and Quality Performance • Daisy Torrez, Member Engagement Supervisor
Staff Virtual:	• Michelle Curioso, Director of Population Health Management	• Cynthia Cardona, Cultural & Linguistics Services Manager	• Martha Quiroz, Member Services Manager

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
QUORUM	Attendance / Roll Call	N/A – Workshop-style Committee	N/A
CALL TO ORDER	Pawan Gill, Health Equity Manager and Chair called the meeting to order at 2:05pm.	N/A	N/A
COMMITTEE MINUTES	There were no previous minutes to approve.	N/A	N/A

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
OLD BUSINESS	There was no old business to present.	N/A	N/A
NEW BUSINESS	**1) JEDI Charter Revisions** • Pawan G. gave an update on the Justice, Equity, Diversity, and Inclusion (JEDI) Charter revisions where she announced Tiffany Chatman as the Vice Chairperson and Vanessa Nevarez as the point person for any inquiries from departments that would like to leverage JEDI services as you would for Health Equity in your program development. • Pawan G. announced that the JEDI Charter will be getting an addendum which includes committees using JEDI to help fill external seats to ensure diversity. Cesar C. asked what committees would have outside seats to be filled? Pawan G. gave Community Advisory Committee (CAC) and Executive Quality Improvement Health Equity Committee (EQIHEC) as examples. **2) 2025 HEO Workplan** • Pawan G. provided an update on the 2025 HEO Workplan which includes QI and Health Equity combining their program descriptions and workplans. • Pawan G. thanked those that added their program and activities to the spreadsheet that was circulated in 2024. **3) TGI/SOGI Training Update** • Pawan G. provided an update on the TGI (Transgender Intersex Identities) training requirement that is associated with Senate Bill 9-23 and APL 24-018.	• The JEDI Charter revisions will be presented to the EQIHEC in March for approval. • If anyone has an open seat on their committees start reaching out to JEDI now. • The combined program charter and workplans will be presented to the EQIHEC in March for approval. • Pawan G. will circulate the program and activities spreadsheet to all to remove any programs that have since ended that were added to the list last year. • Departments with member facing staff are to email list of names to Vanessas N.	N/A N/A N/A N/A N/A

	Pawan G. explained that the TGI training will look very similar to the SOGI (Sexual Orientation Gender Identity), required by NCQA, and that both will be happening beginning of March for employees that have direct contact with KFHC members. Pawan G. added that eventually, a DEI training will also be given. KHS was unable to combine the DEI training with the TGI and/or SOGI in year one.	• Share training dates with the L&D department to add to their calendar.	N/A
	4) EPT Update - Presentation • Marilu R. gave a presentation on the EPT (Equity and Practice Transformation) Payment Program which provided an overview of how providers receive their payments.	• Informational only.	N/A
	5) Doula Update – Presentation • Ana L. presented The Doula Journey and announced that doulas are now a provider benefit at KFHC. Ana L. added that KHS staff have been involved since the release of the doula benefit in January 2023. The presentation highlighted the benefits and challenges doulas face.	• Informational only.	

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
OPEN FORUM	Pawan opened the floor for announcements.	N/A	N/A
NEXT MEETING	Next meeting will be held Tuesday, May 13th, 2025, at 2:00pm.	N/A	N/A

ADJOURNMENT	The Committee adjourned at 2:55 pm. ***Respectfully submitted:*** ***Vanessa Nevarez, Health Equity Coordinator***	N/A	N/A

For Signature Only – HETSC Minutes 02/11/25

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: **Network Adequacy Committee**
DATE OF MEETING: **February 27, 2025**
CALL TO ORDER: **9:04 AM by James Winfrey, KHS - Deputy Director of Provider Network Management, Chair**

Members Present On-Site:	Traco Matthews, KHS - Chief Health Equity Officer Deb Murr, KHS - Chief Compliance and Fraud Prevention Officer
Members Virtual Remote:	Melissa McGuire, KHS - Senior Director of Delegation and Oversight Alan Avery, KHS - Chief Executive Officer
Members Excused (E), Absent (A)	Amisha Pannu, KHS - Senior Director of Provider Network Management (E)
Staff Present:	Greg Panero, KHS - Provider Network Analytics Program Manager (on-site) Beatriz Quiroz, KHS - Provider Network Analyst I (virtual) Pawan Gill, KHS - Health Equity Manager (on-site)

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
CALL TO ORDER	- James Winfrey called the meeting to order at 9:04 AM - Quorum/Attendance	- Committee quorum requirements met.	N/A
APPROVAL OF MINUTES	- James Winfrey presented the Q4 2024 Network Adequacy Committee meeting minutes for approval.	☑ **CLOSED**: The committee members in attendance approved Q4 2024 Network Adequacy Minutes.	*2/27/25*
OLD BUSINESS	- No items.	☑ **CLOSED**: Informational only.	*2/27/25*
NEW BUSINESS	Provider Network Management, Q4 2024 Quarterly Network Review - Greg Panero presented the Provider Network Management Q4 2024 Quarterly Network Review. o After Hours Survey Results: Emergency Access at 99% compliant, Urgent Care Access at 99% compliant. Reviewed trending results and discussed Plan follow up action. ▪ During discussion of after-hours survey Greg Panero indicated there was one primary care provider found to be non-	☑ **CLOSED**: The committee members in attendance approved Provider Network Management, Q4 2024 Quarterly Network Review.	*2/27/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	compliant with both standards, Draco Mattews inquired about what region the provider was in. This was found to be Ming Primary Care in the 93304 zip code/Central Region. ○ Provider Accessibility Monitoring Survey: Plan compliant with all standards (appointment availability, hours of operation, phone answering timeliness, in-office wait times) based on results of Q4 2024 Survey. ○ Traco Matthews commented the 60% compliance with the urgent standard in the East region is to be expected. James agreed as that East region is where a lot of the providers are located. Access Grievance Review: The Plan has 342 access grievances found in favor of the member in Q2 2024, for a total of .41 grievances for every 1,000 members. ▪ During discussion of Access grievance review, James Winfrey pointed out that although all though all of the access grievance types are increasing, Timely Access is increasing more and potentially may need to be addressed. Deb Murr, inquired about the provider type that is receiving these grievances. James explained all grievance are reviewed and categorized by provider type, but no trends have been identified at this time. ▪ Alan Avery questioned if grievances are tracked per 1,000 members since there was a membership increase in 2024. James went over analysis that the increase of membership was identified as one of the potential causes on increase access grievances. ▪ James went over analysis further noting the Plan has seen a continued rise in Access Grievances, with a potential cause being the increase in membership during the Q1 2024 health plan transition. The primary grievance type contributing to this		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	rise is Timely Access Grievances. Geographically, the East and Central Regions have been most affected over the past two quarters. James also explained that one of the things that PNM is hoping will address this issue is the ongoing retention and recruitment grant that initiated in November 2023. The Provider Network Analytics team will continue monitoring grievances to gauge success of the grant. ▪ Pawan Gill inquired about what type pf providers the grant covers? James explained this is for primary care, specialty care and behavioral health. ▪ James suggested a staff member from grants attend the next NAC meeting to speak on the grant. ○ Geographic Accessibility & DHCS Network Certification: The Plan is in compliance with DHCS Network Standards or maintains a DHCS-approved access standard when non-compliance identified. ▪ In Q1 2024, the Plan submitted 343 AAS requests to DHCS. On November 15, 2024, the DHCS approved the Plan's submission of the AAS requests, identified no deficiencies, and deemed the Plan had passed the 2023 Annual Network Certification. ▪ Greg Panero added, in Q1 2025 the Plan received the 2024 Annual Certification request. This year the Plan received 232 AAS requests. ○ Network Adequacy & Provider Counts: ▪ FTE PCP ratio at 1:1514 ▪ FTE Physician ratio 1:256 ▪ PCP Accepting new members: 88% ▪ NPMH accepting new members: 97% ▪ NPMH locations accepting new members: 91% ▪ PCP Count: 505		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	▪ Specialist Provider Count: 3269 ▪ Mental Health Provider Count: 237 ▪ Alan Avery asked about adding Rheumatology to the list of specialties listed in the Network Adequacy & Provider Counts slide for internal monitoring. Deb Murr also asked to add Podiatry. Draco Matthews suggested differentiating which providers require monitoring from the DHCS and which ones will be monitored internally in the future. ▪ Deb inquired if the Mental Health providers are physical locations or telehealth. James confirmed the counts include both type of providers. James added PNM is currently working with Behavioral Health on Telehealth vs In Person appointments and monitoring. ▪ Deb asked if the Plan is required to monitor FTE by midlevel providers. James explained the graph's shown include physicians only and both physicians and midlevel providers calculated with approved methodology. ○ Significant Network Change: In Q3 2024, the Plan submitted a new significant network change filing on September 20, 2024. ▪ As of the end of Q4 2024, the Plan has not received any feedback from the DMHC regarding this filing. ○ During the Q2 2024 EQIHEC meeting a committee member raised concerns regarding access to OB/GYN services in the eastern part the Plan's Service Area. ▪ In Q4 2024, Ridgecrest Regional Hospital reopened its Labor & Delivery Unit, and the Plan contracted with Northern Inyo Hospital in Bishop to offer labor and delivery services. The Plan believes these network changes will ensure appropriate access to these services for members		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	within this geographic region.		
OPEN FORUM	**Open Forum** - No items.	☑ **CLOSED**: Informational only.	*2/27/25*
NEXT MEETING	Next meeting will be held Friday, May 9, 2025.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 9:46 AM. . ***Respectfully submitted: James Winfrey; Deputy Director of Provider Network Management***	**N/A**	*N/A*

For Signature Only – AADVOC Minutes 2/27/25

The foregoing minutes were APPROVED AS PRESENTED on: 3/5/2025 (Date) _____ (Name)

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ (Date) _____ (Name)

KERN HEALTH SYSTEMS

COMMITTEE: **DRUG UTILIZATION REVIEW (DUR) COMMITTEE**
DATE OF MEETING: **NOVEMBER 25, 2024**
CALL TO ORDER: **6:30 P.M. BRUCE WEARDA, RPh, DIRECTOR OF PHARMACY – ALTERNATE CHAIR**

Members Present On-Site:	Alison Bell, PharmD – Network Provider, Geriatrics Dilbaugh Gehlawat, MD – Pediatrician Kimberly Hoffmann, Pharm D. - Pharmacist and BOD Member	James "Patrick" Person, RPh – Network Provider	Martha Tasinga, MD – KHS Chief Medical Officer Bruce Wearda, RPh – KHS Director of Pharmacy
Members Virtual Remote:	Abdolreza Saadabadi, MD – Network Provider, Psy.D. Vasanthi Srinivas, MD – Network Provider, OB/GYN	Sarabjeet Singh, MD - Network Provider, Cardiology	
Members Excused=E Absent=A	Joseph Tran, MD – Network Provider – A		
Staff Present:	Amy Daniel, KHS Executive Health Srvs Coordinator Sukhpreet Sidhu, MD, KHS Medical Director		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirement met.	*N/A*
APPROVAL OF MINUTES	The Committee's Alternate Chairperson, Bruce Wearda, RPh, presented the meeting minutes for approval.	☑ **ACTION**: Vasanthi Srinivas moved to approve minutes of September 30, 2024, seconded by Alison Bell. 7 approved, 0 nays.	*11/25/24*
OLD BUSINESS	• Incontinent Supplies Audit	• Dr. Miller reported no evidence of Fraud, Waste, and Abuse.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	• Report of Plan Utilization Metrics Pat Person asked if the plan could ensure or enforce pharmacies to bill for nebulizers as opposed to sending them to other pharmacies. He stated he often sees instances where people have the medicine, but not the nebulizer to utilize it. Dr. Dilbaugh Gehlawat also commented he has seen it too – where the pharmacy will tell a member it's denied or make them pay for the nebulizer. Dr. Kim Hoffmann wanted to know what the time limits are for billing different medical devices. Bruce replied it varies upon the device. Nebulizers are 3 years; Blood Pressure Machines are 5 years but those go to Medi-Cal Rx. Other devices have varying time frames as well. Dr. Vasanthi Srinivas wanted to know the billing time limits for blood glucose monitors. Bruce replied these also are carved out to Medi-Cal Rx. However, manufacturers often provide at no charge, so it seems odd that there should ever be a scenario where they are denied or not available. • Educational Articles The State DUR Educational Article on Drug-Drug Interactions (Amlodipine with Simvastatin or Lovastatin) was shared. We also share this information with the KHS Network. • DUR General Topics 1. Oncology Criteria 2. PA Criteria/UM Program Description 3. Zynteglo Criteria	It was suggested that a memo be sent to the pharmacies explaining coverage and how to bill for medical devices that KHS is responsible for. KHS PR Rep will educate the specific pharmacies not billing appropriately. ☑ **ACTION**: Pat Person moved to approve the Oncology Criteria (accepting NCCN guidelines as the criteria.) It was seconded by Dr. Dilbaugh Gehlawat. 7 Ayes, 0 Nays. ☑ **ACTION**: Alison Bell moved to approve the UM Program Description (Procedures for evaluating or reviewing PAD type requests.) It was seconded by Dr. Vasanthi Srinivas. 7 Ayes, 0 Nays. ☑ **ACTION**: Pat Person moved to approve the Zynteglo Criteria. It was seconded by Dr. Vasanthi Srinivas. 7 Ayes, 0 Nays.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• DHCS/Executive Order N-01-09 Medi-Cal • Global DUR Dr. Kimberly Hoffmann asked what our program for actions will be regarding the Retro DUR GLP-1/DPP-4 Initiative Report. Dr. Kimberly Hoffmann asked about what the state expects or requires regarding the SUPPORT Act. Bruce responded there is no specific guidelines as to what or how to do the monitoring and identifying of potential inappropriate therapies. The plans must monitor and identify. Bruce outlined the different reports identified in the SUPPORT Act. Dr. Kimberly Hoffmann wanted to know if it was ok to dispense Naloxone without a corresponding opioid on the same prescription.	It was recommended to send a bulletin to the Provider and Pharmacy Networks and send letters to the providers identified in the report.	
OPEN FORUM	There were no topics presented during open forum.	☑ **ACTION**: N/A	*11/25/24*
NEXT MEETING	Next meeting will be held Monday, March 31, 2025 at 6:30 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned 7:15 pm.	☑ **ACTION**: Kim Hoffmann moved to adjourn the meeting. It was seconded by Dr. Vasanthi Srinivas. 7 Ayes, 0 Nays.	*11/25/24*

Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator

For Signature Only – Drug Utilization Review Committee Minutes 11/25/24

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***OCTOBER 2, 2024***
CALL TO ORDER: ***7:02AM BY JOHN MILLER, MD – KHS MEDICAL DIRECTOR***

Members Present On-Site:	John Miller MD, Quality Improvement Medical Director Atul Aggarwal, MD – Network Provider, Cardiology Hasmukh Amin, MD – Network Provider, Pediatrics	Gohar Gevorgyan, MD – Network Provider, FP Miguel Lascano – Network Provider, OB/GYN Ashok Parmar, MD– Network Provider, Pain Medicine	Raju Patel, MD - Network Provider, Internal Medicine
Members Virtual Remote:			
Members Excused=E Absent=A	Martha Tasinga, MD – KHS Chief Medical Officer (E) David Hair, MD - Network Provider, Ophthalmology (E)		
Staff Present:	Alan Avery, Chief Operating Office (REMOTE) Michelle Curioso, Director of PHM Amy Daniel, Executive Health Services Coordinator Jake Hall, Deputy Director of Contracting	Yolanda Herrera, Credentialing Manager Magdee Hugais, Director of Quality Improvement Abdolreza Saadabadi MD, BH Medical Dir. (REMOTE)	Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. John Miller MD, KHS Chief Medical Officer, called the meeting to order at 7:02 am.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. Miller presented the meeting minutes for approval.	☑ **ACTION**: Dr. Amin moved to approve minutes of September 4, 2024, seconded by Dr. Lascano. Motion carried.	*10/2/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Peer Review Reports **CREDENTIALING REPORT** **Mental Health Pre-Approvals from -Report dated 10/2/2024:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on 10/**02/2024** Credentialing Report, all files met clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **10/02/2024.** The clean files were accepted as presented with no additional discussion. There were (5) [redacted] **RECREDENTIALING REPORT** **Recredentialing Providers List Dated 10/2/2024.** Recredentialing files meeting clean file review were accepted as presented with no additional questions or alternative actions. Recredentialing with comprehensive reviews were conducted for the	☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated September 4, 2024, seconded by Dr. Patel. Motion carried.	*10/2/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	listed providers below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the [redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated October 2, 2024, were accepted as presented with no additional questions or comments by the committee members.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS: There were no additional adverse events or disciplinary monitoring reported for September 2024 other than what was reported in the recredentialing report. [redacted]	☑ **ACTION**: Monthly Monitoring for September 2024 accepted as presented. Providers will continue to be monitored monthly with any additional reporting to the committee as it is received.	*10/2/24*
	DELEGATED CREDENTIALING: **VSP Annual Oversight Summary** Audit Results for Vision Services Plan (VSP) was presented to the committee for review and approval. KHS Credentialing conducted a desk top audit for VSP on 8/16/24. • **Results:** VSP scored 100% utilizing the HICE Accredited-Certified Audit Tool. VSP is CR Accredited with NCQA and expires 4/21/2026. • **Opportunity for Improvement:** There were no opportunities for improvement only an observation regarding Practitioner Rights outlined in VSP 2000 Credentialing P&P reference a URL to the Provider Manual which could not be accessed easily.	☑ **ACTION**: Dr. Amin moved to approve the VSP Annual Oversight Summary as presented. Seconded by Dr. Patel. Motion carried.	*10/2/24*
OLD BUSINESS	**Bariatric Surgery Quality of Care Issues**	☐ **PENDING**: Dr. Miller conduct random 10-case review in 6-months as follow-up on this issue.	***10/2/24***
NEW BUSINESS	**REVISED QP-Credentialing Policy and Procedures:** **23.10-P Delegated Credentialing & Agreement** Yolanda Herrera, KHS Credentialing Manager, presented the revision to QP Delegated Credentialing and Agreement Policy 23.10-P for review. The policy revisions were extensive to bring the process in line with current requirements, NCQA Standards after review with	☑ **ACTION**: Dr. Amin moved to approve the revised Policy & Procedures 23.10-P Delegated Credentialing and 23.06-P Non-Physician Medical Practitioners as presented. Dr. Patel seconded. Motion carried.	*10/2/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	NCQA Consultants; The Mahalik Group, and outside legal counsel DSR. Additionally, the Delegation Agreement Template was also revised under advisement with KHS Compliance in an effort to streamline and outlines delegation activities using the same template for all departments who delegate various health plan activities. **23.06-P Non-Physician Medical Practitioners & Supervising Agreement Form** Yolanda Herrera, KHS Credentialing Manager, presented the revision to QP Non-Physicians Medical Practitioners & Supervising Agreement form Policy 23.06-P for review. The policy revisions were extensive to bring the process in line with current state requirements related to new regulations for nurse practitioners and physician assistants.		
OPEN FORUM	**Pediatric Age Limits** Yolanda Herrera, KHS Credentialing Manager, informed the members that there was a request from a pediatrician to raise the pediatric age limits to 25 years old. The current pediatric age limits are 0-18 or 0-21. After discussion and input from the members, it was the consensus of the members to leave the pediatric age limits at 0-18 and 0-21.	☑ **CLOSED** – Informational Only	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, November 6, 2024	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 7:24 am **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator.**	**N/A**	*N/A*

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***NOVEMBER 6, 2024***
CALL TO ORDER: ***7:07AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Atul Aggarwal, MD – Network Provider, Cardiology Hasmukh Amin, MD – Network Provider, Pediatrics	Miguel Lascano – Network Provider, OB/GYN Ashok Parmar, MD– Network Provider, Pain Medicine Raju Patel, MD - Network Provider, Internal Medicine	
Members Virtual Remote:	David Hair, MD - Network Provider, Ophthalmology		
Members Excused=E Absent=A	Gohar Gevorgyan, MD – Network Provider, FP (E)		
Staff Present:	Alan Avery, Chief Operating Office Jake Hall, Deputy Director of Contracting Amy Daniel, Executive Administrative	Yolanda Herrera, Credentialing Manager Magdee Hugais, Director of Quality Improvement John Miller MD, QI Medical Director (REMOTE)	Abdolreza Saadabadi MD, BH Medical Dir. (REMOTE) Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:07 am.		N/A
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of October 2, 2024 for review and approval.	☑ **ACTION**: Dr. Patel moved to approve minutes of October 2, 2024, seconded by Dr. Amin. Motion carried.	*11/6/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from -Report dated 11/1/2024:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on **11/01/2024** Credentialing Report, all files met clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **11/06/2024.** The clean files were accepted as presented with no additional discussion. [redacted]	☑ **ACTION**: Dr. Parmar moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 11/1/2024 & 11/6/2024, seconded by Dr. Amin. Motion carried.	*11/6/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	RECREDENTIALING REPORT **Recredentialing Providers List Dated 11/6/2024.** Recredentialing files meeting clean file review were accepted as presented with no additional questions or alternative actions. 		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	NEW VENDOR CONTRACTS New Vendor Contracts List Dated November 6, 2024 were accepted as presented with no additional questions or comments by the committee members. **MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:** There were no additional adverse events or disciplinary monitoring reported for October 2024 other than what was reported in the recredentialing report. Current monthly monitoring report that includes licensing disciplinary issues, adverse events or sanctioned/excluded providers which was discussed during credentialing review. [redacted]	☑ **ACTION**: Monthly Monitoring for October 2024 accepted as presented. Providers will continue to be monitored monthly with any additional reporting to the committee as it is received.	*11/6/24*
	DELEGATED CREDENTIALING: There were no delegated credentialing activites to report.	☑ **CLOSED** – Informational Only.	*N/A*
	LEVEL 2 PQI CASE DISCUSSION (HANDOUT): As part of the Potential Quality Improvement Policy and Procedure, Dr. Miller presented three (3) cases identified as Level 2 for presentation at the PAC Meeting as required by this policy. [redacted]	☐ **PENDING**: Dr. Tasinga and Dr. Miller expressed appreciation for the feedback and will bring back these cases in a template and will send out the PQI Policy and Procedure to all committee members for review and to become familiar with the review process and case level outcomes..	*12/4/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		
OLD BUSINESS	**Bariatric Surgery Quality of Care Issues** Dr. Miller informed the members that the follow-up review is still in process and anticipates completion in the next 30-60 days.	☐ **PENDING**: Dr. Miller conduct random 10-case review in 6-months as follow-up on this issue.	***Pending***
NEW BUSINESS	There was no new business to report	**N/A**	*N/A*
OPEN FORUM	**Prior Authorization (PA) List** Dr. Martha Tasinga, KHS Chief Medical Officer informed the members that there has been commentary regarding the published Prior Authorization (PA) List. Dr. Tasinga informed the members	☑ **CLOSED** – Informational Only	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	that after many years of what was identified as a complicated list that many of our current Medical Directors were not part of preparing, it was started from scratch removing those procedures/services that KHS identified as not denying or if there was 95% approval rate, the procedure/service was removed. This identified approximately 50-codes added to the PA List which was analyzed resulting in a handful of codes that have been placed on the current PA List. Dr. Tasinga asked for feedback as KHS continues to clean up the PA List and is open to any suggestions from our network providers.		
NEXT MEETING	Next meeting will be held Wednesday, December 4, 2024	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:19 am **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator.**	**N/A**	*N/A*

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***DECEMBER 4, 2024***
CALL TO ORDER: ***7:09 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Atul Aggarwal, MD – Network Provider, Cardiology	Miguel Lascano – Network Provider, OB/GYN Raju Patel, MD - Network Provider, Internal Medicine	
Members Virtual Remote:	Hasmukh Amin, MD – Network Provider, Pediatrics David Hair, MD - Network Provider, Ophthalmology Ashok Parmar, MD– Network Provider, Pain Medicine		
Members Excused=E Absent=A	Gohar Gevorgyan, MD – Network Provider, FP (E)		
Staff Present:	Jake Hall, Deputy Director of Contracting Amy Daniel, Executive Administrative Yolanda Herrera, Credentialing Manager (REMOTE)	Magdee Hugais, Director of Quality Improvement John Miller MD, QI Medical Director Abdolreza Saadabadi MD, BH Medical Dir. (REMOTE)	Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director Bruce Wearda, Director of Pharmacy

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:09 am.		N/A
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of November 6, 2024 for review and approval.	☑ **ACTION**: Dr. Patel moved to approve minutes of November 6, 2024, seconded by Dr. Hair. Motion carried.	*12/4/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from -Report dated 12/4/2024:** [redacted] **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **12/04/2024.** [redacted] **RECREDENTIALING REPORT** **Recredentialing Providers Lists Dated 11/27/2024 and 12/4/2024.** [redacted]	☑ **ACTION**: Dr. Patel moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 11/27/2024 & 12/4/2024, seconded by Dr. Hair. Motion carried.	*12/4/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated December 4, 2024, were accepted as presented with no additional questions or comments by the committee members. **MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:** [redacted]	☑ **ACTION**: Monthly Monitoring for November 2024 accepted as presented. Providers will continue to be monitored monthly with any additional reporting to the committee as it is received.	*12/4/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted].		
	Delegated Credentialing 3rd Quarter 2024 - Quarter Oversight Reports Yolanda Herrera KHS Credentialing Manager informed the committee that the 3rd Quarter 2024 Delegated Oversight Reports have all been received and reviewed for CHLA Medical Group, ConferMED, Valley Children's Child Net, Vision Services Plan, UCLA Medical Group and USC Medical Group. During 3rd Quarter 2024, delegates reported Credentialing Committee dates for initial credentialing, recredentialing and terminations. There were no significant changes in provider network that would affect KHS members. **There were no identified issues.**	☑ **CLOSED** – Report Received and Filed.	*12/4/24*
	LEVEL 2 PQI CASE DISCUSSION (HANDOUT): [redacted]	☑ **ACTION**: [redacted] Motion carried.	*12/4/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OLD BUSINESS	**Bariatric Surgery Quality of Care Issues** Dr. Miller informed the members that the follow-up review is still in process and anticipates completion in 1st Quarter 2025.	☐ **PENDING**: Dr. Miller conduct random 10-case review in 6-months as follow-up on this issue.	***Pending***
NEW BUSINESS	**Pharmacy Criteria** Bruce Wearda presented the Pharmacy criteria submitted for approval under pharmaceutical covered medical benefit as follows: • Casgevy • Zynteglo • Oncology Criteria	☑ **ACTION**: Dr. Patel moved to approve the Casgevy criteria, seconded by Dr. Parmar. Motion carried. ☑ **ACTION**: Dr. Lascano moved to approve the Zynteglo criteria, seconded by Dr. Patel. Motion carried. ☑ **ACTION**: Dr. Lascano moved to approve the Oncology criteria, seconded by Dr. Amin. Motion carried.	*12/4/24*
OPEN FORUM	There was no open discussion.	☑ **CLOSED** – Informational Only	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, February 5, 2025	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:17 am. **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator**	**N/A**	*N/A*

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***POPULATION HEALTH MANAGEMENT COMMITTEE***
DATE OF MEETING: ***DECEMBER 4, 2024***
CALL TO ORDER: ***11:03 AM BY SUKHPREET SIDHU, MD - CHAIR***

Members Present On-Site:	Paula De La Riva-Barrera, Manager at First 5 Kern Lordes Bucher, Administrator at KCSOS	Dixie Denmark-Speer, SS Director at Height Street SNF Desiree Escobedo, Admissions at Height Street SNF	Sukhpreet Sidhu, MD PHM Medical Director Curt Williams, Director Homeless/Foster at KCSOS
Members Virtual Remote:	Alissa Lopez, Administrator at KCBHRS Dr. Vivek Radhakrishan, Primary Care ECM Provider	Colleen Philley, Program Director at KC Aging & Adult Martin Reynoso, Supervisor at KC Aging & Adult	
Members Excused=E Absent=A	Maria Bermudez, Asst. Director at Dept. of Human Services (E) Christopher Boyd, Licensed Clinical Psychologist (E) Brynn Carrigan, Director at KC Public Health (E) Cristina Castro, Recovery Specialist at KCBHRS (E) Valerie Civelli, MD at LTC Premier Valley Med. Group (E)	Babita Datta, MD OB/GYN at Wasco Medical Plaza (E) Minty Dillon, Administrator at Premier Valley Medical Grp (E) Laura Hasting, NP at Priority Urgent Care (E) Kristine Khuu, Assistant Director at Kern Regional Ctr. (E) Gina Lascon, DON at Delano SNF (E) Lito Morillo, Executive Director at KC Human Services (E)	Jasmine Ochoa, Manager at KC Public Health (E) Ashok Parmar MD, Pain Mgmt. (E) Cody Rasmussen, Administrator at Height Street SNF (E) Jennie Sill, Administrator at KCBHRS (E) Alejandra Vargas, BOM at Height Street SNF (E)
Staff Present:	Missy Clendenen, RN PHM LTC Case Manager Amy Daniel, Executive Health Services Coordinator Shellby Dumlao, Special Programs Nurse Consultant Pawan Gill, Health Equity Manager Russell Hasting, PHM Manager of CM Loni Hill-Pirtle, Director of ECM	Magdee Hugais, KHS Director of QI Diane Lay, RN, CCM, PHM Triage Nurse III Jacinto Marcelo II, Director of Special Programs John Miller, MD QI Medical Director Noehmi Morfin, RN PHM Clinical Auditor & Trainer Adriana Salinas, Director of Community & Social Services	Nate Scott, Senior Director of Member Services Melinda Santiago, Director of Behavioral Health Isabel Silva, Senior Director of Wellness & Prevention Elliott Smith, PHM Outreach Specialist Ty Williams, PHM Outreach Specialist

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Sukhpreet Sidhu, MD, KHS PHM Medical Director called the meeting to order at 11:05 AM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of September 4, 2024 were presented for review and approval.	☑ **ACTION**: Curt Williams moved to approve minutes of September 4, 2024, seconded by Paula De La Riva-Barrera. Motion carried.	*12/04/24*
OLD BUSINESS	There was no old business to present	N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	**<u>Welcome & Introduction</u>** **Committee Member Announcements:** Members and KHS Staff introduced themselves and from the facility/organization they are representing.	☑ **CLOSED**: Informational discussion only.	*12/04/24*
	<u>Review and Approval of Policy</u> The following PHM Policy and Procedures were presented as follows: • Initial Health Appointment • Indian Health Liaison • Long Term Plan of Care • Long Term Care Quality Assurance Performance Improvement	☑ **ACTION**: Curt Williams moved to approve the listed Policy and Procedures, seconded by Paula De La Riva-Barrera. Motion carried.	*12/04/24*
	<u>Maternal Access to Care</u> Russell Hastings, Manager of PHM Case Management, presented the Maternal Access to Care as follows: • Maternal Care Access in East Kern – Members in the East Kern Area have limited resources to maternal care providers, including prenatal and postpartum care as well as Labor and Delivery Services. • Develop Workgroup – Planning is being made to assess the population, of childbearing women ages 12-51 residing in the area, to analyze the existing health care infrastructure and develop a work plan to address these limited resources.		*12/04/24*
	<u>CCM Interdisciplinary Care Team</u> Diane Lay, PHM Triage Nurse III, presented the CCM Interdisciplinary Care Team staff roles and partnership with other agencies. This team of healthcare professionals will work together to manage physical, psychological and spiritual needs of the patient. The goals of this team are to support safe transition of members to a least restrictive environment to meet their health care needs; connect members to appropriate community resources; improve compliance with healthcare goals and provide more efficient cost-effective delivery system. Members will be identified through acute change in member conditions, social conditions, members who are non-improving, at member request and those identified in ER and Inpatient utilization.	☑ **ACTION**: Curt Williams moved to approve presented ICT Meeting Structure, seconded by Paula De La Riva-Barrera. Motion carried.	*12/04/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	**Open Forum** No additional items presented for discussion.	**N/A**	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, March 5, 2025 at 11:00 am	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 11:46 AM. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Quality Improvement Committee Minutes 12/04/24

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***UTILIZATION MANAGEMENT COMMITTEE***
DATE OF MEETING: ***DECEMBER 11, 2024***
CALL TO ORDER: ***12:05 PM BY MANINDER KHALSA, MD, UM MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Ashok Parmar, MD –Specialist Pain Medicine	Parikshat Sharma, MD – Outpatient Specialist	
Members Virtual Remote:	Maninder Khalsa, MD – KHS UM Medical Director		
Members Excused=E Absent=A	Philipp Melendez, MD – OB/GYN (E)		
Staff Present:	Linda Corbin, KHS Health Services Consultant (Remote) Amy Daniel, KHS Executive Health Services Coordinator Amanda Gonzalez, KHS Director of UM Kulwant Kaur, UM Outpatient Clinical Manager Yolanda Herrera, Credentialing Manager	Magdee Hugais, Director of Quality Improvement Loni Hill-Pirtle, Director of Enhanced Case Mgmt. John Miller, MD, QI Medical Director Christine Pence, Sr. Director for Health Services	Melinda Santiago, Director of Behavioral Health Nate Scott, Director of Member Services Sukhpreet Sidhu, MD, PHM Medical Director Isabel Silva, Director of Health & Wellness

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were not met as the composition as described in the committee charter are still in development and recruiting participating providers.	N/A
Call to Order	Dr. Maninder Khalsa, KHS UM Medical Director called the meeting to order at 12:02 PM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of September 11, 2024 were presented for review and approval.	☑ **ACTION**: Dr. Sharma moved to approve minutes of September 11, 2024, seconded by Dr. Parmar. Motion carried.	N/A
OLD BUSINESS	There was no old business to present.	N/A	N/A
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Dr. Khalsa welcomed the members of UM Committee.	☑ **CLOSED**: Informational only.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Policy Review and Approval Dr. Khalsa informed the committee that the following policy and procedures were revised and sent out prior to committee meeting for review and approval. • Policy 3.25-P Prior Authorization Services and Procedures • Policy 3.27-P Radiology Services • Policy 3.35-P On-Line Authorization Tool • Policy 3.50-P Medical Transportation • New Policy – Appropriate UM Staffing • New Policy – Inter-Rater Reliability • New Policy – Referral Systems Control • New Policy – Specialty Referral and Use of Board-Certified Consultants Members reviewed the policies presented and had no further discussion or input on these revisions and new policies.	☑ **ACTION**: Dr. Sharma moved to approve the policy and procedure revisions and the new policies that were presented, seconded by Dr. Parmar. Motion carried.	*12/11/24*
	UM Report 3rd Quarter 2024 Dr. Khalsa presented the Q3 2024 UM Report (Note: Report Cover page indicates Q4 however, date is from 3rd Quarter 2024). The following highlights were noted: • UM Timeliness of Decisions – KHS is at 99% for both Urgent and Routine compliance. • Outpatient Referrals – remain consistent and between current and last quarter. • Adult Referrals – remain consistent in comparison to past quarters. • Denial Percentage – July, August and September appear consistent at an average of 3% referrals denied. • IRR Q3 Results – All staff are able to complete the Q2 IRR Case studies for NCIC process in meeting our passing standards of 95% or higher.	☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members.	*12/11/24*

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION / CONCLUSIONS</th><th>RECOMMENDATIONS/ ACTION</th><th>DATE RESOLVED</th></tr>
<tr><td></td><td><u>UM/Internal Auditing Activities</u>
Dr. Khalsa reported on the UM Auditing Activities that included monitoring the process of referrals that have been delayed by the UM Department. A review of 10 files were reviewed for the month of July, August and September.
<table><tr><th></th><th>July</th><th>August</th><th>September</th></tr><tr><td>Total referrals for the month</td><td>33,078</td><td>33,431</td><td>31,109</td></tr><tr><td>Total referrals that were delayed</td><td>52</td><td>53</td><td>63</td></tr><tr><td>Percent of referrals delayed</td><td><1%</td><td><1%</td><td><1%</td></tr><tr><td>Audit sample size</td><td>10 referrals</td><td>10 referrals</td><td>10 referrals</td></tr></table>As part of the corrective actions, emails have been sent to staff reminding them to print all manual correspondence stored in JIVA to ensure letters are being sent.</td><td>☑ CLOSED: Report accepted as presented with no further discussion or questions from the committee members.</td><td>12/11/24</td></tr>
<tr><td></td><td><u>UM Criteria / DHCS Medi-Cal Provider Manual / MCG 28th Edition and Hayes</u>

The criteria UM uses to review requests were discussed. The DHCS Medi-Cal Provider Manual is primary with MCG as secondary when there is not applicable criteria in the Medi-Cal Provider Manual.</td><td>☑ ACTION: Dr. Sharma moved to approve the criteria, seconded by Dr. Parmar. Motion carried.</td><td></td></tr>
<tr><td>OPEN FORUM</td><td><u>Open Forum</u>
There were no further open items presented for discussion or comment by the committee members.</td><td>☑ CLOSED: Informational discussion only.</td><td>12/11/24</td></tr>
<tr><td>NEXT MEETING</td><td>Next meeting will be held Wednesday, March 7, 2025 at 12:00 PM</td><td>☑ CLOSED: Informational only.</td><td>N/A</td></tr>
<tr><td>ADJOURNMENT</td><td>The Committee adjourned at 12:45 PM

Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator</td><td>N/A</td><td>N/A</td></tr>
</table>

For Signature Only – Utilization Management Committee Minutes 12/11/24

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

To: EQIHEC

From: John Miller, M.D.

Date: March 18, 2025

Re: Quality Improvement Workgroup (QIW)

Background:
The 4th Quarter meeting of the KHS Quality Improvement Workgroup (QIW) took place on December 12, 2024. This committee operates within the new reporting structure, which reports to the Executive Quality Improvement Health Equity Committee (EQIHEC). Committee members include providers and representatives from the community. The meeting covered key updates on quality and safety initiatives, site review performance, appeals and grievances, NCQA accreditation progress, and Enhanced Care Management (ECM) developments.

Discussion:
During this session, quorum was met.

MCAS Performance Review:

Kailey Collier, Director of Quality Performance, presented the 3rd Quarter 2024 MCAS performance comparison to 2023, highlighting:

- 15 measures trending higher than the previous year.
- 3 measures with a lower compliance rate compared to 2023.
- 5 measures meeting Medium Performance Levels (MPL), with another 5 within 5% of MPL.
- Notably, three measures that previously never met MPL are now compliant.

Site Reviews:

- 11 initial Facility Site Reviews (FSRs) and 2 initial Medical Record Reviews (MRRs) were completed.
- 9 periodic FSRs and 9 periodic MRRs conducted, with 97% passing FSRs and 75% passing MRRs.
- 29 of 36 sites required corrective actions, which were completed and closed in Q3 2024.
- Dr. Ayala-Rodriguez emphasized the importance of provider training on MCAS expectations.

Quality of Service & Appeals:

- Kalpna Patel, QI Supervisor, presented Quality-of-Care Grievances and Potential Quality of Care Issues for Q3 2024.
- Appeals and claims disputes were reviewed, with a focus on resolving outstanding concerns.

NCQA Accreditation Progress:

- Steven Kinnison, NCQA Manager, provided an update on the 2024 NCQA Readiness Project, reporting:
    - 90% overall projected Health Plan Accreditation points (up 6%).
    - 63% Health Equity Accreditation points, reflecting a 4% increase.
    - Survey look-back dates and accreditation timeline updates were presented.

Quality Improvement Policies:

- The committee approved the retirement of several outdated QI policies and procedures.

Enhanced Care Management (ECM) Program Update:

- Dan Diaz, ECM Manager, reported that as of December 1, 2024, ECM enrollment had reached 10,715 members.
- Members are assigned across 38 ECM sites, stratified by geographic logic and population focus.

Conclusion & Next Steps:

- The **Q3 2024 Workplan Scorecard** was presented with no major concerns.
- No additional issues were raised during the open forum.
- The next QIW meeting is scheduled for March 2025

Fiscal Impact:

- None.

Requested Action:

- Review and approve.

KERN HEALTH SYSTEMS

COMMITTEE: ***QUALITY IMPROVEMENT WORKGROUP***
DATE OF MEETING: ***DECEMBER 12, 2024***
CALL TO ORDER: ***12:07 PM BY JOHN MILLER, MD, QI MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Danielle Colayco, PharmD, Executive Director Komoto Dr. John Paul Miller, KHS QI Medical Director, Chair	Dr. Michael Komin, Komin Medical Group	
Members Virtual Remote:	Carmelita Magno, Kern Medical Process Improvement Dir. Dr. Irving Ayala-Rodriguez, CSV		
Members Excused=E Absent=A	Jennifer Culbertson, Director of Clinical Quality CSV (E)		
Staff Present:	Kailey Collier, RN, Director of Quality Performance Lela Criswell, Member Engagement Manager Michelle Curioso, Director of PHM Amy Daniel, Executive Health Services Coordinator Mary Jane Dimaano, QI RN I Dan Diaz, RN, ECM Clinical Manager	April Dutton, QI RN I Pawan Gill, Health Equity Manager Amanda Gonzalez, Director of UM Greg Panero, PNM Analytics Program Manager Yolanda Herrera, Credentialing Manager Loni Hill-Pirtle, Director of Enhanced Case Management	Magdee Hugais, Director of QI Steven Kinnison, NCQA Manager Kalpna Patel, QI Supervisor Steve Pocasangre, NCQA Accreditation Specialist Adriana Salinas, Community Support Director Melinda Santiago, Behavioral Health Director

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were not met.	N/A
Call to Order	Dr. John Paul Miller, KHS QI Medical Director called the meeting to order at 12:07 PM.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. John Miller, presented the September 11, 2024 meeting minutes for approval.	☑ **ACTION**: Dr. Irving Ayala-Rodriguez moved to approve minutes of September 11, 2024, seconded by Dr. Michael Komin. Motion carried.	12/12/24
OLD BUSINESS	**No Old Business presented.**		N/A
NEW BUSINESS	**Quality & Safety of Clinical Care** **MCAS** Kailey Collier, Director of Quality Performance presented the 3rd	☑ **CLOSED**: Informational discussion only.	12/12/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Quarter 2024 MCAS 2024 vs. 2023 Comparison. The following highlights were noted: • 15 measures are trending higher than the previous year at the same point in time. • Three 3-mearsures have a lower compliance rate than 2023 • Five 5-measures are meeting Medium Performance Levels (MPL) • And five 5-measures are within 5% of the meeting MPL • More measures are meeting MPL than in the previous 4-years and 3-measures that never met MPL are now compliant. The following improvements and highlights efforts were noted: • Met MPL for 8 out of 18 measures: ◦ CBP, HBD, PPC-Pre, PPC-Post, AMR, BCS-E, CCS, and CHL • Met HPL for PPC-Post • 16 out of 18 measures showed improvement compared to previous year: ◦ CCS, HBD, CBP, IMA-2, PPC-Post, LSC, AMR, BCS-E, CHL, DEV, FUA, FUM, TFL, W30 (0-15), W30(15-30), and WCV. **Site Reviews** Kailey presented 11 initial facility site reviews (FSRs) and 2 initial medical record reviews (MRRs) were completed in Q3-2024. Nine 9-Periodic FSRs and 9-periodic MRRs were also completed with 97% of FSRs passing and 75% of MRRs passing. There were 29 of the 36-sites failed and Corrective Action Plans (CAPs) were completed and closed in Q3-2024.	☑ **FOLLOW-UP**: Dr. Ayala-Rodriguez commented on the importance of Kailey's presentation on MCAS as well as the importance for all providers to fully understand the expectation and possible trainings.	
	QUALITY OF SERVICE / APPEALS Kalpna Patel, QI Supervisor presented the Quality-of-Care Grievances and Potential Quality of Care issues for 3rd Quarter 2024. 	Quarter	Total Grievances Received for PQOC	Grievances Classified as PQOCs	Grievances Classified as Non-PQOCs	Total Grievances Closed
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Q3 2024	1007	598	409	2755		☑ **CLOSED**: Informational discussion only.	12/12/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED

Severity Level	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024
Level 0 - No Quality Concern	299	265	162	129	129	85	18
Level 1 - Potential for Harm	145	172	138	127	108	75	95
Level 2 - Actual Harm	2	4	2	2	0	2	0
Level 3 - Actual Morbidity	0	0	0	0	0	0	0
Total	446	441	302	258	237	162	113

Kalpna presented the following Appeals information:

	Q3 2024
Member Request	247
Provider Request	107
Unlabeled	2
Total	356

Kalpna presented the following Claims/Disputes information:

	Q3 2024
Inpatient	379
Outpatient	829
Total	1208

	NCQA Accreditation Steven Kinnison presented the 2024 NCQ Readiness Project Status Report. Some key accomplishments included: • HPA projected points now at 90% overall – Up by 6% • HEA points increased from 63% - Up by 4% Survey look back dates and project time line were also presented as informational.	☑ **CLOSED**: Informational/discussion only.	12/12/24

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION / CONCLUSIONS</th><th>RECOMMENDATIONS/ ACTION</th><th>DATE RESOLVED</th></tr>
<tr><td></td><td><u>QI Policies</u>
Dr. Miller presented the following list of retired Quality Improvement Policies to be retired as follows:
<table>
<tr><th>Policy #</th><th>I or P</th><th>Policy Name</th><th>2024 Review</th><th>Notes</th></tr>
<tr><td>2.01</td><td>P</td><td>General Exam Guidelines</td><td>Retired</td><td>Not needed in QI</td></tr>
<tr><td>2.21</td><td>P</td><td>Management of Biohazardous Waste</td><td>Retired</td><td>Incorporated into Policy 2.20</td></tr>
<tr><td>2.40</td><td>I</td><td>Enhanced Medical Home for SPDs</td><td>Retired</td><td>No longer a program at KHS</td></tr>
<tr><td>2.43</td><td>I</td><td>Pay-for-Performance Program</td><td>Retired</td><td>Per Contracts Department</td></tr>
<tr><td>2.51</td><td>I</td><td>Disease Management Staffing</td><td>Retired</td><td>No longer a program at KHS</td></tr>
<tr><td>2.52</td><td>I</td><td>Ethics Training for Disease Management Staff</td><td>Retired</td><td>No longer a program at KHS</td></tr>
<tr><td>2.53</td><td>I</td><td>Disease Management Outcomes Reporting</td><td>Retired</td><td>No longer a program at KHS</td></tr>
<tr><td>2.54</td><td>I</td><td>DM Program - Financial Outcomes Reporting</td><td>Retired</td><td>No longer a program at KHS</td></tr>
<tr><td>2.56</td><td>I</td><td>Communications with Treating Providers</td><td>Retired</td><td>PHM Responsibility</td></tr>
<tr><td>2.60</td><td>I</td><td>Case Management Case Closure Criteria</td><td>Retired</td><td>PHM Responsibility</td></tr>
<tr><td>2.61</td><td>I</td><td>KHS CM Documentation</td><td>Retired</td><td>PHM Responsibility</td></tr>
<tr><td>2.62</td><td>I</td><td>Case Management Ethics</td><td>Retired</td><td>PHM Responsibility</td></tr>
<tr><td>2.63</td><td>I</td><td>Case Management Provider Communication</td><td>Retired</td><td>PHM Responsibility</td></tr>
<tr><td>2.64</td><td>I</td><td>Case Manager Qualifications</td><td>Retired</td><td>PHM Responsibility</td></tr>
<tr><td>2.65</td><td>I</td><td>Case Management Assessment</td><td>Retired</td><td>PHM Responsibility</td></tr>
</table></td><td>☑ ACTION: Dr. Michael Komin moved to approve retirement of the noted QI Policy and Procedures, seconded by Dr. Irving Ayala-Rodriguez. Motion carried.</td><td>12/12/24</td></tr>
<tr><td></td><td><u>Enhanced Care Management</u>
Dan Diaz ECM Manager presented the ECM 3rd Quarter Report. The following highlights were noted:
As of December 1st, 2024, ECM had a total of 10,715 members currently enrolled in ECM
Members are stratified into 38 ECM sites via geographic logic and are assigned into the above distinct populations of focus</td><td>☑ CLOSED: Informational only.</td><td>12/12/24</td></tr>
<tr><td></td><td><u>Workplan Scorecard – Q3 2024</u>
The Q3 scorecard was presented with no concerns.</td><td>☑ ACTION: Carmi Magno moved to approve retirement of the noted QI Policy and Procedures, seconded by Dr. Michael Komin. Motion carried.</td><td></td></tr>
<tr><td>OPEN FORUM</td><td><u>Open Forum</u>
No additional questions or issues were presented for open forum.</td><td>☑ CLOSED: Informational only.</td><td>N/A</td></tr>
<tr><td>NEXT MEETING</td><td>Next meeting will be held Wednesday, March 7, 2025 at 12:00 pm</td><td>☑ CLOSED: Informational only.</td><td>N/A</td></tr>
<tr><td>ADJOURNMENT</td><td>The Committee adjourned at 1:05 PM.
Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator</td><td>N/A</td><td>N/A</td></tr>
</table>

For Signature Only – Quality Improvement Committee Minutes 12/12/24

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

To: EQIHEC

From: John Miller, M.D.

Date: March 18, 2025

Re: Quality Improvement Workgroup (QIW)

Background

The 1st Quarter meeting of the KHS Quality Improvement Workgroup (QIW) took place on March 7, 2025. This committee reports to the Executive Quality Improvement Health Equity Committee (EQIHEC). Committee members include providers and representatives from the community. The meeting covered key updates on quality and safety initiatives, site review performance, appeals and grievances, NCQA accreditation progress, and Enhanced Care Management (ECM) developments.

Discussion

During this session, quorum was met.

2024 Quality Program Evaluation, 2025 Quality Improvement Health Equity Program Description, and 2025 Quality Improvement Work Plan

Magdee Hugais, Director of Quality Improvement, presented the three documents for review and feedback. They will be next presented to the EQIHEC March meeting.

- The 2024 Quality Program Evaluation assesses the effectiveness of the QI Program in enhancing member health outcomes, ensuring regulatory compliance, and promoting health equity. It reviews governance, departmental changes, performance metrics, clinical care quality, safety, service quality, and member experience. Key achievements include meeting 26 of 28 program goals, improving several Managed Care Accountability Set (MCAS) measures, and enhancing provider engagement and member outreach. However, challenges remain in meeting minimum performance levels for select quality measures and timely grievance resolutions.
- The 2025 Quality Improvement Health Equity Program (QIHEP) Description outlines the organization's commitment to improving health outcomes, reducing disparities, and ensuring equitable care for Medi-Cal members in Kern County. It provides an in-depth framework for quality improvement, including governance, program scope, goals, and responsibilities of key committees and departments. The document highlights efforts to address social determinants of health (SDOH), expand provider networks, and enhance culturally competent care. Key initiatives include data-driven quality improvement projects, member engagement strategies, and oversight of performance metrics such as

Managed Care Accountability Set (MCAS) measures. The program integrates clinical and non-clinical approaches to promote whole-person care, with a strong emphasis on health equity, member satisfaction, and continuous performance evaluation.

- The 2025 QI Work Plan lists the Key Performance measures with measurable goals for the year. The domains of the plan include program structure, quality and safety of clinical care, quality of service, and member and provider satisfaction.

MCAS Performance Review

Kailey Collier, Director of Quality Performance, submitted the 4th quarter report.

- Currently meeting MPL for 6 out of 18 measures:
  - PPC-Pre, IMA, LSC, AMR, BCS-E, CHL
- Within 5% of MPL for 6 additional measures
  - CCS, CIS-10, W30(15-30), WCV, TFL-CH, PPC-Post
- 9 out of 18 measures showing improvement compared to previous year.

Quality Improvement Report

Magdee Hugais, Director of Quality Improvement, submitted the 4th quarter report.

- Data on Quality-of-Care Grievance, Potential Quality Issues, Appeals, Claims & Disputes, Initial Health Appointment audits, and lead screening in Children audits was included.

Member Satisfaction Results Report

Lela Criswell, Manager of Member Engagement submitted the results of the Member satisfaction report.

NCQA Accreditation Progress

Steven Kinnison, NCQA Manager, provided an update on the 2025 NCQA Readiness Project, reporting:

- Survey date for Health Plan Accreditation is April 8, 2025
- Survey date for Health Equity Accreditation is June 10, 2025.
- Overall projected points are at 91% for HEA and 98% for HEA.

Quality Improvement Policies

- No policies for approval.

Enhanced Care Management (ECM) Program Update

Dan Diaz, ECM Manager, presented 4th Quarter ECM report.

- Cost-Saving Measures: ECM focused on improving transitions of care to reduce avoidable emergency department (ED) and inpatient utilization, with a 57.7% reduction in ED visits per 1,000 members from Q3 to Q4.
- Clinical Quality Metrics: ECM tracked MCAS measures, prioritizing cervical cancer screening (CCS), breast cancer screening (BCS), and diabetes care (HBD). CCS compliance increased by 4.4%, BCS by 2.7%, but non-compliance in diabetes management rose by 11%.
- Patient Satisfaction & Grievances: ECM deployed a member experience survey and closely monitored grievances. ECM-related grievances increased by 23.8% from Q3 to Q4, though preliminary 2025 data showed no active grievances.

Cultural and Linguistics Monitoring Q4 Report

Cynthia Cardona, W&P Manager, presented 4th Quarter report. Key highlights include:

- Bilingual Staff Call Audits: 30 Spanish-language calls were audited, with 100% of staff reporting no communication difficulties with non-English-speaking members.
- Post-Call Surveys: 9,943 Spanish-language post-call surveys were completed, showing a 97% satisfaction rate with bilingual staff's linguistic performance.
- Vendor Bilingual Call Audits: 91 calls from vendors (e.g., American Logistics, Vision Services, Harte Hanks) were reviewed, with 98% of bilingual staff demonstrating effective communication.
- Interpreter Call Monitoring Audit: 30 Over-the-Phone Interpretation (OPI) calls in Mandarin, Punjabi, Spanish, Cantonese, Yemeni Arabic, Vietnamese, Nepali, and Khmer were assessed, with 100% of calls meeting expectations.

Member Wellness and Prevention Program Monitoring Q4 Report

Flor Del Hoyo Galvan, W&P Manager, presented 4th Quarter report. Key highlights include:

- Service Audit Results:
    - Areas achieving 100% compliance:
        - Classes started on time.
        - Member sign-ins were completed.
        - Instructors provided clear examples for topics, concepts, or myths.
        - All planned activities were explained and completed.
    - Areas needing improvement (below 50% compliance):
        - Coverage of SMART (Specific, Measurable, Achievable, Relevant, Time-bound) goals and objectives.
- Satisfaction Survey Highlights:
    - Positive Feedback:
        - Members appreciated the delivery, tone, and teaching style of instructors.
        - Learning about healthy eating habits, food substitutions, and general health topics was valued.
        - Content was relevant and easy to understand.
        - A supportive environment made participants look forward to attending.

- Suggested Improvements:
  - More interaction and engagement in classes.
  - Expansion of topics covered.
  - Adjustments to class structure or format.
  - Consideration of incentives or rewards to encourage participation.

2024 Work Plan Scorecard

Magdee Hugais, Director of Quality Improvement, submitted the 4th quarter scorecard.

Conclusion & Next Steps

- No additional issues were raised during the open forum.
- The next QIW meeting is scheduled for May 22, 2025

Fiscal Impact
None.

Requested Action
Approval of committee proceedings.

To: EQIHEC

From: Isabel Silva, Senior Director of Wellness and Prevention

Date: March 18, 2025

Re: 3rd and 4th Quarter 2024 Wellness & Prevention Department Reports

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Background

KHS' contract with the DHCS requires that it implements evidence-based wellness and prevention programs inclusive of a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all members. The contract also requires that KHS have a Cultural and Linguistic Services Program and that KHS monitors, evaluates and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services.

Discussion

Enclosed are the quarterly Wellness and Prevention Department reports summarizing all activities performed during the 3rd and 4th quarters of 2024:

- Q3 2024 Wellness & Prevention Activities Report
- Q3 2024 Cultural and Linguistic Services Activities Report
- Q4 2024 Wellness & Prevention Activities Report
- Q4 2024 Cultural and Linguistic Services Activities Report

Fiscal Impact

- None.

Requested Action

- Approve and file.

Executive Summary

Report Date: November 1, 2024

OVERVIEW

Kern Health Systems' Wellness and Prevention (WP) department provides comprehensive evidence-based services to plan members with the intent of promoting healthy behaviors, improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care. The Executive Summary below highlights the larger efforts currently being implemented by the WP department followed by the ongoing activity for Q3 2024.

1. Community Health and Wellness

- Live Better Program – The community of Delano continues to have over 100 attendees participating in Zumba or Yoga classes each month. KHS has partnered with Greenfield Family Resource Center to offer Zumba classes starting in October. KHS has also partnered with Danica's School of Dance to offer Zumba, Yoga and Hip-Hop dance classes in Lake Isabella and Kernville starting in December. The Kern River Valley Family Resource was trained by KHS to facilitate KHS' Diabetes Prevention Program.
- The 2024-2026 School Wellness Grant Cycle opened on September 6, 2024. Communities of focus will include Wasco, Shafter, Rosamond, Tehachapi, Ridgecrest, Mojave, rural areas and schools working with special needs populations. Applications will be accepted through October 15, 2024.
- The Community Health and Wellness team participated in 56 community events to strengthen presence and promote the wellness and prevention services. Events included facilitation of community health education classes for the Children First Splash Event and the Deaf and Hard of Hearing Children of Color, participation in the Kern Health Equity Partnership Community Health Conversations and the Kern Immunization Coalition and attendance at school events such as the Edison School District Attendance Summit.

2. Wellness & Prevention Partnerships

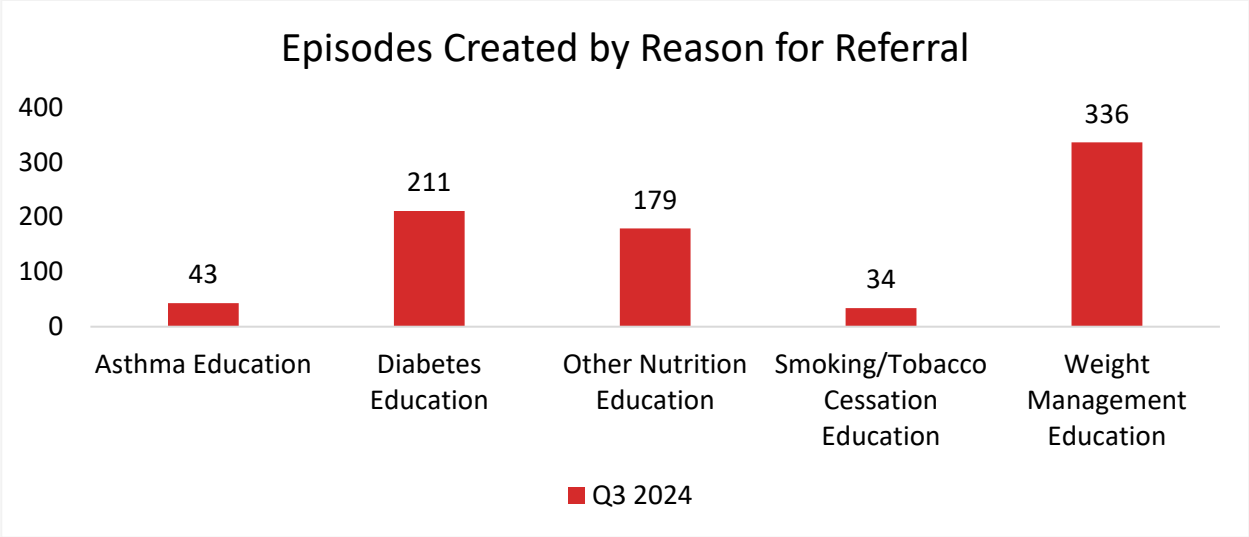
- 3rd Party Memorandums of Understanding (MOUs) are required under KHS' contract with DHCS. The MOUs are intended to enhance care coordination and improve the quality of care to members. The WP department continues to lead this county MOU execution effort with Kern Public Health, Aging & Adult Services, Kern Regional Center, Kern County Human Services, Kern County Probation, and Women, Infant and Children (WIC). In Q4, KHS anticipates executing MOUs with Kern Public Health, CSV WIC and Kern County Probation.
- The Department of Health Care Services requires KHS to have a tribal liaison dedicated to working with Indian health care providers and coordinating referrals and services for American Indian KHS members. KHS and the Bakersfield American Indian Health Project have interviewed and hired a new team member to serve as KHS' tribal liaison to better understand and meet the needs of members.

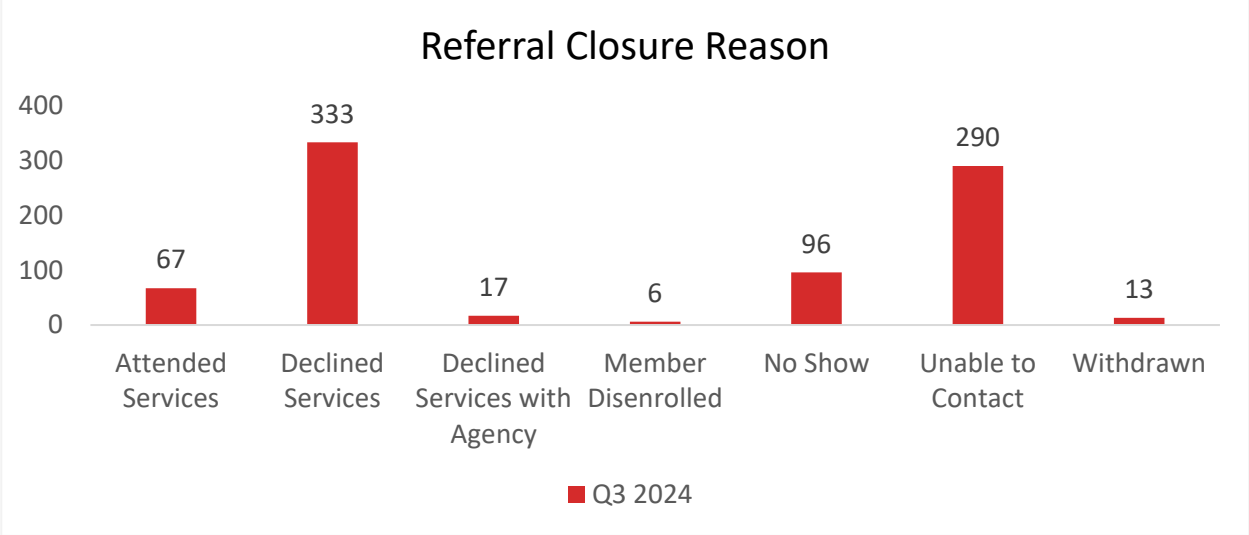
Respectfully submitted,
Isabel Silva, MPH, CHES
Senior Director of Wellness and Prevention

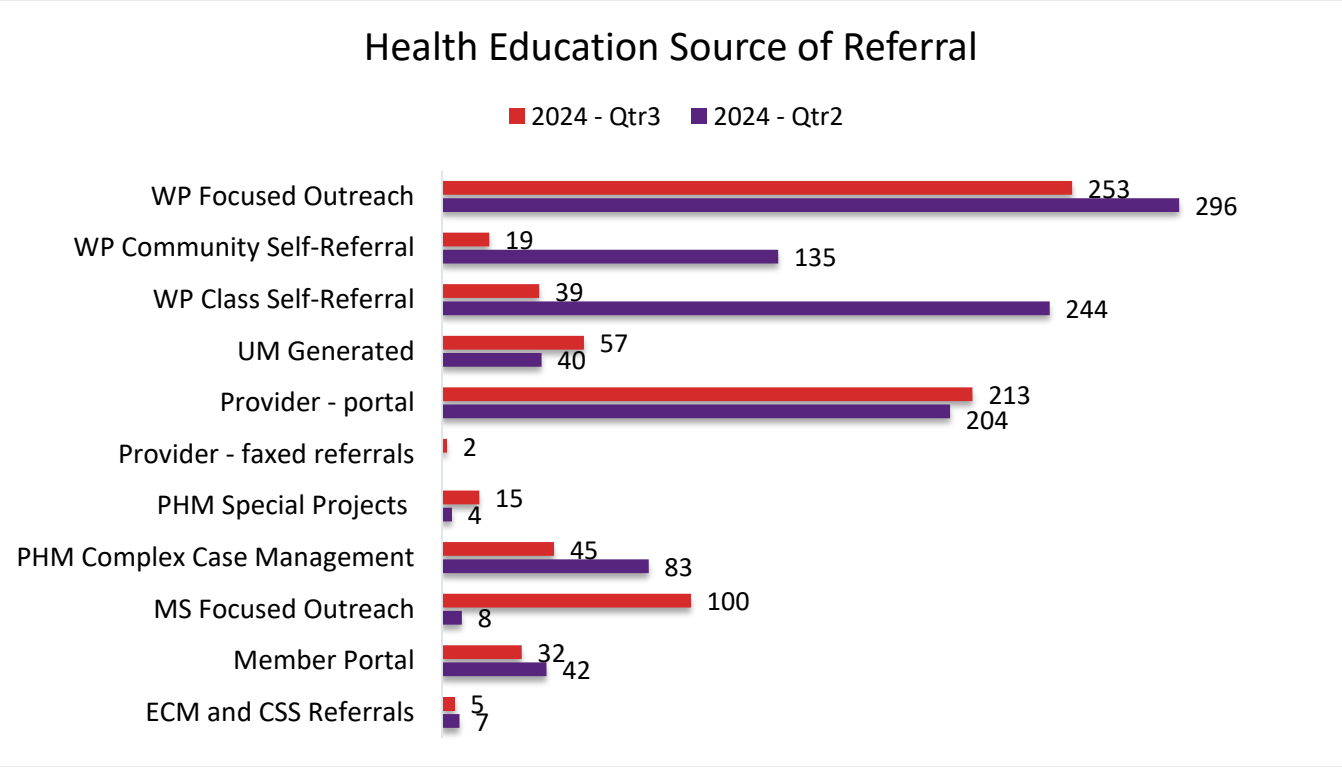
Member Wellness and Prevention

Health Education Referrals

During Q3, there were 1,017 referrals for Member Wellness and Prevention (MWP) services which is a 9% decrease in comparison to the previous quarter. In Q3, the MWP team directed outreach efforts to register members for the Diabetes Prevention Program and Diabetes Empowerment Education Program virtual classes hosted by the California Health Collaborative (CHC). Outreach for CHC-provided services was focused on the outlying communities and members 35-49 years of age who are more likely to use virtual services or have greater barriers related to distance and transportation. Additionally, the health education class service acceptance rates decreased by 16% between Q2 to Q3 whereas the received services rate decreased from 3% in Q2 (43%) to Q3(40%). The decrease observed in Q3 may be due to seasonal trends considering summer travel and back to school.

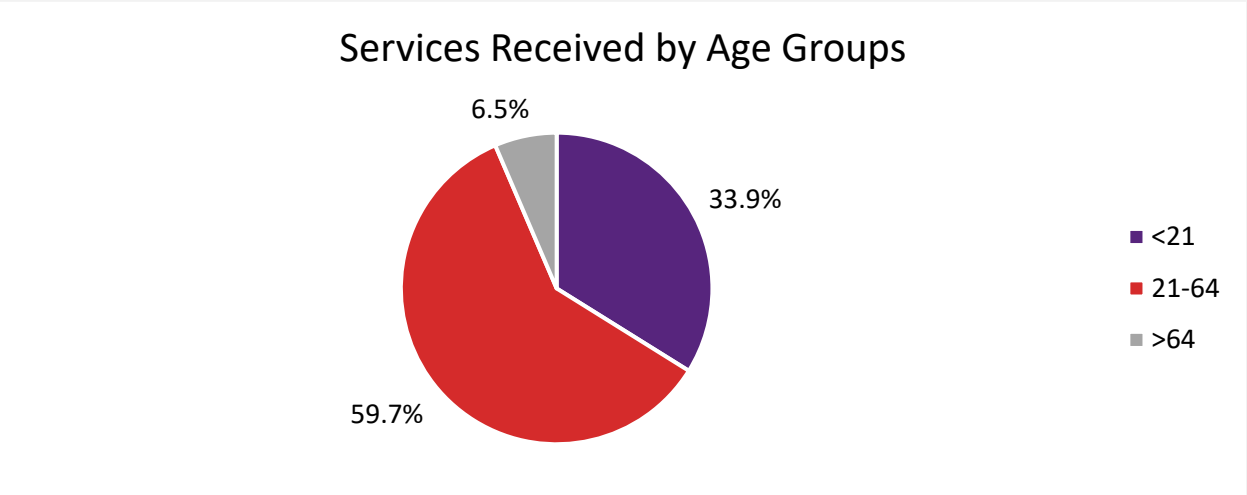


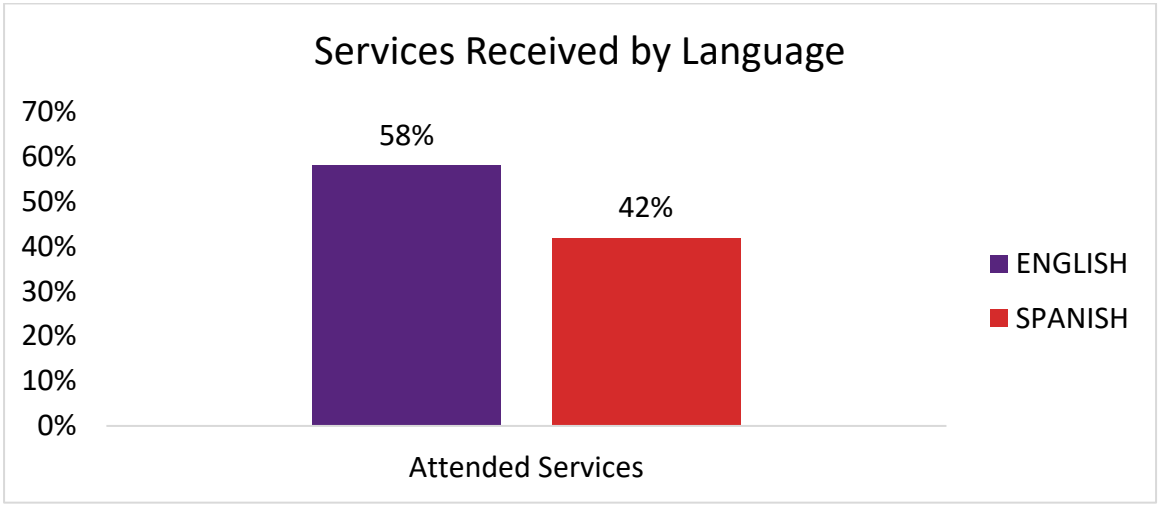


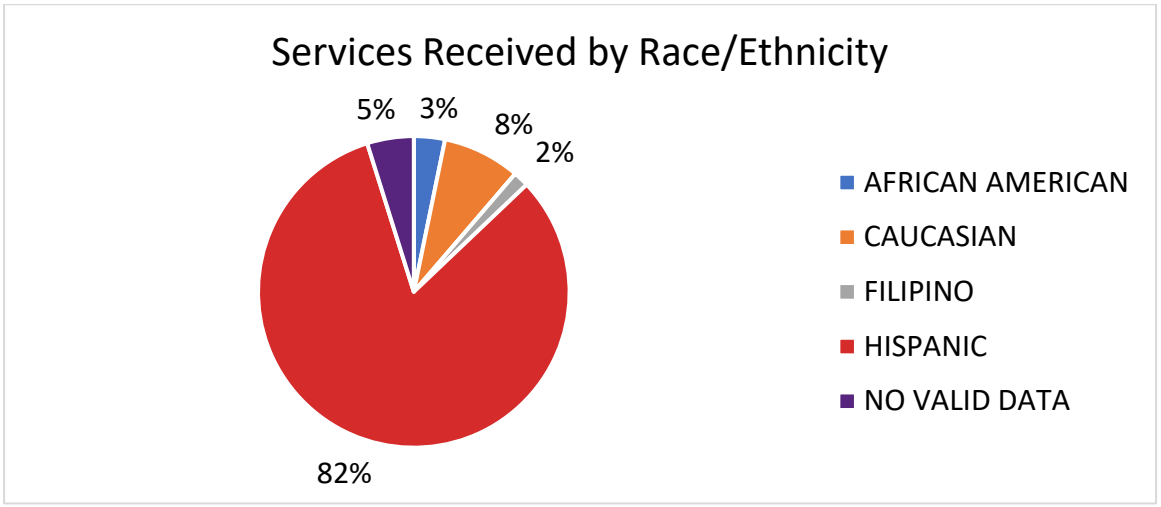


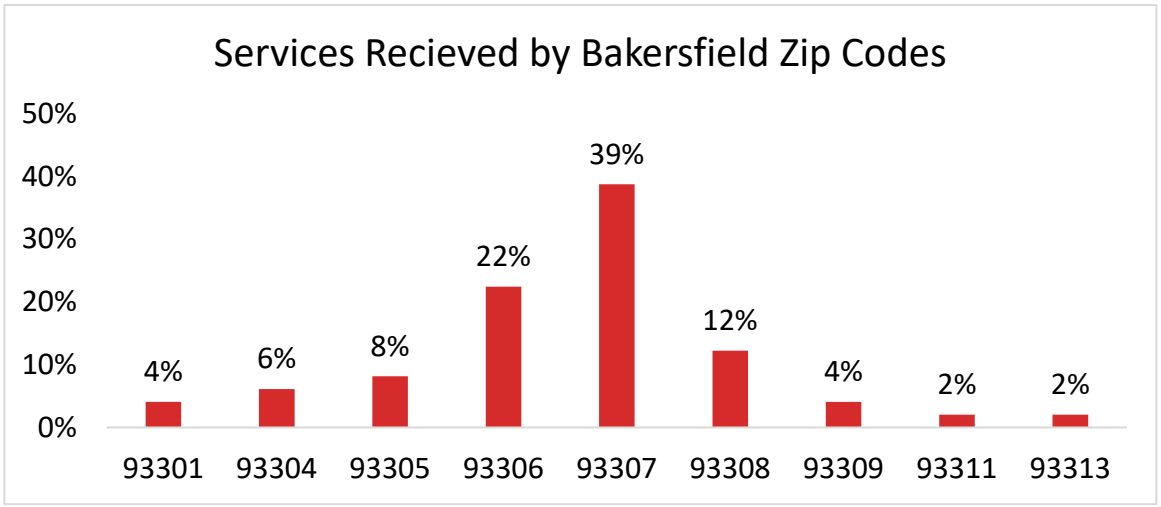
Demographics of Members

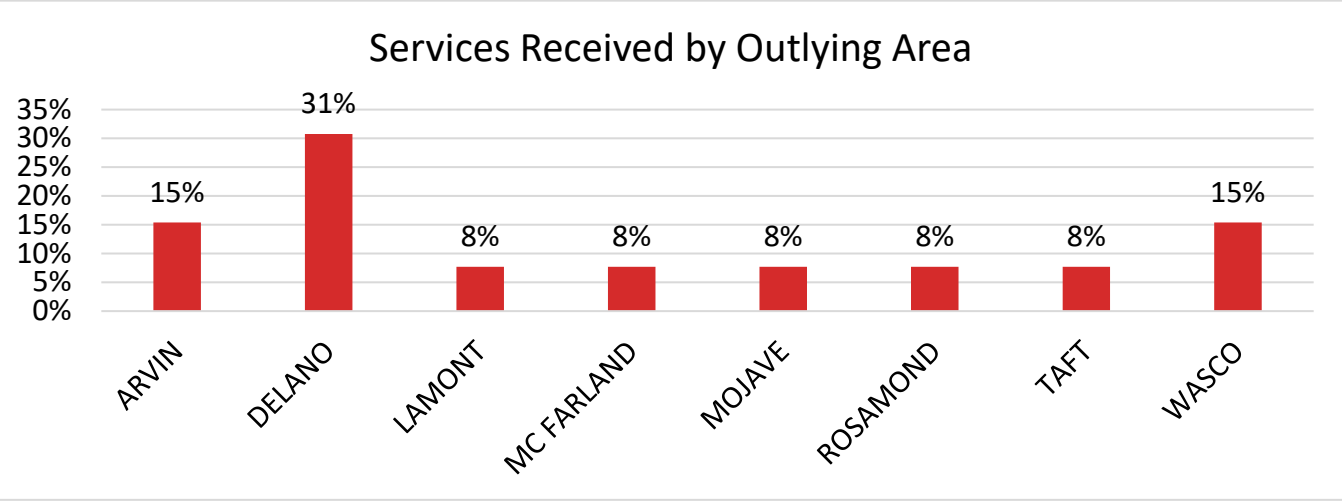
KHS provides services to a culturally and linguistically diverse member population in Kern County. Of the members who received services, the largest age groups were 21-64 years (59.7%) followed by members under 21 years of age (33.9%). A breakdown of member classifications by race and language preferences revealed that many members who received services are Hispanic and preferred to receive services in English. Most members who received services reside in Bakersfield with the highest concentration in the 93307 area and Delano in the outlying areas of the county. Our English-speaking population has a higher attendance rate in comparison to our Spanish population that has a higher no-show rate this quarter compared to Q2.




Services Received by Language
70%
60%
50%
40%
30%
20%
10%
0%
58%
42%
ENGLISH
SPANISH
Attended Services


Services Received by Race/Ethnicity
5%
3%
8%
2%
82%
AFRICAN AMERICAN
CAUCASIAN
FILIPINO
HISPANIC
NO VALID DATA

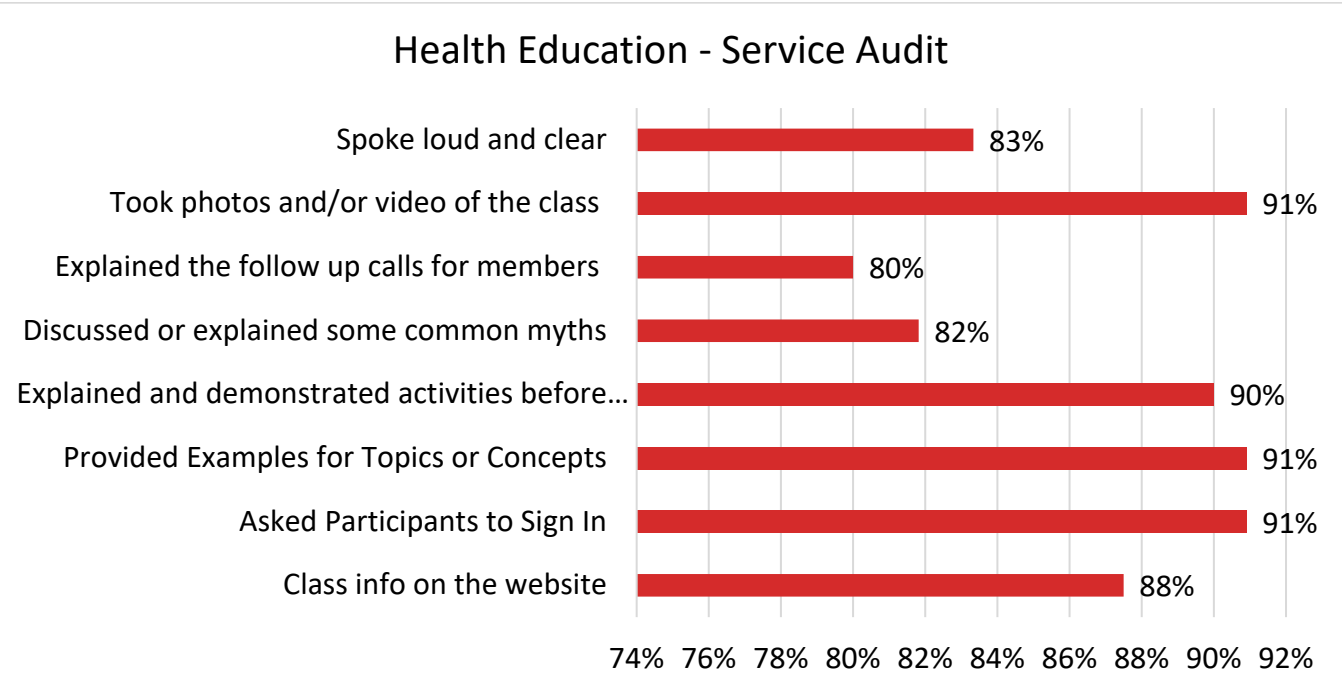

Services Recieved by Bakersfield Zip Codes
50%
40%
30%
20%
10%
0%
4%
6%
8%
22%
39%
12%
4%
2%
2%
93301
93304
93305
93306
93307
93308
93309
93311
93313



Health Education Class Service Audit

The Health Education Class Service Audit Tool considers a variety of markers to determine the quality of Health Education Class Services being provided to members. It includes observations on planning and preparation, implementation and delivery, and member engagement during health education classes.

In Q3, class facilitators demonstrated mastering preparing for the class, encouraging members to ask questions, and completing administrative tasks. In addition, the facilitators reached 100% in the following areas: covering SMART goals, doing all planned activities and covering all information, thereby demonstrating improved time management skills. Areas of improvement for next quarter are: starting and ending class on time and using various teaching methods . During Q3, 0 items were observed to fall below the 50% mark.



Health Education Class Evaluations

Health Education classes include an evaluation questionnaire for participants. The questionnaire is provided at the end of the class. Below is an analysis of the findings from open-ended questions in Q3 for 2024.

What did you like most about the class?

More than 95% percent of participants who responded expressed great satisfaction in the workshops and suggested no change, and that instructors were very effective and engaging.
More than half of members who responded:

- Expressed high levels of satisfaction with the class, appreciating both the overall experience and the instructors.
- The clarity of explanations and effective communication of concepts made the material easy to understand.
- The content was found to be relevant and informative, which made the classes easy to understand.
- Interactive and engaging elements such as quizzes and discussions were highly appreciated for enhancing participation.
- Valued the supportive environment and the opportunity to connect with others in similar situations while building community.

How could we improve the class?

Members responded:

- Feedback highlights the clarity of instruction, with many feeling the content is well-explained and perfectly presented.
- Activity & Eating program respondents requested for longer sessions to allow for more in-depth exploration of topics.
- Participants desire increased engagement through more interactive activities, such as polls, games, quizzes, and discussions.
- Suggestions include providing more diverse content, such as recipes and information on healthier food choices.

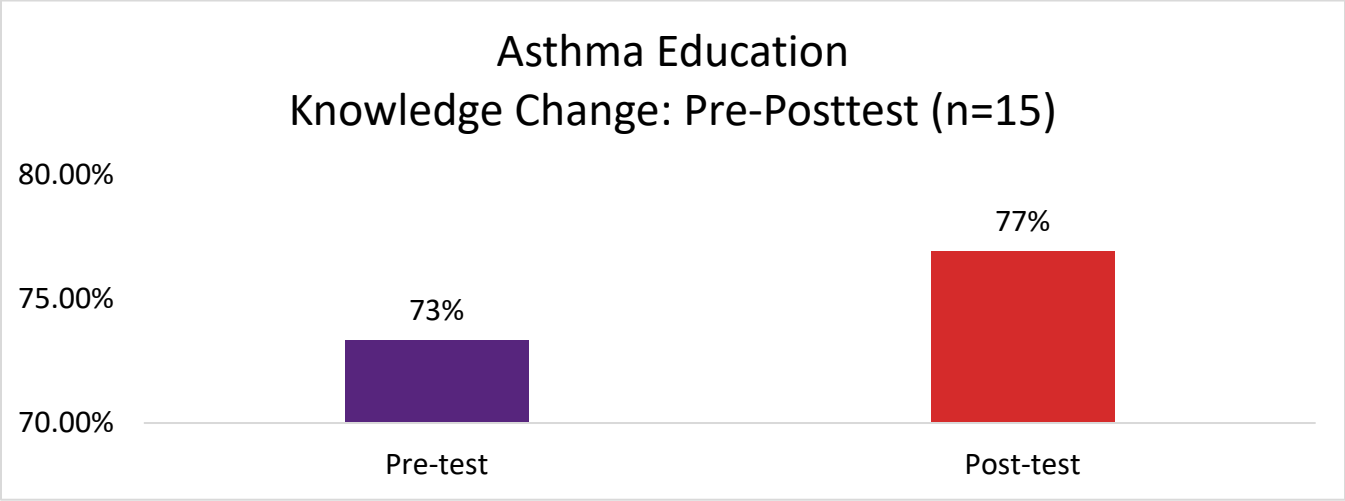
In addition, members referred to the Kick It California (KIC) Quitline are surveyed to gauge satisfaction with this service. 0 members accepted services to KIC in Q3.

Health Education Class Effectiveness

Asthma: Breathe Better

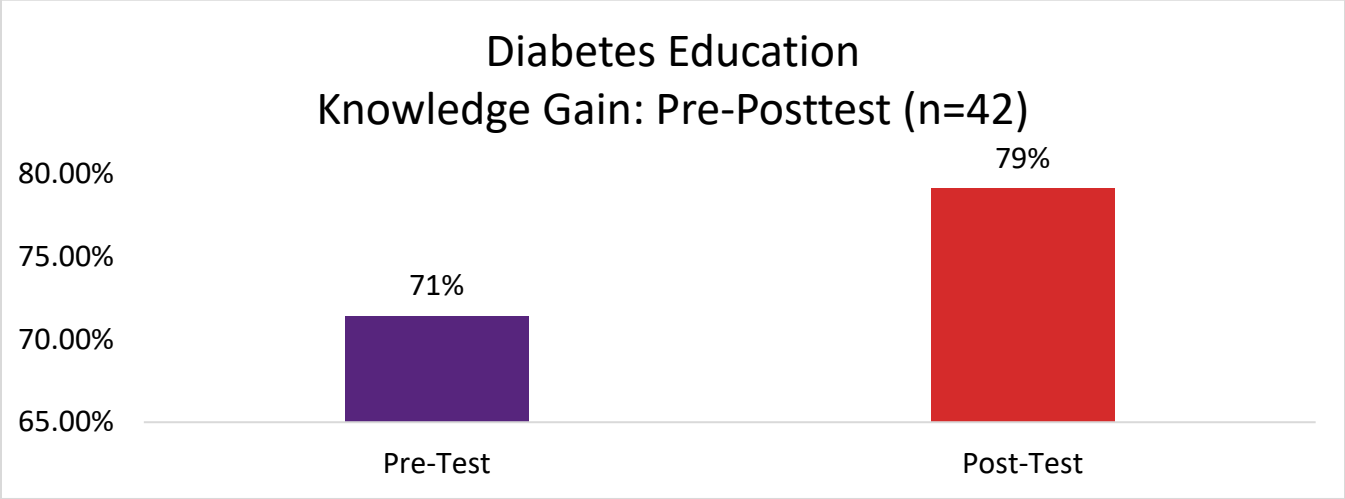
The asthma education program consists of 2 classes and at least 2 follow-up calls. A pre and posttest questionnaire is distributed per series. During Q3, findings revealed there was an average 4 percentage point increase in knowledge gained after completing the series. The largest increase in understanding was understanding that there is no cure for asthma, controlling asthma when exercising, understanding if attacks always occur suddenly without warning, and in reducing

environmental asthma triggers.



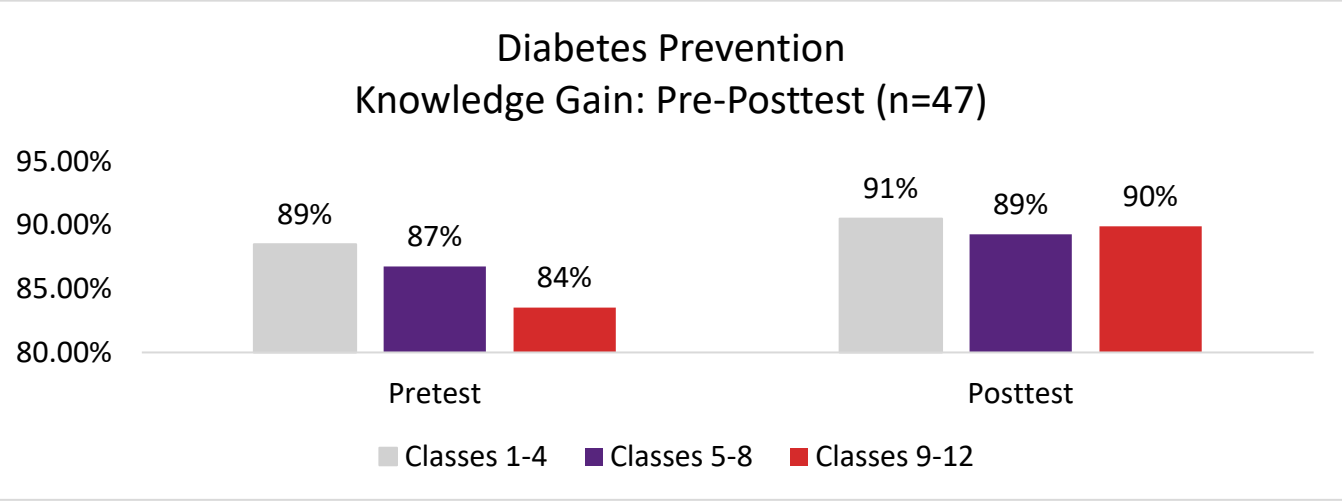
Diabetes Empowerment Education Program: DEEP

DEEP is a diabetes self-management program that has been shown to be successful in helping participants take control of their disease and reduce the risk of complications. The program was developed for low-income, racial and ethnic minority populations. During Q3, findings revealed an 8-percentage point increase in knowledge when comparing members who completed a pretest (average 71% correct answers) to members who completed a posttest (average 79% correct answers).



Diabetes Prevention Program

The National DPP aims to simplify access to an affordable, high-quality lifestyle change program for individuals with prediabetes or those at risk of type 2 diabetes. The program helps lower their chances of developing type 2 diabetes and enhances their overall health. In Q3, 47 members completed a pre- and posttest. There was an average 4 percent-point increase in knowledge gain for the first 12 classes, an average 86% correct answers at pre-test to members who completed a posttest (average 90% correct answers).



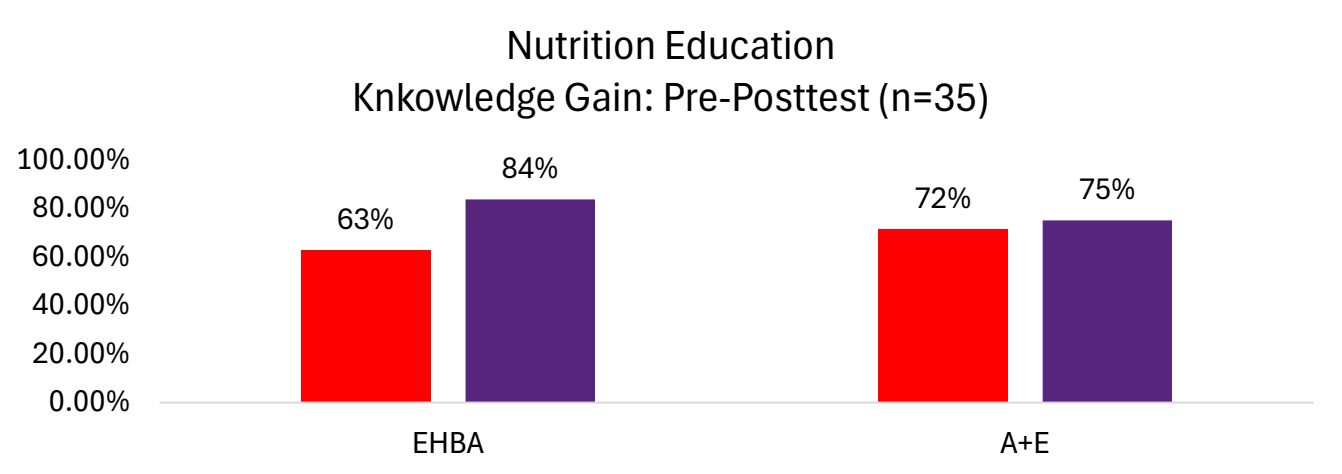
Nutrition and Weight Management: Eat Healthy, Be Active (EHBA)/Activity & Eating (A+E)

The nutrition and weight managed program include two curriculums that focus on creating healthy habits around eating and physical activity to reduce the risk of chronic illness among the KFHC members and Kern County population. In September 2023, the Eat Healthy, Be Active curriculum, a 6-class series, along with the Activity & Eating one-time class were launched. Each class lasts about 90 minutes. Evidence shows that these programs can positively impact behavior around physical activity and nutrition. A pre and posttest questionnaire is distributed per class.

During Q3, findings revealed that among those members who completed the core pre and posttest for both programs, there was an average 12-percentage point increase in knowledge gained after completing classes.

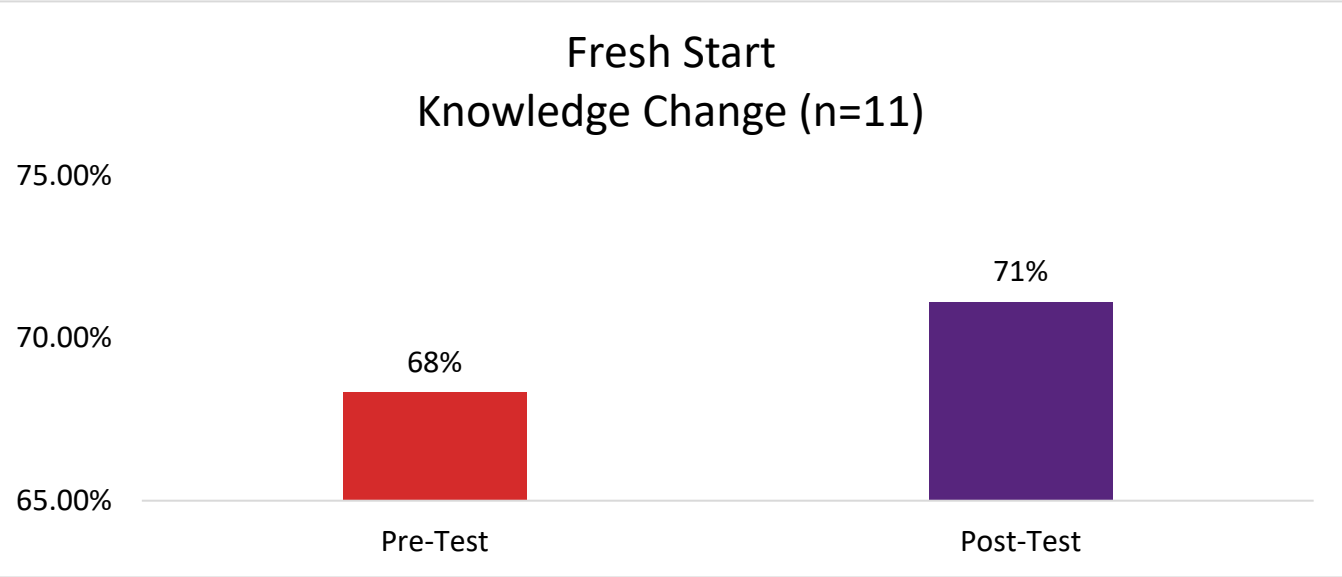
- Members who completed a pretest scored an average of 67% in correct answers.
- Members who completed a posttest scored an average of 79%.
- The largest increase in knowledge from pre- to posttest was observed among members who attended the Eat Healthy, Be Active course (6 classes).

There was also an increase in awareness on the relationship of calorie intake and physical activity, and the five recommended food groups.



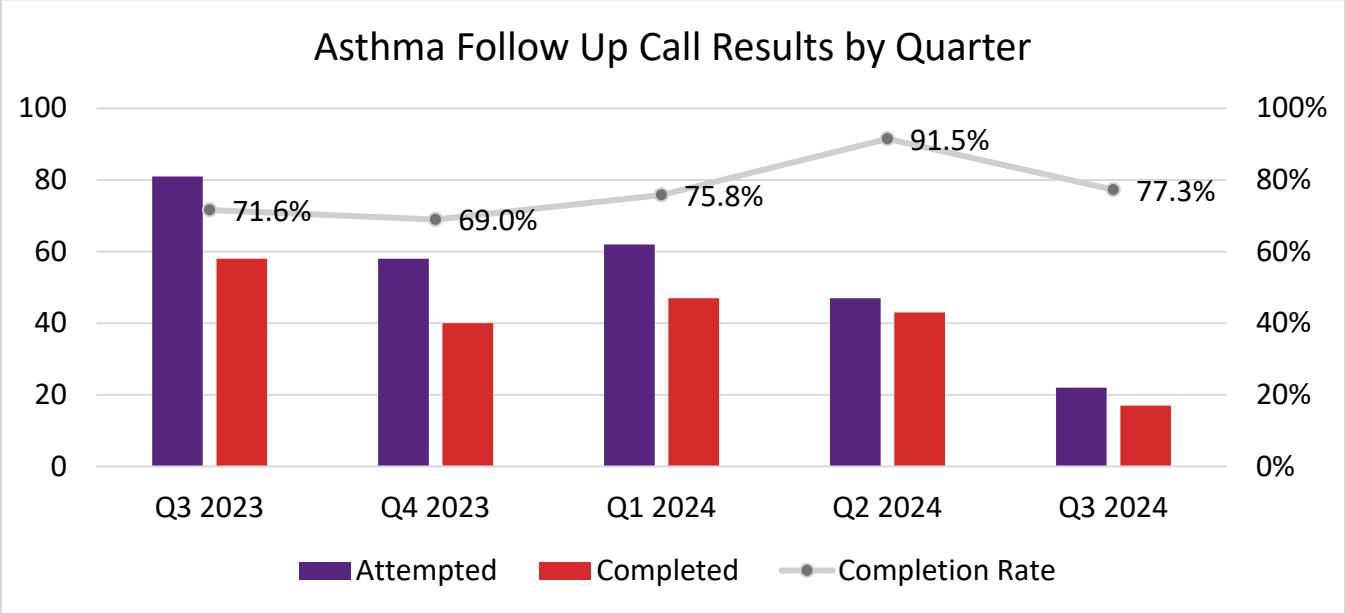
Smoking/Tobacco Cessation: Fresh Start

The Fresh Start program has the goal of reducing harm from tobacco products. Knowledge tests are implemented each series. In Q3, 13 members completed a pre- and posttest, with a total of 20 tests completed during this period. There was an average 3-percent point knowledge gain increase between all responses. Members appear to gain knowledge on committing to a quit date, and Nicotine Replacement Therapy. More emphasis is needed in learning about and having a quit plan and understanding withdrawal symptoms.



Chronic Disease Prevention and Management: Asthma Education Effectiveness

Members who have attended the KFHC Breathe Better Asthma Classes are offered asthma follow up calls. These calls occur at 1 month, 3 months, and 6 months (optional or only if needed) after attending the classes. During the follow up call, members are screened to determine if asthma symptoms are well controlled using the Asthma Control Test (ACT) screening tool. An ACT score of 20 or higher is an indicator of well controlled asthma. During Q3 2024, 77.3% of members completed an asthma follow up call. There was a decrease to 91.5% during the previous quarter. There was an improvement in average ACT score for that age group when comparing the initial assessment to the 3 month follow up. There was no data found for 1 month and 6 month follow up calls.

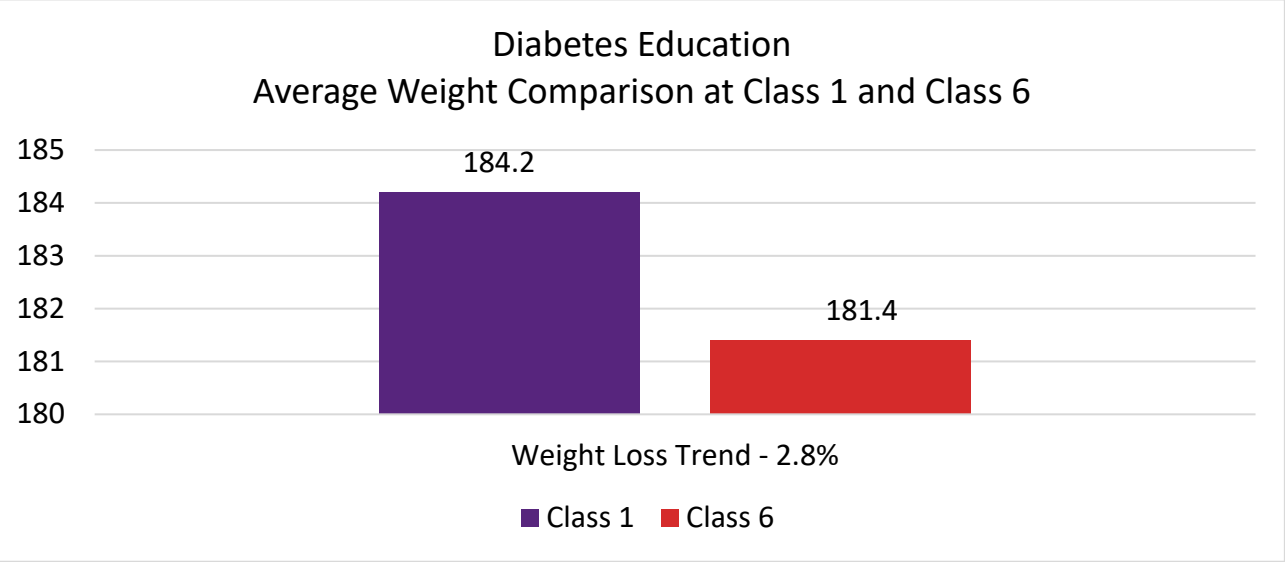


Q3 2024 Average ACT Scores During Asthma Follow Up Calls

Call Month	<12 years of age	12+ years of age
Initial	18.2	13.4
1	No data	No data
3	20	17.8
6	No data	No data

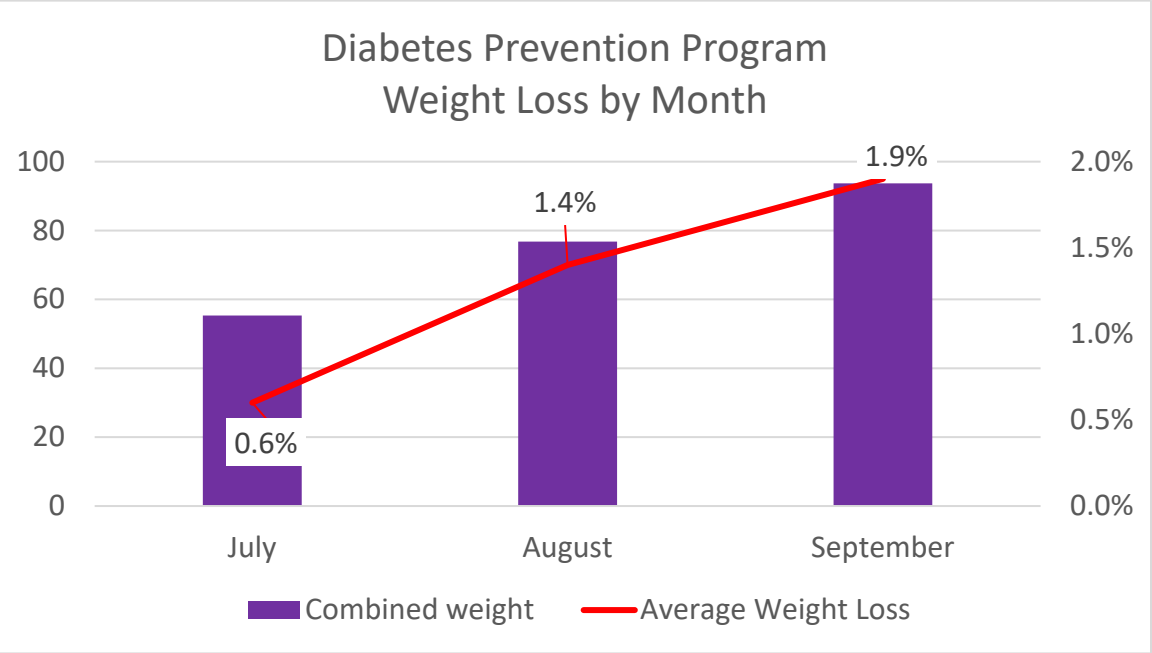
Chronic Disease Prevention and Management: Diabetes Empowerment Education Program

Members who participate in DEEP are weighed in at every class as one way to measure program impact. The bar chart below compares the average weight of participants before and after attending the DEEP program, for class 1 and class 6 during Q3. Overall, the data shows that participants experienced an average weight loss of almost three percentage (3%) points, suggesting that behavior modifications and recommendations presented during the series are effective.



Chronic Disease Prevention and Management: Diabetes Prevention Program

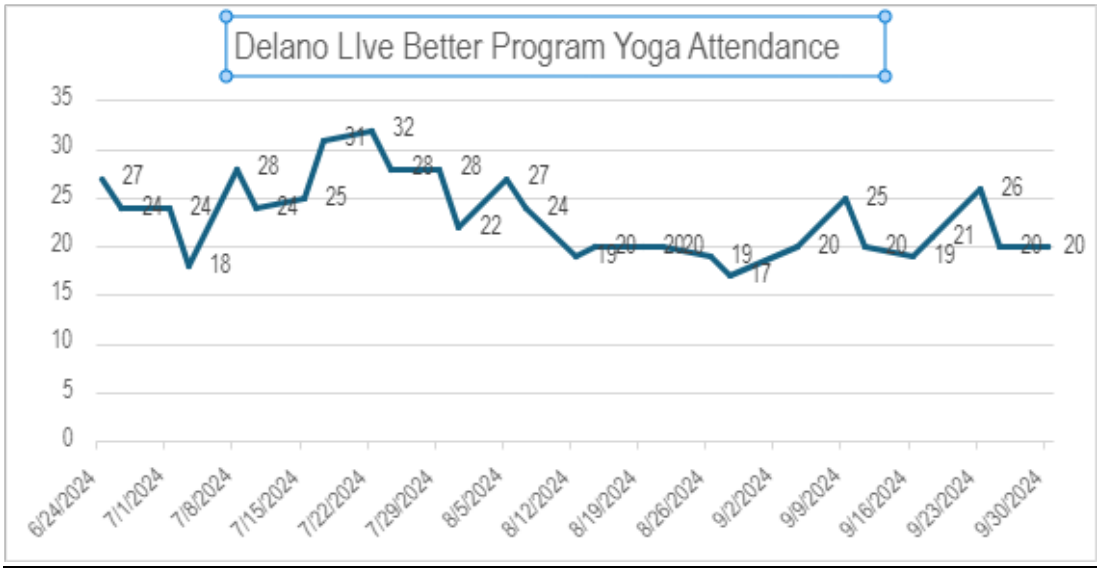
Members who participate in DPP are weighed in at every class as one way to measure impact. Weight loss totals and percentages that compare initial combined cohort weight with combined weight at the end of each month. Q3 2024 weigh-ins are shown in the chart below. By the end of Q3 2024, 23 members were enrolled in the English DPP cohort with an average weight loss of 1.9%. There was no Spanish DPP series being offered in Q3 2024.

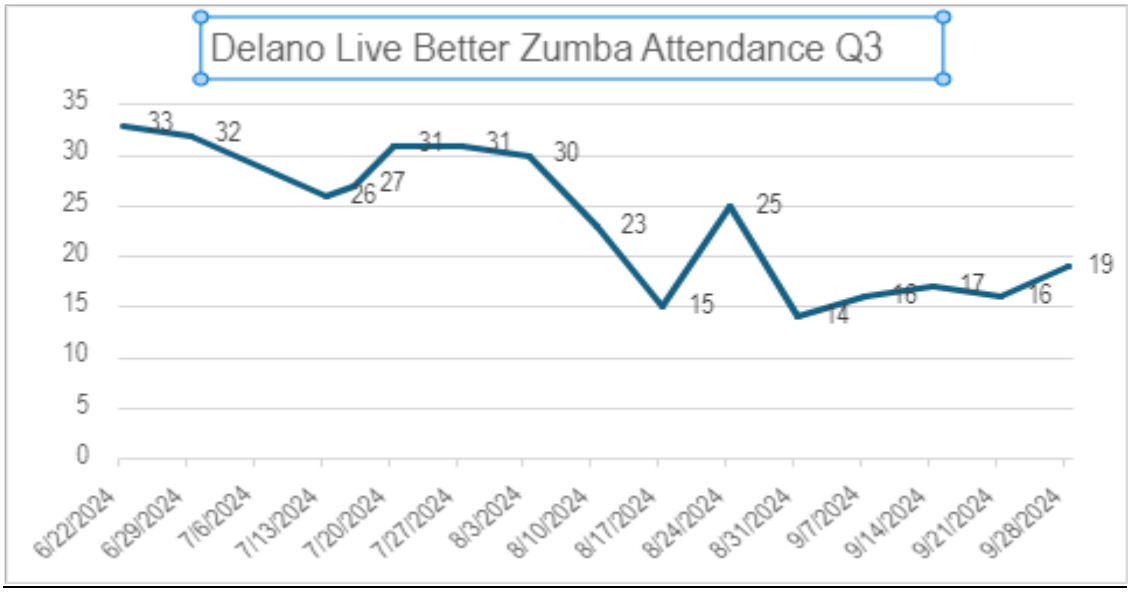


Community Health and Wellness

Live Better Program

The average daily yoga class attendance in Delano was 23.1 participants in Q3 compared to 26 participants in Q2 2024. The average daily Zumba class attendance was 23.6 participants in Q3 compared to 28.7 participants in Q2 2024.





Kern Health Systems
Cultural & Linguistic Services Activities Report
3rd Quarter 2024

Executive Summary

Report Date: October 22nd, 2024

OVERVIEW
Kern Health Systems' Cultural and Linguistic (C&L) Services Program helps ensure that comprehensive, culturally, and linguistically competent services are provided to plan members with the intent of improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care. The Executive Summary below highlights the larger efforts currently being implemented by the C&L Team. Following this summary reflects the statistical measurements for the C&L Services Program detailing the ongoing activity for Q3 of 2024.

1. Interpreter Requests

- Language Breakdown:
  - ✓ Top OPI languages
  - ✓ Top Onsite languages
  - ✓ Top VRI languages

2. Service Monitoring

- Linguistic Performance:
  - ✓ Written translations
  - ✓ 100 % Vendor Over-the-Phone (OPI) Interpreter Call Monitoring
  - ✓ 99% members satisfaction with bilingual KHS staff communications
  - ✓ 99% of KHS calls, and 98% of vendor calls reviewed did not have difficulty communicating with members in a non-English language.
  - ✓ 100% members satisfaction with in-person interpreter
  - ✓ 99% members satisfaction with telephonic interpreter
  - ✓ 97% members satisfaction with KHS and vendor translations
  - ✓ 98% KHS staff satisfaction with vendor Over-the-Phone Interpreter (OPI) communications

Respectfully submitted,

Isabel Silva, MPH, CHES
Senior Director of Wellness and Prevention

Kern Health Systems
Cultural & Linguistic Services Activities Report
3rd Quarter 2024

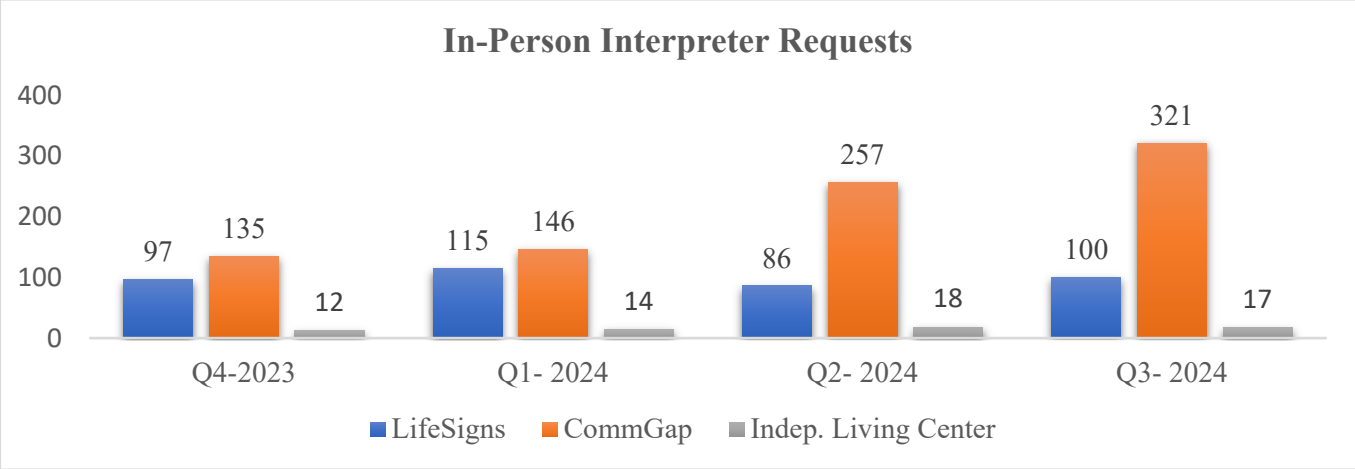
Cultural and Linguistic Services

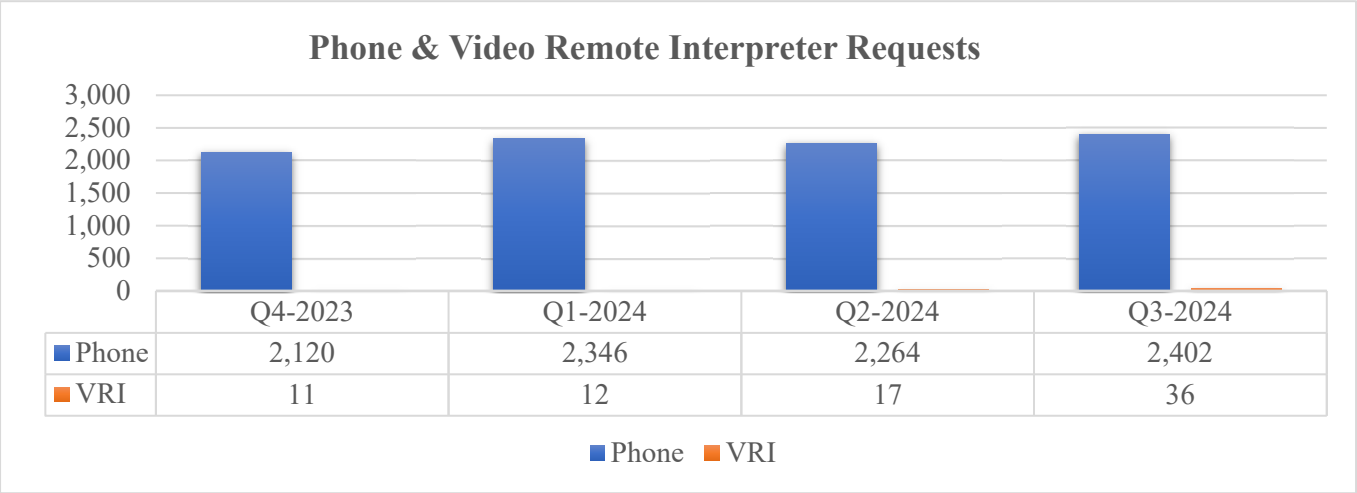
Interpreter Requests

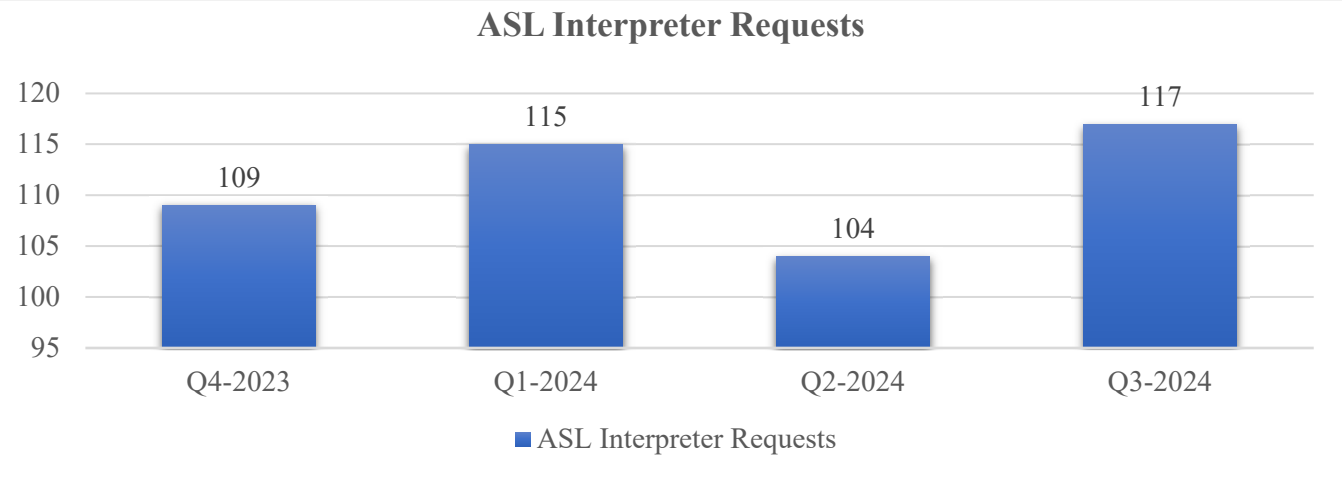
During this quarter, there were 321 requests for Face-to-Face Interpreting, 2,402 requests for Telephonic Interpreting, 36 for Video Remote Interpreting (VRI) and 117 requests for an American Sign Language (ASL) interpreter.

Interpreting Languages Requested
Phone and Video Remote
Spanish
Punjabi
Arabic

Interpreting Languages Requested
In-person
Spanish
Punjabi
Arabic

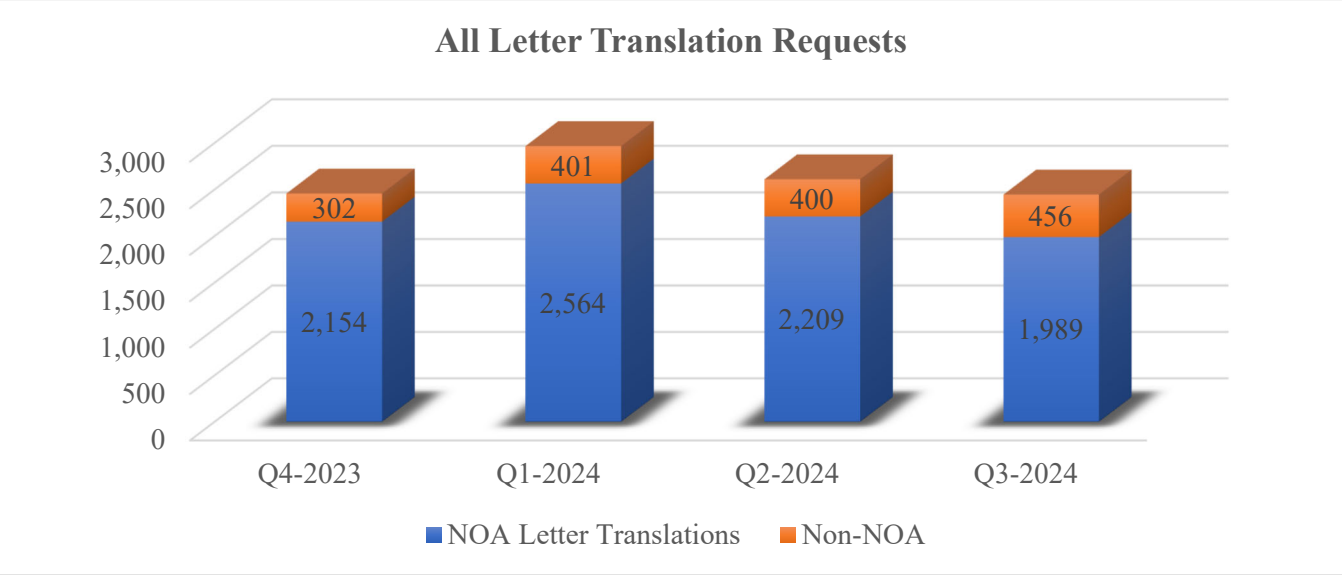



Phone & Video Remote Interpreter Requests
3,000
2,500
2,000
1,500
1,000
500
0
Q4-2023
Q1-2024
Q2-2024
Q3-2024
Phone
2,120
2,346
2,264
2,402
VRI
11
12
17
36
Phone
VRI


ASL Interpreter Requests
120
115
110
105
100
95
109
115
104
117
Q4-2023
Q1-2024
Q2-2024
Q3-2024
ASL Interpreter Requests

Written Translations

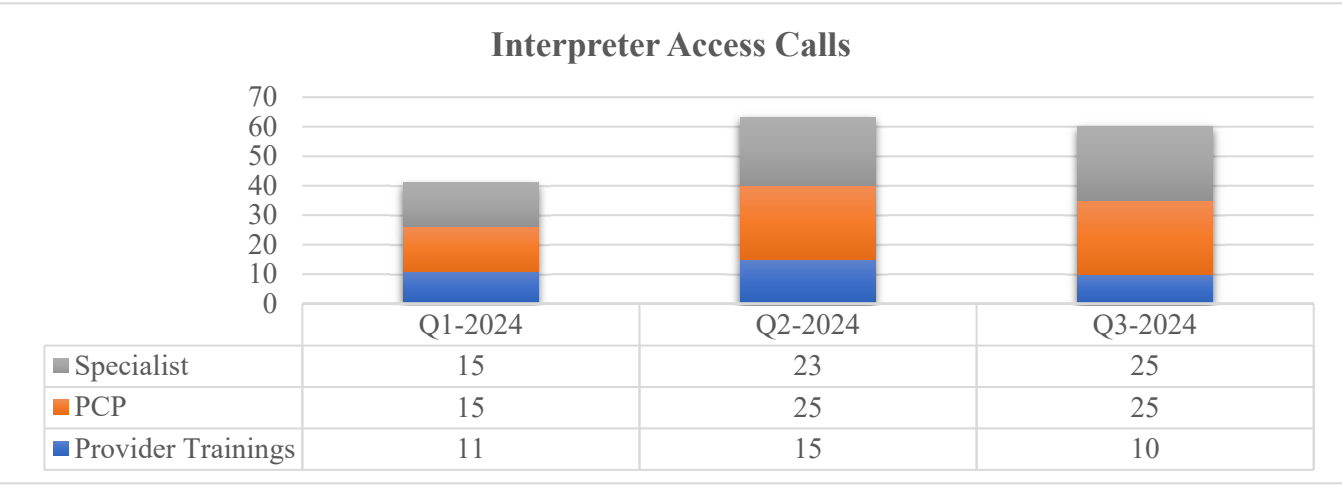
The W&P department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 2,445 requests for written translations were received.



Cultural and Linguistic Services Audits

Interpreter Access Survey Calls

Each quarter, the Provider Network Management (PNM) department conducts an interpreter access survey among KHS providers. During Q3, 25 PCPs and 25 Specialists participated in this survey. Of these providers, 10 needed a refresher training on KHS' C&L services.



	Q1-2024	Q2-2024	Q3-2024
Specialist	15	23	25
PCP	15	25	25
Provider Trainings	11	15	10

Vendor Over-the-Phone (OPI) Interpreter Call Monitoring

During this quarter, Language Line Solutions conducted an audit on 30 random OPI interpreter services calls. These calls were randomly selected from the vendors monthly invoices. Calls audited were in Arabic, Mandarin, Punjabi, Spanish, Tagalog, and Vietnamese languages. Calls were evaluated on the following items: Interpreter's Customer Service, Interpretation Skills, and the ability to follow the Code of Ethics and Standards of Practice. Audit findings revealed 100% of calls "Met Expectations."

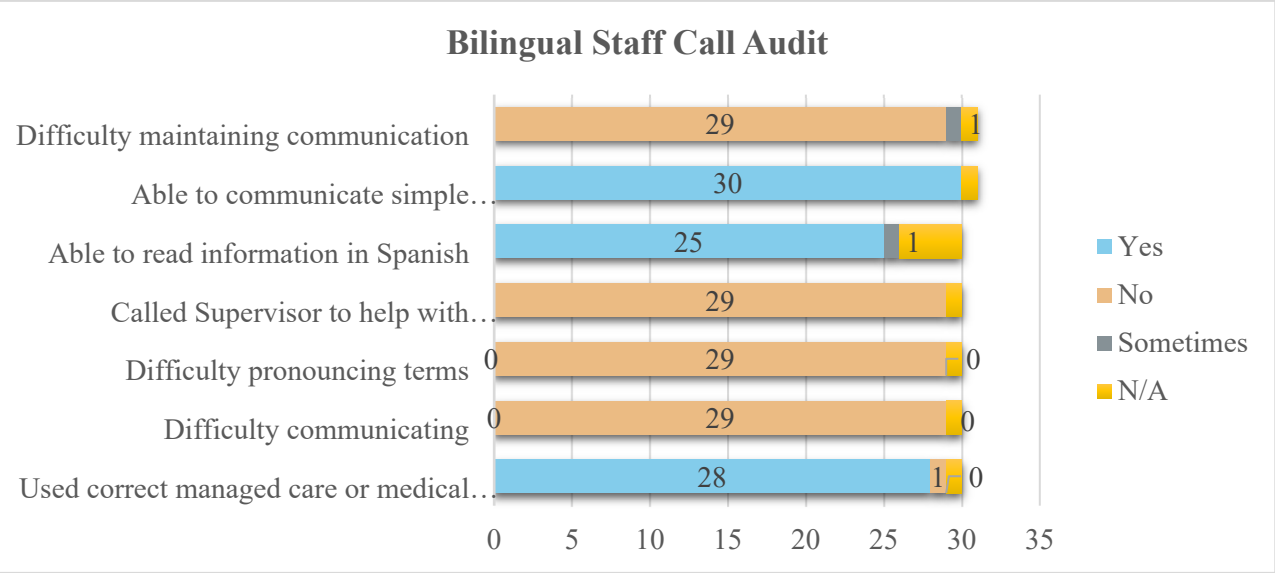
LanguageLine Solutions

Interpreter File Audit Evidence

Call Number	Interpreter ID	Status	Language	Annual Compliance Training Date	Medical Interpreter Skills Assessment Date	Medical Interpreter Skills Assessment Result	QA Observation Date	QA Observation Score
CR-0466304799	401260	Active	TAGALOG	6-May-24	3-Dec-22	Pass	7/29/2024	3/3
CR-0466310369	397613	Active	SPANISH	29-Jun-24	2-Feb-23	Pass	9/10/2024	3/3
CR-0466313184	257179	Active	SPANISH	4-Jul-24	5-Apr-19	Pass	7/29/2024	3/3
CR-0466314816	432445	Active	SPANISH	27-Feb-24	26-Feb-24	Pass	8/16/2024	3/3
CR-0466329974	418503	Inactive	SPANISH	7-Apr-24	27-Oct-23	Pass	7/30/2024	3/3
CR-0466331936	439307	Active	SPANISH	22-Apr-24	15-Apr-24	Pass	7/2/2024	3/3
CR-0466329688	433367	Active	PUNJABI	30-Apr-24	12-Mar-24	Pass	9/3/2024	3/3
CR-0466333552	432149	Active	SPANISH	27-Feb-27	27-Feb-24	Pass	7/26/2024	3/3
CR-0466352950	386498	Active	SPANISH	26-Jun-24	11-Oct-22	Pass	7/12/2024	3/3
CR-0466373604	431766	Active	ARABIC	20-Feb-24	19-Feb-24	Pass	8/16/2024	3/3
CR-0474355131	379576	Active	SPANISH	10-May-24	25-Aug-21	Pass	7/24/2024	3/3
CR-0474647696	369174	Active	VIETNAMESE	12-May-21	5-Feb-21	Pass	8/8/2024	3/3
CR-0474678227	389571	Active	SPANISH	4-Jul-24	18-Aug-22	Pass	8/15/2024	3/3
CR-0474687676	430762	Active	SPANISH	13-Feb-24	12-Feb-24	Pass	9/20/2024	3/3
CR-0474697112	447641	Active	PUNJABI	26-Jun-24	25-Jul-24	Pass	8/28/2024	3/3
CR-0474705000	433768	Active	SPANISH	23-Feb-24	11-Mar-24	Pass	8/19/2024	3/3
CR-0474741882	435586	Active	SPANISH	15-Mar-24	4-Apr-24	Pass	7/23/2024	3/3
CR-0474741371	433575	Inactive	SPANISH	23-Feb-24	12-Mar-24	Pass	7/4/2024	3/3
CR-0474751896	436051	Active	SPANISH	15-Mar-24	8-Apr-24	Pass	9/25/2024	3/3
CR-0474747881	446532	Active	TAGALOG	24-Jun-24	24-Jun-24	Pass	8/14/2024	3/3
CR-0481804123	254168	Active	MANDARIN	18-Apr-24	23-Jan-18	Pass	9/3/2024	3/3
CR-0481806385	448107	Active	ARABIC	28-Jun-24	17-Jul-24	Pass	8/19/2024	3/3
CR-0481821433	408798	Active	SPANISH	16-Jul-24	30-Jan-23	Pass	7/1/2024	3/3
CR-0481825357	422109	Active	SPANISH	14-May-24	9-Oct-23	Pass	8/9/2024	3/3
CR-0482010241	404814	Active	SPANISH	13-May-24	23-Feb-24	Pass	7/26/2024	3/3
CR-0482018364	451198	Active	VIETNAMESE	26-Aug-24	27-Aug-24	Pass	9/20/2024	3/3
CR-0482020217	401361	Active	SPANISH	12-Apr-24	15-Mar-23	Pass	7/31/2024	3/3
CR-0482021521	386223	Active	PUNJABI	16-Apr-24	5-Oct-22	Pass	9/25/2024	3/3
CR-0482158529	437364	Active	SPANISH	29-Mar-24	15-Apr-24	Pass	9/16/2024	3/3
CR-0482170389	408026	Active	SPANISH	6-May-24	24-Feb-23	Pass	9/25/2024	3/3

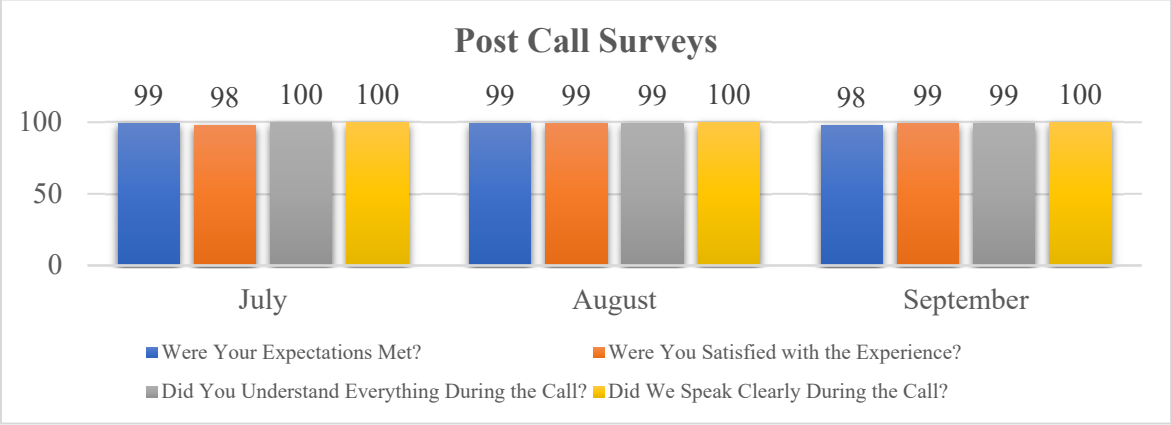
Bilingual Staff Call Audit

During this quarter, a total of 30 Spanish audio calls from KHS member facing departments were reviewed to assess the linguistic performance of the Bilingual Staff. Findings revealed that 99% of Bilingual staff did not have difficulty communicating with members in a non-English language.



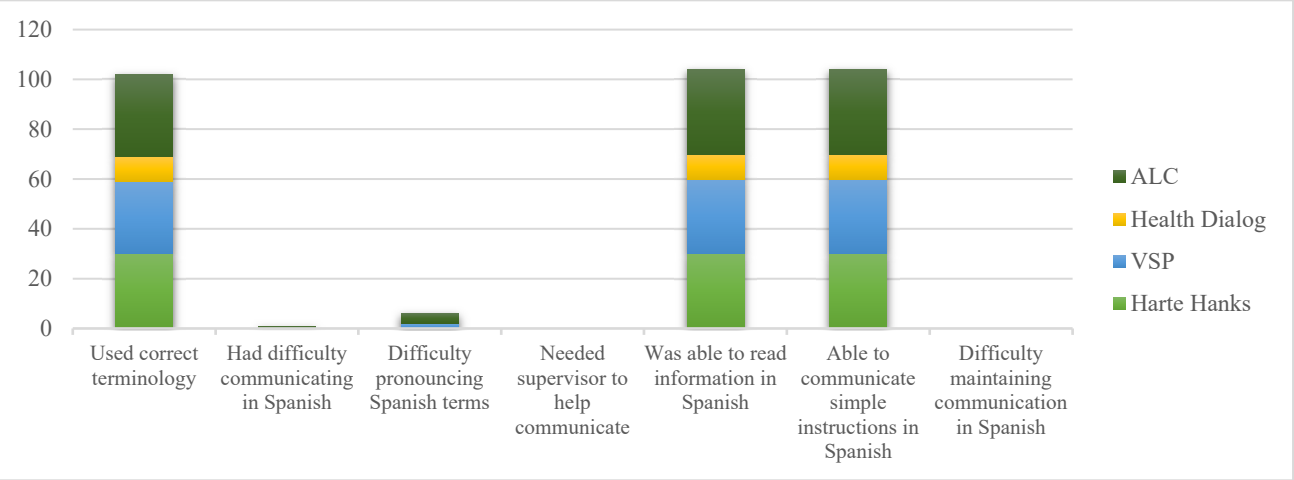
Post Call Surveys

During this quarter, a total of 10,771 Spanish Post Call Surveys were collected from members for all KHS member facing departments to assess the linguistic performance of the Bilingual Staff. KHS' post call survey evaluates member's call experience by language. Findings revealed that 99% of members are satisfied with the linguistic performance of bilingual staff.



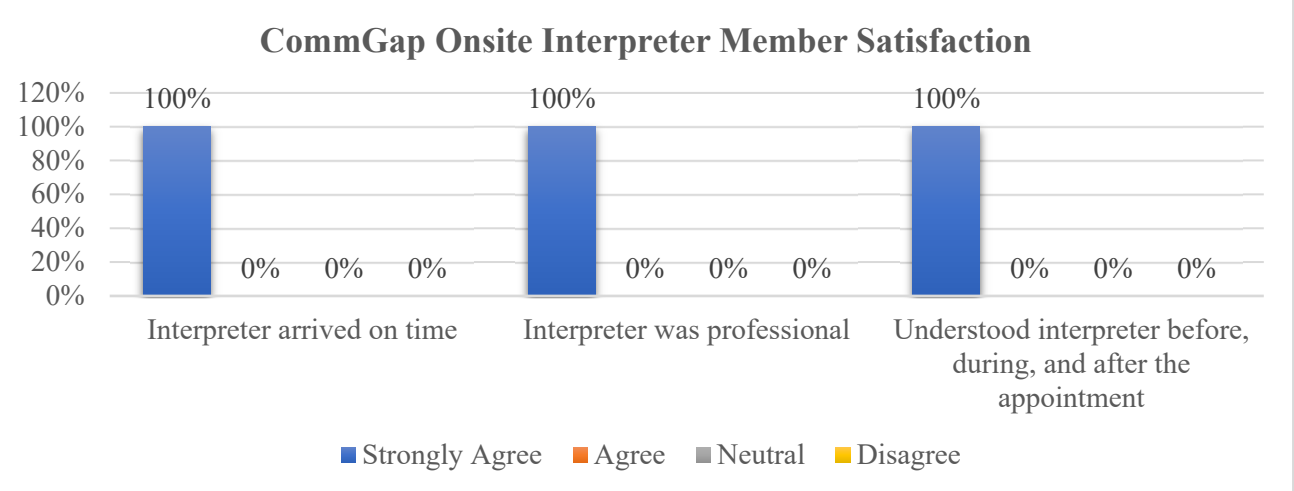
Vendor Bilingual Call Audits

During this quarter, a total of 104 Spanish audio calls were received from contracted vendors with KHS. These vendors include: ALC Transportation, Health Dialog, VSP, and Harte Hanks. These audio calls were reviewed to assess the linguistic performance of the vendor's Bilingual staff. Findings revealed that 98% of Bilingual staff did not have difficulty communicating with members in a non-English language.



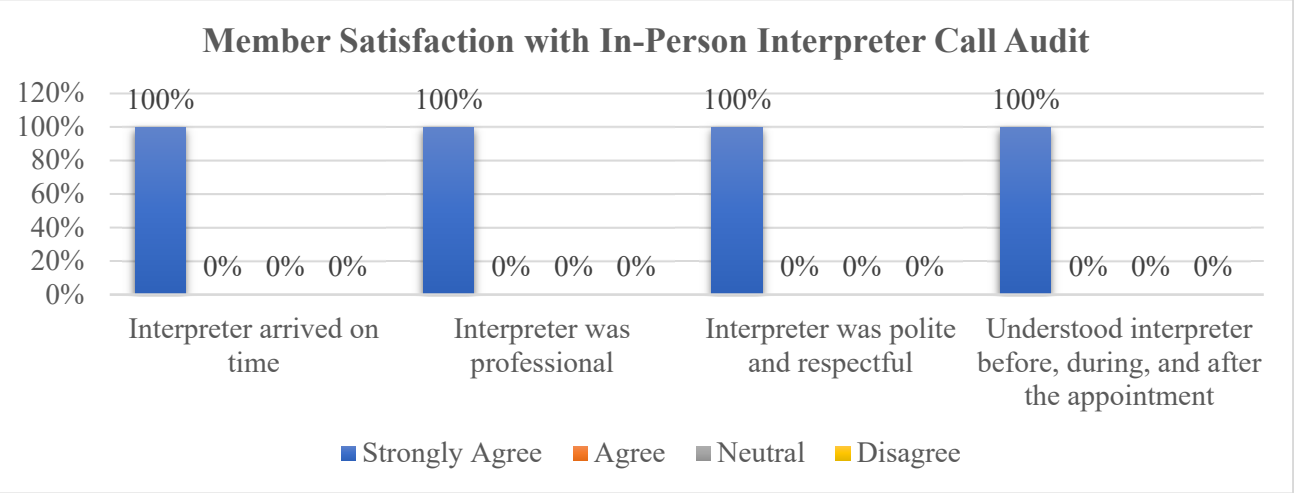
CommGap Onsite Interpreting Member Satisfaction Survey

During this quarter, an interpreter satisfaction survey was sent out by our vendor CommGap who surveyed 25 members after their onsite encounter with their provider. Of the 25 surveys sent out, 100% of respondents "Strongly Agreed" that they were satisficed with the interpreter services they received from the vendor.



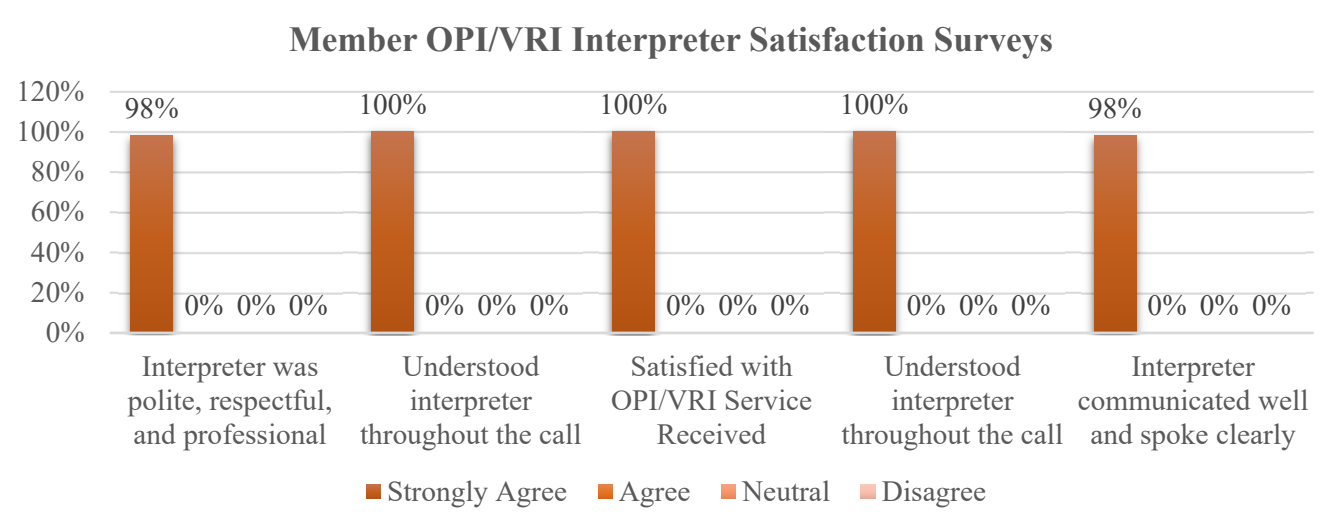
Member In-person Interpreting Satisfaction Call Surveys

During this quarter, a total of 30 satisfaction surveys were collected from members who received in-person interpreting services and more than 100% of members reported they "Strongly Agreed" being satisfied with their interpreter.



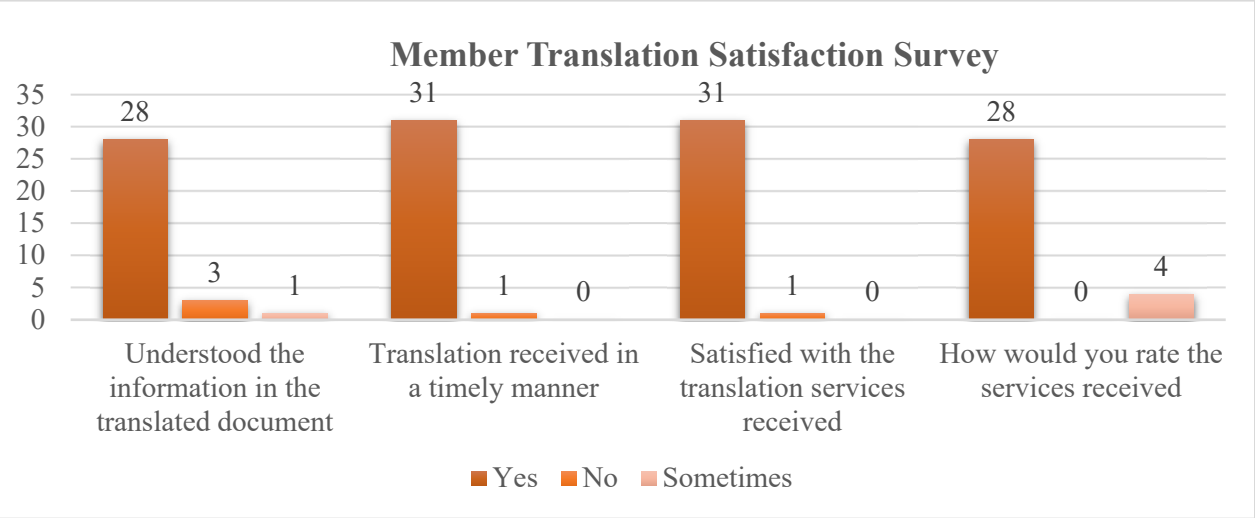
Member OPI & VRI Interpreting Satisfaction Call Surveys

During this quarter, a total of 30 satisfaction surveys were collected from members who received Over-The-Phone (OPI) and Video Remote (VRI) interpreting services. Of the 30 surveys, 27 responses were for OPI services, and 3 responses were for VRI services. The survey concluded with 99% of members reporting they "Strongly Agreed" being satisfied with the OPI/VRI interpreter services they received.



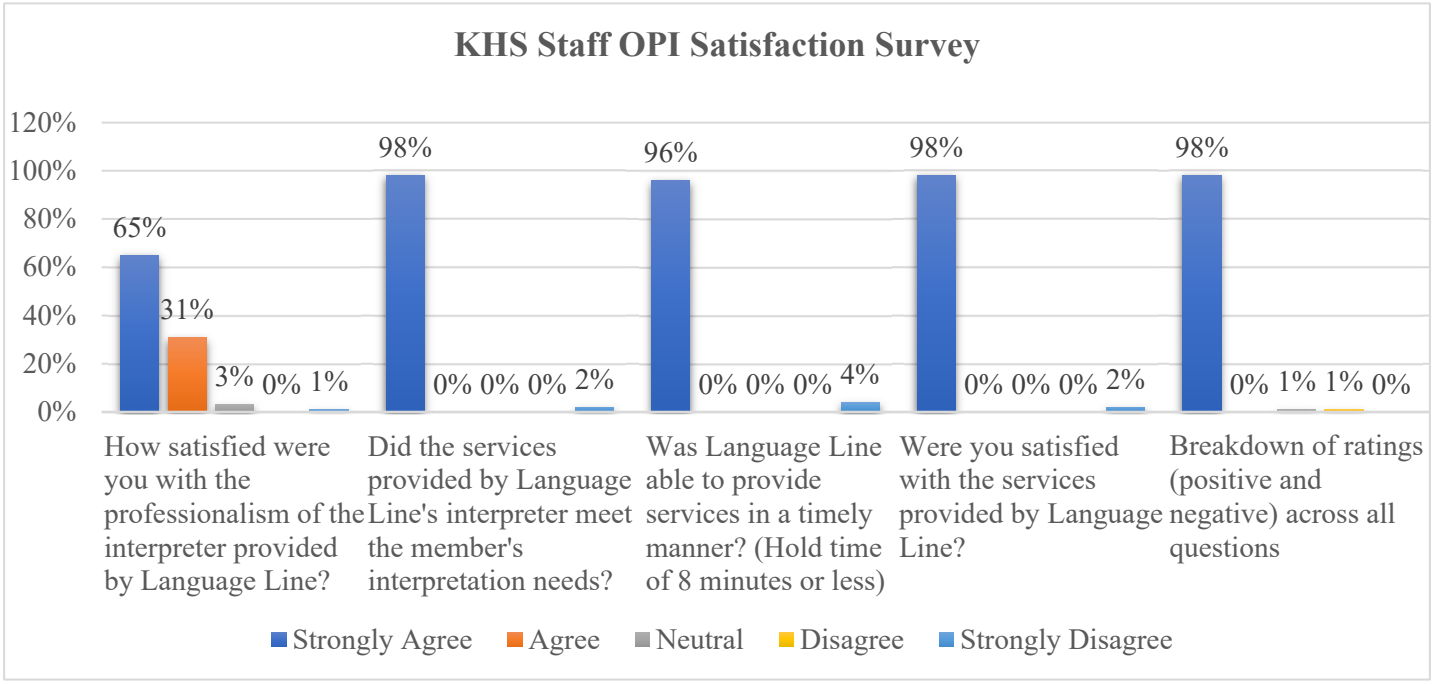
Translation Member Satisfaction Survey

During this quarter, a total of 32 translation satisfaction call surveys were conducted for members who received a translation completed by C&L translators and by our vendor Language Line Solutions. This survey is to determine the members satisfaction regarding our translation services. Of the 32 calls completed 97% of members were satisfied with the services received.



KHS Staff Satisfaction Over-the-Phone (OPI) Survey

During this quarter, a total of 135 surveys were received from KHS member facing department staff regarding their satisfaction with our vendor Language Line Services concerning over-the-phone interpretation. Findings revealed that 98% of KHS staff are satisfied with the linguistic performance of our vendors' interpreters.


KHS Staff OPI Satisfaction Survey
120%
100%
80%
60%
40%
20%
0%
65%
31%
3%
0%
1%
98%
0%
0%
0%
2%
96%
0%
0%
0%
4%
98%
0%
0%
0%
2%
98%
0%
1%
1%
0%
How satisfied were you with the professionalism of the interpreter provided by Language Line?
Did the services provided by Language Line's interpreter meet the member's interpretation needs?
Was Language Line able to provide services in a timely manner? (Hold time of 8 minutes or less)
Were you satisfied with the services provided by Language Line?
Breakdown of ratings (positive and negative) across all questions
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

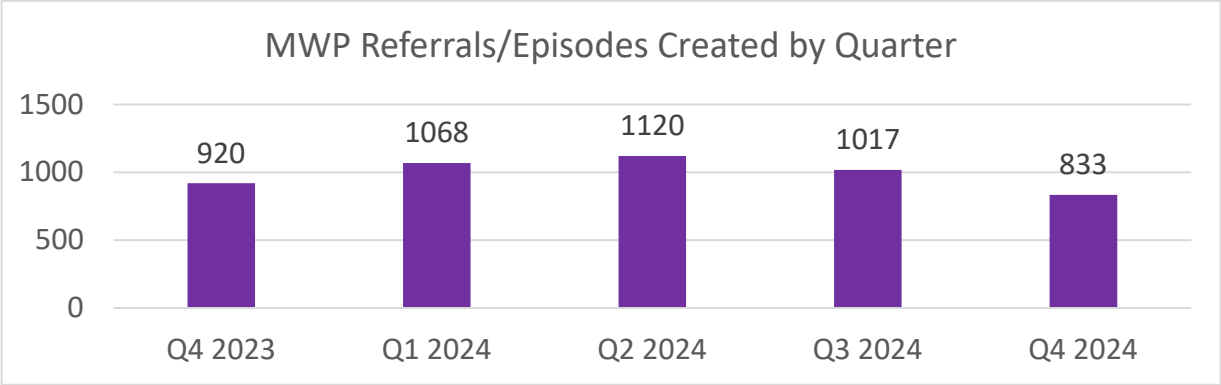
Kern Health Systems
Wellness & Prevention Activities Report
4th Quarter 2024

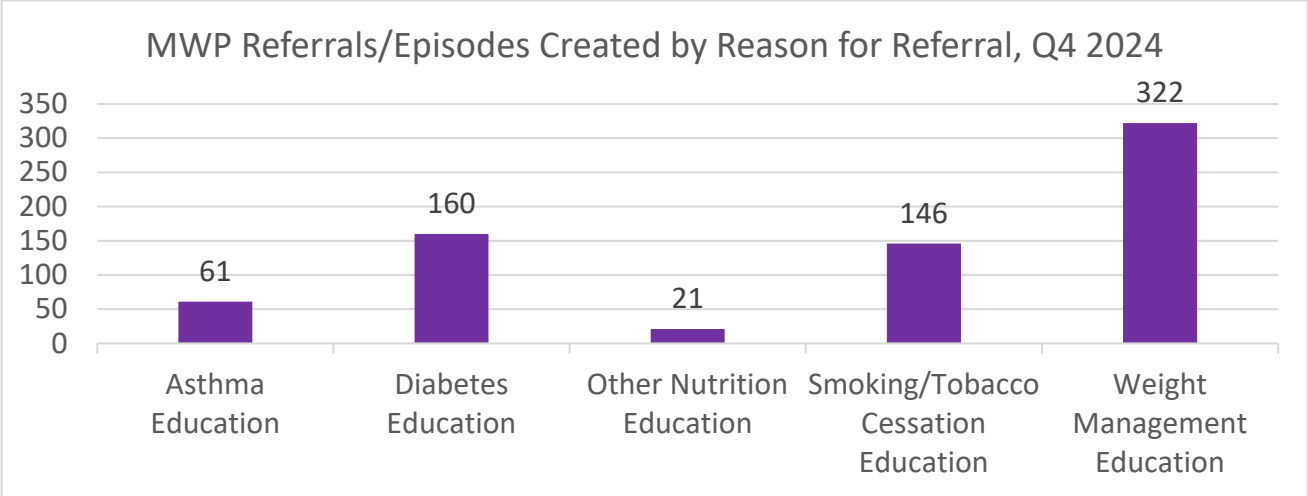
Member Wellness and Prevention

Health Education Referrals

During Q4 2024, there were 833 referrals for Member Wellness and Prevention (MWP) services, which is an 18% decrease in comparison to the previous quarter. In Q4 2024, the MWP team directed outreach efforts to register members for the Diabetes Empowerment Education Program and weight management programs (Activity & Eating and Eat Healthy Be Active). Outreach for the in-person classes focused on members living in Central, East, and North Bakersfield, and McFarland. As for the virtual classes, outreach focused on the outlying communities and members 35-49 years of age.

The health education class service acceptance rate decreased by 5% between Q3 2024 to Q4 2024 whereas the received services rate increased by 3 percentage points from 40% to 43% during the same time period. The increase observed in Q4 2024 may be due to a more focused outreach effort and the identification of neighborhood-centric locations highlighting the need for partnerships such as with the Kern County Library and the Housing Authority of Kern.

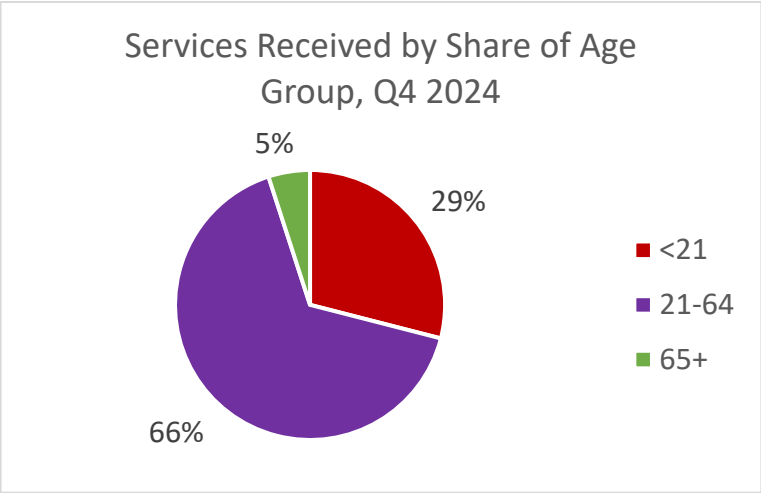


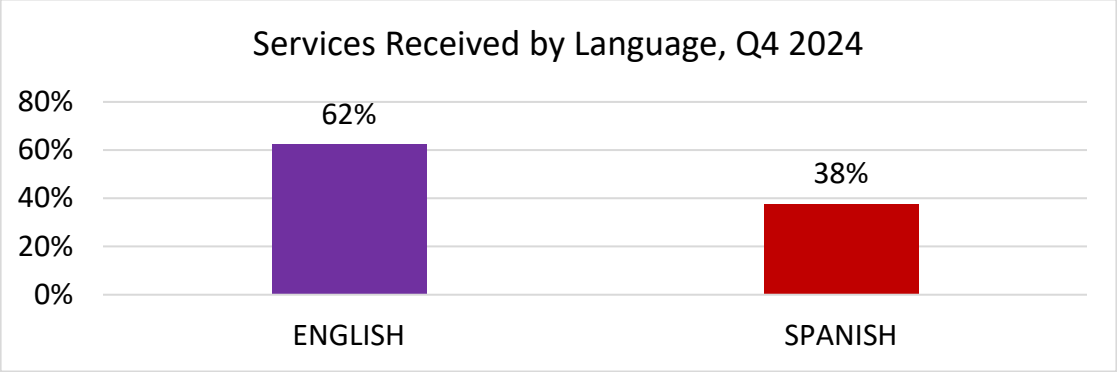


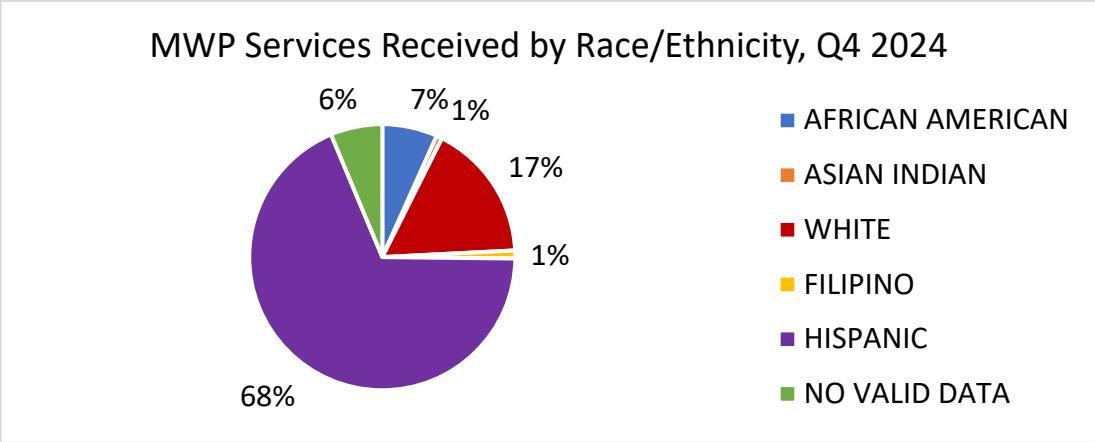
Member Demographics

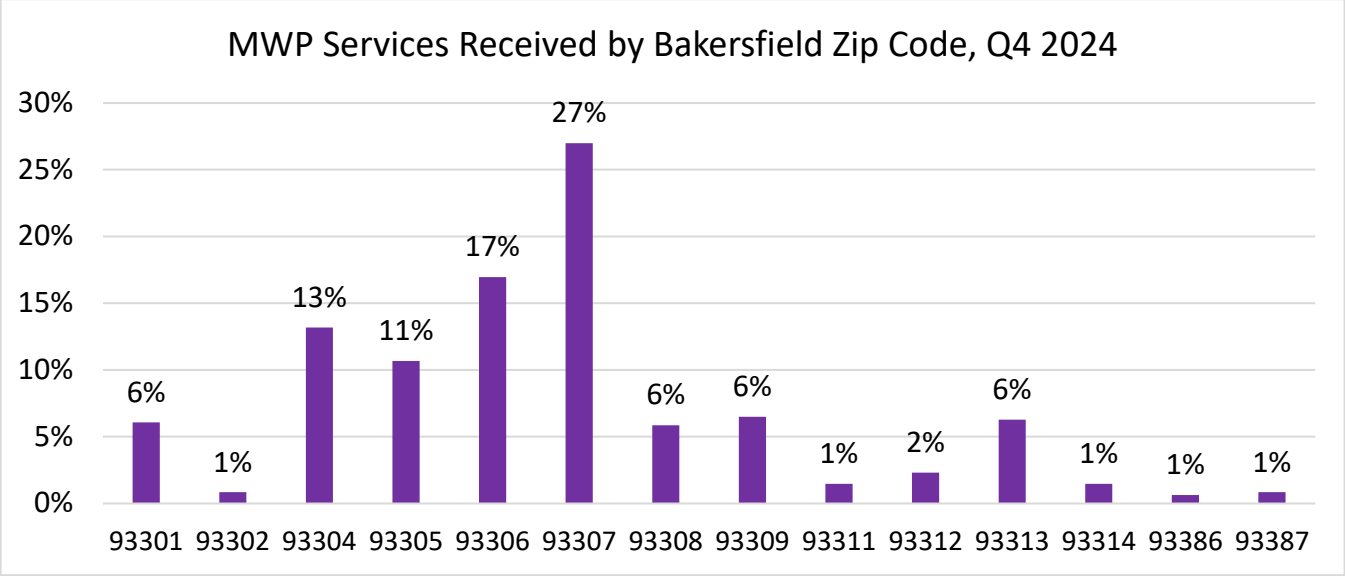
KHS provides services to a culturally and linguistically diverse member population in Kern County. A demographic analysis of the members who received services included the following findings:

- The largest age groups were 21-64 years (66%) followed by members under 21 years of age (29%).
- Most members were Hispanic (68%) and English speakers (62%).
- Most members resided in Bakersfield with the highest concentration in the 93307 area.
- In the outlying areas of Kern County, Arvin accounted for the largest share of members.
- English speakers had a higher attendance rate compared to Spanish speakers.






MWP Services Received by Race/Ethnicity, Q4 2024
6%
7%
1%
17%
1%
68%
AFRICAN AMERICAN
ASIAN INDIAN
WHITE
FILIPINO
HISPANIC
NO VALID DATA


MWP Services Received by Bakersfield Zip Code, Q4 2024
30%
25%
20%
15%
10%
5%
0%
6%
1%
13%
11%
17%
27%
6%
6%
1%
2%
6%
1%
1%
1%
93301
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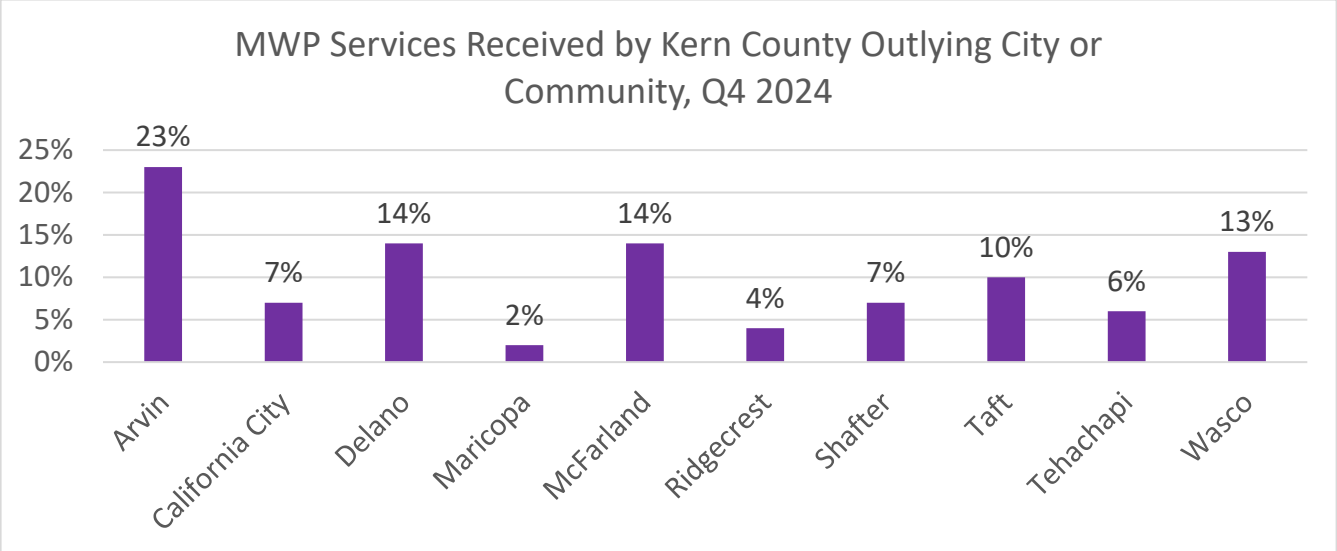

MWP Services Received by Kern County Outlying City or Community, Q4 2024
25%
20%
15%
10%
5%
0%
23%
7%
14%
2%
14%
4%
7%
10%
6%
13%
Arvin
California City
Delano
Maricopa
McFarland
Ridgecrest
Shafter
Taft
Tehachapi
Wasco

Health Education Class Service Audit

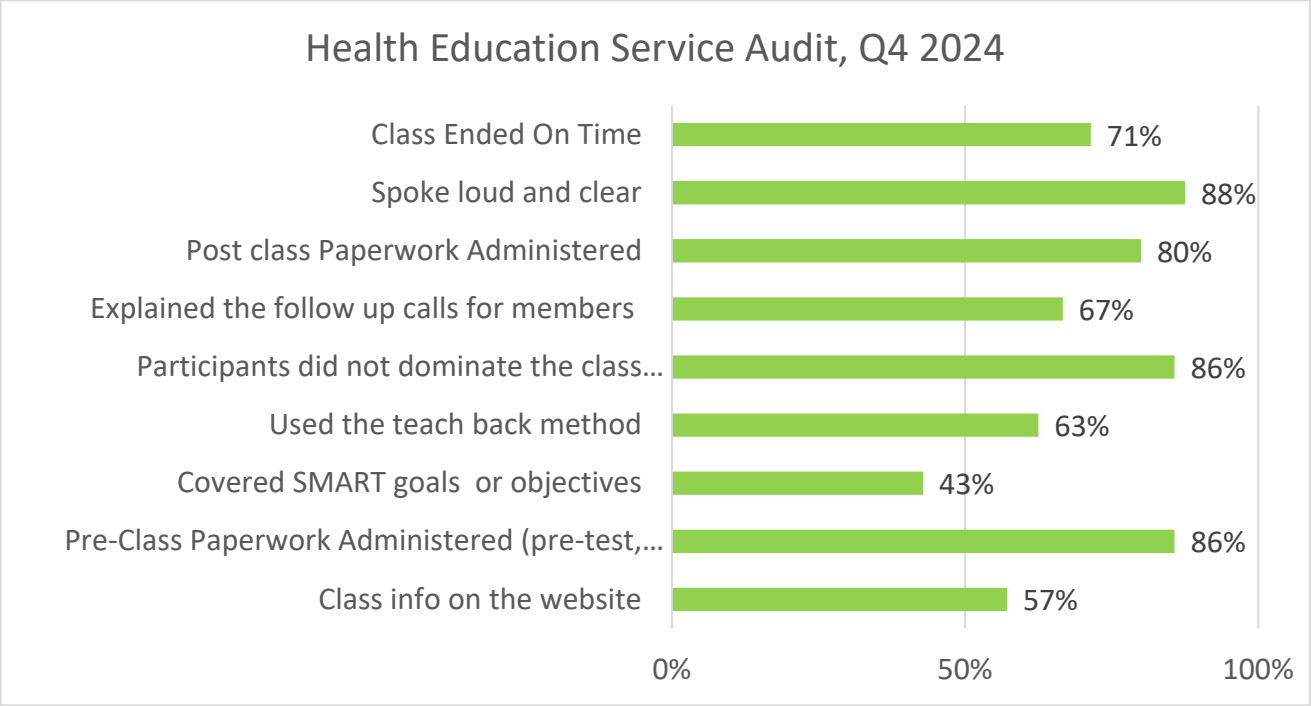
The Health Education Class Service Audit Tool considers a variety of markers to determine the quality of Health Education Class Services being provided to members. It includes observations on planning and preparation, implementation and delivery, and member engagement during health education classes.

In Q4 2024, class facilitators demonstrated mastery of class facilitation in the following areas:

- Starting on time
- Asking members to sign in
- Providing examples for topics or concepts and myths
- Explaining activities before doing them
- Doing all planned activities
- Taking photos or videos of the class

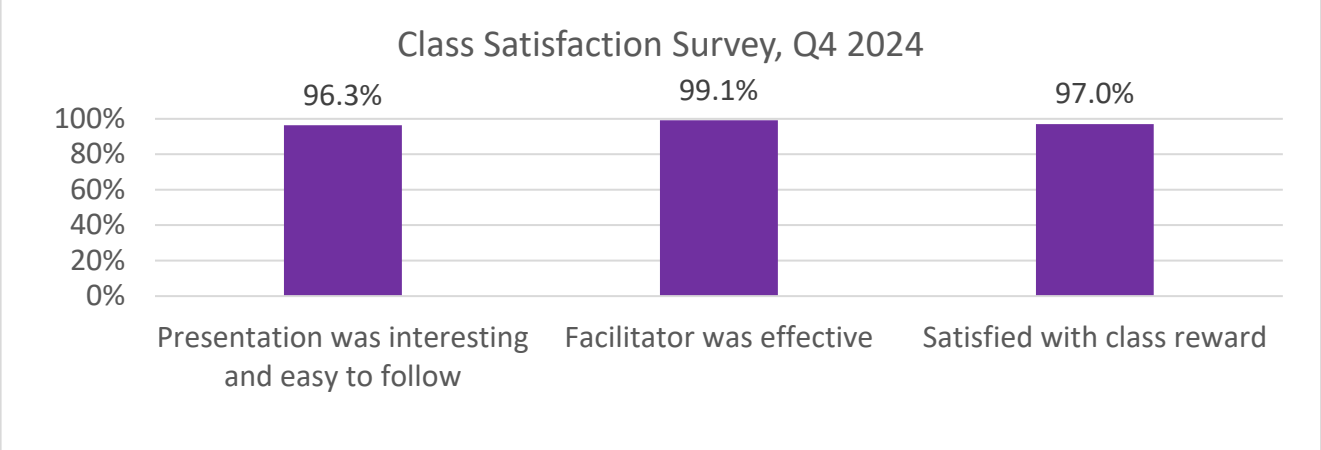
Areas of improvement included:

- Ensuring administrative paperwork is completed
- Covering SMART goals
- Maintaining control of the class
- Explaining follow-up calls to members



Health Education Class Evaluations

Health Education classes include an evaluation questionnaire for participants. The questionnaire is administered at the end of the class session or series. Findings revealed high ratings on three measures of class satisfaction as shown in the chart below**.**



Below is an analysis of the findings from open-ended questions for Q4 2024.

What did you like most about the class?

Participants were asked what they liked most about the class, more than 95% percent of participants expressed great satisfaction in the class and suggested no change. More than half of members who responded shared the following responses:

- Participants appreciated the delivery and tone of voice used by the instructors
- Learning about eating habits, substitutions, and health topics was appreciated
- The content was found to be relevant and informative, which made the classes easy to understand.
- Clear explanations and easy-to-understand material were highlighted
- The teaching techniques and presentation style were praised
- The supportive environment and opportunity to connect with others were valued
- Participants felt supported and looked forward to attending the classes

How could we improve the class?

Participants were asked how the class could be improved. Responses included:

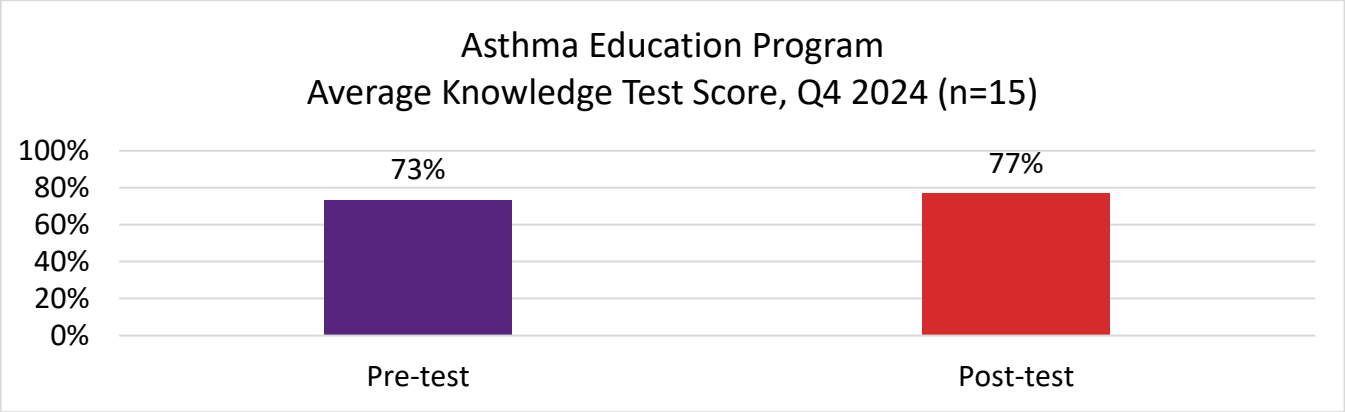
- Suggestions for more interaction and engagement during the class
- Requests for additional content or topics to be covered
- Suggestions for changes in class structure or format
- Ideas for providing incentives or rewards to participants

In addition, members referred to the Kick It California (KIC) Quitline are surveyed to gauge satisfaction with this service. No satisfaction survey responses were collected during this quarter. One member accepted services to KIC in Q4 2024 but eventually declined services.

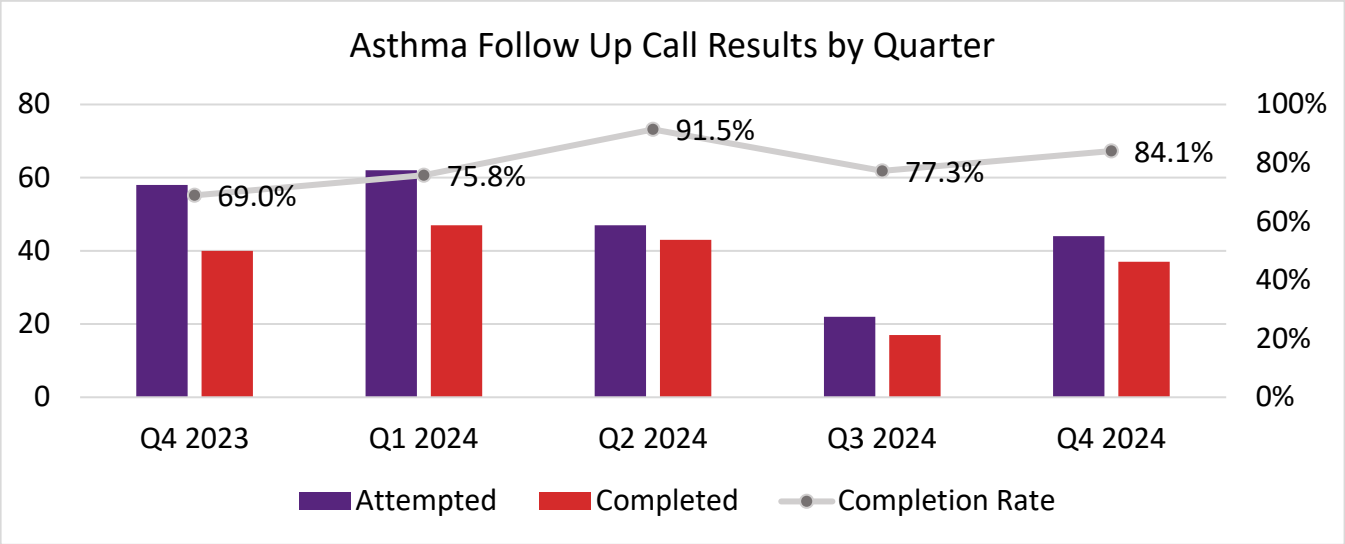
Health Education Class Effectiveness

Asthma: Breathe Better Program

The asthma education program consists of 2 classes and at least 2 follow-up calls. A pre and posttest questionnaire is administered each series. During Q4 2024, findings revealed there was an average 4 percentage point increase in knowledge test score after completing the series. The largest increases were in understanding what an asthma trigger is and knowing when to use control inhalers as directed by their provider.

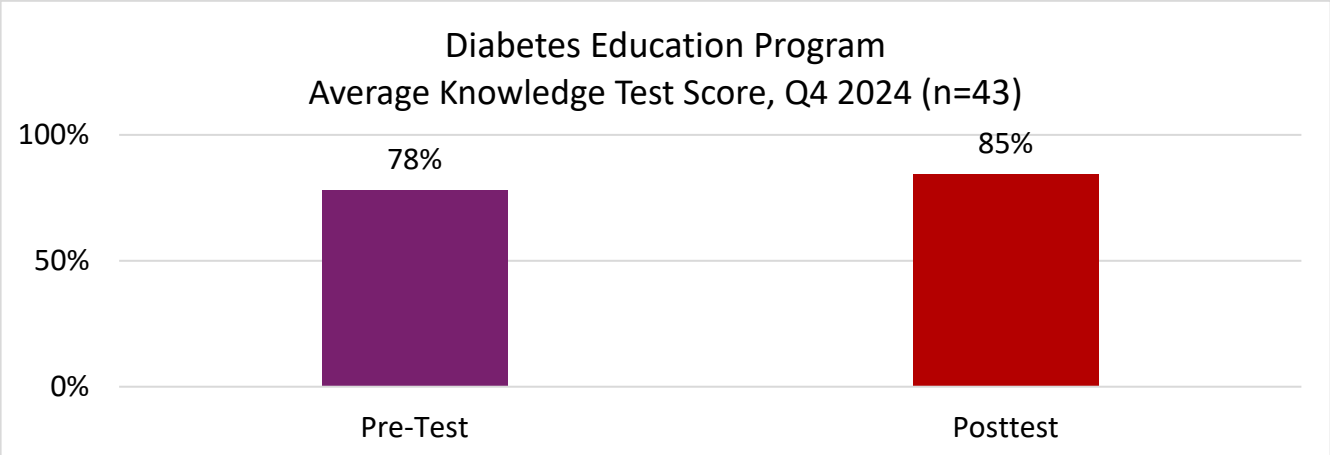


Members who have attended the KFHC Breathe Better Asthma Classes are offered asthma follow up calls. These calls occur at 1 month, 3 months, and 6 months (optional or only if needed) after attending the classes. During the follow up call, members are screened to determine if asthma symptoms are well controlled using the Asthma Control Test (ACT) screening tool. An ACT score of 20 or higher is an indicator of well controlled asthma. During Q4 2024, 84.1% of members completed an asthma follow up call. This was an increase from 77.3% during the previous quarter. There was an improvement in average ACT score for both members under 12 years of age and those 12 years and older when comparing the initial assessment to the 3 month follow up. There was no data collected for the 1 month and 6 month follow up calls.

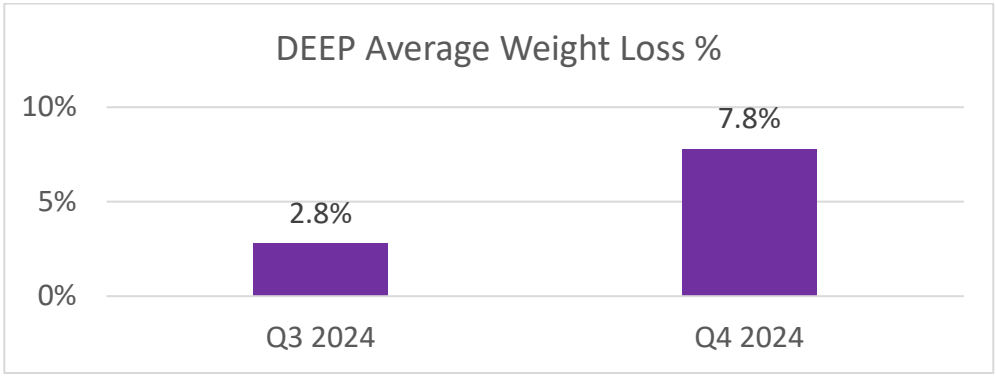


Average ACT Scores During Asthma Follow Up Calls, Q4 2024		
Call Month	**<12 years of age**	**12+ years of age**
Initial	9	16
1	No data	No data
3	25	17
6	No data	No data

Chronic Disease Prevention and Management: Diabetes Empowerment Education Program (DEEP)
DEEP is a diabetes self-management program that has been shown to be successful in helping participants take control of their disease and reduce the risk of complications. The program was developed for low-income and racial and ethnic minority populations. During Q4 2024, findings revealed a 7-percentage point increase in average knowledge test score from 78% at pretest to 85% at posttest.

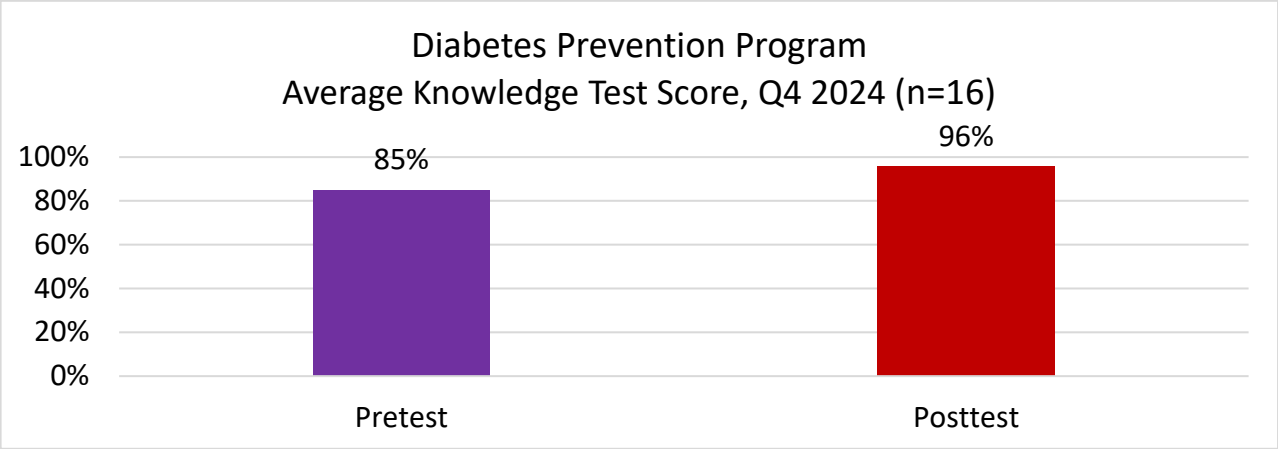


Members who participate in DEEP are weighed in at every class as one way to measure program impact. The bar chart below compares the average weight of participants at the beginning (class 1) and end (class 6) of the DEEP program during Q3 2024 and Q4 2024. Overall, the data shows that participants experienced an average weight loss of almost three percentage (2.8%) in Q3 2024 and almost 8 percentage (7.8%) in Q4 2024. This suggests that behavior modifications and recommendations presented during the series may be effective.

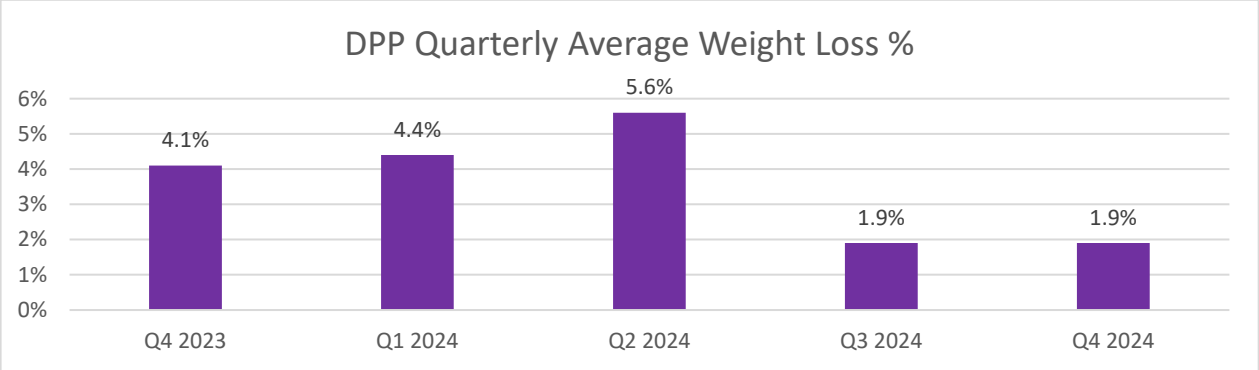


Chronic Disease Prevention and Management: Diabetes Prevention Program (DPP)

The National DPP aims to simplify access to an affordable, high-quality lifestyle change program for individuals with prediabetes or those at risk of type 2 diabetes. The program helps lower their chances of developing type 2 diabetes and enhances their overall health. In Q4 2024, 16 members completed a pretest and posttest. There was an average 11 percentage-point increase in average knowledge test score for classes 13-16, with an average of 85% correct answers at pretest compared to an average of 96% correct answers at posttest.



Members who participate in DPP are weighed in at every class as one way to measure impact. The initial combined cohort weight is compared with the combined weight at the end of each month to calculate average weight loss per member each month and quarter. The average individual weight loss by quarter is shown in the chart below. A significant drop occurred in Q3 2024 since a Spanish DPP cohort ended in June 2024 and an English cohort started the following month. By the end of Q4 2024, 18 members were enrolled in the KHS English DPP cohort with an average weight loss of 1.9%. There was no Spanish DPP series being offered in Q4 2024.



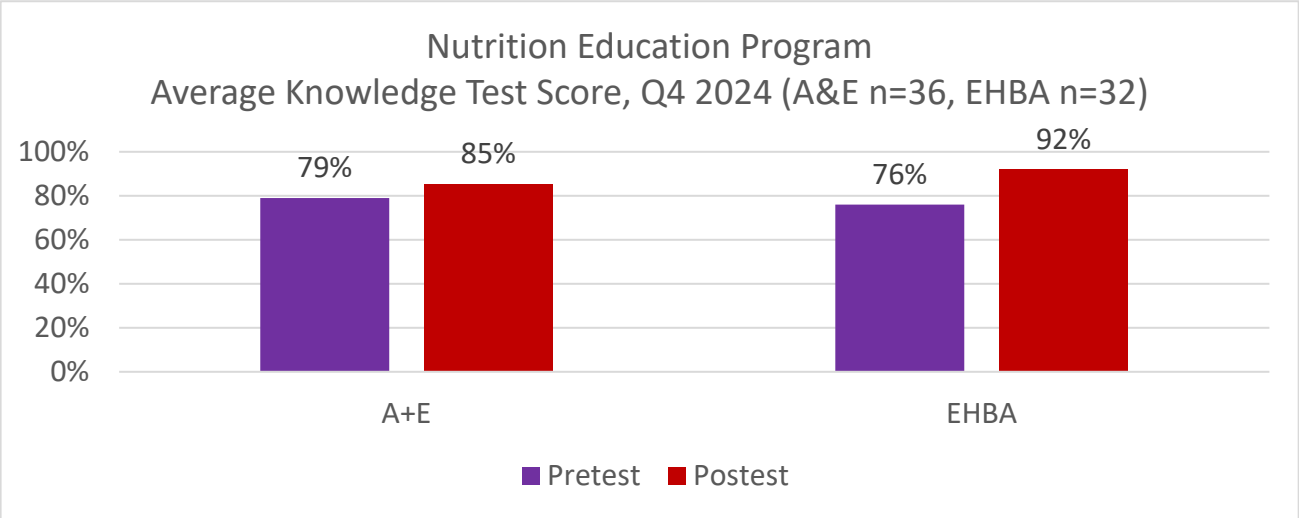
Nutrition and Weight Management: Activity and Eating and Eat Healthy, Be Active

The nutrition and weight management program includes two curriculums that focus on creating healthy habits around eating and physical activity to reduce the risk of chronic illness among the KFHC members and the Kern County population. In September 2023, the Eat Healthy, Be Active (EHBA) curriculum, a 6-class series, along with the Activity and Eating (A+E) one-time class were launched. Each class lasts about 90 minutes. Evidence shows that these programs can positively impact behavior around physical activity and nutrition. A pre and posttest questionnaire is distributed per class.

During Q4 2024, findings revealed that among those members who completed the core pre and posttest for both programs, there was a combined average 11-percentage point increase in knowledge gained after completing classes.

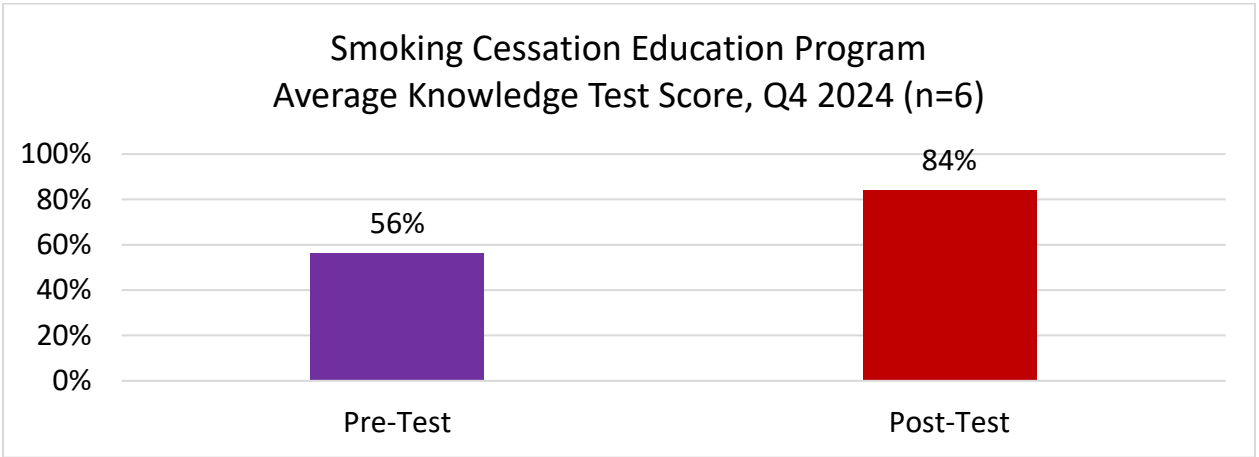
- Members who completed a pretest scored an average of 78% in correct answers.
- Members who completed a posttest scored an average of 89%.
- The largest increase in knowledge from pre- to posttest was observed among members who attended the EHBA course (6 classes) – a 16-percentage point increase.

There was also an increase in awareness of the relationship between calorie intake and physical activity, the five recommended food groups, daily recommended exercise for adults, portion control, and shopping on a budget.



Smoking/Tobacco Cessation: Fresh Start

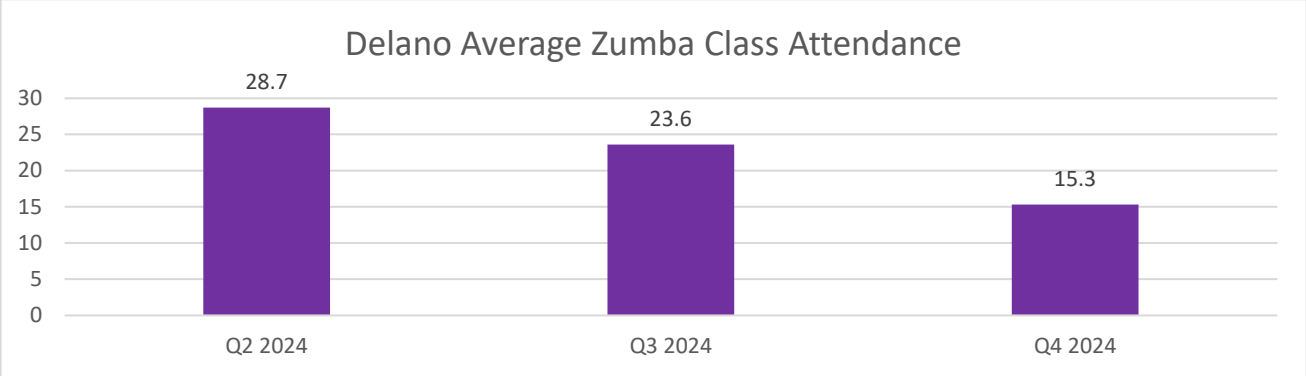
The Fresh Start program has the goal of reducing harm from tobacco products. Knowledge tests are implemented each series. In Q4 2024, 6 members completed a pretest and/or posttest. There was an average 28-percent point increase in average knowledge test score when comparing pretest and posttest responses. Members appear to have gained knowledge on committing to a quit date, nicotine replacement therapy, and writing down a personal quit plan.

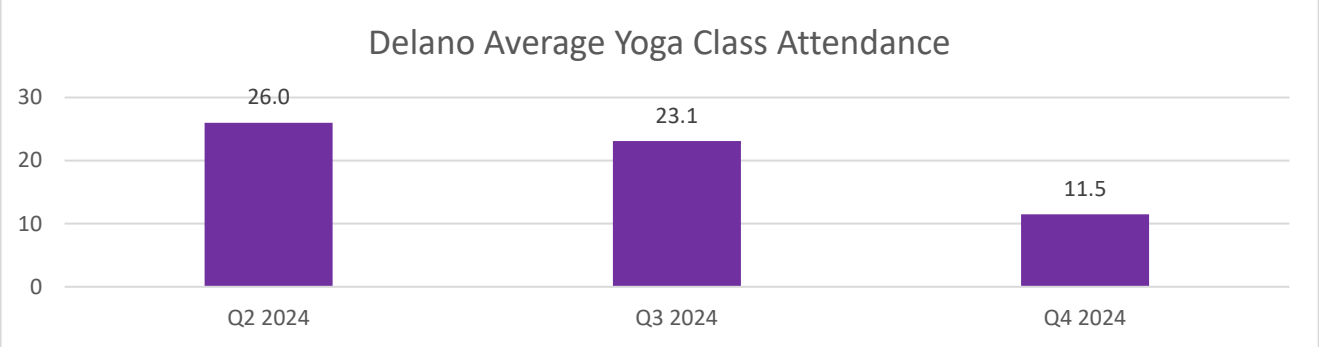


Community Health and Wellness

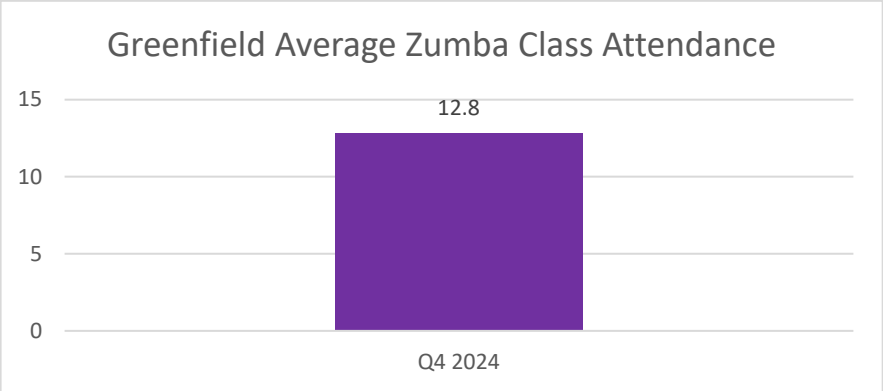
Live Better Program

Due to the success of the Live Better Program in Delano, the contract with the City of Delano was expanded to include one additional Zumba class on Tuesday and an additional program, Live Better Kids, which will engage a younger population of children (3-14). This program has rotating sessions including Zumba, fit camp and yoga classes. Live Better Kids is held every Saturday, 11:00 am-12:00 PM. The agreement with the City of Delano was renewed for 2025. Average attendance in Q4 2024 for the Zumba and yoga classes was 15.3 and 11.5, respectively.

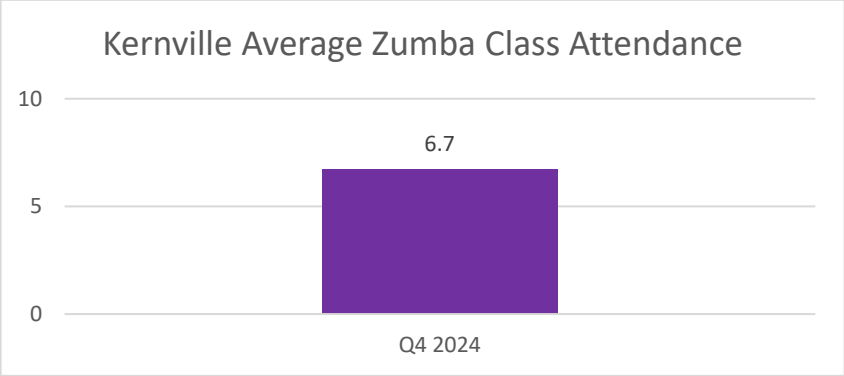


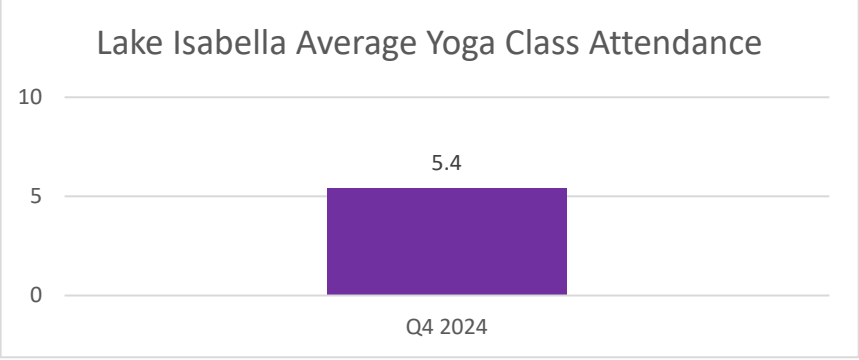


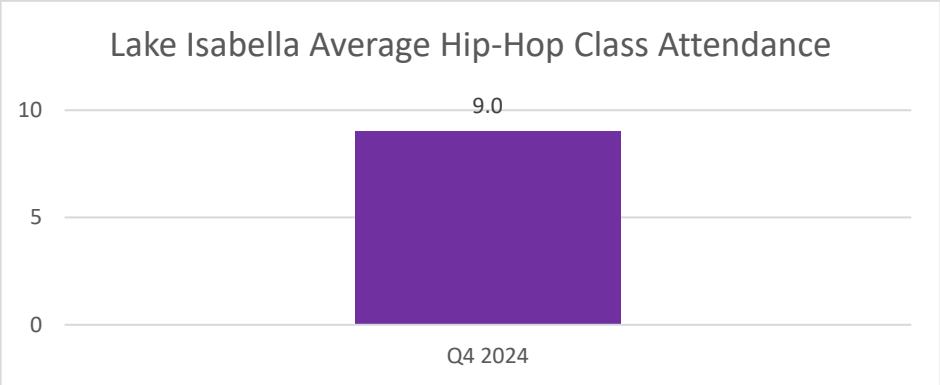
The Greenfield Live Better Program agreement was signed with Greenfield Union School District (GUSD) in association with Greenfield Family Resource Center. The program began in October 2024. Zumba classes are held every Monday, Tuesday and Wednesday evening from 6:00 pm- 7:00 PM at Stiern Park across the street from the Greenfield Family Resource Center. The Greenfield Walking Group is working directly with GUSD to facilitate the Zumba classes. The health education component of the program will be facilitated by our KHS Community Health and Wellness (CH&W) Team and includes monthly classes of the EHBA series, which will be held every 3rd Monday of the month. Zumba class attendance averaged 12.8 in Q4 2024.



The Lake Isabella Live Better Program agreement was signed with Danica's School of Dance to facilitate fitness classes in the Lake Isabella and Kernville. The program began in November 2024. The program includes adult hip-hop classes held on Wednesday 5:30-6:30 pm and yoga classes held 10-11 am located at Danica's School of Dance in Lake Isabella. Zumba classes are also held Thursday 5:45-6:45 pm at Fit Hauss Health Club located in Kernville. The health education component for the Live Better Program will eventually be facilitated by the Kern River Valley Family Resource center starting in Q1 2025. Average attendance in Q4 2024 for the Zumba, yoga, and hip-hop classes was 6.7, 5.4, and 9.0, respectively.







Community Health and Wellness Initiatives

- Ten (10) Kern County schools were selected for a 2024-2026 School Wellness Grant out of 31 applications. Schools in East Bakersfield, Southwest Bakersfield, Lamont, Ridgecrest, Shafter, Wasco, and Weedpatch were selected. The school wellness grant orientation for the selected schools was held virtually on January 17, 2025.
- Two KHS staff were certified as child passenger safety technicians as part of the Car Seat Safety Check event held on October 26, 2024, in partnership with First 5 Kern. Approximately 17 parents or guardians, including one expectant mother, and 26 children, were served.
- KHS sponsored a shaken baby syndrome prevention education program by Kern County Network for Children. This program will target educational sessions towards parents at high schools and college campuses.
- KHS sponsored the Youth Tobacco Prevention Program facilitated by the Dignity Health Community Wellness Program. The program provided tobacco prevention education to 920 5th and 6th grade students during the 2023/2024 school year. During the 2024/2025 school year, 295 students have received education.

Kern Health Systems
Cultural & Linguistic Services Activities Report
4th Quarter 2024

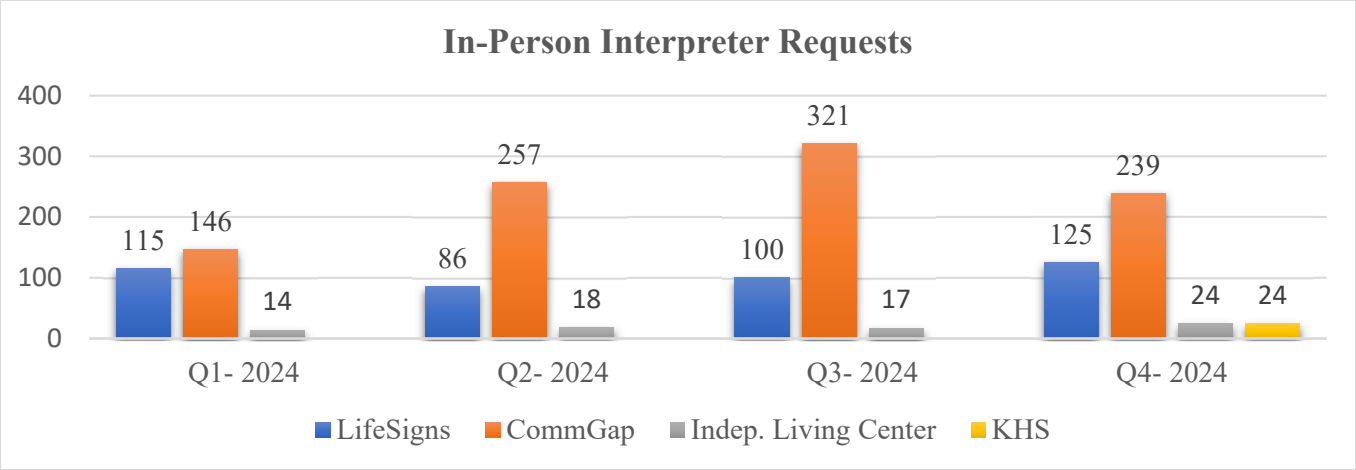
Cultural and Linguistic Services

Interpreter Requests

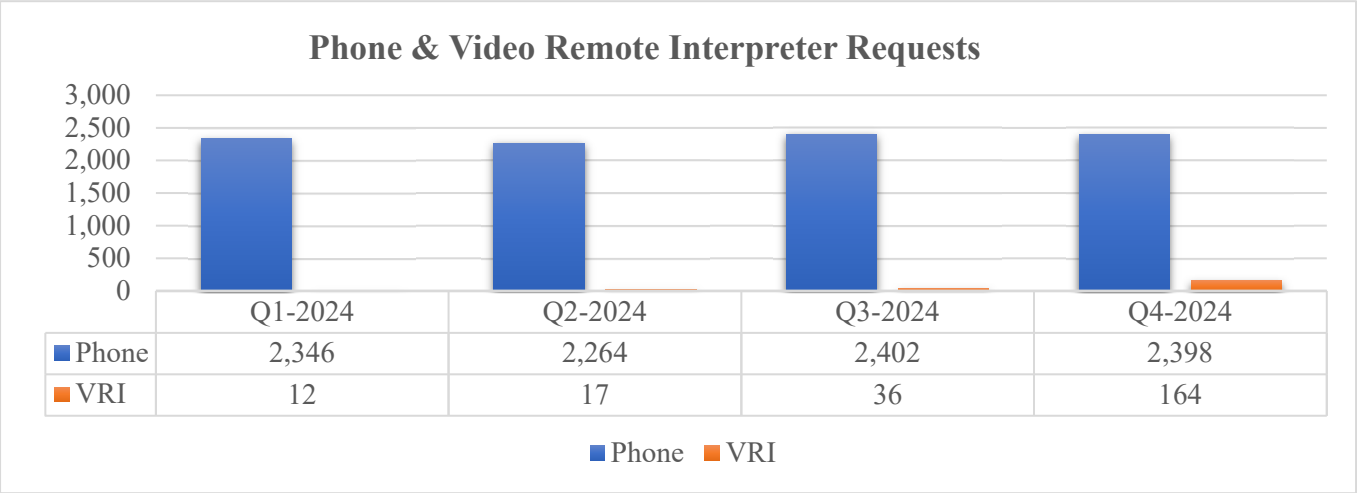
During this quarter, there were 265 requests for Face-to-Face Interpreting, 2,398 requests for Telephonic Interpreting, 169 for Video Remote Interpreting (VRI) and 125 requests for an American Sign Language (ASL) interpreter. The top three languages requested are shown as follows.

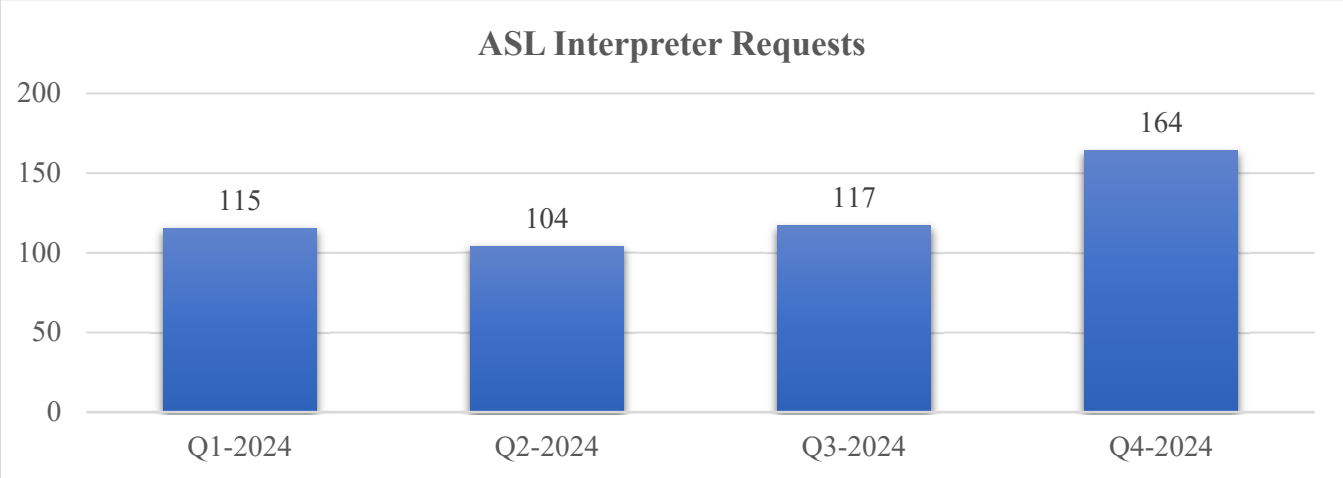
Interpreting Languages Requested
Phone and Video Remote
Spanish
ASL
Punjabi

Interpreting Languages Requested
In-person
Spanish
Vietnamese
Arabic



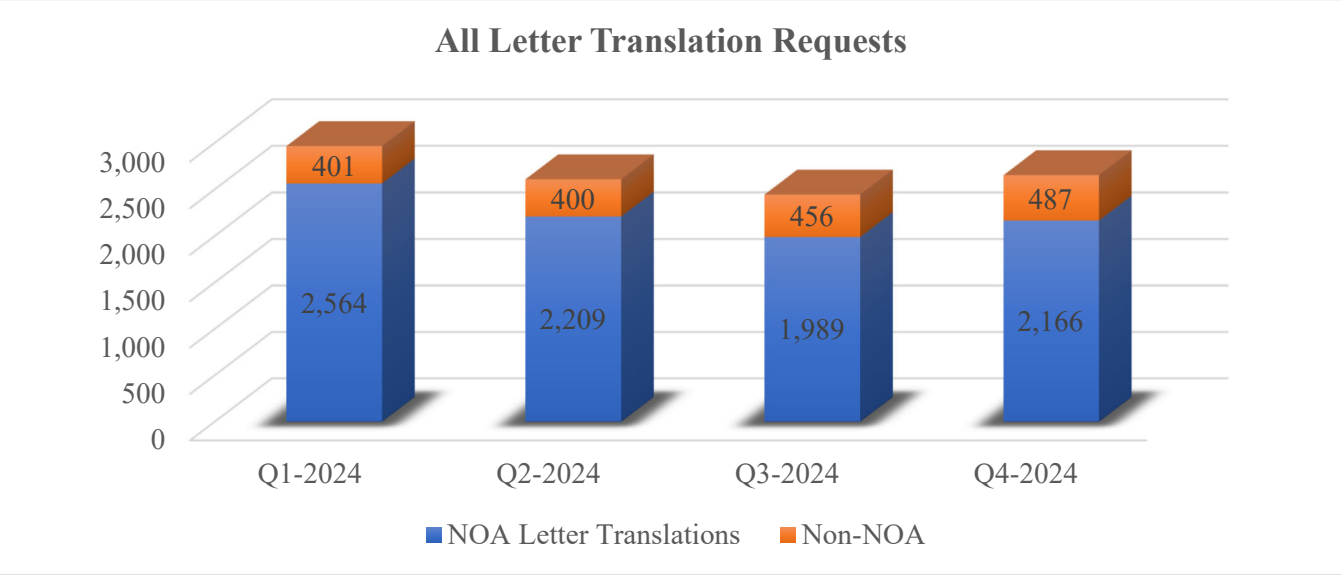
Kern Health Systems
Cultural & Linguistic Services Activities Report
4th Quarter 2024





Written Translations

The C&L department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 2,445 requests for written translations were received and completed.



Cultural and Linguistic Services Audits

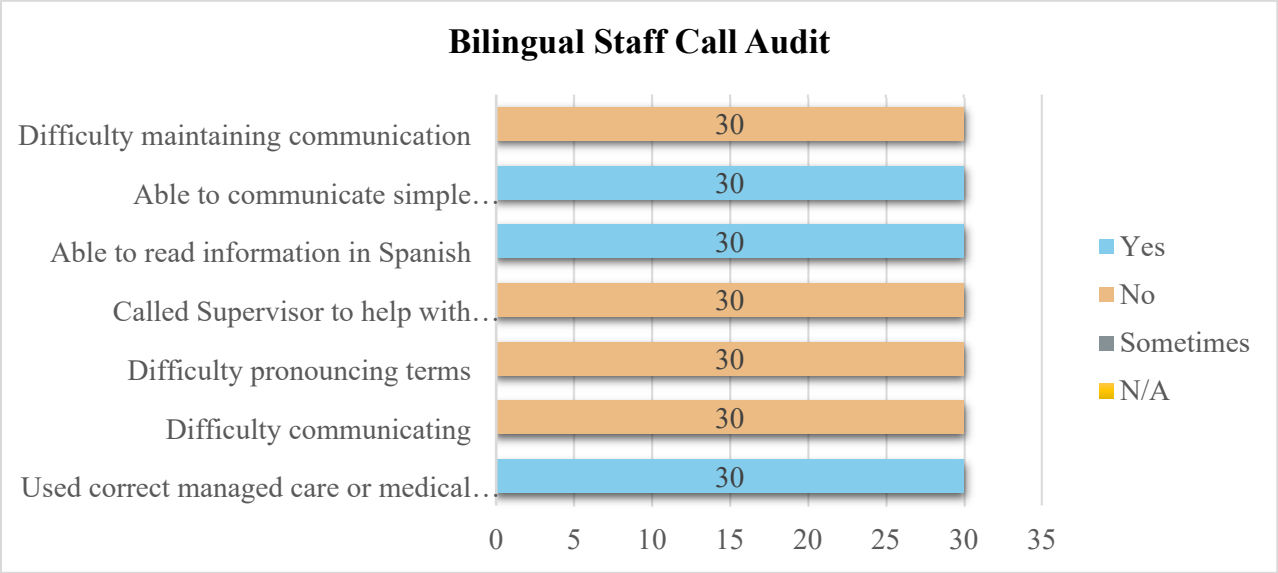
Vendor Over-the-Phone (OPI) Interpreter Call Monitoring

During this quarter, Language Line Solutions conducted an audit on 30 random OPI interpreter services calls. These calls were randomly selected from the vendors monthly invoices. Calls audited were in Mandarin, Punjabi, Spanish, Cantonese, Yemeni Arabic, Vietnamese. Nepali and Khmer languages. Calls were evaluated on the following items: Interpreter's Customer Service, Interpretation Skills, and the ability to follow the Code of Ethics and Standards of Practice. Audit findings revealed 100% of calls "Met Expectations."

Call Number	Interpreter ID	Status	Language	Annual Compliance Training Date	Medical Interpreter Skills Assessment Date	Medical Interpreter Skills Assessment Result	QA Observation Date	QA Observation Score
CR-	438741	Active	SPANISH	4/29/2024	5/8/2024	Pass	12/12/24	3/3
CR-	446913	Active	PUNJABI	6/27/2024	6/28/2024	Pass	11/11/24	3/3
CR-	406258	Active	PUNJABI	4/19/2024	2/13/2023	Pass	10/31/24	3/3
CR-	451363	Active	VIETNAMESE	8/12/2024	8/26/2024	Pass	10/02/24	3/3
CR-	434924	Active	VIETNAMESE	3/22/2024	3/26/2024	Pass	10/28/24	3/3
CR-	262232	Active	PUNJABI	4/16/2024	9/13/2018	Pass	12/10/24	3/3
CR-	432895	Active	SPANISH	2/23/2024	3/7/2024	Pass	12/30/24	3/3
CR-	405498	Active	SPANISH	6/25/2024	3/27/2024	Pass	12/06/24	3/3
CR-	406722	Active	SPANISH	8/13/2024	2/14/2023	Pass	12/10/24	3/3
CR-	453434	Active	NEPALI	9/16/2024	9/26/2024	Pass	11/20/24	3/3
CR-	454011	Active	KHMER	9/18/2024	9/23/2024	Pass	10/24/24	3/3
CR-	433668	Active	SPANISH	3/10/2024	3/13/2024	Pass	12/20/24	3/3
CR-	390643	Active	SPANISH	6/30/2024	12/27/2022	Pass	12/09/24	3/3
CR-	414074	Active	SPANISH	6/7/2024	5/8/2023	Pass	11/08/24	3/3
CR-	456923	Active	PUNJABI	10/11/2024	10/21/2024	Pass	11/22/24	3/3
CR-	451073	Active	SPANISH	8/23/2024	8/26/2024	Pass	10/28/24	3/3
CR-	251151	Active	MANDARIN	4/16/2024	11/8/2016	Pass	12/27/24	3/3
CR-	435939	Active	PUNJABI	3/30/2024	4/3/2024	Pass	12/02/24	3/3
CR-	454549	Active	PUNJABI	9/25/2024	9/30/2024	Pass	12/03/24	3/3
CR-	430653	Active	SPANISH	2/11/2024	6/25/2024	Pass	10/24/24	3/3
0506675925	417061	Active	ARABIC	6/23/2024	5/8/2024	Pass	11/07/24	3/3
CR-	399666	Active	SPANISH	7/10/2024	5/1/2024	Pass	11/22/24	3/3
CR-	426382	Active	SPANISH	5/23/2024	12/18/2023	Pass	11/07/24	3/3
CR-	454236	Active	SPANISH	9/27/2024	9/30/2024	Pass	12/02/24	3/3
CR-	452001	Active	SPANISH	9/22/2024	9/23/2024	Pass	12/23/24	3/3
CR-	442969	Active	SPANISH	5/16/2024	10/30/2024	Pass	11/15/24	3/3
CR-	353015	Active	CANTONESE	5/26/2024	7/12/2019	Pass	11/17/24	3/3
CR-	458996	Active	SPANISH	11/8/2024	11/18/2024	Pass	12/31/24	2/2
CR-	403688	Active	SPANISH	5/5/2024	4/18/2023	Pass	12/16/24	3/3
CR-	436810	Active	SPANISH	4/5/2024	4/12/2024	Pass	12/12/24	3/3

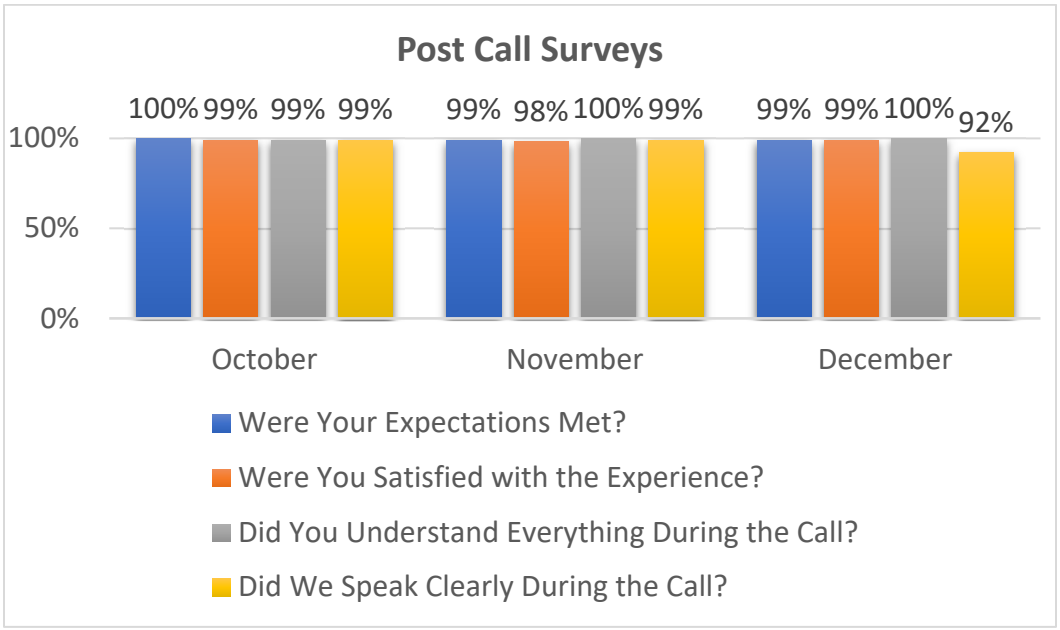
Bilingual Staff Call Audit

During this quarter, a total of 30 Spanish audio calls from KHS member facing departments were reviewed to assess the linguistic performance of the bilingual staff. The calls were audited using a group of measures to identify any potential difficulty communicating with members in a language other than English as shown below in the chart. Findings revealed that 100% of bilingual staff did not have difficulty communicating with members in a non-English language.



Post Call Surveys

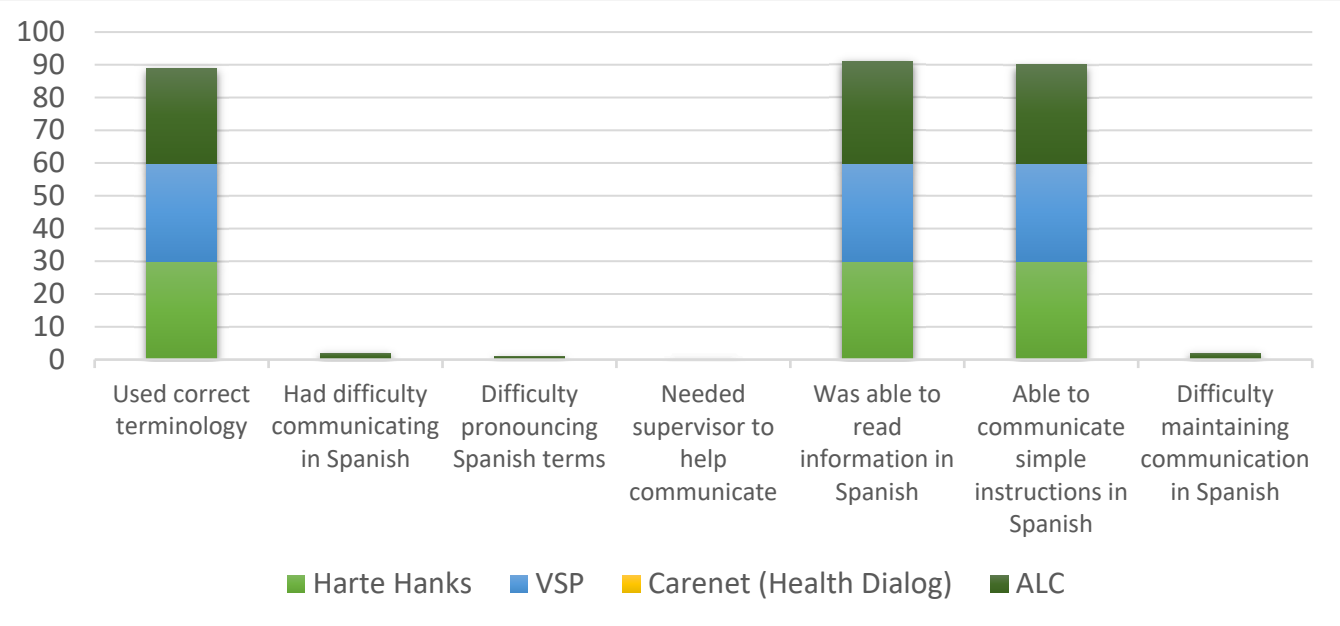
During this quarter, a total of 9,937 Spanish Post Call Surveys were collected from members for all KHS member facing departments to assess the linguistic performance of the bilingual staff. KHS' post call survey evaluates a member's call experience by language. Findings revealed that 99% of members are satisfied with the linguistic performance of bilingual staff.



Vendor Bilingual Call Audits

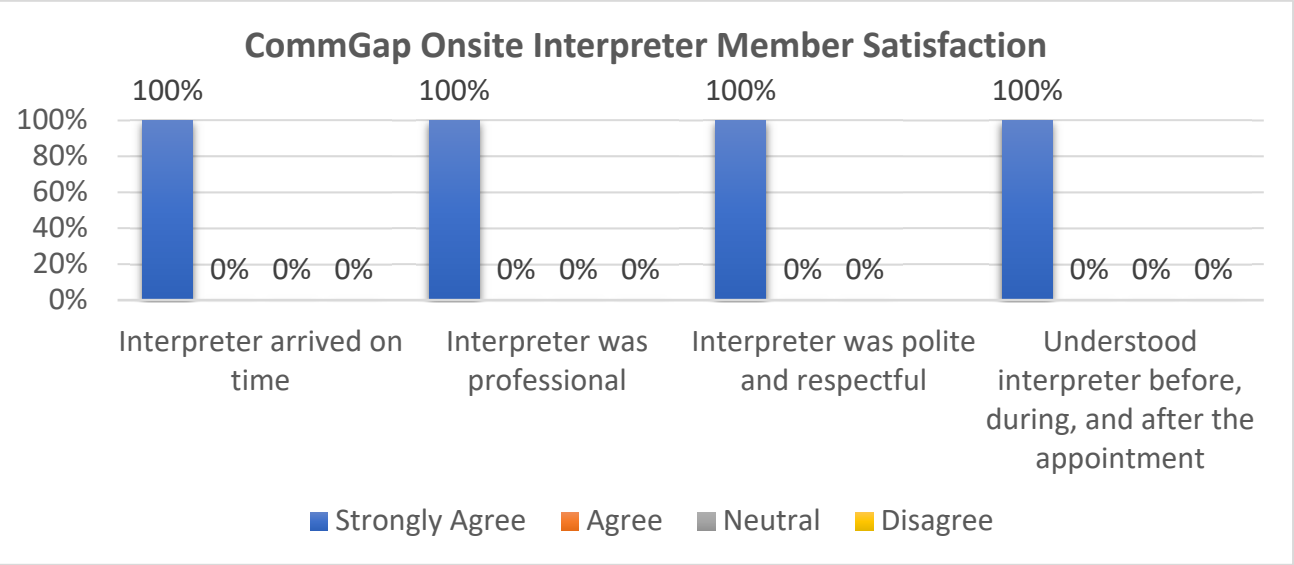
During this quarter, a total of 91 Spanish audio calls were received from contracted vendors with KHS. These vendors include: ALC Transportation and Harte Hanks. These audio calls were reviewed to assess the linguistic performance of the vendor's bilingual staff. Findings revealed that 98% of bilingual staff did not have difficulty communicating with members in a non-English language.

Note: Due to software updates, Carenet (Health Dialog) will provide data in Q1 of 2025.



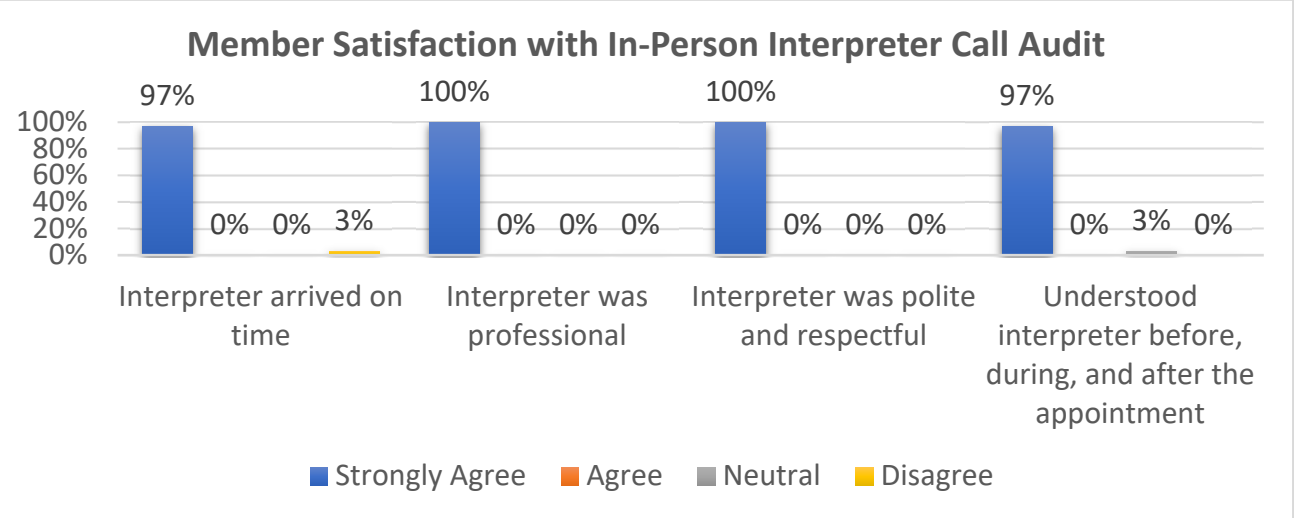
CommGap Onsite Interpreting Member Satisfaction Survey

During this quarter, an interpreter satisfaction survey was sent out by our vendor CommGap who surveyed 18 members after their onsite encounter with their provider. Of the 18 surveys sent out, 100% of respondents "Strongly Agreed" that they were satisfied with the interpreter services they received from the vendor.



Member In-person Interpreting Satisfaction Call Surveys

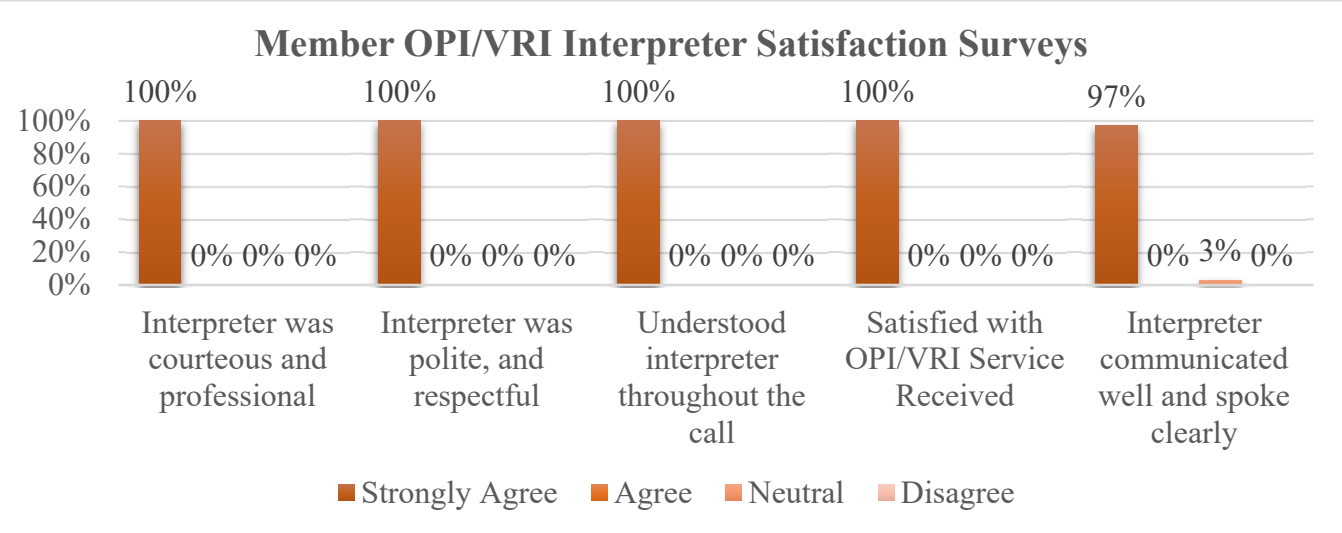
During this quarter, a total of 32 satisfaction surveys were collected from members who received in-person interpreting services and more than 97% of members reported they "Strongly Agreed" being satisfied with their interpreter.



Member OPI & VRI Interpreting Satisfaction Call Surveys

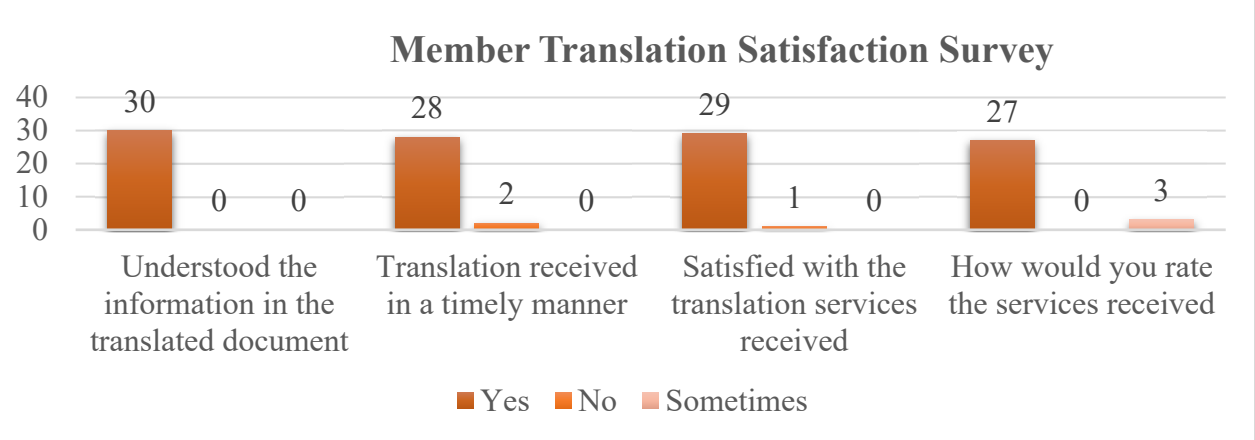
During this quarter, a total of 30 satisfaction surveys were collected from members who received Over-The-Phone (OPI) and Video Remote (VRI) interpreting services. Of the 30 surveys, 26 responses were for OPI services, and 4 responses were for VRI services. The survey concluded with

97% of members reporting they "Strongly Agreed" being satisfied with the OPI/VRI interpreter services they received.



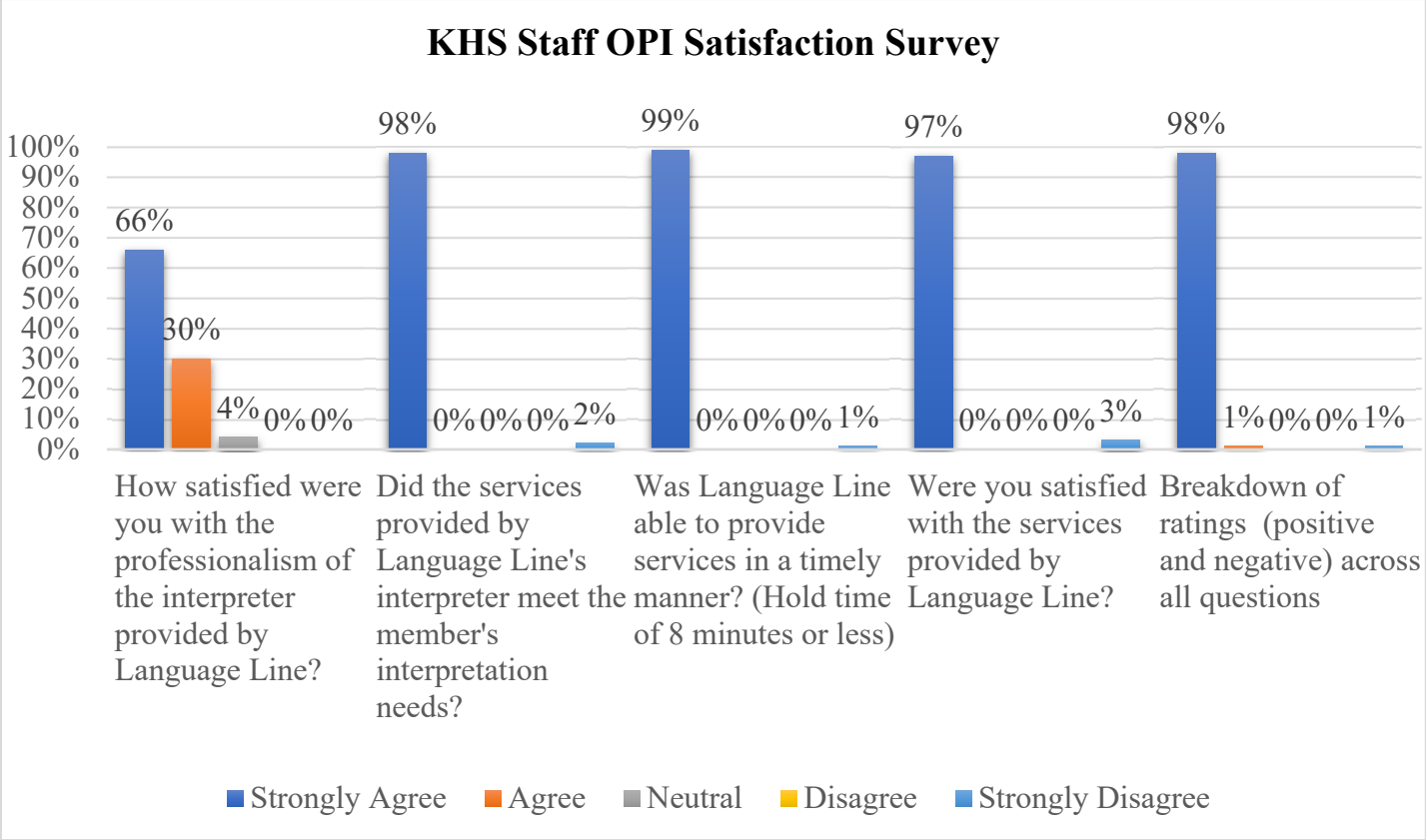
Translation Member Satisfaction Survey

During this quarter, a total of 30 translation satisfaction call surveys were conducted for members who received a translation completed by C&L translators and by our vendor Language Line Solutions. This survey is to determine the members satisfaction regarding our translation services. Of the 30 calls completed, 97% of members were satisfied with the services received.



KHS Staff Satisfaction Over-the-Phone (OPI) Survey

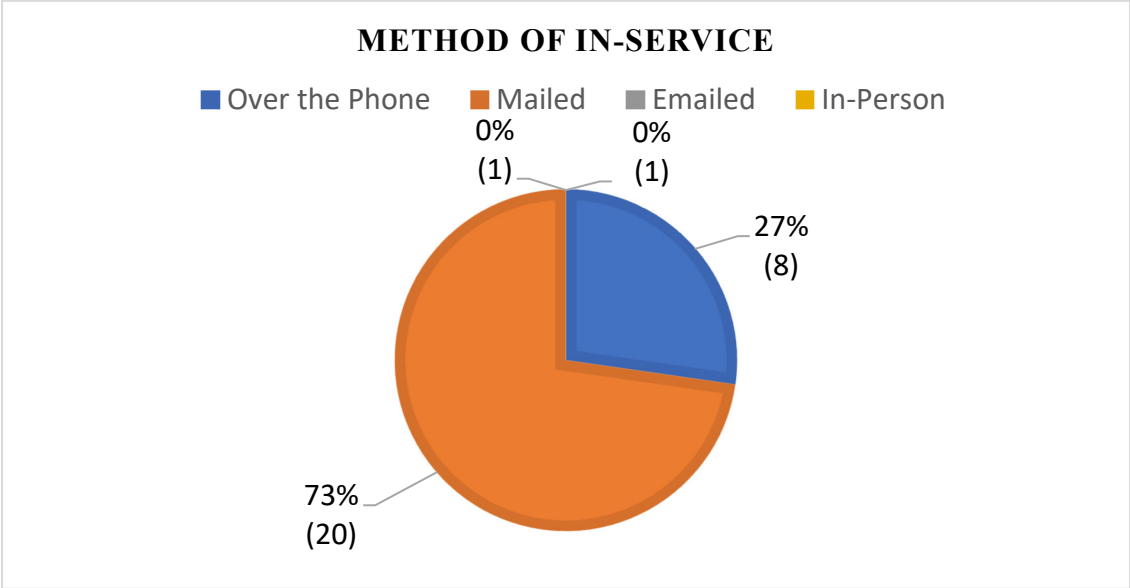
During this quarter, a total of 115 surveys were received from KHS member facing department staff regarding their satisfaction with our vendor Language Line Services concerning over-the-phone interpretation. Findings revealed that 96% of KHS staff are satisfied with the linguistic performance of our vendors' interpreters.



C&L Trainings

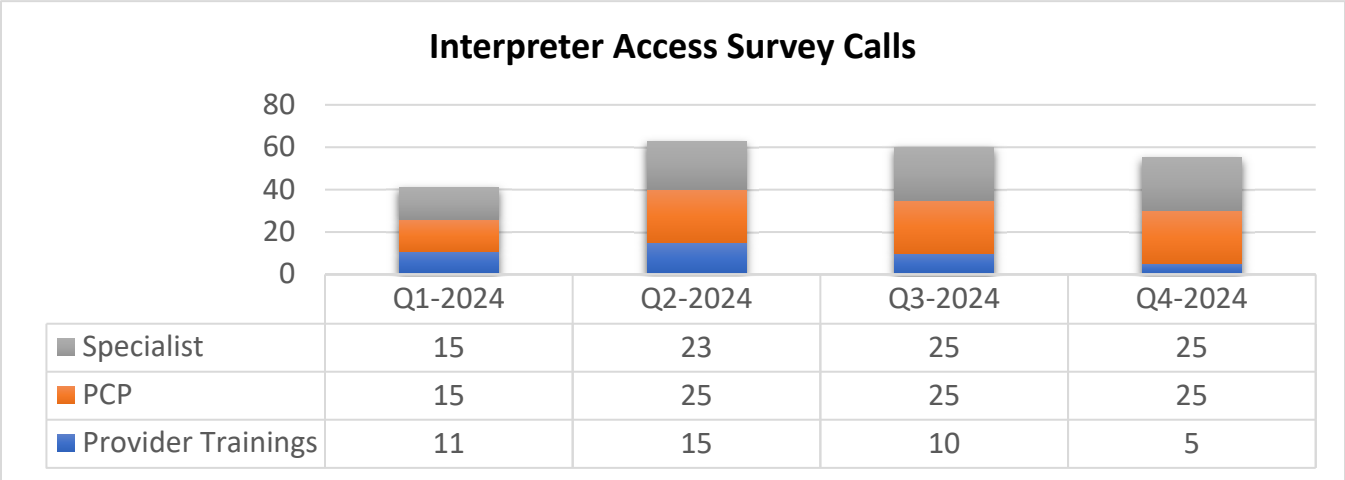
C&L Grievance Provider Trainings

During this quarter, 8 Cultural and Linguistic (C&L) related grievances were filed against providers contracted with Kern Family Health Care (KFHC) due to a lack of language access for members. For this quarter, 8 contracted providers were contacted, and a C&L Services in-service was provided. The C&L team conducted a total of 20 calls to these providers. These call attempts were tracked and marked either “successful” (provided an in-service over the phone or via providers ‘preferred method) or “unsuccessful” (unable to reach someone or provider refused). Those that were “successful” were provided the in-service via telephone, mail, email, and/or in-person. Those that were unsuccessful were still provided with KFHC C&L services educational material via mail.



Interpreter Access Survey Calls

Each quarter, the Provider Network Management (PNM) department conducts an interpreter access survey among KHS providers. During Q4, 25 PCPs and 25 Specialists participated in this survey. Of these providers, 5 needed a refresher training on KHS' C&L services.

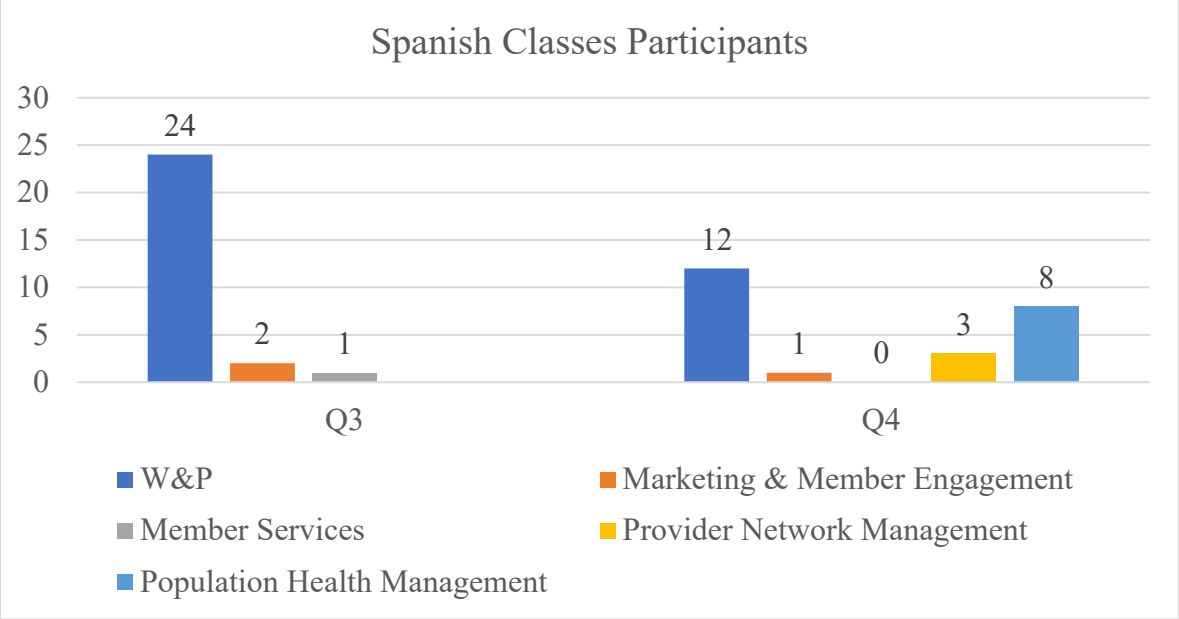


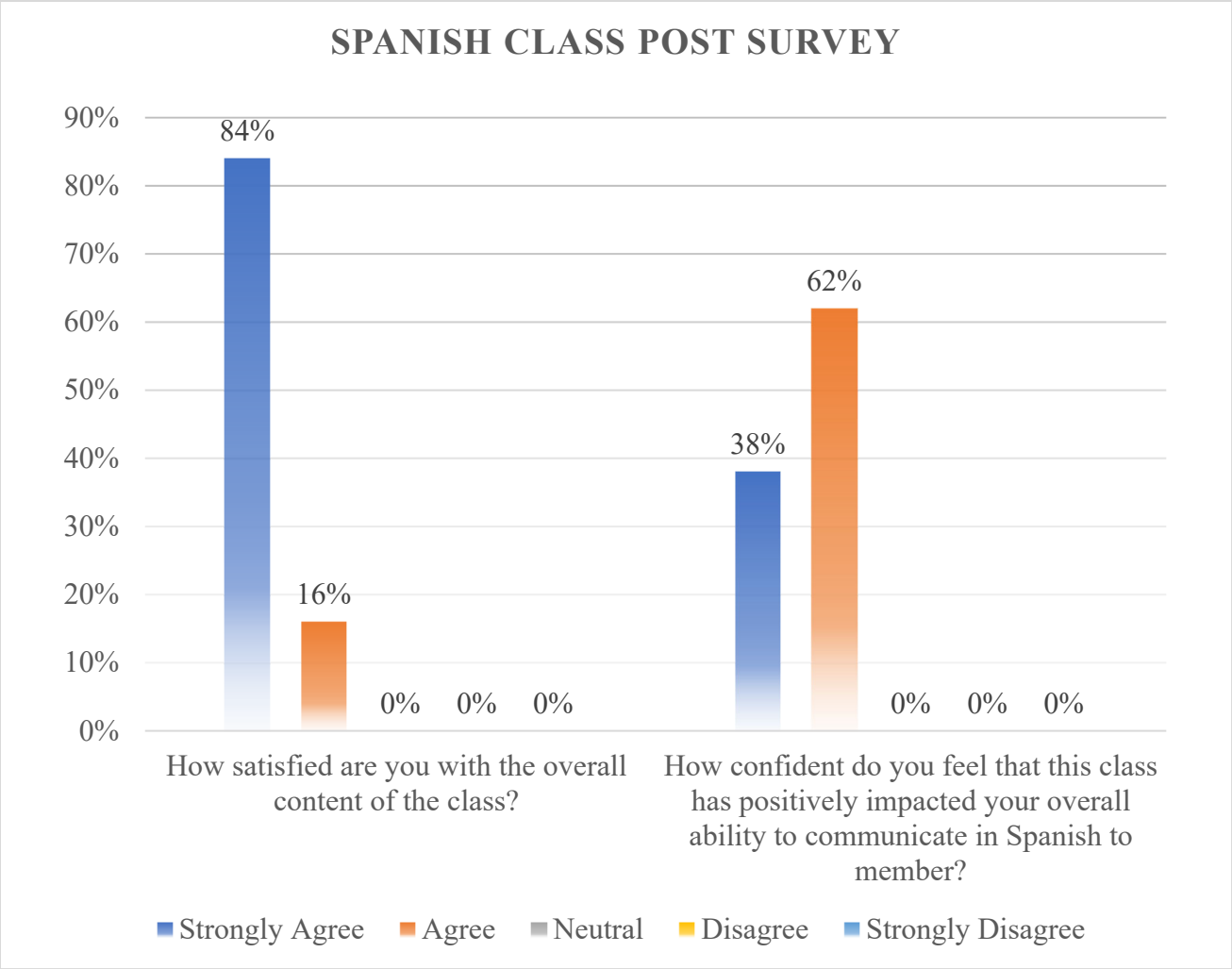
	Q1-2024	Q2-2024	Q3-2024	Q4-2024
Specialist	15	23	25	25
PCP	15	25	25	25
Provider Trainings	11	15	10	5

KHS Bilingual Staff Training

The C&L Department supports the professional development of all KHS internal staff, especially those who are bilingual, by offering a cycle of trainings to enhance their Spanish skills. During Q4 2024, one class was held with a total of 24 participants from several KHS departments such as PHM, C&L, W&P, Member Engagement, and ECM.
The classes give participants the opportunity to practice the 4 skills in a language, including reading, writing, speaking and listening. For this quarter's class, the topic covered was "acentos/tildes", in which participants completed writing exercises as well as speaking activities where they had the chance to practice real life interactions with members in Spanish.

Compared to the class offered in Q3, there was a decrease of 3 attendees. During class, all attendees complete a pre and a post survey, which helps us understand their expectations as well as their satisfaction with the class.




SPANISH CLASS POST SURVEY
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
84%
16%
0%
0%
0%
38%
62%
0%
0%
0%
How satisfied are you with the overall content of the class?
How confident do you feel that this class has positively impacted your overall ability to communicate in Spanish to member?
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

COMMITTEE: ***EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (EQIHEC)***
DATE OF MEETING: ***DECEMBER 12, 2024***
CALL TO ORDER: ***7:17 AM BY TRACO MATTHEWS, CHAIR***

Members Present On-Site:	Jennifer Ansolabehere, KC Public Health Satya Arya, MD - ENT. Danielle Colayco, PharmD – Komoto	Allen Kennedy – Quality Team DME Michael Komin, MD – Komin Medical Group Chan Park, MD – Vanguard Family Medicine	Rukiyah Polk - CAC Chair Traco Matthews – KHS Chief Health Equity Officer
Members Virtual Remote:			
Members Excused=E Absent=A	Debra Cox – Omni Family Health (A) Jasmine Ochoa - Health Equity Manager of Public Health (E)	Todd Jeffries – Bakersfield Community Healthcare (E) Philipp Melendez, MD – OB/GYN (A)	
Staff Present:	Michelle Curioso - Director of Pop Health Management Pawan Gill - Health Equity Manager Sukhpreet Sidhu, MD – Pop Health Medical Director Anastasia Lester – Sr. Health Equity Analyst Devin Brown – Chief Human Resources Officer John Miller – Quality Improvement Medical Doctor Martha Tasinga, MD – KHS Chief Medical Officer	Magdee Hugais – Director of Quality Improvement Kailey Collier - Director of Quality Performance Maninder Khalsa – Medical Director Christine Pence, Senior Director of Health Services Adriana Salinas – Director of CSS Nate Scott – Member Services Director	Vanessa Nevarez - Health Equity Coordinator Greg Panero – Provider Network Analytics Abdolreza Saadabadi, MD – BH Medical Director Isabel Silva - Senior Director of Wellness & Prevention Melinda Santiago – Director of Behavioral Health Aurora De La Torre – MCAS Supervisor

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Quorum	8 of 12 committee members present; Debra Cox, Jasmine Ochoa, Todd Jeffries, and Philipp Melendez were absent.	Committee quorum requirements met.	N/A
Call to Order	Traco Matthews, Chair, called meeting to order at 7:17 am.	N/A	N/A
Public Presentation	There were no public presentations.	N/A	N/A

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Committee Announcements	Traco Matthews gave the opportunity for member updates. • There were no committee announcements.		
Committee Minutes	**<u>Approval of Minutes</u>** CA-3) The Committee's Chairperson, Traco Matthews, presented the EQIHEC Minutes for approval.	**Action:** • Satya A. first, Chan P. second. All aye's. Motion carried.	12/12/24
Old Business	There was no old business to present.	N/A	N/A
New Business	**<u>Consent Agenda Items</u>** • CA-4) Behavioral Health Advisory Committee (BHAC) Minutes from October 16, 2024 • CA-5) Health Equity Transformation Steering Committee (HETSC) Minutes from September 12, 2024 • CA-6) Network Advisory Committee (NAC) Minutes from October 18, 2024 • CA-7) Pharmacy Drug Utilization Review (DUR) Minutes from September 30, 2024 • CA-8) Physician Advisory Committee (PAC) August 7, 2024, Redacted Summary of Proceedings • CA-9) Physician Advisory Committee (PAC) September 4, 2024, Redacted Summary of Proceedings • CA-10) Population Health Management (PHMC) Minutes from September 4, 2024 • CA-11) Utilization Management Committee (UMC) Minutes from September 11, 2024 • CA-12) Quality Improvement Workgroup (QIW) Minutes from September 26, 2024 • A motion to approve Consent Agenda Items was requested.	**Action:** • Satya A. first, Chan P. second. All aye's. Motion carried.	12/12/24

	13) Behavioral Health Advisory Committee Report • Melinda S. gave a presentation that covered the Q3 and Q4 reports of the Behavioral Health Department and posed a question to the committee regarding how the current KHS provider information is being promoted. • Chan P. replied to Melinda S. that he would like a more hands-on approach that includes more communication and follow-up. He recommended having more staff and resources for internal provider staff. • A motion to approve the Behavioral Health Advisory Committee Report was requested.	**Action:** • Michael K. first, Satya A. second. All aye's. Motion carried.	12/12/24
	14) Quality Performance Report • Kailey C. presented the Quality Performance Summary Report that covered Q3 2024 data. Kailey C. concluded by asking the group if site reviews have been helpful and for specifics within their practice that are working with their patients. • Danielle C. asked if the HPV rate is bringing down compliance rates. • Kailey C. responded that yes, the second dose is bringing down rates and that Care Data is required to report vaccines. The oversight and monitoring can be improved by KHS and KHS will work better with providers to report the data. • Kailey C. asked the committee how KHS can better educate our members. • Danielle C. identified an opportunity to start HPV vaccinations at age 9. • A motion to approve the Quality Performance Report was requested.	• No response was given from the committee. • No response was given from the committee. • Kailey C. will follow up on HPV age requirements. • Chan P. first, Satya A. second. All aye's. Motion carried.	12/12/24 12/12/24 12/12/24 12/12/24

	15) Quality Improvement Workgroup Report • Magdee H. presented the Quality Improvement Report that covered Q3 2024 data. • Quality of Care (QOC) Grievances for Q2 2024 was presented: 490 grievances were classified as Quality of Care (QOC) concerns and closed. 2,543 grievances were classified as non-QOCs and closed. 3,033 total grievances were closed. • A summary of PQI activity for Q2 2024 was presented: 162 PQIs were reviewed. 85 were classified as "No Quality Concern." 75 were classified as "Potential Harm." 2 were classified as "Actual Harm." • The results of the 2024 KHS Provider Satisfaction Survey showed significant improvements compared to 2023: Overall Satisfaction: 90%. Would Recommend: 98.8% (up from 98.3% in 2023). Coordination of Care: increased to 53.1%. • Magdee H. concluded by asking the group for any recommendations for QIW. • A motion to approve the Quality Improvement Workgroup Report was requested. **16) Grievance Summary Report** • Nate S. presented the 2023 Grievance Analysis, the Q3 2024 Grievance Operational Board Update, and the Q3 2024 Summary Report. • Michael K. asked if the 10 grievances KHS currently has is per provider. • Nate S. responded that the grievances are not per provider, they are overall. He then began to define what a grievance is. He explained that KHS is required to accept a member's dissatisfaction as a grievance, even though the member did not want to formally file a grievance. Nate S. added that per our member satisfaction survey, our members are very happy, however, there is always room for improvement as NCQA continues to raise the bar for quality assurance.	• No response was given from the committee. • Satya A. first, Michael K. second. All aye's. Motion carried.	12/12/24 12/12/24

	• Michael K. asked if providers ask to dismiss their grievances. • Dr. Martha T. responded no. She added that when providers ask to no longer have members as patients it is usually due to their relationship being broken. Also, if a member wants to change their doctor at any time, KHS will do that for them. • A motion to approve the Grievance Summary Report was requested. **<u>17) Utilization Management Program Report</u>** • Dr. Maninder K. presented the UM Program report that contains a synopsis of analytics that reflect the performance of the Utilization Management Department's in the 3rd quarter of 2024 including Utilization Management Metrics, and Internal Audit Results. • On October 1, 2024, KHS revised the codes required for Prior Authorization. Although a small number of codes were added, a significantly larger number of codes were removed to result in an overall reduction in authorizations throughout the Provider Network. The UM team is monitoring the impact of these changes and addressing Provider questions and concerns. • The Utilization Management Team audits performance to ensure regulatory and industry standards are met or exceeded. In addition, available data is analyzed using a Health Equity lens and identifying areas where additional effort will benefit the population we serve. • Dr. Martha T. added that KHS has 72 hours for urgent referrals and routine referrals are 5 days. • Satya A. left the meeting at 8:30am. • A motion to approve the Utilization Management Program Report was requested.	• Jennifer A. first, Satya A. second. All aye's. Motion carried. • Allen K. first, Chan P. second. All aye's. Motion carried.	12/12/24 12/12/24

	18) Network Adequacy Committee Report • Greg P. presented the Network Adequacy Report that covered Q4 2024 data. • Greg P. addressed a follow-up from a previous concern that Jennifer A. had regarding lack of birthing centers at the 9-12-24 EQIHEC meeting. KHS is currently trying to be contracted with the Antelope Valley Hospital which has OBGYN access and that the Ridgecrest Regional Hospital should be opening their labor and delivery hospital soon. Dr. Sukhpreet S. added that KHS has recently credentialed a provider for OB services in Ridgecrest. • A motion to approve the Network Adequacy Committee Report was requested. **19) Pop Health Management Report** • Michelle C. presented the Pop Health Management Report that covered Q4 2024 data. She also addressed a concern that Jennifer A. had regarding lack of access of maternal healthcare in East Kern at the 9-12-24 EQIHEC meeting. • Michelle C. presented the problem of access to maternal healthcare in East Kern and sets the stage for understanding the issues surrounding this gap in care. The presentation evaluates healthcare access for pregnant women in East Kern, presenting population demographics, healthcare utilization data, and analyzing disparities related to age, ethnicity, and socioeconomic factors. The data on pregnancy care utilization (54% of pregnant women received care from a provider) provides insights into how well the current system is serving the community. The recommendation for action—improving access to healthcare for pregnant women in the region.	• Chan P. first, Allen K. second. All aye's. Motion carried.	12/12/24

	• A call to action by the PHM Committee has resulted in a workgroup that was developed to tackle the issue of limited access to healthcare services for pregnant women in East Kern. • These actions are: Following up on the reopening of the Ridgecrest Hospital, increasing access to healthcare providers – new provider was added per PNM, offering mobile health clinics or improving telemedicine availability. Providing community outreach and education to increase utilization of available services. Partnering with CBOs. • Ongoing monitoring and assessment to ensure that improvements are being made include Tracking maternal health outcomes over time to see if access to care improves, conducting follow-up surveys with pregnant women in East Kern to assess whether access to care and the quality of care have improved, Monitoring changes in maternal and fetal health outcomes, such as rates of complications or preterm births, following the proposed interventions. • Jennifer A. questioned the data in Michelle C's. presentation that stated 46% of pregnant members were not seen by their providers. • Dr. Martha T. responded that some of the possibilities for such a high percentage is because some women may not keep their baby, or their cultural norm is to not see a doctor in the first trimester. Michelle C. added that KHS is participating in groups that are trying to find resolutions to address education and health literacy issues. • A motion to approve the Population Health Management Report was requested.	• Jennifer A. first, Chan P. second. All aye's. Motion carried.	12/12/24

	20) Health Equity Transformation Steering Committee • Pawan G. presented policy 22.08-I Collection of SOGI (Sexual Orientation & Gender Identity) Data 2024-140. • Danielle C. asked if unisex is an option under the category 'sex assigned at birth' and stated she would like to get with Pawan offline to answer additional questions due to time constraints. • Pawan G. responded that she welcomes feedback. • The committee was asked to approve and adopt policy 22.08-I Collection of SOGI (Sexual Orientation & Gender Identity) Data. **21) EQIHEC Report Templates** • Traco M. presented the new EQIHEC report template which includes a written summary that will be published on the KHS website for approval.	• Chan P. first, Danielle C. second. All aye's. Motion carried. • Danielle C. first, Chan P. second. All aye's. Motion carried.	12/12/24 12/12/24

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Open Forum	N/A	Informational only.	N/A
Next Meeting	The next meeting will be held Tuesday, March 18, 2024, at 7:15am.	Informational only.	N/A
Adjournment	The Committee adjourned at 9:17am. ***Respectfully Submitted:*** ***Vanessa Nevarez, Health Equity Project Coordinator***	• Danielle C. first, Chan P. second. All aye's. Motion carried.	N/A

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: **BEHAVIORAL HEALTH ADVISORY COMMITTEE**
DATE OF MEETING: **JANUARY 15, 2025**

Members Present On-Site:	Marisa Garcia-Trebizo, LMFT - Director at CSV Heather Hornibrook, LMFT – Deputy Dir. KBHRS	Mesha Muwanga, LMFT – Rhema Therapy Inc. Melinda Santiago, KHS Director of Behavioral Health	Martha Tasinga MD, KHS Chief Medical Officer
Members Virtual Remote:	Matthew Beare, MD – Clinica Sierra Vista Anuradha Rao, MD - Omni	Franco Song, MD – Psychiatric Wellness Center	
Members Excused=E Absent=A	Cherilyn Haworth, CSUB (A)		
Staff Present:	Amy Daniel, KHS Executive Health Services Coordinator Vanessa Hernandez, KHS Senior Support Clerk Yolanda Herrera, KHS Credentialing Manager	John Miller, MD - KHS QI Medical Director Courtney Morris, KHS Behavioral Health Supervisor Steve Pocasongre, KHS NCQA Accreditation Specialist	Abdolreza Saadabadi, MD PhD Pam Thomsen, KHS NCQA Program Manager Julie Ybarrra, KHS Supervisor BH

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga, CMO and Melinda Santiago, KHS Director of Behavioral Health called the meeting to order at 12:05 PM.		N/A
Committee Minutes	**Approval of Minutes** Approval of Minutes from October 16, 2024 meeting.	☑ **APPROVED**: A motion was made by A.Saadabadi MD and seconded by M.Garcia-Trebizo LMFT, to approve the minutes of October 16, 2024. Motion carried.	1/15/25
OLD BUSINESS	**NCQA Standards** **NCQA QI 4 A-B Continuity and Coordination Between Medical and Behavioral Health Care**	☑ **CLOSED**: Informational discussion only	1/15/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Melinda Santiago, Dir. Of Behavioral Health informed the members that this standard has been finalized and submitted for feedback which was accepted and submitted the key indicators for AMM, ADD and SSD which was voted and agreed at the last meeting. The identified barriers and interventions will be a focus for 2025.	☑ **CLOSED**: Informational discussion only	1/15/25
	ME 7E (BH) Grievance and Appeal – Review qualitative and quantitative analysis Melinda Santiago, Dir. Of Behavioral Health reported that we have met our goal regarding complaints for Behavioral Health as we are u under 10 complaints per 1,000 members. Area of focus appears to be mainly regarding access to care, attitude and services and improving quality of care. Melinda informed the members that although we met our goal these areas of concern will be addressed and attention on how we can improve communication, office training, and overall member education in virtual formats.	☑ **CLOSED**: Informational discussion only	
	ME 7E – Annual Assessment of Behavioral Healthcare and Services – Review (BH) Member Experience Surveys Melinda Santiago, Dir. Of Behavioral Health informed the members that KHS is participating in the Regional Advisory Committees that have identified areas of opportunity to improve telehealth access including education to members on the benefits available through virtual formats. Also, the Regional Advisory Committee has identified training opportunities for offices and will present some best practices for offices and providers to adopt. Members asked for additional information as to what provider support will be offered. Melinda informed the committee that there will be conversations on training needs, on-line trainings available and the plan to start focusing on low penetration rates such as non-specialty mental health services to better understand the barriers, cultural sensitivities and how best can we support and provide additional training. Melinda provided an executive summary of the 2024 ECHO Member Satisfaction Survey. Item specific attributes such as Office Wait time and Medication Side effects are slightly lower in comparison	☑ **CLOSED**: Informational discussion only	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	with benchmarks. Members discussed this may be part of the patient's perception as well as some patients may get confused during the intake process specific to medication management.		
	Eating Disorders Follow-up Melinda reported that KHS anticipates aligning our Policy and Procedures with Kern Behavioral Heath & Recovery Services due to the shared responsibilities and will begin to streamline this process and will bring back to this committee when it is ready. No additional follow-up is necessary at this time.	☑ **CLOSED**: Informational discussion only and will be brought back to committee once P&P is finalized.	1/15/25
NEW BUSINESS	**Welcome New Member -Tribal Liaison** The new Tribal Liaison is Tara Grey, who unfortunately was not able to be here today. Ms. Grey will be the liaison between the health plan and Tribal Clinics to help KHS engage in the Tribal Community. Ms. Grey will be present at our April meeting.	☑ **CLOSED**: Informational discussion only	1/15/25
	NSMHS Outreach & Education Plan Melinda reported that KHS has submitted their NSMHS Outreach and Education Plan to the State (DHCS) who will then submit their feedback on our plan. KHS will be revamping our Mental Health website page to include resource links and platforms that will be free to our members to access. There will also be provider trainings for our primary care providers.	☑ **CLOSED**: Informational discussion only	1/15/25
OPEN FORUM	**Open Forum** Committee Dates were provided for 2025 and consensus was that Wednesdays were better than Mondays.	☑ **CLOSED**: Informational discussion only.	1/15/25
NEXT MEETING	Next meeting will be held April 9, 2025.	☑ **CLOSED**: Informational only.	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
ADJOURNMENT	The Committee adjourned at 1:10 pm. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Behavioral Health Advisory Committee Minutes 01/15/2025

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

COMMITTEE: ***HEALTH EQUITY TRANSFORMATION STEERING COMMITTEE (HETSC)***
DATE OF MEETING: ***February 11, 2025***
CALL TO ORDER: ***2:00pm - Pawan Gill, Health Equity Manager – CHAIR***

Staff Present:	• Jackie Byrd, Senior Marketing and Communications Specialist • Lela Criswell, Member Engagement Manager • Pawan Gill, Health Equity Manager • Anastasia Lester, Senior Health Equity Analyst • Finster Paul III, Manager of Community Health and Wellness • Cesar Chavez, HRIS and Analytics Manager • Magdee Hugais, Director of QI	• Marilu Rodriguez, Senior Health Equity Analyst • Melinda Santiago, Director of Behavioral Health • Adriana Salinas, Director of Community and Social Services • Nate Scott, Director of Member Services • Tiffany Chatman, Wellness & Prevention Manager	• Frankie Gonzalez, Employee Relations Manager • Vanessa Nevarez, Health Equity Coordinator • Amy Sanders, Member Services Manager • Maritza Jimenez, Community Engagement Supervisor • Jake Hall, Senior Director of Contracting and Quality Performance • Daisy Torrez, Member Engagement Supervisor
Staff Virtual:	• Michelle Curioso, Director of Population Health Management	• Cynthia Cardona, Cultural & Linguistics Services Manager	• Martha Quiroz, Member Services Manager

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
QUORUM	Attendance / Roll Call	N/A – Workshop-style Committee	N/A
CALL TO ORDER	Pawan Gill, Health Equity Manager and Chair called the meeting to order at 2:05pm.	N/A	N/A
COMMITTEE MINUTES	There were no previous minutes to approve.	N/A	N/A

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
OLD BUSINESS	There was no old business to present.	N/A	N/A
NEW BUSINESS	**1) JEDI Charter Revisions** • Pawan G. gave an update on the Justice, Equity, Diversity, and Inclusion (JEDI) Charter revisions where she announced Tiffany Chatman as the Vice Chairperson and Vanessa Nevarez as the point person for any inquiries from departments that would like to leverage JEDI services as you would for Health Equity in your program development. • Pawan G. announced that the JEDI Charter will be getting an addendum which includes committees using JEDI to help fill external seats to ensure diversity. Cesar C. asked what committees would have outside seats to be filled? Pawan G. gave Community Advisory Committee (CAC) and Executive Quality Improvement Health Equity Committee (EQIHEC) as examples. **2) 2025 HEO Workplan** • Pawan G. provided an update on the 2025 HEO Workplan which includes QI and Health Equity combining their program descriptions and workplans. • Pawan G. thanked those that added their program and activities to the spreadsheet that was circulated in 2024. **3) TGI/SOGI Training Update** • Pawan G. provided an update on the TGI (Transgender Intersex Identities) training requirement that is associated with Senate Bill 9-23 and APL 24-018.	• The JEDI Charter revisions will be presented to the EQIHEC in March for approval. • If anyone has an open seat on their committees start reaching out to JEDI now. • The combined program charter and workplans will be presented to the EQIHEC in March for approval. • Pawan G. will circulate the program and activities spreadsheet to all to remove any programs that have since ended that were added to the list last year. • Departments with member facing staff are to email list of names to Vanessas N.	N/A N/A N/A N/A N/A

	Pawan G. explained that the TGI training will look very similar to the SOGI (Sexual Orientation Gender Identity), required by NCQA, and that both will be happening beginning of March for employees that have direct contact with KFHC members. Pawan G. added that eventually, a DEI training will also be given. KHS was unable to combine the DEI training with the TGI and/or SOGI in year one.	• Share training dates with the L&D department to add to their calendar.	N/A
	4) EPT Update - Presentation • Marilu R. gave a presentation on the EPT (Equity and Practice Transformation) Payment Program which provided an overview of how providers receive their payments.	• Informational only.	N/A
	5) Doula Update – Presentation • Ana L. presented The Doula Journey and announced that doulas are now a provider benefit at KFHC. Ana L. added that KHS staff have been involved since the release of the doula benefit in January 2023. The presentation highlighted the benefits and challenges doulas face.	• Informational only.	

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
OPEN FORUM	Pawan opened the floor for announcements.	N/A	N/A
NEXT MEETING	Next meeting will be held Tuesday, May 13th, 2025, at 2:00pm.	N/A	N/A

ADJOURNMENT	The Committee adjourned at 2:55 pm. ***Respectfully submitted:*** ***Vanessa Nevarez, Health Equity Coordinator***	N/A	N/A

For Signature Only – HETSC Minutes 02/11/25

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: **Network Adequacy Committee**
DATE OF MEETING: **February 27, 2025**
CALL TO ORDER: **9:04 AM by James Winfrey, KHS - Deputy Director of Provider Network Management, Chair**

Members Present On-Site:	Traco Matthews, KHS - Chief Health Equity Officer Deb Murr, KHS - Chief Compliance and Fraud Prevention Officer
Members Virtual Remote:	Melissa McGuire, KHS - Senior Director of Delegation and Oversight Alan Avery, KHS - Chief Executive Officer
Members Excused (E), Absent (A)	Amisha Pannu, KHS - Senior Director of Provider Network Management (E)
Staff Present:	Greg Panero, KHS - Provider Network Analytics Program Manager (on-site) Beatriz Quiroz, KHS - Provider Network Analyst I (virtual) Pawan Gill, KHS - Health Equity Manager (on-site)

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
CALL TO ORDER	- James Winfrey called the meeting to order at 9:04 AM - Quorum/Attendance	- Committee quorum requirements met.	N/A
APPROVAL OF MINUTES	- James Winfrey presented the Q4 2024 Network Adequacy Committee meeting minutes for approval.	☑ **CLOSED**: The committee members in attendance approved Q4 2024 Network Adequacy Minutes.	*2/27/25*
OLD BUSINESS	- No items.	☑ **CLOSED**: Informational only.	*2/27/25*
NEW BUSINESS	Provider Network Management, Q4 2024 Quarterly Network Review - Greg Panero presented the Provider Network Management Q4 2024 Quarterly Network Review. o After Hours Survey Results: Emergency Access at 99% compliant, Urgent Care Access at 99% compliant. Reviewed trending results and discussed Plan follow up action. ▪ During discussion of after-hours survey Greg Panero indicated there was one primary care provider found to be non-	☑ **CLOSED**: The committee members in attendance approved Provider Network Management, Q4 2024 Quarterly Network Review.	*2/27/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	compliant with both standards, Draco Mattews inquired about what region the provider was in. This was found to be Ming Primary Care in the 93304 zip code/Central Region. ○ Provider Accessibility Monitoring Survey: Plan compliant with all standards (appointment availability, hours of operation, phone answering timeliness, in-office wait times) based on results of Q4 2024 Survey. ○ Traco Matthews commented the 60% compliance with the urgent standard in the East region is to be expected. James agreed as that East region is where a lot of the providers are located. Access Grievance Review: The Plan has 342 access grievances found in favor of the member in Q2 2024, for a total of .41 grievances for every 1,000 members. ▪ During discussion of Access grievance review, James Winfrey pointed out that although all though all of the access grievance types are increasing, Timely Access is increasing more and potentially may need to be addressed. Deb Murr, inquired about the provider type that is receiving these grievances. James explained all grievance are reviewed and categorized by provider type, but no trends have been identified at this time. ▪ Alan Avery questioned if grievances are tracked per 1,000 members since there was a membership increase in 2024. James went over analysis that the increase of membership was identified as one of the potential causes on increase access grievances. ▪ James went over analysis further noting the Plan has seen a continued rise in Access Grievances, with a potential cause being the increase in membership during the Q1 2024 health plan transition. The primary grievance type contributing to this		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	rise is Timely Access Grievances. Geographically, the East and Central Regions have been most affected over the past two quarters. James also explained that one of the things that PNM is hoping will address this issue is the ongoing retention and recruitment grant that initiated in November 2023. The Provider Network Analytics team will continue monitoring grievances to gauge success of the grant. ▪ Pawan Gill inquired about what type pf providers the grant covers? James explained this is for primary care, specialty care and behavioral health. ▪ James suggested a staff member from grants attend the next NAC meeting to speak on the grant. ○ Geographic Accessibility & DHCS Network Certification: The Plan is in compliance with DHCS Network Standards or maintains a DHCS-approved access standard when non-compliance identified. ▪ In Q1 2024, the Plan submitted 343 AAS requests to DHCS. On November 15, 2024, the DHCS approved the Plan's submission of the AAS requests, identified no deficiencies, and deemed the Plan had passed the 2023 Annual Network Certification. ▪ Greg Panero added, in Q1 2025 the Plan received the 2024 Annual Certification request. This year the Plan received 232 AAS requests. ○ Network Adequacy & Provider Counts: ▪ FTE PCP ratio at 1:1514 ▪ FTE Physician ratio 1:256 ▪ PCP Accepting new members: 88% ▪ NPMH accepting new members: 97% ▪ NPMH locations accepting new members: 91% ▪ PCP Count: 505		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	▪ Specialist Provider Count: 3269 ▪ Mental Health Provider Count: 237 ▪ Alan Avery asked about adding Rheumatology to the list of specialties listed in the Network Adequacy & Provider Counts slide for internal monitoring. Deb Murr also asked to add Podiatry. Draco Matthews suggested differentiating which providers require monitoring from the DHCS and which ones will be monitored internally in the future. ▪ Deb inquired if the Mental Health providers are physical locations or telehealth. James confirmed the counts include both type of providers. James added PNM is currently working with Behavioral Health on Telehealth vs In Person appointments and monitoring. ▪ Deb asked if the Plan is required to monitor FTE by midlevel providers. James explained the graph's shown include physicians only and both physicians and midlevel providers calculated with approved methodology. ○ Significant Network Change: In Q3 2024, the Plan submitted a new significant network change filing on September 20, 2024. ▪ As of the end of Q4 2024, the Plan has not received any feedback from the DMHC regarding this filing. ○ During the Q2 2024 EQIHEC meeting a committee member raised concerns regarding access to OB/GYN services in the eastern part the Plan's Service Area. ▪ In Q4 2024, Ridgecrest Regional Hospital reopened its Labor & Delivery Unit, and the Plan contracted with Northern Inyo Hospital in Bishop to offer labor and delivery services. The Plan believes these network changes will ensure appropriate access to these services for members		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	within this geographic region.		
OPEN FORUM	**Open Forum** - No items.	☑ **CLOSED**: Informational only.	*2/27/25*
NEXT MEETING	Next meeting will be held Friday, May 9, 2025.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 9:46 AM. . ***Respectfully submitted: James Winfrey; Deputy Director of Provider Network Management***	**N/A**	*N/A*

For Signature Only – AADVOC Minutes 2/27/25

The foregoing minutes were APPROVED AS PRESENTED on: 3/5/2025 (Date) _____ (Name)

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ (Date) _____ (Name)

KERN HEALTH SYSTEMS

COMMITTEE: **DRUG UTILIZATION REVIEW (DUR) COMMITTEE**
DATE OF MEETING: **NOVEMBER 25, 2024**
CALL TO ORDER: **6:30 P.M. BRUCE WEARDA, RPh, DIRECTOR OF PHARMACY – ALTERNATE CHAIR**

Members Present On-Site:	Alison Bell, PharmD – Network Provider, Geriatrics Dilbaugh Gehlawat, MD – Pediatrician Kimberly Hoffmann, Pharm D. - Pharmacist and BOD Member	James "Patrick" Person, RPh – Network Provider	Martha Tasinga, MD – KHS Chief Medical Officer Bruce Wearda, RPh – KHS Director of Pharmacy
Members Virtual Remote:	Abdolreza Saadabadi, MD – Network Provider, Psy.D. Vasanthi Srinivas, MD – Network Provider, OB/GYN	Sarabjeet Singh, MD - Network Provider, Cardiology	
Members Excused=E Absent=A	Joseph Tran, MD – Network Provider – A		
Staff Present:	Amy Daniel, KHS Executive Health Srvs Coordinator Sukhpreet Sidhu, MD, KHS Medical Director		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirement met.	*N/A*
APPROVAL OF MINUTES	The Committee's Alternate Chairperson, Bruce Wearda, RPh, presented the meeting minutes for approval.	☑ **ACTION**: Vasanthi Srinivas moved to approve minutes of September 30, 2024, seconded by Alison Bell. 7 approved, 0 nays.	*11/25/24*
OLD BUSINESS	• Incontinent Supplies Audit	• Dr. Miller reported no evidence of Fraud, Waste, and Abuse.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	• Report of Plan Utilization Metrics Pat Person asked if the plan could ensure or enforce pharmacies to bill for nebulizers as opposed to sending them to other pharmacies. He stated he often sees instances where people have the medicine, but not the nebulizer to utilize it. Dr. Dilbaugh Gehlawat also commented he has seen it too – where the pharmacy will tell a member it's denied or make them pay for the nebulizer. Dr. Kim Hoffmann wanted to know what the time limits are for billing different medical devices. Bruce replied it varies upon the device. Nebulizers are 3 years; Blood Pressure Machines are 5 years but those go to Medi-Cal Rx. Other devices have varying time frames as well. Dr. Vasanthi Srinivas wanted to know the billing time limits for blood glucose monitors. Bruce replied these also are carved out to Medi-Cal Rx. However, manufacturers often provide at no charge, so it seems odd that there should ever be a scenario where they are denied or not available. • Educational Articles The State DUR Educational Article on Drug-Drug Interactions (Amlodipine with Simvastatin or Lovastatin) was shared. We also share this information with the KHS Network. • DUR General Topics 1. Oncology Criteria 2. PA Criteria/UM Program Description 3. Zynteglo Criteria	It was suggested that a memo be sent to the pharmacies explaining coverage and how to bill for medical devices that KHS is responsible for. KHS PR Rep will educate the specific pharmacies not billing appropriately. ☑ **ACTION**: Pat Person moved to approve the Oncology Criteria (accepting NCCN guidelines as the criteria.) It was seconded by Dr. Dilbaugh Gehlawat. 7 Ayes, 0 Nays. ☑ **ACTION**: Alison Bell moved to approve the UM Program Description (Procedures for evaluating or reviewing PAD type requests.) It was seconded by Dr. Vasanthi Srinivas. 7 Ayes, 0 Nays. ☑ **ACTION**: Pat Person moved to approve the Zynteglo Criteria. It was seconded by Dr. Vasanthi Srinivas. 7 Ayes, 0 Nays.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• DHCS/Executive Order N-01-09 Medi-Cal • Global DUR Dr. Kimberly Hoffmann asked what our program for actions will be regarding the Retro DUR GLP-1/DPP-4 Initiative Report. Dr. Kimberly Hoffmann asked about what the state expects or requires regarding the SUPPORT Act. Bruce responded there is no specific guidelines as to what or how to do the monitoring and identifying of potential inappropriate therapies. The plans must monitor and identify. Bruce outlined the different reports identified in the SUPPORT Act. Dr. Kimberly Hoffmann wanted to know if it was ok to dispense Naloxone without a corresponding opioid on the same prescription.	It was recommended to send a bulletin to the Provider and Pharmacy Networks and send letters to the providers identified in the report.	
OPEN FORUM	There were no topics presented during open forum.	☑ **ACTION**: N/A	*11/25/24*
NEXT MEETING	Next meeting will be held Monday, March 31, 2025 at 6:30 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned 7:15 pm.	☑ **ACTION**: Kim Hoffmann moved to adjourn the meeting. It was seconded by Dr. Vasanthi Srinivas. 7 Ayes, 0 Nays.	*11/25/24*

Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator

For Signature Only – Drug Utilization Review Committee Minutes 11/25/24

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***OCTOBER 2, 2024***
CALL TO ORDER: ***7:02AM BY JOHN MILLER, MD – KHS MEDICAL DIRECTOR***

Members Present On-Site:	John Miller MD, Quality Improvement Medical Director Atul Aggarwal, MD – Network Provider, Cardiology Hasmukh Amin, MD – Network Provider, Pediatrics	Gohar Gevorgyan, MD – Network Provider, FP Miguel Lascano – Network Provider, OB/GYN Ashok Parmar, MD– Network Provider, Pain Medicine	Raju Patel, MD - Network Provider, Internal Medicine
Members Virtual Remote:			
Members Excused=E Absent=A	Martha Tasinga, MD – KHS Chief Medical Officer (E) David Hair, MD - Network Provider, Ophthalmology (E)		
Staff Present:	Alan Avery, Chief Operating Office (REMOTE) Michelle Curioso, Director of PHM Amy Daniel, Executive Health Services Coordinator Jake Hall, Deputy Director of Contracting	Yolanda Herrera, Credentialing Manager Magdee Hugais, Director of Quality Improvement Abdolreza Saadabadi MD, BH Medical Dir. (REMOTE)	Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. John Miller MD, KHS Chief Medical Officer, called the meeting to order at 7:02 am.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. Miller presented the meeting minutes for approval.	☑ **ACTION**: Dr. Amin moved to approve minutes of September 4, 2024, seconded by Dr. Lascano. Motion carried.	*10/2/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Peer Review Reports **CREDENTIALING REPORT** **Mental Health Pre-Approvals from -Report dated 10/2/2024:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on 10/**02/2024** Credentialing Report, all files met clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **10/02/2024.** The clean files were accepted as presented with no additional discussion. There were (5) [redacted] **RECREDENTIALING REPORT** **Recredentialing Providers List Dated 10/2/2024.** Recredentialing files meeting clean file review were accepted as presented with no additional questions or alternative actions. Recredentialing with comprehensive reviews were conducted for the	☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated September 4, 2024, seconded by Dr. Patel. Motion carried.	*10/2/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	listed providers below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the [redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated October 2, 2024, were accepted as presented with no additional questions or comments by the committee members.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS: There were no additional adverse events or disciplinary monitoring reported for September 2024 other than what was reported in the recredentialing report. [redacted]	☑ **ACTION**: Monthly Monitoring for September 2024 accepted as presented. Providers will continue to be monitored monthly with any additional reporting to the committee as it is received.	*10/2/24*
	DELEGATED CREDENTIALING: **VSP Annual Oversight Summary** Audit Results for Vision Services Plan (VSP) was presented to the committee for review and approval. KHS Credentialing conducted a desk top audit for VSP on 8/16/24. • **Results:** VSP scored 100% utilizing the HICE Accredited-Certified Audit Tool. VSP is CR Accredited with NCQA and expires 4/21/2026. • **Opportunity for Improvement:** There were no opportunities for improvement only an observation regarding Practitioner Rights outlined in VSP 2000 Credentialing P&P reference a URL to the Provider Manual which could not be accessed easily.	☑ **ACTION**: Dr. Amin moved to approve the VSP Annual Oversight Summary as presented. Seconded by Dr. Patel. Motion carried.	*10/2/24*
OLD BUSINESS	**Bariatric Surgery Quality of Care Issues**	☐ **PENDING**: Dr. Miller conduct random 10-case review in 6-months as follow-up on this issue.	*10/2/24*
NEW BUSINESS	**REVISED QP-Credentialing Policy and Procedures:** **23.10-P Delegated Credentialing & Agreement** Yolanda Herrera, KHS Credentialing Manager, presented the revision to QP Delegated Credentialing and Agreement Policy 23.10-P for review. The policy revisions were extensive to bring the process in line with current requirements, NCQA Standards after review with	☑ **ACTION**: Dr. Amin moved to approve the revised Policy & Procedures 23.10-P Delegated Credentialing and 23.06-P Non-Physician Medical Practitioners as presented. Dr. Patel seconded. Motion carried.	*10/2/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	NCQA Consultants; The Mahalik Group, and outside legal counsel DSR. Additionally, the Delegation Agreement Template was also revised under advisement with KHS Compliance in an effort to streamline and outlines delegation activities using the same template for all departments who delegate various health plan activities. **23.06-P Non-Physician Medical Practitioners & Supervising Agreement Form** Yolanda Herrera, KHS Credentialing Manager, presented the revision to QP Non-Physicians Medical Practitioners & Supervising Agreement form Policy 23.06-P for review. The policy revisions were extensive to bring the process in line with current state requirements related to new regulations for nurse practitioners and physician assistants.		
OPEN FORUM	**Pediatric Age Limits** Yolanda Herrera, KHS Credentialing Manager, informed the members that there was a request from a pediatrician to raise the pediatric age limits to 25 years old. The current pediatric age limits are 0-18 or 0-21. After discussion and input from the members, it was the consensus of the members to leave the pediatric age limits at 0-18 and 0-21.	☑ **CLOSED** – Informational Only	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, November 6, 2024	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 7:24 am **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator.**	**N/A**	*N/A*

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***NOVEMBER 6, 2024***
CALL TO ORDER: ***7:07AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Atul Aggarwal, MD – Network Provider, Cardiology Hasmukh Amin, MD – Network Provider, Pediatrics	Miguel Lascano – Network Provider, OB/GYN Ashok Parmar, MD– Network Provider, Pain Medicine Raju Patel, MD - Network Provider, Internal Medicine	
Members Virtual Remote:	David Hair, MD - Network Provider, Ophthalmology		
Members Excused=E Absent=A	Gohar Gevorgyan, MD – Network Provider, FP (E)		
Staff Present:	Alan Avery, Chief Operating Office Jake Hall, Deputy Director of Contracting Amy Daniel, Executive Administrative	Yolanda Herrera, Credentialing Manager Magdee Hugais, Director of Quality Improvement John Miller MD, QI Medical Director (REMOTE)	Abdolreza Saadabadi MD, BH Medical Dir. (REMOTE) Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:07 am.		N/A
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of October 2, 2024 for review and approval.	☑ **ACTION**: Dr. Patel moved to approve minutes of October 2, 2024, seconded by Dr. Amin. Motion carried.	*11/6/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from -Report dated 11/1/2024:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on **11/01/2024** Credentialing Report, all files met clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **11/06/2024.** The clean files were accepted as presented with no additional discussion. [redacted]	☑ **ACTION**: Dr. Parmar moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 11/1/2024 & 11/6/2024, seconded by Dr. Amin. Motion carried.	*11/6/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	RECREDENTIALING REPORT **Recredentialing Providers List Dated 11/6/2024.** Recredentialing files meeting clean file review were accepted as presented with no additional questions or alternative actions. 		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	NEW VENDOR CONTRACTS New Vendor Contracts List Dated November 6, 2024 were accepted as presented with no additional questions or comments by the committee members. **MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:** There were no additional adverse events or disciplinary monitoring reported for October 2024 other than what was reported in the recredentialing report. Current monthly monitoring report that includes licensing disciplinary issues, adverse events or sanctioned/excluded providers which was discussed during credentialing review. [redacted]	☑ **ACTION**: Monthly Monitoring for October 2024 accepted as presented. Providers will continue to be monitored monthly with any additional reporting to the committee as it is received.	*11/6/24*
	DELEGATED CREDENTIALING: There were no delegated credentialing activites to report.	☑ **CLOSED** – Informational Only.	*N/A*
	LEVEL 2 PQI CASE DISCUSSION (HANDOUT): As part of the Potential Quality Improvement Policy and Procedure, Dr. Miller presented three (3) cases identified as Level 2 for presentation at the PAC Meeting as required by this policy. [redacted]	☐ **PENDING**: Dr. Tasinga and Dr. Miller expressed appreciation for the feedback and will bring back these cases in a template and will send out the PQI Policy and Procedure to all committee members for review and to become familiar with the review process and case level outcomes..	*12/4/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		
OLD BUSINESS	**Bariatric Surgery Quality of Care Issues** Dr. Miller informed the members that the follow-up review is still in process and anticipates completion in the next 30-60 days.	☐ **PENDING**: Dr. Miller conduct random 10-case review in 6-months as follow-up on this issue.	***Pending***
NEW BUSINESS	There was no new business to report	**N/A**	*N/A*
OPEN FORUM	**Prior Authorization (PA) List** Dr. Martha Tasinga, KHS Chief Medical Officer informed the members that there has been commentary regarding the published Prior Authorization (PA) List. Dr. Tasinga informed the members	☑ **CLOSED** – Informational Only	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	that after many years of what was identified as a complicated list that many of our current Medical Directors were not part of preparing, it was started from scratch removing those procedures/services that KHS identified as not denying or if there was 95% approval rate, the procedure/service was removed. This identified approximately 50-codes added to the PA List which was analyzed resulting in a handful of codes that have been placed on the current PA List. Dr. Tasinga asked for feedback as KHS continues to clean up the PA List and is open to any suggestions from our network providers.		
NEXT MEETING	Next meeting will be held Wednesday, December 4, 2024	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:19 am **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator.**	**N/A**	*N/A*

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***DECEMBER 4, 2024***
CALL TO ORDER: ***7:09 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Atul Aggarwal, MD – Network Provider, Cardiology	Miguel Lascano – Network Provider, OB/GYN Raju Patel, MD - Network Provider, Internal Medicine	
Members Virtual Remote:	Hasmukh Amin, MD – Network Provider, Pediatrics David Hair, MD - Network Provider, Ophthalmology Ashok Parmar, MD– Network Provider, Pain Medicine		
Members Excused=E Absent=A	Gohar Gevorgyan, MD – Network Provider, FP (E)		
Staff Present:	Jake Hall, Deputy Director of Contracting Amy Daniel, Executive Administrative Yolanda Herrera, Credentialing Manager (REMOTE)	Magdee Hugais, Director of Quality Improvement John Miller MD, QI Medical Director Abdolreza Saadabadi MD, BH Medical Dir. (REMOTE)	Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director Bruce Wearda, Director of Pharmacy

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:09 am.		N/A
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of November 6, 2024 for review and approval.	☑ **ACTION**: Dr. Patel moved to approve minutes of November 6, 2024, seconded by Dr. Hair. Motion carried.	*12/4/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from -Report dated 12/4/2024:** [redacted] **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **12/04/2024.** [redacted] **RECREDENTIALING REPORT** **Recredentialing Providers Lists Dated 11/27/2024 and 12/4/2024.** [redacted]	☑ **ACTION**: Dr. Patel moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 11/27/2024 & 12/4/2024, seconded by Dr. Hair. Motion carried.	*12/4/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated December 4, 2024, were accepted as presented with no additional questions or comments by the committee members. **MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:** [redacted]	☑ **ACTION**: Monthly Monitoring for November 2024 accepted as presented. Providers will continue to be monitored monthly with any additional reporting to the committee as it is received.	*12/4/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted].		
	Delegated Credentialing 3rd Quarter 2024 - Quarter Oversight Reports Yolanda Herrera KHS Credentialing Manager informed the committee that the 3rd Quarter 2024 Delegated Oversight Reports have all been received and reviewed for CHLA Medical Group, ConferMED, Valley Children's Child Net, Vision Services Plan, UCLA Medical Group and USC Medical Group. During 3rd Quarter 2024, delegates reported Credentialing Committee dates for initial credentialing, recredentialing and terminations. There were no significant changes in provider network that would affect KHS members. **There were no identified issues.**	☑ **CLOSED** – Report Received and Filed.	*12/4/24*
	LEVEL 2 PQI CASE DISCUSSION (HANDOUT): [redacted]	☑ **ACTION**: [redacted] Motion carried.	*12/4/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OLD BUSINESS	**Bariatric Surgery Quality of Care Issues** Dr. Miller informed the members that the follow-up review is still in process and anticipates completion in 1st Quarter 2025.	☐ **PENDING**: Dr. Miller conduct random 10-case review in 6-months as follow-up on this issue.	***Pending***
NEW BUSINESS	**Pharmacy Criteria** Bruce Wearda presented the Pharmacy criteria submitted for approval under pharmaceutical covered medical benefit as follows: • Casgevy • Zynteglo • Oncology Criteria	☑ **ACTION**: Dr. Patel moved to approve the Casgevy criteria, seconded by Dr. Parmar. Motion carried. ☑ **ACTION**: Dr. Lascano moved to approve the Zynteglo criteria, seconded by Dr. Patel. Motion carried. ☑ **ACTION**: Dr. Lascano moved to approve the Oncology criteria, seconded by Dr. Amin. Motion carried.	*12/4/24*
OPEN FORUM	There was no open discussion.	☑ **CLOSED** – Informational Only	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, February 5, 2025	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:17 am. **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator**	**N/A**	*N/A*

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***POPULATION HEALTH MANAGEMENT COMMITTEE***
DATE OF MEETING: ***DECEMBER 4, 2024***
CALL TO ORDER: ***11:03 AM BY SUKHPREET SIDHU, MD - CHAIR***

Members Present On-Site:	Paula De La Riva-Barrera, Manager at First 5 Kern Lordes Bucher, Administrator at KCSOS	Dixie Denmark-Speer, SS Director at Height Street SNF Desiree Escobedo, Admissions at Height Street SNF	Sukhpreet Sidhu, MD PHM Medical Director Curt Williams, Director Homeless/Foster at KCSOS
Members Virtual Remote:	Alissa Lopez, Administrator at KCBHRS Dr. Vivek Radhakrishan, Primary Care ECM Provider	Colleen Philley, Program Director at KC Aging & Adult Martin Reynoso, Supervisor at KC Aging & Adult	
Members Excused=E Absent=A	Maria Bermudez, Asst. Director at Dept. of Human Services (E) Christopher Boyd, Licensed Clinical Psychologist (E) Brynn Carrigan, Director at KC Public Health (E) Cristina Castro, Recovery Specialist at KCBHRS (E) Valerie Civelli, MD at LTC Premier Valley Med. Group (E)	Babita Datta, MD OB/GYN at Wasco Medical Plaza (E) Minty Dillon, Administrator at Premier Valley Medical Grp (E) Laura Hasting, NP at Priority Urgent Care (E) Kristine Khuu, Assistant Director at Kern Regional Ctr. (E) Gina Lascon, DON at Delano SNF (E) Lito Morillo, Executive Director at KC Human Services (E)	Jasmine Ochoa, Manager at KC Public Health (E) Ashok Parmar MD, Pain Mgmt. (E) Cody Rasmussen, Administrator at Height Street SNF (E) Jennie Sill, Administrator at KCBHRS (E) Alejandra Vargas, BOM at Height Street SNF (E)
Staff Present:	Missy Clendenen, RN PHM LTC Case Manager Amy Daniel, Executive Health Services Coordinator Shellby Dumlao, Special Programs Nurse Consultant Pawan Gill, Health Equity Manager Russell Hasting, PHM Manager of CM Loni Hill-Pirtle, Director of ECM	Magdee Hugais, KHS Director of QI Diane Lay, RN, CCM, PHM Triage Nurse III Jacinto Marcelo II, Director of Special Programs John Miller, MD QI Medical Director Noehmi Morfin, RN PHM Clinical Auditor & Trainer Adriana Salinas, Director of Community & Social Services	Nate Scott, Senior Director of Member Services Melinda Santiago, Director of Behavioral Health Isabel Silva, Senior Director of Wellness & Prevention Elliott Smith, PHM Outreach Specialist Ty Williams, PHM Outreach Specialist

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Sukhpreet Sidhu, MD, KHS PHM Medical Director called the meeting to order at 11:05 AM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of September 4, 2024 were presented for review and approval.	☑ **ACTION**: Curt Williams moved to approve minutes of September 4, 2024, seconded by Paula De La Riva-Barrera. Motion carried.	*12/04/24*
OLD BUSINESS	There was no old business to present	N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	**<u>Welcome & Introduction</u>** **Committee Member Announcements:** Members and KHS Staff introduced themselves and from the facility/organization they are representing.	☑ **CLOSED**: Informational discussion only.	*12/04/24*
	<u>Review and Approval of Policy</u> The following PHM Policy and Procedures were presented as follows: • Initial Health Appointment • Indian Health Liaison • Long Term Plan of Care • Long Term Care Quality Assurance Performance Improvement	☑ **ACTION**: Curt Williams moved to approve the listed Policy and Procedures, seconded by Paula De La Riva-Barrera. Motion carried.	*12/04/24*
	<u>Maternal Access to Care</u> Russell Hastings, Manager of PHM Case Management, presented the Maternal Access to Care as follows: • Maternal Care Access in East Kern – Members in the East Kern Area have limited resources to maternal care providers, including prenatal and postpartum care as well as Labor and Delivery Services. • Develop Workgroup – Planning is being made to assess the population, of childbearing women ages 12-51 residing in the area, to analyze the existing health care infrastructure and develop a work plan to address these limited resources.		*12/04/24*
	<u>CCM Interdisciplinary Care Team</u> Diane Lay, PHM Triage Nurse III, presented the CCM Interdisciplinary Care Team staff roles and partnership with other agencies. This team of healthcare professionals will work together to manage physical, psychological and spiritual needs of the patient. The goals of this team are to support safe transition of members to a least restrictive environment to meet their health care needs; connect members to appropriate community resources; improve compliance with healthcare goals and provide more efficient cost-effective delivery system. Members will be identified through acute change in member conditions, social conditions, members who are non-improving, at member request and those identified in ER and Inpatient utilization.	☑ **ACTION**: Curt Williams moved to approve presented ICT Meeting Structure, seconded by Paula De La Riva-Barrera. Motion carried.	*12/04/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	**Open Forum** No additional items presented for discussion.	**N/A**	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, March 5, 2025 at 11:00 am	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 11:46 AM. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Quality Improvement Committee Minutes 12/04/24

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***UTILIZATION MANAGEMENT COMMITTEE***
DATE OF MEETING: ***DECEMBER 11, 2024***
CALL TO ORDER: ***12:05 PM BY MANINDER KHALSA, MD, UM MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Ashok Parmar, MD –Specialist Pain Medicine	Parikshat Sharma, MD – Outpatient Specialist	
Members Virtual Remote:	Maninder Khalsa, MD – KHS UM Medical Director		
Members Excused=E Absent=A	Philipp Melendez, MD – OB/GYN (E)		
Staff Present:	Linda Corbin, KHS Health Services Consultant (Remote) Amy Daniel, KHS Executive Health Services Coordinator Amanda Gonzalez, KHS Director of UM Kulwant Kaur, UM Outpatient Clinical Manager Yolanda Herrera, Credentialing Manager	Magdee Hugais, Director of Quality Improvement Loni Hill-Pirtle, Director of Enhanced Case Mgmt. John Miller, MD, QI Medical Director Christine Pence, Sr. Director for Health Services	Melinda Santiago, Director of Behavioral Health Nate Scott, Director of Member Services Sukhpreet Sidhu, MD, PHM Medical Director Isabel Silva, Director of Health & Wellness

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were not met as the composition as described in the committee charter are still in development and recruiting participating providers.	N/A
Call to Order	Dr. Maninder Khalsa, KHS UM Medical Director called the meeting to order at 12:02 PM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of September 11, 2024 were presented for review and approval.	☑ **ACTION**: Dr. Sharma moved to approve minutes of September 11, 2024, seconded by Dr. Parmar. Motion carried.	N/A
OLD BUSINESS	There was no old business to present.	N/A	N/A
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Dr. Khalsa welcomed the members of UM Committee.	☑ **CLOSED**: Informational only.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Policy Review and Approval Dr. Khalsa informed the committee that the following policy and procedures were revised and sent out prior to committee meeting for review and approval. • Policy 3.25-P Prior Authorization Services and Procedures • Policy 3.27-P Radiology Services • Policy 3.35-P On-Line Authorization Tool • Policy 3.50-P Medical Transportation • New Policy – Appropriate UM Staffing • New Policy – Inter-Rater Reliability • New Policy – Referral Systems Control • New Policy – Specialty Referral and Use of Board-Certified Consultants Members reviewed the policies presented and had no further discussion or input on these revisions and new policies.	☑ **ACTION**: Dr. Sharma moved to approve the policy and procedure revisions and the new policies that were presented, seconded by Dr. Parmar. Motion carried.	*12/11/24*
	UM Report 3rd Quarter 2024 Dr. Khalsa presented the Q3 2024 UM Report (Note: Report Cover page indicates Q4 however, date is from 3rd Quarter 2024). The following highlights were noted: • UM Timeliness of Decisions – KHS is at 99% for both Urgent and Routine compliance. • Outpatient Referrals – remain consistent and between current and last quarter. • Adult Referrals – remain consistent in comparison to past quarters. • Denial Percentage – July, August and September appear consistent at an average of 3% referrals denied. • IRR Q3 Results – All staff are able to complete the Q2 IRR Case studies for NCIC process in meeting our passing standards of 95% or higher.	☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members.	*12/11/24*

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION / CONCLUSIONS</th><th>RECOMMENDATIONS/ ACTION</th><th>DATE RESOLVED</th></tr>
<tr><td></td><td><u>UM/Internal Auditing Activities</u>
Dr. Khalsa reported on the UM Auditing Activities that included monitoring the process of referrals that have been delayed by the UM Department. A review of 10 files were reviewed for the month of July, August and September.
<table><tr><th></th><th>July</th><th>August</th><th>September</th></tr><tr><td>Total referrals for the month</td><td>33,078</td><td>33,431</td><td>31,109</td></tr><tr><td>Total referrals that were delayed</td><td>52</td><td>53</td><td>63</td></tr><tr><td>Percent of referrals delayed</td><td><1%</td><td><1%</td><td><1%</td></tr><tr><td>Audit sample size</td><td>10 referrals</td><td>10 referrals</td><td>10 referrals</td></tr></table>As part of the corrective actions, emails have been sent to staff reminding them to print all manual correspondence stored in JIVA to ensure letters are being sent.</td><td>☑ CLOSED: Report accepted as presented with no further discussion or questions from the committee members.</td><td>12/11/24</td></tr>
<tr><td></td><td><u>UM Criteria / DHCS Medi-Cal Provider Manual / MCG 28th Edition and Hayes</u>
The criteria UM uses to review requests were discussed. The DHCS Medi-Cal Provider Manual is primary with MCG as secondary when there is not applicable criteria in the Medi-Cal Provider Manual.</td><td>☑ ACTION: Dr. Sharma moved to approve the criteria, seconded by Dr. Parmar. Motion carried.</td><td></td></tr>
<tr><td>OPEN FORUM</td><td><u>Open Forum</u>
There were no further open items presented for discussion or comment by the committee members.</td><td>☑ CLOSED: Informational discussion only.</td><td>12/11/24</td></tr>
<tr><td>NEXT MEETING</td><td>Next meeting will be held Wednesday, March 7, 2025 at 12:00 PM</td><td>☑ CLOSED: Informational only.</td><td>N/A</td></tr>
<tr><td>ADJOURNMENT</td><td>The Committee adjourned at 12:45 PM
Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator</td><td>N/A</td><td>N/A</td></tr>
</table>

For Signature Only – Utilization Management Committee Minutes 12/11/24

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

To: EQIHEC

From: John Miller, M.D.

Date: March 18, 2025

Re: Quality Improvement Workgroup (QIW)

Background:
The 4th Quarter meeting of the KHS Quality Improvement Workgroup (QIW) took place on December 12, 2024. This committee operates within the new reporting structure, which reports to the Executive Quality Improvement Health Equity Committee (EQIHEC). Committee members include providers and representatives from the community. The meeting covered key updates on quality and safety initiatives, site review performance, appeals and grievances, NCQA accreditation progress, and Enhanced Care Management (ECM) developments.

Discussion:
During this session, quorum was met.

MCAS Performance Review:

Kailey Collier, Director of Quality Performance, presented the 3rd Quarter 2024 MCAS performance comparison to 2023, highlighting:

- 15 measures trending higher than the previous year.
- 3 measures with a lower compliance rate compared to 2023.
- 5 measures meeting Medium Performance Levels (MPL), with another 5 within 5% of MPL.
- Notably, three measures that previously never met MPL are now compliant.

Site Reviews:

- 11 initial Facility Site Reviews (FSRs) and 2 initial Medical Record Reviews (MRRs) were completed.
- 9 periodic FSRs and 9 periodic MRRs conducted, with 97% passing FSRs and 75% passing MRRs.
- 29 of 36 sites required corrective actions, which were completed and closed in Q3 2024.
- Dr. Ayala-Rodriguez emphasized the importance of provider training on MCAS expectations.

Quality of Service & Appeals:

- Kalpna Patel, QI Supervisor, presented Quality-of-Care Grievances and Potential Quality of Care Issues for Q3 2024.
- Appeals and claims disputes were reviewed, with a focus on resolving outstanding concerns.

NCQA Accreditation Progress:

- Steven Kinnison, NCQA Manager, provided an update on the 2024 NCQA Readiness Project, reporting:
    - 90% overall projected Health Plan Accreditation points (up 6%).
    - 63% Health Equity Accreditation points, reflecting a 4% increase.
    - Survey look-back dates and accreditation timeline updates were presented.

Quality Improvement Policies:

- The committee approved the retirement of several outdated QI policies and procedures.

Enhanced Care Management (ECM) Program Update:

- Dan Diaz, ECM Manager, reported that as of December 1, 2024, ECM enrollment had reached 10,715 members.
- Members are assigned across 38 ECM sites, stratified by geographic logic and population focus.

Conclusion & Next Steps:

- The **Q3 2024 Workplan Scorecard** was presented with no major concerns.
- No additional issues were raised during the open forum.
- The next QIW meeting is scheduled for March 2025

Fiscal Impact:

- None.

Requested Action:

- Review and approve.

KERN HEALTH SYSTEMS

COMMITTEE: ***QUALITY IMPROVEMENT WORKGROUP***
DATE OF MEETING: ***DECEMBER 12, 2024***
CALL TO ORDER: ***12:07 PM BY JOHN MILLER, MD, QI MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Danielle Colayco, PharmD, Executive Director Komoto Dr. John Paul Miller, KHS QI Medical Director, Chair	Dr. Michael Komin, Komin Medical Group	
Members Virtual Remote:	Carmelita Magno, Kern Medical Process Improvement Dir. Dr. Irving Ayala-Rodriguez, CSV		
Members Excused=E Absent=A	Jennifer Culbertson, Director of Clinical Quality CSV (E)		
Staff Present:	Kailey Collier, RN, Director of Quality Performance Lela Criswell, Member Engagement Manager Michelle Curioso, Director of PHM Amy Daniel, Executive Health Services Coordinator Mary Jane Dimaano, QI RN I Dan Diaz, RN, ECM Clinical Manager	April Dutton, QI RN I Pawan Gill, Health Equity Manager Amanda Gonzalez, Director of UM Greg Panero, PNM Analytics Program Manager Yolanda Herrera, Credentialing Manager Loni Hill-Pirtle, Director of Enhanced Case Management	Magdee Hugais, Director of QI Steven Kinnison, NCQA Manager Kalpna Patel, QI Supervisor Steve Pocasangre, NCQA Accreditation Specialist Adriana Salinas, Community Support Director Melinda Santiago, Behavioral Health Director

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were not met.	N/A
Call to Order	Dr. John Paul Miller, KHS QI Medical Director called the meeting to order at 12:07 PM.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. John Miller, presented the September 11, 2024 meeting minutes for approval.	☑ **ACTION**: Dr. Irving Ayala-Rodriguez moved to approve minutes of September 11, 2024, seconded by Dr. Michael Komin. Motion carried.	12/12/24
OLD BUSINESS	**No Old Business presented.**		N/A
NEW BUSINESS	**Quality & Safety of Clinical Care** **MCAS** Kailey Collier, Director of Quality Performance presented the 3rd	☑ **CLOSED**: Informational discussion only.	12/12/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Quarter 2024 MCAS 2024 vs. 2023 Comparison. The following highlights were noted: • 15 measures are trending higher than the previous year at the same point in time. • Three 3-mearsures have a lower compliance rate than 2023 • Five 5-measures are meeting Medium Performance Levels (MPL) • And five 5-measures are within 5% of the meeting MPL • More measures are meeting MPL than in the previous 4-years and 3-measures that never met MPL are now compliant. The following improvements and highlights efforts were noted: • Met MPL for 8 out of 18 measures: ◦ CBP, HBD, PPC-Pre, PPC-Post, AMR, BCS-E, CCS, and CHL • Met HPL for PPC-Post • 16 out of 18 measures showed improvement compared to previous year: ◦ CCS, HBD, CBP, IMA-2, PPC-Post, LSC, AMR, BCS-E, CHL, DEV, FUA, FUM, TFL, W30 (0-15), W30(15-30), and WCV. **Site Reviews** Kailey presented 11 initial facility site reviews (FSRs) and 2 initial medical record reviews (MRRs) were completed in Q3-2024. Nine 9-Periodic FSRs and 9-periodic MRRs were also completed with 97% of FSRs passing and 75% of MRRs passing. There were 29 of the 36-sites failed and Corrective Action Plans (CAPs) were completed and closed in Q3-2024.	☑ **FOLLOW-UP**: Dr. Ayala-Rodriguez commented on the importance of Kailey's presentation on MCAS as well as the importance for all providers to fully understand the expectation and possible trainings.	
	QUALITY OF SERVICE / APPEALS Kalpna Patel, QI Supervisor presented the Quality-of-Care Grievances and Potential Quality of Care issues for 3rd Quarter 2024. 	Quarter	Total Grievances Received for PQOC	Grievances Classified as PQOCs	Grievances Classified as Non-PQOCs	Total Grievances Closed
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Q3 2024	1007	598	409	2755		☑ **CLOSED**: Informational discussion only.	12/12/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED

Severity Level	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024
Level 0 - No Quality Concern	299	265	162	129	129	85	18
Level 1 - Potential for Harm	145	172	138	127	108	75	95
Level 2 - Actual Harm	2	4	2	2	0	2	0
Level 3 - Actual Morbidity	0	0	0	0	0	0	0
Total	446	441	302	258	237	162	113

Kalpna presented the following Appeals information:

	Q3 2024
Member Request	247
Provider Request	107
Unlabeled	2
Total	356

Kalpna presented the following Claims/Disputes information:

	Q3 2024
Inpatient	379
Outpatient	829
Total	1208

	<u>NCQA Accreditation</u> Steven Kinnison presented the 2024 NCQ Readiness Project Status Report. Some key accomplishments included: • HPA projected points now at 90% overall – Up by 6% • HEA points increased from 63% - Up by 4% Survey look back dates and project time line were also presented as informational.	☑ **CLOSED**: Informational/discussion only.	12/12/24

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION / CONCLUSIONS</th><th>RECOMMENDATIONS/ ACTION</th><th>DATE RESOLVED</th></tr>
<tr><td></td><td><u>QI Policies</u>
Dr. Miller presented the following list of retired Quality Improvement Policies to be retired as follows:
<table>
<tr><th>Policy #</th><th>I or P</th><th>Policy Name</th><th>2024 Review</th><th>Notes</th></tr>
<tr><td>2.01</td><td>P</td><td>General Exam Guidelines</td><td>Retired</td><td>Not needed in QI</td></tr>
<tr><td>2.21</td><td>P</td><td>Management of Biohazardous Waste</td><td>Retired</td><td>Incorporated into Policy 2.20</td></tr>
<tr><td>2.40</td><td>I</td><td>Enhanced Medical Home for SPDs</td><td>Retired</td><td>No longer a program at KHS</td></tr>
<tr><td>2.43</td><td>I</td><td>Pay-for-Performance Program</td><td>Retired</td><td>Per Contracts Department</td></tr>
<tr><td>2.51</td><td>I</td><td>Disease Management Staffing</td><td>Retired</td><td>No longer a program at KHS</td></tr>
<tr><td>2.52</td><td>I</td><td>Ethics Training for Disease Management Staff</td><td>Retired</td><td>No longer a program at KHS</td></tr>
<tr><td>2.53</td><td>I</td><td>Disease Management Outcomes Reporting</td><td>Retired</td><td>No longer a program at KHS</td></tr>
<tr><td>2.54</td><td>I</td><td>DM Program - Financial Outcomes Reporting</td><td>Retired</td><td>No longer a program at KHS</td></tr>
<tr><td>2.56</td><td>I</td><td>Communications with Treating Providers</td><td>Retired</td><td>PHM Responsibility</td></tr>
<tr><td>2.60</td><td>I</td><td>Case Management Case Closure Criteria</td><td>Retired</td><td>PHM Responsibility</td></tr>
<tr><td>2.61</td><td>I</td><td>KHS CM Documentation</td><td>Retired</td><td>PHM Responsibility</td></tr>
<tr><td>2.62</td><td>I</td><td>Case Management Ethics</td><td>Retired</td><td>PHM Responsibility</td></tr>
<tr><td>2.63</td><td>I</td><td>Case Management Provider Communication</td><td>Retired</td><td>PHM Responsibility</td></tr>
<tr><td>2.64</td><td>I</td><td>Case Manager Qualifications</td><td>Retired</td><td>PHM Responsibility</td></tr>
<tr><td>2.65</td><td>I</td><td>Case Management Assessment</td><td>Retired</td><td>PHM Responsibility</td></tr>
</table></td><td>☑ ACTION: Dr. Michael Komin moved to approve retirement of the noted QI Policy and Procedures, seconded by Dr. Irving Ayala-Rodriguez. Motion carried.</td><td>12/12/24</td></tr>
<tr><td></td><td><u>Enhanced Care Management</u>
Dan Diaz ECM Manager presented the ECM 3rd Quarter Report. The following highlights were noted:
As of December 1st, 2024, ECM had a total of 10,715 members currently enrolled in ECM
Members are stratified into 38 ECM sites via geographic logic and are assigned into the above distinct populations of focus</td><td>☑ CLOSED: Informational only.</td><td>12/12/24</td></tr>
<tr><td></td><td><u>Workplan Scorecard – Q3 2024</u>
The Q3 scorecard was presented with no concerns.</td><td>☑ ACTION: Carmi Magno moved to approve retirement of the noted QI Policy and Procedures, seconded by Dr. Michael Komin. Motion carried.</td><td></td></tr>
<tr><td>OPEN FORUM</td><td><u>Open Forum</u>
No additional questions or issues were presented for open forum.</td><td>☑ CLOSED: Informational only.</td><td>N/A</td></tr>
<tr><td>NEXT MEETING</td><td>Next meeting will be held Wednesday, March 7, 2025 at 12:00 pm</td><td>☑ CLOSED: Informational only.</td><td>N/A</td></tr>
<tr><td>ADJOURNMENT</td><td>The Committee adjourned at 1:05 PM.
Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator</td><td>N/A</td><td>N/A</td></tr>
</table>

For Signature Only – Quality Improvement Committee Minutes 12/12/24

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

To: EQIHEC

From: John Miller, M.D.

Date: March 18, 2025

Re: Quality Improvement Workgroup (QIW)

Background

The 1st Quarter meeting of the KHS Quality Improvement Workgroup (QIW) took place on March 7, 2025. This committee reports to the Executive Quality Improvement Health Equity Committee (EQIHEC). Committee members include providers and representatives from the community. The meeting covered key updates on quality and safety initiatives, site review performance, appeals and grievances, NCQA accreditation progress, and Enhanced Care Management (ECM) developments.

Discussion

During this session, quorum was met.

2024 Quality Program Evaluation, 2025 Quality Improvement Health Equity Program Description, and 2025 Quality Improvement Work Plan

Magdee Hugais, Director of Quality Improvement, presented the three documents for review and feedback. They will be next presented to the EQIHEC March meeting.

- The 2024 Quality Program Evaluation assesses the effectiveness of the QI Program in enhancing member health outcomes, ensuring regulatory compliance, and promoting health equity. It reviews governance, departmental changes, performance metrics, clinical care quality, safety, service quality, and member experience. Key achievements include meeting 26 of 28 program goals, improving several Managed Care Accountability Set (MCAS) measures, and enhancing provider engagement and member outreach. However, challenges remain in meeting minimum performance levels for select quality measures and timely grievance resolutions.
- The 2025 Quality Improvement Health Equity Program (QIHEP) Description outlines the organization's commitment to improving health outcomes, reducing disparities, and ensuring equitable care for Medi-Cal members in Kern County. It provides an in-depth framework for quality improvement, including governance, program scope, goals, and responsibilities of key committees and departments. The document highlights efforts to address social determinants of health (SDOH), expand provider networks, and enhance culturally competent care. Key initiatives include data-driven quality improvement projects, member engagement strategies, and oversight of performance metrics such as

Managed Care Accountability Set (MCAS) measures. The program integrates clinical and non-clinical approaches to promote whole-person care, with a strong emphasis on health equity, member satisfaction, and continuous performance evaluation.

- The 2025 QI Work Plan lists the Key Performance measures with measurable goals for the year. The domains of the plan include program structure, quality and safety of clinical care, quality of service, and member and provider satisfaction.

MCAS Performance Review

Kailey Collier, Director of Quality Performance, submitted the 4th quarter report.

- Currently meeting MPL for 6 out of 18 measures:
  - PPC-Pre, IMA, LSC, AMR, BCS-E, CHL
- Within 5% of MPL for 6 additional measures
  - CCS, CIS-10, W30(15-30), WCV, TFL-CH, PPC-Post
- 9 out of 18 measures showing improvement compared to previous year.

Quality Improvement Report

Magdee Hugais, Director of Quality Improvement, submitted the 4th quarter report.

- Data on Quality-of-Care Grievance, Potential Quality Issues, Appeals, Claims & Disputes, Initial Health Appointment audits, and lead screening in Children audits was included.

Member Satisfaction Results Report

Lela Criswell, Manager of Member Engagement submitted the results of the Member satisfaction report.

NCQA Accreditation Progress

Steven Kinnison, NCQA Manager, provided an update on the 2025 NCQA Readiness Project, reporting:

- Survey date for Health Plan Accreditation is April 8, 2025
- Survey date for Health Equity Accreditation is June 10, 2025.
- Overall projected points are at 91% for HEA and 98% for HEA.

Quality Improvement Policies

- No policies for approval.

Enhanced Care Management (ECM) Program Update

Dan Diaz, ECM Manager, presented 4th Quarter ECM report.

- Cost-Saving Measures: ECM focused on improving transitions of care to reduce avoidable emergency department (ED) and inpatient utilization, with a 57.7% reduction in ED visits per 1,000 members from Q3 to Q4.
- Clinical Quality Metrics: ECM tracked MCAS measures, prioritizing cervical cancer screening (CCS), breast cancer screening (BCS), and diabetes care (HBD). CCS compliance increased by 4.4%, BCS by 2.7%, but non-compliance in diabetes management rose by 11%.
- Patient Satisfaction & Grievances: ECM deployed a member experience survey and closely monitored grievances. ECM-related grievances increased by 23.8% from Q3 to Q4, though preliminary 2025 data showed no active grievances.

Cultural and Linguistics Monitoring Q4 Report

Cynthia Cardona, W&P Manager, presented 4th Quarter report. Key highlights include:

- Bilingual Staff Call Audits: 30 Spanish-language calls were audited, with 100% of staff reporting no communication difficulties with non-English-speaking members.
- Post-Call Surveys: 9,943 Spanish-language post-call surveys were completed, showing a 97% satisfaction rate with bilingual staff's linguistic performance.
- Vendor Bilingual Call Audits: 91 calls from vendors (e.g., American Logistics, Vision Services, Harte Hanks) were reviewed, with 98% of bilingual staff demonstrating effective communication.
- Interpreter Call Monitoring Audit: 30 Over-the-Phone Interpretation (OPI) calls in Mandarin, Punjabi, Spanish, Cantonese, Yemeni Arabic, Vietnamese, Nepali, and Khmer were assessed, with 100% of calls meeting expectations.

Member Wellness and Prevention Program Monitoring Q4 Report

Flor Del Hoyo Galvan, W&P Manager, presented 4th Quarter report. Key highlights include:

- Service Audit Results:
    - Areas achieving 100% compliance:
        - Classes started on time.
        - Member sign-ins were completed.
        - Instructors provided clear examples for topics, concepts, or myths.
        - All planned activities were explained and completed.
    - Areas needing improvement (below 50% compliance):
        - Coverage of SMART (Specific, Measurable, Achievable, Relevant, Time-bound) goals and objectives.
- Satisfaction Survey Highlights:
    - Positive Feedback:
        - Members appreciated the delivery, tone, and teaching style of instructors.
        - Learning about healthy eating habits, food substitutions, and general health topics was valued.
        - Content was relevant and easy to understand.
        - A supportive environment made participants look forward to attending.

- Suggested Improvements:
  - More interaction and engagement in classes.
  - Expansion of topics covered.
  - Adjustments to class structure or format.
  - Consideration of incentives or rewards to encourage participation.

2024 Work Plan Scorecard

Magdee Hugais, Director of Quality Improvement, submitted the 4th quarter scorecard.

Conclusion & Next Steps

- No additional issues were raised during the open forum.
- The next QIW meeting is scheduled for May 22, 2025

Fiscal Impact
None.

Requested Action
Approval of committee proceedings.

To: EQIHEC

From: Isabel Silva, Senior Director of Wellness and Prevention

Date: March 18, 2025

Re: 3rd and 4th Quarter 2024 Wellness & Prevention Department Reports

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Background

KHS' contract with the DHCS requires that it implements evidence-based wellness and prevention programs inclusive of a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all members. The contract also requires that KHS have a Cultural and Linguistic Services Program and that KHS monitors, evaluates and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services.

Discussion

Enclosed are the quarterly Wellness and Prevention Department reports summarizing all activities performed during the 3rd and 4th quarters of 2024:

- Q3 2024 Wellness & Prevention Activities Report
- Q3 2024 Cultural and Linguistic Services Activities Report
- Q4 2024 Wellness & Prevention Activities Report
- Q4 2024 Cultural and Linguistic Services Activities Report

Fiscal Impact

- None.

Requested Action

- Approve and file.

Executive Summary

Report Date: November 1, 2024

OVERVIEW

Kern Health Systems' Wellness and Prevention (WP) department provides comprehensive evidence-based services to plan members with the intent of promoting healthy behaviors, improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care. The Executive Summary below highlights the larger efforts currently being implemented by the WP department followed by the ongoing activity for Q3 2024.

1. Community Health and Wellness

- Live Better Program – The community of Delano continues to have over 100 attendees participating in Zumba or Yoga classes each month. KHS has partnered with Greenfield Family Resource Center to offer Zumba classes starting in October. KHS has also partnered with Danica's School of Dance to offer Zumba, Yoga and Hip-Hop dance classes in Lake Isabella and Kernville starting in December. The Kern River Valley Family Resource was trained by KHS to facilitate KHS' Diabetes Prevention Program.
- The 2024-2026 School Wellness Grant Cycle opened on September 6, 2024. Communities of focus will include Wasco, Shafter, Rosamond, Tehachapi, Ridgecrest, Mojave, rural areas and schools working with special needs populations. Applications will be accepted through October 15, 2024.
- The Community Health and Wellness team participated in 56 community events to strengthen presence and promote the wellness and prevention services. Events included facilitation of community health education classes for the Children First Splash Event and the Deaf and Hard of Hearing Children of Color, participation in the Kern Health Equity Partnership Community Health Conversations and the Kern Immunization Coalition and attendance at school events such as the Edison School District Attendance Summit.

2. Wellness & Prevention Partnerships

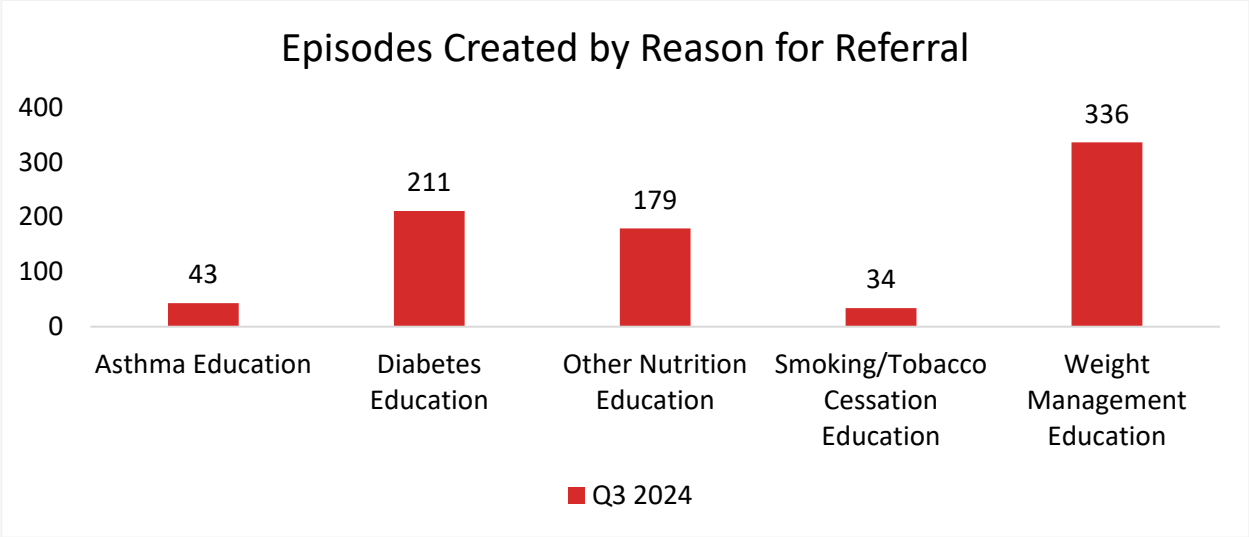
- 3rd Party Memorandums of Understanding (MOUs) are required under KHS' contract with DHCS. The MOUs are intended to enhance care coordination and improve the quality of care to members. The WP department continues to lead this county MOU execution effort with Kern Public Health, Aging & Adult Services, Kern Regional Center, Kern County Human Services, Kern County Probation, and Women, Infant and Children (WIC). In Q4, KHS anticipates executing MOUs with Kern Public Health, CSV WIC and Kern County Probation.
- The Department of Health Care Services requires KHS to have a tribal liaison dedicated to working with Indian health care providers and coordinating referrals and services for American Indian KHS members. KHS and the Bakersfield American Indian Health Project have interviewed and hired a new team member to serve as KHS' tribal liaison to better understand and meet the needs of members.

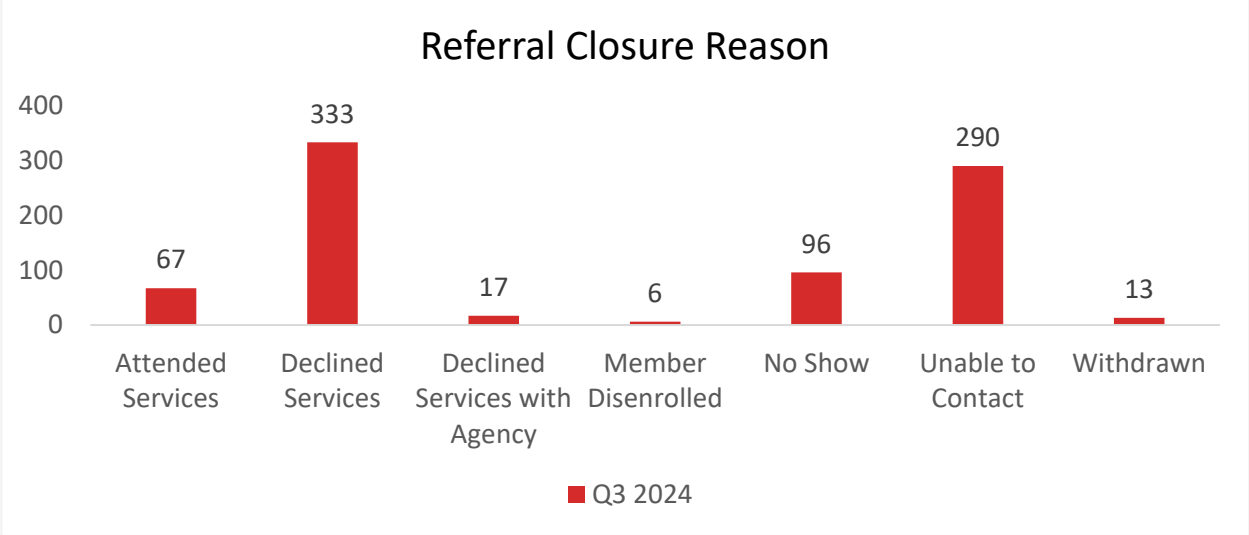
Respectfully submitted,
Isabel Silva, MPH, CHES
Senior Director of Wellness and Prevention

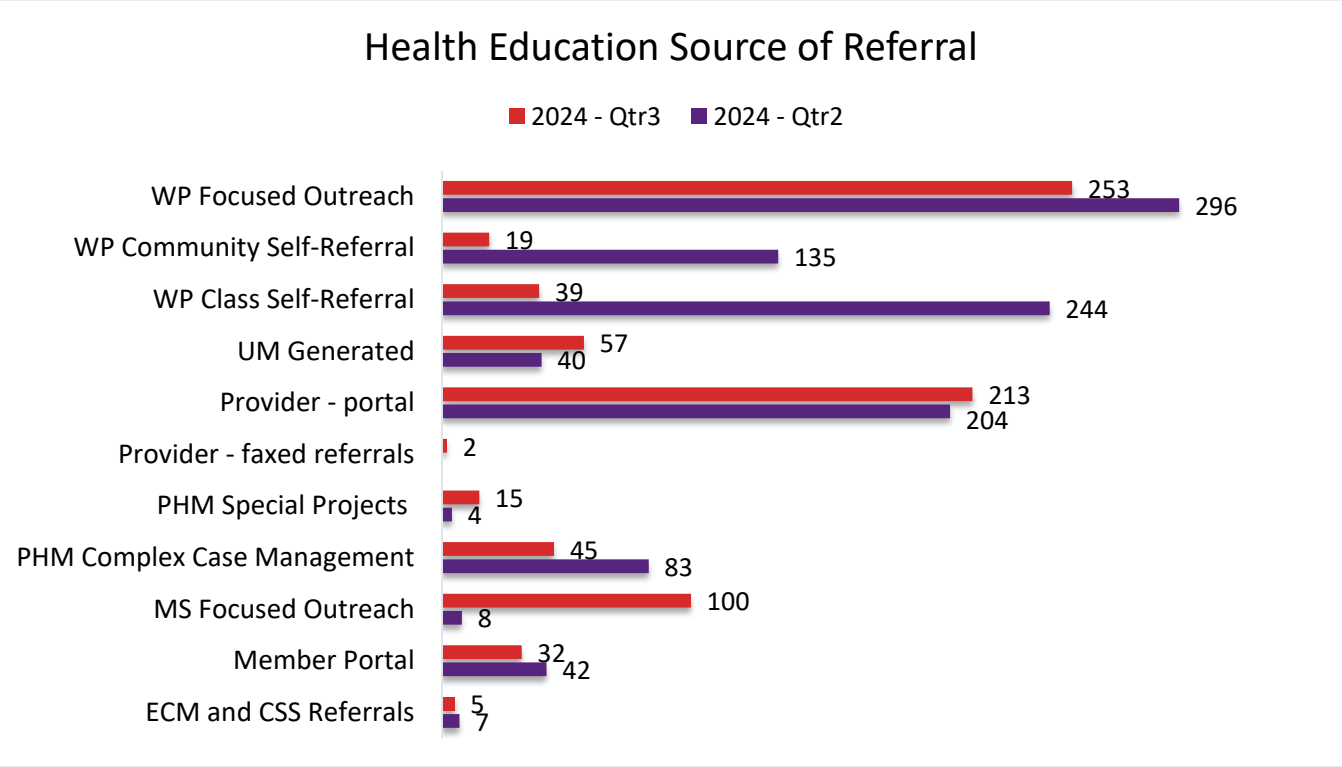
Member Wellness and Prevention

Health Education Referrals

During Q3, there were 1,017 referrals for Member Wellness and Prevention (MWP) services which is a 9% decrease in comparison to the previous quarter. In Q3, the MWP team directed outreach efforts to register members for the Diabetes Prevention Program and Diabetes Empowerment Education Program virtual classes hosted by the California Health Collaborative (CHC). Outreach for CHC-provided services was focused on the outlying communities and members 35-49 years of age who are more likely to use virtual services or have greater barriers related to distance and transportation. Additionally, the health education class service acceptance rates decreased by 16% between Q2 to Q3 whereas the received services rate decreased from 3% in Q2 (43%) to Q3(40%). The decrease observed in Q3 may be due to seasonal trends considering summer travel and back to school.

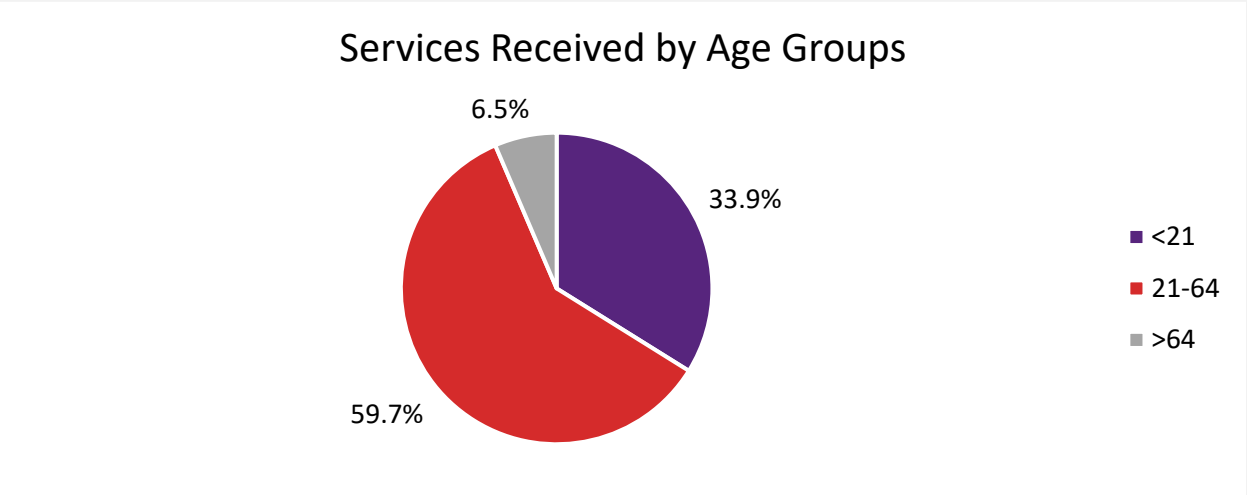


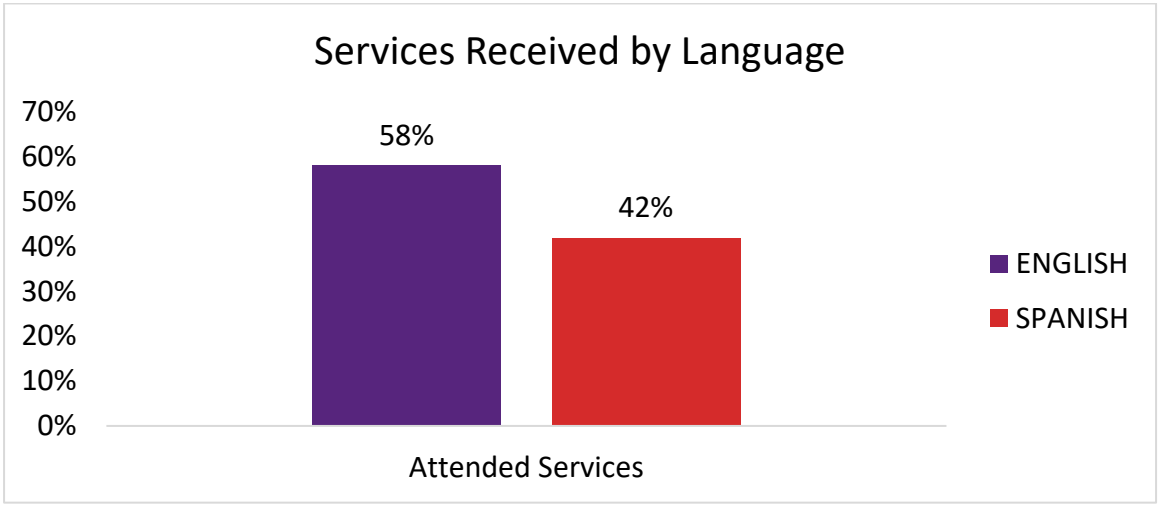


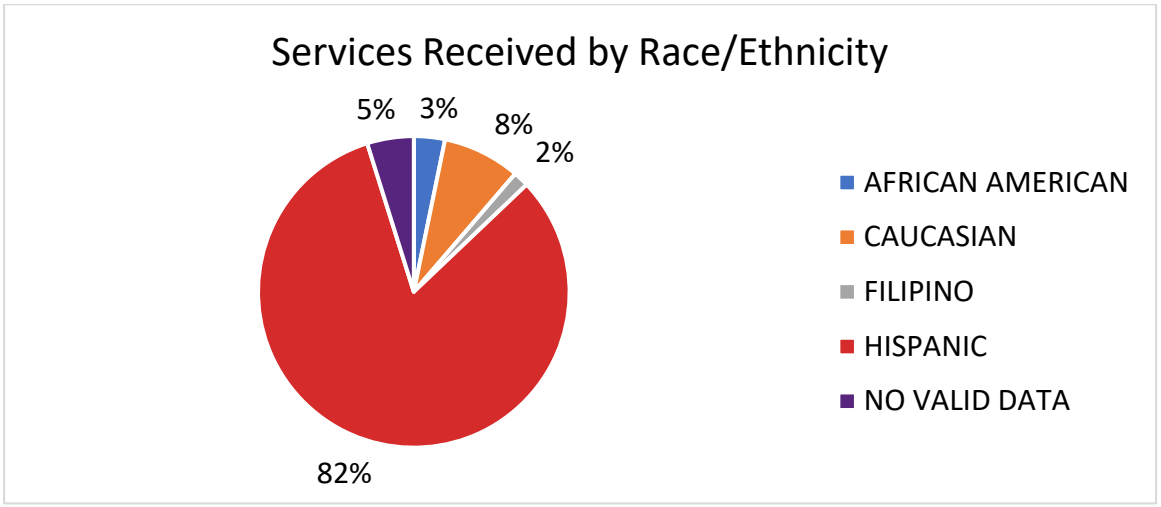


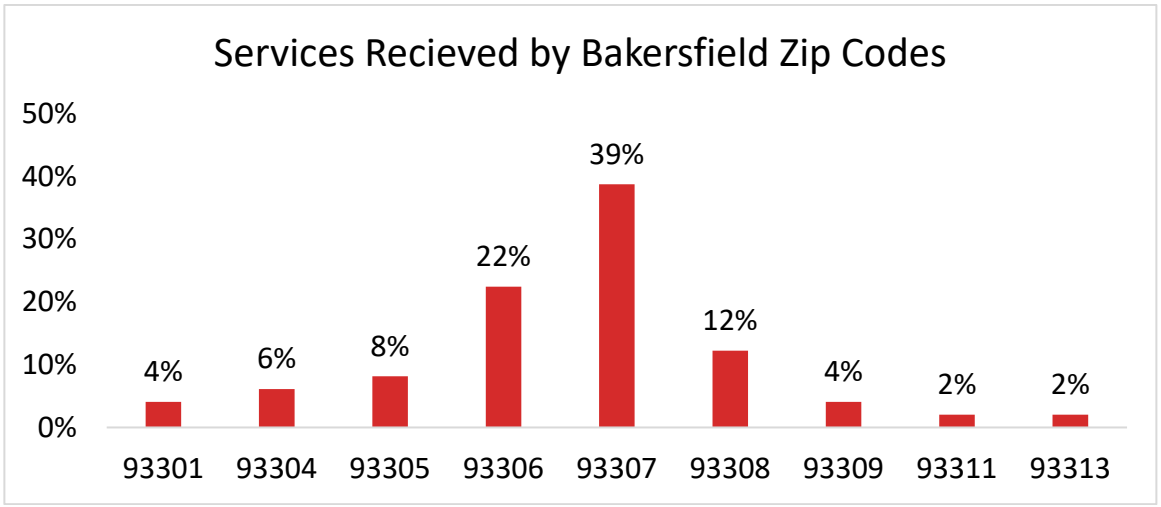
Demographics of Members

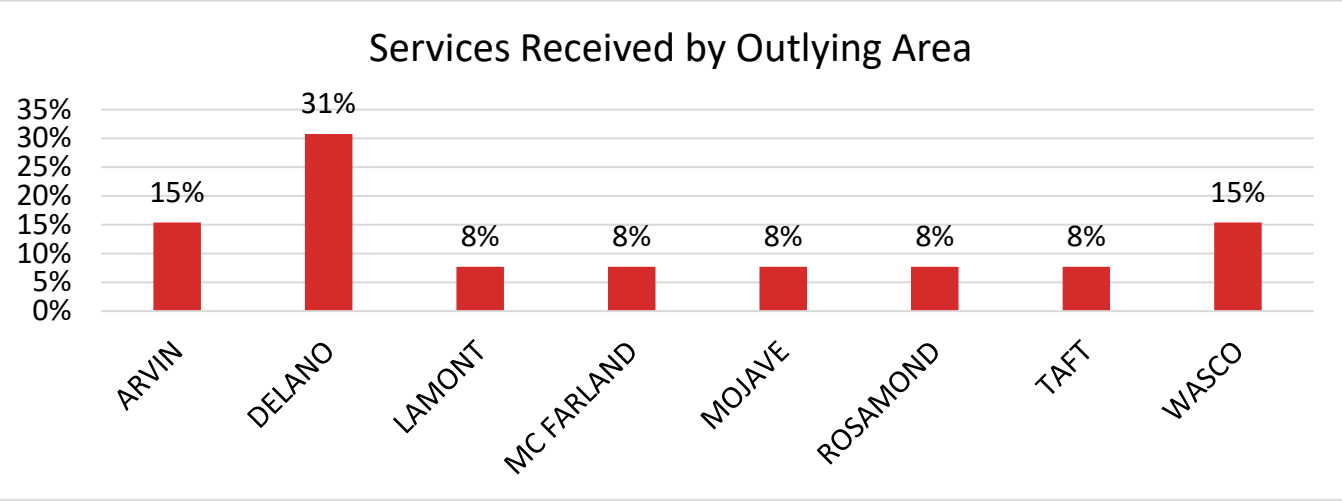
KHS provides services to a culturally and linguistically diverse member population in Kern County. Of the members who received services, the largest age groups were 21-64 years (59.7%) followed by members under 21 years of age (33.9%). A breakdown of member classifications by race and language preferences revealed that many members who received services are Hispanic and preferred to receive services in English. Most members who received services reside in Bakersfield with the highest concentration in the 93307 area and Delano in the outlying areas of the county. Our English-speaking population has a higher attendance rate in comparison to our Spanish population that has a higher no-show rate this quarter compared to Q2.




Services Received by Language
70%
60%
50%
40%
30%
20%
10%
0%
58%
42%
ENGLISH
SPANISH
Attended Services


Services Received by Race/Ethnicity
5%
3%
8%
2%
82%
AFRICAN AMERICAN
CAUCASIAN
FILIPINO
HISPANIC
NO VALID DATA

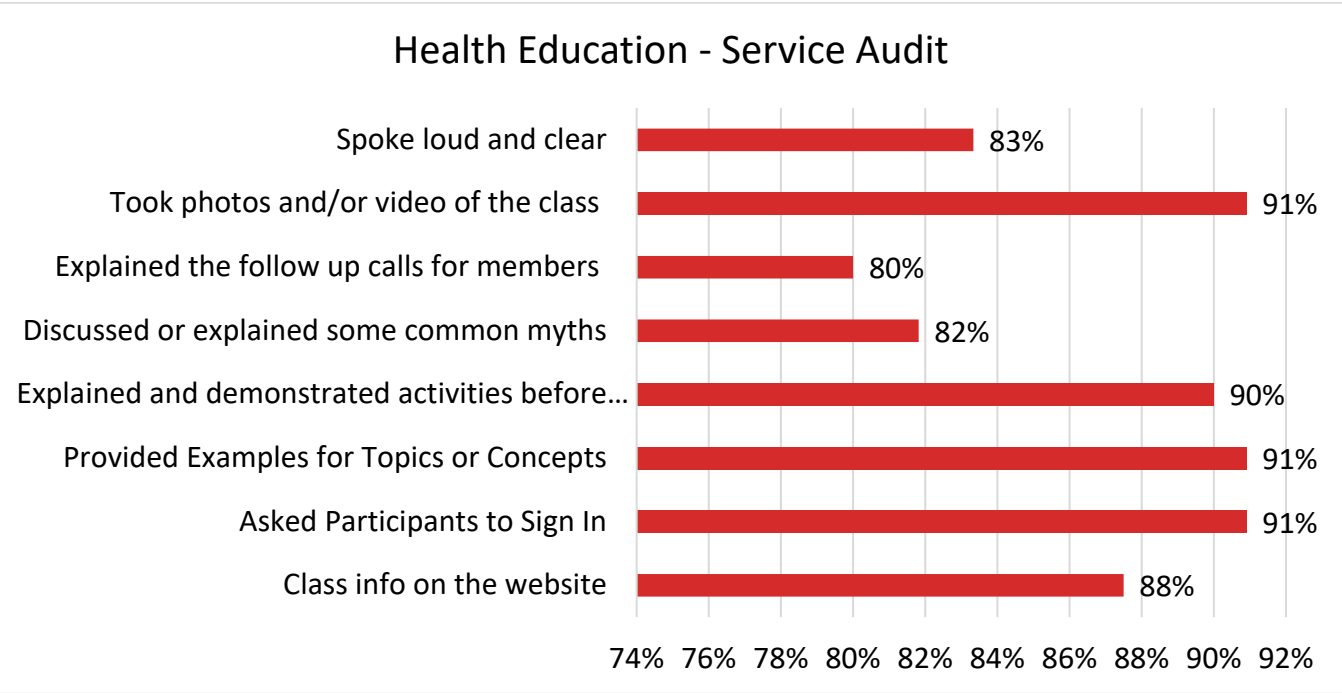

Services Recieved by Bakersfield Zip Codes
50%
40%
30%
20%
10%
0%
4%
6%
8%
22%
39%
12%
4%
2%
2%
93301
93304
93305
93306
93307
93308
93309
93311
93313



Health Education Class Service Audit

The Health Education Class Service Audit Tool considers a variety of markers to determine the quality of Health Education Class Services being provided to members. It includes observations on planning and preparation, implementation and delivery, and member engagement during health education classes.

In Q3, class facilitators demonstrated mastering preparing for the class, encouraging members to ask questions, and completing administrative tasks. In addition, the facilitators reached 100% in the following areas: covering SMART goals, doing all planned activities and covering all information, thereby demonstrating improved time management skills. Areas of improvement for next quarter are: starting and ending class on time and using various teaching methods . During Q3, 0 items were observed to fall below the 50% mark.



Health Education Class Evaluations

Health Education classes include an evaluation questionnaire for participants. The questionnaire is provided at the end of the class. Below is an analysis of the findings from open-ended questions in Q3 for 2024.

What did you like most about the class?

More than 95% percent of participants who responded expressed great satisfaction in the workshops and suggested no change, and that instructors were very effective and engaging.
More than half of members who responded:

- Expressed high levels of satisfaction with the class, appreciating both the overall experience and the instructors.
- The clarity of explanations and effective communication of concepts made the material easy to understand.
- The content was found to be relevant and informative, which made the classes easy to understand.
- Interactive and engaging elements such as quizzes and discussions were highly appreciated for enhancing participation.
- Valued the supportive environment and the opportunity to connect with others in similar situations while building community.

How could we improve the class?

Members responded:

- Feedback highlights the clarity of instruction, with many feeling the content is well-explained and perfectly presented.
- Activity & Eating program respondents requested for longer sessions to allow for more in-depth exploration of topics.
- Participants desire increased engagement through more interactive activities, such as polls, games, quizzes, and discussions.
- Suggestions include providing more diverse content, such as recipes and information on healthier food choices.

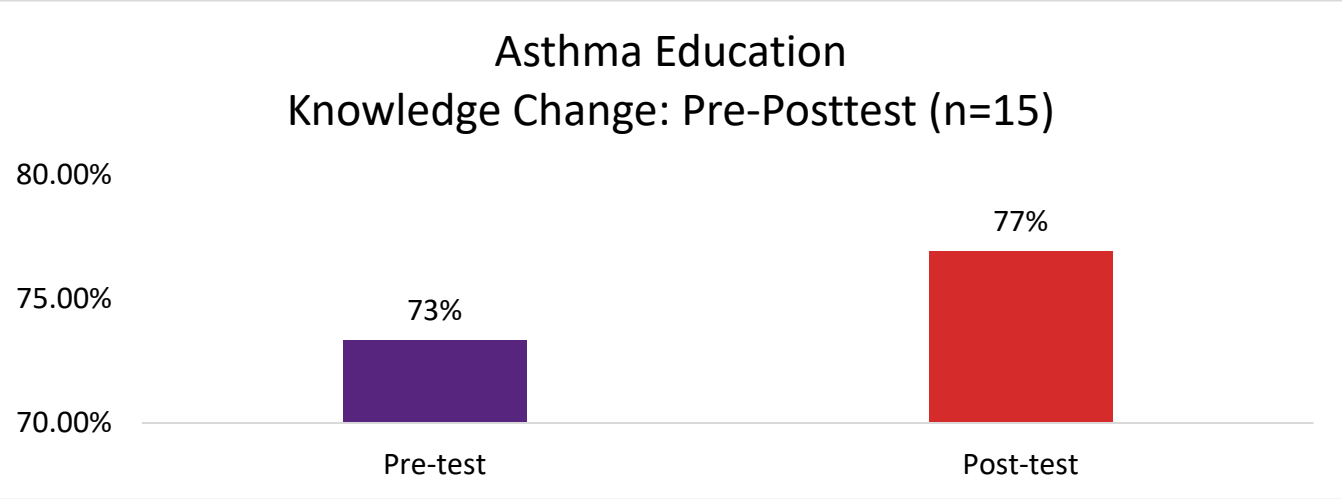
In addition, members referred to the Kick It California (KIC) Quitline are surveyed to gauge satisfaction with this service. 0 members accepted services to KIC in Q3.

Health Education Class Effectiveness

Asthma: Breathe Better

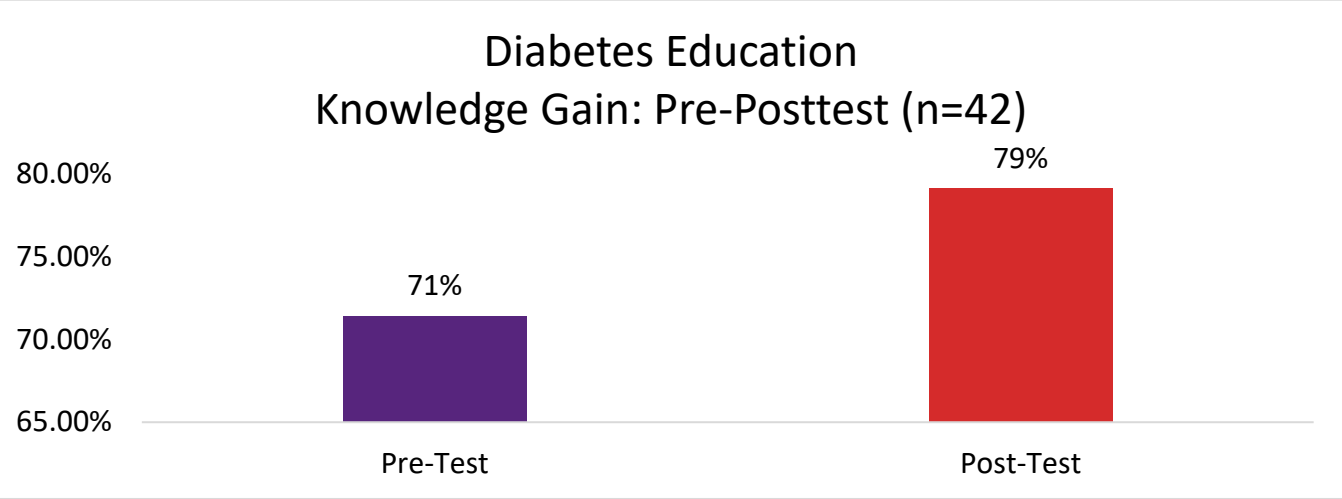
The asthma education program consists of 2 classes and at least 2 follow-up calls. A pre and posttest questionnaire is distributed per series. During Q3, findings revealed there was an average 4 percentage point increase in knowledge gained after completing the series. The largest increase in understanding was understanding that there is no cure for asthma, controlling asthma when exercising, understanding if attacks always occur suddenly without warning, and in reducing

environmental asthma triggers.



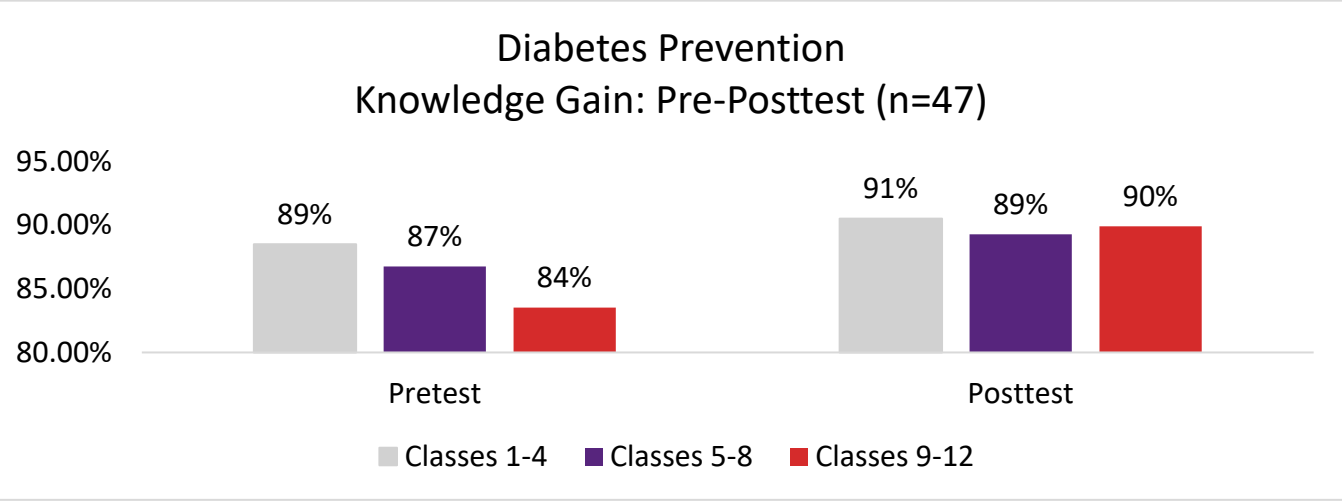
Diabetes Empowerment Education Program: DEEP

DEEP is a diabetes self-management program that has been shown to be successful in helping participants take control of their disease and reduce the risk of complications. The program was developed for low-income, racial and ethnic minority populations. During Q3, findings revealed an 8-percentage point increase in knowledge when comparing members who completed a pretest (average 71% correct answers) to members who completed a posttest (average 79% correct answers).



Diabetes Prevention Program

The National DPP aims to simplify access to an affordable, high-quality lifestyle change program for individuals with prediabetes or those at risk of type 2 diabetes. The program helps lower their chances of developing type 2 diabetes and enhances their overall health. In Q3, 47 members completed a pre- and posttest. There was an average 4 percent-point increase in knowledge gain for the first 12 classes, an average 86% correct answers at pre-test to members who completed a posttest (average 90% correct answers).



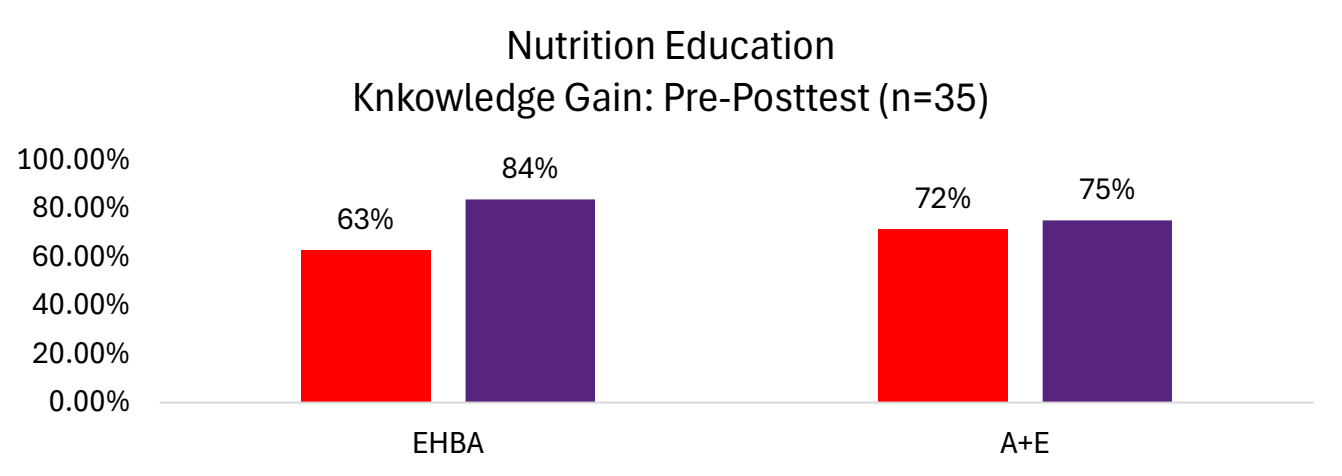
Nutrition and Weight Management: Eat Healthy, Be Active (EHBA)/Activity & Eating (A+E)

The nutrition and weight managed program include two curriculums that focus on creating healthy habits around eating and physical activity to reduce the risk of chronic illness among the KFHC members and Kern County population. In September 2023, the Eat Healthy, Be Active curriculum, a 6-class series, along with the Activity & Eating one-time class were launched. Each class lasts about 90 minutes. Evidence shows that these programs can positively impact behavior around physical activity and nutrition. A pre and posttest questionnaire is distributed per class.

During Q3, findings revealed that among those members who completed the core pre and posttest for both programs, there was an average 12-percentage point increase in knowledge gained after completing classes.

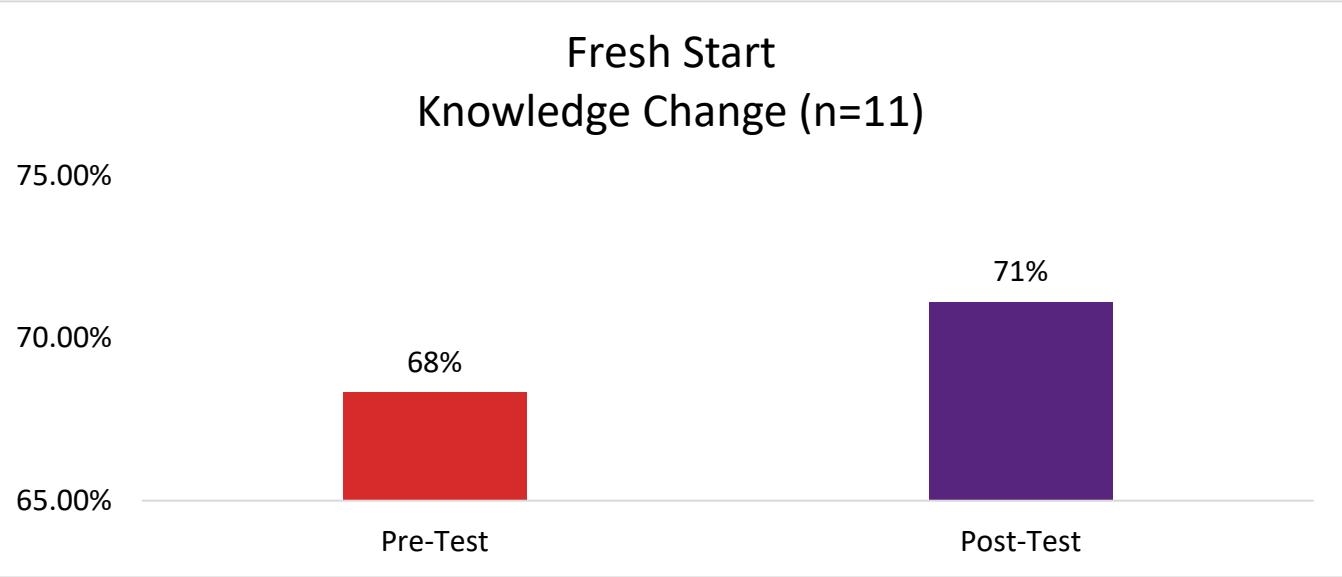
- Members who completed a pretest scored an average of 67% in correct answers.
- Members who completed a posttest scored an average of 79%.
- The largest increase in knowledge from pre- to posttest was observed among members who attended the Eat Healthy, Be Active course (6 classes).

There was also an increase in awareness on the relationship of calorie intake and physical activity, and the five recommended food groups.



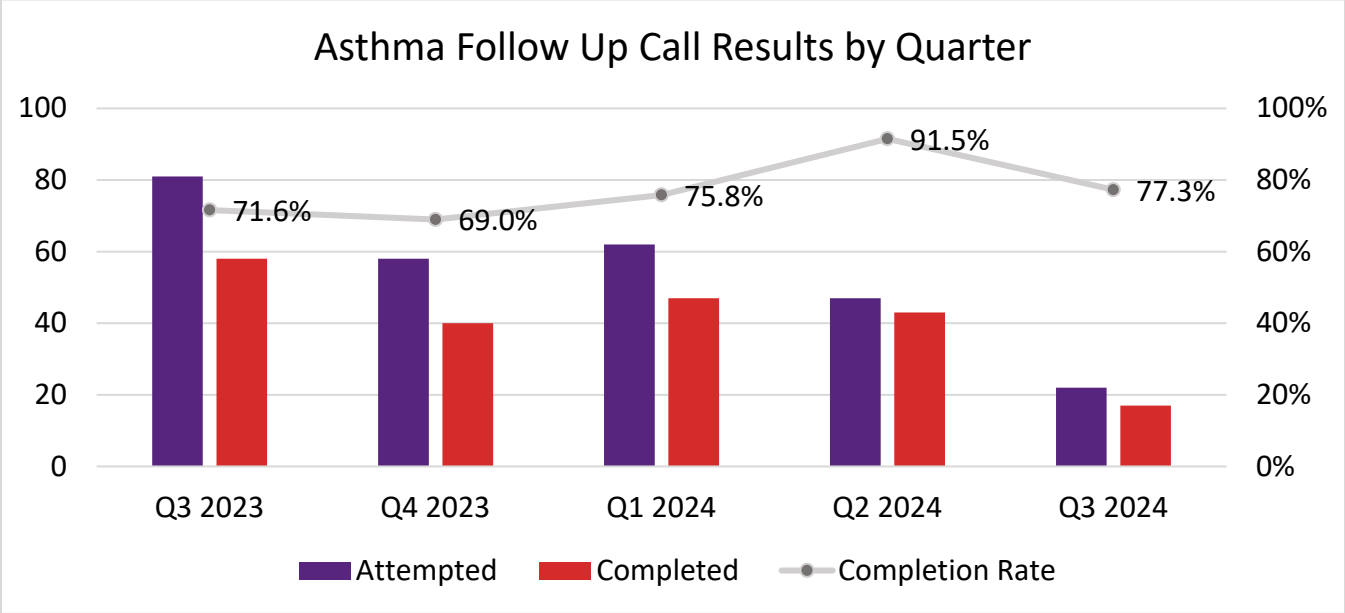
Smoking/Tobacco Cessation: Fresh Start

The Fresh Start program has the goal of reducing harm from tobacco products. Knowledge tests are implemented each series. In Q3, 13 members completed a pre- and posttest, with a total of 20 tests completed during this period. There was an average 3-percent point knowledge gain increase between all responses. Members appear to gain knowledge on committing to a quit date, and Nicotine Replacement Therapy. More emphasis is needed in learning about and having a quit plan and understanding withdrawal symptoms.



Chronic Disease Prevention and Management: Asthma Education Effectiveness

Members who have attended the KFHC Breathe Better Asthma Classes are offered asthma follow up calls. These calls occur at 1 month, 3 months, and 6 months (optional or only if needed) after attending the classes. During the follow up call, members are screened to determine if asthma symptoms are well controlled using the Asthma Control Test (ACT) screening tool. An ACT score of 20 or higher is an indicator of well controlled asthma. During Q3 2024, 77.3% of members completed an asthma follow up call. There was a decrease to 91.5% during the previous quarter. There was an improvement in average ACT score for that age group when comparing the initial assessment to the 3 month follow up. There was no data found for 1 month and 6 month follow up calls.

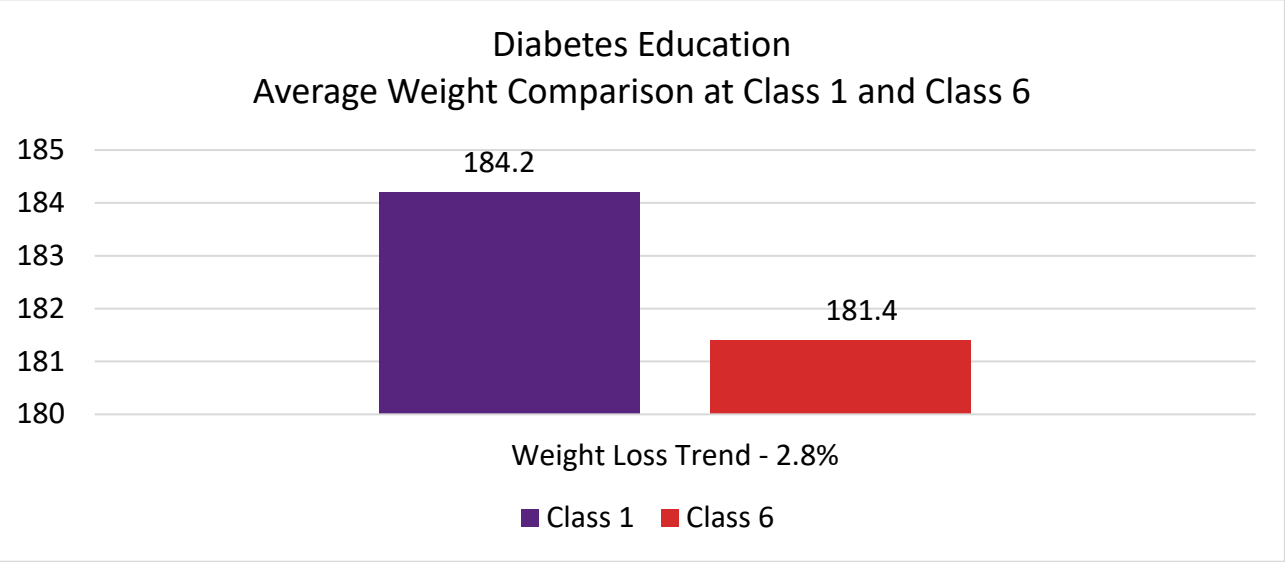


Q3 2024 Average ACT Scores During Asthma Follow Up Calls

Call Month	<12 years of age	12+ years of age
Initial	18.2	13.4
1	No data	No data
3	20	17.8
6	No data	No data

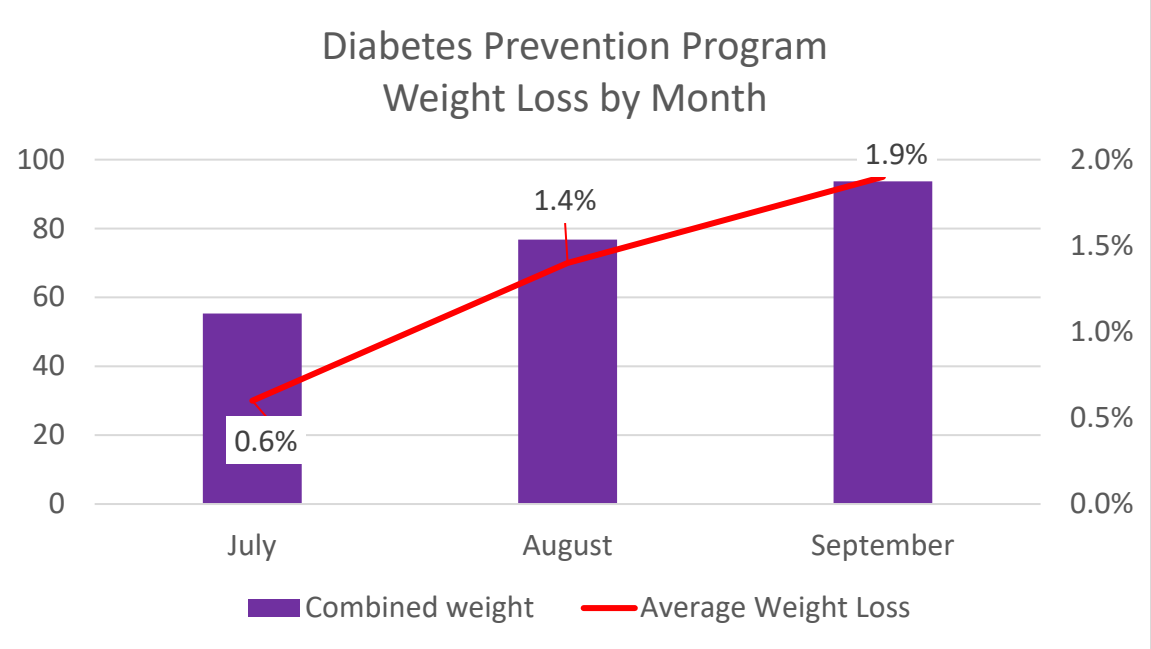
Chronic Disease Prevention and Management: Diabetes Empowerment Education Program

Members who participate in DEEP are weighed in at every class as one way to measure program impact. The bar chart below compares the average weight of participants before and after attending the DEEP program, for class 1 and class 6 during Q3. Overall, the data shows that participants experienced an average weight loss of almost three percentage (3%) points, suggesting that behavior modifications and recommendations presented during the series are effective.



Chronic Disease Prevention and Management: Diabetes Prevention Program

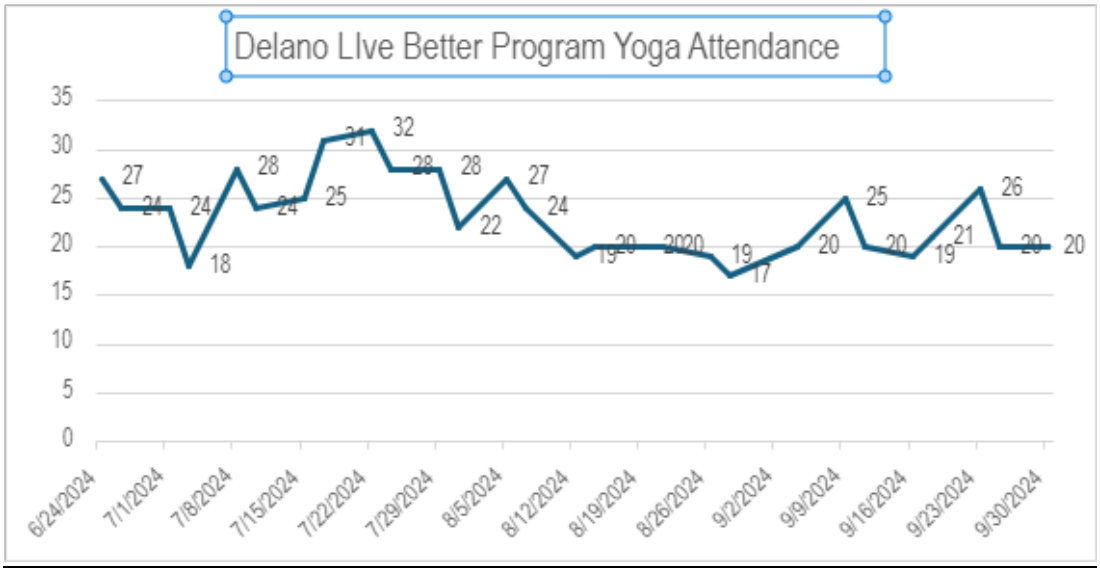
Members who participate in DPP are weighed in at every class as one way to measure impact. Weight loss totals and percentages that compare initial combined cohort weight with combined weight at the end of each month. Q3 2024 weigh-ins are shown in the chart below. By the end of Q3 2024, 23 members were enrolled in the English DPP cohort with an average weight loss of 1.9%. There was no Spanish DPP series being offered in Q3 2024.

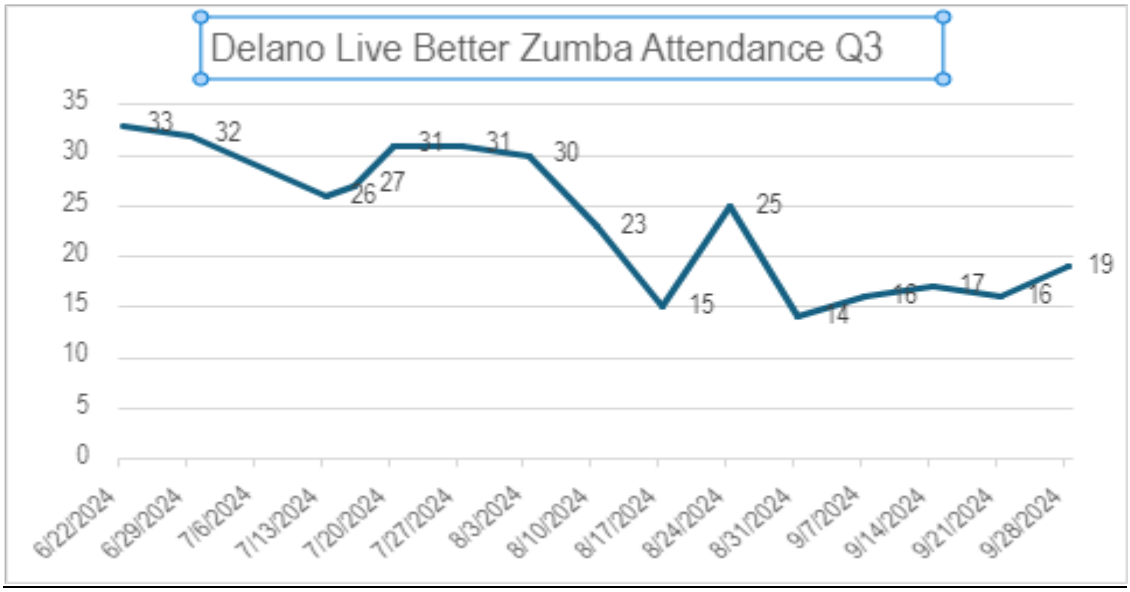


Community Health and Wellness

Live Better Program

The average daily yoga class attendance in Delano was 23.1 participants in Q3 compared to 26 participants in Q2 2024. The average daily Zumba class attendance was 23.6 participants in Q3 compared to 28.7 participants in Q2 2024.





Kern Health Systems
Cultural & Linguistic Services Activities Report
3rd Quarter 2024

Executive Summary

Report Date: October 22nd, 2024

OVERVIEW

Kern Health Systems' Cultural and Linguistic (C&L) Services Program helps ensure that comprehensive, culturally, and linguistically competent services are provided to plan members with the intent of improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care. The Executive Summary below highlights the larger efforts currently being implemented by the C&L Team. Following this summary reflects the statistical measurements for the C&L Services Program detailing the ongoing activity for Q3 of 2024.

1. Interpreter Requests

- Language Breakdown:
  - ✓ Top OPI languages
  - ✓ Top Onsite languages
  - ✓ Top VRI languages

2. Service Monitoring

- Linguistic Performance:
  - ✓ Written translations
  - ✓ 100 % Vendor Over-the-Phone (OPI) Interpreter Call Monitoring
  - ✓ 99% members satisfaction with bilingual KHS staff communications
  - ✓ 99% of KHS calls, and 98% of vendor calls reviewed did not have difficulty communicating with members in a non-English language.
  - ✓ 100% members satisfaction with in-person interpreter
  - ✓ 99% members satisfaction with telephonic interpreter
  - ✓ 97% members satisfaction with KHS and vendor translations
  - ✓ 98% KHS staff satisfaction with vendor Over-the-Phone Interpreter (OPI) communications

Respectfully submitted,

Isabel Silva, MPH, CHES
Senior Director of Wellness and Prevention

Kern Health Systems
Cultural & Linguistic Services Activities Report
3rd Quarter 2024

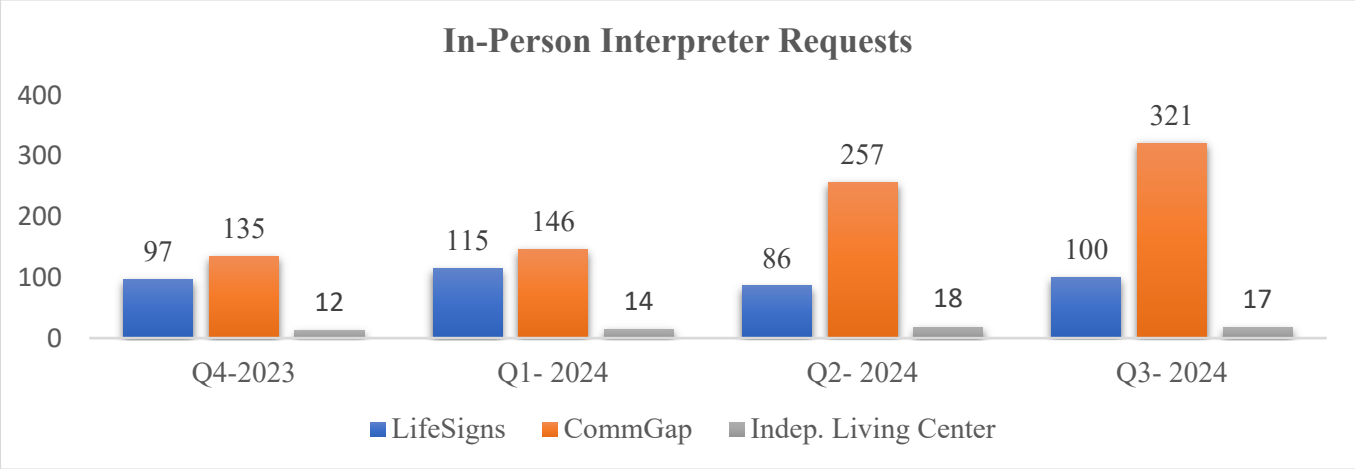
Cultural and Linguistic Services

Interpreter Requests

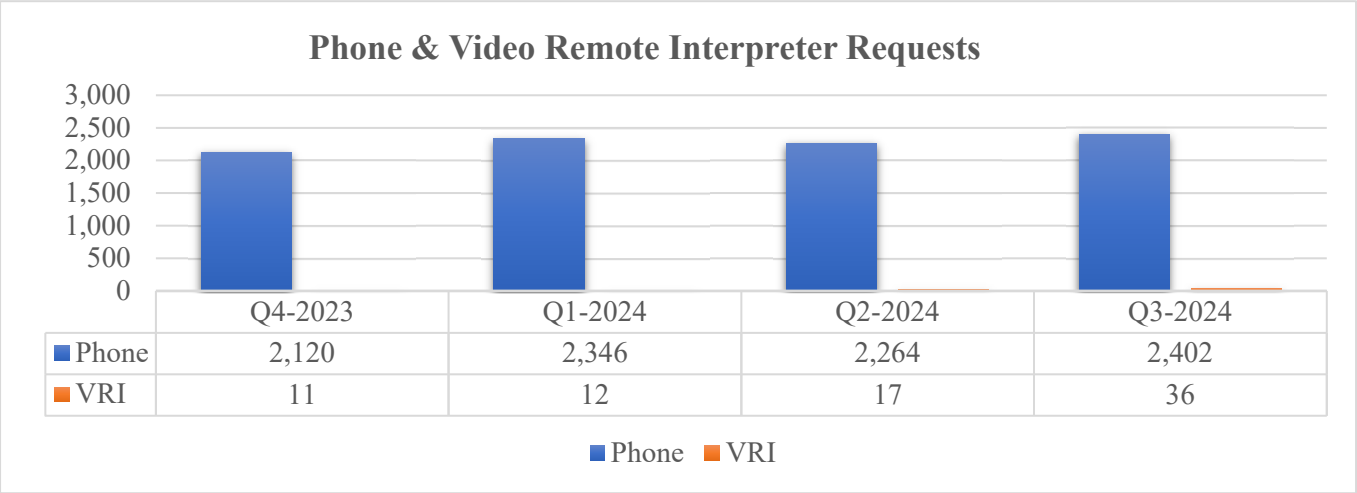
During this quarter, there were 321 requests for Face-to-Face Interpreting, 2,402 requests for Telephonic Interpreting, 36 for Video Remote Interpreting (VRI) and 117 requests for an American Sign Language (ASL) interpreter.

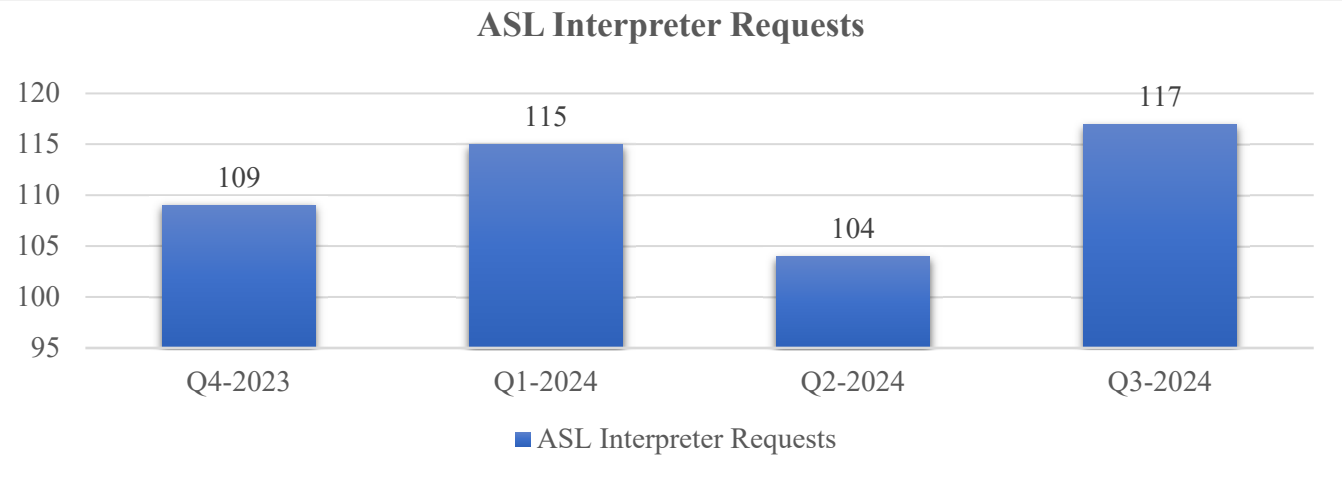
Interpreting Languages Requested
Phone and Video Remote
Spanish
Punjabi
Arabic

Interpreting Languages Requested
In-person
Spanish
Punjabi
Arabic



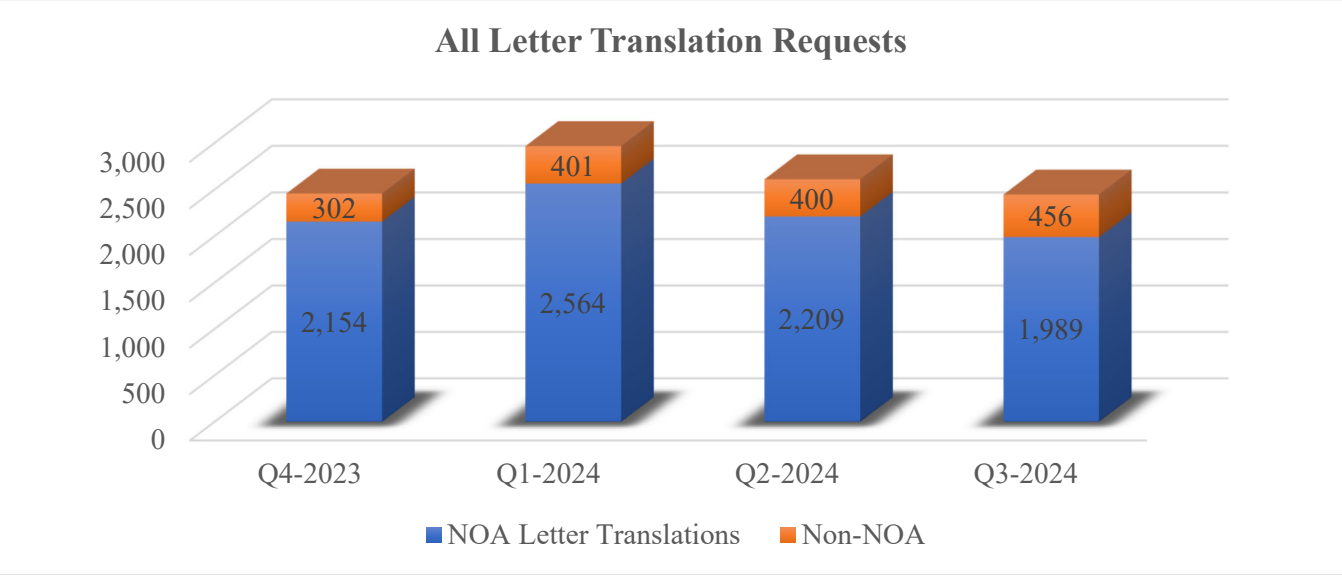
Kern Health Systems
Cultural & Linguistic Services Activities Report
3rd Quarter 2024





Written Translations

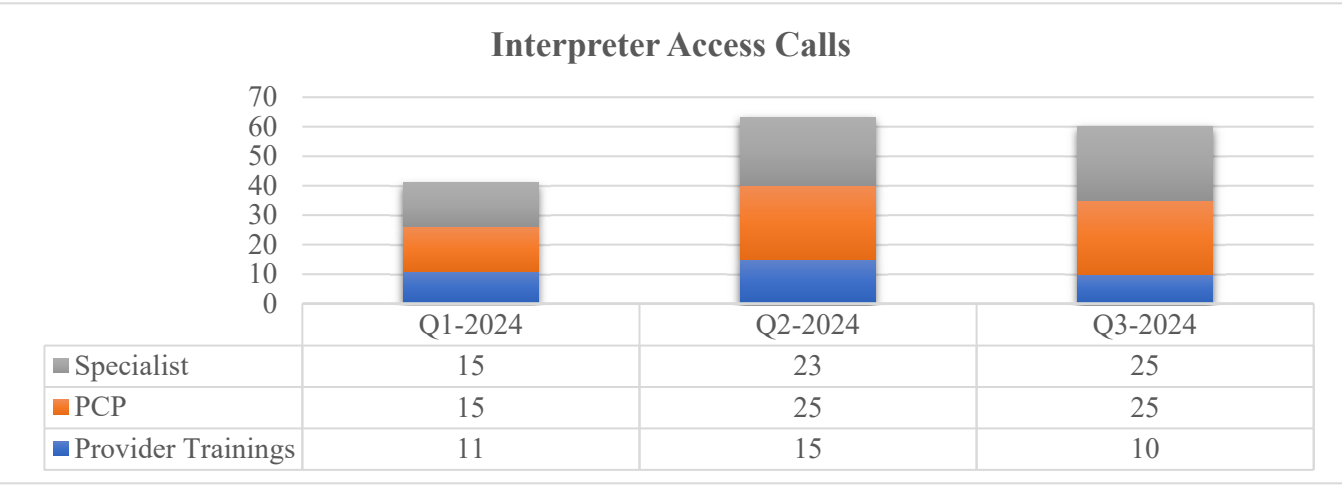
The W&P department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 2,445 requests for written translations were received.



Cultural and Linguistic Services Audits

Interpreter Access Survey Calls

Each quarter, the Provider Network Management (PNM) department conducts an interpreter access survey among KHS providers. During Q3, 25 PCPs and 25 Specialists participated in this survey. Of these providers, 10 needed a refresher training on KHS' C&L services.



	Q1-2024	Q2-2024	Q3-2024
Specialist	15	23	25
PCP	15	25	25
Provider Trainings	11	15	10

Vendor Over-the-Phone (OPI) Interpreter Call Monitoring

During this quarter, Language Line Solutions conducted an audit on 30 random OPI interpreter services calls. These calls were randomly selected from the vendors monthly invoices. Calls audited were in Arabic, Mandarin, Punjabi, Spanish, Tagalog, and Vietnamese languages. Calls were evaluated on the following items: Interpreter's Customer Service, Interpretation Skills, and the ability to follow the Code of Ethics and Standards of Practice. Audit findings revealed 100% of calls "Met Expectations."

LanguageLine Solutions

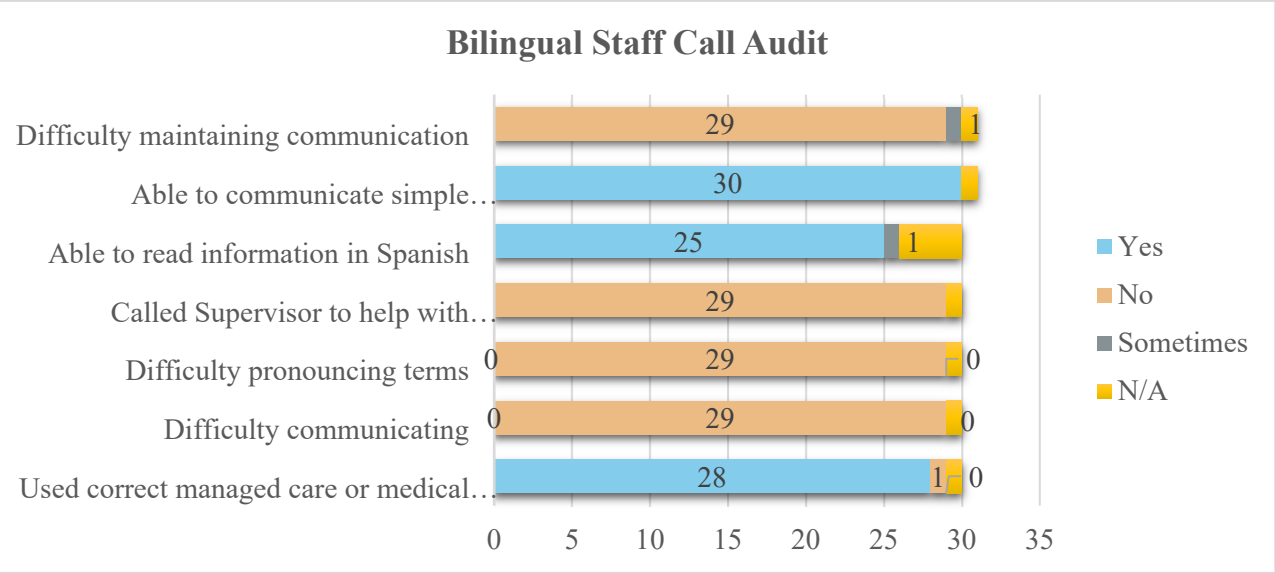
Interpreter File Audit Evidence

Call Number	Interpreter ID	Status	Language	Annual Compliance Training Date	Medical Interpreter Skills Assessment Date	Medical Interpreter Skills Assessment Result	QA Observation Date	QA Observation Score
CR-0466304799	401260	Active	TAGALOG	6-May-24	3-Dec-22	Pass	7/29/2024	3/3
CR-0466310369	397613	Active	SPANISH	29-Jun-24	2-Feb-23	Pass	9/10/2024	3/3
CR-0466313184	257179	Active	SPANISH	4-Jul-24	5-Apr-19	Pass	7/29/2024	3/3
CR-0466314816	432445	Active	SPANISH	27-Feb-24	26-Feb-24	Pass	8/16/2024	3/3
CR-0466329974	418503	Inactive	SPANISH	7-Apr-24	27-Oct-23	Pass	7/30/2024	3/3
CR-0466331936	439307	Active	SPANISH	22-Apr-24	15-Apr-24	Pass	7/2/2024	3/3
CR-0466329688	433367	Active	PUNJABI	30-Apr-24	12-Mar-24	Pass	9/3/2024	3/3
CR-0466333552	432149	Active	SPANISH	27-Feb-27	27-Feb-24	Pass	7/26/2024	3/3
CR-0466352950	386498	Active	SPANISH	26-Jun-24	11-Oct-22	Pass	7/12/2024	3/3
CR-0466373604	431766	Active	ARABIC	20-Feb-24	19-Feb-24	Pass	8/16/2024	3/3
CR-0474355131	379576	Active	SPANISH	10-May-24	25-Aug-21	Pass	7/24/2024	3/3
CR-0474647696	369174	Active	VIETNAMESE	12-May-21	5-Feb-21	Pass	8/8/2024	3/3
CR-0474678227	389571	Active	SPANISH	4-Jul-24	18-Aug-22	Pass	8/15/2024	3/3
CR-0474687676	430762	Active	SPANISH	13-Feb-24	12-Feb-24	Pass	9/20/2024	3/3
CR-0474697112	447641	Active	PUNJABI	26-Jun-24	25-Jul-24	Pass	8/28/2024	3/3
CR-0474705000	433768	Active	SPANISH	23-Feb-24	11-Mar-24	Pass	8/19/2024	3/3
CR-0474741882	435586	Active	SPANISH	15-Mar-24	4-Apr-24	Pass	7/23/2024	3/3
CR-0474741371	433575	Inactive	SPANISH	23-Feb-24	12-Mar-24	Pass	7/4/2024	3/3
CR-0474751896	436051	Active	SPANISH	15-Mar-24	8-Apr-24	Pass	9/25/2024	3/3
CR-0474747881	446532	Active	TAGALOG	24-Jun-24	24-Jun-24	Pass	8/14/2024	3/3
CR-0481804123	254168	Active	MANDARIN	18-Apr-24	23-Jan-18	Pass	9/3/2024	3/3
CR-0481806385	448107	Active	ARABIC	28-Jun-24	17-Jul-24	Pass	8/19/2024	3/3
CR-0481821433	408798	Active	SPANISH	16-Jul-24	30-Jan-23	Pass	7/1/2024	3/3
CR-0481825357	422109	Active	SPANISH	14-May-24	9-Oct-23	Pass	8/9/2024	3/3
CR-0482010241	404814	Active	SPANISH	13-May-24	23-Feb-24	Pass	7/26/2024	3/3
CR-0482018364	451198	Active	VIETNAMESE	26-Aug-24	27-Aug-24	Pass	9/20/2024	3/3
CR-0482020217	401361	Active	SPANISH	12-Apr-24	15-Mar-23	Pass	7/31/2024	3/3
CR-0482021521	386223	Active	PUNJABI	16-Apr-24	5-Oct-22	Pass	9/25/2024	3/3
CR-0482158529	437364	Active	SPANISH	29-Mar-24	15-Apr-24	Pass	9/16/2024	3/3
CR-0482170389	408026	Active	SPANISH	6-May-24	24-Feb-23	Pass	9/25/2024	3/3

Kern Health Systems
Cultural & Linguistic Services Activities Report
3rd Quarter 2024

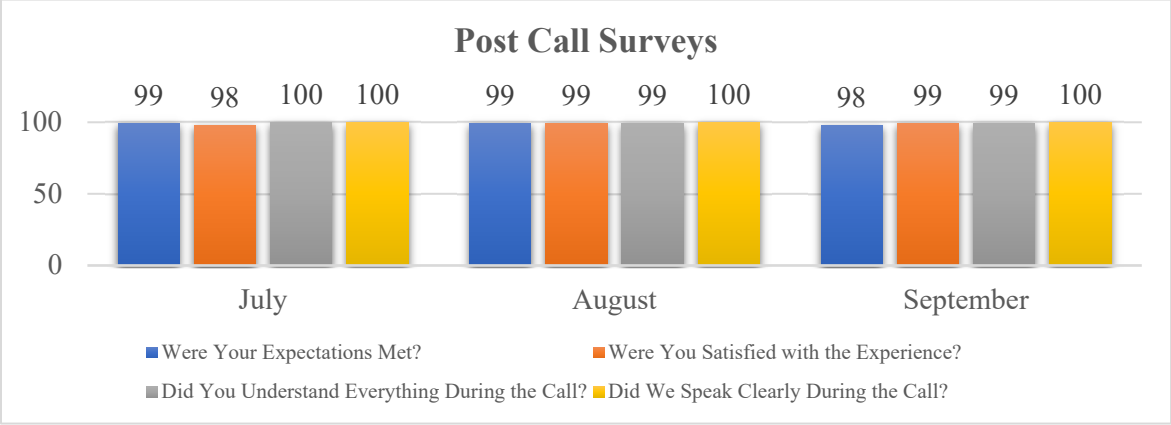
Bilingual Staff Call Audit

During this quarter, a total of 30 Spanish audio calls from KHS member facing departments were reviewed to assess the linguistic performance of the Bilingual Staff. Findings revealed that 99% of Bilingual staff did not have difficulty communicating with members in a non-English language.



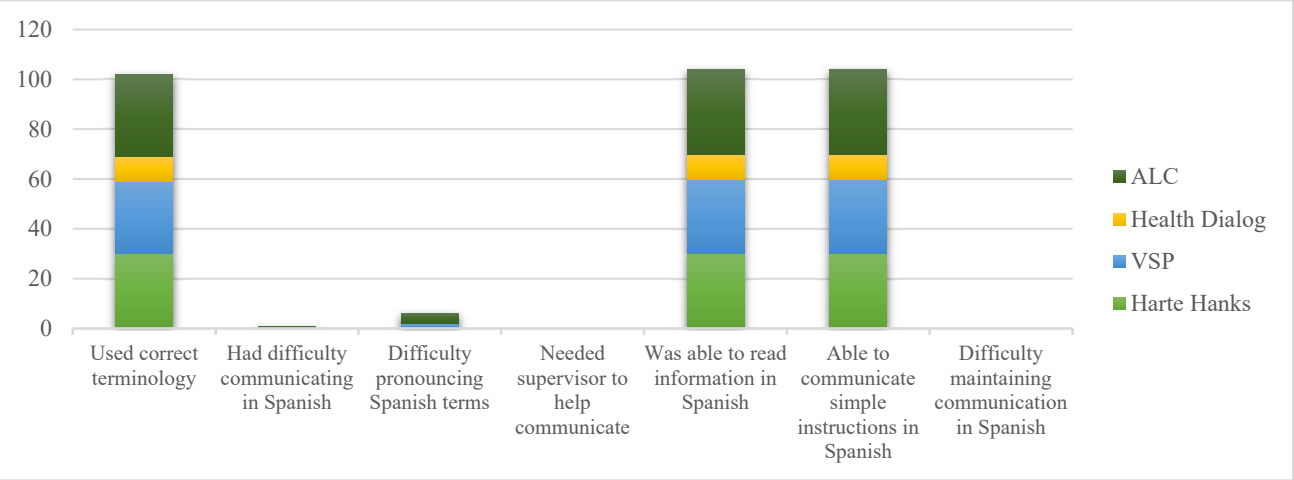
Post Call Surveys

During this quarter, a total of 10,771 Spanish Post Call Surveys were collected from members for all KHS member facing departments to assess the linguistic performance of the Bilingual Staff. KHS' post call survey evaluates member's call experience by language. Findings revealed that 99% of members are satisfied with the linguistic performance of bilingual staff.



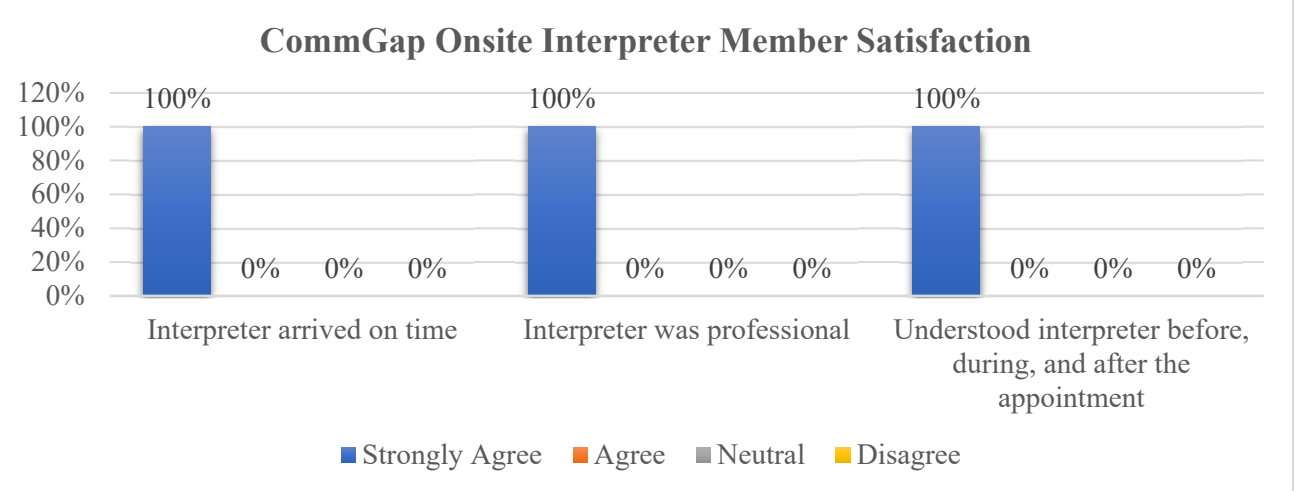
Vendor Bilingual Call Audits

During this quarter, a total of 104 Spanish audio calls were received from contracted vendors with KHS. These vendors include: ALC Transportation, Health Dialog, VSP, and Harte Hanks. These audio calls were reviewed to assess the linguistic performance of the vendor's Bilingual staff. Findings revealed that 98% of Bilingual staff did not have difficulty communicating with members in a non-English language.



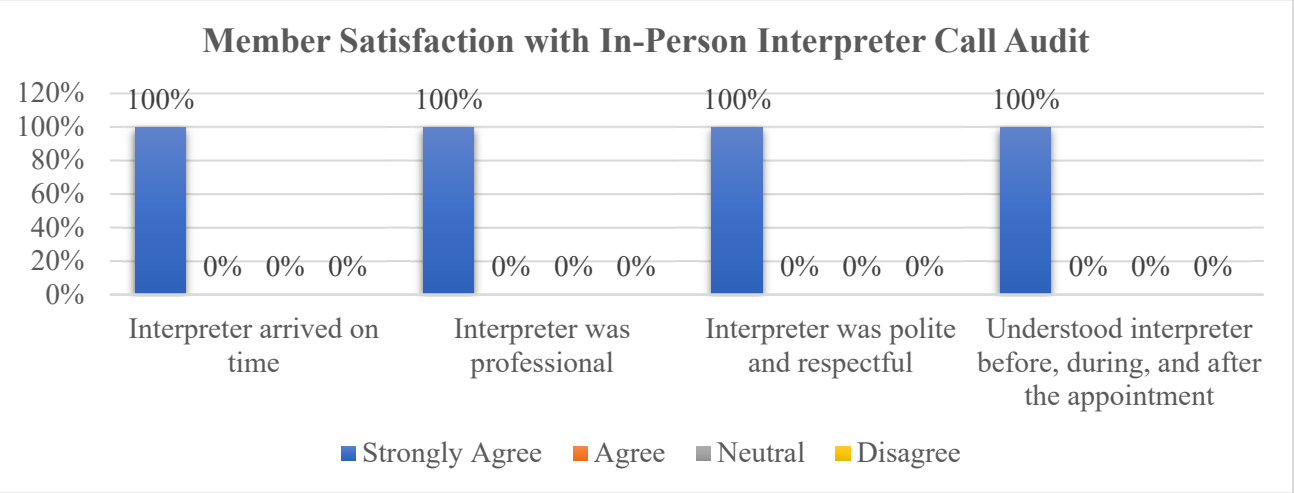
CommGap Onsite Interpreting Member Satisfaction Survey

During this quarter, an interpreter satisfaction survey was sent out by our vendor CommGap who surveyed 25 members after their onsite encounter with their provider. Of the 25 surveys sent out, 100% of respondents "Strongly Agreed" that they were satisficed with the interpreter services they received from the vendor.



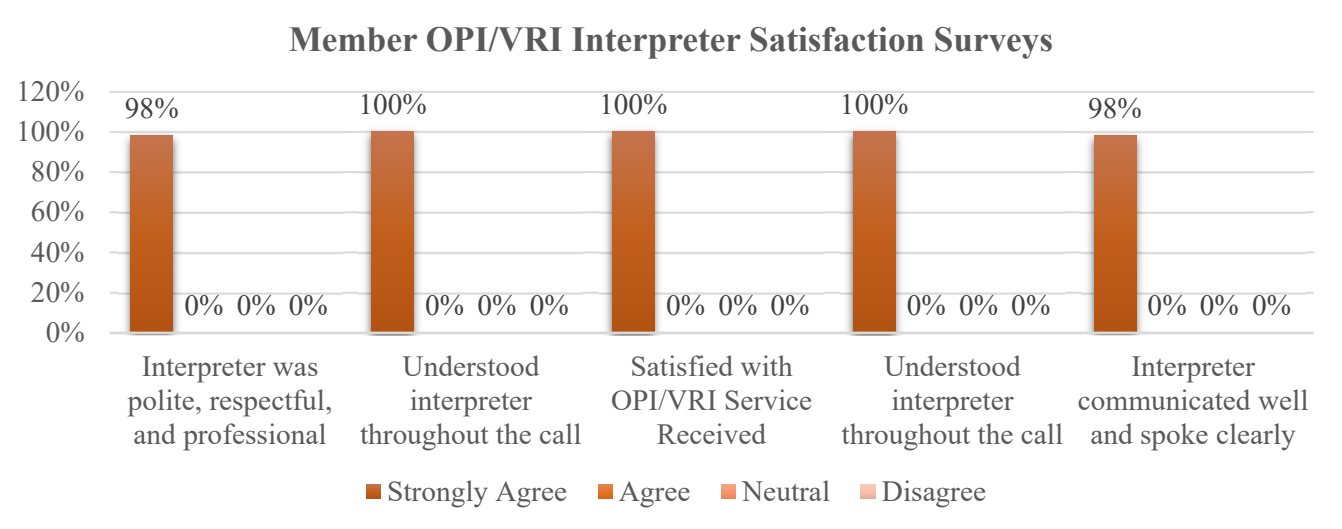
Member In-person Interpreting Satisfaction Call Surveys

During this quarter, a total of 30 satisfaction surveys were collected from members who received in-person interpreting services and more than 100% of members reported they "Strongly Agreed" being satisfied with their interpreter.



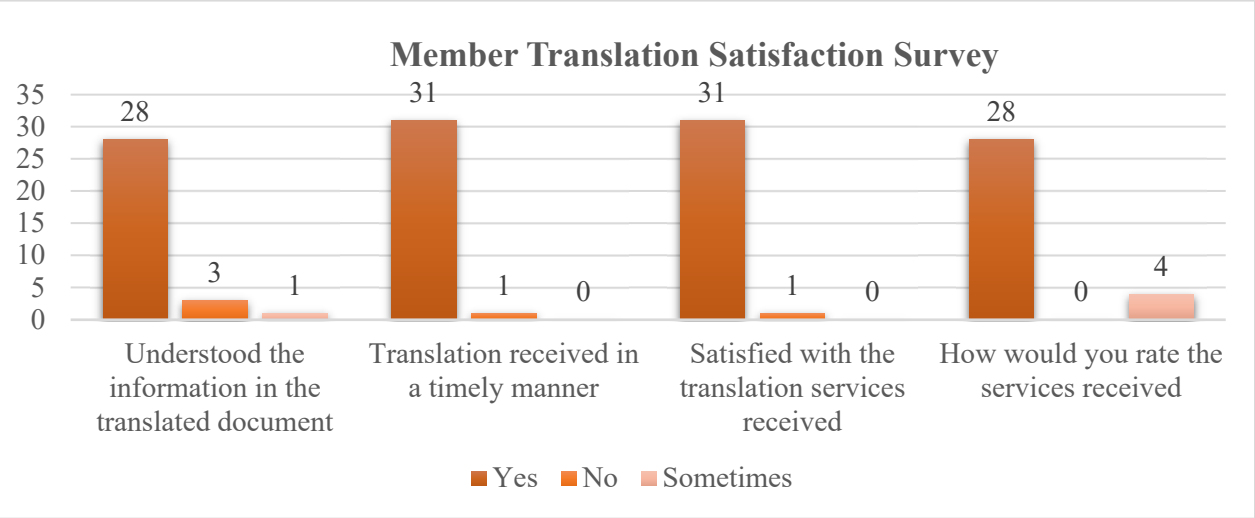
Member OPI & VRI Interpreting Satisfaction Call Surveys

During this quarter, a total of 30 satisfaction surveys were collected from members who received Over-The-Phone (OPI) and Video Remote (VRI) interpreting services. Of the 30 surveys, 27 responses were for OPI services, and 3 responses were for VRI services. The survey concluded with 99% of members reporting they "Strongly Agreed" being satisfied with the OPI/VRI interpreter services they received.



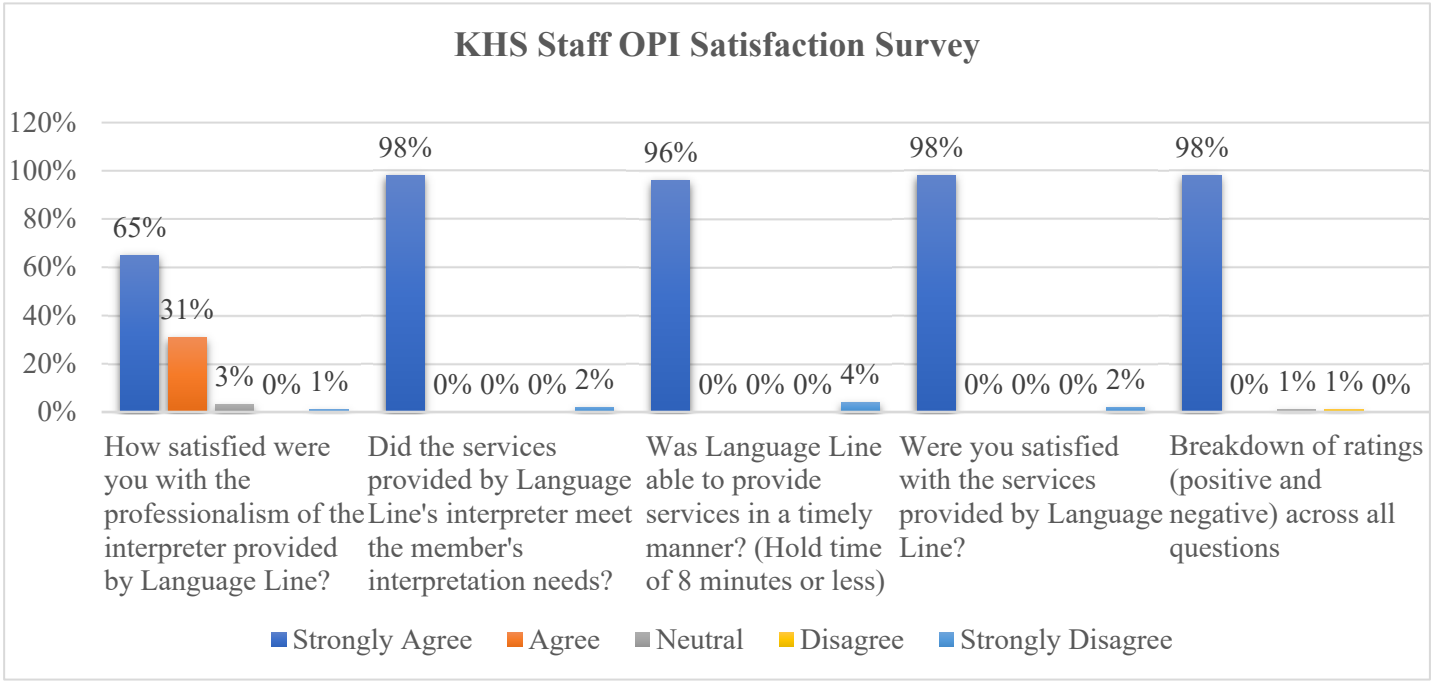
Translation Member Satisfaction Survey

During this quarter, a total of 32 translation satisfaction call surveys were conducted for members who received a translation completed by C&L translators and by our vendor Language Line Solutions. This survey is to determine the members satisfaction regarding our translation services. Of the 32 calls completed 97% of members were satisfied with the services received.



KHS Staff Satisfaction Over-the-Phone (OPI) Survey

During this quarter, a total of 135 surveys were received from KHS member facing department staff regarding their satisfaction with our vendor Language Line Services concerning over-the-phone interpretation. Findings revealed that 98% of KHS staff are satisfied with the linguistic performance of our vendors' interpreters.


KHS Staff OPI Satisfaction Survey
120%
100%
80%
60%
40%
20%
0%
65%
31%
3%
0%
1%
98%
0%
0%
0%
2%
96%
0%
0%
0%
4%
98%
0%
0%
0%
2%
98%
0%
1%
1%
0%
How satisfied were you with the professionalism of the interpreter provided by Language Line?
Did the services provided by Language Line's interpreter meet the member's interpretation needs?
Was Language Line able to provide services in a timely manner? (Hold time of 8 minutes or less)
Were you satisfied with the services provided by Language Line?
Breakdown of ratings (positive and negative) across all questions
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

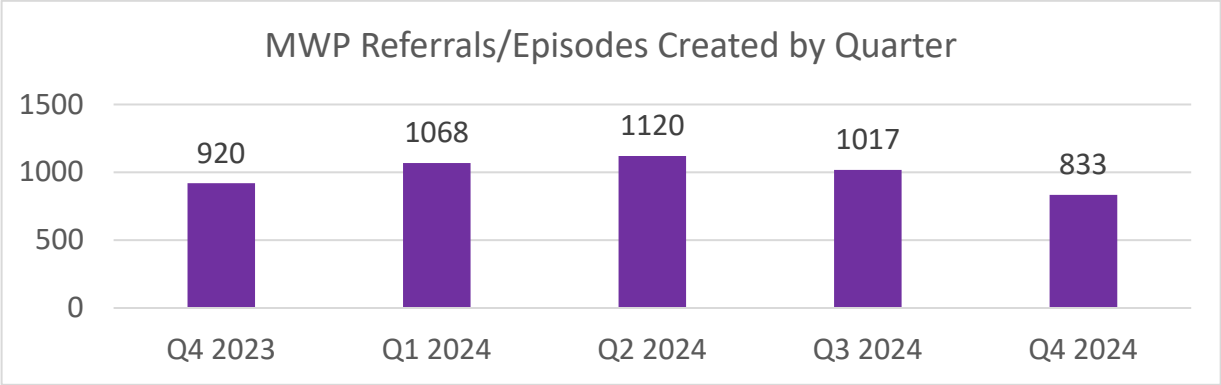
Kern Health Systems
Wellness & Prevention Activities Report
4th Quarter 2024

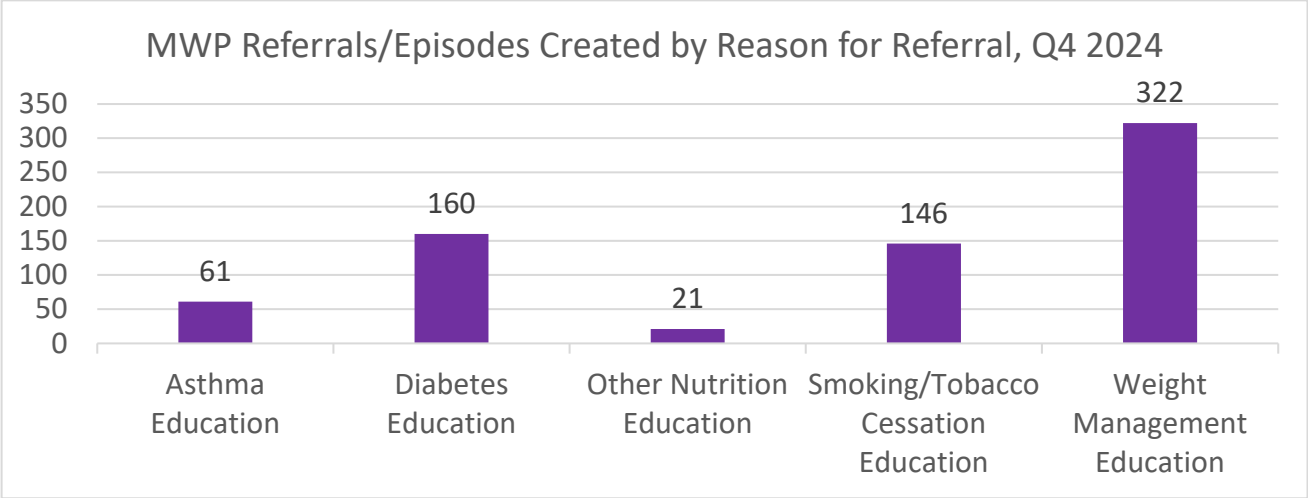
Member Wellness and Prevention

Health Education Referrals

During Q4 2024, there were 833 referrals for Member Wellness and Prevention (MWP) services, which is an 18% decrease in comparison to the previous quarter. In Q4 2024, the MWP team directed outreach efforts to register members for the Diabetes Empowerment Education Program and weight management programs (Activity & Eating and Eat Healthy Be Active). Outreach for the in-person classes focused on members living in Central, East, and North Bakersfield, and McFarland. As for the virtual classes, outreach focused on the outlying communities and members 35-49 years of age.

The health education class service acceptance rate decreased by 5% between Q3 2024 to Q4 2024 whereas the received services rate increased by 3 percentage points from 40% to 43% during the same time period. The increase observed in Q4 2024 may be due to a more focused outreach effort and the identification of neighborhood-centric locations highlighting the need for partnerships such as with the Kern County Library and the Housing Authority of Kern.

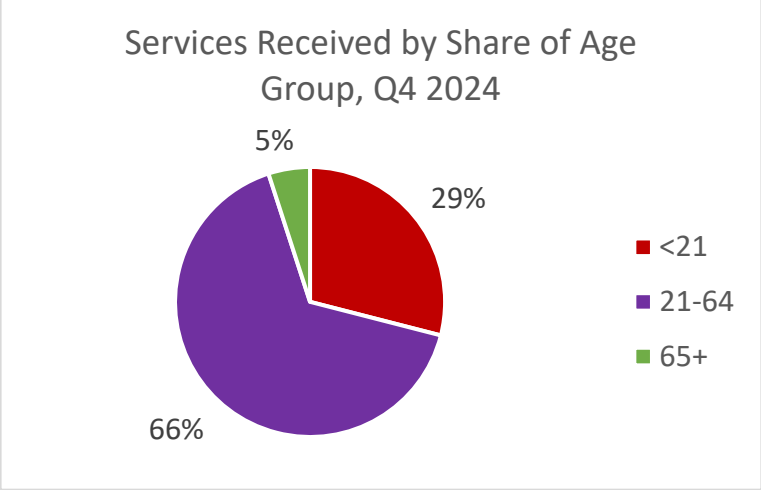


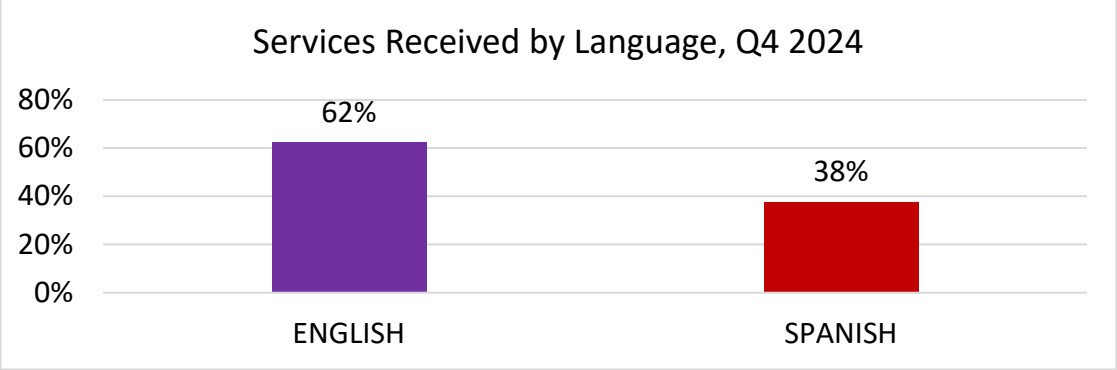


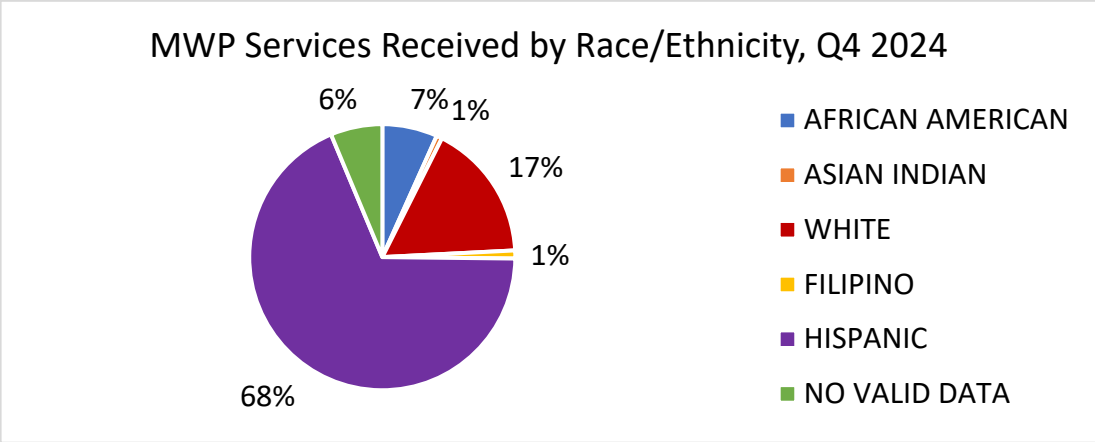
Member Demographics

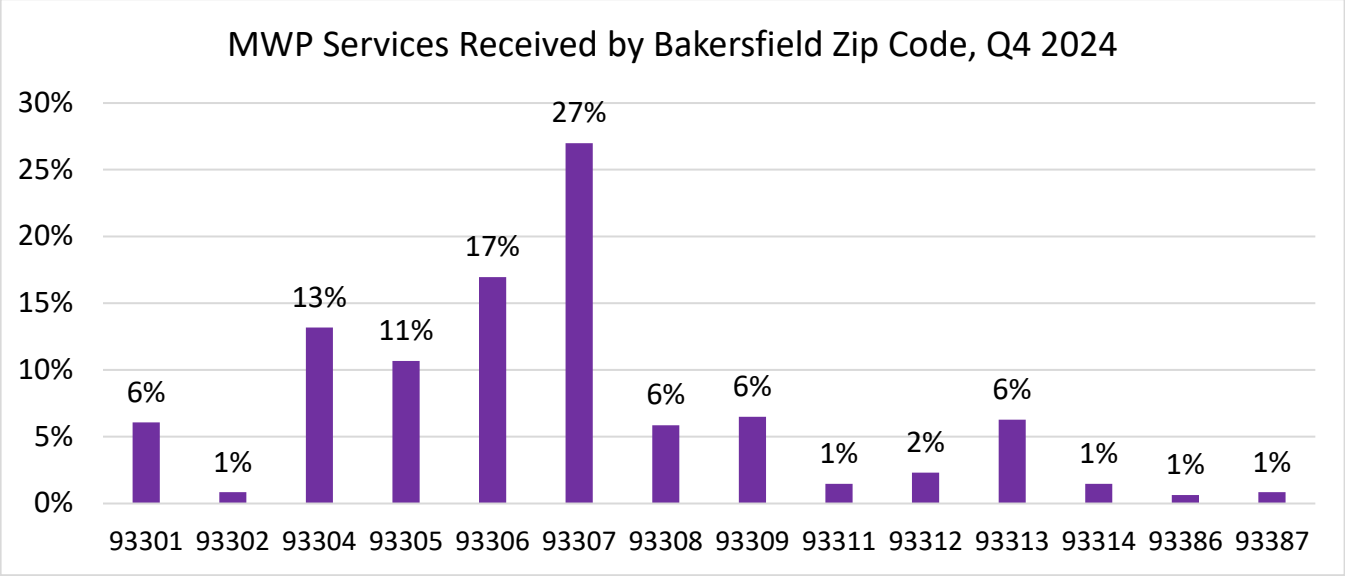
KHS provides services to a culturally and linguistically diverse member population in Kern County. A demographic analysis of the members who received services included the following findings:

- The largest age groups were 21-64 years (66%) followed by members under 21 years of age (29%).
- Most members were Hispanic (68%) and English speakers (62%).
- Most members resided in Bakersfield with the highest concentration in the 93307 area.
- In the outlying areas of Kern County, Arvin accounted for the largest share of members.
- English speakers had a higher attendance rate compared to Spanish speakers.






MWP Services Received by Race/Ethnicity, Q4 2024
6%
7%
1%
17%
1%
68%
AFRICAN AMERICAN
ASIAN INDIAN
WHITE
FILIPINO
HISPANIC
NO VALID DATA


MWP Services Received by Bakersfield Zip Code, Q4 2024
30%
25%
20%
15%
10%
5%
0%
6%
1%
13%
11%
17%
27%
6%
6%
1%
2%
6%
1%
1%
1%
93301
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93311
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93386
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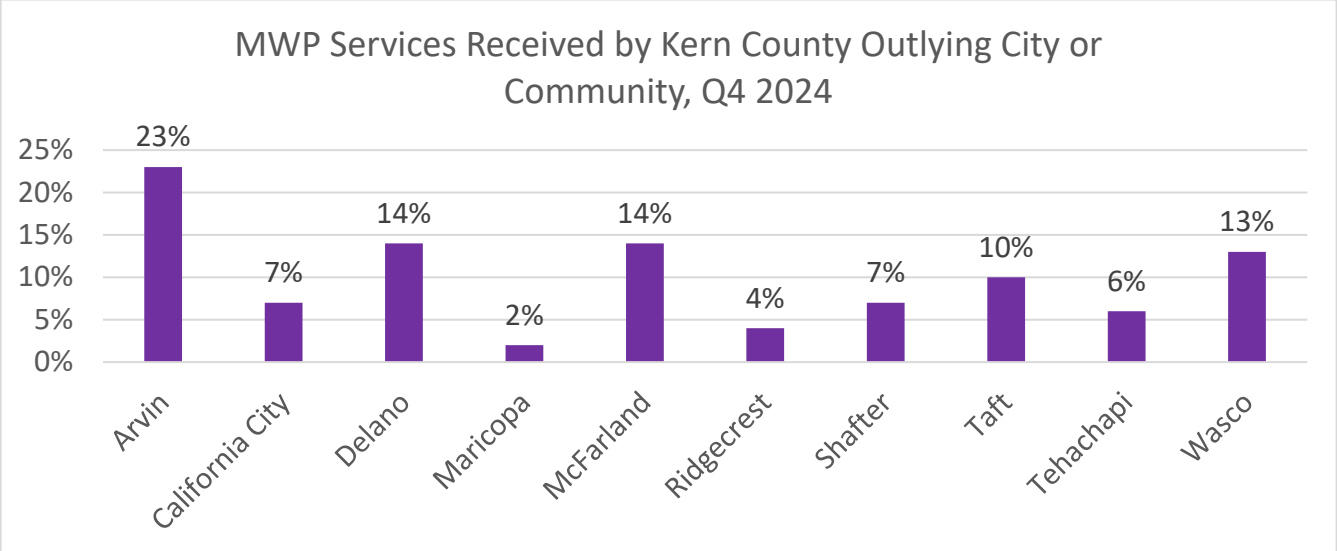

MWP Services Received by Kern County Outlying City or Community, Q4 2024
25%
20%
15%
10%
5%
0%
23%
7%
14%
2%
14%
4%
7%
10%
6%
13%
Arvin
California City
Delano
Maricopa
McFarland
Ridgecrest
Shafter
Taft
Tehachapi
Wasco

Health Education Class Service Audit

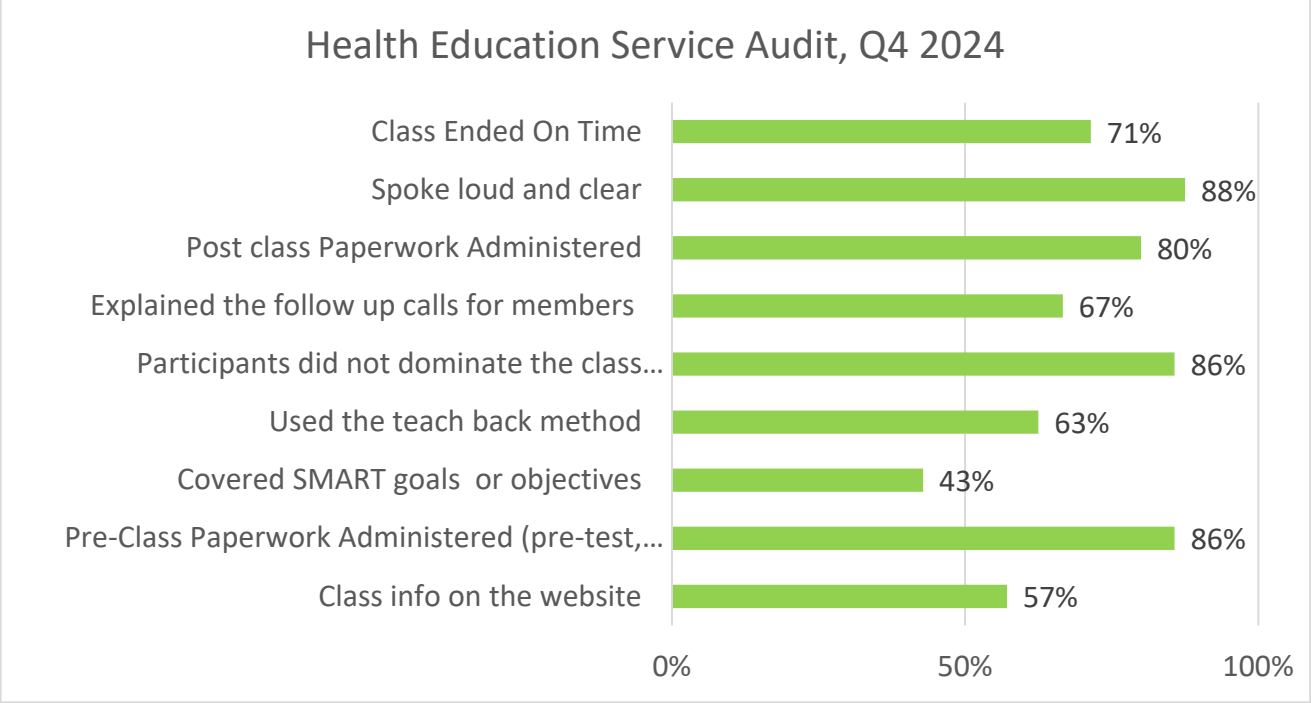
The Health Education Class Service Audit Tool considers a variety of markers to determine the quality of Health Education Class Services being provided to members. It includes observations on planning and preparation, implementation and delivery, and member engagement during health education classes.

In Q4 2024, class facilitators demonstrated mastery of class facilitation in the following areas:

- Starting on time
- Asking members to sign in
- Providing examples for topics or concepts and myths
- Explaining activities before doing them
- Doing all planned activities
- Taking photos or videos of the class

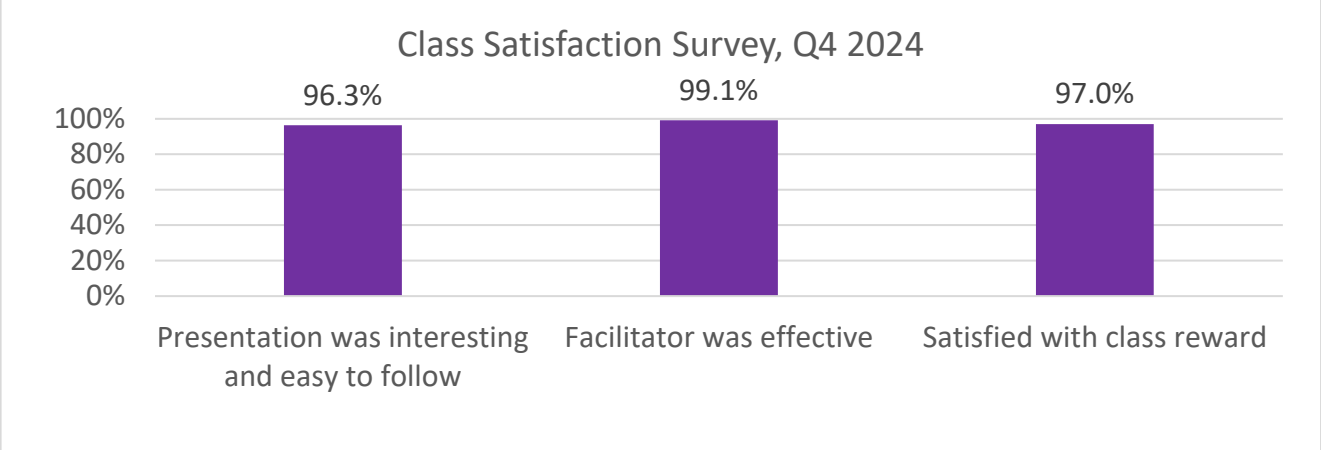
Areas of improvement included:

- Ensuring administrative paperwork is completed
- Covering SMART goals
- Maintaining control of the class
- Explaining follow-up calls to members



Health Education Class Evaluations

Health Education classes include an evaluation questionnaire for participants. The questionnaire is administered at the end of the class session or series. Findings revealed high ratings on three measures of class satisfaction as shown in the chart below**.**



Below is an analysis of the findings from open-ended questions for Q4 2024.

What did you like most about the class?

Participants were asked what they liked most about the class, more than 95% percent of participants expressed great satisfaction in the class and suggested no change. More than half of members who responded shared the following responses:

- Participants appreciated the delivery and tone of voice used by the instructors
- Learning about eating habits, substitutions, and health topics was appreciated
- The content was found to be relevant and informative, which made the classes easy to understand.
- Clear explanations and easy-to-understand material were highlighted
- The teaching techniques and presentation style were praised
- The supportive environment and opportunity to connect with others were valued
- Participants felt supported and looked forward to attending the classes

How could we improve the class?

Participants were asked how the class could be improved. Responses included:

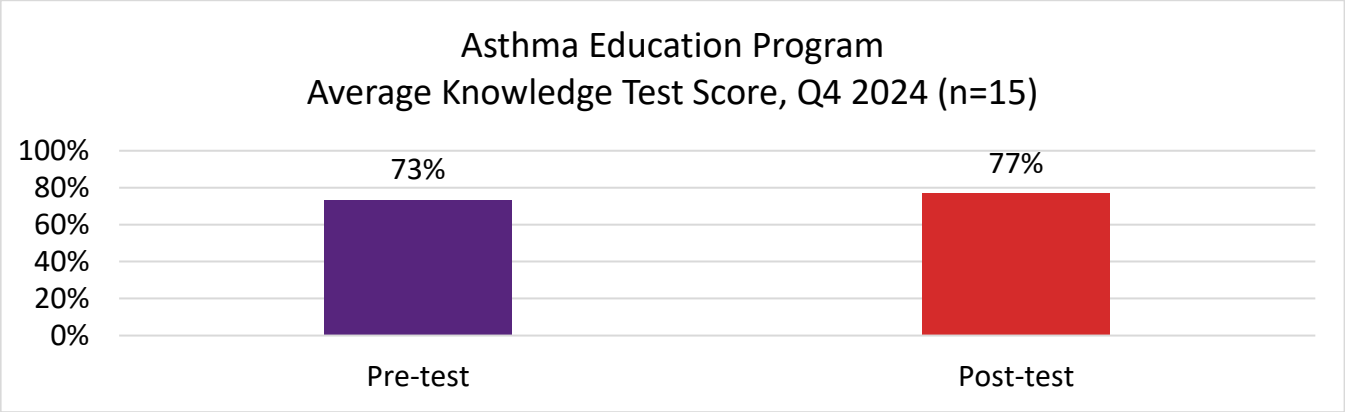
- Suggestions for more interaction and engagement during the class
- Requests for additional content or topics to be covered
- Suggestions for changes in class structure or format
- Ideas for providing incentives or rewards to participants

In addition, members referred to the Kick It California (KIC) Quitline are surveyed to gauge satisfaction with this service. No satisfaction survey responses were collected during this quarter. One member accepted services to KIC in Q4 2024 but eventually declined services.

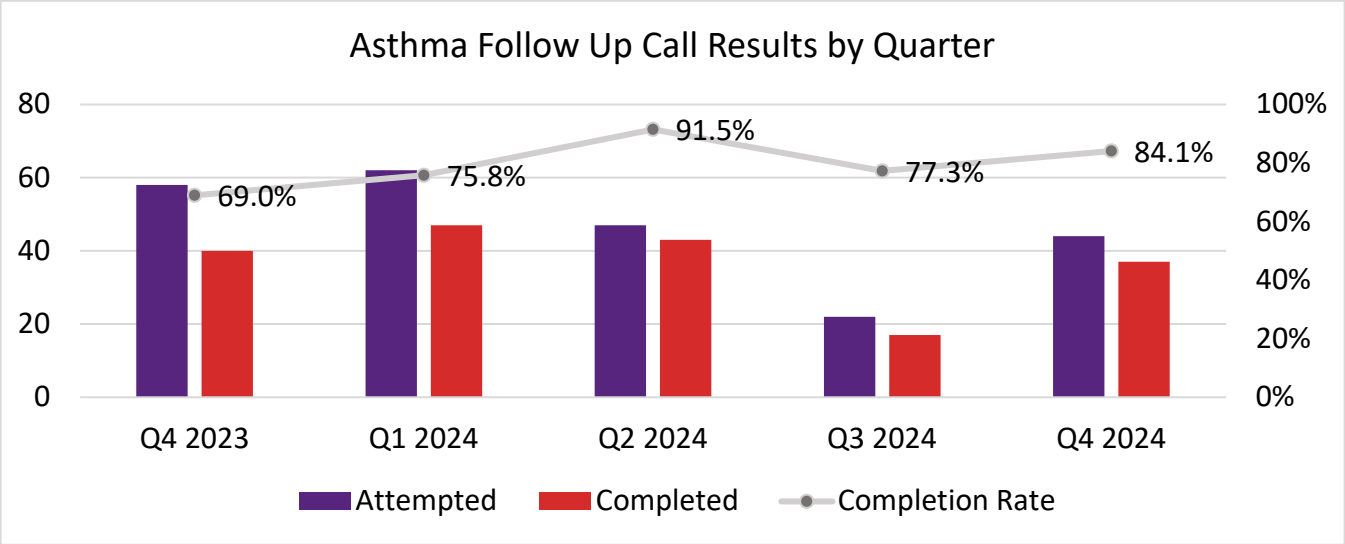
Health Education Class Effectiveness

Asthma: Breathe Better Program

The asthma education program consists of 2 classes and at least 2 follow-up calls. A pre and posttest questionnaire is administered each series. During Q4 2024, findings revealed there was an average 4 percentage point increase in knowledge test score after completing the series. The largest increases were in understanding what an asthma trigger is and knowing when to use control inhalers as directed by their provider.

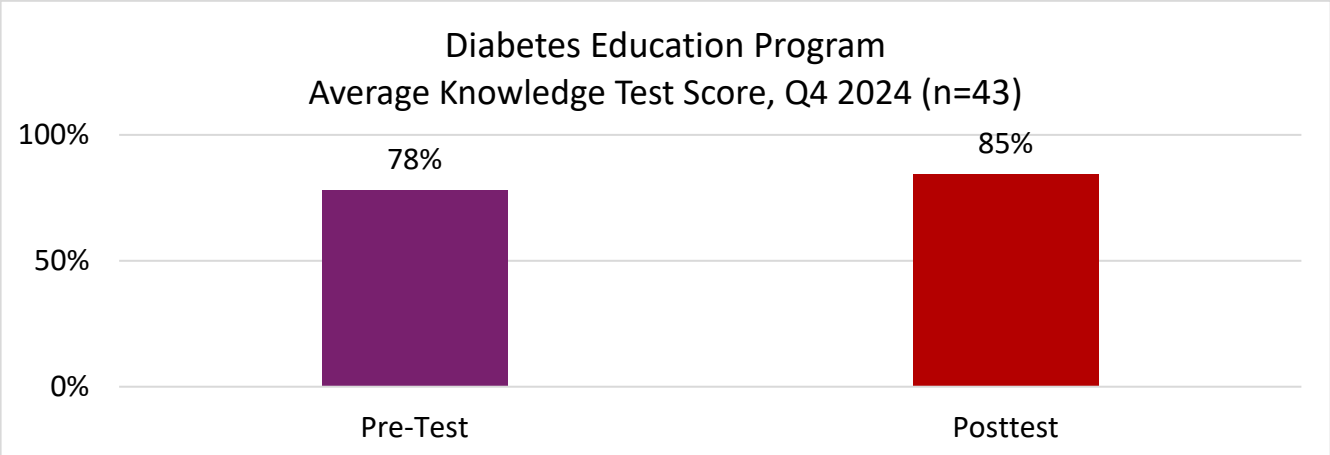


Members who have attended the KFHC Breathe Better Asthma Classes are offered asthma follow up calls. These calls occur at 1 month, 3 months, and 6 months (optional or only if needed) after attending the classes. During the follow up call, members are screened to determine if asthma symptoms are well controlled using the Asthma Control Test (ACT) screening tool. An ACT score of 20 or higher is an indicator of well controlled asthma. During Q4 2024, 84.1% of members completed an asthma follow up call. This was an increase from 77.3% during the previous quarter. There was an improvement in average ACT score for both members under 12 years of age and those 12 years and older when comparing the initial assessment to the 3 month follow up. There was no data collected for the 1 month and 6 month follow up calls.

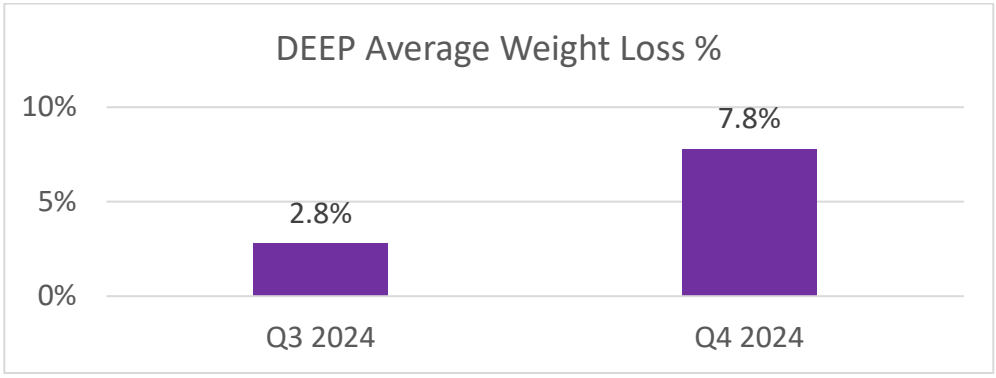


Average ACT Scores During Asthma Follow Up Calls, Q4 2024		
Call Month	**<12 years of age**	**12+ years of age**
Initial	9	16
1	No data	No data
3	25	17
6	No data	No data

Chronic Disease Prevention and Management: Diabetes Empowerment Education Program (DEEP)
DEEP is a diabetes self-management program that has been shown to be successful in helping participants take control of their disease and reduce the risk of complications. The program was developed for low-income and racial and ethnic minority populations. During Q4 2024, findings revealed a 7-percentage point increase in average knowledge test score from 78% at pretest to 85% at posttest.

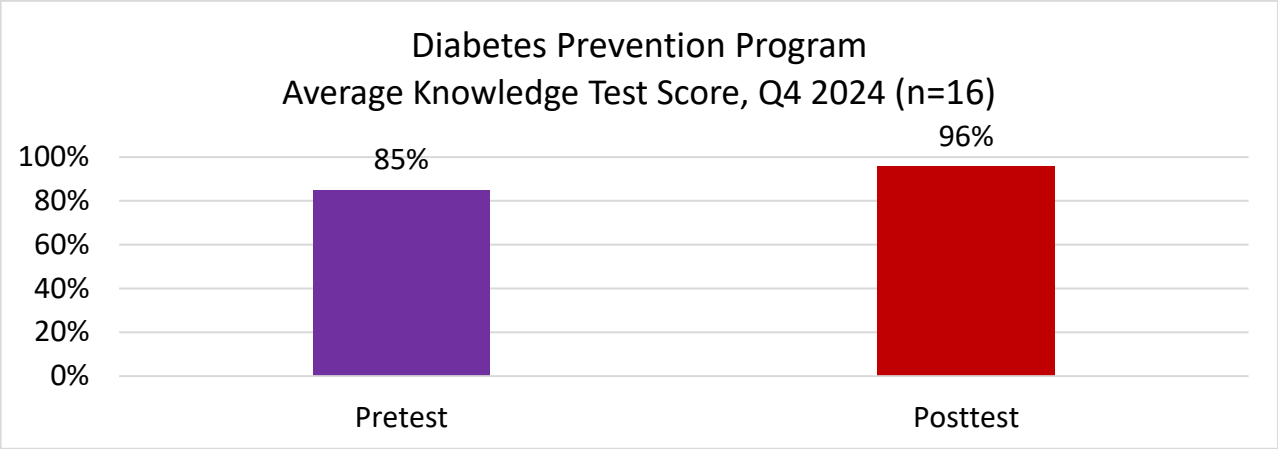


Members who participate in DEEP are weighed in at every class as one way to measure program impact. The bar chart below compares the average weight of participants at the beginning (class 1) and end (class 6) of the DEEP program during Q3 2024 and Q4 2024. Overall, the data shows that participants experienced an average weight loss of almost three percentage (2.8%) in Q3 2024 and almost 8 percentage (7.8%) in Q4 2024. This suggests that behavior modifications and recommendations presented during the series may be effective.

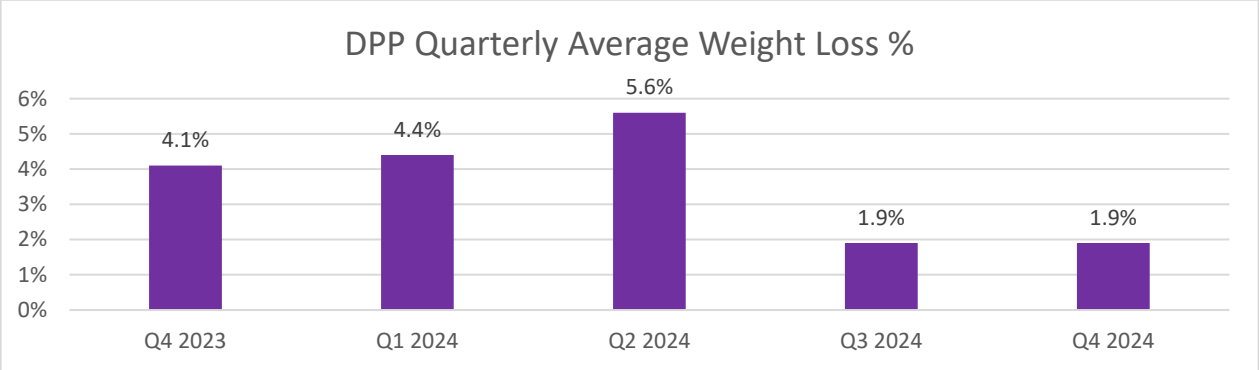


Chronic Disease Prevention and Management: Diabetes Prevention Program (DPP)

The National DPP aims to simplify access to an affordable, high-quality lifestyle change program for individuals with prediabetes or those at risk of type 2 diabetes. The program helps lower their chances of developing type 2 diabetes and enhances their overall health. In Q4 2024, 16 members completed a pretest and posttest. There was an average 11 percentage-point increase in average knowledge test score for classes 13-16, with an average of 85% correct answers at pretest compared to an average of 96% correct answers at posttest.



Members who participate in DPP are weighed in at every class as one way to measure impact. The initial combined cohort weight is compared with the combined weight at the end of each month to calculate average weight loss per member each month and quarter. The average individual weight loss by quarter is shown in the chart below. A significant drop occurred in Q3 2024 since a Spanish DPP cohort ended in June 2024 and an English cohort started the following month. By the end of Q4 2024, 18 members were enrolled in the KHS English DPP cohort with an average weight loss of 1.9%. There was no Spanish DPP series being offered in Q4 2024.



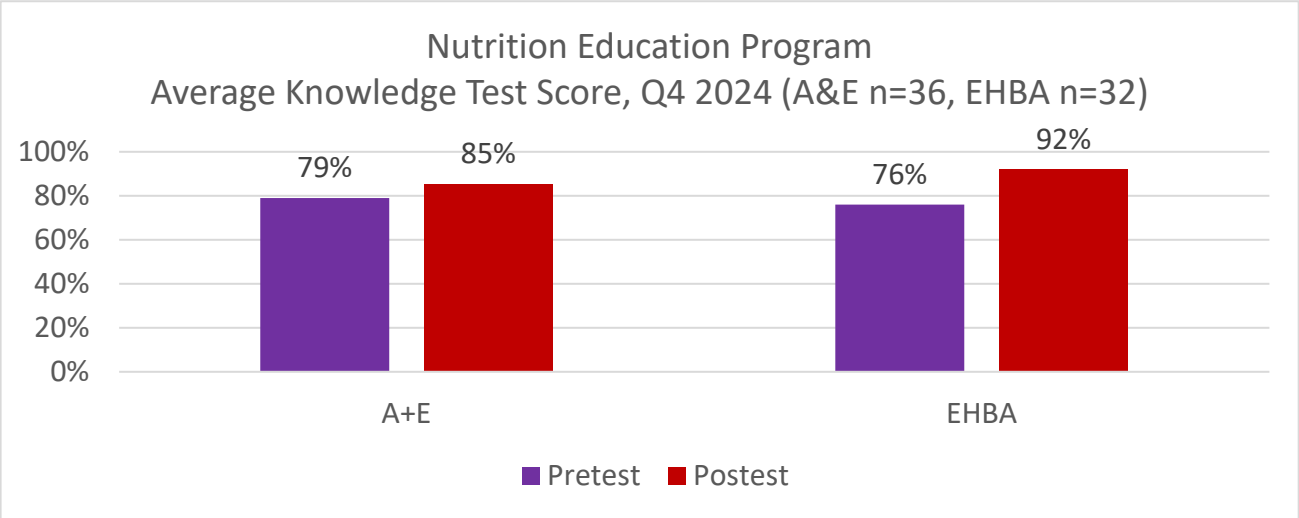
Nutrition and Weight Management: Activity and Eating and Eat Healthy, Be Active

The nutrition and weight management program includes two curriculums that focus on creating healthy habits around eating and physical activity to reduce the risk of chronic illness among the KFHC members and the Kern County population. In September 2023, the Eat Healthy, Be Active (EHBA) curriculum, a 6-class series, along with the Activity and Eating (A+E) one-time class were launched. Each class lasts about 90 minutes. Evidence shows that these programs can positively impact behavior around physical activity and nutrition. A pre and posttest questionnaire is distributed per class.

During Q4 2024, findings revealed that among those members who completed the core pre and posttest for both programs, there was a combined average 11-percentage point increase in knowledge gained after completing classes.

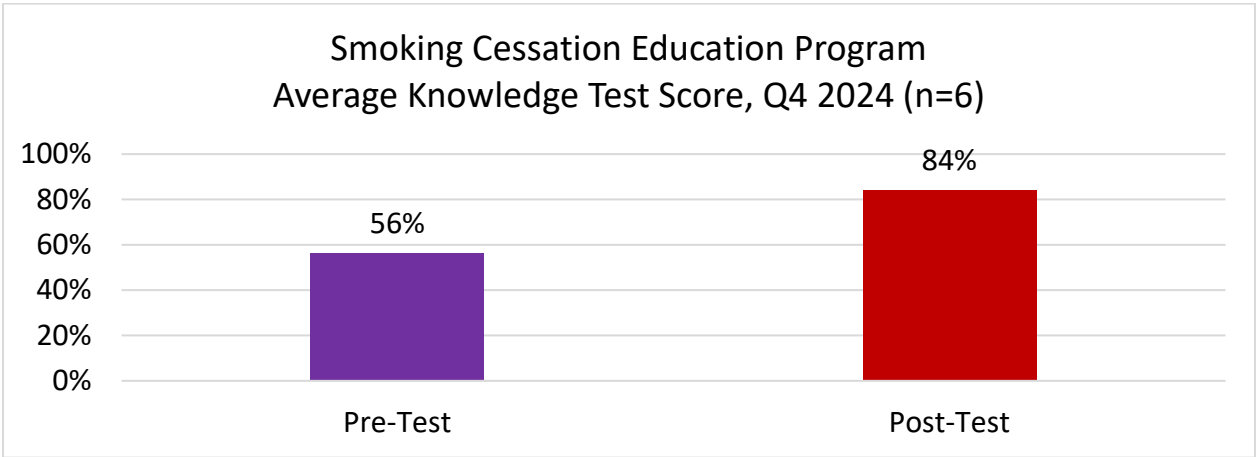
- Members who completed a pretest scored an average of 78% in correct answers.
- Members who completed a posttest scored an average of 89%.
- The largest increase in knowledge from pre- to posttest was observed among members who attended the EHBA course (6 classes) – a 16-percentage point increase.

There was also an increase in awareness of the relationship between calorie intake and physical activity, the five recommended food groups, daily recommended exercise for adults, portion control, and shopping on a budget.



Smoking/Tobacco Cessation: Fresh Start

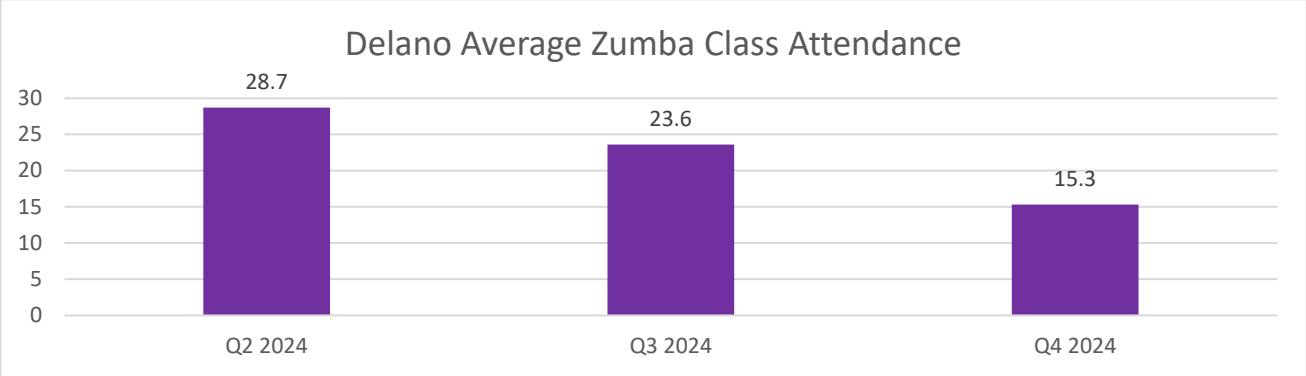
The Fresh Start program has the goal of reducing harm from tobacco products. Knowledge tests are implemented each series. In Q4 2024, 6 members completed a pretest and/or posttest. There was an average 28-percent point increase in average knowledge test score when comparing pretest and posttest responses. Members appear to have gained knowledge on committing to a quit date, nicotine replacement therapy, and writing down a personal quit plan.

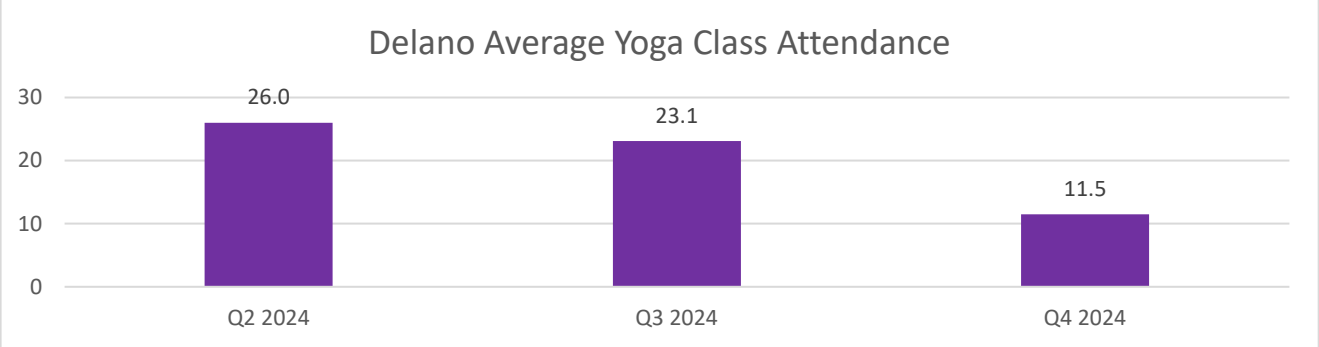


Community Health and Wellness

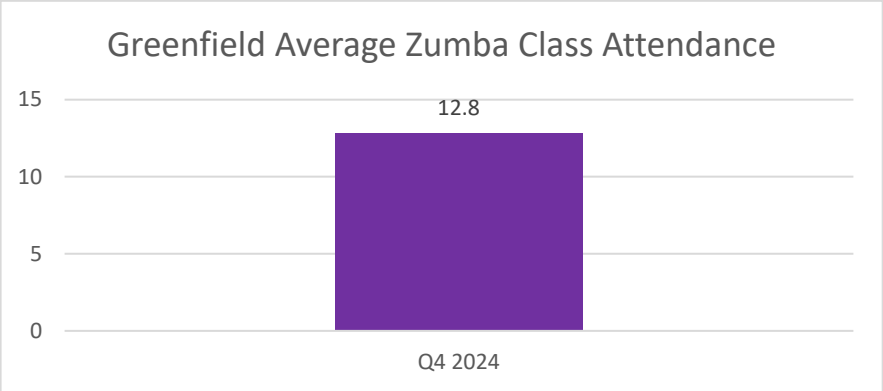
Live Better Program

Due to the success of the Live Better Program in Delano, the contract with the City of Delano was expanded to include one additional Zumba class on Tuesday and an additional program, Live Better Kids, which will engage a younger population of children (3-14). This program has rotating sessions including Zumba, fit camp and yoga classes. Live Better Kids is held every Saturday, 11:00 am-12:00 PM. The agreement with the City of Delano was renewed for 2025. Average attendance in Q4 2024 for the Zumba and yoga classes was 15.3 and 11.5, respectively.

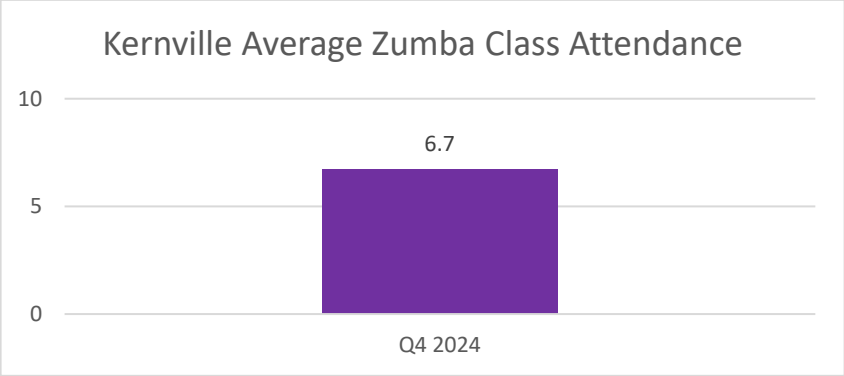


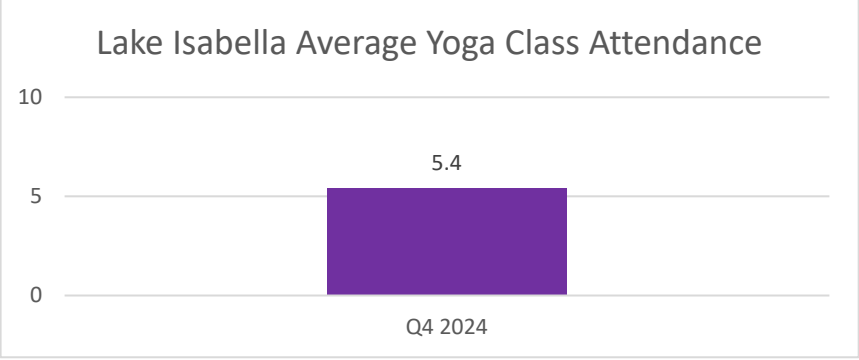


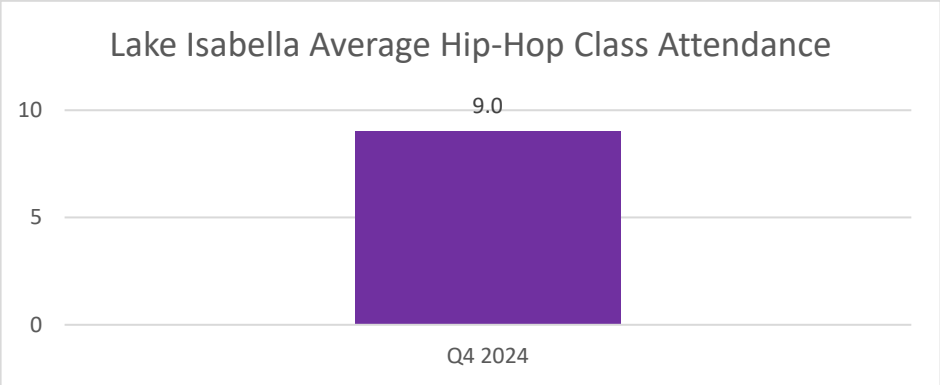
The Greenfield Live Better Program agreement was signed with Greenfield Union School District (GUSD) in association with Greenfield Family Resource Center. The program began in October 2024. Zumba classes are held every Monday, Tuesday and Wednesday evening from 6:00 pm- 7:00 PM at Stiern Park across the street from the Greenfield Family Resource Center. The Greenfield Walking Group is working directly with GUSD to facilitate the Zumba classes. The health education component of the program will be facilitated by our KHS Community Health and Wellness (CH&W) Team and includes monthly classes of the EHBA series, which will be held every 3rd Monday of the month. Zumba class attendance averaged 12.8 in Q4 2024.



The Lake Isabella Live Better Program agreement was signed with Danica's School of Dance to facilitate fitness classes in the Lake Isabella and Kernville. The program began in November 2024. The program includes adult hip-hop classes held on Wednesday 5:30-6:30 pm and yoga classes held 10-11 am located at Danica's School of Dance in Lake Isabella. Zumba classes are also held Thursday 5:45-6:45 pm at Fit Hauss Health Club located in Kernville. The health education component for the Live Better Program will eventually be facilitated by the Kern River Valley Family Resource center starting in Q1 2025. Average attendance in Q4 2024 for the Zumba, yoga, and hip-hop classes was 6.7, 5.4, and 9.0, respectively.







Community Health and Wellness Initiatives

- Ten (10) Kern County schools were selected for a 2024-2026 School Wellness Grant out of 31 applications. Schools in East Bakersfield, Southwest Bakersfield, Lamont, Ridgecrest, Shafter, Wasco, and Weedpatch were selected. The school wellness grant orientation for the selected schools was held virtually on January 17, 2025.
- Two KHS staff were certified as child passenger safety technicians as part of the Car Seat Safety Check event held on October 26, 2024, in partnership with First 5 Kern. Approximately 17 parents or guardians, including one expectant mother, and 26 children, were served.
- KHS sponsored a shaken baby syndrome prevention education program by Kern County Network for Children. This program will target educational sessions towards parents at high schools and college campuses.
- KHS sponsored the Youth Tobacco Prevention Program facilitated by the Dignity Health Community Wellness Program. The program provided tobacco prevention education to 920 5th and 6th grade students during the 2023/2024 school year. During the 2024/2025 school year, 295 students have received education.

Kern Health Systems
Cultural & Linguistic Services Activities Report
4th Quarter 2024

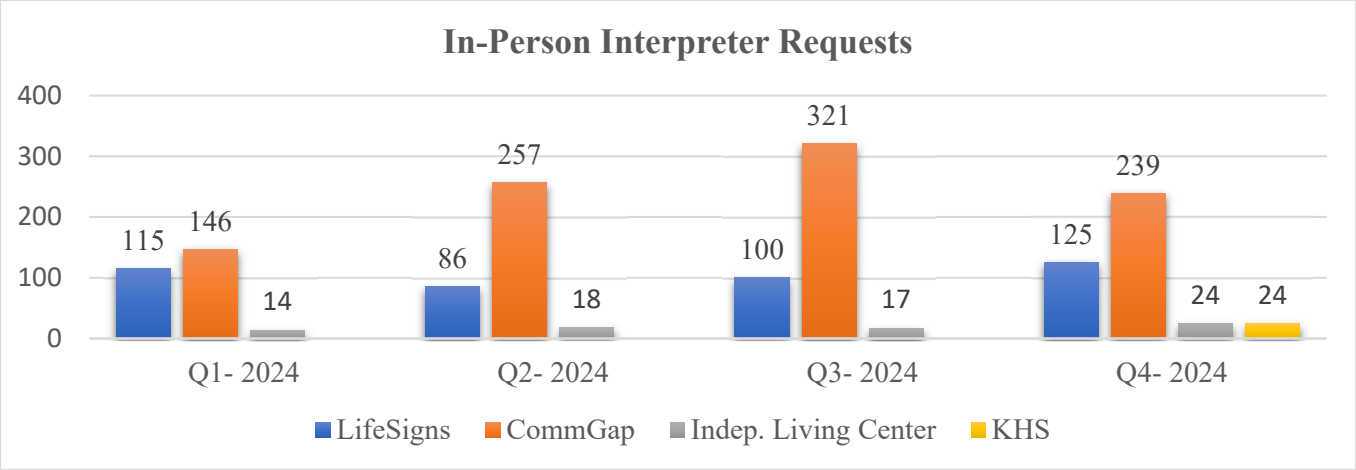
Cultural and Linguistic Services

Interpreter Requests

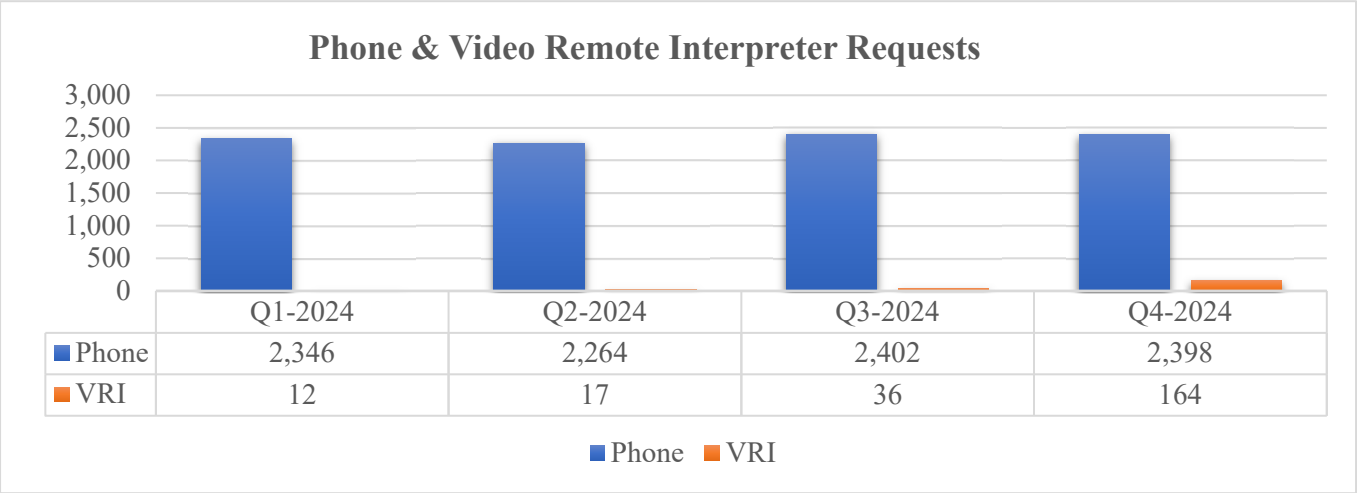
During this quarter, there were 265 requests for Face-to-Face Interpreting, 2,398 requests for Telephonic Interpreting, 169 for Video Remote Interpreting (VRI) and 125 requests for an American Sign Language (ASL) interpreter. The top three languages requested are shown as follows.

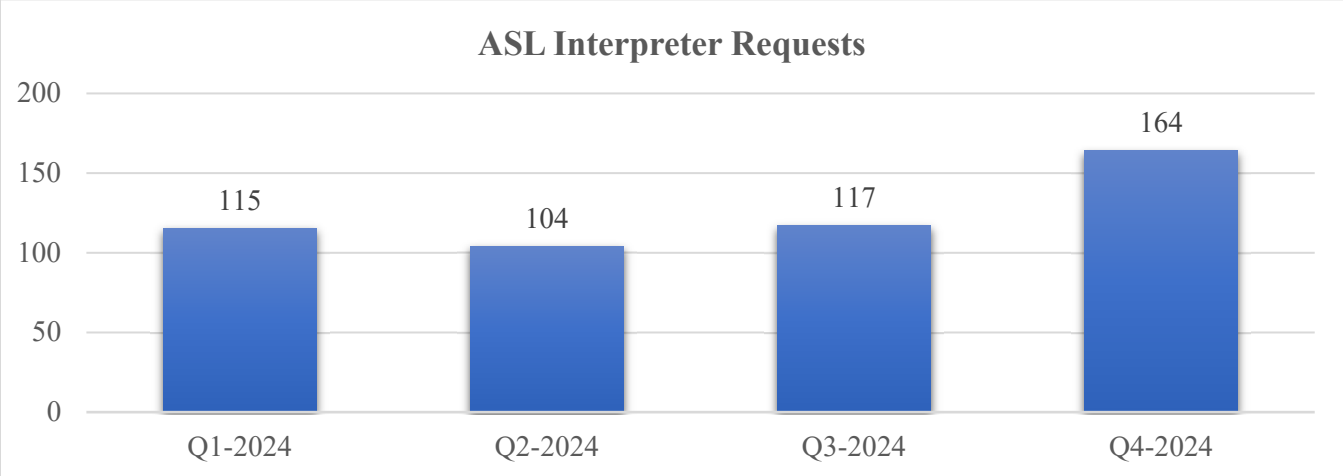
Interpreting Languages Requested
Phone and Video Remote
Spanish
ASL
Punjabi

Interpreting Languages Requested
In-person
Spanish
Vietnamese
Arabic



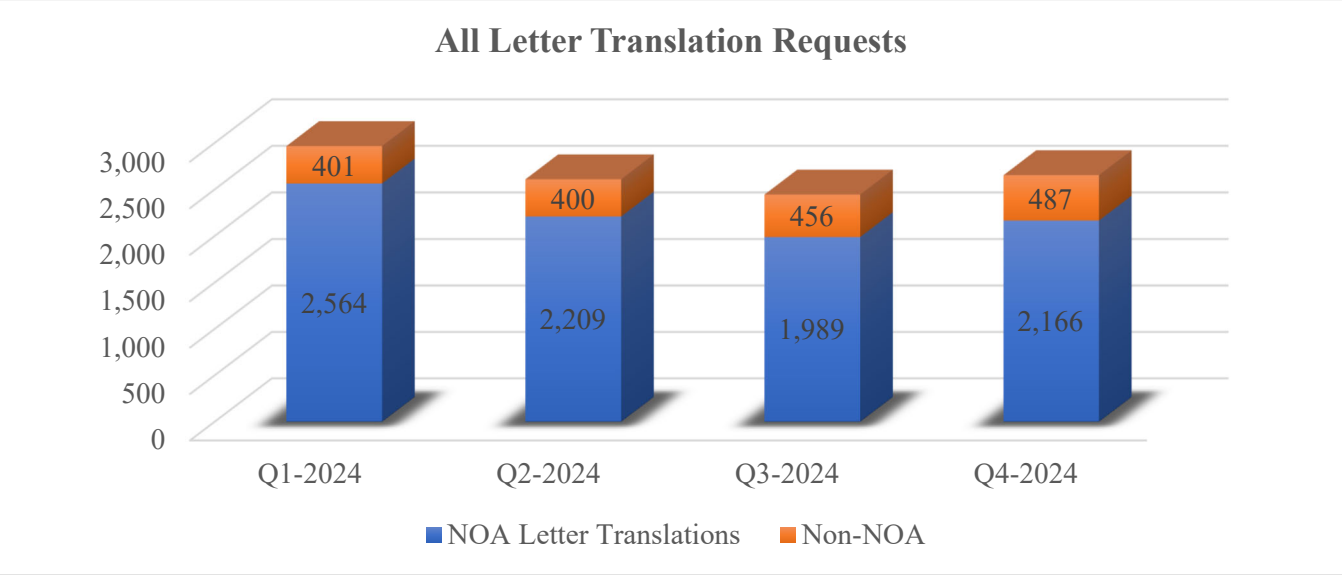
Kern Health Systems
Cultural & Linguistic Services Activities Report
4th Quarter 2024





Written Translations

The C&L department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 2,445 requests for written translations were received and completed.



Cultural and Linguistic Services Audits

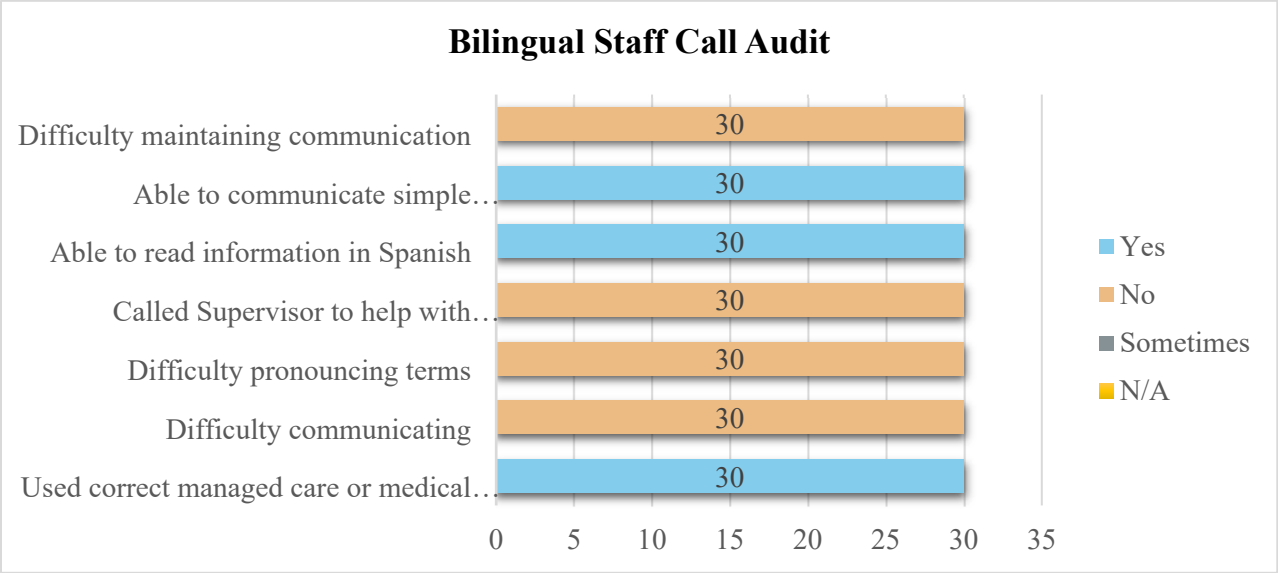
Vendor Over-the-Phone (OPI) Interpreter Call Monitoring

During this quarter, Language Line Solutions conducted an audit on 30 random OPI interpreter services calls. These calls were randomly selected from the vendors monthly invoices. Calls audited were in Mandarin, Punjabi, Spanish, Cantonese, Yemeni Arabic, Vietnamese. Nepali and Khmer languages. Calls were evaluated on the following items: Interpreter's Customer Service, Interpretation Skills, and the ability to follow the Code of Ethics and Standards of Practice. Audit findings revealed 100% of calls "Met Expectations."

Call Number	Interpreter ID	Status	Language	Annual Compliance Training Date	Medical Interpreter Skills Assessment Date	Medical Interpreter Skills Assessment Result	QA Observation Date	QA Observation Score
CR-	438741	Active	SPANISH	4/29/2024	5/8/2024	Pass	12/12/24	3/3
CR-	446913	Active	PUNJABI	6/27/2024	6/28/2024	Pass	11/11/24	3/3
CR-	406258	Active	PUNJABI	4/19/2024	2/13/2023	Pass	10/31/24	3/3
CR-	451363	Active	VIETNAMESE	8/12/2024	8/26/2024	Pass	10/02/24	3/3
CR-	434924	Active	VIETNAMESE	3/22/2024	3/26/2024	Pass	10/28/24	3/3
CR-	262232	Active	PUNJABI	4/16/2024	9/13/2018	Pass	12/10/24	3/3
CR-	432895	Active	SPANISH	2/23/2024	3/7/2024	Pass	12/30/24	3/3
CR-	405498	Active	SPANISH	6/25/2024	3/27/2024	Pass	12/06/24	3/3
CR-	406722	Active	SPANISH	8/13/2024	2/14/2023	Pass	12/10/24	3/3
CR-	453434	Active	NEPALI	9/16/2024	9/26/2024	Pass	11/20/24	3/3
CR-	454011	Active	KHMER	9/18/2024	9/23/2024	Pass	10/24/24	3/3
CR-	433668	Active	SPANISH	3/10/2024	3/13/2024	Pass	12/20/24	3/3
CR-	390643	Active	SPANISH	6/30/2024	12/27/2022	Pass	12/09/24	3/3
CR-	414074	Active	SPANISH	6/7/2024	5/8/2023	Pass	11/08/24	3/3
CR-	456923	Active	PUNJABI	10/11/2024	10/21/2024	Pass	11/22/24	3/3
CR-	451073	Active	SPANISH	8/23/2024	8/26/2024	Pass	10/28/24	3/3
CR-	251151	Active	MANDARIN	4/16/2024	11/8/2016	Pass	12/27/24	3/3
CR-	435939	Active	PUNJABI	3/30/2024	4/3/2024	Pass	12/02/24	3/3
CR-	454549	Active	PUNJABI	9/25/2024	9/30/2024	Pass	12/03/24	3/3
CR-	430653	Active	SPANISH	2/11/2024	6/25/2024	Pass	10/24/24	3/3
0506675925	417061	Active	ARABIC	6/23/2024	5/8/2024	Pass	11/07/24	3/3
CR-	399666	Active	SPANISH	7/10/2024	5/1/2024	Pass	11/22/24	3/3
CR-	426382	Active	SPANISH	5/23/2024	12/18/2023	Pass	11/07/24	3/3
CR-	454236	Active	SPANISH	9/27/2024	9/30/2024	Pass	12/02/24	3/3
CR-	452001	Active	SPANISH	9/22/2024	9/23/2024	Pass	12/23/24	3/3
CR-	442969	Active	SPANISH	5/16/2024	10/30/2024	Pass	11/15/24	3/3
CR-	353015	Active	CANTONESE	5/26/2024	7/12/2019	Pass	11/17/24	3/3
CR-	458996	Active	SPANISH	11/8/2024	11/18/2024	Pass	12/31/24	2/2
CR-	403688	Active	SPANISH	5/5/2024	4/18/2023	Pass	12/16/24	3/3
CR-	436810	Active	SPANISH	4/5/2024	4/12/2024	Pass	12/12/24	3/3

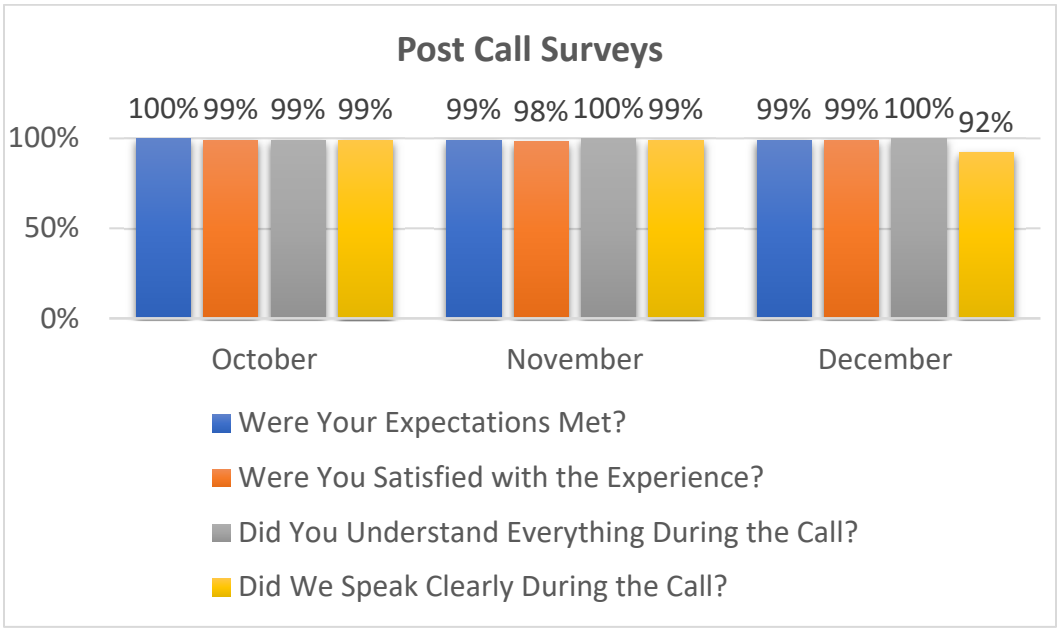
Bilingual Staff Call Audit

During this quarter, a total of 30 Spanish audio calls from KHS member facing departments were reviewed to assess the linguistic performance of the bilingual staff. The calls were audited using a group of measures to identify any potential difficulty communicating with members in a language other than English as shown below in the chart. Findings revealed that 100% of bilingual staff did not have difficulty communicating with members in a non-English language.



Post Call Surveys

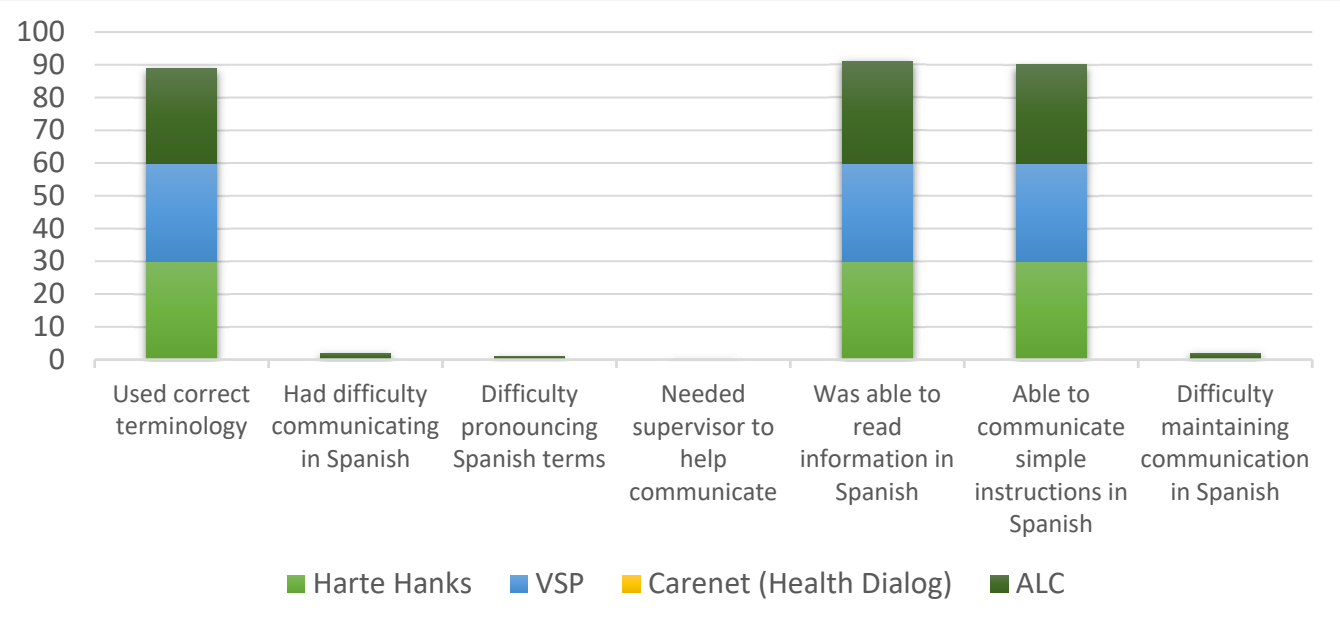
During this quarter, a total of 9,937 Spanish Post Call Surveys were collected from members for all KHS member facing departments to assess the linguistic performance of the bilingual staff. KHS' post call survey evaluates a member's call experience by language. Findings revealed that 99% of members are satisfied with the linguistic performance of bilingual staff.



Vendor Bilingual Call Audits

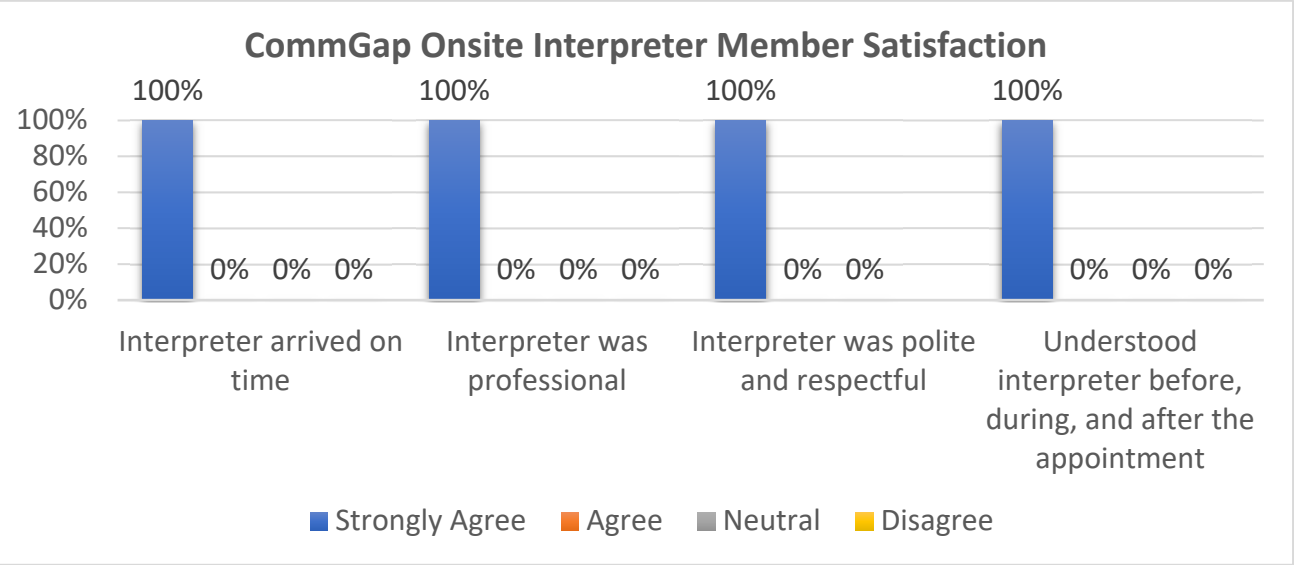
During this quarter, a total of 91 Spanish audio calls were received from contracted vendors with KHS. These vendors include: ALC Transportation and Harte Hanks. These audio calls were reviewed to assess the linguistic performance of the vendor's bilingual staff. Findings revealed that 98% of bilingual staff did not have difficulty communicating with members in a non-English language.

Note: Due to software updates, Carenet (Health Dialog) will provide data in Q1 of 2025.



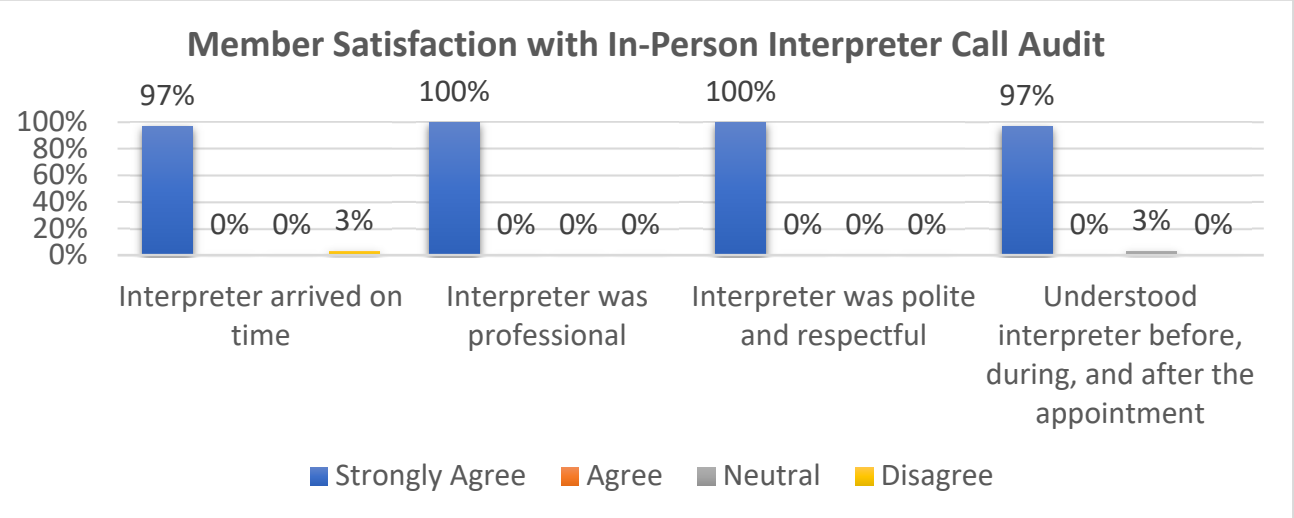
CommGap Onsite Interpreting Member Satisfaction Survey

During this quarter, an interpreter satisfaction survey was sent out by our vendor CommGap who surveyed 18 members after their onsite encounter with their provider. Of the 18 surveys sent out, 100% of respondents "Strongly Agreed" that they were satisfied with the interpreter services they received from the vendor.



Member In-person Interpreting Satisfaction Call Surveys

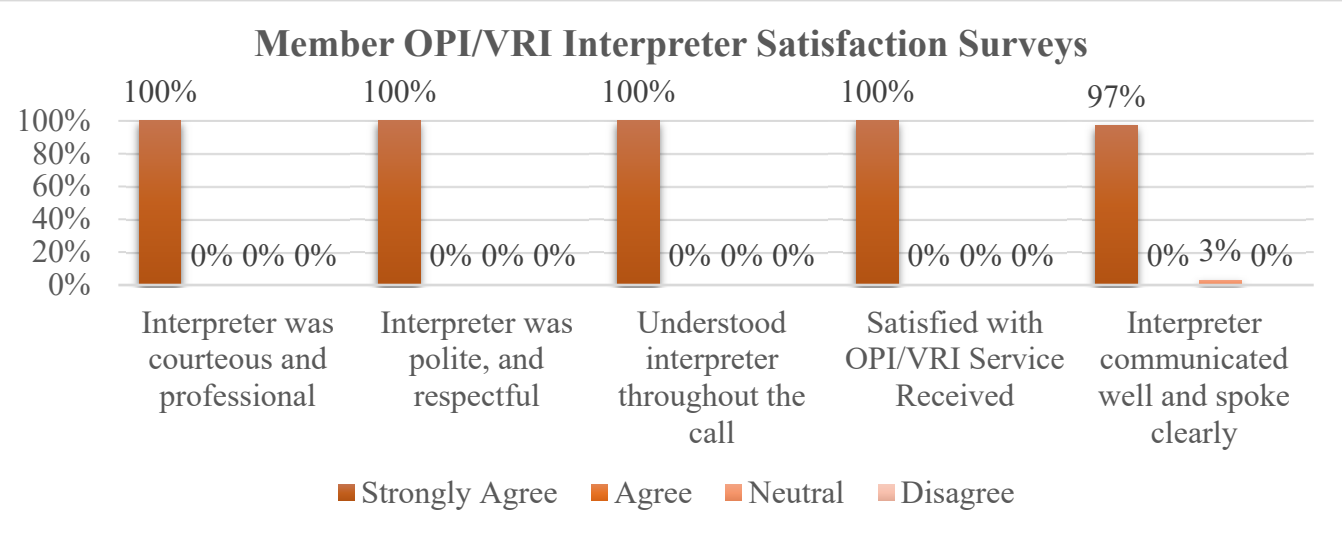
During this quarter, a total of 32 satisfaction surveys were collected from members who received in-person interpreting services and more than 97% of members reported they "Strongly Agreed" being satisfied with their interpreter.



Member OPI & VRI Interpreting Satisfaction Call Surveys

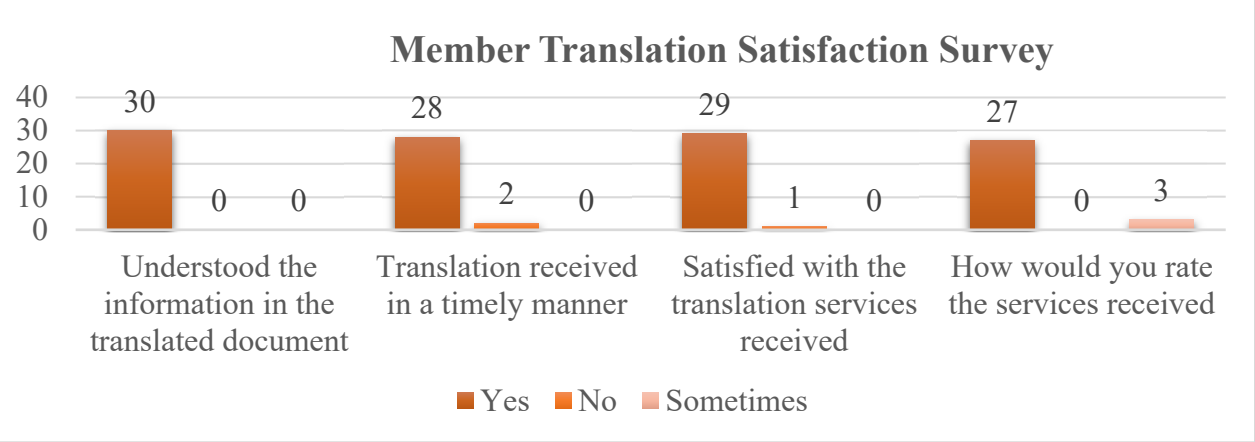
During this quarter, a total of 30 satisfaction surveys were collected from members who received Over-The-Phone (OPI) and Video Remote (VRI) interpreting services. Of the 30 surveys, 26 responses were for OPI services, and 4 responses were for VRI services. The survey concluded with

97% of members reporting they "Strongly Agreed" being satisfied with the OPI/VRI interpreter services they received.



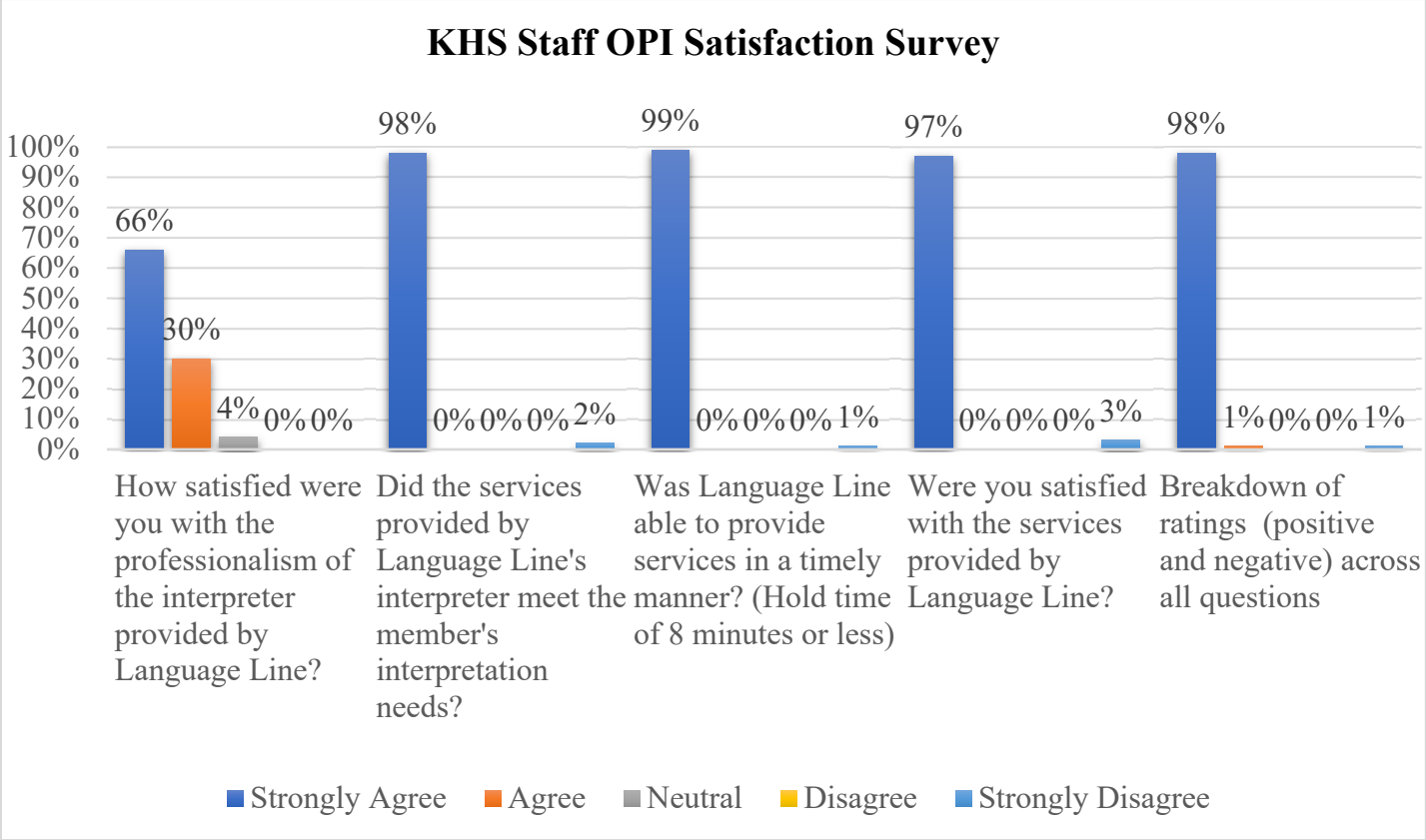
Translation Member Satisfaction Survey

During this quarter, a total of 30 translation satisfaction call surveys were conducted for members who received a translation completed by C&L translators and by our vendor Language Line Solutions. This survey is to determine the members satisfaction regarding our translation services. Of the 30 calls completed, 97% of members were satisfied with the services received.



KHS Staff Satisfaction Over-the-Phone (OPI) Survey

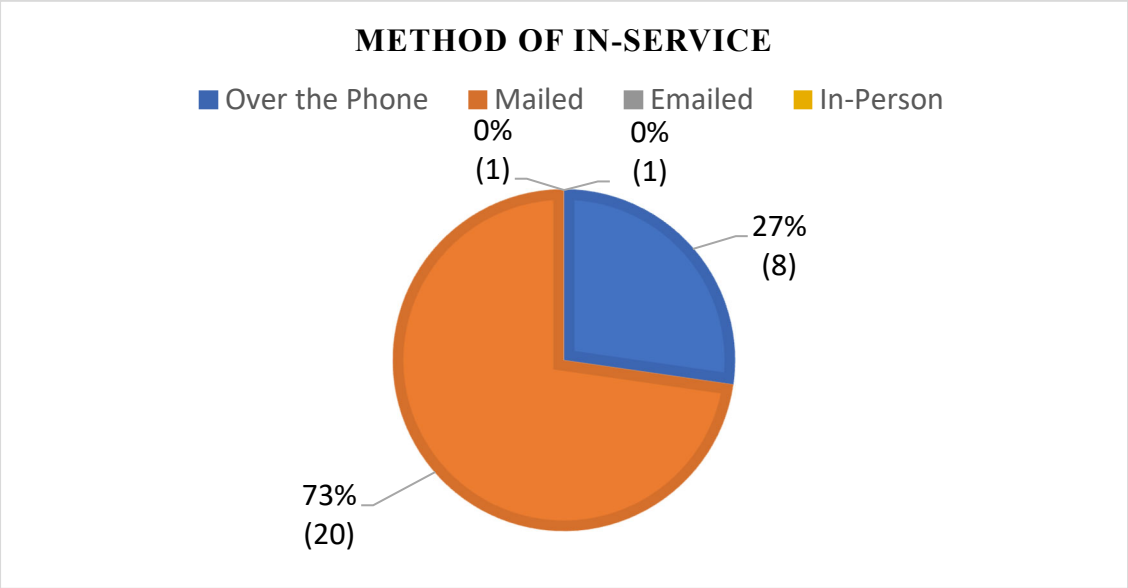
During this quarter, a total of 115 surveys were received from KHS member facing department staff regarding their satisfaction with our vendor Language Line Services concerning over-the-phone interpretation. Findings revealed that 96% of KHS staff are satisfied with the linguistic performance of our vendors' interpreters.



C&L Trainings

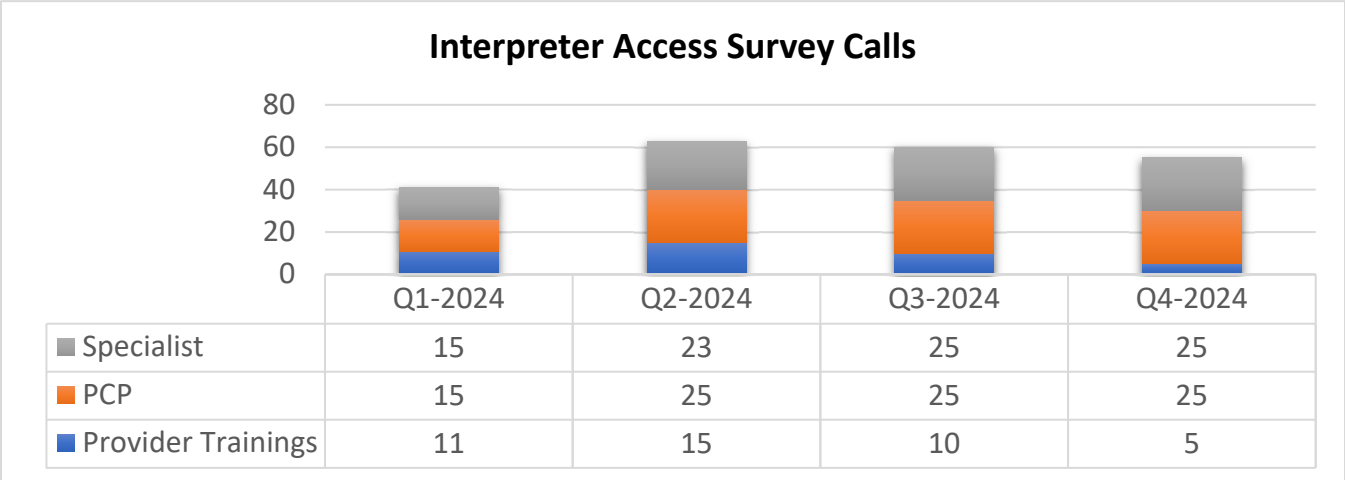
C&L Grievance Provider Trainings

During this quarter, 8 Cultural and Linguistic (C&L) related grievances were filed against providers contracted with Kern Family Health Care (KFHC) due to a lack of language access for members. For this quarter, 8 contracted providers were contacted, and a C&L Services in-service was provided. The C&L team conducted a total of 20 calls to these providers. These call attempts were tracked and marked either “successful” (provided an in-service over the phone or via providers ‘preferred method) or “unsuccessful” (unable to reach someone or provider refused). Those that were “successful” were provided the in-service via telephone, mail, email, and/or in-person. Those that were unsuccessful were still provided with KFHC C&L services educational material via mail.



Interpreter Access Survey Calls

Each quarter, the Provider Network Management (PNM) department conducts an interpreter access survey among KHS providers. During Q4, 25 PCPs and 25 Specialists participated in this survey. Of these providers, 5 needed a refresher training on KHS' C&L services.

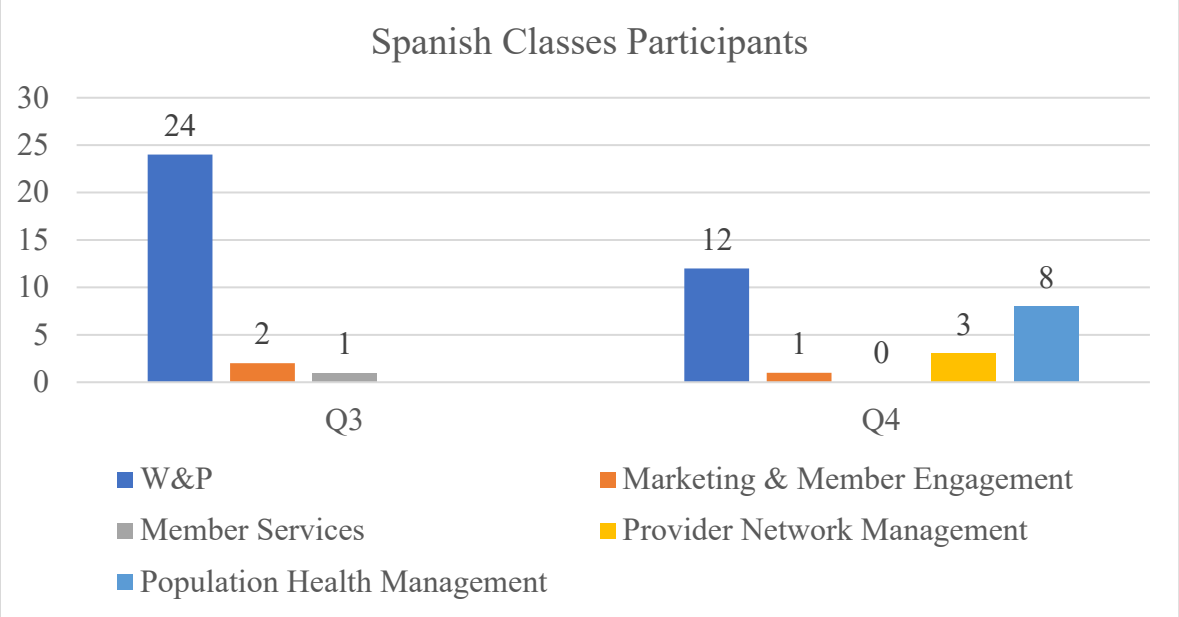


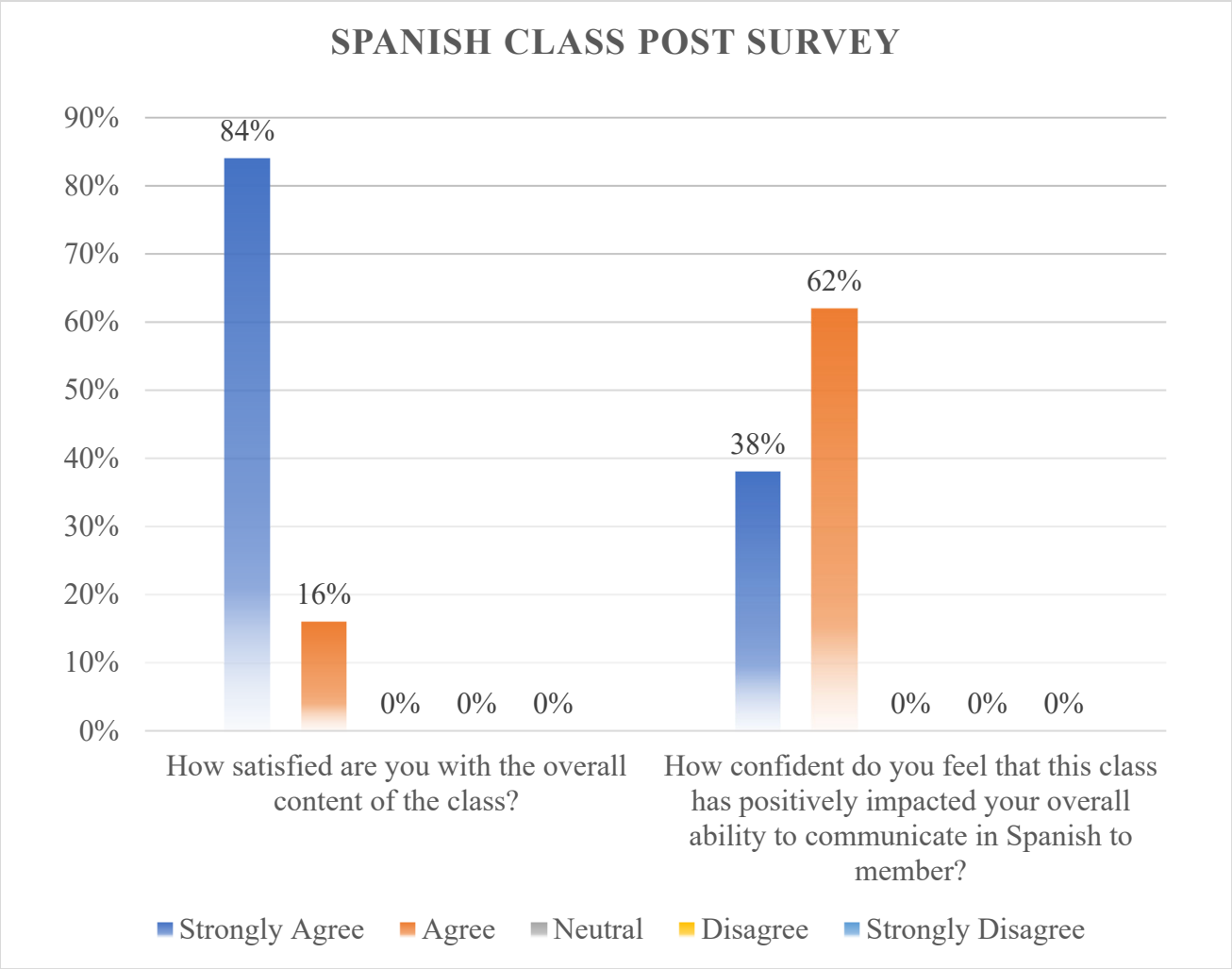
	Q1-2024	Q2-2024	Q3-2024	Q4-2024
Specialist	15	23	25	25
PCP	15	25	25	25
Provider Trainings	11	15	10	5

KHS Bilingual Staff Training

The C&L Department supports the professional development of all KHS internal staff, especially those who are bilingual, by offering a cycle of trainings to enhance their Spanish skills. During Q4 2024, one class was held with a total of 24 participants from several KHS departments such as PHM, C&L, W&P, Member Engagement, and ECM.
The classes give participants the opportunity to practice the 4 skills in a language, including reading, writing, speaking and listening. For this quarter's class, the topic covered was "acentos/tildes", in which participants completed writing exercises as well as speaking activities where they had the chance to practice real life interactions with members in Spanish.

Compared to the class offered in Q3, there was a decrease of 3 attendees. During class, all attendees complete a pre and a post survey, which helps us understand their expectations as well as their satisfaction with the class.




SPANISH CLASS POST SURVEY
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
84%
16%
0%
0%
0%
38%
62%
0%
0%
0%
How satisfied are you with the overall content of the class?
How confident do you feel that this class has positively impacted your overall ability to communicate in Spanish to member?
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree

To: KHS EQIHEC Committee

From: John Miller, M.D.

Date: March 18, 2025

Re: Trilogy Documents

Background

Kern Health Systems remains dedicated to improving health outcomes, ensuring regulatory compliance, and advancing health equity for Medi-Cal members in Kern County. As part of its ongoing commitment to quality improvement, KHS has developed three key documents for review and approval: **the 2024 Quality Program Evaluation, 2025 Quality Improvement Health Equity Program Description, and 2025 Quality Improvement Work Plan.** These documents provide a comprehensive assessment of program performance, outline strategic priorities for the coming year, and establish measurable goals to enhance clinical care, service quality, and member experience. Approval of these documents will guide KHS's quality initiatives and reinforce its mission to deliver equitable, high-quality healthcare.

Discussion

2024 Quality Program Evaluation, 2025 Quality Improvement Health Equity Program Description, and 2025 Quality Improvement Work Plan

Magdee Hugais, Director of Quality Improvement, presenting the three documents for review and approval.

- The 2024 Quality Program Evaluation assesses the effectiveness of the QI Program in enhancing member health outcomes, ensuring regulatory compliance, and promoting health equity. It reviews governance, departmental changes, performance metrics, clinical care quality, safety, service quality, and member experience. Key achievements include meeting 26 of 28 program goals, improving several Managed Care Accountability Set (MCAS) measures, and enhancing provider engagement and member outreach. However, challenges remain in meeting minimum performance levels for select quality measures and timely grievance resolutions.
- The 2025 Quality Improvement Health Equity Program (QIHEP) Description outlines the organization's commitment to improving health outcomes, reducing disparities, and ensuring equitable care for Medi-Cal members in Kern County. It provides an in-depth framework for quality improvement, including governance, program scope, goals, and responsibilities of key committees and departments. The document highlights efforts to

address social determinants of health (SDOH), expand provider networks, and enhance culturally competent care. Key initiatives include data-driven quality improvement projects, member engagement strategies, and oversight of performance metrics such as Managed Care Accountability Set (MCAS) measures. The program integrates clinical and non-clinical approaches to promote whole-person care, with a strong emphasis on health equity, member satisfaction, and continuous performance evaluation.

- The 2025 QI Work Plan lists the Key Performance measures with measurable goals for the year. The domains of the plan include: program structure, quality and safety of clinical care, quality of service, and member and provider satisfaction.

Fiscal Impact

None.

Requested Action

Approval of:

1. 2024 Quality Program Evaluation
2. 2025 Quality Improvement Health Equity Program Description
3. 2025 Quality Improvement Work Plan

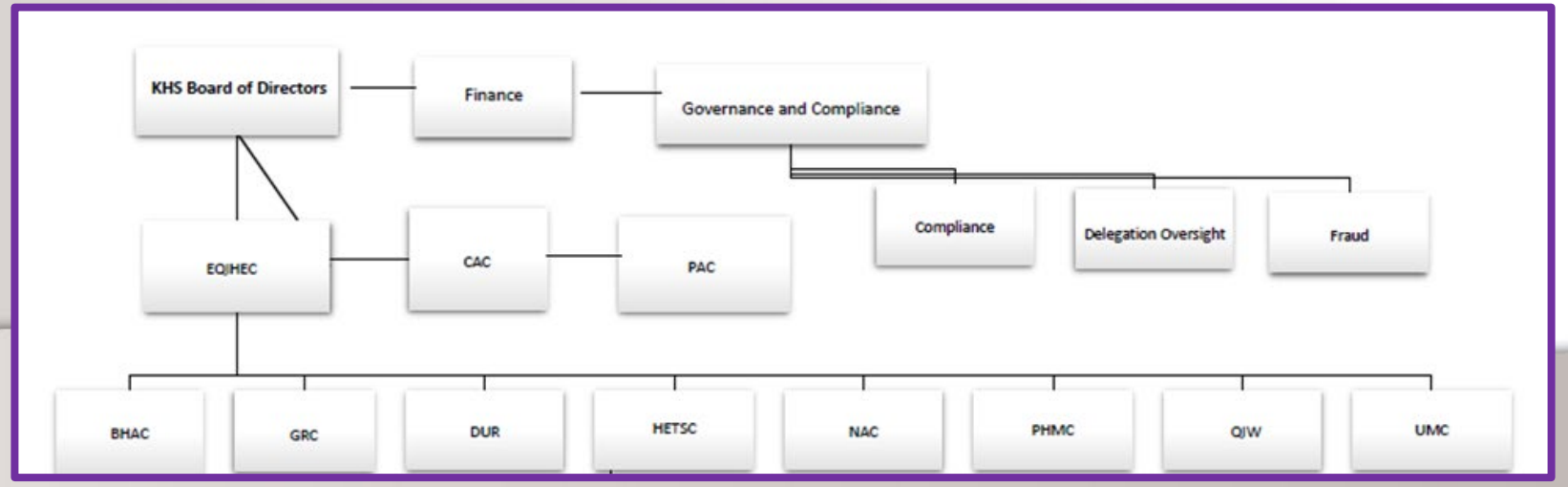
2024 Workplan Evaluation

- Quality Program Governance
- Quality Department Changes
- 2024 Workplan Summary
- Quality Program Structure
- Quality of Clinical Care
- Safety of Clinical Care
- Quality of Service
- Member Experience
- Provider Engagement
- Conclusion

KERN HEALTH SYSTEMS

2024 Workplan Evaluation

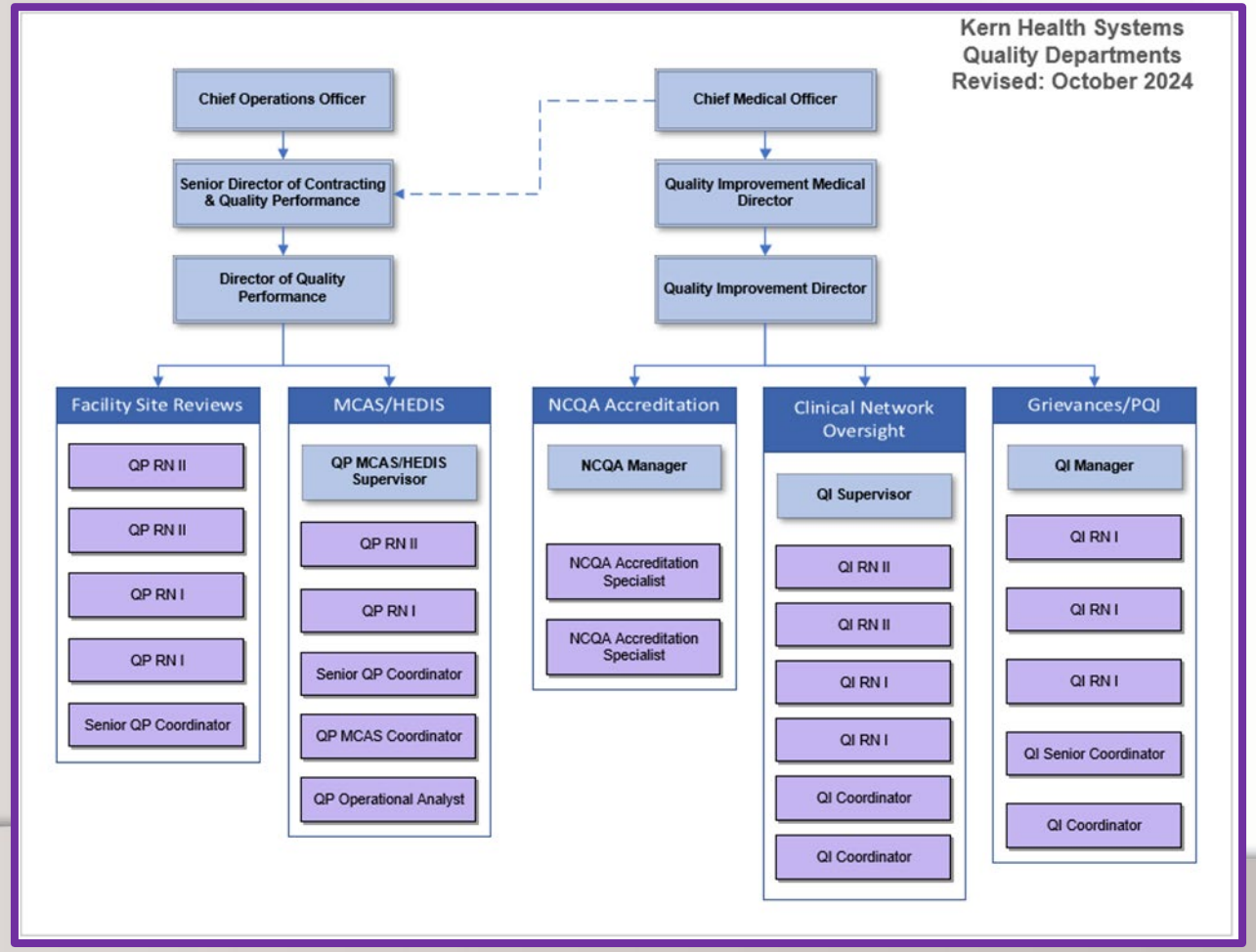
- Quality Program Governance
  - Board of Directors
  - CEO
  - CMO
  - CHEO
  - EQIHEC
    - All committees & subcommittees parameters for membership and meeting frequency were met for 2024.



KERN HEALTH SYSTEMS

2024 Workplan Evaluation

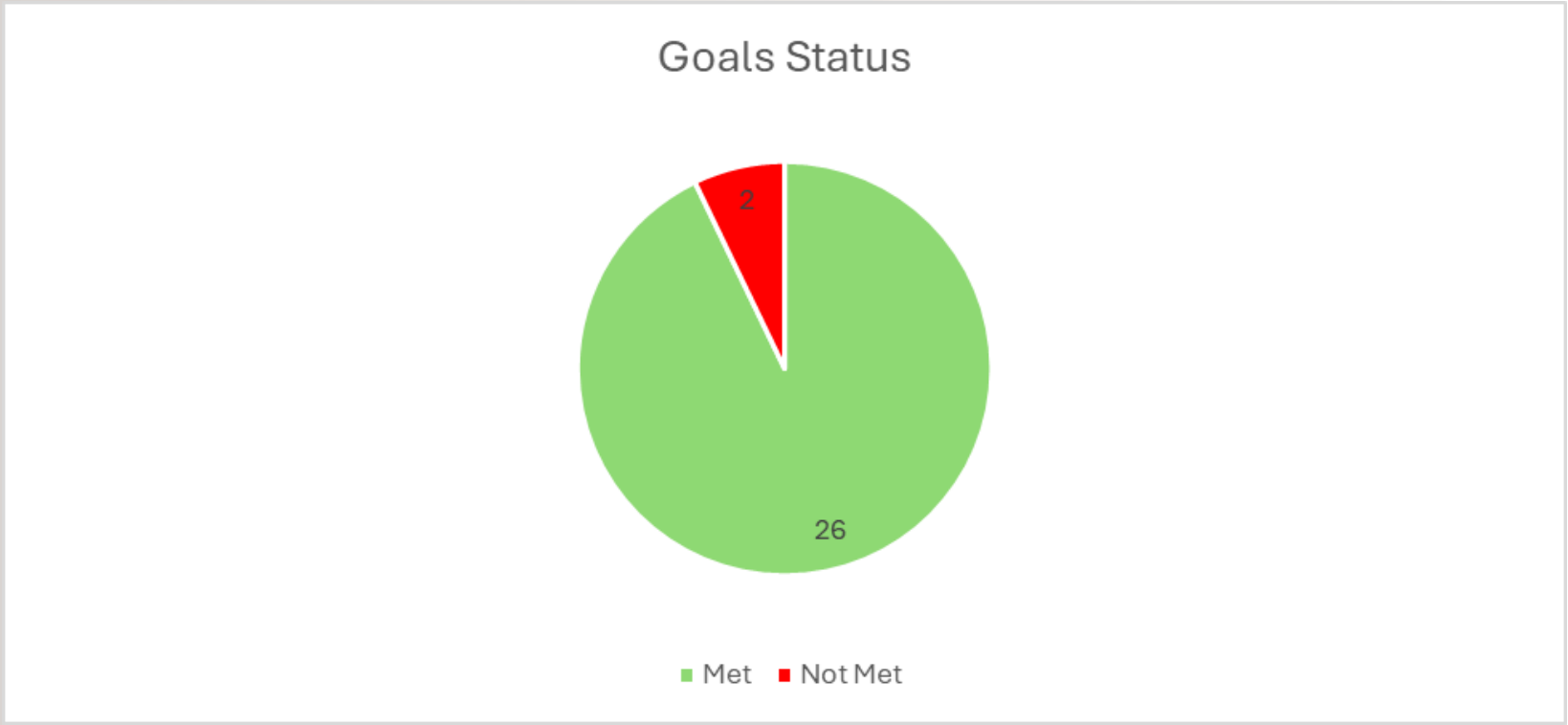
- Quality Department Changes



KERN HEALTH SYSTEMS

2024 Workplan Evaluation

- 2024 Workplan Summary



KERN HEALTH SYSTEMS

2024 Workplan Evaluation

- Quality Program Structure

	Metric	Goal	Result
1	QI Program Description	Annual Approval by the EQIHEC and the BOD	Met
2	Annual QI Work Plan	Annual Approval by the EQIHEC and the BOD	Met
3	Annual QI Evaluation	Annual Approval by the EQIHEC and the BOD	Met
4	Policies & Procedures	Annual Approval by the QI Subcommittee	Met
5	Executive Quality Improvement Health Equity Committee (EQIHEC)	Conduct Quarterly Meetings as required by the QI Program	Met

KERN HEALTH SYSTEMS

2024 Workplan Evaluation

- Quality of Clinical Care

	Metric	Goal	Result
6	MCAS Measures meet MPL	Timely submission of all 18 measures and meet MPL for all 18 measures	Not Met
7	Clinical PIP	Establish interventions in 2024	Met
8	Non-Clinical PIP	Establish interventions in 2024	Met
9	Monitor PQI Volume month over month	Decrease Median Volume of last 12 months	Met
10	PQI Volume by Provider and by severity	Severity Level 2/3 Volume is less than 30	Met
11	PQI Volume by Ethnicity and by Severity	Severity Level 2/3 Volume is less than 30	Met
12	PQI Timeliness of resolution	Within 120 Days	Met
13	Continuity and Coordination of Medical Care	Establish Baseline	Met
14	Continuity and Coordination Between Medical Care and Behavioral Healthcare	Establish Baseline	Met

KERN HEALTH SYSTEMS

2024 Workplan Evaluation

- Safety of Clinical Care

	Metric	Goal	Result
15	Facility Site Review	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	Met
16	Physical Accessibility Review Surveys	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	Met
17	Medical Record Reviews	Achieve medical record review score of 85% for each practitioner	Met
18	Credentialing/Recredentialing	100% timely credentialing/recredentialing of practitioners	Met

KERN HEALTH SYSTEMS

2024 Workplan Evaluation

- Quality of Service

	Metric	Goal	Result
19	Grievances & Appeals Timeliness of acknowledgement letters	Within 5 calendar days	Met
20	Grievances & Appeals Timeliness of resolution	Within 30 calendar days	Not Met
21	Access to Care – PCP	80% of routine care within 10 days	Met
22	Access to Care – SCP	80% of specialty care within 15 days	Met
23	Telephone Access to Member Services	Speed of answer <30s and call abandonment rate <5%	Met

Metric	Goal	Result
Grievances & Appeals Timeliness of acknowledgement letters	Within 5 calendar days	93.1%
Grievances & Appeals Timeliness of resolution	Within 30 calendar days	76%

KERN HEALTH SYSTEMS

2024 Workplan Evaluation

- Member Experience
- Provider Engagement

	Metric	Goal	Result
24	Adult and Child CAHPS Survey	Establish baseline for Getting Care needed measure	Met
25	Member Rewards	Increase MCAS measure rates by 2% by EOY	Met

	Metric	Goal	Result
26	Provider Satisfaction Survey	Trend results by survey questions	Met
27	Provider Incentive Program	Improve A1C Level	Met
28	Provider Education	Meet Providers Quarterly	Met

KERN HEALTH SYSTEMS

2024 Workplan Evaluation

- Conclusion
  - **Effectiveness of the QI Program**
    In 2024, KHS achieved 26 of its 28 Quality Improvement goals, highlighting its strong commitment to quality enhancement.

Opportunities for 2025

- Strengthening Provider Engagement Strategies to improve compliance with MCAS measures and care coordination responsibilities.
- Enhancing Data Analytics & Timely Reporting to enable faster response times to emerging trends in quality and safety concerns.
- Expanding Access to Preventive Care & Behavioral Health Services through mobile health initiatives and innovative partnerships with local healthcare providers and community organizations.
- Addressing Health Equity Challenges by scaling up targeted interventions for high-risk populations and ensuring culturally competent care delivery.

KERN HEALTH SYSTEMS

2025 QIHE Program Description

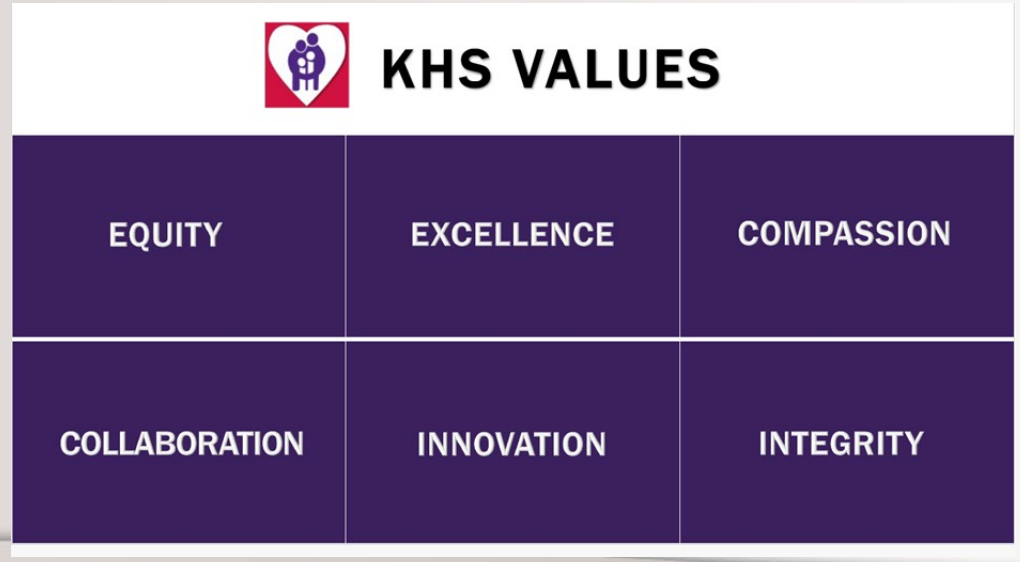
- First year combining QI & Health Equity into one program description.

- Mission & Values
- QIHE Program Overview, Purpose, Scope, Goals
- Authority & Responsibility
- Organizational Structure & Resources
- Role of Participating Providers
- Program Documents
- 2025 Quality Work Plan

KERN HEALTH SYSTEMS

2025 QIHE Program Description

- Mission & Values
  - KHS is committed to improving the health and well-being of our members and the community of Kern County through an integrated, equitable, and member-centered healthcare delivery system.



KERN HEALTH SYSTEMS

2025 QIHE Program Description

- QIHE Program Overview, Purpose, Scope
  - The QIHEP is a written description of the overall scope and responsibilities of the program. The QIHEP actively monitors, evaluates, and takes effective action to address any needed improvements in the quality, appropriateness, safety, and outcomes of covered health care services delivered by all contracting providers rendering services to members.
  - QIHEP is composed of several systematic processes that monitor and evaluate the quality of clinical care and health care service delivery to KHS members. The QIHEP scope includes regular needs assessments based on race/ethnicity, language, cultural preferences, health disparities, and stakeholder engagement.

KERN HEALTH SYSTEMS

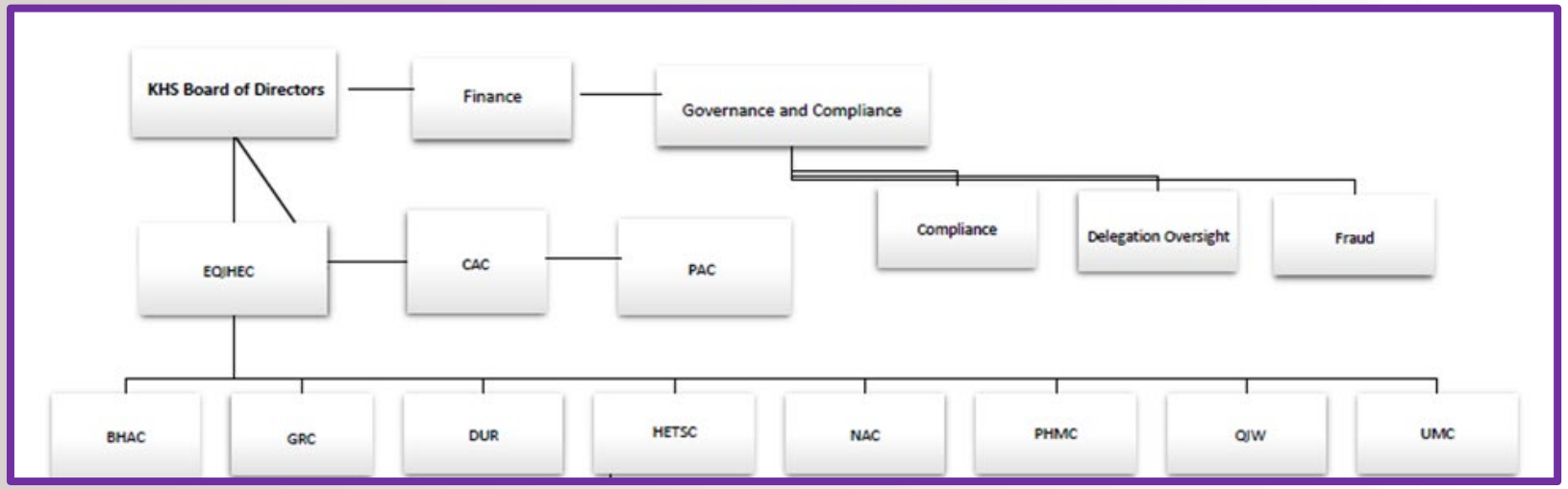
2025 QIHE Program Description

- QIHE Goals
  - Enhancing Member Health
  - Guidelines & Education
  - Practice Standards
  - Open Communication
  - Delegation Oversight
  - Data-Driven Improvement
  - Quality & Safety Commitment
  - Regulatory Compliance
  - Performance Evaluation

KERN HEALTH SYSTEMS

2025 QIHE Program Description

- Authority & Responsibility
- Organizational Structure & Resources



KERN HEALTH SYSTEMS

2025 QIHE Program Description

- Role of Participating Providers

  - **Provider Information** – KHS informs contracting providers through its Provider bulletins, letters and memorandums, distribution of updates to the Provider Policy and Procedure Manual, and training sessions.
  - **Provider Cooperation** – KHS requires that contracting providers and hospitals cooperate with QI Program studies, audits, monitoring, and quality related activities. Requirements for cooperation are included in provider and hospital contract language that describe contractual agreements for access to information.
  - **Provider Performance** – KHS requires contracted providers to comply with DHCS' Managed Care Accountability Set (MCAS) and participate in quality-based initiatives aimed at improving, access, quality, and health equity for our members. Routine meetings are conducted with a subset of participating providers to ensure monitoring, communication, and supporting of achieving MPLs and maintaining high quality care.

KERN HEALTH SYSTEMS

2025 QI Annual Work Plan

- Quality Program Structure
  - Adding a goal of completing NCQA accreditation
- Quality of Clinical Care
  - MCAS, PIPs, Health Equity Sprint Collaborative
- Safety of Clinical Care
  - Patient Safety Program, PQIs, FSR, Drug Utilization, Credentialing/Recredentialing
- Quality of Service
  - Grievance & Appeals Timeliness, Access to Care, Telephone Access
- Member Experience – CAHPS survey
- Provider Engagement
  - Satisfaction survey & Provider Education

KERN HEALTH SYSTEMS

Your Role

- **Review and approve** 2024 Quality Program Evaluation, 2025 QIHE Program Description & 2025 Workplan
- **Monitor KHS Quality Plan** throughout the year – Scorecard brought every quarter
- **Provide feedback** on trends, priorities, community health, equity and disparities
- **Identify and address gaps in care**
- **Provide recommendations** for Improvement opportunities
- **Serve as the voice** of your organization and the community

KERN HEALTH SYSTEMS

You + Us = **a better day!**

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

2024 Quality Program Evaluation

Executive Quality Improvement Health Equity Committee (EQIHEC)
Approval Date: 03/18/25

Table of Contents

I. Introduction

Kern Health Systems (KHS), doing business as Kern Family Health Care (KFHC), was established in 1993 by the Kern County Board of Supervisors as the local initiative, Medi-Cal managed care health plan. KFHC is the largest health plan in Kern County, serving most of the Medi-Cal beneficiaries through a contract with the State of California Department of Healthcare Services (DHCS).

KHS is a special county health authority created by special county ordinance and is governed by a board that consists of sixteen members. The board consists of the Chief Executive Officer of the local safety net hospital, a safety net care provider, ten community representatives nominated by each of the five County Supervisors, two traditional Medi-Cal primary care physicians, one representative from a rural acute care general hospital within the county and one pharmacist. All members must be at least twenty-one years of age and work or reside within Kern County. The Board is responsible for establishing and operating a comprehensive managed care system providing health care services, ensuring delivery of publicly assisted medical care in Kern County, promoting quality and cost efficiency, and arranging for the provision of health care services pursuant to Chapter 7, Part 3 of Division 9, section 14000 of the Welfare and Institutions Code.

The mission of KHS is to improve our members' health status through an integrated managed health care delivery system. KHS strives to “meet people where they are” and nurture individual wellness one member at a time to cumulatively improve the overall health and wellness of our community. The objective of KHS is to provide equitable, high-quality, cohesive care to our members that not only addresses physical health but mental, emotional, and social health as well.

In a commitment to the community of Kern County and the members of Kern Health Systems (KHS), the Quality Improvement (QI) Program is designed to objectively monitor, systematically evaluate, and effectively improve the health and care of those being served. The KHS Quality Improvement Department manages the Program and oversees activities undertaken by KHS to achieve improved health of the covered population. All contracting providers of KHS participate in the Quality Improvement (QI) program.

KHS’ total membership in 2024 is approximately 403,000 members with 49% assigned to the County Hospital system and two large Federally Qualified Health Centers (FQHC).

Over 66% of the population is concentrated in Bakersfield, while the remaining population reside in the rural areas. Highest racial group is the Hispanic population, which account for 63% of the membership.

English is the primary language spoken by 70% of the population, 29% speak Spanish and 1% is a mix of other languages.

Kern County’s health risk factors include higher rates of adult smoking, adult obesity, physical inactivity, alcohol-impaired driving deaths, sexually transmitted infections and teen births compared to state-wide statistics. Kern County ranked better than California in state average for food environment index, due to percentage of l ow income and low access to grocery store, and excessive drinking.

II. Quality Program Governance

KHS has multiple provider specialties and members from the KHS community and population represented in the following committees:

Board of Directors (BOD)

The KHS Board of Directors (BOD) seeks to improve access to quality healthcare, maintain and preserve a healthcare safety net for Kern County, and ensure the fiscal integrity of KHS. The BOD has accountability, authority and responsibility for the overall QI program. The BOD has delegated the coordination of the QI Program to the Executive Quality Improvement Health Equity Committee (EQIHEC). The members of the BOD are appointed by the County Board of Supervisors with backgrounds in business, finance, managed care, hospital administration, information technology, medicine, healthcare policy and law. The BOD meets at least four times per year.

Chief Executive Officer

The KHS Chief Executive Officer (CEO) is responsible for the implementation of the QI Program and a voting member of the Board. The CEO provides organizational leadership and direction, participate in prioritization and organizational oversight of quality improvement activities, and ensure availability of resources necessary to implement the approved QI Program. The Executive Team provides oversight, accountability and support for NCQA, HEDIS and related quality improvement initiatives. The CEO's level of involvement in quality improvement activities was appropriate to ensure executive level accountability in support of the organizational goals.

Chief Medical Officer

The Chief Medical Officer (CMO) is responsible for the day-to-day oversight of the Medical Management, Quality Improvement, Utilization Management, Case Management, Behavioral Health, Community Based Programs and Peer Review Activities. The CMO serves as the Co-Chair of the EQIHEC and is involved in all QI and Health Services activities. The CMO provides oversight for the QI Program on a day-to-day basis and participates in the EQIHEC meetings.

The Health Services team is comprised of:

• Medical Directors – Assist CMO with utilization management review, review of appeals decisions and review of Potential Quality of Care Issues (PQI). The Medical Directors also provides physician support for varying activities within the Quality department, including Performance Improvement, Member Safety, and Peer Review. The time allocated and scope of responsibilities for quality activities was set appropriately to meet the needs of the QI department.

• Senior Director for Health Services – Reports to the CMO and works collaboratively with the CMO and Director of Quality Improvement on the QI Program. Responsible for the day-today implementation of Quality Improvement, Utilization Management, Pharmacy, Case Management, Community Based Programs and Behavioral Health programs. This role provides oversight, guidance, and evaluation of ongoing UM activities and programs.

• Director of Quality Improvement – Reports to the QI Medical Director and works collaboratively to define strategy, develop programs and services and evaluate effectiveness of the QI Program. Along

with the QI Management Team, including Medical Directors, provides oversight of PQIs, compliance with DHCS and NCQA standards, and other performance measures data collection and performance reporting.

The number of associated Health Services staff and level of involvement of the CMO was appropriate for meeting the objectives of the QI Program for 2024.

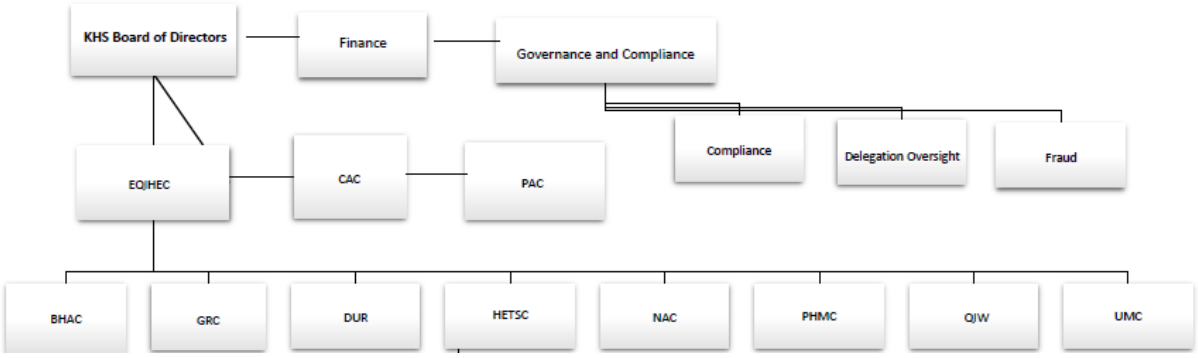
Chief Health Equity Officer

The Chief Health Equity Officer oversees development, implementation, review and revision of health equity policies and procedures; maintains the QIHEP description and work plan; coordinates implementation activities; and ensures reporting to the EQIHEC. The CHEO also serves as the primary liaison between Kern Health Systems and any regulatory agencies on health equity issues and programs. The CHEO sits on the EQIHEC and provides health equity perspective for all non-clinical areas; the CHEO seat may not be delegated. The CHEO oversees the development, evaluation, and/or revision of the QIHEP description. The CHEO also oversees how health equity is embedded into the KHS culture for all non-clinical aspects (i.e., marketing, member engagement, member services, community supports, etc.).

Executive Quality Improvement Health Equity Committee (EQIHEC)

The Executive Quality Improvement Health Equity Committee (EQIHEC) reports to the Board of Directors (BOD) and retains oversight of the QI Program with direction from the Chief Medical Officer (CMO). The EQIHEC provides overall direction for continuous improvement and evaluation of activities, including improving member outcomes. Additionally, EQIHEC is responsible for monitoring and ensuring that all QI activities are implemented to improve care and services for KHS members through a health equity lens. Thirteen (13) positions are filled; four (4) EQIHEC meetings were held in the reporting period with attendance from the CMO, CHEO, primary care practitioners, specialists, pharmacist, home health/hospice, DME providers, county Public Health Department, and members for the Community Advisory Committee (CAC). Quorum was met at every meeting. Overall, the EQIHEC structure was sufficient and EQIHEC provided oversight and support to the QI Program. The parameters for membership and meeting frequency were met for 2024, and activities included discussion, review and approval of reports and policies and procedures for QI and accreditation activities.

EQIHEC Sub-committees



There are KHS sub-committees in place to support the EQIHEC and QIHEP objectives and goals. The activities of the subcommittees are formally documented in transcribed minutes, which summarize each agenda item, the discussion, action taken, and follow-up required. This information is reported at a minimum quarterly to the EQIHEC in the format of formal reports.

Behavioral Health Advisory Committee (BHAC)

The KHS Behavioral Health Advisory Committee (BHAC) is a subcommittee to the EQIHEC and is charged with facilitating collaborative coordination of medical and behavioral health and substance use disorder services between KHS and Kern County Medi-Cal Behavioral Organization (MBHO) and Certified SUD providers caring for KHS members with the goal to maintain continuity and reduce barriers to appropriate initial and continuity of care.

KHS responsibility for administering and managing behavioral health and substance use care is dependent on the Medi-Cal member's severity of impairment. For behavioral health, KHS services are typically for treatment of mild to moderate impairment also referred to as non-specialty mental Health. Kern County MBHO manages severe mental health impairment referred to as Specialty Mental Health Services.

For substance use disorders KHS provides screening, brief intervention, and counseling (SBIRT) services and refers members for treatment for misuse of alcohol. Active treatment for Medi-Cal members with substance use disorder (SUD) services must be rendered by a SUD Drug Medi-Cal certified program. KHS covers Behavioral Health Treatment (BHT), including Applied Behavior Analysis (ABA) therapy, for Medi-Cal beneficiaries under the age of 21.

The BHAC is chaired by a KHS credentialed and participating behavioral health provider. Committee attendees include community providers and stakeholders and internal KHS staff in Population Health Management, Utilization Management, Health Equity, Pharmacy, and Quality Improvement Departments. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

Drug Utilization Review Committee (DUR)

The Drug Utilization Review (DUR) committee is a subcommittee that reports to the EQIHEC. The DUR is comprised of KHS' CMO and Director of Pharmacy along with network pharmacists and providers in the community serving KHS members. The DUR is responsible for reviewing matters related to the use of medications provided to KHS members. The basic objectives are to provide appropriate medication management for members improving their health and safety (administered in the outpatient settings by physicians under KHS' Division of responsibility, assist with case management, and monitor for possible FWA). RX Medi-Cal retains responsibility for formulary drugs carved out to them by the DHCS. KHS may address alternatives, based on safety and efficacy, and to minimize therapeutic redundancies; for those drugs dispensed under the MCRx program.

Four (4) DUR meetings were held during the reporting period with attendance from CMO, independent/retail pharmacy, pediatrician, RX representative (board member), pharmacy specialty practice, pharmacy/geriatric specialist, general practice/geriatrics and KHS Pharmacy Director/Alternate Chairperson. Quorum was met at every meeting. The parameters for membership

and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

Grievance Review Committee (GRC)

Under the direction and oversight of the Chief Medical Officer (CMO) and physician designee, individual and aggregate data on member grievances are reviewed by the Grievance Review Committee (GRC). The GRC is a subcommittee of the EQIHEC. The committee is charged with evaluating and analyzing Grievance data to identify systemic patterns of improper services, denials and other trends impacting health care delivery to members by implementing necessary changes and process improvements for any adverse trends identified.

All complaints, grievances, investigations, follow-up, tracking, and trending reports are prepared by the KHS Member Services Department and submitted to the GRC. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024.

Health Equity Transformation Steering Committee (HETSC)

The Health Equity Transformation Steering Committee (HETSC) is a subcommittee of the EQIHEC. The HETSC is established to ensure that KHS remains an organization that understands and addresses social and racial justice and health equity to meet member needs. The HETSC is responsible for implementing organizational-wide initiatives that promote social and racial justice and health equity through various internal and external activities or training. The HETSC participates in the EQIHEC by assigning HETSC designees to regularly participate and provide input in the EQIHEC meeting. The HETSC is responsible for submitting and presenting regularly scheduled summaries of HETSC formal reports to the EQIHEC reflective of planned activities, goals, interventions, and ongoing goal progress. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

Network Advisory Committee (NAC)

The Network Advisory Committee (NAC) is charged with implementing industry best practices related to KHS contracted providers and delegates to ensure network practitioners participation in the QI program through planning, design, and review of programs, quality improvement activities, interventions, and evidence based clinical practice guidelines designed to improve performance. Access and availability include meeting geographical distance, timeliness, network adequacy, and cultural and linguistic standards to meet the needs of the KHS membership. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

Physician Advisory Committee (PAC)

Serves as the KHS Peer Review and Credentialing Committee on health care issues, peer review, provider discipline, the evaluation of basic practitioner qualifications, competency and professional conduct in the credentialing/recredentialing decisions. This committee meets at least ten times per year and is responsible for reviewing practitioner/provider grievances and/or appeals,

practitioner/provider quality issues, and other peer review matters as directed by the KHS Chief Medical Officer.

The PAC has a total of ten (10) voting committee positions. There were nine (9) active voting members in 2024. Ten (10) PAC meetings were held during the reporting period with attendance from CMO, pediatrician, cardiologist, ophthalmologist, OB-GYN, pain medicine provider, family practitioner and internal medicine provider. Quorum for voting members was met at each meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of credentialing policies and procedures, evaluating the credentials of all current and prospective practitioners and providers in a non-discriminatory manner; delegated credentialing oversight; conducting performance monitoring from quality improvement activities and member complaints in the recredentialing decision making process; and recommending corrective or disciplinary action concerning network participation in the KHS Provider Network, when applicable.

Population Health Management Committee (PHMC)

The Population Health Management Committee (PHMC) is a subcommittee of the EQIHEC. The PHMC oversees the Population Health Management (PHM) Model of Care (MOC) that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of the PHMC is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost effective and tailored health solutions. The PHMC is a collaborative committee that engages community providers and partners along with internal business units from multiple KHS departments across the organization that are involved in the development, execution and monitoring and evaluation of programs for members across the continuum of health. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

Community Advisory Committee (CAC)

The Community Advisory Committee (CAC) meets every quarter and reports to the BOD. CAC has fourteen (14) committee positions. All fourteen (14) positions are filled; Four (4) CAC meetings were held in the reporting period with attendance from Kern County Dept of Public Health, Kern County Dept of Human Services, community representatives, participating healthcare provider, members of KHS BOD, and KFHC members. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

Quality Improvement Workgroup (QIW)

The focus of the QIW is on clinical quality, patient safety, and patient and provider experience in four functional areas of HEDIS, Medi-Cal Managed Care Accountability Sets (MCAS), NCQA Accreditation, and Network Clinical Oversight. The QIW is a subcommittee of the EQIHEC and is responsible for ensuring meeting or exceeding minimum performance levels (MPLs). The QIW oversees the DHCS-required Studies: Performance Improvement Projects (PIPs) selected by KHS. The QIW will ensure KHS members receive quality health care by identifying and addressing

outcomes that deviate from standards. Quorum was met at three (3) of four quarterly meetings. The parameters for membership and meeting frequency were met for 2024.

Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a subcommittee of the EQIHEC and focuses on UM activities. The UMC supports the EQIHEC in the appropriate provision of medical services and provides recommendations for UM activities. The UMC consists of actively participating KHS medical providers that include PCPs and Specialists including a Behavioral Health practitioner. The responsibilities of the UMC are to develop, recommend, and refine the UM program and policies and procedures, including medical necessity criteria, establishment of thresholds for acceptable utilization levels, and reliability of clinical information with the involvement of appropriate, actively practicing practitioners. Only physicians have voting rights on clinical matters. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

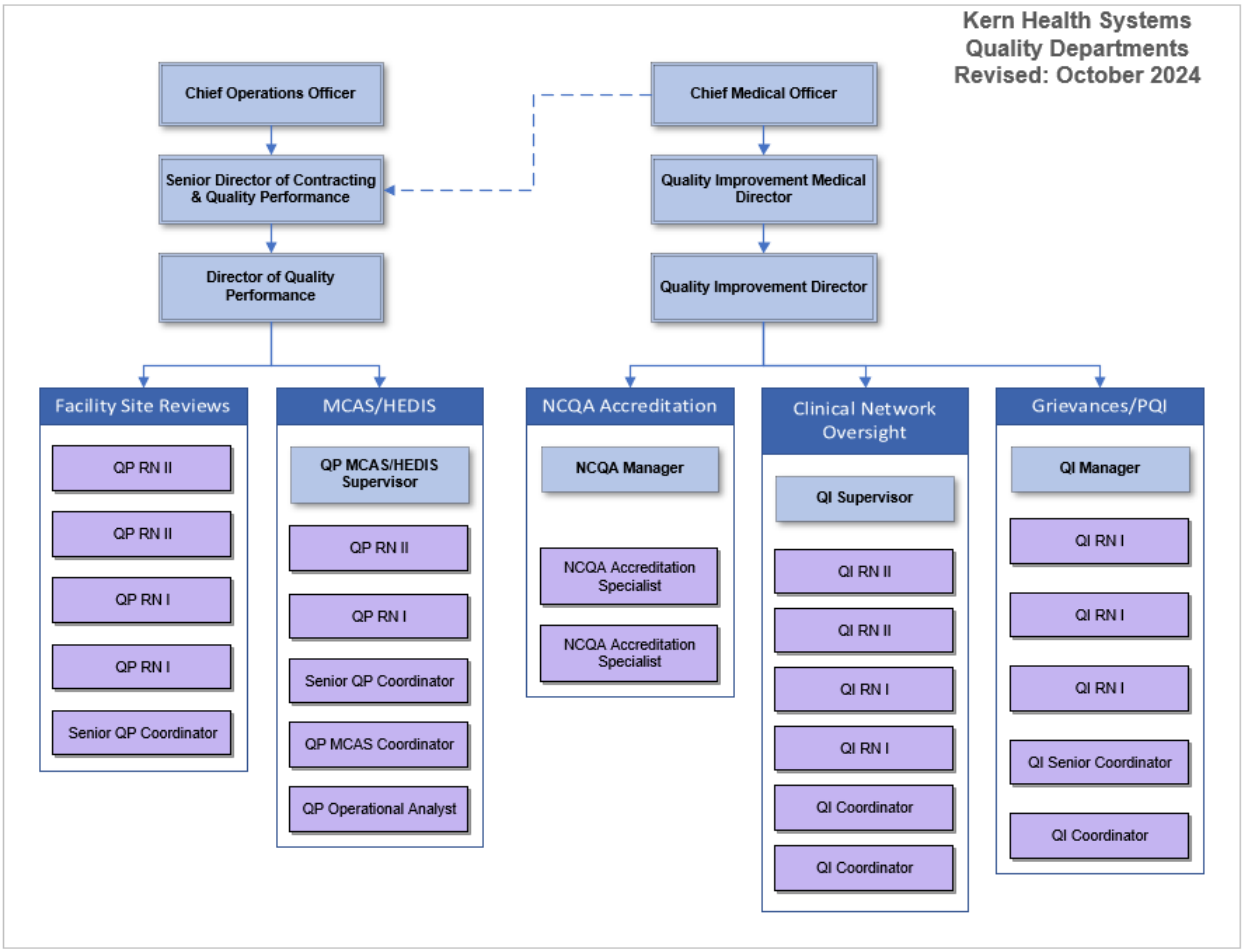
III. Quality Improvement Departmental Changes

The structure of the QI Department, including committee structure, position changes, staff and team roles and responsibilities are periodically assessed. Consideration is given to new state and regulatory directives and requirements, member safety and network needs, general business needs and capabilities, staff growth and development, and fiscal responsibility.

The following changes were made in 2024:

- Member Safety
    - Clinical Network Oversight was added as a function of the Quality Improvement Department. The goal of the Clinical Network Oversight (CNO) program is to support and improve the health and well-being of KHS members. This is achieved by ensuring consistency of KHS providers in the use of evidence-based standards of practice. Achieving this goal incorporates the following activities:
        - Defining and adopting evidence-based, clinical guidelines for key conditions.
        - Educating relevant providers of the adopted evidence-based, clinical standards of care.
        - Conducting an auditing process to measure actual provider performance against the adopted standards of practice.
        - Identifying opportunities for improvement using tools to evaluate network use of adopted standards of care.
        - Acting on identified opportunities for improvement.
        - Evaluating outcomes of changes made to ensure intended goals are achieved.
        - Sharing best practices identified with the provider network.

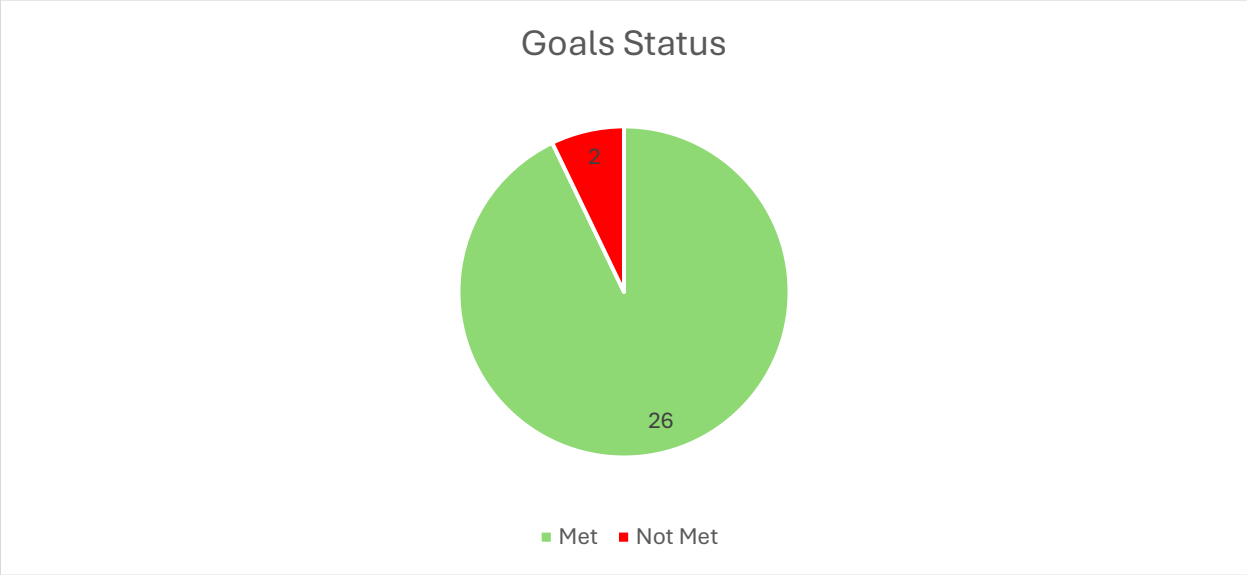
- Quality Performance
    - With the growing responsibilities and scope of the Quality program at KHS, the Quality Improvement Department split into two separate departments with distinct roles and shared responsibility of the QI Program.
        - The Quality Improvement Department is responsible for Quality-of-Care grievances, Appeals, Clinical claims and disputes, and Clinical Network Oversight.
        - The new Quality Performance Department is responsible for the Managed Care Accountability Set (MCAS) measures, Facility Site Reviews, Medical Record Reviews, and Physical Accessibility Review Surveys.
- Personnel
    - The following positions were added to meet the demands of the business:
        - Senior Director of Contracting and Quality Performance
        - Director of Quality Performance
        - Quality Performance MCAS/HEDIS Supervisor
        - Quality Improvement Supervisor



IV. 2024 QI Work Plan Summary

The QI Work Plan is designed to track progress on key Quality activities and initiatives throughout the year. Approved by the EQIHEC and the Governing Board, it included progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care and quality of service. This update includes progress on activities from January 1, 2024 through December 31, 2024.

Goals were assessed on level of completion based on results presented from the responsible stakeholders. For 2024, KHS was able to achieve twenty-six (26) goals as "Met" and two (2) goals as "Not Met". Resources were adequate to support the QI Program overall. KHS has increased the number of resources in the Quality Departments and Member Services Department to meet the goals and work towards achieving the unmet goals in the near future (See Section *IV. Quality Improvement Departmental Changes*).



V. Quality Program Structure

	Metric	Goal	Result
1	QI Program Description	Annual Approval by the EQIHEC and the BOD	Met
2	Annual QI Work Plan	Annual Approval by the EQIHEC and the BOD	Met
3	Annual QI Evaluation	Annual Approval by the EQIHEC and the BOD	Met
4	Policies & Procedures	Annual Approval by the QI Subcommittee	Met
5	Executive Quality Improvement Health Equity Committee (EQIHEC)	Conduct Quarterly Meetings as required by the QI Program	Met

Kern Health Systems (KHS) maintains a comprehensive Quality Improvement (QI) Program designed to enhance member health outcomes, ensure regulatory compliance, and drive continuous improvement in healthcare services. The program is guided by structured policies, strategic

planning, and oversight from key governance bodies, ensuring that all initiatives align with organizational and regulatory standards.

The QI Program Description serves as the foundational document outlining the scope, objectives, and key components of the Quality Improvement Program. It defines the framework for monitoring performance, identifying opportunities for improvement, and implementing interventions that enhance member care. This document was reviewed and approved by the Executive Quality Improvement Health Equity Committee (EQIHEC) and the Board of Directors (BOD) to ensure alignment with strategic priorities and regulatory requirements.

The Annual QI Work Plan is a structured roadmap that details the initiatives and activities planned for the year to achieve quality improvement goals. It includes specific performance measures, responsible parties, and timelines for execution. The plan was reviewed and approved by the EQIHEC and BOD, ensuring that quality initiatives remain on track and are responsive to emerging healthcare trends and member needs.

The Annual QI Evaluation assesses the effectiveness of the QI Program by analyzing data, reviewing completed initiatives, and measuring progress against established goals. It identifies areas of success and opportunities for enhancement, providing a data-driven approach to refining the program. This evaluation undergoes annual approval by the EQIHEC and BOD, ensuring accountability and continuous program evolution.

To maintain compliance and standardization across quality initiatives, KHS implements and regularly updates QI Policies & Procedures. These policies provide clear guidelines for quality-related processes, ensuring that all actions align with best practices and regulatory requirements. The QI Department conducted an annual review and approval of these policies, reinforcing a structured approach to quality governance.

The Executive Quality Improvement Health Equity Committee (EQIHEC) plays a vital role in overseeing quality and health equity efforts across KHS. The committee convenes quarterly, as mandated by the QI Program, to review progress, address challenges, and guide strategic decision-making. In 2024, all required meetings were conducted, ensuring continuous oversight and engagement in quality and health equity initiatives.

Through these governance processes, KHS demonstrates its commitment to excellence in healthcare delivery, continuous quality improvement, and equitable health outcomes for all members.

VI. Quality of Clinical Care

	Metric	Goal	Result
6	MCAS Measures meet MPL	Timely submission of all 18 measures and meet MPL for all 18 measures	Not Met
7	Clinical PIP	Establish interventions in 2024	Met
8	Non-Clinical PIP	Establish interventions in 2024	Met
9	Monitor PQI Volume month over month	Decrease Median Volume of last 12 months	Met
10	PQI Volume by Provider and by severity	Severity Level 2/3 Volume is less than 30	Met

11	PQI Volume by Ethnicity and by Severity	Severity Level 2/3 Volume is less than 30	Met
12	PQI Timeliness of resolution	Within 120 Days	Met
13	Continuity and Coordination of Medical Care	Establish Baseline	Met
14	Continuity and Coordination Between Medical Care and Behavioral Healthcare	Establish Baseline	Met

A. Quality Measures & Performance Improvement

MCAS measures are selected by DHCS and typically include a combination of HEDIS and Medicaid's Adult and Child Health Care Quality Measures. The previous calendar year is the standard measurement year for MCAS data. Therefore, the MCAS Report Year (RY) 2024 results reflect Measurement Year (MY) 2023 data. MCAS RY 2025 results are not available until June 1, 2025, following the timeline for submission of these rates to NCQA and DHCS. The Minimum Performance Level (MPL) is set by DHCS, and the percentile benchmarks are provided by NCQA in their annual Quality Compass Report. All Managed Care Plans (MCPs) are required to exceed the 50th percentile for each measure benchmark.

Results:

	Measurement Year	MY2022			MY2023		
	Total Measures Held to MPL	15			18		
	Met MPL	5			8		
	Did not meet MPL	10			10		
	Measure	Rate	MPL	Rate Vs MPL	Rate	MPL	Rate Vs MPL
	Hybrid Measures Held to MPL						
AWC	Adolescent Well-Care Visits						
ABA	Adult Body Mass Index Assessment						
CCS	Cervical Cancer Screening	52.8	57.64	-4.84	57.18	57.11	0.07
CIS-3	Childhood Immunization Status – Combo 3						
CIS-10	Childhood Immunization Status Combo 10	27.98	34.79	-6.81	24.82	30.9	-6.08
CDC-E	Comprehensive Diabetic care- Eye Exam (Retinal) Performed						
CDC-HT	HbA1c Testing						
CDC-H9*	HbA1c Poor Control (>9.0%)						
CDC-H8	HbA1c Control (<8.0%)						
CDC-N	Medical Attn. for Nephropathy						
CDC-BP	Blood Pressure Control <140/90						
CBP	Controlling High Blood Pressure	60.58	59.85	0.73	65.21	61.31	3.9
HBD*	Hemoglobin A1c Testing & Control for Patients With Diabetes	39.17	39.9	-0.73	32.85	37.96	-5.11
IMA-2	Immunizations for Adolescents (Combo 2)	29.68	35.04	-5.36	34.06	34.31	-0.25
LSC	Lead Screening in Children	47.45	63.99	-16.54	58.64	62.79	-4.15
PPC-Pre	Timeliness of Prenatal Care	87.35	85.4	1.95	87.1	84.23	2.87
PPC-Pst	Postpartum Care	83.94	77.37	6.57	86.37	78.1	8.27
WCC-BMI	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents						
WCC-N	Counseling for Nutrition						
WCC-PA	Counseling for Phys Activity						
W-34	Well-Child Visits						

Administrative Measures Held to MPL							
AMR	Asthma Medication Ratio				72.1	65.61	6.49
BCS	Breast Cancer Screening	56.68	50.95	5.73	59.3	52.6	6.7
CHL	Chlamydia Screening in Women Ages 16 – 24	53.67	55.32	-1.65	56.87	56.04	0.83
DEV	Developmental Screening in the First Three Years of Life				25.94	34.7	-8.76
FUA - 30 Day Follow-up*	Follow-Up After Emergency Department Visit for Substance Use	15.74	21.24	-5.5	18.85	36.34	-17.49
FUM - 30 Day Follow-up*	Follow-Up After Emergency Department Visit for Mental Illness	18.8	54.51	-35.71	19.12	54.87	-35.75
TFL-CH	Topical Fluoride for Children				16.44	19.3	-2.86
W30 (0-15M)	Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.	37.12	55.72	-18.6	39.21	58.38	-19.17
W30(15-30M)	Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	55.12	65.83	-10.71	63.74	66.76	-3.02
WCV	Child and Adolescent Well-Care Visits	37.12	48.93	-11.81	46.55	48.07	-1.52

MCAS measures were stratified by race/ethnicity in MY 2023:

- Measures held to MPL:
  - Breast Cancer Screening (BCS-E)
  - Prenatal and Postpartum Care:
    - Timeliness of Prenatal Care (PPC-Pre)
    - Postpartum Care (PPC-Pst)
  - Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9%) - (HBD)
  - Asthma Medication Ratio (AMR)
  - Controlling High Blood Pressure (CBP)
  - Well-Child Visits in the First 30 Months of Life
    - 0-15 months (W30 15M)
    - 15-30 months (W30 30M)
  - Immunizations for Adolescents: Combo 2 (IMA2)
  - Follow-Up After ED Visit for Mental Illness – 30 Days (FUM)
  - Follow-Up After ED Visit for Substance Abuse - 30 Days (FUA)
  - Child and Adolescent Well-Care Visits (WCV)

- Measures not held to MPL
  - Colorectal Cancer Screening – (COL-E)
  - Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
  - Follow-Up After ED Visit for Mental Illness – 7 Days (FUM)
  - Follow-Up After ED Visit for Substance Abuse - 7 Days (FUA)
  - Pharmacotherapy for Opioid Use Disorder (POD)
  - Plan All-Cause Readmissions (PCR)

QUANTITATIVE ANALYSIS: Based on results for MY2023/RY2024:

KHS met the MPL in 8 out of 18 MCAS measures:

- Cervical Cancer Screening (CCS)
- Controlling High Blood Pressure (CBP)
- Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9%) - (HBD)
- Timely Prenatal Care (PPC-Pre)
- Timely Postpartum Care (PPC-Post)
- Breast Cancer Screening (BCS - E)
- Chlamydia Screening in Women (CHL)
- Asthma Medication Ratio (AMR)

13 out of 18 measures showed improvement from MY2023/RY2024 compared to MY 2022:

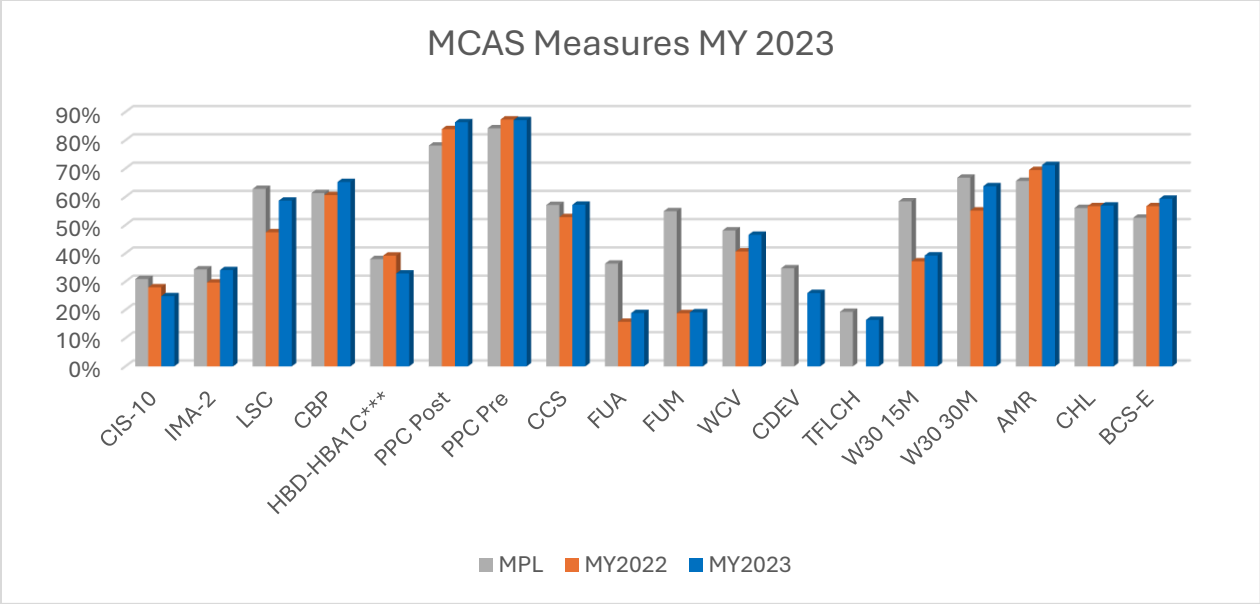
- Immunizations for Adolescents: Combo 2 (IMA2)
- Lead Screening in Children (LSC)
- Cervical Cancer Screening (CCS)
- Controlling High Blood Pressure (CBP)
- Postpartum Care (PPC-Post)
- Follow-up After ED Visit for Substance Use (FUA)
- Follow-up After ED Visit for Mental Illness (FUM)
- Breast cancer Screening (BCS-E)
- Well Child Visits (0-15 mos)
- Well Child Visits (15-30 mos)
- Child and Adolescent Well Care Visits (WCV)
- Chlamydia Screening for Women (CHL)
- Asthma Medication Ratio (AMR)

3 out of 18 measures had lower levels of compliance compared to MY2022/RY2023

- Childhood Immunization Status: Combo 10 (CIS-10)
- Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9%) - (HBD)
- Timeliness of Prenatal Care (PPC-Pre)

No measures were removed, and the following measures were added for monitoring starting in MY 2023:

- Asthma Medication Ratio
- Developmental Screening in the First Three Years of Life
- Topical Fluoride for Children



As illustrated above, measures that surpassed the minimum performance levels (MPL) include Controlling Blood Pressure, Prenatal and Postpartum Care, Breast Cancer Screening, Asthma Medication Ratio, Hemoglobin A1c Control for Patients with Diabetes, Cervical Cancer Screening, and Chlamydia Screening for Women.

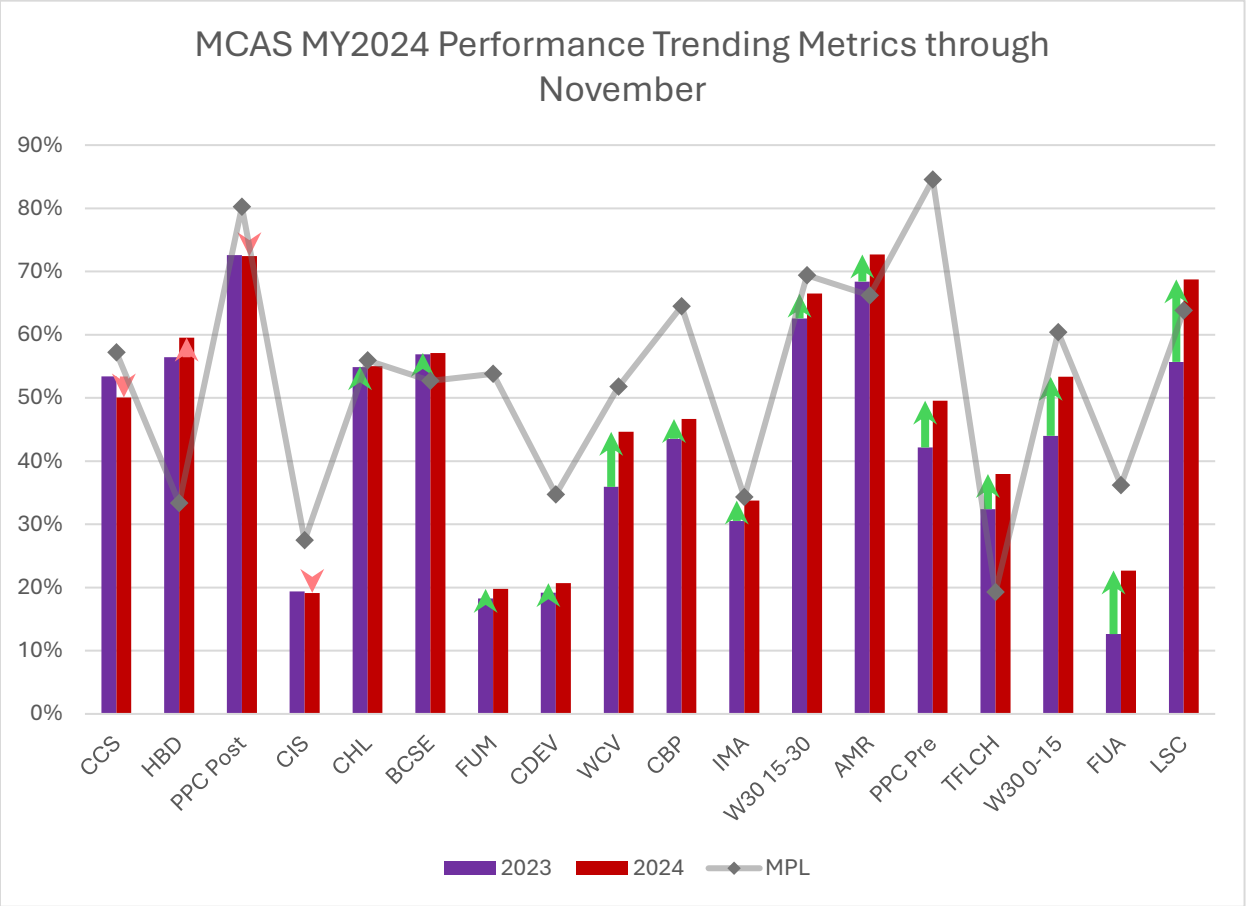
MCAS measures under the Children and Behavioral Health Domain not meeting state-wide minimum performance level (MPL), include:

- WCV
- CIS-10
- IMA 2
- LSC
- W30
- W15
- TFL
- CDEV
- FUM
- FUA

Year over Year MCAS Performance

Measurement Year	MY2017	MY2018	MY2019	MY2020	MY2021	MY2022	MY2023
KHS Membership	242,265	246,564	251,280	277,616	299,864	334,078	346,049
MPL Percentile	25th	25th	50th	50th	50th	50th	50th
Total Held to MPL	21	20	18	19	15	15	18
Met MPL	19	18	3	2	5	5	8
Did Not Meet MPL	1	2	15	17	10	10	10

MY2024 MCAS Trending Performance:



14 measures are trending higher than the previous year at the same point in time:

- Asthma Medication Ratio
- Breast Cancer Screening
- Controlling Blood Pressure
- Developmental Screening in the First 3 Years of Life
- Chlamydia Screening in Women
- Follow-Up After Emergency Department Visit for Substance Use
- Follow-Up After Emergency Department Visit for Mental Illness
- Immunization for Adolescents
- Lead Screening in Children
- Prenatal and Postpartum Care – Pre
- Topical Fluoride for Children
- Well-Child Visits in the First 30 Months of Life – 0-15months
- Well-Child Visits in the First 30 Months of Life – 15-30months
- Child and Adolescent Well-Care Visits

4 measures are trending lower than the previous year at the same point in time:

- Cervical Cancer Screening

- Childhood Immunization Status
- Hemoglobin A1c Testing & Control for Patients with Diabetes
- Prenatal and Postpartum Care – Post

QUALITATIVE ANALYSIS:

The primary factors impacting compliance with MCAS measures:

- Opportunity to improve software vendor processes and communication
- Acquisition of high-volume lab provider led to short term decreased incoming data, which impacted MCAS compliance rate for specific measures
- Residual effects of Covid 19
    - Vaccine hesitancy
    - Reduced volume of members going to their PCP for preventive health services continued to reflect in lower-than-normal compliance rates for the MCAS measures.
- Members in rural areas have difficulty accessing care because of difficulty in transportation services. KHS has a dedicated team focused on member outreach and transportation assistance.
- Members do not understand the importance of preventive care.
- Lack of primary care physicians to provide services in the rural areas.

In summary, these factors affected the results of MCAS measures:

1. **Training Resources**
    a) Insufficient QI knowledge for external staff (including leadership) to support quality initiatives.
    b) Lack of QI SMEs to serve as company-wide resources and to lead the initiatives.
    c) Ineffective member outreach to support member engagement and active participation in their care due to insufficient understanding of MCAS measures and development of effective engagement strategies.

2. **Collaboration/Communication**
    a) ELT working in silos and not coordinating with QI and other departments.
    b) Lack of staff and department accountability for not participating in QI activities.
    c) Lack of organization alignment with QI activities.
    d) Insufficient collaboration and coordination with community partners and provide network to support compliance with preventive health measures.

3. **Providers**
    a) Lack of accountability for providers to address gaps in care due to non-specific data exchange requirements.
    b) Provider contracts and payment structure do not follow a payment model for providers to proactively manage members from a quality-of-care perspective.
    c) Insufficient provider resources to fully establish quality goals within their practice management processes.

d) Lack of focused provider education to help with the interpretation of data and strategies to yield positive outcomes.

4. **Outcomes/Process**
   a) Departments work in silos due to lack of uniform communication process for issues and activities impacting MCAS.
   b) Lack of evaluation process for identifying the departments should be involved in the QI initiatives and projects.
   c) Lack of adequate staff and continuous staff turnover.
   d) Lack of timely and effective outcomes analysis to make strategic changes quickly in sync with the results due to untimely receipt of outcomes data.
   e) Lack of established process to identify lessons learned that strategically support changes for future MCAS initiatives to improve results.
   f) Lack of internal KHS staff accountability for follow-through due to lack of misaligned priorities of MCAS measures to the plan.

CORRECTIVE ACTION REQUIRED BY DHCS:
Failure to meet MPL resulted in corrective actions and financial penalties. DHCS established a new Performance Tier System effective for MY2024 MCAS compliance results with follow-up corrective actions and sanctions based on overall performance, domains of care, and improvements compared to previous performance years.

Strategies and Action Plan:

Goals: Improve the following QI Gaps and meet 50th percentile or minimum performance level.

1. Provider Engagement
2. Collaboration
3. Member Engagement
4. Collaboration and Partnerships

Strategies	Action Items
# 1 Provider Engagement Objective: Coordinate with providers to address appointment availability challenges with PCPs and BH within timeframe of 7 and/or 30 days of ED visit.	**1.a.** Identify 3 providers who are low performing for FUA and FUM MCAS measures and meet with them bi-monthly to develop interventions to support improvement. **1.b.** Leverage mobile units to increase appointment options.
# 2 Collaboration Objective: Increase timely ED visit notifications to providers and support outreach to members for timely follow-ups.	**2.a.** Update internal dashboard and provider portal for ease of access to members requiring follow-up visit. **2.b**. Focused outreach specialist to contact members with ED visits identified in dashboard and assist with scheduling appointment with PCP or BH.
# 3 Member Engagement Objective:	**3.a.** Work with Marketing and Member Engagement to develop a routine text message campaign for mobile unit notification for KHS members.

Leveraging internal (Marketing, Health Equity, Health Education) and external stakeholders to develop specific initiatives/engagement of efforts to the children's domain of care.	**3.b.** Leverage mobile units to close gaps in care in coordination with 5 mobile unit providers. **3.c.** Evaluate effectiveness of text messaging campaign
#4 Collaboration/Partnerships Objective: Improved communication and collaboration between MCP, providers, and parents/guardians. (Parent square, provider meetings, mobile units at schools).	**4.a.** Identify top 20 providers by membership volume and schedule routine joint operations meetings to support overall education and improvement of MCAS performance. **4.b.** Collaborate with school districts to promote school based mobile events via electronic parent communication systems.

Action Plan for 2025:

Ensuring access to high quality and equitable care is part of KHS' mission. The Quality Performance team will continue with initiatives that have led to positive outcomes and gaps in care closed for our members. This includes:

- Diabetic Management program led by a contracted Endocrinologist
- A dedicated Member Outreach team solely focused on telephonic outreach to close gaps in care
- Collaboration and partnerships with local providers to offer extended hours and weekend appointments for children and adolescents
- Mobile Unit partnerships across Kern County with school districts and various community-based organizations
- Improved data quality and increased data sources
- Monthly campaigns for preventive services in collaboration with Marketing and member facing departments

B. Performance Improvement Projects (PIPs)

Performance Improvement Projects (PIPs) are a key federal protocol used by DHCS for the External Quality Review (EQR) of MCPs. DHCS has identified two categories for the two PIPs MCPs are required to conduct: a) Children's Health and b) Behavioral Health. Each PIP occurs over approximately 3 years, from 2023-2026. MCPs must design PIPs to systematically improve these areas. The PIPs are designed to enhance quality and outcomes of health care for Medi-Cal members.

Each PIP utilizes a rapid cycle improvement model. The core component of the model includes testing changes on a small-scale using Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning and evaluation that informs the project theory and practice during the improvement project.

Both PIPs completed 2 of the 4 modules. Module 1 for both PIPs have been accepted by DHCS. Module 2 requires a re-submission to DHCS for both PIPs. Module 1 focused on outlining the framework for each project. Module 2 identified the Quality Improvement activities that have a potential impact to the SMART Aim (defining the population and PIP process). Module 3 will include continued incremental testing of interventions to support adjustments to the interventions and will

be submitted in September of 2025. Module 4 will be completed in September of 2026 and will provide a conclusive summary of outcomes and recommendations.

KHS initiated a cycle of PIPs for 2023-2026 in September of 2023 through the External Quality Review Organization (EQRO), HSAG, acting on behalf of DHCS. The two active PIPs during 2023 included:

1. **Clinical PIP: Improving W30 Measure Rates Among Black/African American Infants 0 -15 Months Old.**

This clinical Performance Improvement Project is three years in length, with a baseline measurement period of 2023 and remeasurements in 2024 and 2025. Yearly submissions are conducted the September of the following year, meaning the last submission will occur in September of 2026.

This PIP has the potential to improve member health, functional status, and/or satisfaction:

- Regular well care visits provide opportunities for preventive care, review and discussion of child's milestones/behaviors/development, and identification and prompt treatment of any delays or anomalies, resulting in a reduction of hospitalizations and emergency department use.
- Regular well care visits create stronger trust-based relationships between pediatrician, caregiver, and child, and engage families in care during a critical time of growth in early life.
- Regular well care visits provide a long-lasting foundation of preventive health care and education for caregivers/parents, passed along to the children as they grow, resulting in long-term benefits in the child's health and care costs.

The defining AIM statement for this PIP helps to maintain focus and set a framework for data collection, analysis, and interpretation: Do targeted interventions improve the percentage of Black/African American children who complete six (6) or more well care visits on or before fifteen (15) months of life?

Included in each measurement period are the total number of (self-reported within race/ethnicity stratification) Black/African American infants within KHS' health plan who turned 15 months during the measurement year. Continuous enrollment is required, and members who used hospice or died anytime during the measurement year are excluded.

Data Elements: Collecting and calculating the W30 (0-15 Months) compliance rate is an automated process. KHS creates a report (Real Time HEDIS Trending) that calculates real time HEDIS rate for HEDIS measures including the W30 (0-15 months) Compliance rate. This program uses NCQA Technical specifications to determine numerators and denominators based on administrative data for the W30 measure. This HEDIS Trending Data will be reviewed yearly from January to December to identify any health disparity in the W30 (0-15 months) measure. Final rate as of each December are run after the claims lag of three months and are reported to HSAG.

Final MCAS rates for the W30, 0-15 months measure were 20.47% in MY2022, and 33.33% in MY2023. Preliminary rates in November of 2024 show W30, 0-15 months at 53.33% overall. The Minimum Performance Level (MPL) for W30, 0-15 months in MY2024 is 60.38%.

Activities: Our Quality Performance Director, MCAS Program Supervisor, and QP RN have monitored and utilized data from collaborative activities that effect this PIP population, including working with our internal departments (Health Equity Team, Health Education Team, Member Services Team, Member Engagement Team, Business Intelligence Team) and with external provider partners.

Regular meetings were conducted within our Quality Team, with supporting KHS teams (above), and external provider partners to learn if/how identified barriers were being addressed. Where gaps in the care process were identified, brainstorming was conducted, with recommendations and modifications taken where feasible. Specific intervention details are included on the separate Intervention Worksheets. Ongoing and regular meetings with mobile clinic providers take place to tailor care, as well as monthly meetings within the Quality team to review interventions and adjust where necessary.

QI Tools used to identify and prioritize barriers include a Key Driver Diagram, Cause & Effect (Fishbone/Ishikawa) Diagram, and a Process Map.

Two interventions were initiated in 2024 and continue into 2025, addressing the following barriers:

1. Mobile Well Visit Clinics- Pediatric Population- Access to care concerns such as transportation difficulties (having to move/install car seats or bringing multiple children to an appointment via bus or rideshare), scheduling that does not accommodate working parent(s) schedules, and childcare needs for other dependents that may hinder the ability of the parent/guardian to bring the infant for well-baby visits. At the time of September 2024 submission, a limited volume of members were engaged in events for this PIP's specific age range. The feedback from providers active with these mobile events is that members are happy with and appreciate the opportunity/process. Due to the nature and infancy stage of these events, it will take time to grow our audience to its full potential.

2. Member Services Outreach to the W30 Population for Scheduling and Transportation Assistance- Identification and engagement of members with gaps in care through collaboration with providers for scheduling and supporting access to care through transportation arrangements as needed. Data from 01/01/24 – 08/27/24 shows a 27% correlation rate between outreach calls and completed well baby visits. Conclusions indicate that this personal outreach has the potential to build relationships with our members and their families over more automated options, such as robocalls, however, a multi-pronged approach may increase compliance even further.

2. Non-Clinical PIP: Improve the percentage of provider notifications for members with SMH/SUD diagnoses following or within 7 days of emergency department (ED) visit.

The Non-Clinical Performance Improvement Project runs the length of 3 years. The baseline measurement period is 2023. Remeasurements are performed in September of 2024 and 2025. The final submission will be in September of 2026 and will summarize outcomes and recommendations. The non-clinical PIP targets ED visits for members 6 years and older with a principal diagnosis of mental illness or intentional self-harm (SMH) and members 13 years and older with a principal diagnosis of substance use or and diagnosis of drug overdose (SUD). Submission 1 was completed in 2023 and accepted by HSAG. Final submission will

be in September of 2026, Submission 4 will be completed detailing outcomes and the sustainability of the interventions.

The question that KHS must answer is, "Do targeted interventions improve the percentage of provider notifications for members with SMH/SUD diagnoses following or within 7 days of ED visit?" This PIP focuses on developing targeted interventions that are sustainable and measurable. This topic has the possibility to enhance member health, functional status, and/or satisfaction due to the following reasons:

- The period immediately after the ED visit is important for engaging individuals in treatment and establishing continuity of care.
- Provider notification of ED visits has the potential to improve care coordination and ensuring timely follow-up care.
- Timely follow-up care after and ED visit for mental illness or substance use disorder may reduce repeat ED visits, prevent hospital admissions, improve physical and mental function, and increase compliance.

The Non-Clinical PIP is currently in the intervention development and implementation stage. We are leveraging the following resources during this phase:

- Daily Admission, Discharge, and Transfer (ADT) report from participating EDs.
- Participating Providers are provided the ADT report through secure email or SFTP files.
- The ADT report is uploaded to the Provider Portal, offering an additional option to Providers to obtain this information.
- Using the ADT report, the KHS Behavioral Health (BH) team has been performing Provider outreach.
- Provider meetings are performed regularly to share updates and education regarding the notification process.
- KHS Provider Network Management is notified and educated on updates to the notification process to also assist Providers with questions/issues.

These interventions have helped increase our Provider notifications to 84% in 2024.

C. Potential Quality of Care Issues (PQI)

PQI Identification and Review Process

When a potential quality issue (PQI) is identified from a member grievance, the Grievance Team refers the case to the Quality Improvement (QI) Registered Nurse (RN) for initial review. If the QI RN determines that a PQI may be present, the grievance is escalated to the Medical Director for further investigation and final determination. If the Medical Director confirms the presence of a PQI, the case is referred to the QI Department to initiate the formal PQI investigation.

The grievance referred as a PQI is entered into the KHS Medical Management System, triggering an RN to begin the investigation. After completing the investigation, the QI Medical Director conducts a final review, determines the existence of a quality-of-care issue, and assigns the PQI severity level as follows:

- **Level 0** – No quality of care concern
- **Level 1** – Potential for harm
- **Level 2** – Actual harm
- **Level 3** – Actual morbidity or mortality failure

PQI Volume Month over Month

Severity	2023 Total	2023 Median	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	2024 Total	2024 Median
0	855	58.5	42	44	45	19	34	33	19	25	21	10	30	32	354	31
1	582	45.5	50	31	27	30	39	38	44	40	23	39	23	42	426	38.5
2	10	1	0	0	0	2	0	0	0	0	0	0	0	2	4	0
3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	1447	99	92	75	72	51	73	71	63	65	44	49	53	76	784	68

Quantitative Analysis:

In 2024, the total PQI volume was 784, achieving the target of reducing the median PQI volume from the previous 12 months. The 2024 median monthly PQI volume was 68, a reduction from 99 in 2023, indicating successful mitigation of quality concerns.

- Level 0 cases: 354
- Level 1 cases: 426
- Level 2 cases: 4 (below the target threshold of 30)
- Level 3 cases: 0

PQI volumes fluctuated month-to-month, with December 2024 having the highest number (76) and September 2024 the lowest (44). The data suggests that proactive quality interventions contributed to stabilization and reduction of PQIs across all severity levels.

Qualitative Analysis:

The timeliness of PQI resolution was maintained within the 120-day benchmark, meeting compliance standards. The severity-based target of keeping Level 2 and Level 3 cases below 30 was also achieved, highlighting the effectiveness of intervention efforts.

Analysis identified provider-patient communication gaps as a primary driver of PQIs, leading to targeted training initiatives and improved care coordination strategies. Collaboration between the Grievance Team, QI Department, and Medical Directors strengthened PQI identification and classification accuracy. Additionally, disparities in ethnicity-related PQI severity were closely monitored, with Level 2 and Level 3 cases remaining below established thresholds. Moving forward, provider engagement, member education, and culturally responsive care will remain key priorities to sustain quality improvements in 2025.

PQI Volume by Provider and by Severity

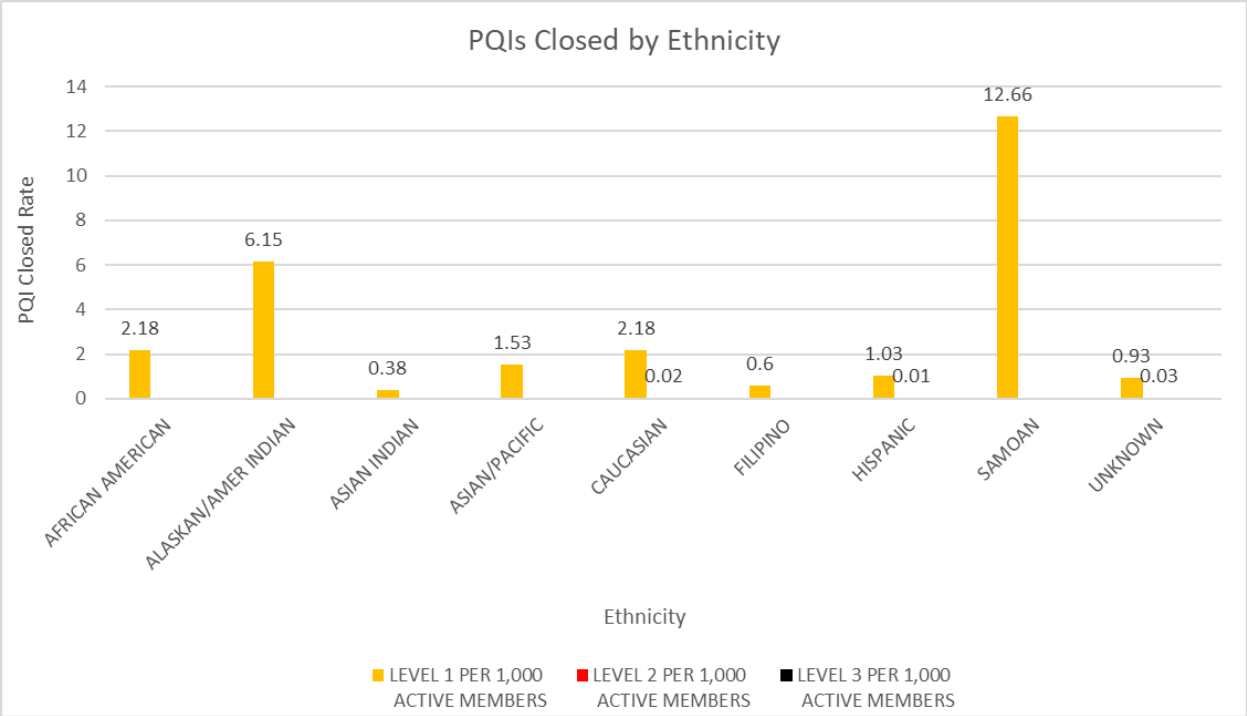
TOP 5 Outpatient Providers with PQIs January 2024 - December 2024					
Top 5 Providers with PQIs leading to Actual Harm or Morbidity (Level 2 and 3)	Level 1- Potential for Harm PQIs Per 1000 Visits	Level 2-- Potential for Harm PQIs Per 1000 Visits	Level 3-Actual Morbidity PQIs Per 1000 Visits	Total Outpatient Visits	Total PQI's Per 1000 Visits
PROVIDER A	0.0	1.86	0.00	539	1.86
PROVIDER B	0.0	0.46	0.00	2,174	0.46
Top 5 Provider for Total PQIs (Level 1, 2 and 3)	Level 1- Potential for Harm PQIs Per 1000 Visits	Level 2-- Potential for Harm PQIs Per 1000 Visits	Level 3-Actual Morbidity PQIs Per 1000 Visits	Total Outpatient Visits	Total PQI's Per 1000 Visits
PROVIDER C	0.97	0.00	0.00	10,334	0.97
PROVIDER D	0.56	0.00	0.00	14,221	0.56
PROVIDER E	0.53	0.00	0.00	15,175	0.53
PROVIDER F	0.20	0.00	0.00	9,946	0.20
PROVIDER G	0.51	0.00	0.00	7,826	0.51

Based on the trending analysis conducted, above are the top 5 outpatient providers for the rolling 12 months (January 2024 – December 2024). The top 5 providers with PQIs leading to actual harm or morbidity to the member is based on the PQIs per 1000 Outpatient visits. From the above data, there were no providers identified with severity Level 3. Provider A and B had one PQI each at severity Level 2. Majority of the PQIs were closed at severity Level 0 and Level 1. There were no Level 3's.

Top 5 Inpatient Providers with PQIs January 2024 - December 2024						
Top Providers with PQIs leading to Actual Harm or Morbidity (Level 2 and 3)	Level 1- Potential for Harm	Level 1-Potential for Harm PQIs Per 1000 Discharges	Level 2-PQIs Per 1000 Discharges	Level 3-PQI's Per 1000 Discharges	Total Discharges	Total PQI's Per 1000 Discharges
PROVIDER A	6	1.21	0.40	0	4,946	1.62
Top 5 Provider for Total PQIs (Level 1, 2 and 3)	Level 1- Potential for Harm	Level 1-Potential for Harm PQIs Per 1000 Discharges	Level 2-PQIs Per 1000 Discharges	Level 3-PQI's Per 1000 Discharges	Total Discharges	Total PQI's Per 1000 Discharges
PROVIDER B	1	0.2	0.00	0.00	4254	0.24
PROVIDER A	6	1.2	0.40	0.00	4946	1.62
PROVIDER C	4	0.6	0.00	0.00	6713	0.60
PROVIDER D	1	4.3	0.00	0.00	232	4.31
PROVIDER E	0	0.0	0.00	0.00	7249	0.00

One inpatient provider had two (2) PQIs with severity Level – 2. None had a PQI with severity Level – 3. No providers were flagged for systemic quality concerns. QI will continue monitoring PQI trends for any emerging patterns

PQI Volume by Ethnicity and by Severity



Although the Samoan population had the highest PQI rate per 1,000 active members, this was based on a single PQI case within the population. Samoans account for approximately 0.03% of KHS membership, and with only half of the total membership having at least one interaction over the rolling 12 months, the PQI rate appears disproportionately high compared to other populations. No concerns have been identified, and QI will continue monitoring for potential trends.

The largest active member populations by ethnicity are Hispanic and Caucasian, both of which had over 100 PQIs closed, with Hispanic members having the highest volume. The majority of Hispanic PQIs were classified as Level 1 (223 cases). No concerning trends have been identified, and QI will continue tracking these volumes.

The 2024 PQI analysis demonstrates significant improvements in quality issue mitigation, provider performance, and timeliness of resolution. Despite fluctuations in monthly PQI volumes, key targets were met, including:

- Reduction in median PQI volume from 99 (2023) to 68 (2024)
- Level 2 and Level 3 cases remained below the threshold of 30 by provider and by ethnicity
- Timeliness of PQI resolution within 120 days

While no urgent concerns were identified, QI will continue monitoring trends and strengthening provider engagement, member education, and culturally responsive care to drive continuous quality improvement into 2025.

D. Continuity and Coordination of Medical Care

Kern Health Systems (KHS) assessed continuity and coordination of medical care, focusing on member movement between practitioners and across care settings. Key findings revealed persistent gaps in diabetic eye exam rates, with only 33.66% of eligible members receiving exams, falling short of the 51.5% national benchmark. Barriers included lack of care coordination, insufficient provider communication, and member access challenges. Additionally, only 39% of discharged members had a follow-up visit within seven days, highlighting the need for improved hospital-to-PCP communication and patient education. Interventions proposed include provider education, enhanced referral processes, leveraging technology for interoperability, and increasing member outreach on available resources like transportation. KHS remains committed to implementing targeted strategies to improve care transitions and achieve measurable health equity outcomes. See Appendix B for the full report.

E. Continuity and Coordination Between Medical Care and Behavioral Healthcare

Kern Health Systems (KHS) focused on enhancing the continuity and coordination of care between medical and behavioral health services to improve member outcomes. Key areas of assessment included the exchange of information between providers, the appropriate diagnosis and treatment of behavioral health disorders, the management of psychotropic medications, and access to follow-up care for individuals with co-existing medical and behavioral health conditions. The evaluation identified ongoing challenges such as fragmented communication, lack of standardized referral processes, and limited provider collaboration, particularly between primary care providers (PCPs) and behavioral health (BH) specialists. Despite these challenges, notable improvements were achieved in areas such as antidepressant medication management (AMM) and follow-up care for children prescribed ADHD medication (ADD), with targeted interventions increasing medication adherence and provider engagement. Additionally, the Behavioral Health Advisory Committee (BHAC) played a critical role in identifying barriers and implementing strategies to enhance care coordination, including provider education, the development of a more integrated provider portal, and improved data-sharing mechanisms. Moving forward, the QI program will continue to prioritize strategies that enhance communication, streamline referral processes, and foster a collaborative approach between medical and behavioral health providers to ensure equitable, high-quality care for all members. See Appendix C for the full report.

VII. Safety of Clinical Care

	Metric	Goal	Result
15	Facility Site Review	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	Met
16	Physical Accessibility Review Surveys	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	Met
17	Medical Record Reviews	Achieve medical record review score of 85% for each practitioner	Met

18	Credentialing/Recredentialing	100% timely credentialing/recredentialing of practitioners	Met

A. Facility Site Review (FSR)

Kern Health Systems (KHS) QP nurses who are DHCS-certified site reviewers perform a facility site review and medical record review on all contracted primary care providers (PCP) upon contracting and at least every three years thereafter. This includes Internal Medicine, General and Family Practice, OB/GYN and Pediatricians serving in PCP capacity in free-standing offices, IPAs, or Clinics.

Personnel performing the site review are trained by a DHCS certified Master Trainer nurse on the required criteria for site compliance. All contracting plans within a county have equal responsibility for the coordination and consolidation of provider site reviews. Site review responsibilities are shared equally by all plans within the county. KHS has a Memorandum of Understanding (MOU) with Anthem Blue Cross and Kaiser, and all plans share site review information.

The purpose of conducting site reviews is to ensure that all contracted PCP sites used by managed care plans for delivery of services to plan members have sufficient capacity to:

1. provide appropriate primary health care services.
2. carry out processes that support continuity and coordination of care.
3. maintain patient safety standards and practices; and
4. operate in compliance with all applicable federal, state, and local laws and regulations.

Quantitative Analysis:
In 2024 YTD, 97% of the Initial and Periodic Facility Site Reviews performed passed, 3% of them scored less than 80%. There were 37 Facility Site Reviews completed YTD, 1 of these reviews failed in the first audit. The one failed site completed and closed their CAPs. We will continue to monitor this for any trends.

For YTD 2024, top #3 deficiencies identified for Opportunities for improvement in site reviews are:

1. Site does not utilize California Immunization registry (CAIR).
2. Calibration of equipment not done.
3. Airway management- Ambu bags and masks are deflated.

Site Review Timeliness:

A spreadsheet of reviews due and reviews completed were obtained through our site review system. Following a Corrective Action Plan (CAP), education is given to the providers and Focus Reviews are conducted three months after CAP closure to ensure site review compliance. Below is a table summarizing the reviews completed in 2024.

Review Type	# Reviews Due	# Reviews Completed	# Reviews Not Completed
Initial Facility Site Review	15	15	0
Initial Medical Record Review	17	17	0

Periodic Facility Site Review	21	21	0
Periodic Medical Record Review	19	19	0
Interim Review	33	33	0
Focused Facility Site Review	0	0	0
Focused Medical Record Review	13	13	0
Annual Review Medical Record Review	2	2	0
Annual Facility Site Review	1	1	0

In 2024 YTD, 78% of the Initial and Periodic medical record reviews performed passed, 22% of them scored less than 80%. There were 50 medial record reviews completed YTD, 11 of these reviews failed in the first audit.

For YTD 2024, top #3 deficiencies identified for Opportunities for improvement in medical record reviews are:

1. Yearly HIV Screening not being performed for both pediatrics and adults.
2. Member Risk Assessments not being assessed for both pediatrics and adults.
3. Adult Immunization not being given according to ACIP guidelines.

Qualitative Analysis:

Due to the increase of failed reviews, there is initial outreach one month prior to reviews to offer onsite provider education to ensure site readiness, technical assistance and education is offered through the entire CAP process. We will continue to monitor for any trends.

Barriers:

A new All Plan Letter, 22-017 for Facility Site Reviews took effect July 1, 2022. The new Tools and Standards were released 7/1/2022 becoming fully effective 1/1/2023. Due to the new DHCS Tools and Standards, there has been an increase in failed Medical Record Reviews. Educational sessions are being provided to providers and continued support is consistently offered and provided by the site review nurses in collaboration with Provider Network Representatives.

B. Physical Accessibility Review Surveys (PARS)

The Physical Accessibility Review Survey (PARS) is not a scored review and focuses entirely on physical accessibility of the healthcare site for seniors and persons with disabilities (SPDs). The PARS assesses the physical accessibility of provider sites for PCPs and high-volume specialists, ancillary, and CBAS provider who serve KHS SPD members. PARS are available to any contracted provider that request to be evaluated, regardless of whether they are determined to be high volume. KHS conducts PARS for new PCP sites at the time of initial credentialing or contracting, and every three years thereafter as a requirement for participation in the California state Medi-Cal Managed Care (MMCD) Program. In 2024, 16 PARS were completed.

C. Medical Records Review (MRR)

Quantitative Analysis:

1. Initial: 17 Initial Medical Record Reviews were due and 17 were completed.
2. Periodic:19 Periodic Medical Record Reviews (PMRR) were due and 19 were completed. 2 Annual MRR were completed.
3. Interim: 33 interim reviews were due, and 33 were completed.

Qualitative Analysis:

Several Provider offices that have not had a recent medical record review are having difficulty complying with the new tools and standards making it more difficult to pass the Medical Record Review. We will continue to monitor for trends.

Barriers

There is one common deficiency noted over the course of 2024: Risk assessments not being performed for both pediatric and adults. This has been impacted by the sunset of the Staying Healthy Assessment form (SHA) in 2023. Providers are now required to complete the Social Determinants of Health (SDOH), Adverse Childhood experiences (ACES), Pediatric ACES and Related Life Events Screener (PEARLS) in place of the SHA.

Focus in 2024

Starting in January of 2024 with the sunset of the Staying Healthy Assessment (SHA), we saw an increase in failed medical record reviews. In response, we developed a strategy of educating office staff before Site Reviews were scheduled. This is not mandatory, but many of our sites welcomed the opportunity for education, especially our new offices. These risk assessments are the cornerstone of this new tool. There are 6 or more risk assessments required at an IHA, and one on one education has been the best way to bond with the office staff and effect change in the office.

D. Credentialing & Recredentialing

Credentialing of new applicants are processed within 180 calendar days and recredentialing is processed every 36 months. In 2024, 100% of the providers were credentialed or recredentialed timely. There are access challenges within the provider network and KHS is working with its delegated groups and network providers to identify opportunities to improve access.

VIII. Quality of Service

	Metric	Goal	Result
19	Grievances & Appeals Timeliness of acknowledgement letters	Within 5 calendar days	Met
20	Grievances & Appeals Timeliness of resolution	Within 30 calendar days	Not Met
21	Access to Care – PCP	80% of routine care within 10 days	Met
22	Access to Care – SCP	80% of specialty care within 15 days	Met

23	Telephone Access to Member Services	Speed of answer <30s and call abandonment rate <5%	Met

A. Grievance & Appeals

Metric	Goal	Result
Grievances & Appeals Timeliness of acknowledgement letters	Within 5 calendar days	93.1%
Grievances & Appeals Timeliness of resolution	Within 30 calendar days	76%

KHS continuously monitors and reports on member grievances related to access to care, coverage determinations, medical necessity, quality of care and services, cultural and linguistic sensitivity, and other concerns. In 2024, a total of 12,219 grievances were received. Of these, 4,476 were exempt (resolved within one day), while the remainder were processed as formal grievances.

Quantitative Analysis:

KHS achieved a 93.1% compliance rate for acknowledgment letters within the required 5-day timeframe, demonstrating strong performance in initial response timeliness. However, only 76% of grievances were resolved within the 30-day resolution period, indicating a 24% gap in compliance. This suggests potential challenges in case complexity, resource allocation, or operational workflows.

Qualitative Analysis:

A review of grievance trends reveals that Quality of Service, Access to Care, and Quality of Care remain the most frequently cited issues among members. Further analysis suggests that delays in provider access, care coordination issues, and administrative barriers contribute to member dissatisfaction. Additionally, cultural and linguistic sensitivity concerns continue to emerge, indicating opportunities to enhance language access services and culturally competent care delivery. Member feedback also highlights inconsistencies in communication regarding grievance resolutions, which may contribute to confusion or dissatisfaction with outcomes.

Opportunities for Improvement

- Enhance Resolution Timeliness – Address the 24% gap in resolution compliance by optimizing workflow efficiencies, increasing staffing resources, and implementing automated case management tools.
- Improve Member Communication – Strengthen member education on grievance processes to set expectations and ensure clear, transparent communication throughout the resolution process.
- Expand Provider and Staff Training – Focus on cultural competency training and grievance resolution best practices to improve service delivery and reduce the volume of avoidable grievances.
- Strengthen Data-Driven Interventions – Conduct root cause analyses on delayed resolutions to identify operational bottlenecks and implement targeted process improvements.

By leveraging these improvement strategies, KHS can enhance compliance, member satisfaction, and overall service quality, ensuring equitable and timely grievance resolution in 2025.

B. Access to Care

Access and Availability

The Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS) maintain accessibility, availability, and adequacy standards the KHS Health System is required to meet. KHS' standards and monitoring activities are outlined in policy and procedure 4.30-P accessibility standards. KHS utilizes the Provider Network Management Network Review to monitor accessibility, availability, and adequacy standards.

The Provider Network Management Network Review provides the overview and results for the Plan's After-Hours Survey, Appointment Availability Survey, Accessibility Grievance Review, Geographic Accessibility and DHCS Network Certification, Network Adequacy and Provider Counts, and DHCS Quarterly Monitoring Report Template Review.

A. After-Hours Survey

As required by the Department of Managed Health Care (DMHC) Health & Safety Code 1348.8, Kern Health Systems (KHS) uses an after-hours caller program to assess compliance with access standards for Kern Family Health Care (KFHC) Members. KHS policy requires that:

1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

An initial survey is conducted by CareNet; the results are forwarded to KHS' Provider Network Analysts who make additional follow up calls based on compliant/noncompliant data received from the survey vendor. The goal is to achieve above 90%.

Results:

The Plan utilizes the after-hours survey calls to monitor compliance at a network-wide level. The Plan was found compliant with Emergency Access and Urgent Access remaining in line with prior quarters, with percentages in Q4 2024 above 90%.

Compliance with After-Hours Standard	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Emergency Access	99%	99%	100%	99%
Urgent Care Access	99%	99%	99%	99%

Quantitative and Qualitative Analysis:

Overall, the goal of 90% was met each quarter. For those offices that were identified as non-compliant, the Provider Relations Representatives conducted targeted education and sent letters notifying the provider groups of the survey results and Plan policy.

Upon review, KHS has found that the outreach and education conducted via both letter and the Provider Relations Representatives/Provider Relations Manager/Deputy Director of Provider Network has seen success.

Plan for 2025:
Continue tracking and trending the quarterly after-hour calls survey and conducting outreach and education for those offices identified as non-compliant.

B. Provider Accessibility Monitoring Survey

As required by the Department of Health Care Services (DHCS) and Title 28 CCR Section 1300.67.2.2, Kern Health Systems (KHS) uses a Provider Accessibility Monitoring Survey to assess compliance with access standards for Kern Family Health Care (KFHC) Members. In line with KHS policies and procedures and Department regulation, the quarterly appointment availability survey monitors:

Type of Appointment	Time Standard
Urgent primary care appointment	Within 48 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Urgent appointment with a specialist	Within 96 hours of a request
Non-urgent appointment with a specialist	Within 15 business days of a request
Non-urgent appointments with a non-physician Mental health provider	Must offer the appointment within 10 business Days of request
Non-urgent appointment for ancillary services	Within 15 days of request
First prenatal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

The survey was conducted internally by KHS staff; the Plan's survey/compliance methodology is based on a survey/compliance methodology utilized by the Department of Health Care Services (DHCS) during their 2017 Medical Audit of the Plan.

The Provider Network Management Department randomly selects five primary care provider offices and five specialist offices in each of the five geographic regions determined by the Health Equity Department. Additionally random samples of 5 non-physician mental health offices, 5 ancillary offices, and 5 OBGYN offices were also contacted to monitor network compliance with regulatory accessibility metrics.

Results:
KHS utilizes the quarterly appointment availability survey to monitor compliance at a network-wide level. KHS reviewed the results of the Q4 2024 Provider Accessibility Monitoring Survey against the results of prior quarters. KHS recognized an increase in the wait time for Non-Urgent NPMH and OB/GYN appointments. KHS recognized decreases in wait time for Non-Urgent PCP, Specialist, Ancillary, Urgent PCP, and Urgent Specialist appointments. KHS does not consider

this increase as a trend currently, as the results are in line with prior quarters. KHS' average wait time remains well within regulatory standards for all appointment types.

Average Urgent Wait Time in Hours	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Primary Care (48 Hours)	34.4	11.9	21.8	20.0
Specialist (96 Hours)	46.2	75	32.5	31.3

Average Wait Time in Days	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Primary Care (10 Days)	2.7	3.2	2.5	1.3
Specialist (15 Days)	4.9	6.8	4.6	3.5
Non-Physician Mental Health (10 Days)	3.8	4.2	2.8	3.6
Ancillary (15 Days)	2.4	7.8	3.6	0.8
OB-GYN (10 Days)	8.2	4.6	1.2	3.0

Quantitative and Qualitative Analysis:
The timeframes for appointment waiting times for PCPs, specialists, Non-Physician Mental Health, OBGYN, and ancillary providers were all met for each quarter of study. For providers who remained noncompliant with Plan appointment availability standards, KHS' Provider Relations Representatives conducted targeted outreach and education to the identified providers regarding their contractual obligation to meet regulatory access standards.

Plan for 2025:
Continue the ongoing quarterly tracking and trending for Provider Accessibility

C. Geographic Accessibility and DHS Network Certification

Per Section 1300.51 (d)(H) of the California Code of Regulations, KHS shall ensure, "all enrollees have a residence or workplace within thirty (30) minutes or fifteen (15) miles of a contracting or plan-operated primary care provider" as well as "within thirty (30) minutes or fifteen (15) miles of a contracting or plan operated hospital". Further, per Section 1300.67.2.1(b), if "a plan's standards of accessibility [...] are unreasonable restrictive [...] the plan may propose alternative access standards of accessibility for that portion of its service area.

Per Exhibit A, Attachment 6 of the KHS contract with the DHCS states that KHS "shall maintain a network of Primary Care Physicians which are located within thirty (30) minutes or ten (10) miles of a member's residence unless [KHS] has a DHCS-approved alternative time and distance standard."

For all geographic areas in which KHS does not currently meet the regulatory accessibility standard, KHS monitors and maintains an alternative access standard that has been reviewed and approved by the DMHC and/or DHCS.

DHCS Annual Network Certification – 2023-2024

DHCS Network Adequacy Standards	
Primary Care (Adult and Pediatric)	10 miles or 30 minutes
Specialty Care (Adult and Pediatric)	45 miles or 75 minutes
OB/GYN Primary Care	10 miles or 30 minutes
OB/GYN Specialty Care	45 miles or 75 minutes
Hospitals	15 miles or 30 minutes
Pharmacy	10 miles or 30 minutes
Non-Specialty Mental Health (Adult and Pediatric)	45 miles or 75 minutes

Results:
As part of its ongoing monitoring, the Plan reviews additions/deletions in the provider network against the most recently completed geographic accessibility analysis. As of the end of Q4 2024, the Plan did not identify any terminations that would affect the Plan's ability to provide access within required time or distance standards.

Plan for 2025:
In compliance with the Annual Network Certification requirement outlined in APL 23-001, KHS will submit geographic access analysis assessing compliance with DHCS Network Adequacy Standards.

D. Network Adequacy and Provider Counts

Per CCR § 1300.67.2, Kern Health Systems (KHS) shall maintain, "at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and [...] approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees."

In 2020, KHS contracted with SPH Analytics to conduct our annual Provider Satisfaction Survey; as a part of that survey, responding providers were asked, "What portion of your managed care volume is represented by Kern Health Systems?" Outreach for the survey was placed to every contracted provider within the KHS network. Responses received, and FTE calculations based on those responses, do not account for providers who refuse to participate in the survey. KHS used the responses collected combined with the most recent available Medi-Cal membership market share data to calculate an average FTE percentage which will be applied to the Plan's network of providers when calculating physician-to-enrollee compliance ratios.

KHS utilized SPH Analytics, an NCQA certified survey vendor, to conduct the survey for 2024. SPH's methodology involved two waves of mail and Internet, with a third wave of phone follow up to administer the survey.

Results:
Based on the results of 2024 survey, KHS calculated a network-wide FTE percentage of 70.81% for Primary Care Providers and 66.84% for Physicians.

PCP to Member Ratio:
As of the end of Q4 2024, KHS was contracted with 505 Primary Care Providers, a combination of 249 physicians and 256 mid-levels. Based on the FTE calculation process outlined above, with a 70.81% PCP FTE percentage, KHS maintains a total of 266.97 FTE PCPs. With a membership enrollment of 404,252 utilizing KHS contracted PCPs, KHS currently maintains a ratio of 1 FTE PCP to every 1,514.23 members; KHS is compliant with state regulations and Plan policy.

Physician to Member Ratio:
As of the end of Q4 2024, the plan was contracted with 2,365 Physicians. Based on the FTE calculation process outlined above, with a 66.84% Physician FTE percentage, KHS maintains a total of 1,580.72 FTE Physicians. With a total membership enrollment of 404,252 utilizing KHS contracted Physicians, KHS currently maintains a ratio of 1 FTE Physician to every 255.74 members; KHS is compliant with state regulations and Plan policy.

C. Telephone Access to Member Services

Activity	Goal	Q1-2024	Q2-2024	Q3-2024	Q4-2024
Incoming Calls		84,175	72,308	74,004	68,844
Abandonment Rate	<5%	10%	1%	1%	2%
Speed of Answer	<0:30	2:22	0:15	0:13	0:18

Ensuring timely access to Kern Health Systems (KHS) is essential in helping members receive the care they need and promptly resolve any issues. To measure and enhance accessibility, KHS closely monitors key performance metrics, including call speed of answer and call abandonment rate.

- **Call Speed of Answer:** A target of less than 30 seconds was established, and in 2024, this goal was exceeded with an average response time of 18 seconds by the 4th quarter.
- **Call Abandonment Rate:** The target was set at less than 5%, and KHS successfully achieved a 2% abandonment rate by the 4th quarter, demonstrating strong member engagement and responsiveness.

By maintaining these high service standards, KHS remains committed to providing seamless access to care, improving member satisfaction, and ensuring that all inquiries are addressed efficiently.

IX. Member Experience

	Metric	Goal	Result
24	Adult and Child CAHPS Survey	Establish baseline for Getting Care needed measure	Met
25	Member Rewards	Increase MCAS measure rates by 2% by EOY	Met

A. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

In 2024 Kern Health Systems again selected SPH Analytics, now under Press Ganey (PG), an NCQA-certified survey vendor, to conduct its Measurement Year (MY) 2023 Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.1 Medicaid Adult Survey.

The objective of the CAHPS® study is to measure how well plans are meeting their members' expectations and goals, to determine which areas of service have the greatest effect on members' overall satisfaction, and to identify areas of opportunity for improvement to aid health plans in increasing the quality of provided care.

TOP THREE PERFORMING MEASURES

MEASURE	2024 Valid n	PLAN SUMMARY RATE SCORE			2023 QC			2024 PG BoB		
		2023	2024	CHANGE	SCORE	GAP	PERCENTILE	SCORE	GAP	PERCENTILE
Rating of Health Plan *(% 9 or 10)*	511	72.0%	71.6%	-0.4	61.5% ▲	10.1	96th	63.1% ▲	8.5	95th
Customer Service + *(% Usually or Always)*	249	91.6%	93.8%	2.2	89.1% ▲	4.7	98th	89.8% ▲	4.0	95th
Rating of Health Care *(% 9 or 10)*	382	61.5%	62.6%	1.1	56.8% ▲	5.8	87th	57.3% ▲	5.3	87th

BOTTOM THREE PERFORMING MEASURES

MEASURE	2024 Valid n	PLAN SUMMARY RATE SCORE			2023 QC			2024 PG BoB		
		2023	2024	CHANGE	SCORE	GAP	PERCENTILE	SCORE	GAP	PERCENTILE
Coordination of Care + *(% Usually or Always)*	248	82.7%	85.5%	2.8	85.6%	-0.1	52nd	86.0%	-0.5	43rd
How Well Doctors Communicate + *(% Usually or Always)*	370	92.5%	92.6%	0.1	93.0%	-0.4	44th	93.2%	-0.6	39th
Rating of Specialist + *(% 9 or 10)*	272	67.5%	66.5%	-1.0	67.7%	-1.2	42nd	68.5%	-2.0	34th

Improvement Strategies

The following strategies are recommendations from PG to improve the performance measures that rated in the bottom three. KHS may adopt some of these strategies and will evaluate internal processes as well related to these measures to determine other strategies that KHS may adopt to improve the ratings of these measures.

Coordination of Care

a. Inform, support, remind and facilitate providers about coordination of care expectations, timely notification requirements, and standards of care for post-visit follow up to all PCPs. Explore options to encourage and support communications between specialists and PCPs.

b. Develop on-going and timely reminders/messaging to promote and improve communication and reporting between all provider types, ideally based directly on available data/information.
c. Assess the status and consistency of coordination of patient care, communication, and information shared within and across provider networks. Assure prompt feedback, standards.
d. Support and facilitate a patient-centered care management approach within and across provider networks. Facilitate a complementary plan-based patient centered care management approach.
e. Explore potential of aligning information flow/EHRs to better integrate, support or facilitate patient care, care coordination and vital medical and personal information among providers.
f. Encourage providers to prompt patients AND patients to prompt providers, i.e., mutual interactions that review and discuss care, tests and/or treatments involving other providers.
g. Encourage patients to bring a list of all medications, including dosage and frequency to all appointments. Encourage providers to prompt patients to do the same for their appointments.
h. How do PCP's, providers, facilities and/or the plan assure common patient "touch points" to facilitate/support scheduling of appointments, tests and/or procedures? Where is the over-arching guidance and support for the patient/member?

How Well Doctors Communicate

a. Cultivate a patient-centered care philosophy and programs across the provider network
b. Support, communicate and educate providers about the vital medical importance of effective doctor-patient communication (i.e., reduced hospitalizations & ER visits, improved adherence).
c. Provide readily available recommendations, tools and guidance to all providers to support and enhance communication skills and effective conversation skills with patients. Providers need to: Provide thorough explanations, provide written materials, illustrations and/or examples to help patient's understand, repeat the patient's concern and then address the topic, ask clarifying questions, make eye contact, avoid medical jargon and technical language, avoid multi-tasking, avoid rushing the patient, use constructive verbal responses and non-verbal cues, apply empathy and interest in response to concerns, by kind, avoid condescending language or actions, address questions and concerns-as much time as necessary, schedule adequate time for each visit, and follow-up after tests or procedures.
d. Collaborate and share with providers tools, resources, and best practices to support, or reinforce, a complete and effective information exchange with all patients (e.g., a summary of medical record or health assessment to facilitate an effective health or wellness discussion, patient testimonials - perhaps from focus groups - of effective and ineffective communication techniques, provide tips and/or testimonials in provider newsletters).

e. Develop tools and guidance for patients to optimize appointment time and specific topic-based conversation guides or question checklists with providers (e.g., Doc Talk).
f. Support patients with chronic illnesses/conditions and their providers with up-to-date tools, resources and conversation guides that address common clinical needs, continual review, modification and update of progress, next steps, and self-management topics.

Rating of Specialist

a. Analyze, investigate, and probe for weakness or QI opportunities among those measures or composites that are Key Drivers (or highly correlated) with rating of specialist or doctor. (e.g., HWDC, GCQ, GNC, Coordination of Care).
b. Review QI recommendations/actions for related CAHPS composite measures: How Well Doctors Communicate, Getting Care Quickly, Getting Needed Care, Coordination of Care.
c. Provide resources, articles, tools and training sessions via multiple channels to support and drive improvement in physician-patient communication and patient-centered interviewing. Examples include: Listen to patients' concerns, Follow-up with the patient. Provide thorough explanations. Ensure that all questions and concerns are answered. All staff focus on being helpful and courteous to patients.
d. Share, report and discuss relative CAHPS health care performance and feedback at the health system and/or within network level.
e. Promote use of a secure online patient portal which allows patients access to their medical record and health care information of relevant to patient needs.
f. Gather and analyze patient feedback on their recent office visit (i.e.., patient "comment cards," follow up call/text/email, CG CAHPS survey, etc.)
g. Assess adequacy of contracted specialist by specialty. If necessary, review quality of care information among specific specialties and/or identify practices of excellence.
h. Explore ability of providers to share with patient's a summary of their medical record or health assessments to facilitate conversation about relevant health and wellness issues.
i. Assess systems (e.g., EHRs) processes and/or procedures used to gather or facilitate distribution of patient information among providers.
j. Suggest providers/practices periodically analyze appointment scheduling timeframes versus types of office visits.

B. Member Rewards Program

The Member Engagement Reward Program (MERP) will continue its targeted outreach efforts in 2025 to encourage members to schedule necessary appointments and close gaps in care, with a focus on key Medi-Cal Accountability Set (MCAS) measures.

- Text Messaging Campaigns: Members will receive text reminders to schedule appointments, prioritizing measures such as Comprehensive Care for Children (CCS), Well-Child Visits in

the First 30 Months of Life (W30), and Child and Adolescent Well-Care Visits (WCV). A focused text messaging campaign for these measures will take place in June.

- Robocalls: Automated calls will be sent to members who do not receive text messages, ensuring outreach coverage across different communication preferences.
- Geomapping Insights: Data-driven geomapping strategies will be leveraged to identify optimal event locations and target outreach efforts toward specific populations in need of engagement.

Through these initiatives, MERP aims to improve health outcomes by increasing preventive care utilization, reducing gaps in care, and enhancing member engagement in their healthcare journey.

X. Provider Engagement

	Metric	Goal	Result
26	Provider Satisfaction Survey	Trend results by survey questions	Met
27	Provider Incentive Program	Improve A1C Level	Met
28	Provider Education	Meet Providers Quarterly	Met

A. Provider Satisfaction Survey

BACKGROUND/METHODOLOGY

On an annual basis, Kern Health System's Provider Network Management Department conducts a Provider Satisfaction Survey to gauge the level of satisfaction and engagement amongst our network of contracted providers. The 2023 Provider Satisfaction Survey asked providers to answer survey questions based on their experiences with KHS during Calendar Year 2022. We engaged an independent survey company, Press Ganey (PG) Analytics to conduct the survey on behalf of the Plan. PG Analytics is able to benchmark KHS performance against other organizations within the industry, by comparing our results against their National Medicaid and Aggregate Books of Business. The PG 2022 Medicaid Book of Business is made up of 104 plans with a total of 19,251 respondents. The PG 2022 Aggregate Book of Business is made up of 180 plans with a total of 27,767 respondents. This is sixth annual Provider Satisfaction Survey that PG Analytics has completed for the Plan.

The 2023 Provider Satisfaction Survey was conducted across three waves, in April, May, and June of 2023. Two waves of mailing outreach were conducted, followed by a third outreach via telephone. The survey is sent to and categorized by provider type, including PCP, Specialist, Behavioral Health, and Other (Facilities, Ancillary providers). All statistical testing is performed at the 95% confidence level.

RESULTS

The Provider Satisfaction Survey was presented and evaluated at the Quality Improvement Workgroup Committee Meeting and in the Executive Quality Improvement and Health Equity Committee.

KHS experienced increases amongst seven (7) of the eight (8) scoring composites (Overall Satisfaction, Compared to Other Plans, Compensation, UM & Quality Improvement, Network and

Continuity of Care, Health Plan Call Center, Provider Relations, and Recommend to Other Providers) when compared to the prior year's Provider Satisfaction Survey. KHS scored within the 90th percentile or higher in all scoring composites/attributes, with both Utilization Management & Quality Improvement and Provider Relations in the 100th percentile when compared against PG's 2022 Medicaid Book of Business.

As KHS scored within the 90th percentile or higher in all scoring composites/attributes, discussion focused on how to increase provider participation with the survey. The Plan determined that sending the survey out earlier in the year may increase provider participation.

B. Provider Incentive Program

The Endocrinologist Diabetic Program is designed to support members with uncontrolled diabetes by providing specialized care aimed at improving their A1C levels through appropriate interventions. This program operates under an incentive-based reimbursement structure, encouraging optimal diabetes management and patient outcomes.

To enhance accessibility and streamline care coordination, the QP leadership team is in the process of establishing an API that will facilitate direct appointment scheduling for this population with the endocrinologist's office. This technological integration aims to improve member engagement, reduce barriers to specialist care, and support more timely interventions for diabetes management.

Through these efforts, the program seeks to improve health outcomes, enhance provider collaboration, and optimize the management of diabetes within the member population.

C. Provider Education

The Quality Performance team has implemented a structured approach to provider engagement by initiating both monthly and quarterly meetings with assigned providers. These meetings, along with scheduled and ad hoc discussions with various provider groups, serve as a platform to address key topics such as reimbursement rates, operational challenges, barriers to care, and notable accomplishments. By maintaining routine interactions, the QP team fosters collaboration, identifies opportunities for improvement, and supports providers in delivering high-quality care to members.

Action Plan for 2025:

In 2025, the QP team will continue its structured monthly and quarterly meetings with providers, fostering ongoing collaboration and addressing key issues such as reimbursement rates, operational challenges, and barriers to care. These meetings will serve as a platform to support providers in delivering high-quality services and improving healthcare outcomes for members.

Additionally, the Quality Improvement (QI) Department remains committed to health education by continuing to provide tailored educational materials for both members and providers. These materials will focus on critical health topics, including chronic disease management, preventive care, and health equity, ensuring that individuals have the necessary knowledge to make informed healthcare decisions.

To further address pressing health concerns, the QI Department will also take a proactive approach to tackling obesity by organizing a dedicated conference on the topic. This event will bring together

healthcare professionals, community leaders, and subject matter experts to discuss the latest research, evidence-based interventions, and best practices for obesity prevention and management. The conference will also explore strategies to improve access to resources, address social determinants of health, and enhance collaboration among stakeholders to develop sustainable solutions for obesity-related challenges.

Through these initiatives, the Quality Departments aim to enhance health literacy, empower members to adopt healthier lifestyles, and support providers in delivering high-quality, equitable care.

XI. Conclusion

The 2024 Quality Improvement (QI) Program at Kern Health Systems (KHS) demonstrated measurable progress in enhancing healthcare quality, patient safety, and service accessibility. Key initiatives, including the MCAS performance improvement efforts, Performance Improvement Projects (PIPs), PQI mitigation strategies, and strengthened provider engagement, contributed to substantial advancements in member outcomes. However, opportunities remain to further refine interventions and optimize processes to ensure sustained, system-wide improvements in clinical care and health equity.

Effectiveness of the QI Program

In 2024, KHS achieved 26 of its 28 Quality Improvement goals, highlighting its strong commitment to quality enhancement. Areas of success included:

- Improved Access to Care: Compliance with state-mandated appointment wait times and telephone access to Member Services improved, with notable reductions in wait times for both primary and specialty care.
- Enhanced Member Engagement: Targeted outreach campaigns, mobile unit initiatives, and care coordination efforts led to higher engagement in preventive services.
- Network Performance Monitoring: Facility Site Reviews (FSRs) and Medical Record Reviews (MRRs) met compliance thresholds, ensuring provider adherence to quality and safety standards.
- Reduction in Potential Quality of Care Issues (PQIs): Median PQI volumes decreased from 99 (2023) to 68 (2024), with Level 2 and Level 3 cases remaining below established thresholds.

However, the failure to meet MCAS minimum performance levels (MPLs) for certain measures, such as Colorectal Cancer Screening, Depression Screening, and Follow-Up After Emergency Visits for Mental Illness and Substance Use, indicates an ongoing need for targeted interventions. Corrective actions required by DHCS, including provider engagement initiatives and expanded community partnerships, will be instrumental in addressing these deficiencies in 2025.

Influence on Network-Wide Safe Clinical Practices

KHS made significant strides in fostering network-wide safe clinical practices through:

- Provider Education and Accountability: Implementation of network-wide training sessions, corrective action plans, and compliance monitoring improved adherence to clinical guidelines. However, provider engagement gaps persist, particularly in addressing social determinants of health and culturally competent care.
- Care Coordination and Follow-Up Interventions: The Non-Clinical PIP targeting provider notifications for members with Severe Mental Health (SMH) and Substance Use Disorder (SUD) diagnoses following ED visits led to an 84% provider notification rate—a critical step in improving continuity of care.
- Safety and Quality Audits: FSR, PARS, and MRR results exceeded compliance targets, ensuring facilities maintained safe and accessible environments. However, challenges such as gaps in provider documentation, calibration issues, and risk assessment compliance indicate areas for process refinement.
- Population Health Management & Health Equity Integration: The integration of health equity principles within the QI framework led to expanded outreach programs, particularly targeting African American infant well-care visit rates (W30 PIP) and transportation barriers in rural communities.

Opportunities for 2025

While the 2024 QI Program laid a strong foundation for quality improvement and patient safety, areas for continued growth include:

- Strengthening Provider Engagement Strategies to improve compliance with MCAS measures and care coordination responsibilities.
- Enhancing Data Analytics & Timely Reporting to enable faster response times to emerging trends in quality and safety concerns.
- Expanding Access to Preventive Care & Behavioral Health Services through mobile health initiatives and innovative partnerships with local healthcare providers and community organizations.
- Addressing Health Equity Challenges by scaling up targeted interventions for high-risk populations and ensuring culturally competent care delivery.

In summary, the 2024 QI Program effectively advanced patient care, provider accountability, and member engagement, yet systemic challenges in provider collaboration, preventive care participation, and health equity require sustained focus in 2025. Through ongoing performance monitoring, strategic partnerships, and provider-driven initiatives, KHS remains committed to enhancing network-wide clinical quality, safety, and equity for its Medi-Cal population. Using the analysis and identified barriers in this evaluation, KHS will continue to plan for future interventions and develop the 2025 Work Plan and obtain approval from the Executive Quality Improvement Health Equity Committee (EQIHEC).

XII. Appendix

Appendix A: Population Needs Assessment October 2024

Appendix B: QI 3A – Continuity and Coordination of Medical Care

Appendix C: QI 4AB – Continuity and Coordination Between Medical Care and Behavioral Healthcare

KERN HEALTH SYSTEMS

2025 Quality Improvement Health Equity Program Description

Executive Quality Improvement Health Equity Committee (EQIHEC)
Approval Date: 03/18/25

Table of Contents

I. Introduction

Kern Health Systems (KHS), operating as Kern Family Health Care (KFHC), was established in 1993 by the Kern County Board of Supervisors as a local initiative Medi-Cal managed care health plan. KFHC is the largest health plan in Kern County, serving the majority of Kern County's Medi-Cal beneficiaries through a contract with the State of California Department of Health Care Services (DHCS).

KHS is a special county health authority governed by a 16-member Board of Directors. This diverse board includes representatives such as the Chief Executive Officer of the local safety net hospital, a safety net care provider, ten community representatives nominated by the County Supervisors, two Medi-Cal primary care physicians, one representative from a rural acute care general hospital, and one pharmacist. Board members must work or reside in Kern County and meet the minimum age requirement of 21. The Board oversees the establishment and operation of a comprehensive managed care system, ensuring access to high-quality medical care, promoting cost efficiency, and adhering to the principles of Chapter 7, Part 3 of Division 9, Section 14000 of the California Welfare, and Institutions Code.

As of 2024, KHS serves approximately 403,000 members, with 49% receiving care through the County Hospital system and two large Federally Qualified Health Centers (FQHCs). While 66% of the population resides in Bakersfield, the remainder is spread across rural areas of Kern County. The largest racial group is Hispanic, accounting for 63% of membership. Language diversity is a key factor, with 70% of members speaking English as their primary language, 29% speaking Spanish, and 1% speaking other languages.

Kern County faces significant health challenges compared to statewide statistics, including higher rates of adult smoking, obesity, physical inactivity, alcohol-impaired driving deaths, sexually transmitted infections, and teen births. However, the county ranks favorably in food environment indices due to fewer low-income residents with limited access to grocery stores and lower rates of excessive drinking.

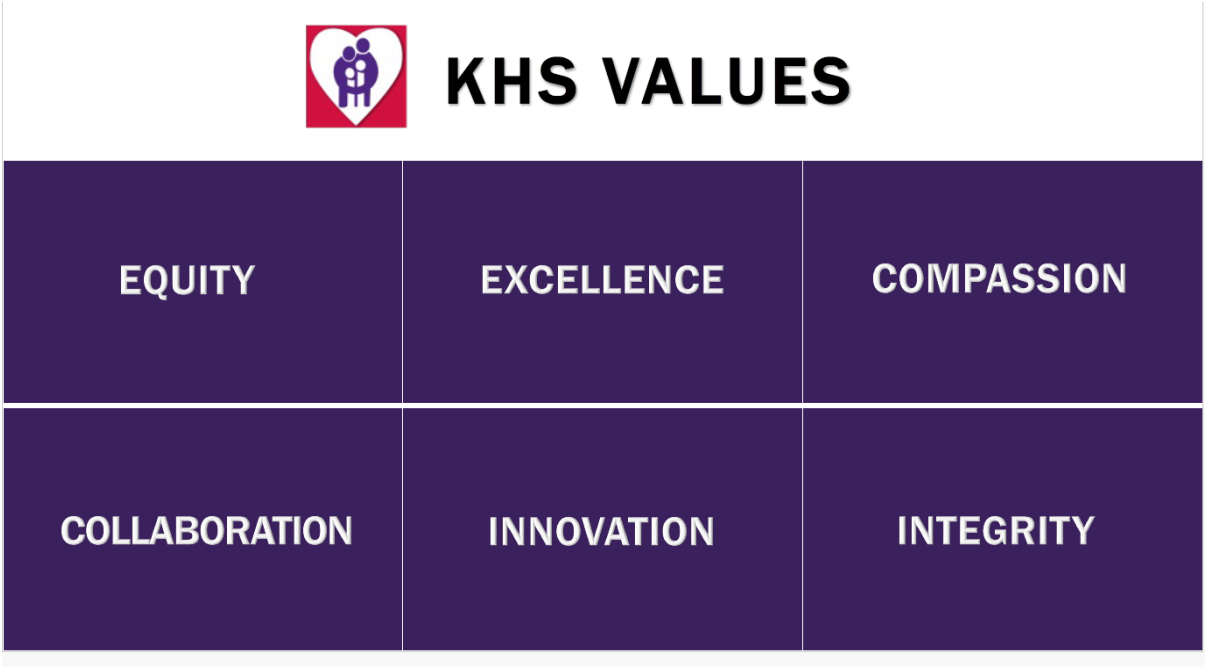
A. Mission & Values

Mission

KHS is committed to improving the health and well-being of our members and the community of Kern County through an integrated, equitable, and member-centered healthcare delivery system. The Quality Improvement Health Equity Program (QIHEP) is designed to objectively monitor, systematically evaluate, and effectively improve the quality, safety, and outcomes of care delivered to our members. By prioritizing health equity and addressing social determinants of health, KHS strives to meet members where they are, empowering them to achieve their optimal health outcomes.

The KHS Quality Improvement Department, in collaboration with the Quality Performance and Health Equity Departments, oversees the program's initiatives and activities, working closely with contracting providers to deliver high-quality care to the populations we serve.

Values



- **Equity**

We foster a culture of fairness and inclusion, ensuring all members and employees are supported, regardless of their zip code, race, ethnicity, preferred language, cultural preferences, or personal history. Equity is at the core of what we do because every person matters. We celebrate diversity and strive to create opportunities for everyone to thrive and contribute their unique gifts.

- **Excellence**

We uphold the highest standards in all that we do, aiming for outstanding results that resonate with the community we serve. Through continuous improvement and dedication, we achieve quality outcomes that lead to a stronger and healthier community. Excellence is reflected in our pride, commitment, and measurable impact.

- **Compassion**

We seek to understand and empathize with others' experiences, extending care and kindness to everyone we serve. Compassion drives our actions and shapes our solutions, ensuring we respond meaningfully to the needs of our members and colleagues.

- **Collaboration**

We harness the collective expertise of our team, providers, and community partners to solve problems and achieve shared goals. Collaboration brings diverse perspectives and strengths together, driving creativity and producing impactful, sustainable results.

- **Innovation**

We embrace new ideas, methods, and solutions to expand possibilities and improve outcomes. Through experimentation and forward-thinking, we adapt to the changing needs of our members and create innovative strategies that maximize efficiency and value.

- **Integrity**

We act with honesty and accountability, staying true to our commitments and values. Integrity builds trust and provides a strong foundation for performance and meaningful impact, ensuring we consistently do the right thing, even when it is not the easy thing.

KHS is committed to delivering on its values by:

- Ensuring all members obtain equal access to socioeconomic and environmental resources,
- Applying a health equity lens at all levels of and in all services provided by KHS,
- Embracing new knowledge and new ways of providing services,
- Practicing tolerance (accepting differences), embracing diversity (celebrating differences where possible), and pursuing inclusivity (finding commonalities and soliciting voice),
- Identifying and challenging historic assumptions and biases,
- Collaborating across programs, divisions, and community agencies/organizations to address community needs and barriers and obtain recommendations to improve services,
- Managing fiscal resources and the use of resources for greatest impact,
- Keeping consumers informed of Health Equity activities and outcome summaries by making them publicly available on the KHS website. Updates and ongoing information are posted at a minimum, on a quarterly basis,
- Leveraging our financial resources to help historically under-supported businesses and communities of color to build stronger capacity and economic health,
- Holding itself accountable through measurement and quality improvement/assurance,
- Building strong internal leaders in the health equity field that demonstrate a sustained, resolute commitment to DEI and collaboration with all stakeholders,
- Committing to eliminating health inequities in Kern County.

B. Background

Kern County is very diverse, with many residents identifying as Hispanic. As the racial and ethnic composition of Kern County continues to change, it is important to create culturally sensitive systems, policies, and environments while protecting the health of the public.

Spanish-language education, documents, and services will continue to be needed as the Hispanic population continues to grow. Additionally, while the total number of Non-Hispanic Asians in Kern County remains small, the proportion of residents identifying as Non-Hispanic Asian has increased 21 percent since 2009. In comparison, during the same time frame, the Hispanic population in Kern County grew by 11 percent.

In Kern County, children 17 and under are at higher risk of living below the poverty level than adults 18 and older. Overall, 31.3% of children live below the poverty level while 22.6% of all Kern County residents live below the poverty level. Studies have shown that children in poverty are more likely to have physical and mental health problems than their peers. This includes lower achievement in test scores, which could limit an individual's ability to make a living wage.

Moreover, Kern County continues to have a smaller proportion of residents with a high school diploma or equivalency than California's average. However, Kern County is expected to have the largest increase in high school graduates in the State by 2028.

Due to the diverse geography of Kern County, from arid high desert to the mountains to the valley, climate also varies. In the summer, heat exhaustion, heat stroke, and heat-related deaths are of concerns in Kern County (i.e., dehydration can exacerbate underlying conditions). Another example, high winds and dust storms in certain parts of the county can aggravate respiratory disorders and contribute to infectious diseases like Valley Fever (coccidioidomycosis).

Kern County's service area has been challenged with provider shortages. Large portions of the county are designated as Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P). These issues are more severe and prevalent in Kern County than other counties within California. The following 4 rural areas are in this classification:

- Taft
- Lost Hills/Wasco
- Fort Tejon
- Lake Isabella

C. KHS Population

The population served by Kern Health Systems (KHS), operating as Kern Family Health Care (KFHC), reflects the diverse demographic, geographic, and socioeconomic characteristics of Kern County. As of 2024, KHS serves approximately 403,000 Medi-Cal members, encompassing a wide range of health and social needs.

Demographics

- Geographic Distribution:
    - Over 66% of KHS members reside in Bakersfield, the county's largest metropolitan area.
    - The remaining members are distributed across rural areas, highlighting a need for geographically equitable healthcare access.

Area	Rural Portions per HRSA	KHS Population	Percentage
Bakersfield	N	223,973	66.9%
Delano & North Kern	Y	30,610	9.1%
Arvin/Lamont	Y	21,978	6.6%
Shafter/Wasco	Y	21,596	6.4%
California City & Southeast Kern	Y	9,434	2.8%
Taft & Southwest Kern	Y	8,897	2.7%
Tehachapi	Y	5,632	1.7%
Ridgecrest & Northeast Kern	Y	4,883	1.5%
Lake Isabella & Kern River Valley	Y	4,023	1.2%
Lost Hills & Northwest Kern	Y	2,194	0.7%
Frazier Park & South Kern	Y	1,244	0.4%
Outside Service Area	N/A	465	0.1%

- Racial and Ethnic Composition:
    - The Hispanic population represents 63% of the membership, emphasizing the importance of culturally relevant care and services.
    - Other racial/ethnic groups include White, African American, Asian, Native American, and individuals identifying as multiracial, reflecting the community's diversity.

Ethnic or Racial Group	% KHS Enrollment
Hispanic	63%
Caucasian	17%
No valid data, unknown or other	11%
Black/African American	6%
Asian Indian	1%
Filipino	1%
Asian/Pacific	1%

- Language Diversity:
    - 70% of members identify English as their primary language.
    - 29% primarily speak Spanish, underscoring the need for language assistance services.
    - 1% speak other languages, requiring culturally and linguistically appropriate services to ensure equitable access to care.

Socioeconomic Characteristics

- Many KHS members face significant socioeconomic challenges, including:
    - Poverty: A large proportion of the population lives at or below the federal poverty level.
    - Unemployment: Economic instability affects access to housing, transportation, and other basic needs.
    - Educational Barriers: Limited education levels impact health literacy and the ability to navigate the healthcare system.

Health Risk Factors

- Kern County exhibits a higher prevalence of health risks compared to statewide averages:
    - Chronic Conditions: High rates of diabetes, hypertension, and obesity among the population.
    - Lifestyle Factors: Elevated smoking rates, physical inactivity, and alcohol use disorders.
    - Maternal and Child Health: Teen births and limited access to prenatal care contribute to poor outcomes in maternal and child health.

Key health behaviors affecting the Kern population are reflected in the following table obtained from County Health Rankings & Roadmaps. :

Health Factors			
Health Behaviors	Kern (KE) County	California	United States
Adult Smoking	15%	10%	16%
Adult Obesity	36%	26%	32%
Food Environment Index	7.4	8.9	7.8
Physical Inactivity	33%	22%	26%
Access to Exercise Opportunities	82%	93%	80%
Excessive Drinking	16%	19%	20%
Alcohol-Impaired Driving Deaths	32%	28%	27%
Sexually Transmitted Infections	763.8	599.1	551.0
Teen Births	32	16	19

Social Determinants of Health (SDOH)

- KHS actively identifies and addresses social determinants that impact the health of its members, including:
    - Housing Insecurity: A significant portion of the population experiences unstable or unsafe housing conditions.
    - Food Insecurity: Access to affordable and nutritious food remains a concern for many families.
    - Transportation Barriers: Limited public transportation options impede access to healthcare facilities, particularly in rural areas.
    - Access to Technology: Digital inequities hinder member engagement in telehealth services and health education initiatives.

Behavioral Health Needs

The mental health and substance use disorder needs of KHS members are significant, with many individuals requiring coordinated care for mild-to-moderate behavioral health conditions. KHS partners with the Kern County Behavioral Health and Recovery Services (KBHRS) to address the needs of members requiring specialty mental health services.

Vulnerable Subpopulations

KHS tailors its programs and services to address the unique needs of vulnerable groups, including:

- Seniors and Persons with Disabilities (SPDs): Older adults and individuals with disabilities require specialized care and enhanced care management services.
- Homeless Individuals: Outreach efforts target unsheltered populations, including street medicine initiatives to deliver care in nontraditional settings.
- Children and Adolescents: Programs focus on preventive care, developmental screenings, and health education for younger members.

Kern County ranks lower compared to other California counties for a variety of public health indicators. Kern County ranks in the bottom 10 California counties for age-adjusted death rates due to diabetes, Alzheimer's disease, coronary heart disease, chronic lower respiratory disease, homicide, and drug-induced deaths1. It is also among the bottom 10 California counties for the incidence of chlamydia, gonorrhea among people 15-44 years old, congenital syphilis, primary and secondary syphilis, infant mortality, and persons under 18 in poverty.

In Kern County's most recent Community Health Assessment, asthma and other respiratory diseases were identified as the top community health problems. According to the California Health Interview Survey, 15.7% of the Kern County population has been diagnosed with asthma. In 2019, the emergency department (ED) rate due to asthma was 46.1 per 100,000 compared to the state average of 42.6 per 100,000. Black/African American people in Kern County experience asthma disparities as demonstrated by their asthma ED visit rate of 181.5 per 100,000 people. This rate is more than four times the rate of the next highest racial/ethnic group in Kern County and more than double the rate of any age group in the county.

Other health disparities identified within Kern County include the teen birth rate (25.9 per 1,000 live births) which was more than double the state average (12.5 per 1,000 live births); the percentage of all pregnancies accessing early prenatal care which was below the state average (KC-79.6%; CA-85.1%); and the obesity rate which was 35.5% compared to 30.3 for California.

Regarding mental health, Kern County's age-adjusted mortality rate due to suicide is 13.5 per 100,000 which is higher than the state averages (CA-10.7 per 100,000).

In accordance with the World Health Organization definition of social determinants of health, (SDOH) are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems.

The improvement of long-term health outcomes, particularly for populations experiencing the greatest inequities in health over time, requires a shift in focus to the upstream factors that are the underlying causes of ill health (Harris County Public Health: Health Equity Policy, 2015). Such health inequities include disparate rates of disease, disability, and premature death. A shift to upstream (Appendix A) factors provides all individuals, regardless of socioeconomic or environmental conditions, the opportunity to attain their full health potential.

Addressing health disparities among identified populations is a priority of KHS. To ensure robust insights regarding disparities, KHS leverages the External Quality Review (EQR) Technical Report, and the KHS Population Needs Assessment. An annual analysis of the EQR is used to identify specific disparities and/or targeted areas of focus to incorporate into strategies to improve member satisfaction, close gaps in care, and highlight other specific needs

for the KHS population. KHS utilizes the EQR recommendations to develop strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services. The KHS PNA uses internal and external data to identify and assess vulnerable member groups by race or ethnicity, age, sex, language, and other member characteristics, including cultural and linguistic needs. The KHS PNA builds upon previous needs assessments and uses various data collection methods and sources. The goal of the PNA is to improve health outcomes for KHS members and ensure that KHS is meeting the needs of its members through:

1. Identification of member health needs and health disparities.
2. Evaluation of current health education (HE), cultural and linguistic (C&L), and quality improvement (QI) activities and available resources to address identified concerns; and
3. Implementation of targeted strategies for HE, C&L, and QI programs and services to address member needs.

Population Health Management (PHM) services (i.e., basic population health management, enhanced care management, etc.) are offered to all KHS members, and provided in a manner to address member needs and preferences and address health disparities.

Opportunities for Improvement

KHS leverages insights from its annual Population Needs Assessment to identify gaps in care and develop targeted interventions. Key opportunities include:

- Expanding provider networks to improve access in underserved areas.
- Reducing health disparities by addressing inequities in chronic disease management and preventive care.
- Enhancing member engagement through culturally competent health education and communication strategies.
- Strengthening partnerships with community organizations to address SDOH and improve overall member well-being.

II. QIHEP Overview

A. QIHEP Purpose

The KHS Quality Improvement Health Equity Program (QIHEP) is a written description of the overall scope and responsibilities of the program. The QIHEP actively monitors, evaluates, and takes effective action to address any needed improvements in the quality, appropriateness, safety, and outcomes of covered health care services delivered by all contracting providers rendering services to members.

KHS recognizes that a strong program must be the foundation for a successful Managed Care Plan (MCP). In the basic program design and structure, KHS QI systems and processes have been developed and implemented to improve, monitor, and evaluate the quality and safety of care and service provided by contracting providers for all aspects of health care delivery consistent with standards and laws.

The mission of the KHS Health Equity Program is to improve the health and well-being of the community through the delivery of trusted, high quality, cost-effective, and accessible health to all members regardless of race/ethnicity, language spoken, or their cultural/personal preferences. In partnership with the county KHS serves, the goal is to offer whole person-centered care that reflects the best practices available today. KHS's program is built on a foundation of dedication to trusted messaging, high-quality care, culturally sensitive engagement with members, regular collaboration with community partners, continuous improvement, and service by working together with providers. KHS acknowledges an ongoing shared responsibility with its providers, facilities, community stakeholders and other provider organizations to deliver trusted, effective, and timely care and services for its members.

At a high level, the program seeks to emulate the guidance found in the Department of Health Care Services' 2022 Comprehensive Quality Strategy, which summarizes the state's goal of helping Medi-Cal members achieve longer, healthier, and happier lives through both clinical health care services and non-clinical services. This program integrates clinical and non-clinical services to create a holistic healthcare environment, improving member health outcomes. Disparate impacts from the COVID-19 pandemic have underscored the need for urgency and the necessity of building partnerships with trusted community stakeholders to increase trust with members. These two areas of providing additional non-clinical supports and increasing trust are key changes designed to catalyze different outcomes.

KHS staff are constantly evaluating member differences and preferences regarding race, ethnicity, culture, gender identity, sexual orientation, and language. Through its Quality Improvement Health Equity Program (QIHEP), KHS intends to implement standards on culturally and linguistically appropriate services to achieve the following key objectives:

- Respond to current and projected demographic changes in the populations served.
- Understand the impact of race, ethnicity, culture, gender identity, sexual orientation, and language in whole person health.
- Improve the quality of services and outcomes for members.

B. QIHEP Scope

KHS QIHEP is composed of several systematic processes that monitor and evaluate the quality of clinical care and health care service delivery to KHS members. The QIHEP scope includes regular needs assessments based on race/ethnicity, language, cultural preferences, health disparities, and stakeholder engagement. Again, it should be

noted that this expanded scope covers both clinically focused and non-clinically focused areas. Each of these defined areas of program scope include, but are not limited to, the following:

- Monitor and identify opportunities to monitor, evaluate, and take action to address needed improvements in the quality of care delivered by all KHS network providers rendering services to KHS members.
- Maintain a process and structure for quality improvement with contracting providers that includes identification of quality-of-care problems and a corrective action process for resolution for all provider entities.
- Promote efficient use of health plan financial resources.
- Identify health disparities and take action to support health equity.
- Oversee and direct processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
- Monitor and improve the quality and safety of clinical care for covered services for KHS members.
- Ensure members have access to covered health care in accordance with federal and state regulations, and our contractual obligations with the California Department of Health Care Services (DHCS).

This is accomplished through the development and maintenance of an interactive health care system that includes the following elements:

1. Development and implementation of a structure for monitoring, evaluating, and taking effective action to address any needed improvements in the quality of care delivered by all KHS network providers rendering services to KHS members.
2. A process and structure for quality improvement with contracting providers. This includes identification of quality-of-care problems and a corrective action process for resolution for all provider entities.
3. Oversight and direction of processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
4. Assurance that members have access to covered health care in accordance with federal and state regulations, and our contractual obligations with the California Department of Health Care Services (DHCS).
5. Monitoring and improvement of the quality and safety of clinical care for covered services for members.

The KHS QIHE Program applies to all programs, services, facilities, and individuals that have direct or indirect influence over the delivery of health care to KHS members. This may range from choice of contracted provider to the provision and a commitment to activities that improve clinical quality of care (including behavioral health), promotion of safe clinical practices and enhancement of services to members throughout the organization.

The scope of the QIHE Program includes the following elements:

1. The QIHE Program is designed to monitor, oversee, and implement improvements that influence the delivery, outcome, and safety of the health care of members, whether direct or indirect.
    a. KHS does not unlawfully discriminate against members based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability.
    b. KHS will arrange covered services in a culturally and linguistically appropriate manner. The QIHE Program reflects the population served and applies equally to covered medical and behavioral health services.
2. The QIHE Program monitors the quality and safety of covered health care administered to members through contracting providers. This includes all contracting physicians, hospitals, vision care providers, behavioral health care practitioners, pharmacists and other applicable personnel providing health care to members in inpatient, ambulatory, and home care settings. New this year is the addition of street medicine providers. Street medicine provider refers to a licensed medical provider who conducts patient visits outside of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be living.
3. The QIHE Program assessment activities encompass all diagnostic and therapeutic activities, and outcomes affecting members, including primary care and specialty practitioners, vision providers, behavioral health care providers, pharmaceutical services, preventive services, prenatal care, and family planning services in all applicable care settings, including emergency, inpatient, outpatient, and home health.
4. The QIHE Program evaluates quality of service, including the availability of practitioners, accessibility of services, coordination, and continuity of care. Member input is obtained through member participation on the Community Advisory Committee (CAC), grievances, and member satisfaction surveys.
5. The QIHE Program activities are integrated internally across appropriate KHS departments. This occurs through multi-departmental representation on the QI/UM Committee.
6. KHS and Kern County Department of Health jointly cover mental health care. It is arranged and covered, in part, by Kern County Behavioral Health and Recovery Services (KBHRS) pursuant to a contract between the County and the State.

Application of the Quality Improvement Health Equity Program occurs with all procedures, care, services, facilities, and individuals with direct or indirect influence over the delivery of health care to members.

Quality Improvement Integration: the QIHE Program includes quality improvement, utilization management, risk management, credentialing, member's rights and responsibilities, and preventive health & health education.

As part of KHS' commitment to ensure the rights of our members to quality health care, the following six rights to Quality Health Care have been adopted:

1. Right to Needed Care
    - Accurately diagnosed and treated
    - Care is coordinated across all the doctors and specialists
2. Right to Equitable Care
    - All people, regardless of their gender, race, ethnicity, geographical location, or socioeconomic status receive the good quality health care they need
    - Developing culturally competent care; for example, by expanding medical translation services, after-hours appointment, mobile health clinics or telehealth, etc.
3. Right to Place of Care
    - Did the patient go to the right place for care?
    - Is the patient going to the ER or Urgent Care for primary care?
    - Is the patient transitioned to the right place for care?
4. Right to Timely Care
    - Timely access to care
    - How long did the patient have to wait to get health care appointments and telephone advise?
    - Is the patient up to date with their preventative care?
5. Right to Be Part of Your Care
    - Patients and their families are part of the care team and play a role in decisions.
    - Information is shared fully and in a timely manner so that patients and their family members can make informed decisions.
6. Right to Safe Care
    - Conduct continuous quality assurance and improvement
    - Customer and provider satisfaction surveys or interviews
    - Chart audits
    - Site reviews
    - Administration of medications

The QIHEP scope includes regular needs assessments based on race/ethnicity, language, cultural preferences, health disparities, and stakeholder engagement. Again, it should be noted that this expanded scope covers both clinically focused and non-clinically focused areas. Each of these defined areas of program scope include, but are not limited to, the following:

- Quality Improvement – Understanding health disparities is critical to identify the differences in treatment provided to members of different racial/ethnic or cultural groups that are not justified by the underlying health conditions or treatment preferences of patients. KHS will implement multiple programs to monitor, assess, and improve healthcare services to reduce health disparities within its membership.
- Quality Performance – Identification of gaps in care, opportunities to support providers and members, and overall responsibility for high quality and equitable care for the members we serve. Quality Performance is comprised of site reviews, MCAS/HEDIS, performance improvement projects, and organizational initiatives related to quality.
- Health Education & Cultural Linguistics – Ensuring members have access to appropriate language services including bilingual services, oral interpretation, and written/sight translations as appropriate. The network providers have access to these services to ensure the members receive information in their preferred method.
- Population Health Management – Promoting meaningful engagement and partnerships with network providers, communities, public health agencies, and schools and community-based organizations (CBOs), to support the improvement of data sharing among delivery systems to identify and mitigate SDOH to reduce disparities and ensure that all members are connected to primary care, appropriate wellness, prevention, and disease management activities and to identify and connect those members who are at risk for developing complex health issues to more specialized services.
- Member Engagement – Engaging all key stakeholders is a very critical process to collect and evaluate feedback from members, practitioners, and other community groups. The information is collected through multiple avenues including Member Advisory Committees, ongoing surveys from members and practitioners, discussions with large provider groups, etc.
- Provider Network Management – Evaluating the network's cultural responsiveness is one of the key components of the health equity program. This includes the ability of practitioners and providers to understand the individual values, beliefs, and behaviors shaped by cultural factors of diverse groups. KHS educates providers and practitioners annually on how to consider and integrate these members preferences into the delivery of healthcare services.
- Utilization Management – Facilitating, communicating, and collaborating among members, practitioners, providers, and the organization, to support cooperation and appropriate utilization of health care benefits.

Monitoring and reporting under and over utilization trends to eliminate care variations within vulnerable populations and proactively closing gaps in the care continuum.

- Policies & Procedures – The following components are integrated into KHS' policies and procedures across multiple areas:
    - Community input and advisement on relevant cultural, linguistic and Seniors and Persons with Disabilities (SPD) awareness issues via the established Community Advisory Committee
    - A Population Needs Assessment is conducted periodically to assess the need for special initiatives regarding cultural competency, linguistic sensitivity, and SPD awareness issues among practitioners and members.
    - Best efforts will be made to recruit and retain staffing that is reflective of the membership.
    - Creative efforts will be made to increase partnership with vendors and community-based organizations (CBOs) that are reflective of the membership.
    - KHS staff and provider network will be provided with opportunities for training and tools to promote cultural competency, linguistic sensitivity, and SPD awareness.
    - KHS will participate with government, community and educational institutions in symposiums related to cultural competency, linguistic sensitivity, and SPD awareness.
    - KHS will maintain systems that readily identify language and ethnic specific member data.
    - Through grant programs, KHS gives preference to funding agencies that can provide culturally and linguistically appropriate services that are accessible to the membership and the community.

C. QIHEP Goals

KHS has developed and implemented a plan of activities to encompass a progressive health care delivery system working in cooperation with contracting providers, members, community partners and regulatory agencies. The QI Department annually evaluates program objectives and progress, making modifications based on guidance from the KHS Board of Directors. The results of the evaluation are considered in the subsequent year's program description. Specific objectives of the QIHE Program include:

1. Improving the health status of members by identifying potential areas for improvement in the health care delivery system.
2. Developing, distributing, and promoting guidelines for care including preventive health care and disease management through education of members and contracting providers.
3. Developing and promoting health care practice guidelines through maintenance of standards of practice, credentialing, and recredentialing. This applies to services rendered by medical, behavioral health and pharmacy providers.

4. Establishing and promoting open communication between KHS and contracting providers in matters of quality improvement. This includes maintaining communication avenues between KHS, members, and contracting providers to seek solutions to problems that will lead to improved health care delivery systems.
5. Monitoring and oversight of delegated activities.
6. Performing tracking and trending on a wide variety of information, including:
    a. Over and underutilization data,
    b. Grievances,
    c. Potential and actual quality of care issues,
    d. Accessibility of health care services,
    e. Compliance with Managed Care Accountability Set (MCAS) preventive health and chronic condition management services,
    f. Pharmacy services, and
    g. Primary Care Provider facility site and medical record reviews to identify patterns that may indicate the need for quality improvement and that ensure compliance with State and Federal requirements.
7. Promoting awareness and commitment in the health care community toward quality improvement in health care, safety, and service.
8. Continuously identifying opportunities for improvement in care processes, organizations or structures that can improve safety and delivery of health care to members.
9. Providing appropriate evaluation of professional services and medical decision making and to identify opportunities for professional performance improvement.
10. Reviewing concerns regarding quality-of-care issues for members that are identified from grievances, the Community Advisory Committee (CAC), or any other internal, provider, or other community resource.
11. Identifying and meeting external federal and state regulatory requirements for licensure.
12. Continuously monitoring internal processes to improve and enhance services to members and contracting providers.
13. Performing an annual assessment and evaluation of the effectiveness of the QIHE Program and its activities to determine:
    a. How well resources have been deployed in the previous year to improve the quality and safety of clinical care,
    b. The quality of service provided to members, and
    c. Modifications needed to the QIHE Program.

Results of the annual evaluation are presented to the Executive Quality Improvement Health Equity Committee (EQIHEC) and Board of Directors.

KHS acknowledges that culture change is necessary to achieve its health equity vision. As such, the vision and goals include a combination of qualitative and quantitative metrics. Some efforts will be initiated simply because they align with KHS's values and are perceived as being the "right thing to do" for the organization. Other objectives will have discrete measurements that are directly connected to DHCS contract requirements or KHS's annual goals or strategic plan. Some may be a blend of values-based goals and contractual obligations. Populations of focus particularly include:

A. Members affected by Health Disparities,

B. Limited English Proficiency (LEP) Members,

C. Children with Special Health Care Needs,

D. Seniors and Persons with Disabilities,

E. Persons with chronic conditions.

Culture (values-based) goals:

• Provide leadership to staff and provider network to support the long-term culture change needed to address any identified health disparities.

• Invite all stakeholder groups (i.e., members, providers, staff, community stakeholders, contractors, subcontractors, etc.) to better understand and engage in health equity work because it belongs to all of us.

• Provide educational opportunities to all stakeholders (above). Trainings will be provided through multiple modalities including not limited to:

o Online self-education classes

o In-person coaching/training

o Live Webinars

o Dissemination of educational materials

• Support development, workforce diversity, and training that increase cultural sensitivity, cultural awareness, and cultural humility in KHS's staffing and provider network.

• Establish partnerships and collaborations with community-based organizations that elevate social and racial justice in the communities served.

• Continue to solicit and incorporate diverse stakeholder perspectives through surveys and stakeholder meetings.

Goals to Meet Member's Cultural and Linguistic Needs:

• Target 90% of members who utilized interpreting and translation services are "satisfied" as indicated in satisfaction survey results.

• Deliver 90% of translation and interpretation service requests before or on the requested due date.

• Resolve 100% of cultural and language related grievances within 30 business days.

Goals to Directly Address Health Disparities:

• Identify disparities in care for selected MCAS/HEDIS measures. These may include, but will not be limited to, the following:

o Well Child Care (i.e., Well child visits, childhood immunizations, etc.)

o Maternity Care (i.e., disparities for Black and Native American persons)

o Mental Health (i.e., maternal, and adolescent depression screenings, follow up for mental health and substance use disorder)

o Cancer Screenings (i.e., Breast, Cervical, and Colorectal)

o Management of Chronic Conditions (i.e., Diabetes, hypertension, asthma, etc.)

• Address at least one disparity in care in each of the groups mentioned in the bullet above. Reduce the disparity between the highest and lowest performing populations (with reasonable membership) by 5% by 2025. For example:

o Increase well child visits for Black children by 15% by 2025.

o Increase maternal depression screenings for Black mothers by 15% by 2025.

o Increase the rate of annual diabetes screening for members who speak an Asian language in comparison to English speaking patients.

o Increase equity of member involvement in treatment planning for Black Non-Hispanic (77%), Hispanic (66%), and other race/ethnic populations (64%) to 85% or higher on the member satisfaction survey.

• MCAS measures - KHS is held accountable to meet the 50th percentile or better for measurement year (MY) 2025. Results for the 2024 measures will be calculated and submitted in report year (RY) 2025. The measures are in the following table:

#	MEASURE	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
Behavioral Health Domain				
1	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	Administrative	Yes
2	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	Administrative	Yes
Children's Health Domain				
3	Child and Adolescent Well-Care Visits*	WCV	Administrative	Yes
4	Childhood Immunization Status: Combination 10*	CIS-10-E	ECDS	Yes
5	Developmental Screening in the First Three Years of Life	DEV	Administrative	Yesiii
6	Immunizations for Adolescents: Combination 2*	IMA-2-E	ECDS	Yes
7	Lead Screening in Children	LSC	Hybrid/Admin**	Yes
8	Topical Fluoride for Children	TFL-CH	Administrative	Yesiii
9	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	W30-6+	Administrative	Yes
10	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits*	W30-2+	Administrative	Yes
Chronic Disease Management Domain				

11	Asthma Medication Ratio*	AMR	Administrative	Yes
12	Controlling High Blood Pressure*	CBP	Hybrid/Admin**	Yes
13	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	GSD	Hybrid/Admin**	Yes
Reproductive Domain				
14	Chlamydia Screening in Women	CHL	Administrative	Yes
15	Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	Hybrid/Admin**	Yes
16	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	Hybrid/Admin**	Yes
Cancer Prevention Domain				
17	Breast Cancer Screening*	BCS-E	ECDS	Yes
18	Cervical Cancer Screening	CCS-E	ECDS	Yes
Report only Measures to DHCS				
19	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED ii	Administrative	No
20	Adults' Access to Preventive/Ambulatory Health Services	AAP	Administrative	No
21	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	No

22	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	Administrative	No
23	Colorectal Cancer Screening*	COL-E	ECDS	No^^
24	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	No
25	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	Administrative	No
26	Depression Remission or Response for Adolescents and Adults	DRR-E	ECDS	No^^
27	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	ECDS	No^^
28	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Administrative	No
29	Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	Administrative	No
30	Follow-Up After ED Visit for Substance Use – 7	FUA	Administrative	No

	days*			
31	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	No
32	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase	ADD-Init	Administrative	No
33	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	No
34	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	Administrative	No
35	Pharmacotherapy for Opioid Use Disorder*	POD	Administrative	No^^
36	Plan All-Cause Readmissions*	PCR ii	Administrative	No
37	Postpartum Depression Screening and Follow Up*	PDS-E	ECDS	No^^

38	Prenatal Depression Screening and Follow Up*	PND-E	ECDS	No^^
39	Prenatal Immunization Status	PRS-E	ECDS	No^^
Long Term Care Report Only Measures to DHCS				
40	Number of Out-patient ED Visits per 1,000 Long Stay Resident Days*	HFS	Administrative^	No
41	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization*	SNF-HAI	Administrative^	No
42	Potentially Preventable 30- day Post-Discharge Readmission*	PPR	Administrative^	No

III. Authority and Responsibility

The organizational structure includes the following personnel and committees:

A. KHS Board of Directors (BOD)

The Kern Health System (KHS) Board of Directors (BOD) has final authority and accountability for the KHS Quality Improvement Health Equity Program (QIHEP). The Board has delegated the responsibility for development and implementation of the QIHEP to the Executive Quality Improvement Health Equity Committee (EQIHEC). The EQIHEC is chaired by the KHS's Chief Medical Officer (CMO) and Co-Chaired by the KHS Health Equity Officer.

KHS's Board of Directors (BOD) is the governing body of the organization and has ultimate responsibility for the quality of care and service delivered by Kern Health Systems. The BOD:

- Approves the annual QIHEP description.
- Approves the annual quality management work plan which contains measures specific to the QIHEP.
- Reviews the annual QIHEP Evaluation.
- Reviews reports about QIHEP activities and measures as provided by the Quality Improvement Health Equity Committee (described below).
- Reviews and confirms the appropriate resources needed to implement the QIHEP recommended by the Quality Improvement Health Equity Committee.

B. Chief Executive Officer (CEO)

Appointed by the Board of Directors, the CEO has the overall responsibility for KHS management and viability. Responsibilities include: KHS direction, organization, and operation; developing strategies for each department including the QIHE Program; Human Resources direction and position appointments; fiscal efficiency; public relations; governmental and community liaison, and contract approval. The CEO directly supervises the Chief Financial Officer (CFO), CMO, Compliance Department, and the Director of Marketing and Member Services. The PAC reports to the CEO and contributes information regarding provider issues. The CEO interacts with the CMO regarding ongoing QIHE Program activities, progress towards goals, and identified health care problems or quality issues requiring corrective action.

C. Chief Medical Officer (CMO)

KHS' Chief Medical Officer (CMO) is a physician, Board Certified in his or her primary care specialty, holding a current valid, unrestricted California Physician and Surgeon License. The CMO is an ex-officio member of the BOD and reports to the Chief Executive Officer (CEO). The CMO is the senior healthcare clinician and has the ultimate responsibility for the QIHE Program and assigns authority for aspects of the program to the Chief Equity Officer and Quality Medical Director.

The KHS CMO must have a valid license to practice medicine in the State of California, the ability to effectively function as a member of a team, and excellent written and verbal communication skills. The CMO is responsible to the Board of Directors to provide medical direction for KHS, including professional input and oversight of all medical activities of the QIHE Program.

The CMO reports to the CEO and communicates directly with the Board of Directors. The CMO devotes the majority of the time to quality improvement activities.

The responsibilities of the CMO include:

- supervising the following Medical Services departments and related staff: Quality Improvement, Utilization Management, Pharmacy, Wellness & Prevention.
- supervising all QI activities performed by the Quality Improvement Department.
- providing direction for all medical aspects of KHS, preparation, implementation, and oversight of the QIHE Program, medical services management, resolution of medical disputes and grievances; and medical oversight on provider selection, provider coordination, and peer review.
- developing and implementing medical policy for utilization and QI functions, reviewing current medical practices so that that medical protocols and medical personnel of KHS follow rules of conduct, assigned members are provided healthcare services and medical attention at all locations, and medical care rendered by providers meets applicable professional standards for acceptable medical care and quality. These standards should equal or exceed the standards for medical practice developed by KHS and approved by the California Department of Health Care Services (DHCS) or the California Department of Managed Health Care (DMHC).
- providing direction to the EQIHEC and associated committees including PAC and Drug Utilization Review (DUR) Committee.
- providing assistance with study development and coordination of the QIHE Program in all areas to provide continued delivery of quality health care for members.
- assisting the Director of Provider Network Management with provider network development
- communicating with the CFO to ensure that financial considerations do not influence the quality of health care administered to members.
- providing oversight for the development and ongoing revision of the Provider Policy and Procedure Manual related to health care services.
- executing, maintaining, and updating a yearly QIHE Program for KHS and an annual summary of the QIHE Program activities to be presented to the Board of Directors.
- assuring timely resolution of medical disputes and grievances.
- working with the appropriate departments to develop culturally and linguistically appropriate member and provider materials that identify benefits, services, and quality expectations of KHS.
- providing continuous assessment of monitoring activities, direction for member, provider education, and coordination of information across all levels of the QIHE Program and among KHS functional areas and staff.
- providing direction for internal and external QIHE Program functions, and supervision of KHS staff including:
    - Application of the QIHE Program by KHS staff and contracting providers
    - Participation in provider quality activities, as necessary

- Monitoring and oversight of provider QIHE Programs, activities, and processes
- Oversight of KHS delegated and non-delegated credentialing and recredentialing activities
- Retrospective review of KHS credentialed providers for potential or suspected deficiencies related to quality of care
- Monitoring and oversight of any delegated UM activities
- Supervision of Health Services staff involved in the QIHE Program, including: Director of Quality Improvement, Director of Wellness & Prevention and Cultural & Linguistics Services, Population Health Management (PHM) Director, Utilization Management (UM) Director, Pharmacy Director, and other related staff
- Supervision of all Quality Improvement Activities performed by the QI Department
- Monitoring covered medical and behavioral health care provided to ensure they meet industry and community standards for acceptable medical care
- Active participation in the functioning of the plan grievance procedures

D. Chief Health Equity Officer (CHEO)

The Chief Health Equity Officer oversees development, implementation, review and revision of health equity policies and procedures; maintains the QIHEP description and work plan; coordinates implementation activities; and ensures reporting to the EQIHEC. The CHEO also serves as the primary liaison between Kern Health Systems and any regulatory agencies on health equity issues and programs. The CHEO sits on the EQIHEC and provides health equity perspective for all non-clinical areas; the CHEO seat may not be delegated. The CHEO oversees the development, evaluation, and/or revision of the QIHEP description. The CHEO also oversees how health equity is embedded into the KHS culture for all non-clinical aspects (i.e., marketing, member engagement, member services, community supports, etc.).

E. Chief Operating Officer (COO)

Under direction of the CEO, plans, directs, monitors, coordinates, interprets, and administers all functional activities and policies related to Claims, Member Services, and AIS/Compliance departments. The COO is responsible for directing all activities of the Claims, Provider Relations, Member Services, and AIS/Compliance departments for a Knox-Keene Act-licensed health maintenance organization. COO maintains authority for setting policies and procedures for the departments, which are consistent with the policies and procedures set by the KHS Board of Directors and the CEO and fall in compliance with regulatory requirements. Executive is responsible for and has decision making authority regarding the organization in the absence of the CEO.

F. Quality Improvement Medical Director

The Medical Director of Quality must have a valid license to practice medicine in the State of California, the ability to effectively function as a member of a team, and excellent written and verbal communication skills. The Medical Director will provide clinical leadership and guidance in the development and measurement of the strategic approach to quality, performance improvement, and patient satisfaction, and safety. As determined by the plan CMO, the Medical Director assists in short- and long-range program planning, total quality management including quality improvement, and external relationships, as well as develops and implements systems and procedures for all medical components of health plan operations.

In collaboration with the CMO and others, the Medical Director creates and implements health plan medical policies and protocols. The Medical Director monitors provider network performance and reports all issues of clinical quality management to the CMO and EQIHEC. Additionally, he or she represents the health plan on various committees and routinely reports to the Board of Directors on credentialing and re-credentialing of network providers. The Medical Director provides medical oversight into the medical appropriateness and necessity of healthcare services provided to Plan members and is responsible for meeting medical cost and utilization performance targets.

Under direction of the Chief Medical Officer:

- Serve as a member of the following committees of the KHS Board of Directors: EQIHEC, PAC, P&T/DUR, Quality Improvement Committee, and Grievance Committee.
- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS.
- Is responsible for reviewing and managing utilization of health care services at all levels of care to achieve high quality outcomes in the most cost-effective manner.
- Provides clinical leadership to the clinical departments staff and works collaboratively with the directors of the other Departments of KHS to ensure compliance with the contractual and regulatory requirements.
- Provide clinical support and education to the provider network in support of standards of care and evidence-based medicine and use of clinical criteria in decision management.
- Represents KHS in the medical community and in general community public relations.
- Participates in the implementation of the KHS Credentialing Program.
- Responsible for Review and identification of area for improvement and provide clinical leadership in the implementation of KHS Quality Improvement Plan and the Utilization Management Plan.
- Lead and/or attend and actively participate in meetings and committees as assigned by the CMO.

- Actively Participates as a member of the Health Services management team.
- Performs duties and responsibilities identified for the Medical Director under the Quality Improvement Plan, the Utilization Management Plan.

G. Behavioral Health Provider

The Behavioral Health Provider is a participating BH provider with an MD or PhD in Psychology and is licensed to practice in California. The Behavioral Provider is involved in all behavioral health aspects of the QI and UM Programs and advises the BHAC Committee aimed at improving behavioral healthcare services. Responsibilities include acting as the chairperson in the KHS Behavioral Health Advisory Committee (BHAC), reports to EQIHEC and provides reports on the key BHAC monitoring activities including but not limited to:

- Exchange of information between PCPs and behavioral health specialists.
- Coordination between KHS and Kern County Managed Behavioral Health Organization (MBHO) and certified SUD providers for substance use disorder services to promote continuity of care.
- Supervision of diagnosis, treatment, and referral for members with co-existing medical and behavioral conditions.
- Collaboration with pharmacy for the use of psycho-pharmaceutical medications.
- Identification of social determinants of health, and other potential barriers to receiving BH care, including access.
- Actively participating in the BHAC Committee and related subcommittees in collaboration with the CMO.
- Establishing QI and UM policies and procedures relating to behavioral healthcare.
- Participating in quality activities related to continuity and coordination of care between medical and BH practitioners.

H. Executive Quality Improvement Health Equity Committee (EQIHEC)

The EQIHEC provides overall direction for the continuous improvement process and monitors that activities are consistent with KHS's strategic goals and priorities. The EQIHEC addresses equity, quality, and safety, of clinical care and service, program scope, yearly objectives, planned activities, timeframe for each activity, responsible staff, monitoring previously identified issues from prior years, and conducts an annual evaluation of the overall effectiveness of the Quality Improvement Health Equity Program (QIHEP) and its progress toward influencing network-wide safe clinical practices. The QIHEP utilizes a population management approach to members, providers, and the community, and collaborates with Local, State, and Federal Public Health Agencies and Programs.

The EQIHEC consists of actively participating clinical and non-clinical providers. The physicians are voting members for clinical decision making. The QIHEC is comprised of internal and community participants. This process promotes an interdisciplinary and interdepartmental and community approach and drives actions when opportunities for improvement are identified.

The EQIHEC members consist of:

- Community Attendees:
    - 2 Participating Primary Care Physicians 2 Participating Specialty Physicians
    - 1 Federally Qualified Health Center (FQHC) Provider
    - 2 CAC members 1-Member of Board of Directors consumer & 1-community consumer 1 Pharmacy Provider
    - 1 Kern County Public Health Officer or Representative 1 Home Health/Hospice Provider
    - 1 DME Provider
- Internal KHS Attendees:
    - CMO
    - Health Equity Officer
    - Quality Improvement Medical Director
    - Quality Improvement Director
    - Quality Performance Director
    - Utilization Management Director
    - Population Health Management Director
    - BH Committee Behavioral Health Provider
    - KHS Chief Operating Officer (Grievances & Appeals)
    - P&T Committee Pharmacist
    - Public Policy Physician Advisory Committee Physician
    - Wellness & Prevention Director
    - Health Equity Manager
    - Provider Relations Director

The EQIHEC is required to meet at least four times annually and more frequently as determined. The activities of the EQIHEC and QI subcommittees providing information to the EQIHEC are formally documented in transcribed minutes, which summarize each agenda item, including deliberations, decisions, actions taken, recommendations and required follow-up. Key activities of the EQIHEC are the review and approval of the QIHE Program and Work-Plan, and QIHE quarterly and annual evaluations. The EQIHEC's findings and recommendations are reported quarterly by the CMO to the BOD.

The EQIHEC monitors and evaluates equity, quality, safety, appropriateness and outcomes of care and services to KHS members.

Activities:

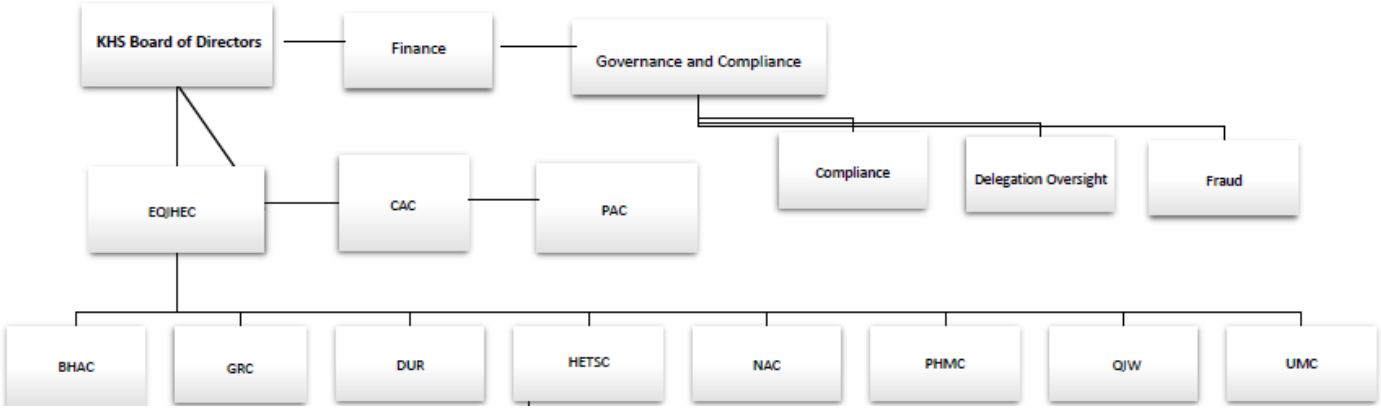
1. Formulates organization-wide improvement activities with QIHE subcommittee support.
2. Identifies appropriate performance measures, standards, and opportunities for performance improvement,
3. Assures QIHE Program activities are compliant with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, and NCQA,
4. Evaluates contract-specific interventions and outcomes.
5. Identifies actions to improve quality and prioritize based on analysis and significance; and indicate how the Committee determines these actions to ensure satisfactory outcomes,
6. Works closely with the IT Department for collection of data strategy and analytics to effectively analyze data related to the goals and objectives and establish performance goals to monitor improvement,
7. Ensures all departments can align project goals and map out responsibilities and deadlines prior to project implementation,
8. Ensures outcomes undergo quantitative and qualitative analyses that incorporate aggregated results over time and compare results against goals and benchmarks,
9. Reviews the analysis and evaluation of QIHE activities of subcommittees and identifies needed actions and ensures follow up as appropriate,
10. Ensures that root cause analyses and barrier analyses are conducted for identified underperformance with appropriate targeted interventions,
11. Reviews and modify the QIHE program description, annual QIHE Work Plan, quarterly work plan reports and annual evaluation of the QIHE program as necessary to maintain goals and priorities,
12. Communicates the quality health equity improvement process to practitioners/providers and members through appropriate persons and venues,
13. Ensures that the information available to the Plan regarding accessibility, availability and continuity of care is reviewed and evaluated, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services,
14. Ensures the annual HEDIS, CAHPS and Health Outcomes Survey (HOS) submissions are delivered according to technical specifications and deadlines,
15. Support and assist practitioners and providers to improve safety within their practices,
16. Design and implement strategies to improve compliance,
17. Develop objective criteria and processes to evaluate and continually monitor performance and adherence to the clinical and preventive health guidelines,

18. Meets healthcare industry standards of practice,
19. Improves quality, safety, and equity of care and service to members,
20. Conducts facility site and medical record reviews to ensure and support safe and effective provision of equitable clinical service,
21. Reviews, evaluates, and makes recommendations regarding oversight of delegated activities, such as audit findings, trending, and reports.

I. Quality Subcommittees

There are multiple KHS sub-committees in place to support the QIHEC and QIHEP objectives and goals. The activities of the quality subcommittees are formally documented in transcribed minutes, which summarize each agenda item, the discussion, action taken, and follow-up required. This information is reported at a minimum quarterly to the QIHEC in the format of formal reports.

Committee Structure



1. Behavioral Health Advisory Committee (BHAC)

KHS' responsibility for administering and managing behavioral health and substance use care is dependent on the Medi-Cal member's severity of impairment. For behavioral health, KHS services are typically for treatment of mild to moderate impairment also referred to as non-specialty mental Health. Kern County Medi-Cal Behavioral Organization manages severe mental health impairment referred to as Specialty Mental Health Services. In for substance use disorders KHS provides screening, brief intervention, and counseling (SBIRT) services and refers members for treatment for misuse of alcohol. Active treatment for Medi-Cal members with substance use disorder (SUD) services must be rendered by a SUD Drug Medi-Cal certified program.

KHS covers Behavioral Health Treatment (BHT), including Applied Behavior Analysis (ABA) therapy, for Medi- Cal beneficiaries under the age of 21.

The KHS Behavioral Health Advisory Committee (BHAC) is a subcommittee to the EQIHEC and is charged with facilitating collaborative coordination of medical and behavioral health and substance use disorder services between KHS and Kern County MBHO and Certified SUD providers caring for KHS members with the goal to maintain continuity and reduce barriers to appropriate initial and continuity of care.

The BHAC is chaired by a KHS credentialed and participating behavioral health provider with an M.D. or Psychologist. Committee attendees include community providers and stakeholders, and internal KHS departmental staff in the Population Health Management, Utilization Management, Health Equity, Pharmacy, and Quality Improvement Departments.

The committee meets at a minimum four (4) times a year. The key activities of the committee include:

a. Methods to exchange information and data between KHS the MBHO, Certified SUD Providers, PCP, and Specialists.
b. Appropriate diagnosis, treatment, and referral for members with coexisting medical, behavioral and SUDs for all levels of care.
c. Management of treatment, access, and follow-up care for members with coexisting medical, behavioral and SUDs for all levels of care.
d. Appropriate use of psycho-pharmaceuticals meds.
e. Addressing access to care barriers, health inequities, social determinants of health, and cultural and linguistic needs differences for the BH and SUD populations.

All BHAC review reports, discussions, and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

2. Drug Utilization Review Committee (DUR)

The Drug Utilization Review (DUR) committee is a subcommittee that reports to the (EQIHEC). The DUR committee is comprised of KHS' CMO and Director of Pharmacy along with network pharmacists and providers in the community serving KHS members. The DUR is responsible for reviewing matters related to the use of medications provided to KHS members. The basic objectives are to provide appropriate medication management for members improving their health and safety (administered in the outpatient settings by physicians under KHS' Division of responsibility, assist with case management, and monitor for possible FWA). RX Medi-Cal retains responsibility for formulary drugs carved out to them by the DHCS. KHS may address alternatives, based on safety and efficacy, and to minimize therapeutic redundancies; for those drugs dispensed under the MCRx program.

Activities:

a. Pharmacy guidelines, and policies and procedures based on clinical evidence for those drugs under the medical benefit, often referred to as Physician Administered Drugs (PADs).
b. Pharmacy utilization safety measures.
c. Drug Utilization Review.
d. Review of reports to identify members and providers with potentially inappropriate/excessive utilization of medication therapy.

The DUR Committee meets at a minimum (four) times a year. All reports, discussions, and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

3. Grievance Review Committee (GRC)

Kern Health System Grievance and Appeals Process pursuant to which a member, or a provider or Authorized Representative acting on behalf of a member and with the Member's written consent, may submit a Grievance or Appeal for review and resolution. The Grievances and Appeals process addresses the receipt, handling, and disposition of Member Grievances and Appeals, in accordance with the Department of Health Care Services (DHCS) Contract and applicable state and federal statutes, regulations and DHCS All Plan Letters. KHS maintains written records of each Grievance and Appeal as detailed in Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations.

All complaints, grievances, investigations, follow-up, tracking, and trending reports are prepared by the KHS Quality Improvement Department and submitted to the Grievance and Appeals (G&A) Review Committee. This committee is a subcommittee of the EQIHEC. The G&A Review Committee meets at a minimum four (4) times a year.

Under the direction and oversight of the Chief Medical Officer (CMO) or physician designee, individual and aggregate data on member grievances and appeals is reviewed by the G&A Review Committee. The committee is charged with evaluating and analyzing G&A data to identify systemic patters of improper services denials and other trends impacting health care delivery to Members By implementing necessary changes and process improvements for any adverse trends identified.

Grievances may address, but are not limited to, the following issues:

a. Difficulty obtaining an appointment,
b. Customer service at the provider or practitioner office,
c. Billing issues,
d. Difficulty accessing specialists,

e. Facility Conditions,
f. Confidentiality issues,
g. Refusals of PCP to refer the member for care,
h. Cultural Issues.

Appeals may address, but are not limited to, the following issues:

a. Appeals of denied Treatment Authorization Requests (TAR),
b. Appeals of level-of-care determinations,
c. Appeals of KHS claims payment denials,
d. Appeals of primary care physician request for disenrollment.

All G&A review reports and discussions and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

4. Health Equity Transformation Steering Committee (HETSC)

The Health Equity Transformation Steering Committee (HETSC)is an internal committee established to ensure KHS remains an organization that understands and addresses social and racial justice and health equity to meet member needs. The committee is responsible for identification and management of equity efforts throughout the organization including the planning, organization, and the direction, of the Health Equity Program. The HETSC is charged with systematic analysis to identify root causes of health disparities impacting KHS members and collaborating across the organization, with providers, and with other community agencies to eradicate inequities for KHS members served. The HETSC reviews and updates relevant health equity policies and procedures and may review the annual Population Needs Assessment (PNA) to identify opportunities for advancing health equity, incorporating applicable findings into the QIHE program. The HETSC, shall monitor, evaluate, and take timely action to address necessary improvements in the quality and equity of care delivered by Network Providers in any setting, and take appropriate action to improve upon quality improvement and health equity goals.

This workgroup includes the areas of focus described below. Due to significant overlap and alignment, the KHS DEI/JEDI workgroup may serve as the steering workgroup for health equity.

1. Development of Internal Resources:
   - The focus is to provide learning opportunities and activities for staff that promote personal and professional growth and understanding around issues of social and racial justice, equity, diversity, inclusion, and cultural humility.
2. Provider Network Development:

- Focus is to assess specific regional needs and existing skills of the provider network around health equity and provide training, resources, and support to providers to help build on their professional skills and help ensure they provide culturally sensitive and equitable treatment to all members.

3. Member Advocacy & Community Engagement:
    - Primary focus is to identify and promote ways that members can be educated about and provide feedback regarding their experiences with providers, KHS, and other systems in which their health is affected. Member feedback will be utilized to inform strategies developed to advocate for members' needs. The secondary focus is to sponsor and or participate in community events that are geared toward social and racial justice, develop initiatives that engage the community, impact health disparities, and help erase the stigmas surrounding mental health and substance use.
4. Human Resources Enhancement:
    - The focus is to work on recruitment, retention, and promotion of a more diverse workforce, as well as to ensure KHS has a welcoming and inclusive environment for all employees. The HR department is responsible for creating, implementing, and overseeing DEI policies and practices that have a direct impact on the workforce and its stakeholders. Also, the HR department is committed to upholding the highest standards for prioritizing equitable and inclusive practices and ensuring that the organization is representative of the communities it serves. By working closely with all departments and stakeholders, this workgroup will partner with the HR department to help ensure that the organization is inclusive, equitable, and responsive to the needs of the employees and communities it serves.
5. Monitoring and Evaluation for Continuous Improvement:
    - Focus is to identify how effectively staff apply internal QIHEP policies and procedures. The policy workgroup will determine areas of staff development and training to ensure discrimination is not present through the application of policies and procedures.

The Health Equity Department Manager reports to the Health Equity Officer and is charged with overseeing the day-to-day operations of the Health Department and is responsible for organizing and preparing the HETSC agenda, minutes, reporting and committee activities for reporting to the Executive Quality Improvement Health Equity Committee (EQIHEC).

The HETSC has established objectives to address health disparities to include:

a. Increase the awareness of health equity and quality and implement strengthened, expanded and/or new health equity quality activities to support providers and members ultimately reducing health inequities within KHS' membership.
b. Ensure services provided to members promote equity and are free of implicit bias or discrimination.

c. Implement programs that address the causes of inequity that members and their communities experience, food insecurity, housing problems, tobacco use, and other concerns.
d. Analyze the existence of significant health care disparities in clinical areas.
e. Reduce health disparities among members by implementing targeted quality improvement programs.
f. Promote physician involvement in health equity/ disparities and activities.
g. Conduct focused groups or key informant interview with cultural or linguistic minority members to determine how to meet their needs.
h. Address social determinants of health.

5. Network Adequacy Committee (NAC)

The Network Adequacy Committee (NAC) shall advance the mission of Kern Health Systems (KHS) of improving the health status of our members through an integrated managed health care delivery system. The NAC will report to the KHS Executive Quality Improvement Health Equity Committee (EQIHEC) on KHS' monitoring activities, corrective actions, and regulatory requirements related to network access, availability, and adequacy.

Function – The functions of the NAC are as follows:

1. **Establish Network Standards**: Ensuring network accessibility standards (capacity/adequacy, appointment availability, geographic accessibility, etc.) align with Department Health Care Services (DHCS), Department of Managed Health Care (DMHC), and National Committee for Quality Assurance (NCQA) standards.

2. **Monitor Network Compliance:** Review monitoring activities conducted by the Plan to measure network compliance with established standards.

3. **Promote Health Equity**: Implement review processes that monitor network adequacy amongst diverse populations, focusing on equitable access to care across different demographic and geographic groups.

4. **Steer Continuous Improvement:** Provide feedback on proposed corrective actions and ensure they are appropriate to address identified issues. Track progress of active corrective action plans.

Composition – The NAC is delegated by the EQIHEC to monitor and report on network adequacy. The committee will make recommendations and report findings to the EQIHEC.

Cadance - The NAC will meet quarterly with additional meetings, as necessary.

6. Population Health Management Committee (PHMC)

KHS follows the NCQA definition for Population Health Management: "Population Health Management is a model of care that addresses individuals' health needs at all points along the continuum of care with a "Whole Person"

approach supported through participation, engagement, and targeted interventions for a defined population." The Population Health Management Committee oversees the Population Health Management (PHM) Model of Care (MOC) that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of the PHM MOC is to maintain or improve the physical and psychosocial well- being of individuals and address health disparities through cost effective and tailored health solutions.

The PHMC is a collaborative group that engages business units from multiple KHS departments across the organization that are involved in the development, execution and monitoring and evaluation of programs for members across the continuum of health. Each year a Population Needs Assessment is conducted by KHS. The annual PNA describes the overall health and social needs of KHS's membership by analyzing service utilization patterns, disease burden, and gaps in care of members, considering their risk level, geographic location, and age groups. PHMC members focus on strategies related to gaps identified in the PNA, addressing adverse patterns and outcomes to improve members' physical and psychosocial well-being through cost-effective and tailored solutions.

The following departments support the PHMC:

- Quality Improvement
- Quality Performance
- Utilization Management
- Member Services
- Behavioral Health
- Enhanced Care Management
- Health Equity
- Wellness and Prevention

These departments provide the analysis of service utilization patterns, disease burden, health and functioning of eligible members with chronic medical conditions that may also be exacerbated by significant psychosocial needs, and other gaps in care for KHS members.

The following programs are incorporated into PHM and fall under the administration of the afore mentioned Departments:

- LTC & LTSS
- Major Organ Transplants
- Transitions of Care (TOC)

PHM works collaboratively with the following programs and Departments:

- California Children's Services (CCS)
- Enhanced Care Management (ECM)
- Community Support Services (CSS)
- Behavioral Health

The PHM strategy focuses on the "whole person" throughout the care continuum to:

- Provide wellness services and intervene on the highest-risk members,
- Improve clinical health outcomes,
- Promote efficient and coordinated health care utilization,
- Maintain cost effectiveness, and quality care,
- Improve access to essential medical, mental health, and social services,
- Improve access to affordable care,
- Ensure appropriate utilization of services,
- Improve coordination of care through an identified point of contact,
- Improve continuity of services for members across transitions in healthcare setting, providers, and health services.
- Improve access to preventive health services.
- Improve beneficiary health outcomes

Activities:

a. Responsibilities of the committee include leading strategic analytics, evaluation design, clinical and economic evaluation, and optimizing programing, ensuring that PHM addresses health at all points on the continuum of care,
b. Ensures that the medical care provided meets the community standards for acceptable medical care,
c. Collaborates with behavioral health practitioners and entities to ensure appropriate utilization of behavioral health services and continuity and coordination of medical and behavioral healthcare.
d. Improve communications (exchange of information- data sharing) between primary care practitioners, specialists, behavioral health practitioners, and health delivery organizations and ancillary care provider,
e. Monitors appropriate use and monitoring of medications,
f. Incorporates Population Health Management Model into policies, procedures, and workflows,
g. Improving member access to primary and specialty care, ensuring members with complex health conditions receive appropriate service,

h. Identifies and reduces barriers to needed healthcare and social services for members with complex health conditions,
i. Improve member health status through the delivery of wellness and disease prevention services, programs, and resources by educating and empowering members to effectively use primary and preventive health care services, modify personal health behaviors, achieve, and maintain healthier lifestyles, and follow self-care regimens and treatment therapies for existing medical conditions,
j. Ensures continuity in treatment access and follow-up for members with co-occurring medical, behavioral health, and SUD conditions.
k. Promotes routine depression, anxiety, trauma-based care, and substance use disorder screenings are completed, and appropriate follow-up referrals are made for adolescent and adult members with chronic health conditions and for women during pregnancy and the postpartum period.
l. Link members to ECM, CSS, SUD Providers and other community-based programs with comprehensive and holistic approaches.

7. Community Advisory Committee (CAC)

The Community Advisory Committee (CAC) provides a mechanism for structured input from KHS members regarding how KHS operations impact the delivery of their care. The Board of Directors delegates the CAC to provide input in the development of public policy activities for KHS. The committee makes recommendations and reports findings to the Board of Directors. The role of the CAC is to implement and maintain community linkages.

Function – The functions of the CAC are as follows:

1. Review changes in policy or procedures that affect KHS Members.
2. Provide updates on state policies or issues that affect Members.
3. Allow committee members to have input on issues that have an impact on KHS Members (i.e. marketing materials, KHS website including the web Provider Directory or Doctor Search, the Evidence of Coverage, brochures, flyers, Health Education materials, Radio/TV/Billboard advertisements, incentive ideas/items, etc.).
4. Allow committee members to share experiences that will help KHS improve how care is delivered.
5. Advise on educational and operational issues affecting members who speak a primary language other than English;
6. Advise on cultural and linguistic issues.

8. Quality Improvement Workgroup (QIW)

The focus of the QIW is on clinical quality, patient safety, and patient and provider experience in four functional areas: HEDIS/Medi-Cal Managed Care Accountability Sets (MCAS), NCQA Accreditation, Quality Improvement, and Network Clinical Oversight. The QIW will ensure KHS members receive quality health care by identifying and addressing outcomes that deviate from standards in the afore-mentioned committee responsibilities.

Activities:

1. Review and approve the QIHE Program Description, the annual Work Plan, and annual Evaluation of the work plan.
2. Ensure compliance with DHCS facility site review requirements.
3. Review aggregate data of potential quality of care issues (PQIs), identify areas of improvement, and oversee implementation of improvements.
4. Oversee KHS safety program.
5. Oversee the identification of quality-of-care trends and recommend corrective action as needed.
6. Monitor evidence-based care through the HEDIS and Managed Care Accountability Set (MCAS) audit and make recommendations for areas of improvement.
7. Review and discuss YTD quality improvement initiatives.
8. Monitor member satisfaction by reviewing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Outcomes and address measures of dissatisfaction.

9. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a subcommittee of the EQIHEC and focuses on the UM activities. The UM Committee supports the QIHEC around appropriate provision of medical services and provides recommendations for UM activities. The responsibilities of the UMC are to develop, recommend, and refine the UM program policies and procedures, including medical necessity criteria, establishment of thresholds for acceptable utilization levels, and reliability of clinical information with the involvement of appropriate, actively practicing practitioners; and develop and implement a monitoring system to track, compile and evaluate UM measures against pre-established standards and the identification of over and under and utilization patterns.

Activities:

a. Establish and implement written utilization management protocols and criteria applicable to the review of medical necessity for inpatient, outpatient, and ancillary services.
b. Ensure that UM decisions:

1) Are made independent of financial incentives or obligations.
2) Medical decisions, including those by delegated providers and rendering providers, are not unduly influenced by fiscal and administrative management
3) Physician compensation plans do not include incentives for denial decisions.
4) Physician and UM decision designees are not rewarded for utilization review decisions.

c. Educate staff, contracted practitioners, and vendors on KHS utilization management policies and procedures to ensure compliance with the goals and objectives of the Utilization Management Program.
d. Review established nationally acceptable utilization benchmarks, medical literature, and outcome data, as applicable.
e. Develop and implement a monitoring system to track, compile and evaluate patterns and variations in care.
f. Continually monitor and evaluate utilization practice patterns of staff and contracted practitioners and vendors and identify variations in care.
g. Review state regulatory oversight of LTC and CBAS facilities and develop and maintain a process to identify and work with Quality and Credentialing teams to address quality issues.
h. Develop and maintain effective relationships with linked and carved-out service providers available to members through County, State, Federal and other community-based programs to ensure optimal care coordination and service delivery.
i. Facilitate and ensure continuity of care for members within and outside of KHS network.
j. Develop and implement performance measures to assure regulatory turn-around-time frames are met.

J. QI Support Committees

1. Delegation Oversight Committee

The purpose of the Kern Health Systems (KHS) Delegation Oversight Committee (DOC) is to ensure adequate oversight of performance and adherence to regulatory contracts, requirements, and KHS standards related to subcontractors to which KHS delegates any plan-required function(s). This includes oversight of the entire spectrum, from pre-delegation auditing, monthly Joint Operating Meetings, routine oversight of delegate reporting and/or audits, and annual audits conducted by KHS Department leads and staff. The Compliance Department is the leader, facilitator, and coordinator of formal audits of Delegated Entities as outlined in the annual compliance and monitoring/auditing work plans.

KHS may choose to delegate Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Credentialing, Compliance, Claims, and other departments activities and responsibilities to qualified entities, where regulatorily allowed. The DOC is responsible to oversee the ongoing assessment of performance results to ensure contract and regulatory requirement adherence, as well as achieving business goals and outcomes to deliver quality outcomes for our members.

Duties and Responsibilities

1. Evaluate prospective delegated vendor's ability to perform the proposed delegated activities prior to delegation through a pre-delegation audit conducted by the relevant business areas.
2. Ensure KHS departments which delegate functions establish performance and reporting deliverables for departmental business needs designed to assess the effectiveness of health care delivery to members and compliance with regulatory requirements.
3. Review business owners' updates on monitoring and oversight activities and subcontractor performance, recommending action and providing feedback where necessary.
4. Assist Departments with establishing effective departmental auditing tools designed to measure and report delegated entity performance to ensure compliance with regulatory requirements.
5. Review results of all annual audits of delegated entities, as coordinated by the Compliance Department in accordance with the annual compliance, monitoring and auditing work plans.
6. In conjunction with the Delegation Oversight department, ensure KHS business owners perform all necessary oversight of the functions delegated as set forth in the written delegation agreement on behalf of KHS.
7. Review and evaluate delegated entity's performance, including business owner updates on monitoring and oversight activities presented to the DOC.
8. Assist with identifying opportunities for performance improvement and /or recommending corrective action plans as needed when a deficiency has been identified.
9. Review findings, recommended changes to contracts and policies, and requested initiatives or project updates by the delegate entity.
10. Make recommendations to the Chief Compliance and Fraud Prevention Officer, Compliance Committee, Contract Business Owners, Governance and Compliance Committee and/or Board of Directors regarding the compliance status of the delegated entity as it relates to compliance with regulatory requirements, performance, and/or other documented requirements.
11. Escalate outstanding issues from the DOC to the Compliance Committee and/or Kern Health Systems Board of Directors, as needed.
12. Recommend and provide oversight of corrective action plans (CAPs) to address deficiencies from initiation through CAP closure.

13. Propose sanctions up to and including the revocation and/or termination of delegation if the delegated entity's performance is inadequate and corrective action plans are not successful.

2. Physician Advisory Committee (PAC)

The functions of the Physician Advisory Committee (PAC) encompass multiple activities to include, serving as the KHS Credentialing and Peer Review Committee, overseeing and determining the review and approval of medical technologies and clinical criteria sets, addressing and managing the review of sentinel conditions or adverse events identified for quality concerns, and evaluates the credentials of all current and prospective practitioners and providers to be added to the KHS network, based upon requirements by DHCS, DMHC, CMS, or applicable law. The PAC is actively involved in the establishment of policies related to KHS Code of Conduct, Protected Health Information (PHI) and Fraud Waste and Abuse (FWA). The PAC is comprised of a broad spectrum of KHS participating physician representatives from primary and specialty care.

PAC- Credentialing and Peer Review

The minutes are confidential, and information is protected under California Business and Professions Evidence Code 1157. In accordance with state law, minutes containing confidential peer review information will be redacted. The responsibilities of the Credentialing/Peer Review Committee are to develop, monitor, and maintain credentialing standards, oversight of the credentialing program, delegated credentialing oversight, conducting performance monitoring from quality improvement activities and member complaints in the recredentialing decision making process for the KHS network of Participating Practitioners and Health Delivery Organizations. The PAC Committee establishes and maintains credentialing/re-credentialing policies and procedures that are consistent with National Committee for Quality Assurance (NCQA) standards, as well as applicable State and Federal laws and regulations. The Credentialing Committee may not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation, patient type or patient's insurance coverage in which the practitioner specializes.

Activities:

a. Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards.
b. Promote continuous improvement in the quality of the care and service provided by the KHS Network Providers.
c. Investigate patient, member or practitioner complaints or concerns about the quality of clinical care or service provided and to make recommendations for corrective actions, if appropriate.
d. Provide guidance on the overall direction of the credentialing program.

e. Review at least annually the Credentialing Committee Program Description to assure that the program is comprehensive, effective in meeting the goals and standards of KHS credentialing/ recredentialing procedures and supports the Continuous Quality Improvement process.
f. Evaluate quality concerns related to medical care and make determinations as to whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards.
g. Monitoring the reporting of Provider Preventable Conditions

PAC-Medical Technologies and Clinical Criteria Sets

a. The PAC uses principles of evidence-based medicine in its evaluation of clinical guidelines oversight and monitoring of the quality and cost-effectiveness of medical care provided to KHS members.
b. Performs reviews of technologies for use by medical and behavioral staff in the utilization review process.
c. Outlines the medical necessity criteria for coverage for a specific technology, service, or device and as applicable incorporates Federal and State regulations.
d. Ensures KHS does not exert economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted, nor to pressure providers or institutions to render care beyond the scope of their training or experience.
e. Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers;

PAC-Code of Conduct, Confidentiality, and Fraud Waste and Abuse

The PAC is instrumental in participating in the establishment and maintenance of:

1. Confidentiality policies and procedures for protection of confidential member, practitioner, and provider information in accordance with applicable state and federal regulations.
2. Protection of member identifiable health information by ensuring members' protected health
   information (PHI) is only released in accordance with federal, state, and all other regulatory agencies.
3. Providing oversight in strategies to reduce FWA in provider networks.

3. Compliance Committee

Kern Health Systems (KHS) is committed to the preservation and integrity of its mission through the enforcement of contractual, legal, ethical, and regulatory standards and guidelines. All KHS employees are expected to adhere to these governing laws, regulations, and ethical standards. Management is responsible for ensuring such compliance; therefore, compliance is an integral part of good organizational governance.

The establishment of the KHS Compliance Committee (Committee) through this Charter evidence KHS' commitment to the highest integrity and ethical standards, thereby supporting compliance with contractual obligations, all applicable laws, and regulations. The Compliance Committee is an oversight committee.

1. The Compliance Committee's responsibilities include, but are not limited to:

a. Determine the appropriate strategy and/or approach to promote compliance; to prevent, detect, and correct potential violations; and to advise the Compliance Officer accordingly.

b. Review and approve training related to Compliance and Fraud, Waste, or Abuse issues and ensure that training and education are effective and appropriately completed;

c. Review Fraud, Waste or Abuse Reports, including member and provider reported cases;

d. Review reported HIP AA Incidents, including prevention education;

e. Review Timely Access Reporting;

f. Review DHCS Attestation Reporting deliverables;

g. Review delegated entities to ensure their performance on delegated functions meet KHS standards;

h. Review internal and external audits reports and auditing tools, including reporting outcomes and remediation efforts. Address when there is risk of program non-compliance and/or potential FWA, and ensure CAPs are implemented and monitored for effectiveness;

i. Review overall effectiveness of the internal controls designed to ensure compliance with applicable regulations in daily operations;

j. Review reports from the Compliance Officer, on at least a quarterly basis, concerning the Compliance Program;

k. Monitor the Quality Improvement and Grievance Processes, including opportunities to improve quality and service through trend management;

l. Validate that KHS has appropriate and current compliance policies and procedures;

m. Review the Office of Compliance's process for soliciting, evaluating, and responding to reports and disclosures within the Compliance Program.

n. Oversee the implementation of applicable federal and state programs, including contractual, legal, and regulatory requirements, as they relate to compliance risk, and coordinate with the Compliance Officer to ensure the adequacy of the Compliance Program to manage the compliance oversite of programs; and

o. Respond and manage Ad Hoc issues.

2. In accordance with KHS Policy 4-40-P Corrective Action Plans, the Compliance Committee will monitor the issuance of Corrective Action Plans (CAPs) by the KHS Physician Advisory Committee (PAC). The Compliance Committee will also review tracking and trending concerns and make recommendations when deemed necessary.

3. In collaboration with the PAC, the Compliance Committee, shall evaluate the effectiveness of each CAP and make recommendations regarding ongoing monitoring activates to ensure continued compliance.

4. Health Equity Advisory Board

The Health Equity Advisory Board recruits racially, ethnically, and culturally diverse (including those from LGBTQI+ communities) people from various stakeholder groups across the County. These include, but are not limited to, general consumers from racial groups that make up KHS's members, Kern County health officer or a designated representative, County Human Services representatives, community advocates, and traditional and safety net providers. Advisory Board members focus on issues of diversity, equity, and inclusion in KHS procedures and metrics to improve health equity. They may:

- Participate in establishing public policy which is defined as acts performed by KHS or its employees and staff to assure comfort, dignity and convenience of patients who rely on KHS' facilities to provide health care services to them, their families, and the public.
- Review and make recommendations on marketing and member materials.
- Review and make recommendations on the complaints and grievance process.
- Review and make recommendations on member and provider satisfaction surveys.
- Review and make recommendations on activities related to Quality Improvement, educational, operational, and cultural competency issues affecting Limited English Proficiency (LEP) members.
- Review and make recommendations on staff & provider health equity related training
- Review and make recommendations on contracted vendors and CBOs.

5. Health Equity and Learning (HEAL)

The mission of the Provider HEAL Committee is to foster a collaborative environment among healthcare providers in Kern Health Systems, dedicated to advancing health equity. The purpose of the committee is to:

1. Solicit Feedback: Act as a platform for providers to share challenges faced in the field and gather feedback to address issues related to health equity to help inform the development of KHS's training offerings, programs and support for Provider Network
2. Resource Sharing: Facilitate the exchange of resources, funding opportunities, best practices, and innovative approaches to improve healthcare service delivery with a focus on health equity
3. Training and Development: Identify, develop, and promote opportunities for training and professional development to enhance providers' knowledge and skills in delivering equitable healthcare
4. Practice Expansion: Explore and discuss opportunities for expanding access and/or services that align with and support health equity initiatives

Composition

The HEAL reports to the Health Equity Steering and Transformation Committee.

Membership

1. Membership in the Provider HEAL Committee is open to all healthcare practices within Kern Health Systems network that express an interest in promoting health equity.
2. Membership is voluntary and may include healthcare professionals, administrators, and other relevant stakeholders.
3. Members are expected to actively contribute to the mission and objectives of the committee.

Meetings

1. The committee shall meet regularly, at least quarterly, either in person or virtually
2. Additional ad-hoc meetings may be called as necessary to address specific issues or opportunities.

6. Regional Advisory Committee (RAC)

The Regional Advisory Committee (RAC) is a quarterly meeting held in one city in each of the five regions of Kern County. Every quarter a topic is selected to discuss with Members and community stakeholders to learn strategies for improvement and challenges being faced. The meetings are open to everyone in the region and information gained from each region is synthesized to help inform gaps and best practices occurring throughout the county.

These finding are presented to the Health Equity Transformation Steering Committee (HETSC) for review and determination of action steps to address the needs of the county and services to Kern Family Health Care members.

IV. Organizational Structure and Resources

A. Clinical Oversight of QIHEP

Under the direction of the CMO, the Medical Directors are responsible for clinical oversight and management of the QI, UM, BH, Wellness and Prevention and PHM activities, participating in QIHEP for KHS and its Practitioners, and overseeing credentialing functions. Medical Directors must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one (1) of the American Specialty Boards. Principal accountabilities include:

1. Developing and implementing medical policy for Health Services department activities and QI functions;
2. Reviewing current medical practices ensuring that protocols are implemented and medical personnel of KHS follow rules of conduct;
3. Ensuring that assigned Members are provided health care services and medical attention at all locations;
4. Ensuring that medical care rendered by Practitioners meets applicable professional standards for acceptable medical care.

B. Quality Improvement Department (QI)

Quality Improvement Director

Under the direction of the Chief Medical Officer (CMO) and Quality Improvement (QI) Medical Director, the Director of Quality Improvement leads the development, implementation, and oversight of QI initiatives to enhance health outcomes and address health disparities within the Kern Health Systems (KHS) membership. The Director ensures alignment with the KHS Quality Management Plan, Medi-Cal contractual requirements, and NCQA accreditation standards while fostering a culture of continuous improvement.

Key responsibilities include:

- QI Program Development: Designs and implements programs that align with KHS's Health Equity and Quality Improvement goals, regulatory standards, and contractual obligations.
- Performance Monitoring & Reporting: Oversees data collection, medical record reviews, and analysis of key performance indicators to inform decision-making.

- Provider & Community Collaboration: Engages with contracted providers and external partners to drive QI initiatives, address disparities, and improve member health outcomes.
- Regulatory Compliance & Accreditation: Ensures compliance with Medi-Cal QI requirements, oversees credentialing, and leads efforts for accreditation preparedness.
- Interdepartmental Coordination: Facilitates collaboration across KHS departments and external agencies to integrate QI activities into organizational workflows.
- Leadership & Workforce Development: Provides mentorship to QI staff, ensuring professional growth and alignment with KHS's health equity objectives.

The Director of QI plays a pivotal role in advancing health equity by identifying disparities, implementing targeted interventions, and continuously improving healthcare quality across the KHS network.

NCQA Manager

The NCQA Manager, under the direction of the Director of Quality Improvement, ensures KHS maintains NCQA accreditation and compliance with State regulations related to the Quality Improvement Program. This role provides oversight for the successful completion of initial and renewal accreditation efforts and ensures ongoing alignment of KHS departments with NCQA standards, State certification, and contractual quality requirements.

Key responsibilities include:

- Accreditation & Regulatory Compliance: Leads the development, implementation, and coordination of policies, procedures, and workflows to meet NCQA, Medi-Cal, and Medicare D-SNP model of care requirements.
- Quality Program Support: Integrates NCQA standards and State regulations into QI processes, ensuring compliance across all KHS business areas.
- Policy & Process Development: Oversees the development and revision of accreditation and compliance policies, incorporating feedback from regulatory agencies.
- Cross-Departmental Collaboration: Works with KHS leadership and staff to embed quality improvement initiatives into organizational operations, supporting a culture of continuous improvement and health equity.

The NCQA Manager plays a critical role in maintaining KHS's commitment to quality, accreditation, and regulatory compliance, ensuring that all initiatives support health equity and member-centered care.

NCQA Accreditation Specialist

Under the direction of the NCQA Manager, the NCQA Accreditation Specialist supports the planning, execution, and maintenance of NCQA Health Plan and Health Equity Accreditation at Kern Health Systems (KHS). This role ensures

accreditation readiness by coordinating efforts across departments, following established guidelines, and maintaining a comprehensive NCQA accreditation work plan.

Key responsibilities include:

- Accreditation Readiness & Compliance: Assists in managing the NCQA accreditation process, ensuring adherence to standards, quality studies, and interventions that support regulatory compliance and health equity goals.
- Process Coordination & Monitoring: Leads interdepartmental coordination to support accreditation requirements, track progress, and facilitate corrective action plans.
- Quality & Performance Enhancement: Works to ensure outstanding clinical performance and a positive member experience, contributing to KHS's commitment to continuous quality improvement and equitable care.

The NCQA Accreditation Specialist plays an essential role in sustaining NCQA compliance, ensuring high-quality care delivery, and reinforcing KHS's mission to advance health equity and member well-being.

Quality Improvement Manager, RN

Under the direction of the Director of Quality Improvement, the Quality Manager ensures state, regulatory, and contractual compliance for the Quality Improvement (QI) Program.

Key responsibilities include:

- Regulatory & Audit Oversight: Manages delegation audits, and external quality reviews, ensuring compliance with Medi-Cal and contractual requirements.
- Quality Improvement Initiatives: Leads Improvement Plans, PIPs, and other targeted quality initiatives aimed at enhancing care delivery and patient outcomes.
- Operational Leadership: Applies clinical expertise and analytical skills to oversee the day-to-day operations of the QI team, driving data-informed strategies to improve performance and member health equity.

The Quality Manager plays a critical role in advancing quality improvement efforts, ensuring compliance, and supporting KHS's mission to enhance equitable and high-quality care.

Quality Improvement Supervisor, RN

The Quality Improvement (QI) Supervisor RN oversees the daily operations and activities of clinical and non-clinical staff within the QI Department, ensuring the effective management of clinical grievances, Potential Quality Issues (PQIs), Performance Improvement Projects (PIPs), and other key quality initiatives. This role involves providing leadership, guidance, and oversight to maintain compliance with regulatory requirements and drive continuous

improvement. The QI Supervisor collaborates closely with the QI Manager to optimize workflows, enhance efficiency, and support the successful execution of quality improvement initiatives.

Quality Improvement Nurse, RN

The QI Nurse assists in clinical activities related to monitoring, assessing, and improving performance in ambulatory and inpatient health care delivery or health care related services to Kern Health Systems (KHS) membership. The QI Nurse assists in the implementation of the KHS QI Program Plan by doing the following activities:

- Communicates with contracted providers regarding studies and audit findings,
- Delivers provider or member education in support of quality health care,
- Conducts medical record reviews and audits, and HEDIS or HEDIS-like chart reviews,
- Performs clinical investigation of potential quality of care issues and grievances and writes an effective clinical summary of the investigation for referral to a medical director,
- Develop and ensure completion of provider corrective action plans related to quality-of-care issues or regulatory or accreditation non-compliance,
- Develop and complete performance improvement projects aimed at improving member compliance with specific preventive health measures.

Quality Improvement Coordinator

Reporting to the Quality Manager, the Quality Improvement (QI) Coordinator plays a key role in data collection, record maintenance, and regulatory compliance support for the QI Program. This position is integral to Managed Care Accountability Set (MCAS) initiatives, intervention development, and provider site review activities.

Key responsibilities include:

- Data Collection & Reporting: Supports MCAS methodology, assists in data entry, report preparation, and ensures accurate documentation for QI activities.
- Regulatory & Compliance Support: Assists in medical record requests, record preparation, and QI interventions, ensuring readiness for audits and compliance with State and contractual requirements.
- Provider Site Review Assistance: Provides administrative support for facility site reviews and collaborates with internal departments and external agencies to facilitate QI initiatives.

The QI Coordinator plays a vital role in supporting quality improvement efforts, ensuring regulatory compliance, and assisting in the execution of data-driven health equity interventions within the QI Program.

C. Quality Performance Department (QP)

Senior Director of Contracting and Quality Performance

Under the direction of the Chief Operating Officer (COO) and Chief Medical Officer (CMO), the Senior Director of Contracting and Quality Performance (QP) is responsible for provider contracting, quality performance, and practice transformation initiatives at Kern Health Systems (KHS). This role ensures the integrity of provider agreements, value-based care initiatives, and quality improvement (QI) programs, aligning with regulatory, legal, and strategic business objectives.

Key responsibilities include:

- Contracting & Compliance: Develops and negotiates provider contracts, ensuring compliance with regulatory requirements, risk mitigation, and alignment with KHS's business needs.
- Quality & Performance Management: Oversees Pay-for-Performance (P4P) programs, Managed Care Accountability Set (MCAS) reporting, and provider QI initiatives to enhance provider engagement and healthcare quality.
- Practice Transformation & Value-Based Care: Supports providers in transitioning to value-based care models, leveraging health IT and data analytics to improve care delivery and health equity.
- Provider Network Efficiency & Financial Performance: Leads process improvements, rate development for provider contracts, and oversight of special provider funding distributions.
- Credentialing & Compliance Oversight: Ensures facility site review processes, credentialing standards, and provider compliance with contractual and legal requirements.

The Senior Director of Contracting and QP plays a critical role in driving provider network integrity, optimizing quality performance, and advancing health equity, ensuring that contracted providers deliver high-quality, culturally competent, and accessible care for KHS members.

Director of Quality Performance

Under the direction of the Senior Director of Contract and Quality Performance, the Director of Quality Performance is responsible for oversight, implementation, and management of new quality improvement initiatives specific to the Provider Network and membership. This includes being responsible for HEDIS and MCAS functions and collaborating and supporting providers to improve health outcomes related to those measures. The Director is also responsible for quality improvement initiatives related to Performance Improvement Projects (PIPs) and Facility Site Reviews (FSRs). The Director will communicate and coordinate with contract providers regarding required studies, participation, and improvement projects. Related duties include ongoing data collection, medical record reviews, report writing, and collaboration with other KHS departments, as well as outside agencies.

The Director of Quality Performance is responsible for HEDIS/MCAS and performance and site review components of the Quality Improvement Program. This position will be responsible for oversight of maintaining compliance with Medi-Cal contractual stipulations for the performance of KHS and KHS contracted providers. In addition, this person will be an effective contributor to the KHS business planning and fiscal processes.

Essential Functions include:

- Builds and develops collaborative relationships (internally and externally) vital to the success of programs.
- Assisting network providers and their staff with practice transformation plans to shift into value-based care, improving quality and encounter data submissions.
- Helps practices to identify areas of need and helps with efficiency measures to improve availability, through sharing of scorecards, delivering gaps-in-care information and risk reports, sharing of satisfaction results as applicable, and delivering other critical operational and efficiency reports.
- Monitors and ensures that key quality activities are completed on time and accurately to present results to key departmental management.
- Evaluates project/program activities and results to identify opportunities for improvement.
- Responsible for Quality Performance staff and processes.
- Work collaboratively with Senior Director and Provider Network team to develop physician practice performance profiling on HEDIS/MCAS/STAR metrics, identify opportunities for improvement, and support/manage change implementation.
- Establishes and maintains tracking and monitoring systems for health care quality improvement activities according to regulatory requirements, policies and procedures, and contractual agreements.
- Track and monitor the HEDIS/MCAS improvement operations.
- Identify opportunities and potential barriers in HEDIS/MCAS
- Research and documents current health care standards for use in performance improvement study design and methodologies related to health outcomes.
- Provides guidance, and oversight to staff regarding study design, methodology, data analysis and reporting of Quality performance improvement projects.
- Works with staff to achieve production, timeliness, accuracy, and quality of work.
- Remains current with Department of Health Care Services and Department of Managed Care policy implementation or revisions.
- Participates in the development, review and updating of policies and procedures.

- Manages and evaluates performance of department staff.
- Coordinates guidelines, studies, and performance improvement activities in concert with the utilization management, quality management, pharmacy services, and population health management teams.
- Remains current with HEDIS/MCAS requirements and participates in planning and implementation of methods to improve HEDIS/MCAS performance.
- Education of providers on HEDIS/MCAS and program goals.
- Ensures compliance with applicable regulatory and reporting requirements.
- Coordinates the regular and systematic review of all potential quality of care issues in accordance with state statute.
- Develops and analyzes reports to monitor and evaluate quality performance in meeting established goals.

Quality Performance Nurse, RN

The QP nurses possess a valid California Registered Nursing license and three years registered nurse experience in an acute health care setting preferably in emergency, critical and/or general medical-surgical care. The QP nurses assist in the implementation of the QI Program and Work Plan through the quality monitoring process. Staffing will consist of an adequate number of QI nurses with the required qualifications to complete the full spectrum of responsibilities for the QI Program development and implementation. Additionally, the QI nurses teach contracting providers DHCS MMCD standards and KHS policies and procedures to assist them in maintaining compliance. The primary function of the QP nurse is implementation and support of MCAS performance and KHS' site review program.

MCAS/HEDIS Supervisor

The QP MCAS/HEDIS Supervisor is responsible for oversight and daily operations of KHS' MCAS/HEDIS performance. The Supervisor possesses a bachelor's degree or higher in Healthcare, Business, Data Science, Project Management, or related field. They have at least 2 years' experience in Quality Improvement or in a health care environment with relevant Quality Improvement experience. They also have at least two (2) years' experience in project management work. Under the direction of the Director, the Supervisor manages, plans, coordinates, and monitors Quality Special Programs including but not limited to:

- Annual Managed Care Accountability Set (MCAS) audit and measurement results submission.
- QI Department Strategic Goals and Projects, and Special Programs (such as member incentives

and engagement, DHCS-required project improvement plans, site reviews, etc.).

Quality Performance Operations Analyst

The QP Operations Analyst is responsible for reporting needs related to MCAS and site review reporting needs. The Analyst serves as the Subject Matter Expert (SME) for MCAS and HEDIS aspects of KHS' Quality Program.

Under the direction of the Supervisor and Director, this position provider oversight, management, and validation of data and reports submissions for the annual DHCS MCAS/HEDIS audit. This includes serving as the liaison between the QP department, vendors, and internal KHS departments, such as IT.

Quality Performance Coordinator

The QP Coordinators are responsible for functions related to data collection, data entry, report preparation, maintenance, collaboration, and regulatory compliance support for the department. The coordinator serves as the liaison between the health plan and provider network for record retrieval, scheduling, and various departmental initiatives and interventions. Under the direction of the QP Director and/or Supervisor, the Coordinators perform Quality related duties, including but not limited to MCAS data collection, sorting, chasing, and analyzing medical records.

D. Health Equity Department

Chief Health Equity Officer (CHEO)

The Chief Health Equity Officer oversees development, implementation, review and revision of health equity policies and procedures; maintains the QIHEP description and work plan; coordinates implementation activities; and ensures reporting to the EQIHEC. The CHEO also serves as the primary liaison between Kern Health Systems and any regulatory agencies on health equity issues and programs. The CHEO sits on the EQIHEC and provides health equity perspective for all non-clinical areas; the CHEO seat may not be delegated. The CHEO oversees the development, evaluation, and/or revision of the QIHEP description. The CHEO also oversees how health equity is embedded into the KHS culture for all non-clinical aspects (i.e., marketing, member engagement, member services, community supports, etc.).

Health Equity Manager

The Health Equity Manager is responsible for the daily management of the QIHEP including development and management of projects and activities to expand and advance the delivery and quality of health equity measures,

cultural competency services, operational effectiveness through process improvement, contract execution, and monitoring. The Health Equity Manager supervises all staff directly working in the Health Equity Office (HEO).

Senior Health Equity Analyst

The Senior Health Equity Analyst will provide reports, data analytics, project management, process improvement, and data integrity based on the collection, association, compliance review, and interpretation of data and operational processes. The Senior Health Equity Analyst is responsible for developing a complete understanding of the stated and actual needs of Health Equity Office stakeholders (internal and external), not simply their expressed desires, through a methodical analytical process, identify and report gaps, and help develop solutions to address revealed findings. The Senior Health Equity Analyst assists the HEO in defining the technical and reporting needs of KHS's QIHEP and HETSC initiatives and may facilitate or govern analytical discussions between various groups.

Health Equity Project Coordinator

The Health Equity Project Coordinator coordinates and organizes projects for the Health Equity Office. Supports the successful implementation of projects within timelines for associated department assignments and tasks. This position also coordinates the functions of the EQIHEC and all subcommittees.

E. Appeals and Grievances

Member Grievances and Appeals System

KHS Member Grievance and Appeal system complies with the requirements set forth in the 42 Code of Federal Regulations Sections 438.228 and 438.400 – 424, 28 California Code of Regulations Sections 1300.68 and 1300.68.01, and 22 CCR Section 53858. KHS use all notice templates included in the All-Plan letter 21-011 and ensures timely written acknowledgement and a notice of resolution to the member as quickly as possible.

Grievances with a Potential Quality Issue (PQI) identified are referred to the QI department as a PQI referral for further investigation and action. All potential quality of care issues are reviewed by the KHS CMO or their designee to determine the severity level and follow-up actions needed. All cases are tracked and the data provided to the CMO or designee during the provider credentialing/re-credentialing process. Other actions may include tracking and trending a provider for additional PQIs and/or request(s) for a corrective action plan (CAP) for issues or concerns identified during review. The CMO or their designee may present select cases to the PAC for review and direction as needed.

KHS regularly analyzes grievance and appeals data to identify, investigate, report and act upon trends impacting health

care access and delivery to the members.

Grievance Satisfaction Data – KHS reviews Member grievances and satisfaction study results as methods for identifying patient safety issues.

F. Credentialing

The Credentialing Department operates under the direction of the Deputy Director of Contracting and Quality Performance, who reports to the COO and is responsible for Provider Operations, including credentialing and re-credentialing functions, oversight for directly contracted Practitioners, Providers, and delegated IPAs, and resolving credentialing-related Provider issues.

Provider Operations, which includes Provider Contracting, Provider Network Management, Provider Relations, and Provider Training & Development, is committed to having a culturally competent and linguistically accessible network comprised of diverse providers who are knowledgeable and responsive to members' cultural practices and beliefs. This includes a commitment to identifying, assessing, and addressing behavioral health inequities to eliminate disparities and ensure access to healthcare for all members. Provider Operations contributions to organizational QIHE initiatives includes the management of providers' profile and demographic data analyses to that of the KHS members' cultural and linguistical needs.

G. Member Services

KHS implements and maintains written policies and procedures that set forth the Member's rights and responsibilities and shall communicate its policies to its Members, Providers, and, upon request, potential members. Members are also assured of their rights to confidentiality, right to advance directives, and rights to linguistic services.

H. Pharmacy Department

Safety Monitoring: Pharmacy will expand on the current monitoring of opioids/controlled substances as defined by the SUPPORT Act. Though previously managed via prospective Pharmacy Benefit Manager (PBM) rules, KHS will retrospectively review claims for possible action in regard to the Beer's list for geriatric members. KHS will also monitor drug recalls issued by the FDA or manufacturer. Currently for monitoring the potentially inappropriate use of opioids, either, high dose, those without naloxone, and/or in combination with other agents acting on the central nervous system such as benzodiazepines, and muscle relaxants, KHS sends notification letters to the physician on record to evaluate the appropriateness of the regimen for that member.

The Director of Pharmacy or designee participates in interdisciplinary teams weekly to discuss drug regimens of select members. KHS also sends letters to providers regarding drug profiles of members that have been identified as having drug duplications, interactions, and/or missing therapies.

Pharmacy is developing a series of report suites that will identify all HEDIS/MCAS measures we are held accountable for or will be added in the following year (2024). These reports identify members who are non-compliant for that measure, and we will be working with other depts to best close the gap. The approach will incorporate brining in the local pharmacies to help with outreach to the members and providers.

I. Population Health Department (PHM)

The Kern Health System (KHS) Population Health Management (PHM) Service will support whole-person care by integrating and aggregating historical administrative, medical, behavioral, dental, social service and program information from disparate sources. This integrated approach will drive risk-stratification, segmentation, tiering, assessment and screening processes, analytics, and reporting. By transforming raw data into actionable insights, PHM will identify opportunities for continuous quality improvement, reduce bias and error in decision-making. KHS will connect its members to the right services and supports at the right time and place depending on their needs and preferences.

In addition to data integration, PHM will facilitate meaningful engagement with network providers, public health agencies, schools, and community-based organizations (CBOs) to enhance data sharing across delivery systems. These partnerships will promote care coordination and help identify and mitigate social determinants of health (SDOH) that contribute to health disparities. Through these collaborative efforts, KHS aims to connect all members to primary care, preventive and wellness services, and disease management programs while ensuring members at risk for complex health issues are linked to specialized services.

PHM will also gather, share, and assess timely and accurate member data to identify efficient and effective opportunities for intervention. This will be achieved through data-driven risk stratification, predictive analytics, identification of care gaps, and standardized assessment processes. These tools will allow KHS to proactively identify members with rising health risks and provide personalized interventions to improve health outcomes and reduce health disparities.

KHS will support the unique needs of members population, including health and social needs (e.g., behavioral, developmental, physical, and oral health); Long-Term Services and Supports (LTSS) needs as well as health risks, rising risks, and health-related social needs due to social determinants of health (SDOH) in the Population Needs Assessment. KHS is committed to ongoing initiatives to deliver comprehensive, equitable care across its service areas.

J. Human Resources Department

The KHS Human Resources Department is dedicated to promoting diversity and inclusivity within the workforce. Comprised of Talent Acquisition, Employee Relations, Benefits and Wellness Programming, and Learning and Professional Development, the department is committed to implementing equitable and accessible recruiting, hiring, onboarding, professional development, and succession planning practices to ensure and sustain a diverse workforce. To enhance cultural and linguistic competency within the organization, the HR department prioritizes creating a culture of trust, empathy, and humility, guiding employees towards a deeper understanding of cultural and linguistic diversity in their daily work. The department will also work towards developing policies and leadership practices that continuously support diversity, equity, and inclusion in compliance with regulations, supportive of organizational values, and in pursuit of industry best practices. This will help the organization remain trusted and highly responsive to the needs of employees and the communities it serves.

1. Hiring Initiatives

As described in the KHS DEI Program charter, KHS is dedicated to building a workforce that is diverse, qualified, and engaged, and one that reflects the diversity of the communities KHS serves in Kern County. KHS strives to create a workplace environment that is safe, inclusive, and strengths-based, providing abundant opportunities for employees of all backgrounds, cultures, and linguistic abilities to belong and flourish. Human Resources and Hiring Managers are responsible for ensuring that recruiting, hiring, and succession planning practices are inclusive and reflect the demographic needs of the communities.

Commitment to health equity in hiring, recruiting, and succession planning includes posting job opportunities in inclusive language across a network of diversity job sites and job boards to help attract a more diverse workforce, including groups of underrepresented individuals. KHS also incorporates inclusive language into job descriptions, conducts panel interviews with members reflective of the community's diversity, and uses standardized assessment tools. KHS aims to create a diverse and inclusive workforce that can provide better services to all communities.

2. KHS Bilingual Workforce

Departments who employ staff members to provide linguistic services to the membership include Behavioral Health, Wellness & Prevention, Marketing, Member Engagement, Member Services, Utilization Management, Population Health Management, Enhanced Care Management, Community Support Services, Quality Improvement, and Pharmacy. All bilingual staff must pass a verbal bilingual assessment before being hired or during employment. Certificates of linguistic proficiency are monitored and maintained by the Cultural and Linguistic Team. For KHS staff who have received certification of bilingual proficiency, a copy of the certificate is kept in their personnel file with Human Resources.

KHS defines qualified bi-lingual staff as:

- Proficient in speaking and understanding a language other than English.
- Having a fundamental knowledge in a language other than English that includes the use and application of specialized vocabulary, terminology and phraseology, and concepts.
- Having the ability to communicate directly effectively, accurately, and impartially with members who have limited English proficiency.

KHS Member Services Bi-lingual Representative staff will only provide oral interpretation services and are prohibited from providing written translation, including editing, and proofreading translated documents, and sight translation services.

K. Provider Network Management (PNM)

The Provider Network Management (PNM) department is responsible for growing and overseeing the Plan's network of providers and is comprised of: Contracting, Credentialing, Provider Relations, Provider Grants, and Analytics and Regulatory Reporting. The Senior Director of Provider Network heads the PNM department. The Deputy Director of Provider Contracts reports to the Senior Director of Provider Network and oversees Contracting and Credentialing. The Deputy Director of Provider Network reports to the Senior Director of Provider Network and oversees Provider Relations, and Provider Grants, and Analytics and Regulatory Reporting.

The Contracting Team is comprised of a Provider Contracts Supervisor, Contract Specialists, Coordinators. The Contracting Team is responsible for contracting with providers within and adjacent to the network service area to ensure network adequacy for all specialty types. The Contracting department also works with contracted providers to negotiate rates and implement special programs. As needed the Contracting team will negotiate single-case, Letter of Agreements (LOAs) with out-of-network providers.

The Credentialing Team is comprised of a Credentialing Manager and five Credentialing Coordinators. The PNM Credentialing team monitors and tracks provider licenses, certificates, training, Medi-Cal enrollment, and other applicable provider requirements. The Credentialing team also aids in maintaining accurate provider data utilized within Plan's regulatory reporting and provider directory.

The Provider Relations Representative Team is comprised of a Provider Relations Supervisor and seven Provider Relations Representatives. The Provider Relations Representatives are the direct link between the Plan and the Provider. The Provider Representatives are responsible for provider communication and education and conduct

outreach to noncontracted providers for potential recruitment.

The Grants Team is comprised of a Grants Manager and a Grants Specialist. The Grants Team is responsible for developing grant programs and identifying and reaching out to providers who may qualify for certain grants from the Plan. The Grants team is responsible for creation and tracking of appropriate grant's milestones and goals. The KHS grant program works to financially aid and encourage innovative efforts to bring beneficial services to our community.

The PNM Analyst team is comprised of the Provider Network Manager, Provider Network Analytics Program Manager, and three Senior Provider Network Analysts. The PNM Analyst Team is responsible for, monitoring network accessibility, network-related regulatory reporting (DMHC Timely Access and Annual Network Review, DHCS Annual Network Certification), the Provider Satisfaction Survey and maintaining the provider directory (in conjunction with credentialing team).

Provider network accessibility is primarily monitored via the Provider Network Management, Quarterly Network Review. The Quarterly Network Review includes, but is not limited to an Access Grievance Review, Provider Accessibility Monitoring Survey, Geographic Accessibility Review, and Network Adequacy/Provider Counts. These reports track and monitor the Plan's regulatory compliance to standards such as: PCP to member and Physician to Member ratios, Appointment Availability, Provider Response times, Provider After-Hours availability, and In-Office wait times. The PNM Analytics Team monitors and tracks members' geographic access to PCP, Specialist, Non-Physician Mental Health, Specialty OB/GYN, and Hospital providers and confirms the geographic access is within regulatory standards. If any provider type/geographic region is not meeting regulatory standards, it is the responsibility the PNM Analytics Team to request an Alternative Access Standard and identify potential providers for recruitment/contracting activities. The PNM Analytics Team reviews Access Grievance data to determine if any provider, group, or specialty is experiencing the same access issue on a continuous basis. The Provider Relations Department provides routine reports of access study data for review and recommended action by the EQIHEC.

L. Utilization Management Department (UM)

Please refer to the Utilization Management Program (UMP) Description for Utilization Management activities and related UM activities. The UMP is a formal Document supported by clinical, operational, and administrative policies and procedures (P&Ps) delineating how UM functions are performed. The UMP and P&Ps are written to adhere to federal and state regulatory requirements to include CA Health & Safety Code, Title 22, Welfare & Institutions Code, CMS Code of Federal Regulations, the CA Department of Health Care Services 22-20202 KHS Contractual Provisions, and current NCQA Standards and Guidelines. The UM documents are developed through the

involvement of actively involved KHS providers in accordance with H&S Code sections 1363.5 and 1367.01 and 28 CCR sections 1300.70(b)(2)(H) and (c). The UM Director is a standing member of the EQIHE Committee.

M. Behavioral Health Department (BH)

The KHS responsibility for administering and managing behavioral health and substance use care is dependent on the Medi-Cal member's severity of impairment. For behavioral health, KHS services are typically for treatment of mild to moderate impairment also referred to as non-specialty mental Health. Kern County Medi-Cal Behavioral Organization manages severe mental health impairment referred to as Specialty Mental Health Services.

For substance use disorders KHS provides screening, brief intervention, and counseling (SBIRT) services and refers members for treatment for misuse of alcohol. Active treatment for Medi-Cal members with substance use disorder (SUD) services must be rendered by a SUD Drug Medi-Cal certified program.

KHS covers Behavioral Health Treatment (BHT), including Applied Behavior Analysis (ABA) therapy, for Medi-Cal beneficiaries under the age of 21.

N. Wellness and Prevention Department- Cultural and linguistics (C&L) and Health Education (HE)

Please refer to the Program Descriptions for Cultural and Linguistics and Health Education for C&L and Health Education activities and related wellness and prevention activities.

The Wellness & Prevention Department is responsible for providing comprehensive, culturally, and linguistically appropriate wellness and prevention services with the intent of promoting health behaviors, improving health outcomes, reducing risk for disease and empowering Members to be active participants in their health care. The W&P department is headed by the Senior Director of Wellness & Prevention and is composed of four teams:

- Cultural & Linguistic Services – comprised of a Manager, Cultural & Linguistic Specialists, and a Cultural & Linguistics Coordinator to provide comprehensive, culturally, and linguistically appropriate competent services to plan members with improved access and health outcomes. These services include, but not limited to linguistic services, translation of written member information materials, training and education for staff, providers, and contracted vendors, and assessing, monitoring, and evaluating the Cultural & linguistics services provided by the Plan, providers, and contracted vendors.
- Community Health & Wellness – comprised of a Manager, Health Education Specialist and Lifestyle Coach to establish community-based health and wellness initiatives that promote health, prevent illness, and improve health literacy to vulnerable communities in Kern County.

- Member Wellness & Prevention (MWP) – comprised of a Manager, Health Educators, Health Education Specialists and Lifestyle Coaches to provide health education, wellness, and prevention programs, services, interventions using evidence-based programs directly to our members or through partnerships with partner organizations. Services are delivered through one on coaching, group classes, written material such as member newsletters, brochures, and other health education material. Partner with providers to enhance provider/patient interaction and increase knowledge of member health education needs. The MWP has oversight of the readability and suitability standards and member incentive programs.
- Wellness & Prevention Partnerships – comprised of a Manager, Program Manager and Program Liaisons to establish and foster relationships and promote preventive service benefits among community partners and providers, such as the local public health department and Women Infants and Children programs, in order to expand access and reach of health and wellness programs and services to members.

KHS is committed to delivering culturally and linguistically appropriate heath care services. Services will comply with Title VI of the Civil Rights Act of 1964, section 1557 of the Affordable Care Act of 2010, 42 CFR section 438.10, Exhibit A, Attachment III, Section 5.2.10 (Access Rights), and APL 21-004. The Senior Director of Wellness and Prevention is a standing member of the EQIHEC.

O. Enhanced Care Management Department (ECM)

Please refer to the Enhanced Care Management Program Description for Enhanced Care Management activities and related ECM activities.

P. Community Support Services (CSS) Department

Please refer to the Community Support Services Program Description for CSS activities and related CSS activities.

Q. Business Intelligence (BI)

Functions include:

- Establish advanced health analytics to ensure that leadership has full purview into the population to improve individual experience of care; improve the health of the population while reducing per capital cost of care for populations.
- Create, manage, and continuously improve Corporate Key Performance Indicators (KPI's)
- Reduce operational silos and proactively manage and improve overall operations.
- Provide and validate standard metrics and information around process improved to ensure that

project goals, objectives, or Return on Investments (ROI) are achieved.

- Establish data governance over various systems to ensure that reliable data can be consumed for analytics and reporting.
- Manage all operational and regulatory reporting inventory for the organization.

R. Information System & Data Management

KHS utilizes information provided through the Information Technology (IT), Operations, and Provider Network Management departments. KHS MIS has the capability to capture, edit, and utilize various data elements for both internal management use and to meet the data quality and timeliness requirements. These include DHCS' encounter data, network provider data, program data, and template data submissions and processes. MIS also has the ability to meet Population Health Management data integration requirements and is able to provide the requested data to DHCS and Centers for Medicare and Medicaid Services upon request.

KHS's Information Technology (IT) Division, comprising of Data Analytics, Information Security, Technical Support Services, and Operational Systems follows the culturally and linguistically appropriate business practices as outlined by KHS Leadership and Human Resources. IT provides new technologies, and enhancing existing systems, to ensure that all KHS staff can perform their work in a culturally competent environment. This includes, but is not limited to, offering technologies and tools compliant with ADA standards, assistive technologies, and website compliance. Data Analytics shall support the organization's QIHE operational initiatives by collecting, storing, analyzing demographic data and profiles of both KHS members and providers, conducting statistical analyses, and aid in the development and facilitation of assessments and surveys.

KHS (MIS) has the capacity to enable interoperability for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks.

KHS MIS supports at a minimum:

- All Medi-Cal eligibility data.
- Information on members enrolled with Kern Health Systems.
- Provider claims status and payment data.
- Health care services delivery encounter data.
- Network provider data.
- Program data.
- Template data.

- Screening and assessment data.
- Referrals including tracking of referred services to follow up with Members to ensure that services were rendered.
- Electronic health records.
- Prior auth requests and specialty referral system.
- Care Management data.
- Care Coordination data.
- Financial information.
- Social drivers of health data.
- Grievance and appeal information.

S. Marketing

The Marketing Department operates under the direction of the Senior Director of Marketing, who reports to the Chief Health Equity Officer. The Marketing Department is responsible for conducting appropriate product and market research to support the development of marketing and Member communication plans for all products including Member materials (e.g., Member Newsletters, Evidence of Coverage, website, etc.). The Quality Improvement and Health Equity Departments work closely with the Marketing and Wellness & Prevention Departments to ensure that Member materials are implemented in a timely manner.

V. Role of Participating Providers

A. Provider Participation

KHS contracts with physicians and other types of health care providers. The Provider Network Management Department conducts a quarterly assessment of the adequacy of contracting providers. All PCPs and specialists must meet KHS credentialing and recredentialing standards. Contracting providers must meet KHS requirements for access and availability. Members may select their PCPs based on cultural needs and preferences. The Provider Directory lists additional languages spoken by PCPs or their office staff.

- **Provider Information** – KHS informs contracting providers through its Provider bulletins, letters and memorandums, distribution of updates to the Provider Policy and Procedure Manual, and training sessions.
- **Provider Cooperation** – KHS requires that contracting providers and hospitals cooperate with QI Program studies, audits, monitoring, and quality related activities. Requirements for cooperation are included in provider and hospital contract language that describe contractual agreements for access to information.

- **Provider Performance** – KHS requires contracted providers to comply with DHCS' Managed Care Accountability Set (MCAS) and participate in quality-based initiatives aimed at improving, access, quality, and health equity for our members. Routine meetings are conducted with a subset of participating providers to ensure monitoring, communication, and supporting of achieving MPLs and maintaining high quality care.

B. Provider and Hospital Contracts

Participating provider and hospital contracts contain language that designates access for KHS to perform monitoring activities and require compliance with KHS QIHE Program activities, standards, and review system.

Provider contracts include provisions for the following:

a. An agreement to participate in the KHS QIHE Program including cooperation with monitoring processes, the grievance resolution system, and evaluations necessary to determine compliance with KHS standards.

b. An agreement to provide access to facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.

c. Cooperation with the KHS QIHE Program including access to applicable records and information.

d. Provisions for open communication between contracting providers and members regarding their medical condition regardless of cost or benefits.

Hospital contracts include provisions for the following:

a. An agreement to participate in the KHS QIHE Program, including cooperation with monitoring processes, the grievance resolution system, utilization review, and evaluations necessary to determine compliance with KHS standards.

b. Development of an ongoing QIHE Program to address the quality of care provided by the hospital including CAPs for identified quality issues.

c. An agreement to provide access of facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.

d. Cooperation with the KHS QIHE Program, including access to applicable records and information.

C. Conflict of Interest

Network practitioners serving on any QI and Health Equity program-related committee, who are or were involved in the care of a member under review by the committee, are not allowed to participate in discussions and determinations regarding the case. Committee members cannot review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issues. All required employees and committee participants sign a Conflict-of-Interest statement on an annual basis. Fiscal and clinical interests are separated. KHS and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care. There are no financial incentives for UM decision-makers that could encourage decisions that result in under-utilization.

Confidentiality Statement

KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process.

VI. Program Documents

A. Work Plan

The annual QIHEP Work Plan is designed to target specific QIHEP activities, projects, tasks to be completed during the upcoming year, and monitoring and investigation of previously identified issues. A focal activity for the Work Plan is the annual evaluation of the QIHE Program, including accomplishments and impact on members. Evaluation and planning the QIHE Program is done in conjunction with other departments and organizational leadership. High volume, high risk or problem prone processes are prioritized.

- The Work Plan is developed by the Quality Improvement and Health Equity Departments on an annual basis and is presented to the EQIHEC and Board of Directors for review and approval. Timelines and responsible parties are designated in the Work Plan.
- The Work Plan includes the objectives and scope of planned projects or activities that address the quality and safety of clinical care, and the quality of service provided to members.

- After review and approval of quality study results including action plans initiated by the EQIHEC, KHS disseminates the study results to applicable providers. This can occur by specific mailings or KHS Provider bulletins to contracting providers.
- The activities in the QIHE Work Plan are annually evaluated for effectiveness.
- QIHE Work Plan responsibilities are assigned to appropriate individuals.

Components of the QIHEP Work Plan:

- Quality and Safety of Clinical Care
- Quality of Service
- Member & Provider Satisfaction

B. Work Plan Evaluation

An annual evaluation of the QIHEP shall be prepared based on the activities presented to the EQIHEC during the calendar year. The EQIHEC reviews and approves the QIHEP evaluation. The QIHEP evaluation shall also be reviewed by the BOD. The Chief Health Equity Officer, with support from the Chief Medical Officer and/or Directors of Quality, will develop an evaluation of the QIHEP based on activities that were presented to the EQIHEC and BOD during the calendar year. The EQIHEC reviews and approves the QIHEP evaluation.

The QIHEP evaluation includes the following:

- A description of completed and ongoing quality improvement activities.
- Trended performance data from indicators to assess quality of care and service.
- An analysis of demonstrated improvements in care and service.
- A thorough evaluation of the program structure and effectiveness of the QIHEP including progress toward influencing safe clinical practices throughout the network.
- Monitoring efforts of medical groups and other subcontractors to ensure that delegated functions meet cultural, linguistic and sensitivity standards.
- Evaluation of patterns/trends for member grievances and discrimination complaints related to cultural/linguistic and sensitivity issues.
- A thorough evaluation of progress on non-clinical goals (i.e., Human Resources, Marketing, Member Engagement, Community Engagement, etc.)

KHS will also utilize the following methods to conduct ongoing monitoring and evaluation of its cultural competency and SPD awareness programs and annual sensitivity, diversity, cultural competency and health equity training for all staff, providers, subcontractors, and downstream subcontractors at key points of contact:

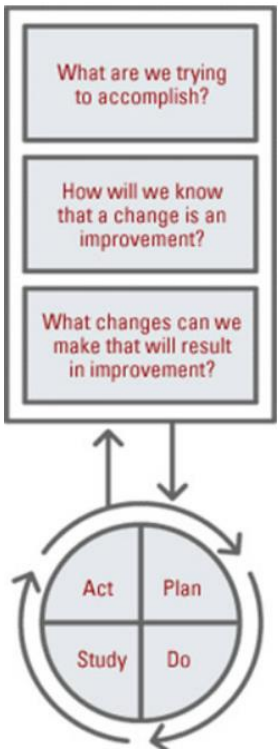
- Disenrollment data,
- MCAS/HEDIS results by race/ethnicity, language, and other demographic factors,
- Complaint and grievance reports,
- Member satisfaction survey results by race/ethnicity, language, and other demographic factors,
- Population Needs Assessments findings results by race/ethnicity, language, and other demographic factors,
- Performance Improvement Projects (PIPS),
- Health Education Activities Reports,
- Training attendance reports, attestations of training completion and/or completion of post-training quizzes.

VII. Quality Improvement Processes

A. KHS Quality Improvement (QI) Initiatives

1. Plan-Do-Study-Act Cycle

The QIHEP quality activities and studies are developed using the Plan-Do-Study-Act (PDSA) Model. The PDSA is an iterative, four-stage problem-solving model used for improving a process or carrying out change.



In accordance with the California Department of Health Care Services (DHCS) 2025 contract KHS will conduct quality studies, quality review activities, results, and assessments and submit the outcomes in reports to the DHCS in the reporting unit level and time frames as directed by DHCS.

2. Data Collection Methodology

KHS employs a structured data collection methodology designed to measure and improve healthcare quality and health equity outcomes. Data collection methods are determined based on the type of measure and available data sources, ensuring accuracy and reliability. Data validation is integral to this process, reinforcing the credibility of findings and supporting data-driven decision-making. Data is continuously collected, aggregated, and analyzed to monitor performance, identify disparities, and uncover opportunities for improvement. When performance gaps are identified, KHS implements targeted interventions with measurable goals. The effectiveness of these interventions is assessed through ongoing data analysis, ensuring that improvements are sustainable over time. If data indicates a need for a different approach, KHS re-evaluates strategies and adjusts action plans accordingly.

3. Measurement Process

KHS systematically monitors and evaluates quality improvement initiatives to assess their effectiveness and compliance with internal policies and external regulatory requirements. Performance is reviewed at least quarterly, with benchmarks and standards derived from:

- Nationally recognized clinical guidelines
- Peer-reviewed research
- Regulatory and contractual requirements
- Internal trend analyses
- State and federal quality measures

KHS uses these metrics to assess accessibility, availability, and equity in healthcare services, ensuring that interventions align with best practices and community needs.

4. Evaluation Process

A comprehensive evaluation framework guides KHS in assessing the effectiveness of Quality Improvement (QI) initiatives. Both quantitative and qualitative methodologies are employed:

- Quantitative Analysis: Benchmark comparisons, trend assessments, and statistical testing are used to evaluate the impact of QI initiatives.
- Qualitative Analysis: Root cause and barrier analyses are conducted collaboratively with key stakeholders to understand systemic challenges and identify sustainable solutions.

Cross-departmental collaboration ensures that evaluation findings inform future quality initiatives, driving continuous improvement in health outcomes.

5. Communication and Feedback

KHS fosters a culture of transparency and engagement through proactive communication with internal teams and external partners, including providers and stakeholders. Key communication channels include:

- Internal Education & Engagement: Staff meetings, committee updates, and training sessions on QI initiatives.
- Provider Communication: Newsletters, targeted mailings, KHS's provider portal, and direct outreach via quality visits.
- Performance Feedback: Providers receive actionable insights, including:
    1. Member-specific service and intervention lists
    2. Clinical guideline recommendations
    3. Performance data from HEDIS, CAHPS, and other quality measures
    4. Recognition for quality improvement achievements
    5. Compliance feedback based on audits, grievances, and utilization trends.

These communications reinforce accountability and foster a collaborative approach to quality improvement.

6. Improvement Processes

Performance indicators are used to identify quality concerns and disparities in care delivery. When deficiencies are detected, KHS initiates corrective actions, which may include:

- Provider-level remediation plans (Corrective Action Plans - CAPs)
- Enhanced provider education and technical assistance
- Temporary restrictions on new member assignments for non-compliant providers
- Delegation oversight adjustments
- Contract terminations for persistent non-compliance.

By integrating rigorous oversight, continuous evaluation, and data-driven decision-making, KHS ensures that quality improvement efforts translate into meaningful and sustainable healthcare enhancements for Medi-Cal members.

VIII. Quality Improvement Work Plan

A. Quality of Clinical Care

1. MCAS Measures

KHS is contractually required to submit data and measurement outcomes for specific health care measures identified by DHCS. The measures are a combination of ones selected by DHCS from the library of Healthcare Effectiveness Data and Information Set (HEDIS) and the Core Measures set from the Centers for Medicare and Medicaid Services (CMS). An audit is performed by DHCS's EQRO to validate that the data collection, data used, and calculations meet the specifications assigned by DHCS.

DHCS has established minimum performance levels (MPL) for several of the MCAS measures. This benchmark is the 50th percentile based on outcomes published in the latest edition of NCQA's Quality Compass report and the National HMO Average. Results submitted to DHCS for the designated MCAS measures are compared to the NCQA benchmarks to determine the Managed Care Plan's (MCP) compliance. When an MCP does not meet the 50th percentile or better for a measure, DHCS may impose financial penalties and require a corrective action plan (CAP). The following table identifies the MCAS measures KHS is held accountable to meet the 50th percentile or better for measurement year (MY) 2025. Results for the 2025 measures will be calculated and submitted in report year (RY) 2026. Please reference table on page 23 for list of MCAS measures.

KHS is contractually required to meet or exceed the DHCS established Minimum Performance Level (MPL) for each required HEDIS measure. For any measure that does not meet the established MPL, or that is reported as a "No Report" (NR) due to an audit failure, an Improvement Plan (IP) is contractually required to be submitted within 60 days of being notified by DHCS of the measures for which IPs are required. Managed Care Plans are required to meet or exceed the performance levels set forth by Department Health Care Services (DHCS) as outlined in their contract.

2. Performance Improvement Projects (PIPs)

KHS is mandated to participate in two (2) PIPs. These PIPs span over an approximate 36-month time frame and are each broken out into four (4) modules. Each module is submitted to HSAG/DHCS for review, input, and approval incrementally throughout the project. The two new PIPS required by DHCS will include annual submissions for 3 years from 2023-2026. The framework for the new PIPs has been updated by DHCS to align with the CMS protocol.

<u>Clinical PIP:</u>

The new cycle of PIPs began in August 2023 and will run through 2026. The clinical PIP is focused on Health Equity,

specific to the W30 0-15 months African American population.

Non-Clinical PIP:

The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health department for support of interventions. QP will be partnering with the Behavioral Health Department, UM, PHM, and any other necessary stakeholders.

B. Safety of Clinical Care

1. Patient Safety Program

KHS recognizes that patient safety is a key component of delivering quality health care and focuses on promoting best practices that are aimed at improving patient safety. KHS engages Members and Providers to promote safety practices. KHS also focuses on reducing the risk of adverse events that can occur while providing medical care in different delivery settings. Some of the safety initiatives include:

1. Appropriate Medication Utilization
2. Review of Inpatient Admissions
    a. Readmissions
    b. Length of Stay
    c. Inappropriate Discharges
    d. Unexpected Mortalities
3. Provider Preventable Conditions (PPCs)
4. Potential Quality Issues (PQIs)
5. Initial Health Assessment Monitoring
6. Over-utilization and Under-utilization
7. Performance with healthcare outcomes and clinical processes
8. Adherence to clinical and preventive health guidelines
9. Effectiveness of chronic conditions, population health and care management programs

2. Potential Quality Issues (PQIs)

The QI Department reviews all Potential Quality Issues (PQIs) and adverse events involving practitioners and providers. Areas of review include primary and specialty care, hospitals, long-term care (LTC) facilities, skilled nursing facilities (SNF), and transportation providers. All identified PQIs are referred to the QI Department for investigation and evaluation, ensuring timely and appropriate actions are taken to address potential concerns. The

Medical Director oversees the process, ensuring alignment with recognized standards of care evaluating all cases and referring matters to the EQIHEC and/or Physician Advisory Committee for further assessment, as necessary.

3. Facility Site Review, Medical Record and Physical Accessibility Reviews

Facility site and medical record reviews are performed before a provider is awarded participation privileges and every three years thereafter. As part of the facility review, KHS QP Nurses review for the following potential safety issues:

- Medication storage practices to ensure that oral and injectable medications, and "like labeled" medications, are stored separately to avoid confusion.
- The physical environment is safe for all patients, personnel, and visitors.
- Medical equipment is properly maintained.
- Professional personnel have current licenses and certifications.
- Infection control procedures are properly followed.
- Medical record review includes an assessment for patient safety issues and sentinel events.
- Bloodborne pathogens and regulated wastes are handled according to established laws.

In collaboration with other Kern County Health Plans for Site Reviews KHS coordinates, as described in APL 22-017, Site Reviews: Facility Site Review and Medical Record Review and the applicable MOU.

4. Credentialing and Recredentialing

KHS maintains a comprehensive pre-contractual and post-contractual assessment and monitoring system to ensure that contracting providers have the capacity and capability to perform required functions. The pre-contractual assessment requires providers seeking to contract with KHS to complete a detailed document covering key areas such as health care delivery systems— including clinical safety, access and waiting times, referral tracking, medical records, and health education— as well as credentialing information. Post-contractual monitoring includes ongoing evaluation to ensure continued compliance with contractual requirements, quality standards, and regulatory guidelines. Specific policies outline the standards, tools, and processes used to support these activities, ensuring accountability and quality in provider credentialing and recredentialing.

C. Quality of Service

1. Grievance and Appeals

KHS monitors performance areas affecting Member experience. KHS has established categories and quantifiable standards to evaluate grievances received by Members. All grievances are categorized in several different categories

including but not limited to the following: continuity of care, geographic access, language access, provider availability, timely access, discrimination, care coordination, and quality of care. The organization's goal is to resolve all grievances within thirty (30) days of receipt. KHS grievances and appeals data is presented on a quarterly basis to the EQIHEC and PAC as needed. KHS goal is to maintain the overall complaint rate below thresholds as established by regulatory agencies such as DHCS, DMHC, and CMS.

2. Access to Care

The Plan maintains ongoing monitoring efforts to ensure its network is able to provide appropriate access to health care services, in line with regulatory standards and member needs. The Plan's Provider Network Management department utilizes appointment availability surveys, capacity/adequacy analysis, grievance reviews, provider/member mapping, and other tools to conduct Plan monitoring; these efforts are presented to the Plan's Network Adequacy Committee (NAC) and EQIHEC on a quarterly basis. Areas monitored include, but are not limited to: appointment availability, access to after-hours-care, time, and distance (geographic) accessibility, provider type availability, and network capacity.

D. Member and Provider Satisfaction

Member Satisfaction

KHS conducts a comprehensive CAHPS survey and analysis annually to assess Member satisfaction with the services and care received. CAHPS is a set of standardized surveys that ask health care consumers to report on and evaluate their care experience. The survey focuses on key areas like getting care needed; getting appointments to PCPs and Specialty Care Providers (SCPs); satisfaction with KHS and its Practitioners; and other key areas of the Plan operations. CAHPS surveys serve as a means to provide usable information about quality of care received by the Members. KHS uses this tool as one of its key instruments to identify opportunities for improvement. As part of the annual evaluation, KHS reviews the CAHPS results to identify relative strengths and weaknesses in performance, determines where improvement is needed, and tracks progress with interventions over time.

Provider Satisfaction

KHS monitors performance areas affecting provider satisfaction annually and submits the results to DHCS and CMS. This study assesses the satisfaction experienced by KHS's network of PCPs, SCPs, and Behavioral Health Providers. Information obtained from these surveys allow plans to measure how well they are meeting their Providers' expectations and needs. This study examines the satisfaction of the Provider network in the following areas: overall satisfaction, all other plans, finance issues, utilization and quality management network, coordination of care, pharmacy, Health Plan Call Center Service Staff, and Provider relations. Based on the data collected, KHS reports

the findings to the QIW and EQIHEC. The committees review the findings and make recommendations on potential opportunities for improvements.

E. Addressing Cultural, Ethnic, Racial and Linguistic Needs of Members

Integrated KHS Resources and Documents Utilized to Support the QIHE Program:

Population Needs Assessment

The Wellness & Prevention Department conducts population needs assessment of KHS' members to determine health education and cultural/linguistic needs. The Population Needs Assessment will be updated every year for the duration of the contract with DHCS. The contents of the Population Needs Assessment will define the goals and objectives, data sources and methodology, member demographics, member health status, disease prevalence and gap analysis, health education and cultural and linguistic service needs, and key recommendations, planned actions and conclusions. (APL19-011). KHS uses the PNA to inform its QIHEP priorities and share pertinent information regarding the PNA findings and the identified targeted strategies with its providers.

Population Health Model of Care

The KHS Population Health Management (PHM) Model of Care (MOC) is to provide a strategic road map defining the approach towards the provision of healthcare and preventative services and focuses on collaborative partnerships with providers to assist in delivering high-quality care to all members in a timely and efficient manner while reducing costs. The PHM MOC is designed to better coordinate member's care and utilize various data sources to draw insights on how to address each member's individual needs and make hospitals and clinics more accessible and effective.

PHM is a proactive, data-driven strategy focused on improving the health of a given population by a defined network of financially linked providers, achieved in partnership with the community (Health Catalyst, 2020). The Primary Care Physician (PCP) forms the backbone of PHM. The PCP is the signal caller who identifies problems early through various clinical and socio-behavioral screenings and refers patients to specialists. At the same time, KHS provides support to the PCP to ensure the patient receives high-quality, comprehensive health care in a timely manner. The Director of PHM is a standing Member of the Health Equity Transformation Steering Committee.

Diversity, Equity, and Inclusion and Health Equity Education and Training

KHS does not delegate health equity activities. Providers are required to actively participate and comply with Health Equity activities. To support this expectation, KHS provides annual training to employees, contracted staff, providers, sub-contractors, and downstream subcontractors at key points of contact on sensitivity, diversity, cultural

competency, effective communication, health equity, and inclusion relating to members. Training will promote access and delivery of services in a culturally competent manner to all members and potential members regardless of their sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation or identification with any other persons or groups defined in Penal Code 422.56. Training will consider structural and institutional racism, heath inequities and its impact on members, staff, providers, subcontractors, and downstream subcontractors. Trainings will include, but not be limited to topics such as:

- Beliefs about illness and health for identified cultural groups within KHS' membership and Kern County,
- Need for gender affirming care,
- Methods for interacting with providers and the health care structure,
- Traditional home remedies that may impact provider recommended treatment plans,
- Skills and practices regarding culture-related health care issues of the membership,
- How cultural competency relates to quality of care and access to care,
- Appropriate use and provision of interpreters,
- Translation process of written informing documents,
- Health literacy,
- PNA findings and identified targeted strategies,
- Culturally and linguistically appropriate community resources,
- Required completion of Continuing Medical Education on cultural competency and implicit bias.

IX. External Audits/Regulatory Audits and Delegation Oversight

A. Auditing and Monitoring Activities

Enforcement/Compliance: The Director of Quality Improvement is responsible for monitoring and oversight of the QIHE Program, including enforcement of compliance with KHS standards and required activities. Compliance activities can be found in sections of policies related to the specific monitoring activity. The general process for obtaining compliance when deficiencies are noted, and CAPs are requested, is delineated in policies. Compliance activities not under the oversight of QI are the responsibility of the Compliance Department.

Medical Reviews and Audits by Regulatory Agencies – The KHS Director of Compliance & Regulatory Affairs, in collaboration with the CHSO and the Director of Quality Improvement manages KHS medical reviews and medical audits

by regulatory agencies. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QIHE Program. CAPs for medical matters are approved and monitored by the EQIHEC.

B. Delegation

KHS delegates quality improvement activities as follows:

1. VSP – delegation of QI processes with oversight through the EQIHEC.

X. Conflict of Interest

All members of the Equity, Quality Improvement, and Health Equity Committee (EQIHEC) and its subcommittees are required to review and sign a Conflict of Interest Statement, affirming their commitment to ethical decision-making. Committee members must disclose any potential conflicts of interest and recuse themselves from discussions and voting on matters where they have a direct or indirect interest. Individuals personally involved in the care or service provided to a patient, or in an event or finding undergoing quality evaluation, may not vote or render a decision regarding the appropriateness of such care. By signing the Conflict of Interest Statement, members agree to abide by its terms, ensuring transparency and integrity in the committee's decision-making process.

XI. Confidentiality

All members, participating staff, and guests of the EQIHEC Committee and subcommittees are required to sign the Committee Attendance Record, including a statement regarding confidentiality and conflict of interest. All KHS employees are required to sign a confidentiality agreement upon hire. Confidentiality agreements are maintained in the practitioner or employee files, as appropriate. All peer review records, proceedings, reports and member records are maintained in a confidential manner in accordance with state and federal confidentiality laws.

Member's Right to Confidentiality:

KHS retains oversight for provider confidentiality procedures. KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process. The EQIHEC Committee reviews

practices regarding the collection, use and disclosure of medical information.

XII. Information Security

Fraud, Waste, and Abuse (FWA) – The Quality Improvement Department provides support to the KHS Fraud, Waste, and Abuse program in the following ways:

a. **PQI Referrals** – In the course of screening and investigating PQI referrals, the QI Department consistently evaluates for any possible FWA concerns. All FWA concerns are referred to the KHS Compliance Department for further evaluation and follow up.

b. **FWA Investigations** – The QI Department clinical staff may provide clinical review support to the Compliance Department for FWA referrals being screened or investigated.

c. **FWA Committee** – The Director of QI or their designee is an active member of the KHS FWA Committee to provide relevant input and suggestions for topics and issues presented.

Health Insurance Portability and Accountability Act (HIPAA)

KHS complies with all applicable HIPAA requirements supported by HIPAA compliance policies. All HIPAA related policies are accessible to all KHS contracted providers and KHS staff. HIPAA information is posted on the KHS website. Ongoing mandatory education is required annually for all staff.

XIII. Communication of Quality and Health Equity Activities

Results of performance improvement activities are communicated to the appropriate department, and/or multidisciplinary committee as determined by the nature of the activity. The EQIHEC subcommittees report their summarized information to the EQIHEC quarterly to facilitate communication along the continuum of care. The EQIHEC reports activities to the Governing Board, through the CMO or designee, on a quarterly basis. EQIHEC participants are responsible for communicating pertinent, non-confidential QIHE issues to all members of KHS staff. Communication of QIHE trends to KHS contracted entities, members, practitioners and providers is through the following:

- Practitioner participation in the EQIHEC and its subcommittees
- Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
- Practitioner and member newsletters regarding relevant QIHE program topics
- The QIHEP description, available to providers and members on the KHS website. This includes QIHEP goals, processes and outcomes as they relate to member care and service.

- Annual practitioner education through provider relations and the Provider Manual

XIV. Annual Evaluation

Annual Evaluation of the KHS Quality Improvement Health Equity Program

On an annual basis, KHS evaluates the effectiveness and progress of the QIHE Program and Work Plan, and updates the program as needed. The CMO, with assistance from the Quality Improvement Medical Director, Director of QI, Pharmacy Director, Director of Wellness & Prevention, Director of Marketing, Director of Member Services, Senior Director of Contracting & QP and Director of QP, documents a yearly summary of all completed and ongoing QIHE Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms.

The report includes pertinent results from QIHE Program studies, member access to care surveys, physician credentialing and facility review compliance, member satisfaction surveys, and other significant activities affecting medical and behavioral health care provided to members. The report demonstrates the overall effectiveness of the QIHE Program. Performance measures are trended over time to determine service, safety, and clinical care issues, and then analyzed to verify improvements. The CMO presents the results to the EQIHEC Committee for comment, suggested program adjustments and revision of procedures or guidelines, as necessary. Also included is a Work Plan for the coming year. The Work Plan includes studies, surveys, and audits to be performed, compliance submissions, reports to be generated, and quality activities projected for completion.

The yearly QIHE Program summary and Work Plan are presented to the Board of Directors for assessment of covered health care rendered to members, comments, activities proposed for the upcoming year, and approval of changes in the QIHE Program. The Board of Directors is responsible for the direction of the QIHE Program and actively evaluates the annual plan to determine areas for improvement. Board of Director comments, actions and responsible parties assigned to changes are documented in the minutes. The status of delegated follow-up activities is presented in subsequent Board meetings. A summary of QIHE activities and progress toward meeting QIHE goals is available to members and contracting providers upon request by contacting KHS Member Services.

_____ Date _____

Chief Executive Officer

Emily Duran

_____ Date _____

Chief Medical Officer

_____ Date _____

Chief Health Equity Officer

_____ Date _____

Chief Operations Officer

_____ Date _____

Medical Director of Quality Improvement

_____ Date _____

Director of Quality Improvement

_____ Date _____

Senior Director of Contracting & Quality Performance

_____ Date _____

Director of Quality Performance

_____ Date _____

Senior Director of Wellness and Prevention

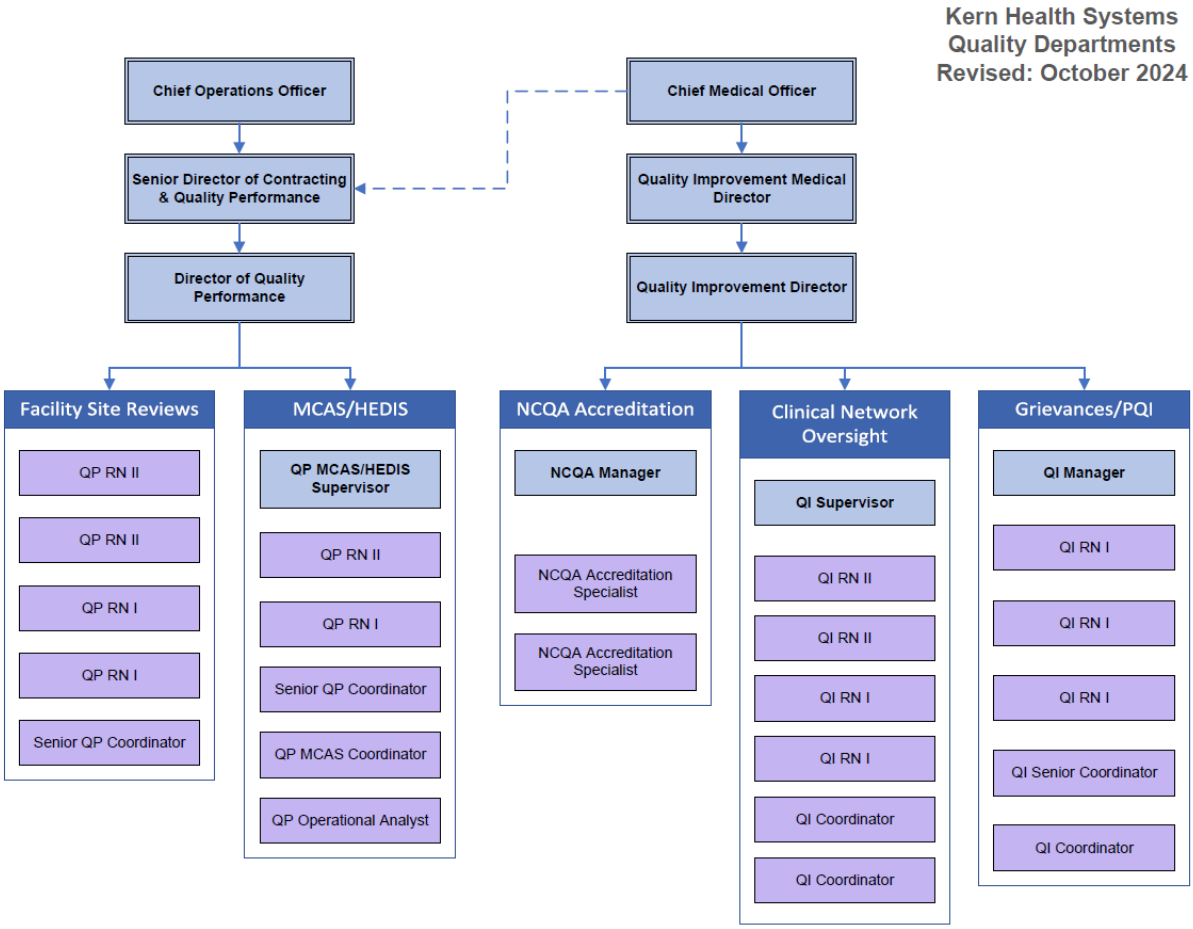
_____ Date _____

Director of Population Health Management

XV. Appendix

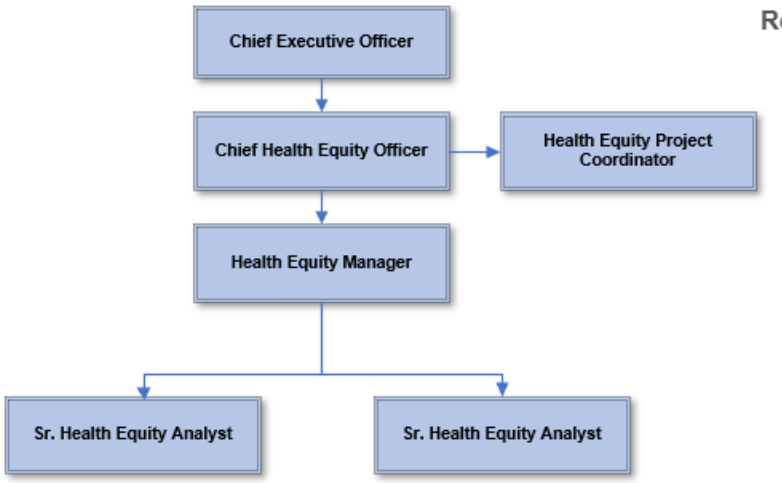
Appendix A: Population Needs Assessment October 2024

Appendix B: Quality Departments Organization Structure



Appendix C: Health Equity Office Organization Structure

Kern Health Systems
Health Equity Office
Revised: December 2024



Kern Health Systems Quality Improvement Annual Work Plan - 2025

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff
I. Quality Program Structure							
NCQA 1D	QIHE Governance	Conduct quarterly EQIHEC Meetings	No issues identified	Meet quorum of voting members at every meeting		12/31/2025	Quality Improvement Director & Health Equity Manager
NCQA 1C	Annual QI Evaluation of 2024	Summary of completed and ongoing QI activities, trending of results and overall evaluation of effectiveness	No issues identified	Annual approval by the EQIHEC and the BOD		4/17/2025	Quality Improvement Director
NCQA 1A	2025 Quality Improvement Health Equity Program Description	QIHE Program description of committee accountability, functional areas and responsibilities, reporting relationship, resources and analytical support	QI and HE Programs were previously two separate documents.	Annual approval by the EQIHEC and the BOD	Combine QI and HE Program documents and update for 2025	4/17/2025	Quality Improvement Director & Health Equity Manager
NCQA 1B	2025 Annual Quality Improvement Health Equity Work Plan	Yearly planned objectives and activities	No issues identified	Annual approval by the EQIHEC and the BOD		4/17/2025	Quality Improvement Director
DHCS	Policies and Procedures	Annual review of KHS Quality Improvement P&Ps	No issues identified	100% of policies reviewed and updated as needed		12/31/2025	Quality Improvement Director
NCQA	NCQA Health Plan Accreditation	Attain Health Plan Accreditation	Initial Accreditation	Attain Full Health Plan Accreditation by 1/1/2026		12/31/2025	Quality Improvement Director
NCQA	NCQA Health Equity Accreditation	Attain Health Equity Accreditation	Initial Accreditation	Attain Full Health Equity Accreditation by 1/1/2026		12/31/2025	Health Equity Manager
II. Quality of Clinical Care							
DHCS	MCAS Measures	AMR	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	BCS	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	CHL	Not Meeting MPL	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	CCS	Not Meeting MPL	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	CIS-10	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	CBP	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	DEV	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	IMA-2	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	LSC	Not Meeting MPL	Meet minimum performance levels (MPLs)	QI Senior Coordinators reached out to Top 10 provider that have less than 150 members to complete Lead Screening in Children before the 2 years of age (LSC)	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	FUA-30Day follow up	Not Meeting MPL	Meet minimum performance levels (MPLs)	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	FUM-30Day follow up	Not Meeting MPL	Meet minimum performance levels (MPLs)	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	HBD	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	PPC-Pre	Met MPL for MY2022/RY2023. Did not meet MPL for MY2023/RY 2024. No issue	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director

Kern Health Systems Quality Improvement Annual Work Plan - 2025

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff
DHCS	MCAS Measures	PPC-Post	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	TFL-CH	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	W30(0-15M)	Not Meeting MPL, but significant YOY improvement over the last two years.	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	W30(15-30M)	Not Meeting MPL, but significant YOY improvement over the last two years.	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	WCV	Not Meeting MPL, but significant YOY improvement over the last two years.	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	Clinical PIP: Focus on Health Equity, specific to the W30 0-15 months African American Population	2023-2026 performance improvement project (PIP) overseen by HSAG focused on increasing the number of children ages 0 - 15 months old with completing an annual well care visit.	Did not meet MPL for multiple measures in Children's Domain of Care	Use MY2023 W30 (0-15months) baseline data to develop PIP interventions and get Annual Approval by HSAG.		12/31/2025	Quality Performance Director
DHCS	Non-Clinical PIP: Specific to FUA and FUM measures	2023-2026 performance improvement project (PIP) overseen by HSAG focused on improving Behavioral Health measures throug provider notivications with in 7-days of the ER visit.	Did not meet MPL for FUA and FUM measures	Use MY2023 baseline data to develop interventions that includes a process for notifying PCPs of ED visits for eligible population. Annual Approval by HSAG		12/31/2025	Quality Performance Director
IHI/DHCS	Health Equity Sprint Collaborative	Completion of well-care visits for African-American babies and children for W30 and WCV MCAS measures	Did not meet MPL for WCV or W30	Utilize MY2023 data to develop strategic provider partnerships to improve compliance for targeted population	2 provider partnerships and 1 CBO partnership in support of well-care visits	4/1/2025	Quality Performance Director
III. Safety of Clinical Care							
	Patient Safety Program/Clinical Network Oversight	Conduct Quarterly Audits of select measures (IHA, Lead Screening, etc.)	Baseline monitoring. No system of tracking provider performances.	Conduct quarterly monitoring of provider performance	Conduct quarterly monitoring of provider performance	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director
DHCS	Potential Quality of Care Issue (PQI)	Monitoring of PQI volume month over month	No issues identified	<30/month	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director
DHCS	Potential Quality of Care Issue (PQI)	PQI Rates by Provider	Baseline monitoring	Baseline monitoring	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director
DHCS	Potential Quality of Care Issue (PQI)	PQI Rates by ethnicity, english as a second language, sexual orientation, gender identity	Baseline monitoring	Baseline monitoring	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director
DHCS	Potential Quality of Care Issue (PQI)	Timeliness of resolution	No issues identified	Within 120 calendar days	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director
DHCS	Facility Site Review	Conduct on site reviews at the time of initial credentialing or contracting, and every three years thereafter, as a requirement for participation in the California state Medi-Cal Managed Care (MMCD) Program	Issues were identified in Critical Elements while conducting FSR.	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	CSR will schedule and complete reviews timely.	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Performance Director

Kern Health Systems Quality Improvement Annual Work Plan - 2025

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff
DHCS	Physical Accessibility Review Survey (PARS)	Conduct PARS audit with FSR	No issues identified	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	QP Senior coorninator will schedule and complete all PARS due 2025	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Performance Director
DHCS	Medical Record Review	Conduct medical record review of practitioners due for facility site reviews	Previously identified issues from MRR: 1. Emergency contact not documented 2. Dental/Oral Assessment not documented 3. HIV infection screening not documented	Achieve medical record review score of 85% for each practitioner	CSR will schedule and complete reviews timely.	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Performance Director
	Drug Utilization Review	Treatment Authorization Request (TAR)	No issues identified	72 hrs for urgent, 5 days for routine	Continue quarterly monitoring & report findings to DUR	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Pharmacy Director
	Drug Utilization Review	Physician Administered Drugs (PAD)	No issues identified	72 hrs for urgent, 5 days for routine	Continue quarterly monitoring & report findings to DUR	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Pharmacy Director
NCQA	Credentialing/Recredentialing	Credential/recredential practitioners timely	No QOC trends for provider re-credentialing in 2024 to prevent moving forward from a QI perspective	100% timely credentialing/recredentialing of practitioners	Review of trends for Grievances and PQIs, QOC look back review 3 years	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Credentialing Manager
IV. Quality of Service							
DHCS	Grievance & Appeals	Timeliness of acknowledgement letters	No issues identified	90% Within 5 calendar days	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director
DHCS	Grievance & Appeals	Timeliness of resolution	No issues identified	90% within 30 calendar days and 72 hours for expedites	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director
DHCS	Access to Care - PCP	Urgent Care within 48 hours	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director
DHCS	Access to Care - PCP	Routine Care - 10 business days	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director
DHCS	Access to Care - SCP	Urgent Care within 48 hours	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director
DHCS	Access to Care - SCP	Routine Care - 15 business days	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director
DHCS	Telephone Access to Member Services	Speed of Answer	No issues identified	< 30 seconds	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director
DHCS	Telephone Access to Member Services	Call abandonment rate	No issues identified	< 5%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director
V. Member Experience							
	CAHPS Survey	Adult and Child Medicad Survey	Getting Needed Care scored lowest in the Adult Survey	Monitor CAHPS Resutls and establish basline for Getting Care needed measure	Trending report on CAHPS results by survey questions	12/31/2025	Member Engagement Manager

Kern Health Systems Quality Improvement Annual Work Plan - 2025

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff
VI. Provider Engagement							
	Provider Satisfaction Survey	Would Recommend	No issues identified	Maintain 98th Percentile	Report survey results to QIW annually	9/30/2025	Provider Network Management Director
	Provider Satisfaction Survey	Utilization and Quality Management	No issues identified	Maintain 97th Percentile	Report survey results to QIW annually	9/30/2025	Provider Network Management Director
	Provider Satisfaction Survey	Degree to which the plan covers and encourages preventive care and wellness	No issues identified	Maintain 96th Percentile	Report survey results to QIW annually	9/30/2025	Provider Network Management Director
	Provider Education	Host at least one educational conference for Providers	No issues identified	Host one educational conference for Providers	Medical Management of Obesity for Primary Care Providers Conference	11/30/2025	Quality Improvement Medical Director

To: EQIHEC

From: Kailey Collier, Director of Quality Performance (QP)

Date: March 18, 2024

Re: Quality Performance Q1 2025 Report

Background

The QP team develops a quarterly report to outline, monitor, and evaluate our ongoing departmental activities. This report also serves as an opportunity for committee members to provide input regarding our work. This report reflects activities and outcomes for the first quarter of 2025.

Discussion

See page 2 of this document.

Fiscal Impact

The fiscal impact of not achieving and maintaining satisfactory MCAS rates may be severe to the health plan. This includes sanctions which may come in the form of monetary fines, reduction in default assignment, reduction in membership, and ultimately revocation of the plan from the Medi-Cal program. Another cost is utilization and increased costs of care associated with the lack of preventive care, that turns preventable conditions into chronic conditions. The ultimate cost is paid by the membership in the form of reduced health status and diminished quality of life. Access to high quality and equitable care is what MCAS drives, and what we as a plan are striving to deliver to the more than 400,000 lives we cover.

Requested Action

Review and approval of the report.

Quality Performance Department
Executive Summary
1st Quarter 2025

I. Facility Site Reviews (FSR) and Medical Record Review (MRR) (pages 2-9)

1 Initial Facility Site Reviews and 2 Initial Medical Record Reviews were completed in Q1 2025. 3 Periodic FSRs and 4 periodic MRRs were also completed. 100% of Facility Site Reviews passed and 95% YTD of Medical Record Reviews passed. 1 of 19 sites failed the first review, however Corrective Action Plans were completed and closed. QP also conducts mid-cycle interim reviews of facilities to monitor facility compliance. The QP department also conducts Physical Accessibility Review Surveys (PARS) and 13 were completed in Q1 2025.

II. Quality Improvement Projects (pages 10-11)

A. ***Performance Improvement Projects (PIPs)***

The current PIPs began in August 2023 and run through 2026. The first PIP is focused on the W30 MCAS measure, specific to Health Equity of the 0-15 months African American Population in Kern County. The second PIP is considered a non-clinical Behavioral Health PIP, specific to the FUA and FUM measures. We will be partnering with KHS' Behavioral Health Department to ensure success of this PIP. The first submission for both PIPs were approved by HSAG. We are currently in the second phase of the PIP, which focuses on interventions and testing. We have developed a provider notification process for ED visits related to Behavioral Health and Substance Use Disorders. For the W30 PIP, we are leveraging activities from mobile units and the IHI/DHCS collaborative focused on well-care visits for the 0-15 months, African American babies.

We are working with two pilot providers to increase adherence to well-child visits for African American babies ages 0-21 years of age. The Sprint Team responsible for the IHI collaborative is exploring opportunities to distribute member rewards for this population of focus for scheduling the visit. As part of the MERP, additional rewards are provided for closing the gaps in care. We have also identified a need for a single page handout for next steps following well care visits in children and adolescents.

III. Managed Care Accountability Set (MCAS) Updates (Pages 10-15)

The QP team continues with MCAS specific initiatives in support of improving all measures for current measurement year with a heavy focus on the Children's domain of care. As of March 2025, 13 of 18 measures have improved compared to last year. We are amid the annual MCAS audit and meeting MPL for 7 MCAS measures for MY2024. We are within 5% MPL for 6 additional measures. Comparative to MY2023, KHS met MPL for 8 of 18 measures and HPL for 1 of those measures. The audit will conclude in June 2025, and rates will continue to fluctuate.

KERN HEALTH SYSTEMS

QUALITY PERFORMANCE DEPARTMENT

QUARTERLY EQIHEC COMMIITTEE REPORT

Q1 2025

The purpose of this report is to provide a summary of the quarterly activities and outcomes for the QI department. It provides a window into the performance of the Quality Improvement Program and Department. It serves as an opportunity for programmatic discussion and input from the QI-UM Committee members. Areas covered in the report include:

I. Facility Site & Medical Record Reviews
    A. Initial Site & Medical Record Reviews
    B. Periodic Site & Medical Record Reviews
    C. Critical Elements
    D. Initial Health Appointments (IHAs)
    E. Interim Reviews
    F. Follow-up Reviews Completed after Corrective Action Plans (CAPs)

II. Quality Improvement Projects
    A. Performance Improvement Projects (PIPs)
    B. Red Tier & Strike Team

V. Managed Care Accountability Set (MCAS) Updates

VI. Policy and Procedures

I. Facility Site Reviews (FSR) and Medical Record Review (MRR) Description:

Certified Site Reviewers perform a Facility Site Review on all contracted primary care provider sites (including OB/GYNs and pediatricians) as well as providers who serve a high volume of SPD beneficiaries. Per PL 14-004, certified site reviewers complete FSRs and MRRs for providers credentialed per DHCS and MMCD contractual and policy requirements.

An Initial Full Site Review (IFSR) is completed as part of the credentialing process on new providers at sites that have not previously been reviewed before being added to the KHS provider network. An IFSR is also completed when an existing KHS provider moves to a new site location. Approximately 3 months after the completion of an IFSR, an Initial Medical Record Review (IMRR) is conducted on sites other than Urgent Care (UC) Facilities. A passing FSR score is considered "current" if it is dated within the last three (3) years.

Subsequent Periodic Full Site Reviews (PFSRs) are conducted as part of the re-credentialing process for providers three (3) years after completion of the IFSR and every three (3) years thereafter.

Critical Elements:

Based on DHCS recommendation, changes were made and implemented to existing critical elements to align with the new tools and standards on 7/1/2022. Below is the updated list of critical elements related to the potential for adverse effect on patient health or safety, previously there were 9 now they are 14:

1. Exit doors and aisles are unobstructed and egress (escape) accessible.
2. Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag
3. Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of ESIP needles/syringes and alcohol wipes.
4. Only qualified/trained personnel retrieve, prepare, or administer medications.
5. Physician Review and follow-up of referral/consultation reports and diagnostic test results
6. Only lawfully authorized persons dispense drugs to patients.
7. Drugs and Vaccines are prepared and drawn only prior to administration.
8. Personal Protective Equipment (PPE) for Standard Precautions is readily available for staff use.

9. Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport, or shipping.
10. Needlestick safety precautions are practiced on site.
11. Cold chemical sterilization/high level disinfection: a) Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.
12. Cold chemical sterilization/high level disinfection: c) Appropriate PPE is available, exposure control plan, Material Safety Data Sheets and clean up instructions in the event of a cold chemical sterilant spill.
13. Autoclave/steam sterilization c) Spore testing of autoclave/steam sterilizer with documented results (at least monthly)
14. Autoclave/steam sterilization Management of positive mechanical, chemical, and biological indicators of the sterilization process.

Scoring and Corrective Action Plans

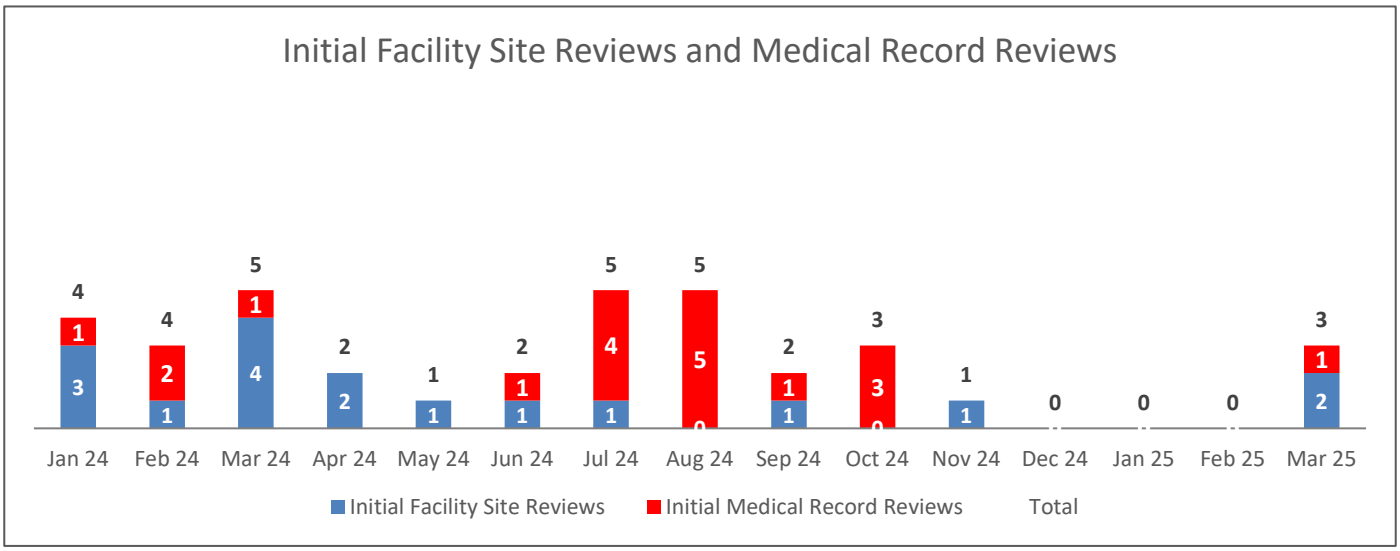
Provider sites that receive an FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are required to complete a CAP addressing each of the noted deficiencies. The compliance level categories for both the FSR and MRR are as listed below:

Exempted Pass: 90% or above.
Conditional Pass: 80-89%
Not Pass: below 80%

Corrective Action Plans (CAPs)

A CAP is issued when an initial, periodic, or focus review has deficiencies identified. DHCS requires follow up at 10 days for failure of any critical element, follow up for other failed elements at 30 days, and if not corrected by the 30 day follow up, at 90 days after a CAP has been issued. Most CAPs issued are corrected and completed within the 30 Day follow up period. Providers are encouraged to speak with us if they have questions or encounter issues with CAP completion. QI nurses provide education and support during the CAP resolution process.

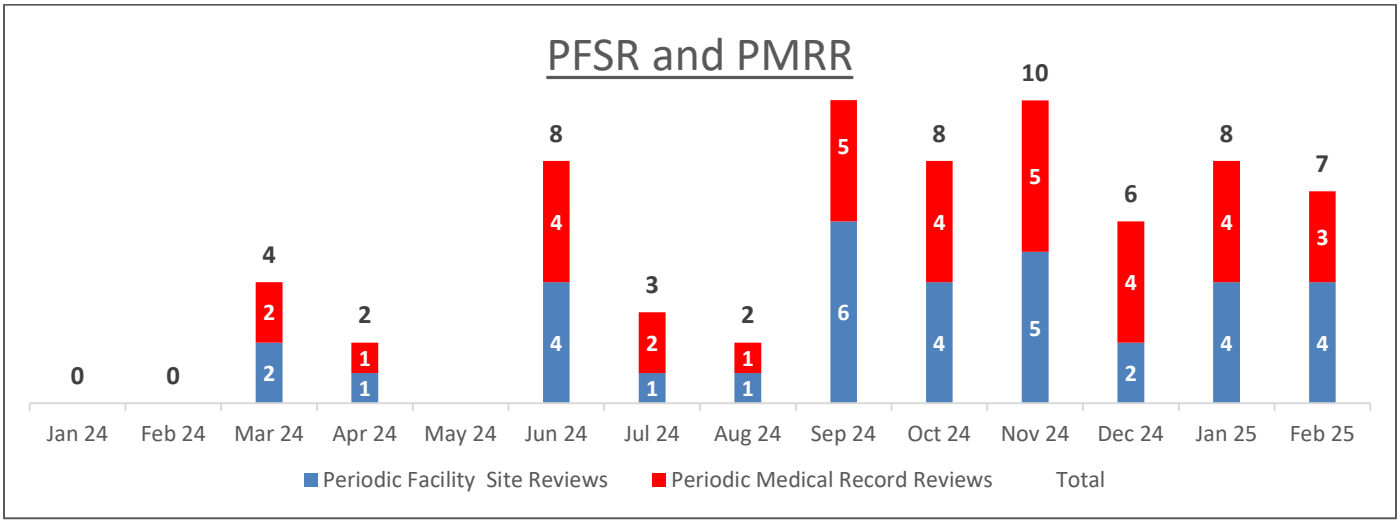
A. Initial Facility Site Review and Medical Record Review Results:



The number of initial site and medical record reviews is determined by the number of new providers requesting to join KHS' provider network. There were 2 IFSRs and 1 IMRR completed in Q1 of 2025.

B. Periodic Full Site and Medical Record Reviews

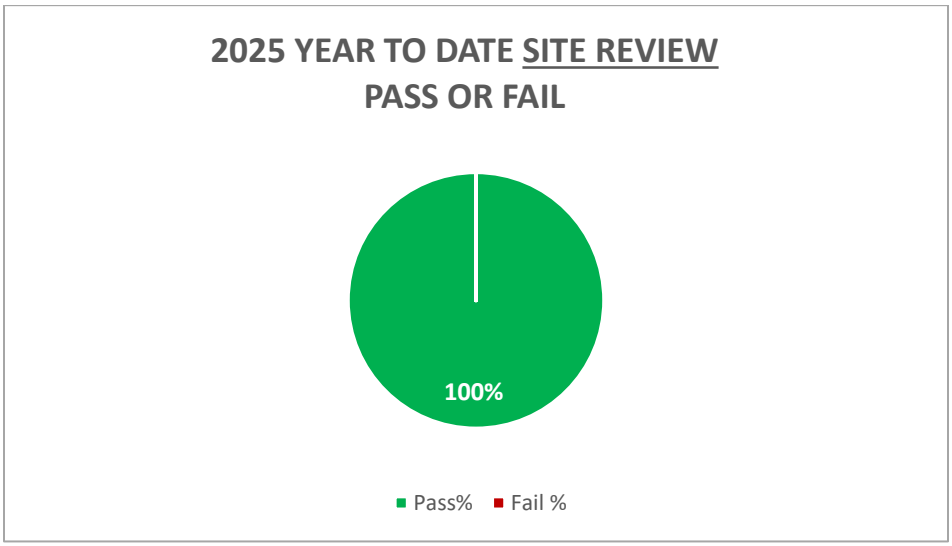
Periodic reviews are required every 3 years. The due date for Periodic FSRs is based on the last Initial or Periodic FSR that was completed. The volume of Periodic Reviews is not controlled by KHS. It is based on the frequency dictated by DHCS.



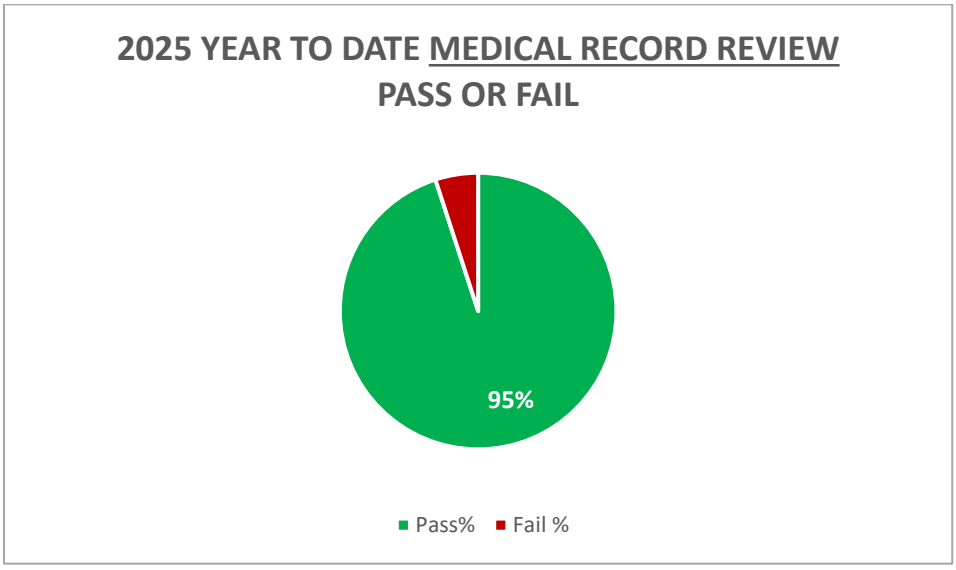
The above chart reflects the number of Periodic Full Site Reviews and Medical Record Reviews that were due and completed for each quarter.

Year to Date (YTD) Initial and Periodic FSR Pass or Fail Rate:

Based on DHCS' standard 80% or higher is considered as passed. Scoring 80% - 89% is considered a "conditional pass" and requires a CAP only for the elements that were non-compliant. A score below 80% is considered a Fail and requires a CAP for the entire site or medical record review.



For 2025 YTD, 100% of the Initial and Periodic site reviews performed passed. YTD there were 5 site reviews completed by the end of February 2025.



For 2025 YTD, 95% of the Initial and Periodic medical record reviews performed passed. YTD there were 19 medial record reviews completed, 1 of these reviews failed in the first audit. However, following the failed review, additional education was provided, and CAPs were issued to correct deficiencies.

For Q1 2025, top #3 deficiencies identified for Opportunities for improvement in site reviews are:

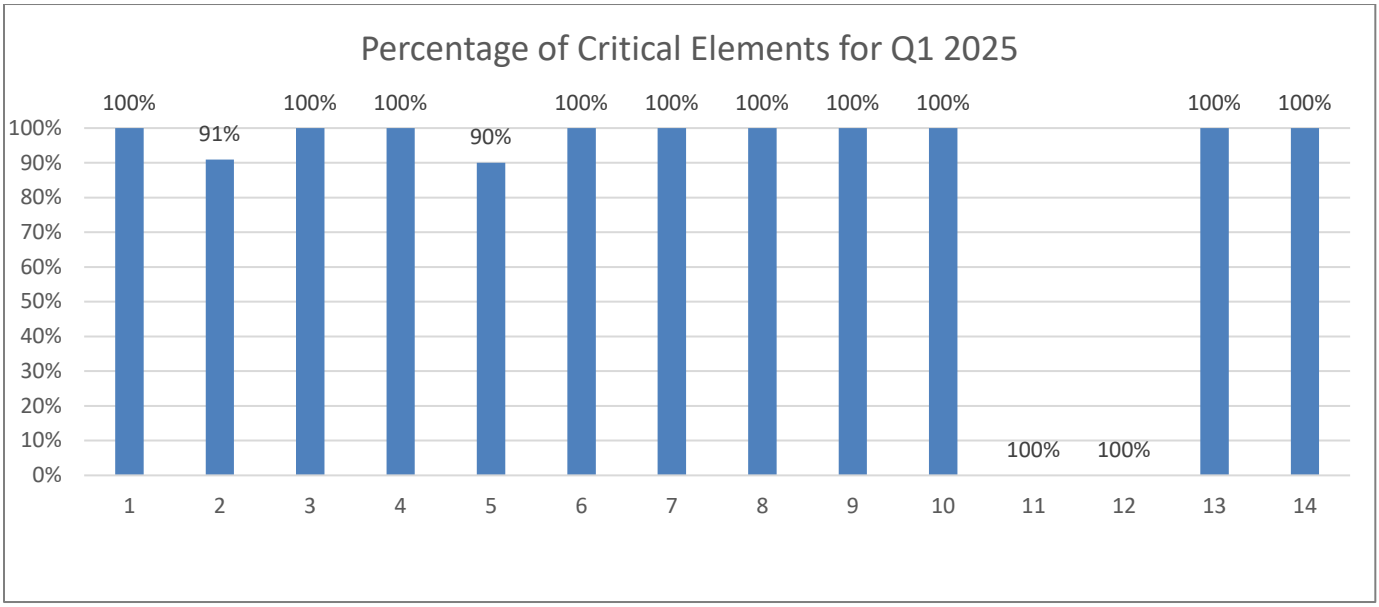
1. Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu-bag; Ambu – bag masks were not functioning properly.
2. Stethoscope and sphygmomanometer with various size cuffs are missing one size
3. Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons; Sign on door was not in English and Spanish.

For Q1 2025, the top #3 deficiencies identified for Opportunities for improvement in Medical Record Reviews are:

1. Hepatitis B Virus Screenings are not being completed for both pediatrics and adults.
2. HIV Screening are not being completed for both adults and pediatrics.
3. Folic Acid supplementation is not being screened or supplemented.

Education was provided regarding these deficiencies. We will continue to monitor for any trends.

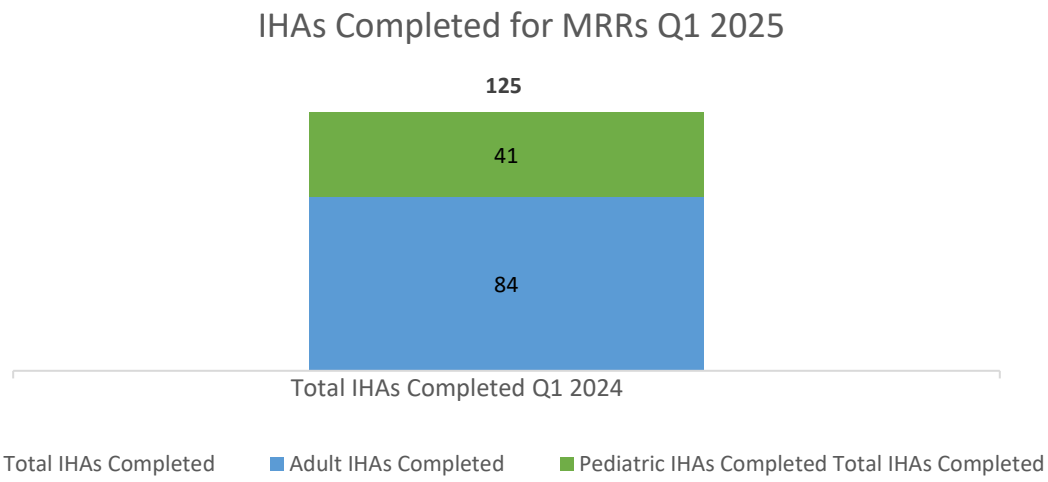
C. Critical Elements (CE) Percentage for Site Reviews:



There were 11 FSRs completed for Q1 2025, and 10 sites have passed the critical elements.

The site review team is working closely with site that failed their Critical Elements by proving ongoing education to ensure compliance. CAPs were issued to correct deficiencies.

D. IHA's percentage for MRRs:



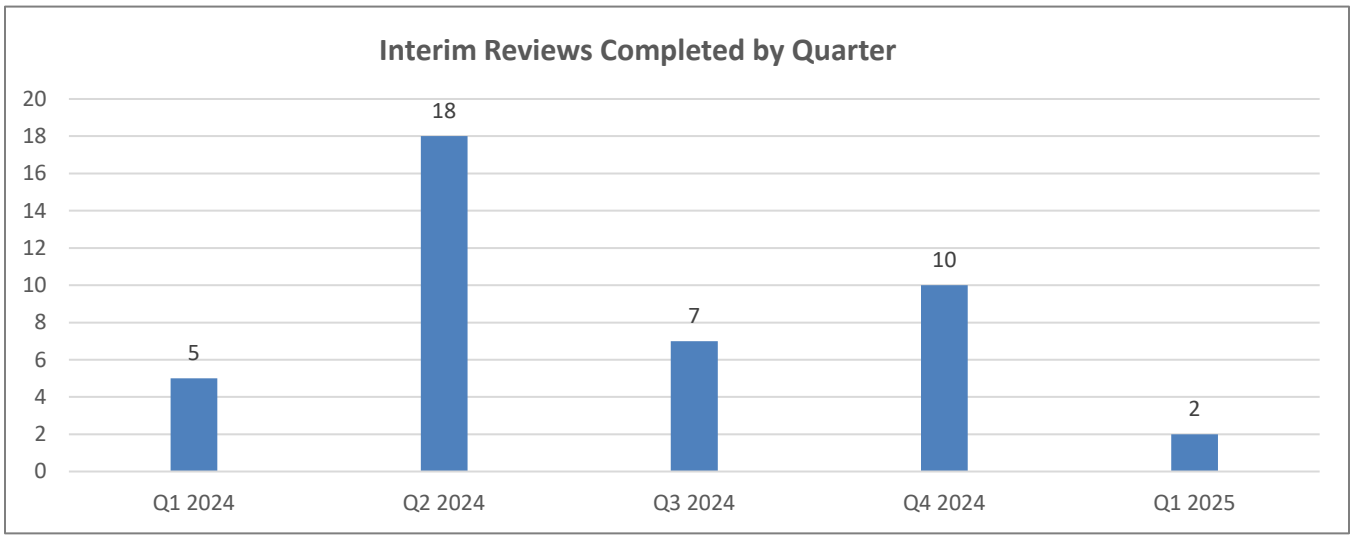
For Q1 2025, based on the medical record reviews, 125 IHA's were completed. 41 total pediatric charts and 84 adult charts. 34 out of the 41 pediatric charts were compliant and 7 were non-compliant. Out of all the 84 Adult charts, 62 adult charts were found to be compliant and 22 were non-compliant. Education was provided for the non-complaint charts.

Effective January 2023, an Initial Health Appointment replaced the Initial Health Assessment. Changes to the IHA no longer requires providers to utilize the age-appropriate Staying Healthy Assessment (SHA). An IHA must include all the following:

- A history of the Member's physical and mental health.
- An identification of risks.
- An assessment of need for preventive screens or services.
- Health education; and
- The diagnosis and plan for treatment of any diseases.

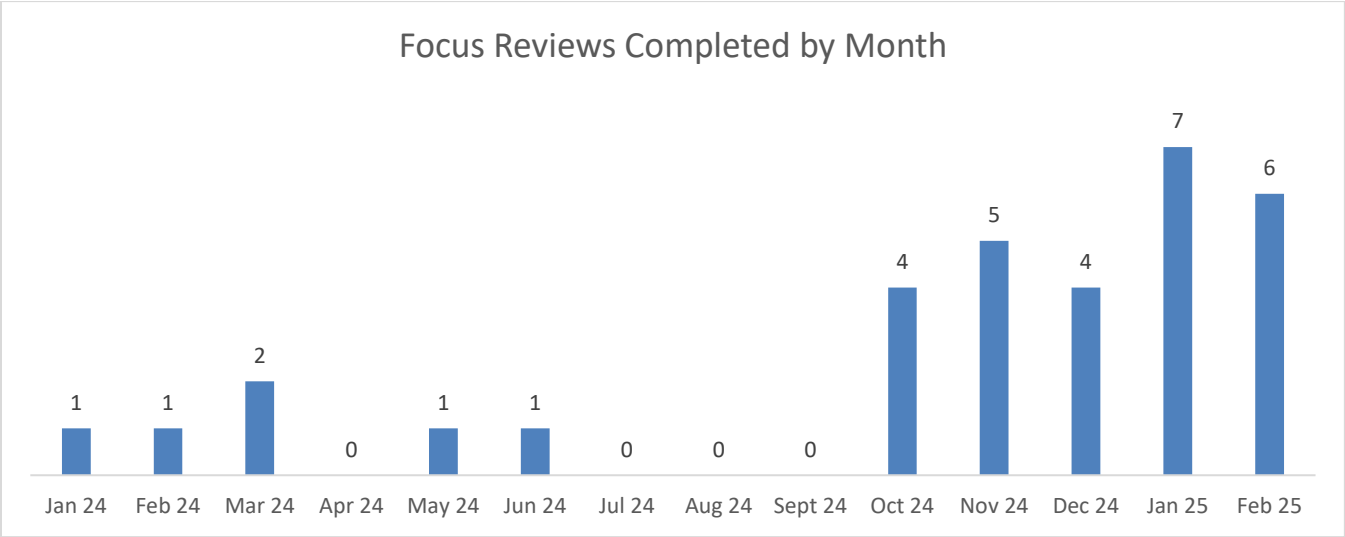
E. Interim Reviews:

Interim Reviews are conducted between Initial and first Periodic Full Site Reviews or between two Periodic Full Site Reviews. Typically, they occur about every 18 months. These reviews are intended to be a check-in to ensure the provider is compliant with the 14 critical elements and as a follow up for any areas found to be non-compliant in the previous Initial or Periodic Full Site Review.



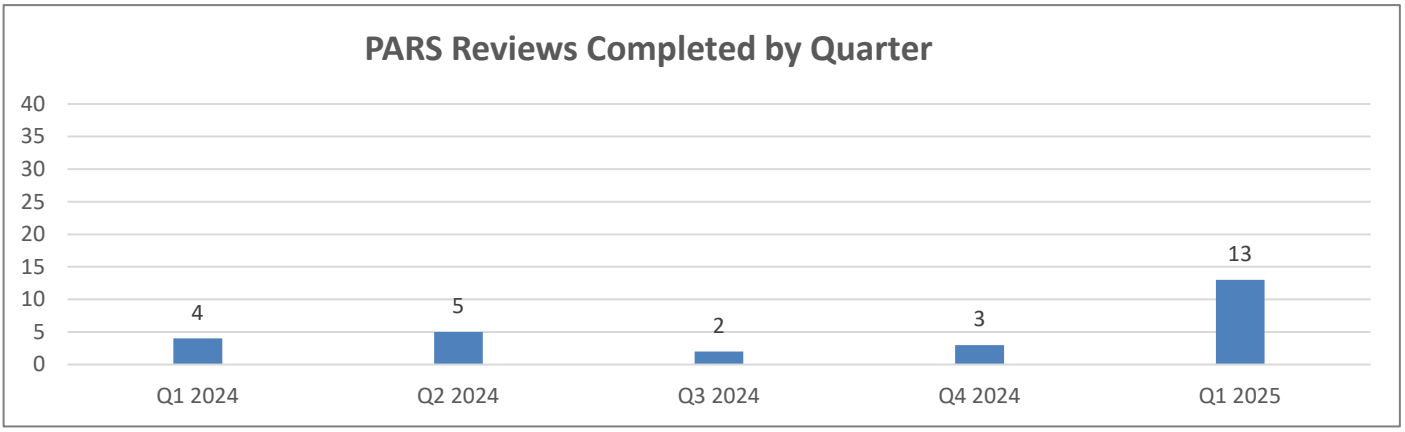
For the Q1 2025, there were 2 Interim reviews completed.

F. Focus Reviews: Focused reviews are conducted when a site fails their review as a follow up to ensure elements are maintained. The focused review consists of FSR and MRR elements and is completed within 3-6 months of the failed review. For Q1 2025, we had 13 Focused MRRs completed YTD.



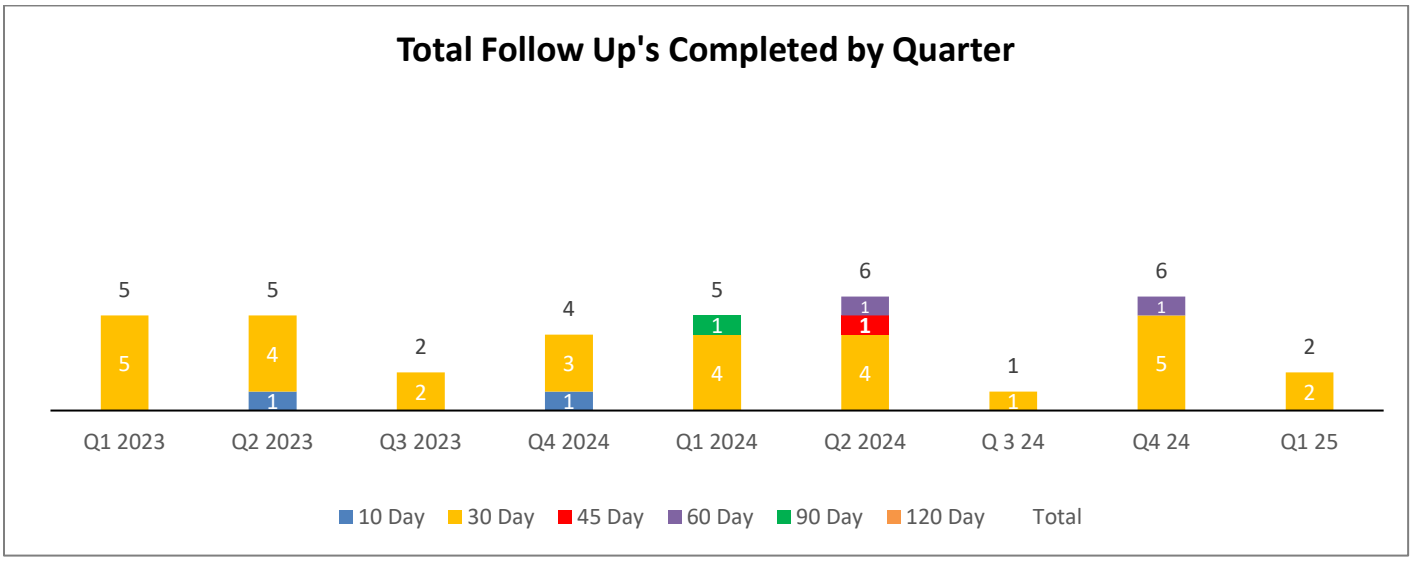
G. Physical Accessibility Review Survey (PARS):

PARS is completed alongside Initial Reviews, and the purpose is to review the accessibility of the site. PARS are completed every 3 years unless an Attestation is completed.



For Q1 2024, 13 PARS were completed.

H. Follow-up Reviews after a Corrective Action Plan (CAP):



The above chart reflects the total number of follow-ups completed for each quarter. For Q3 2024, there were 2 30-day follow-ups completed.

II. Quality Improvement Projects:

A. Performance Improvement Projects (PIPs):

The Department of Health Care Services (DHCS) requires MCPs to annually report performance measurement results and conduct ongoing Performance Improvement Projects (PIPs) specific to measures that did not meet MPL.

Clinical PIP:

The new cycle of PIPs began in August 2023 and runs through 2026. The clinical PIP will be focused on Health Equity, specific to the W30 0-15 months African American population.

> The PIP team Attended 2 Maternal Health Disparities Webinars. Participated in the maternal health disparities webinars and met with PIP team leadership to plan our next steps. We have worked on developing a process map and completed key driver's diagram. All QI Tools completed, including Process Map, with aid from QP department, Member Services, and Member Outreach Marketing. Continued efforts on how to track data (member services outreach on W30, text reminders of WBVs, Mobile unit WBV events). Researching on obtaining race/ethnicity data and Black women's experiences in health care. Continued aiding in IHI-DHCS Children's Health Collaborative, which has crossover ideas with this PIP, attended Roundtable webinar for advancement of Adolescent Immunizations, which provided many resources and ideas for crossover use on this PIP. Working with BI to get data report. Brainstorming PDSA with Dr. Okezie's office after determining they have the highest ratio of eligible population to membership (after Dr. Dixon's office, which is already a pilot clinic for the IHI-DHCS Collab).

Non-Clinical PIP:

The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health department for support of interventions.

> We are partnering with the Behavioral Health Department, UM, PHM, and any other necessary stakeholders. We are working with BI, ADT report was previously updated to pull accurate data from ER visits due to SMH/SUD diagnosis report as per the PIP requirement. ADT report is now disseminated to KHS BH, OMNI, and CSV, in addition to Telehealth Docs. ADT report has been added to the 2D Provider Profile and is updated daily. Providers and KHS PNM are being educated on how to find this in the Provider Profile. Ongoing meetings are scheduled to ensure success and to remain

on track with deliverables. The PIP team is planning to meet with Kern Medical to discuss strategies for FUA/FUM measures.

The re-submission of the 2*nd* iteration of the Non-Clinical BH PIP was reviewed by HSAG and with a "level of low confidence for acceptable methodology". This improves from "no confidence" with the initial submission. HSAG provided feedback for questions regarding this result.

B. MCAS Initiatives

The purpose of this report is to provide an update on interventions put into place to improve the compliance rates of the MCAS measures.

Interventions to improve our performance in MCAS:

- Provider Touchpoint Updates:
    - Met with various scheduled and ad hoc provider groups to discuss rates, focus measures and questions.
        - Full overview of what MCAS is and what DHCS and KHS request from providers team.
        - Resources shared, in-service for fill staff requested and will be arranged with PNM
        - Full set of resources given, including Provider Guide, Coding Card, 2024 MCAS measures list, Member Rewards, and Transportation Benefits.
        - Touching base with providers via email and monthly meetings via teams
- Completed Intervention 4 of the Children's Health Collaborative with IHI and DHCS, collaborating with our pilot clinics to determine what community-based organization they'd like to move forward with in creating an educational project based on where their interests/passions lie.
- Collaborated with Health & Wellness Dept to develop educational text messages for W30 and WCV members regarding well visits
- Completed final review and updates of the Provider Guide and Coding Card for MY2025, with leadership sign off and hand off to Marketing team for updates to the KHS external website
- Contributed an article to Health & Wellness' Member Newsletter for Fall 2025: Importance on IMA and Well Child Visits.
- Alinea partnered with KHS in California City to complete member that have not completed their Breast Cancer Screening, March 1.
- Primary Valley Medical Group partnered with KHS to complete gaps in care for members in California City
- Member Services team is supporting calling applicable members that have a gap in care to schedule their appointment with PCP.
- Member Engagement Reward Program (MERP) Campaigns:
    - IHA
    - BCS

    - CCS
    - CHL
    - GDS (HBD)
    - LSC
    - PPC Pre/ Post
    - W30
    - WCV
  - Text Messages to members encouraging to schedule their appointments for gaps in care with a focus on:
    - Breast Cancer Screening
    - Blood Lead Screening
    - Initial Health Appointment
    - Chlamydia Screening
    - Cervical Cancer Screening
    - Hemoglobin A1c
    - Prenatal & Postpartum Care
    - Well-Care Visits
    - Well-Baby Visits in first 30 Months of Life
  - Targeted efforts for BCS text messaging for the month January.
  - Robocalls will be sent out to members that do not receive text messages.

III. Managed Care Accountability Set (MCAS) Updates (also referred to as HEDIS):

For MY2024 MCAS Reporting:

- MCAS audit is in progress through end of May
- Currently meeting MPL for 6 out of 18 measures (Preliminary Rates):
  - AMR, BCS-E, CHL, IMA-2, LSC and PPC-Pre
  - Within 5% of MPL for 6 additional measures

- Time spent setting up and training with temp abstractor nurses with EMRs and software to perform abstractions of MCAS audit medical records, as well as answering clinical and process questions as the audit progressed in its first month, and over-reads of the abstractions.

	Measure	Admin/Hybrid/ECDS	MY2023 Rate	MPL Rate	HPL Rate	MY2023 Rate vs MPL	Hits Needed	MY 2022 Rate	MY 2022 vs MY2023
Behavioral Health Domain Measures									
FUM	Follow-Up After ED Visit for Mental Illness – 30 days*	Administrative	19.12	54.87	73.26	-35.75	226	18.80	▲ 0.32
FUA	Follow-Up After ED Visit for Substance Abuse – 30 days*	Administrative	18.85	36.34	53.44	-17.49	229	15.74	▲ 3.11
Children's Health Domain Measures									
WCV	Child and Adolescent Well – Care Visits*	Administrative	46.55	48.07	61.15	-1.52	1936	40.64	▲ 5.91
CIS-10	Childhood Immunization Status – Combination 10*	Hybrid/Admin**	24.82	30.9	45.26	-6.08	25	27.98	▼ -3.16
DEV	Developmental Screening in the First Three Years of Life	Administrative	25.94	34.70	N/A	-8.76	1163	13.47	▲ 12.47
IMA-2	Immunizations for Adolescents – Combination 2*	Hybrid/Admin**	34.31	34.31	48.8	0.00	0	29.68	▲ 4.63
LSC	Lead Screening in Children	Hybrid/Admin**	58.64	62.79	79.26	-4.15	17	47.45	▲ 11.19
TFL-CH	Topical Fluoride for Children	Administrative	16.44	19.30	N/A	-2.86	3829	12.27	▲ 4.17
W30-6+	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	Administrative	39.21	58.38	68.09	-19.17	570	37.12	▲ 2.09
W30-2+	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits*	Administrative	63.74	66.76	77.78	-3.02	171	55.12	▲ 8.62
Chronic Disease Management Domain Measures									
AMR	Asthma Medication Ratio*	Administrative	71.20	65.61	75.92	5.59	0	69.48	▲ 1.72
CBP	Controlling High Blood Pressure*	Hybrid/Admin**	65.21	61.31	72.22	3.90	0	60.58	▲ 4.63
HBD	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	Hybrid/Admin**	32.85	37.96	29.44	5.11	0	39.17	▲ -6.32
Reproductive Health Domain Measures									
CHL	Chlamydia Screening in Women	Administrative	56.87	56.04	67.39	0.83	0	53.67	▲ 3.20
PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	Hybrid/Admin**	87.10	84.23	91.07	2.87	0	87.35	▼ -0.25
PPC-Pst	Prenatal and Postpartum Care: Postpartum Care*	Hybrid/Admin**	86.37	78.1	84.59	8.27	0	83.94	▲ 2.43
Cancer Prevention Domain Measures									
BCS-E	Breast Cancer Screening*	ECDS & Admin***	59.30	52.60	62.67	6.70	0	56.68	▲ 2.62
CCS	Cervical Cancer Screening	Hybrid/Admin**	57.18	57.11	66.48	0.07	0	52.80	▲ 4.38

* Measures must be stratified by race/ethnicity per NCQA categorizations.

** Hybrid/Admin: MCPs/PSPs have the option to choose the methodology for reporting applicable measure rates

	Measure Met MPL
	Measure Met HPL
▲	Measure increased compared to last year same time
▼	Measure decreased compared to last year same time

The below chart displays trending rates for MY2024 and MY2025:

MCAS MY2024 & MY2025 Performance Trending Metrics

Measure	Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	2024	70.00%	▼77.54%	75.46%	74.40%	75.00%	75.96%	74.79%	73.99%	73.35%	73.16%	72.32%	71.66%
	2025	52.94%	▲78.89%										
BCS	2024	44.23%	▲45.63%	47.44%	48.73%	50.08%	51.42%	52.66%	54.29%	55.56%	56.51%	57.69%	58.61%
	2025	42.70%	▼44.52%										
CBP	2024	9.26%	▼18.53%	25.05%	29.78%	33.20%	39.86%	43.20%	44.26%	45.40%	46.51%	47.43%	48.39%
	2025	10.99%	▲22.56%										
CCS	2024	37.99%	▼36.76%	38.23%	39.55%	40.91%	42.09%	46.05%	47.50%	48.49%	49.70%	50.69%	51.71%
	2025	45.72%	▲46.22%										
CDEV	2024	6.26%	▼ 9.14%	11.74%	13.71%	15.54%	17.08%	18.38%	19.15%	19.67%	20.64%	20.84%	20.93%
	2025	7.42%	▲10.97%										
CHL	2024	22.15%	▼33.05%	35.23%	37.90%	39.96%	45.63%	48.75%	51.25%	52.92%	54.37%	55.75%	57.05%
	2025	25.79%	▲34.17%										
CIS-10	2024	10.01%	▼11.62%	12.17%	12.53%	12.42%	13.04%	13.14%	18.61%	18.77%	19.03%	19.33%	19.45%
	2025	10.61%	▲12.47%										
FUA 30Day follow up	2024	20.00%	▼16.11%	20.59%	19.96%	18.78%	21.75%	23.36%	24.71%	24.11%	23.16%	23.13%	23.34%
	2025	0.00%	▲22.73%										
FUM 30Day follow up	2024	9.09%	▲25.00%	21.88%	17.86%	15.56%	18.68%	19.49%	19.38%	18.69%	20.53%	21.45%	20.72%
	2025	0.00%	▼20.00%										
GSD*	2024	98.80%	▼93.82%	87.06%	79.96%	75.10%	71.29%	67.58%	66.51%	62.65%	61.58%	59.61%	54.41%
	2025	98.21%	▲96.77%										
IMA-2	2024	20.41%	▼21.78%	23.08%	24.49%	25.82%	27.71%	29.52%	32.00%	32.88%	33.54%	34.05%	34.25%
	2025	23.52%	▲25.63%										
LSC	2024	54.60%	▼57.84%	60.05%	62.04%	63.05%	64.95%	66.60%	67.25%	67.90%	68.60%	68.96%	69.11%
	2025	64.57	▲67.38%										
PPC-Pre	2024	25.10%	▼26.84%	28.68%	30.70%	33.22%	37.55%	43.83%	46.35%	48.18%	49.63%	49.44%	49.27%
	2025	27.34%	▲30.00%										
PPC-Post	2024	47.47%	▼52.40%	57.47%	59.72%	61.74%	63.16%	64.76%	64.28%	64.62%	71.15%	74.06%	74.66%
	2025	53.97%	▲59.25%										
TFL-CH	2024	14.64%	▲17.16%	20.65%	23.68%	26.00%	29.18%	31.71%	33.47%	35.76%	37.77%	39.36%	39.53%
	2025	16.98%	▼16.82%										
W30 (0-15M)	2024	24.72%	▲29.30%	34.04%	37.92%	41.33%	44.51%	47.26%	49.52%	51.70%	53.09%	53.62%	52.20%
	2025	21.56%	▼24.94%										
W30 (15-30M)	2024	51.49%	▼54.30%	56.86%	59.32%	61.71%	63.56%	64.36%	65.26%	66.12%	66.53%	66.71%	65.87%
	2025	53.86%	▲57.50%										
WCV	2024	2.80%	▼ 6.13%	10.59%	15.01%	19.77%	24.31%	29.14%	34.53%	38.73%	43.19%	46.72%	49.77%
	2025	2.75%	▲ 6.25%										

GSD* is an inverse measure, where a lower rate indicates better performance.
Please note the above rates are based on admin and supplemental data, they do not include medical record review.

- Green arrow indicates an increase compared to previous year.
- Red arrow indicates a decrease compared to previous year.

As of March 2025, **13 out of 18 measures showed improvement** compared to this month last year:

- AMR - Asthma Medication Ratio
- CBP- Controlling High Blood Pressure <140/90 mm Hg.
- CCS - Cervical Cancer Screening
- CDEV- Developmental Screening in the First 3 Years of Life
- CHL- Chlamydia Screening in Women Ages 16 – 24
- CIS-10- Childhood Immunization Status- Combo 10
- FUA- Follow-Up After Emergency Department Visit for Substance Abuse
- IMA-2- Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)
- LSC- Lead Screening in Children
- PPV- Pre- Prenatal & Postpartum Care –Prenatal Care
- PPC-Post- Prenatal & Postpartum Care – Postpartum Care
- W30 (15-30M)- Well Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.
- WCV- Child and Adolescent Well-Care Visits

5 Measure that have not shown improvement compared to this month last year:

- BCS- Breast Cancer Screening
- FUM- Follow-Up After Emergency Department Visit for Mental Illness
- GSD- Glycemic Status Assessment for Patients with Diabetes
- TFL-CH- Topical Fluoride for Children
- W30- (0-15M)- Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.

Please note we identified a significant decrease in W30 (0-15 months) rate for June 2024, BI is looking at the issue.

IV. Policy Updates: There were no policy updates in Q1 2025.

KERN HEALTH SYSTEMS

Quality Performance

MCAS

Kailey Collier
Director of Quality Performance

MCAS MY2025 vs. MY2024

Improvements and Highlights

- Currently meeting MPL for 6 out of 18 measures:
  - PPC-Pre, IMA, LSC, AMR, BCS-E, CHL
- Within 5% of MPL for 6 additional measures
  - CCS, CIS-10, W30(15-30), WCV, TFL-CH, PPC-Post
- 9 out of 18 measures showing improvement compared to previous year.

KHS MCAS MY2025 vs. MY2024

- 8 measures are trending higher than the previous year at the same point in time.
- Multiple measures in children's domain continue to reflect improvement

MY2025 Trending Performance

AMR	BCSE	CBP	CCS	CDEV	CHL Adults and Peds
79.89%	44.71%	22.81%	46.34%	11.17%	34.48%
HITS FOR MPL (26)	*HITS FOR MPL 1,579*	*HITS FOR MPL 11,417*	*HITS FOR MPL 7,226*	*HITS FOR MPL 3,244*	*HITS FOR MPL 1,039*
+4.19 % change	-2.73 % change	-2.24 % change	+8.11 % change	-0.69 % change	-0.74 % change
Mar'24 75.70%	Mar'24 47.44%	Mar'24 25.05%	Mar'24 38.23%	Mar'24 11.86%	Mar'24 35.23%

CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	GSD HBA1C >9%	IMA	LSC
12.46%	17.51%	13.55%	96.77%	25.69%	67.49%
HITS FOR MPL 1,248	*HITS FOR MPL 40*	*HITS FOR MPL 64*	*HITS FOR MPL 12,969*	*HITS FOR MPL 728*	*HITS FOR MPL (318)*
+0.30 % change	-2.75 % change	-8.33 % change	-10.81 % change	+2.61 % change	+7.44 % change
Mar'24 12.17%	Mar'24 20.27%	Mar'24 21.88%	Mar'24 85.96%	Mar'24 23.08%	Mar'24 60.05%

PPC Post	PPC Pre	TFLCH	W30 0 - 15 Months	W30 15 - 30 Months	WCV
59.83%	30.00%	16.86%	25.16%	57.43%	6.46%
HITS FOR MPL 407	*HITS FOR MPL 1,210*	*HITS FOR MPL 4,153*	*HITS FOR MPL 1,481*	*HITS FOR MPL 661*	*HITS FOR MPL 64,784*
+2.36 % change	+1.33 % change	-3.78 % change	-8.88 % change	+0.56 % change	-4.13 % change
Mar'24 57.47%	Mar'24 28.68%	Mar'24 20.65%	Mar'24 34.04%	Mar'24 56.86%	Mar'24 10.59%

KERN HEALTH SYSTEMS

KHS MCAS MY2025 Trending Rates

- Meeting MPL for 2 measures
- 1 measure within 5% of meeting MPL

MY2025 YTD Performance

AMR	BCSE	CBP	CCS	CDEV	CHL Adults and Peds
79.89%	44.71%	22.81%	46.34%	11.17%	34.48%
HITS FOR MPL (26)	*HITS FOR MPL 1,579*	*HITS FOR MPL 11,417*	*HITS FOR MPL 7,226*	*HITS FOR MPL 3,244*	*HITS FOR MPL 1,039*
MPL: 65.61% Over MPL by 14.28% AMR is not held to MPL.	MPL: 52.60% Under MPL by 7.89%	MPL: 61.31% Under MPL by 38.50%	MPL: 57.11% Under MPL by 10.77%	MPL: 34.70% Under MPL by 23.53%	MPL: 56.04% Under MPL by 21.56%

CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	GSD HBA1C >9%	IMA	LSC
12.46%	17.51%	13.55%	96.77%	25.69%	67.49%
HITS FOR MPL 1,248	*HITS FOR MPL 40*	*HITS FOR MPL 64*	*HITS FOR MPL 12,969*	*HITS FOR MPL 728*	*HITS FOR MPL (318)*
MPL: 30.90% Under MPL by 18.44%	MPL: 36.34% Under MPL by 18.83%	MPL: 54.87% Under MPL by 41.32%	MPL: 37.96% Under MPL by 58.81% Inverted Measure	MPL: 34.31% Under MPL by 8.62%	MPL: 62.79% Over MPL by 4.70%

PPC Post	PPC Pre	TFLCH	W30 0 - 15 Months	W30 15 - 30 Months	WCV
59.83%	30.00%	16.86%	25.16%	57.43%	6.46%
HITS FOR MPL 407	*HITS FOR MPL 1,210*	*HITS FOR MPL 4,153*	*HITS FOR MPL 1,481*	*HITS FOR MPL 661*	*HITS FOR MPL 64,784*
MPL: 78.10% Under MPL by 18.27%	MPL: 84.23% Under MPL by 54.23%	MPL: 19.30% Under MPL by 2.44%	MPL: 58.38% Under MPL by 33.22%	MPL: 66.76% Under MPL by 9.33%	MPL: 48.07% Under MPL by 41.61%

KERN HEALTH SYSTEMS

Performance Improvement Projects

- DHCS requires MCPs to annually report performance measurement results and conduct ongoing Performance Improvement Projects (PIPs) specific to measures that did not meet MPL.
- Current PIPs began in August 2023 and will run through 2026
  - The clinical PIP is focused on Health Equity, specific to the W30, 0-15 months African American population.
  - The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on BH and BI for support of interventions.

2025 Goals and Initiatives

Regulatory Projects

- 2 PIPs in place and on track with second annual submission
- IHI/DHCS Healthy Equity Sprint Collaborative led by QP
  - Focused on well-care visits for the African-American population
- Annual Quality Strategies and Action Items pending DHCS Nurse review
- DMHC released Health Equity Quality Measure Set (HEQMS). This prompted RFQ for additional NCQA auditor.
- Health Plan and Health Equity Accreditation action items

Collaborations

- Local Pediatrician offering weekend and after hours in support of well-child visits
- Mammogram event at local Oncology group in October
- Routine meetings with providers to discuss rates, challenges, barriers and/or accomplishments.
- In progress- API to allow direct appointment scheduling for with Endocrinologist
- Partnership with mobile mammography vendor to conduct women's event in East Kern
- Inaugural Quality Awards Dinner in October

Mobile Units

- Pharmacy provider offering routine vaccine events focused on children ages 2 and older.
- Large provider groups are operational and on track with grant milestones.
- Various initiatives partnering with school districts and community organizations
- Development of mobile mammogram event in East Kern in progress

Member Engagement

Member Engagement Rewards Program (MERP) Campaigns:

- Text Messages to members encouraging the scheduling of their appointments for gaps in care
- Targeted efforts for CCS, W30, and WCV text messaging
- Robocalls will be sent out to members that do not receive text messages.
- Geomapping insights leveraged to drive location of events and targeted population

KERN HEALTH SYSTEMS

FOR ADDITIONAL INFORMATION, PLEASE CONTACT:

Kailey Collier
Director of Quality Performance

To: EQIHEC

From: Pawan Gill, Health Equity Manager

Date: March 18, 2025

Re: HEO/HETSC Update

Background:

The Medi-Cal Managed Care Plan Health Equity Office Program is defined by the Health Equity Program Description and the Health Equity Program Workplan. The program descriptions for the Health Equity Office and the Quality Improvement Program were combined in 2025 to form the QIHE Program Description which was presented for review and approval by the Quality Improvement Dept. The 2025 HEO workplan is presented separately for review, discussion and approval. The 2024 Annual Report for the HEO is also included for your review.

The JEDI Charter is part of the HEO Program Description and is an integral part of the HEO strategy and our NCQA Health Equity Accreditation efforts. The responsibilities of the JEDI Committee have been explicitly expanded to include providing input and recommendations that help support efforts to ensure internal & external KHS committees have diverse representation where appropriate. A redline version of the charter updates are included for review.

Discussion Items:

- 2025 QIHE Program Description
- 2025 JEDI Charter Updates – Charter amended to expand JEDI's responsibilities to include assisting in reviewing and supporting the recruitment of diverse committee members for internal and/or external committees where appropriate – NCQA HEA
- 2024 HEO Annual Report
- HEO/HETSC Updates - Presentation

Fiscal Impact:

None.

Requested Action:

2025 HEO Workplan – Review & Approve
JEDI Charter updates - Review & Approve
2024 HEO Annual Report – Receive & File

2024 Health Equity Office - Strategic Roadmap

GOAL	OBJECTIVE	RESPONSIBLE PERSON(S)	ACTIVITIES/INTERVENTIONS	MEASURE(S)	TIMEFRAME	TARGET %	PREVIOUSLY IDENTIFIED ISSUE	
MEMBER DOMAIN (45%)								
Focus on member wellness, prevention, reducing health disparity and quality improvement/performance								
Create and maintain a comprehensive report of all organizational wide health equity related programs and interventions to better inform development of key programs and initiatives	Identify, track & report organizational wide, HE related targeted interventions/programs and develop effective tracking mechanism to capture and report health equity related programming	HEO Manager	Create tracking sheet of all targeted interventions including lead dept, focus population, etc.	HETSC reviews organization-wide targeted intervention and discuss engagement strategy for existing pro	Q2	90%	Yes	process measure
Enhance organizational workflows to improve the effectiveness of designed interventions in service of members	Create organization process flow that formalizes HEO engagement in initial design phase of developing targeted interventions or programs	HEO Manager	Create template and process for launch of new health equity related intiatives	Completion of template; review at HETSC & EQIHEC	Q3-Q4	80%	Yes	
Member Needs Assessment	Conduct an annual member needs assessment. Identified gaps in the provider network will be addressed through the recommendations of the Network Adequacy Committee.	Director of Provider Network Management	Run report to assess needs of members. Review with stakeholders. Adjust provider network as necessary.	Percentage increase of providers; # of findings taken to NAC	Q1-Q2	100%	No	
Collection of Providers' Race/Ethnicity Demographic Data	Expand and increase data integrity and reportability related to the the Collection of Provider's Demographic data to enable more effective decision making	Director of Provider Network Management & HEO Manager	Run current report, identify areas of opportunity to validate & update existing data and expand data collection	# of providers with updated demographic collection categories, data sharing capabilities etc	Q1	88%	Yes	
Share CLAS Progress with Stakeholders	Share CLAS progress with stakeholders, including obtaining MHC distinction	Sr Director of Wellness & Prevention	Share with Stakeholders		Q2-Q3	100%	Yes	
Annual evaluation of the CLAS program	Conduct annual evaluation of the CLAS program	Sr Director of Wellness & Prevention	Share with Stakeholders Identify and address areas for improvement	# of actionable items taken to committee; # of actions taken to address gaps	Q2-Q3	100%	Yes	
Improve tracking mechanism of grievances	Enhance current tracking mechanism to capture and easily report types of grievances (particularly discrimination related) and monitor regularly to identify trends	Complaints and Grievances Manager & HEO	Assess current report, add necessary columns and include in HESTC report	Create tracking mechanism with a minmum 2 year look back to establish initial tracking mechanism for grievances with a focus on HE	Q4	80%	No	
Assessment of member experience with Language Resources	Assess baseline of member experience with language resources	Director of Member Services	Run Annual Report Share with Stakeholders Identify and address areas for improvement	# of actionable items taken to committee; # of actions taken to address gaps	Q1 & Q3	100%	No	
						92%		
PROVIDER DOMAIN (15%)								
Provide training, programmatic support and incentives ato provider network to ensure the delivery of quality care to all members								
Multicultural Practices Provider Survey	Assessss provider cultural responsiveness. Additional goals and objectives with a timetable for implementation are documented in the C&L	Director of Provider Network Management	Conduct Survey Review results Adjust provider network and/ or address gaps	# of actionable items taken to committee; # of actions taken to address gaps	Q1-Q2	100%	No	
Assess KHS Provider Network Language Capabilities	Assessss provider language capabilities to that of the KHS member language needs.	Director, Member Services	needs of members. Review with stakeholders. Add to Provider Directory	By December 31, 2024, KHS will increase language access through translation and/or interpreter services to at least 20 events where specific language needs are determined.	Q3-Q4	94%	No	
Provider Training on Language Resources	Offer KHS contracted providers access and availability of language assistance resources	Director Member Services	Run report to assess needs of members. Review with stakeholders.	HEO to review current provider resources available to providers re: language assistance resources - expand current offerings	Q3-Q4	95%	No	
Collection of Providers' Race/Ethnicity Demographic Data	Assess provider's race/ethnicity demographic profile to that of the member race/ethnicity profile	Director of Provider Network Management	Assess race/ethnicity profiles of providers to members Review reports with stakeholders. Take corrective actions	Initial measurement: Meet with at least 2 districts; Once launched measures will be performance based on specific intervention	Q2-Q3	100%	No	
Doula Benefit Implementation	Launch & implement Doula Benefit & Program to asa party of the Birthing Care Pathway to help reduce maternal morbiidy and mortality and address the significant racial and ethnic disparities among Black, American Indian/Alaska native, and Paciifc Islander Individuals	PHM Director & HEO Manager	Establish Doula program by training and onboarding providers; support pathways to Doula training to meet demands and communicate Program benefit to memebers	# of contracxed providers; # of educatoinal and/or training opportunities to expand program with providers & members; # of target population enrolled in Doula program	Q1-Q4	80%	Bi	
EPT Program Administration	Adminstor and support 12 selected Equity Practice Transformation Program participants with EPT program deliverables - 2025 Program Year (Cycle 2, 3 Milestone Completion)	HEO Manager	EPT Program Support; Work with practices to meet established 2025 DHCS milestones and deliverables	Completion of established milestones and deliverables pursuant to DHCS guidelines	Q1-Q4	100%	No	
						94%		
COMMUNITY DOMAIN (25%)								
Build relationships and invest in communities & community based orgnzations (CBOs)								
HEO Regional Listening Sessions	Gather qualitative data directly from members and the community regarding their experience	HEO Manager	Assess baseline of member experience for medical access, quality and trust	On an annual basis, conduct Regional Listening sessions in each of the 5 designated regions of Kern.	Q1	100%	No	
Regional Access Committees's	Gather qualitative data directly from members and the community regarding their experience	HEO Manager	Assess baseline of member experience for medical access, quality and trust	By December 31, 2024, a process will be implemented to track the organizational diversity of community partners outreached for each RAC.	Q3-Q4	100%	No	
Develop Comprehnsive Community Investment Strategy	Assess KHS community investments to ensure equitable and effective use of organizational resources	HEO Manager	Track, analyze and report community investments by activity (sponsorships, contracts, community grants programs), identify areas of improvement & address gap	By December 31, 2024, a process will be implemented to effectively track organizational investments in the community across departments.	Q3-Q4	80%	No	

Develop Comprehensive School Partnership Strategy	Assess KHS school partnership strategy to ensure equitable and effective use of organizational resources and maximize impact	HEO Manager	Streamline and formalize educational partnerships with schools; co-create a strategy with district and multiple KHS depts on health initiatives	Initial measurement: Meet with at least 2 districts; Once launched measures will be performance based on specific intervention	Q3-Q4	80%	No
Assess KHS Provider Network Language Capabilities	Assesss provider language capabilities to that of the KHS member language needs.	PNM Director, HEO Manager	needs of members. Review with stakeholders. Add to Provider Directory	Identify threshold languages and p	Q3-Q4	98%	No
						92%	
EMPLOYEE DOMAIN (15%)							
Engage and develop employees with training, culture inititiaves, and state-mandated DEIB programs. Ensure employments practices are fair & equitable.							
Assessment of KHS Workforce Demographics	Analyze KHS workforce demographics	Health Equity Manager & HR	workforce activities. Review with stakeholders. Monitor workforce demographics for hiring	Complete demographic analysis in line with NCQA HEA requirements; identify opportunities and develop/implement action plans	Q1	100%	No
Diversity, Equity and Inclusion (DEI) Task Force Development	Development of the KHS DEI Task Force will serve as the stepping stone to mobilize efforts around implementation of DEI practices, policies, engagement, climate pulse checks, and training opportunities.	Health Equity Manager & HR	Solicit workforce participation for task force development Establish task force with regular occuring meeting schedule	Y1: Development & launch of committee;	Q2-Q3	100%	No
Organizational Climate Assessment	Conduct Annual Organizational Climate Assessment	Health Equity Manager & HR	Develop KHS Organizational Climate Assessment Tool in conjunction with HR Facilitate Organizational response to results	Launch of survey; survey participation	Q1	100%	No
Diversity, Equity and Inclusion (DEI) Training	Develop organization- wide divesity, equity and inclusion training curriculum	Health Equity Officer	Assess organizational training needs Create DEI Training Curriculum - APL-025		Q1-Q3	100%	No
Ensure Bilingual KHS Workforce	Maintain a bilingual Member Services Department workforce that is representative of 5% of the population	Director of Human Resources Director of Member Services	Maintain Member Service Staffing Share with Stakeholders Add to Qualified	Stated in goal	Q1	100%	No
Bi-Lingual Staff Competency Assessment	Conduct Language Proficiency Test for all new bilingual applicants	Director of Human Resources Director of Member Services	Facilitate LPT Assessment Provide LPT assessment scores	% complete	Q1-Q4	100%	No
Staff Experience with Language Assistance Resources	Assess baseline of staff experience with language resources	Director of Member Services/HR	Run Annual Report Share with Stakeholders Identify and address		Q1 & Q3	95%	No
						99%	
				Overall Score		TRACO	

Justice, Equity, Diversity, and Inclusion (JEDI) Coalition Charter

Mission

Kern Health Systems (KHS) seeks to create an inclusive, equitable, culturally competent, and supportive environment where employees feel enriched and a strong sense of belonging.

The Justice, Equity, Diversity and Inclusion Coalition (JEDI Coalition) is an internal, employee focused workgroup that maintains an active role in identifying, understanding, and communicating relevant information about issues pertaining to diversity, equity, and inclusion in the workplace. The objective of this coalition is to establish and strengthen a culturally competent environment in which model behaviors are demonstrated by all members of our working community. The JEDI Coalition will guide the agency and hold it accountable for the integration of diversity, equity, and inclusion principles and behaviors into all aspects of the workplace in alignment with KHS's community impact. This new workgroup and significant undertaking signals a values-based shift in culture.

Vision

The KHS JEDI Coalition's primary goals are to meet the contractual obligations expressed in the 2024 DHCS contract, to uphold individual civil rights in the workplace, and to pursue the values underlying DEI and cultural competence goals with excellence. Key outcomes for this work should be a more diverse workforce at all organizational levels and in committee representation, greater equity within KHS's internal systems and processes, a higher sense of inclusion and belonging for all KHS employees, stronger alignment with KHS values, and ultimately – stronger performance for individuals and organizational departments. This higher sense of belonging and inclusion should also translate to stronger trust and a better experience for providers, members, and community stakeholders. Local inequities will be understood and addressed.

Guidelines for JEDI Coalition Interactions

- Be present
- Respect the space of other people
- Acknowledge and be willing to understand the real and negative impacts of history
- Share your experiences, use "I" statements
- Assess your safety and use discernment; it's always ok to pause or discuss an item later
- Embrace the stretch zone; confront, critique, and challenge your discomfort
- Accept that everyone deserves to belong to these conversations; all voices are welcome
- The stories of others are theirs to share; maintain confidentially and trust among the group
- Step up, step back; use your ears to listen, then use your voice to speak
- Acknowledge pain or offense in the moment by stating "ouch"
- If you experience yourself making judgements, ask yourself where those unconscious biases and judgements originated
- Impact supersedes intent; consider the impact of your words and actions along with focusing on your intentions
- Acknowledge and understand historical and current privileges; seek to share privileges
- Foster and embrace unity; we are all on the same team

Definitions

Cultural Competence: Generally speaking, cultural competence refers to an understanding of how institutions and individuals can respond respectfully and effectively to people from all cultures, socioeconomic statuses, language backgrounds, races, ethnic backgrounds, disabilities, religions, genders, gender identifications, sexual orientations, veteran status, and other diverse characteristics in a manner that recognizes, affirms and values the worth, preserves the dignity, and honors the history of individuals, families and communities. In a more specific context for KHS, organizational cultural competency is the ability of health care organizations to actively apply knowledge of cultural behavior and linguistic issues when dealing with members from diverse cultural and linguistic backgrounds. This same standard should also apply to employees in the workplace.

- Individuals practicing cultural competency should seek to have greater knowledge of the intersectionality of social identities and the multiple connections of oppression that people from diverse racial and ethnic backgrounds and other minoritized groups face.
- Individuals striving to develop cultural competence should also recognize that it is a dynamic, on-going process that requires a long-term commitment to learning.

Justice: Justice is the concept of fairness. Social justice refers to fairness as it manifests in society. That includes fairness in health care, employment and socioeconomics, housing, food and nutrition, public safety, and more. In a socially-just society, the rights of *all* humans are respected, and discrimination, marginalization, and harassment are not allowed to flourish. In the workplace, social justice translates to systems that ensure fairness for all employees.

- Justice means more than just ensuring public safety system in society or in the workplace. It's a conscious, consistently renewed awareness of how systems have impacted diverse groups of people in society and the implications of those systemic effects. It means working to change systems that have historically impacted some groups more negatively than others.
- Justice is also about building new systems in ways that are fair for everyone in society. To that end, it requires an understanding of the systemic challenges faced by diverse groups in relation to health care, socioeconomics, housing, food, and other social determinants of health. It means creating systems where all voices and communities are valued and included as a default. The "fences" are removed.

Equity: Equity is also a fairness concept that operates within the context of established systems. It means ensuring that everyone has consistent support and access to the resources needed to be successful and proactively identifying and eliminating barriers that have prevented the full engagement and participation of communities most impacted by systemic oppression. This same standard should also apply to employees in the workplace.

- Equity differs from equality. Equality refers to treating everyone the same (everyone gets a box to see over the fence), specifically in the sense that it does not necessarily lead to equitable outcomes because diverse communities have faced different historical obstacles/inequities and therefore have different needs. Equality employs a more standardized method, while equity embraces a more customized approach.
- Improving equity involves increasing fairness within the policies, processes, and practices of institutions and systems, as well as in the distribution of resources. Addressing equity issues requires an understanding of the root causes of outcome

disparities in society and the workplace. It assumes the premise that when given the proper supports and resources, most humans will succeed at relatively equal rates.
- Equity accounts for systematic inequalities that have developed over time, meaning the distribution of resources should provide more assistance for those who need it most or who have historically faced more barriers to success. In the workplace, this could apply to women or people of color.

Diversity: Diversity is a given because humans are infinitely complex. It simply means the range of human differences, including but not limited to race, ethnicity, gender, gender identity, sexual orientation, age, socioeconomic status, physical ability or attributes, religious or ethical values systems, national origin, political beliefs, and cultures. In the workplace, effectively executed diversity programs should translate to organizational practices that make employees feel valued for the diversity they bring to the work environment.

- Diversity means more than just acknowledging and/or tolerating differences. It's a set of conscious practices that seek to understand and *appreciate* the differences and interdependence of humanity,cultures, and the natural environment.
- Diversity is all inclusive and supportive of the proposition that everyone and every group should be valued and appreciated. It is about understanding these differences and moving beyond simple tolerance to embracing and celebrating the rich dimensions of our differences.
- Many diversity programs focus on representation and cultural celebrations. While these are proven ways to help employees feel valued and appreciated and should not be neglected, diversity programs can have even greater impact through providing training and awareness of beautiful human diversity.

Inclusion: Ensuring that people of all backgrounds, identities, abilities, perspectives, and beliefs have an equal opportunity to belong, achieve, and contribute to their workplaces and communities. An inclusive organization promotes and sustains a high sense of belonging; it values and practices respect where all people are recognized for their inherent worth and dignity, talents, beliefs, backgrounds, and ways of living; it seeks to empower every person to flourish with their diverse knowledge and abilities. The perception and reality of full inclusion for employees is typically the goal of a DEI program at most organizations.

- Inclusion means authentically bringing excluded or marginalized individuals or groups into organizational and social processes, practices, and decision/policy making in a way that shares meaningful voice and power.
- It means creating environments of psychological safety so that employees want to bring their ideas and feedback to the table.
- Efforts to strengthen inclusion often focus on consciously including and elevating the voices of those who have traditionally been marginalized to weigh in on processes, practices, discretionary activities, organizational decisions, and key policies that impact their lives and economic futures at a broader level.

Meeting Schedule

The JEDI Coalition will meet monthly during the launch period and may adjust to bimonthly meetings once the structure has been established and implemented. Once selected/appointed, the officers for the workgroup will determine the cadence of meetings based on need, in partnership with the workgroup members.

Scope

The coalition will guide the work of justice, equity, diversity, and inclusion at KHS through the following activities and goals:

1. Developing a Justice, Equity, Diversity, and Inclusion (JEDI) Strategic Plan
2. Executing the implementation of the JEDI Strategic Plan via a JEDI Program
3. Adding information about the JEDI plan and program to the KHS website and social media sites
4. Monitoring the development, implementation, and evaluation of standards for cultural competence as related to employees
5. Providing input on organizational policies and procedures to address justice, equity, diversity, and inclusion issues
6. Evaluating and recommending solutions where organizational inequities have existed historically for minority groups
7. Reviewing organizational policies, processes, and practices to assess impact, address justice, equity, diversity, and inclusion matters related to employees, and make recommendations to the Executive Team when appropriate
8. Informing and consulting with KHS employees, leaders, and executives regarding justice, equity, diversity, and inclusion initiatives
9. Ensuring the maintenance and dissemination of best practices for justice, equity, diversity, and inclusion in organizational policies, hiring, onboarding, training, and retention of employees
10. Serving as a resource for guidance and consultation regarding justice, equity, diversity, and inclusion issues for KHS employees, leaders, and executives
11. Disseminating information about ongoing professional development training around justice, equity, diversity, and inclusion for KHS employees, leaders, and executives
12. Seeking regular feedback from employees and leaders to inform decision-making and understand opportunities for improvement of the JEDI program
13. Sharing the work of the JEDI coalition with the Board of Directors, Executive Team, and all KHS staff
14. Leading the annual measurement and evaluation of how the DEI work is improving the culture environment for KHS employees

15. Researching best practices to ensure the KHS JEDI Program remains relevant and maximizes effectiveness

16. Serving as a resource for KHS staff to make recommendations supporting recruitment of diverse candidates for internal and external committees where appropriate

JEDI Coalition Creation

In January of 2023, Kern Health Systems hired a Chief Health Equity Officer (CHEO) to lead organizational efforts related to health equity. The job description for the CHEO included language affirming the organization's desire and contractual obligation to formally launch a DEI program, with the understanding that success in achieving greater equity with members and in the community is predicated upon KHS's ability to first strengthen DEI awareness and effectiveness internally. This coalition will also help support the organization in ensuring diversity in internal and external committees where appropriate. The formal launch of an internal DEI program was also listed as a requirement of the 2024 DHCS contract and was included on the KHS Strategic Plan.

The definitions and scope incorporate language and best practices from several educational entities (California State University, Bakersfield, Kern Community College District, Cornell University, Clackamas College, Taft College), local nonprofits (Community Action Partnership of Kern, Bakersfield Kern Regional Homeless Collaborative, Kern Behavioral Health and Recovery Services) and other businesses in the region. In alignment with the organization's health equity goals, a JEDI Coalition will be established upon formal approval from the KHS Board of Directors. Once the workgroup members have been selected, strategic planning for the JEDI Coalition is expected to commence during the summer of 2024.

Membership

To ensure broad representation from across the organization, the Justice, Equity, Diversity, and Inclusion Coalition shall be comprised of no less than 10 members and no more than 16 with the membership structure and roles described below.

Executive Sponsor

- A member of the Executive Team will be appointed to provide sponsorship for the JEDI Coalition.
    - Key partners – JEDI Chairs, Executive Team
    - Primary role – provide consultation for the group and help remove barriers.
- This role may include occasional presentations to the Board of Directors.
- The Executive Sponsor will be an ex officio member of the group (no vote).

Chair Positions

- A Chair and Vice Chair will be appointed to provide leadership for the group.
    - Key partners – JEDI Coalition members, HEO, HR, Executive Team
    - Primary role – strategic planning for the workgroup and execution of initiatives.
- Chairs will be appointed by the CEO at the end of the calendar year, with new chairs beginning the following calendar year. After the initial coalition has been established, both the Chair and Vice Chair must be appointed from within the JEDI Coalition, having served for at least one year on the workgroup.

- To maximize diversity of perspective and voice, Chairs who serve together should not be from similar employee types (i.e. Staff, Management, Executive) if possible.
- The first appointed Chair will serve for one year, with the first appointed Vice Chair assuming the Chair position in the second year. Two-year terms will then commence.
- Chair positions may be renewed one (1) time based on mutual interest.

Additional Officer Positions

- Secretary
  - Key partners – JEDI Chairs, HEO, HR
  - Primary role – capture and preserve meeting notes for the JEDI Coalition
- Treasurer
  - Key partners – JEDI Chairs, HEO, HR, and Finance
  - Primary role – develop and steward the JEDI Coalition annual budget
- Communications & Marketing
  - Key partners – JEDI Chairs, HEO, HR, and Marketing
  - Primary role – develop communications for the JEDI Coalition
- Research & Content Development
  - Key partners – JEDI Chairs, HEO, HR, and Finance
  - Primary role – research and create content for internal consumption
- Evaluation & Measurement
  - Key partners – JEDI Chairs, HEO, HR, and Business Intelligence
  - Primary role – drive measurement of success and continuous improvement

Standing Positions

- If neither the Chair or Vice Chair comes from one of the departments listed below, standing positions on the JEDI Coalition will be reserved for employees in the following departments for the sake of sustainability and in accordance with the organization's desire to align internal and external DEI efforts.
  - Health Equity (1)
  - Health Education (1)
  - Human Resources (1)
  - Marketing (1)
  - Member or Community Engagement (1)
  - Quality (1)
  - Communications (1)

Open Positions

- Remaining positions on the JEDI Coalition will be open to all employees and leaders across the organization. Once selected, workgroup members will serve in two-year terms that may be renewed based on mutual interest. To ensure continuity, half of the inaugural JEDI Coalition will serve only one year, with the opportunity to renew subsequent two-year terms.

Application Process

- Applications will be updated annually by the Chairs (if necessary).
- Chairs or a delegate will oversee the communications process for each application cycle.
- All KHS employees are encouraged to apply.
- Completed applications will be submitted electronically to the JEDI coalition chairs.
- All final decisions and appointments will be made by the Chairs, officers, and Executive Team sponsor. Concurrence by the CEO is recommended.

Coalition Member Expectations/Commitment

- Membership terms are for two years with the option for renewal. The JEDI Coalition year coincides with the calendar year (January to December).
- Members are expected to commit at least two hours per month to the JEDI Coalition. The workgroup will meet once every other month, with expected sub workgroup meetings scheduled as needed, and for staff events/celebrations.
- Coalition members are expected to attend the monthly JEDI Coalition meetings, prepared to fully engage. The meeting schedule will be established by the JEDI Coalition Chairs and workgroup members, once selected.
- Members are expected to join at least one sub workgroup and then to meet with their respective sub workgroups outside of regularly schedule JEDI Coalition meetings. Sub workgroup leads will report back to the JEDI Coalition and share information or decisions from their sub workgroups.
- Members are expected to participate and attend JEDI Coalition sponsored events, trainings,and strategic-planning retreats to the extent possible.

Recommended Metrics for Sustainable Success

KHS acknowledges the DHCS contractual obligations to launch a formal DEI program in service of greater workforce diversity and cultural responsiveness. The organization also seeks to move beyond the DHCS contractual obligations to pursue excellence in the DEI space. To be clear, this work represents a values-based shift in culture. To that end, it is recommended that the following categories be considered for annual measurement and evaluation by the JEDI Coalition at a minimum:

- Demographics of KHS leaders at all levels (Executives to Supervisors; compared to regional demographics and demographics of all employees)
- Demographics of all KHS employees (compared to regional demographics)
- A review of demographic data for applications, interviews, and hires
- A review of demographic data for annual promotions
- A review of demographic data for annual separations
- Research and recommendations of best practices for recruiting a diverse workforce that mirrors the local community and how to close gaps (if needed)
- A review of KHS employee experiences broken down by demographics including but not limited to race, ethnicity, gender, gender identity, and sexual orientation
- A review of KHS employee experiences related to informal/formal mentorship, sponsorship, coaching, and discipline broken down by demographics including but not limited to race, ethnicity, gender, gender identity, and sexual orientation
- Research and recommendations of best practices for developing/sustaining a strong DEI culture that maximizes sense of belonging for employees
- Celebrations of diverse groups, cultures, and practices
- Number of offerings for internal DEI trainings
- Return on investment for JEDI Coalition annual activities

AUTHORITY

The Chair is responsible for the periodic review and updates to the JEDI Coalition Charter.

ADOPTION
The JEDI Coalition adopts this Charter of the Delegated Oversight Coalition on XXX xxxx

Signature of Chief Executive Officer: _____ Date: _____
Signature of Chief Human Resources Officer: _____ Date: _____
Signature of Chief Health Equity Officer: _____ Date: _____

KERN HEALTH SYSTEMS

2025 Q1 HEO UPDATE

Pawan Gill
Health Equity Manager

March 2025

2025 Training Update – Changes in Regulatory Landscape

- SOGI training rolled out to W&P, PHM & BH. Upcoming virtual training session will include leaders and trainer from Member Services. HEO will offer training to any departments
- Mandatory TGI Training will be rolled out in April for member facing staff
- DEI Pilot will roll out in summer of 2025 for employees and then extended to all employees, providers, contractors and subcontractors.

EPT Update – Cycle 2 Milestones

- The EPT program is structured in six cycles (0-5) and uses milestones to monitor practice progress. Practices submit deliverables to demonstrate evidence of milestone achievement.

- Current focus: Cycle 2 Milestones running from Nov 1, 2024 - May 1, 2025

May 1, 2025 (Cycle 2)

	Category	Milestone	Deliverable
5.	**Population Health Management Capabilities Assessment (PhmCAT)**	**Complete year 2 2025 PhmCAT**	Assessment
6.	**Data to Enable Population Health Management**	**Data implementation plan**: Develop implementation plan for addressing data and technology gaps and transforming practice operations to support development of KPIs. Plan must include steps for implementing these three strategies: a. Identifying and outreaching to the assigned but unseen population b. Using gaps in care reports that include practice and MCP data c. Data exchange with 2 external partners, at least 1 of which is a Qualified Health Information Organization (QHIO) *Note: Before completing this Milestone, the team needs to have submitted Milestone 4: Data governance and HEDIS reporting assessment*	Implementation Plan
7.	**Stratified HEDIS-like measures**	**Stratify HEDIS-like measures:** Submit report that includes HEDIS-like measures applicable to selected population of focus stratified by race and ethnicity and at least one additional characteristic: primary spoken language, sexual orientation, gender identity, housing status, payer, or disability.	Stratified HEDIS-like Measures Report
18, 19, 20	**Key Performance Indicators (KPI)**	**Submit KPI Updates** • Empanelment • Continuity	KPI Assessment

Doula Update

- Created highly-effective, cross functional team to implement new Doula benefit including representatives from HEO, Provider Relations, Contracting/Credentialing, UM, W&P, Govt. Relations
- Developed comprehensive Doula Training & Onboarding program that resulted in KHS 9 contracted doulas to date with at least one more in the pipeline.
- DHCS Visit – Transforming Maternal Health (TMaH) Model Press Conference
- 2025 Doula Lanyard Pilot Program with Memorial

Other

- Launched Kern Health Equity Fellows Program with BC MESA & Pre-Med Students
- DEI Curriculum approved by the DHCS
- DMHC APL 24-018, 24-023 & DHCS APL 23-017 Compliance Filing
- KHEP Progress
- HEO provided Cultural Complexity training for CoC University – BKRHC, Speaking Panel for ROSE Mentoring Program, Volunteer for PIT count.

KERN HEALTH SYSTEMS

Department of Health Care Services (DHCS) Equity and Practice Transformation (EPT) Payment Program

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Kern Health Systems Update

February 2025

The EPT program uses milestones to monitor practice progress. Practices submit deliverables to demonstrate evidence of milestone achievement.

The EPT program is structured into six cycles (0-5)

Cycle 0	**Due** May 1, 2024
Cycle 1	Due Nov 1, 2024
Cycle 2	Due May 1, 2025
Cycle 3	Due Nov 1, 2025
Cycle 4	Due May 1, 2026
Cycle 5	Due Nov 1, 2026

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	Modules	Deliverables Submission Status				
Name of Practice	completed 1+ Module on PopHealth+	Empanelment & Access Assessment	Empanelment Policy & Procedure	Data Governance & HEDIS Assessment	Data Governance Policy & Procedure	KPI Assessment
Universal Healthcare Services Inc.	completed	accepted	rejected	accepted	accepted	accepted
AJITPAL S TIWANA MD	completed	accepted	Didn't submit	accepted	Didn't submit	accepted
JASLEEN TIWANA MD INC	did not complete	accepted	Didn't submit	accepted	Didn't submit	accepted
POLYCLINIC MEDICAL CENTER INC	completed	accepted	rejected	accepted	accepted	accepted
Pinnacle Primary Care, Inc	completed	accepted	rejected	accepted	accepted	accepted
Kern Rural Wellness Centers, Inc. DBA: Arvin Medical Clinic	completed	accepted	rejected	accepted	rejected	accepted
The Children's Clinic of Bakersfield	completed	accepted	rejected	accepted	accepted	accepted
Infusion and Clinical Services, Inc dba Premier valley Medical Group	completed	accepted	accepted	accepted	accepted	accepted
Good Samaritan Hospital, LP dba Good Samaritan Health Center Wasco	completed	accepted	rejected	accepted	accepted	accepted
Omni Family Health	did not complete	attested out	attested out	accepted	accepted	accepted
Adventist Health Delano	completed	accepted	Didn't submit	Didn't submit	Didn't submit	Didn't submit
Kern County Hospital Authority (Kern Medical)	completed	Didn't submit	Didn't submit	Didn't submit	Didn't submit	accepted

427

Name of Practice	Payment per Milestone (n=25)	Nov deliverables April Payment
POLYCLINIC MEDICAL CENTER, INC.	18,800	$37,600
Universal Healthcare Services Inc.	18,800	$37,600
AJITPAL S TIWANA MD	10,000	$10,000
JASLEEN TIWANA MD INC	10,000	$10,000
Pinnacle Primary Care, Inc	13,980	$27,960
Kern Rural Wellness Centers, Inc. DBA: Arvin Medical Clinic	15,200	$15,200
The Children's Clinic of Bakersfield	10,000	$20,000
Infusion and Clinical Services, Inc dba Premier valley Medical Group	13,200	$39,600
Good Samaritan Hospital, LP dba Good Samaritan Health Center Wasco	10,000	$20,000
Omni Family Health	138,777	$138,777
Kern County Hospital Authority (Kern Medical)	46,315	$0
Adventist Health Delano	16,294	$16,294

May 1, 2025 (Cycle 2)

	Category	Milestone	Deliverable
5.	**Population Health Management Capabilities Assessment (PhmCAT)**	**Complete year 2 2025 PhmCAT**	Assessment
6.	**Data to Enable Population Health Management**	**Data implementation plan:** Develop implementation plan for addressing data and technology gaps and transforming practice operations to support development of KPIs. Plan must include steps for implementing these three strategies: a. Identifying and outreaching to the assigned but unseen population b. Using gaps in care reports that include practice and MCP data c. Data exchange with 2 external partners, at least 1 of which is a Qualified Health Information Organization (QHIO) *Note: Before completing this Milestone, the team needs to have submitted Milestone 4: Data governance and HEDIS reporting assessment*	Implementation Plan
7.	**Stratified HEDIS-like measures**	**Stratify HEDIS-like measures:** Submit report that includes HEDIS-like measures applicable to selected population of focus stratified by race and ethnicity and at least one additional characteristic: primary spoken language, sexual orientation, gender identity, housing status, payer, or disability.	Stratified HEDIS-like Measures Report
18, 19, 20	**Key Performance Indicators (KPI)**	**Submit KPI Updates** • Empanelment • Continuity	KPI Assessment

Kern Family Health Care®

Thank You

Kern Family Health Care®

The Doula Journey

Health Equity Office

KERN HEALTH SYSTEMS

DCHS Doula Benefit

- Doulas are available in fee-for-service and through managed care plans (MCPs).
- The addition of doulas is aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

KERN HEALTH SYSTEMS

Efforts in 2024

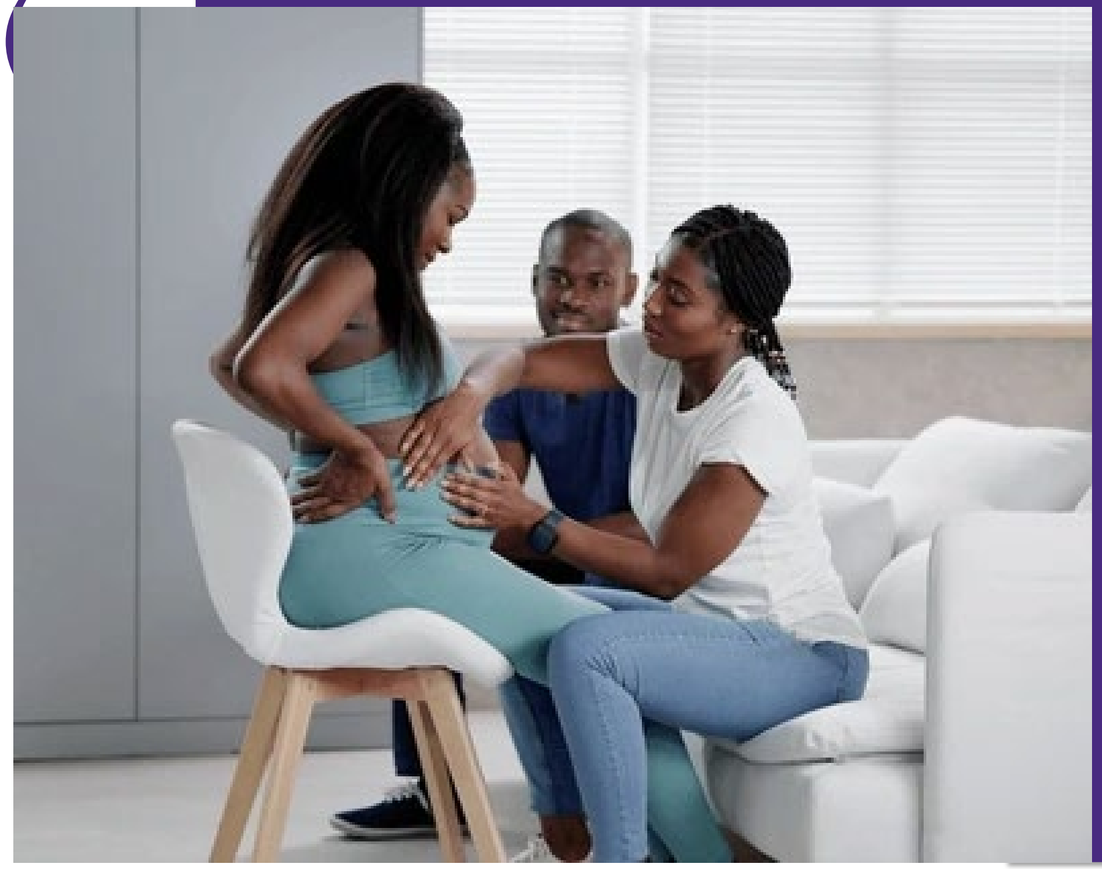
- Meeting with the Doula Circle
- Doula Forum w/ State – 03/06/24
- Monthly Internal Meeting
- Inland Empire Health Plan - 09/17/24
- Monthly Doula Benefit Work Group
- KHS Doula Training – 10/29/24

- Doula/ Memorial Hospital Collaboration – 12/10/24

KERN HEALTH SYSTEMS

Efforts in 2024-25 (

- Quarterly Maternal Care Committee
- Monthly CHIP/CHA – Shared Goal
- KCNC General Collaboratives
  - 01/16/25 - Nikki
  - 02/20/25 - Dani
- Quarterly Doula Statewide Meetings
- Memorial Lanyard Program
- TMaH Launch/Tour – 02/05/25



KERN HEALTH SYSTEMS

T H A N K Y O U .!

Questions?

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

HEALTH EQUITY OFFICE

2024 END OF YEAR REPORT

INNOVATION | INTEGRATION | IMPACT

In 2024, the Health Equity Office expanded efforts to drive meaningful change by amplifying member voices, strengthening partnerships and integrating equity across departments. These initiatives ensure a more inclusive and responsive health care system for Kern Health Systems members.

Member Experience and Qualitative Data

- Expanded data collection through listening sessions, regional access meetings and member surveys.
- Restructured and established new committees to amplify member voices and inform service improvements.

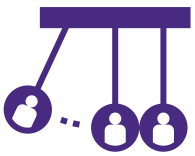
NCQA and Equity Programs

- Closed the year at 96 percent NCQA compliance.
- Hosted the Equity and Quality Awards to recognize health care equity leaders.
- Expanded the EPT program across 12 practices, investing up to $26.2 million.

Strategic Integration & Partnerships

- Advanced geospatial strategy, the HEO dashboard and community investments including PNM grants, school wellness grants and sponsorships.
- Strengthened educational and regional partnerships such as workforce pipeline, quality performance, behavioral health, KHEP, BIMHI and CHIP/CHA.

Cross-Departmental Collaboration



- Impact: Successfully established Doula program and onboarded 7 doulas implementing new benefit in line with DHCS Bold Goals and CHP/CHA (provider domain)
- Quality and provider support: Enhanced provider training, the HEAL program and language access tools.
- Community and wellness initiatives: Expanded community wellness grants, and improved member services outreach.
- Workforce and communications: Integrated NCQA goals into HR processes, launched the JEDI and mentorship programs, and refined equity-driven messaging.

Through innovation, collaboration and strategic integration, the Health Equity Office continues to drive impactful change, ensuring health care equity remains at the forefront of Kern Health Systems' mission.

2024 HIGHLIGHTS

Advancing Health Equity Across Kern County

The Health Equity Office (HEO) at Kern Health Systems achieved major milestones in 2024, driving health equity and inclusivity across its four domains: members, providers, community and employees. Through strategic initiatives and partnerships, the HEO made strides toward building a more equitable healthcare landscape.

Members

- Expanded data collection: Added sexual orientation and gender identity (SOGI) fields to QNXT and the member portal to support inclusive engagement.
- Health equity sessions: Hosted listening sessions in five Kern County regions, connecting with members, providers and community partners.

Providers

- HEAL Committee launch: Formed the Health Equity and Learning (HEAL) Committee to advance equity initiatives in the KFHC network.
- Cultural competency training: Hosted training addressing intimate partner violence in South Asian communities.
- Engaged the doula network to train on becoming contracted KHS providers, streamlined onboarding, and launched a pilot program with Memorial Hospital.

Community

- CAC revitalization: Restructured the Community Advisory Committee to meet regulations and improve feedback quality.
- Grants program: Collaborated to develop, market and evaluate the 2024 community grants program.

Employees

- DEIB survey: Launched a diversity, equity, inclusion and belonging survey to meet NCQA standards.
- Workforce demographics: Partnered with HR to assess workforce data and launched a redesigned employee engagement survey.
- Goal setting: Implemented a structured goal-setting process to foster growth.

CELEBRATING EXCELLENCE IN HEALTH EQUITY

Kern Health Systems hosted its inaugural Health Equity & Quality Awards, honoring local providers and community partners for their dedication to reducing health disparities and improving care. Held at Seven Oaks and hosted by Chief Health Equity Officer Traco Matthews, the event celebrated the collective efforts shaping a healthier Kern County. Matthews praised the honorees for their impact, emphasizing the importance of collaboration in advancing health equity.

Award Winners

- **Innovation Award** – Clinica Sierra Vista
- **Quality Progress Award** – Vanguard Medical Corporation
- **Outstanding Health Equity Champion** – Dr. Kimberly Dixon
- **Quality Excellence Award** – Shafter Pediatrics
- **Community Collaboration Award** – Kern County Department of Human Services
- **Community Impact Award** – Community Action Partnership of Kern
- **Educational Partnership Award** – Lamont Elementary School District

The evening highlighted the power of partnerships, innovation and excellence, reinforcing KHS' mission of health and equity for all.

CONTINUING THE WORK: PROGRESS AND PLANS FOR THE FUTURE

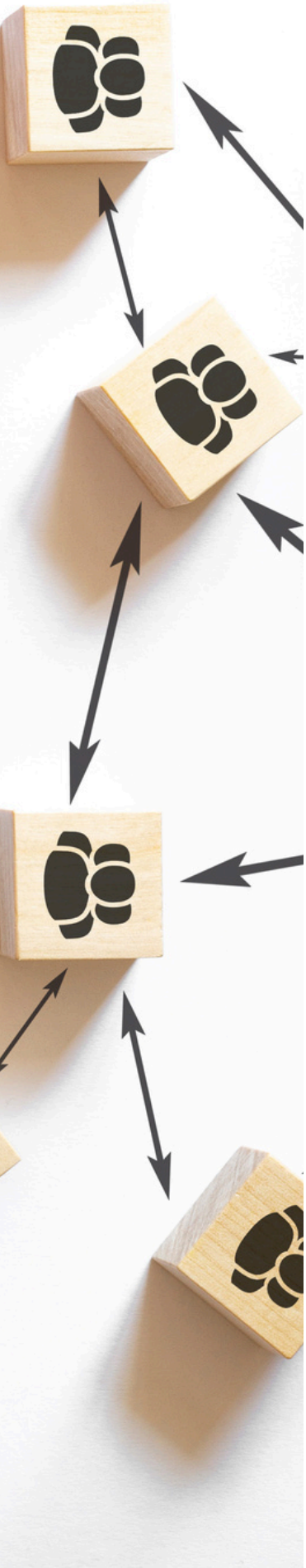
As we reflect on the progress made in 2024, Kern Health Systems remains committed to its mission of health and equity for all. Guided by our values of equity, collaboration and innovation, we are laying the groundwork for initiatives that will further support our members, providers, community and employees. With a focus on inclusivity, compassion and excellence, we are advancing projects that address emerging needs and prepare us for a future where equitable healthcare is accessible to all. The following outlines our ongoing efforts and aspirations for each pillar.

MEMBERS

PROVIDERS

COMMUNITY

EMPLOYEES



MEMBERS

Enhancing Equity and Addressing Barriers

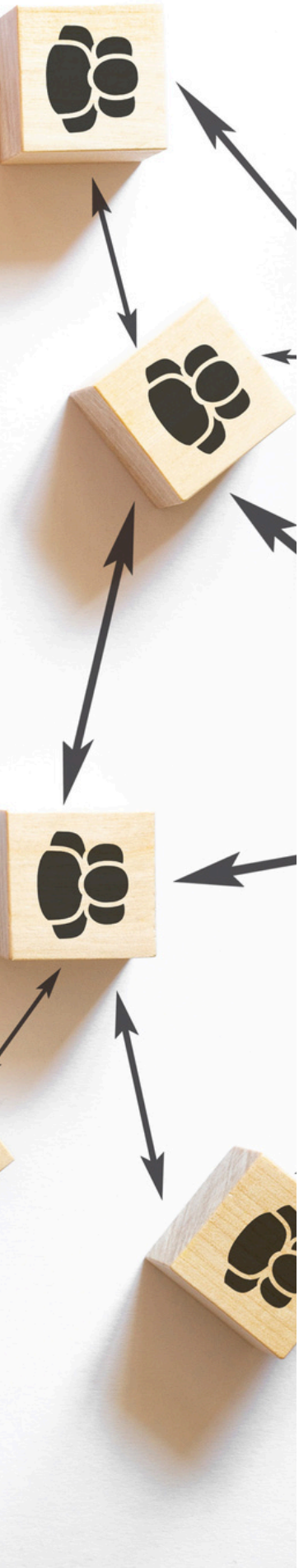
Ongoing Efforts

- **Regional Advisory Committees (RACs):** Established RACs to gather actionable feedback from members and communities, focusing on geographic perspectives and barriers to care. Insights will guide the development of programs, initiatives and training.

- **SOGI training and data collection:** Implementing training and processes for collecting sexual orientation and gender identity data in alignment with NCQA health equity standards.

- **CRM implementation:** Enhancing member experience by incorporating a customer relationship management (CRM) system. Features include visible preferred names, pronouns and other key information on initial screens to ensure members are addressed appropriately.

- **Collaboratives for children's health equity:** Participating in the IHI/DHCS Children's Health Equity Collaborative and the ACAP Equity Learning Collaborative to advance initiatives focused on improving care for children.



MEMBERS

Enhancing Equity and Addressing Barriers

Future Goals

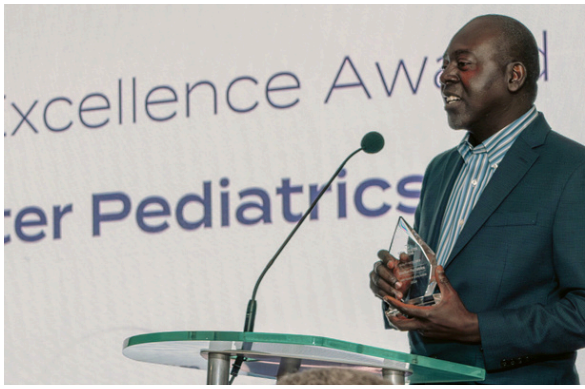
- **Comprehensive reporting:** Develop a detailed report cataloging all health equity-related programs and interventions to better inform future initiatives.
- **Streamlined workflows:** Enhance organizational workflows to improve the effectiveness of interventions, with a focus on member and community engagement.
- **Prioritizing interventions:** Create a formal process to identify and prioritize health equity interventions based on impact and need.
- **Program expansion:** Broaden the scope of current and future health equity programs and interventions led by the Health Equity Office.

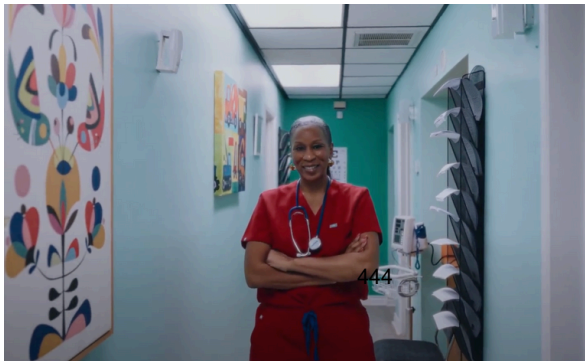
PROVIDERS

Empowering Equity in Health Care Delivery

Ongoing Efforts

- **Equity Practice Transformation** (EPT): Supported 12 practices with up to $26.2 million in funding to improve timely access to treatment.
- **HEAL Committee:** Launched the Health Equity and Learning (HEAL) Committee to gather feedback from providers on health equity challenges and inform the development of training, programs and support.
- **Training and development:** Identified, developed and promoted professional development opportunities to enhance providers' knowledge and skills in delivering equitable care.
- **Compliance Training Development:** Designed and developed curriculum for 2025 launch to meet APL requirements, ensuring providers receive training on health equity and transgender, gender-diverse, and intersex (TGI) care.





PROVIDERS

Empowering Equity in Health Care Delivery

Future Goals

- **Practice and service expansion:** Explore opportunities for providers to expand services and access, supporting health equity initiatives and addressing underserved populations.
- **Training and development program:** Establish a robust, engaging provider training program with regular course offerings and tools for practice transformation.
- **Network expansion:** Identify and assess opportunities to expand the provider network to ensure equitable care for underserved communities.
- **Provider resource hub:** Develop a centralized hub with training materials, guides, templates and best practices to support the provider network.

COMMUNITY
Strengthening Partnerships and Engagement

Ongoing Efforts

- **Regional Advisory Committees (RACs):** Launched RACs to gather actionable feedback from members and communities, focusing on lived experiences and barriers to care to guide the development of programs, initiatives and training.

- **Kern Health Equity Partnership (KHEP):** Advanced collaboration and compliance under APL 24-004 to address equity-related challenges across Kern County.

- **Regional equity initiatives:** Supported equity-focused projects throughout Kern County to build capacity, share expertise and foster stronger community partnerships, aligning with APL 24-004.

COMMUNITY
Strengthening Partnerships and Engagement

Future Goals

- **Community engagement strategy:** Develop and implement a comprehensive framework that includes an Educational Partnership Strategy to co-create health-focused initiatives.
- **Member engagement framework:** Establish a robust strategy to enhance connections and engagement with members.
- **Community investment framework:** Design and launch a framework to guide strategic community investments.
- **Review of CBO contracts:** Conduct an organization-wide evaluation of contracts with community-based organizations to ensure equitable and effective allocation of resources.

EMPLOYEES

Fostering Equity and Excellence in the Workforce

Ongoing Efforts

- **Employee Engagement and DEIB Surveys:** Revamped and launched the Employee Engagement Survey and DEIB Survey to gather valuable insights on workplace culture and employee satisfaction.
- **DEIB/JEDI Committee launch:** Established the Diversity, Equity, Inclusion, and Belonging (DEIB) Committee in alignment with NCQA Health Equity standards.
- **Change management training:** Implemented training programs focused on managing organizational change to support a culture of equity and inclusion.
- **Recruitment and selection policy:** Developed and refined policies and procedures for recruitment and selection, ensuring alignment with NCQA Health Equity standards.
- **Compliance and Health Equity Training:** Designed and developed curriculum for 2025 launch to meet APL requirements, ensuring employees receive training on health equity, TGI care and DEIB to support organizational equity initiatives.

EMPLOYEES

Fostering Equity and Excellence in the Workforce

Future Goals

- **Organizational culture and development strategy:** Co-design and implement a formal strategy with HR to strengthen KHS's organizational culture and development practices.
- **Recruitment and retention program:** Collaborate with the HR Talent Acquisition team to build and implement a comprehensive recruitment and retention program.
- **Training and development opportunities:** Partner with HR's Learning & Development team to create robust training programs that promote organizational excellence.
- **Job description standardization:** Work with HR to standardize job descriptions, language, format, and education/experience requirements in alignment with NCQA health equity standards.

LOOKING AHEAD: CONTINUING OUR COMMITMENT TO HEALTH AND EQUITY

As we reflect on the strides made throughout 2024, it is clear that our work is driven by a deep commitment to advancing health equity and creating a more inclusive environment for our members, providers, community, and employees. With continued focus on collaboration, innovation, and integrity, we are excited to build on these efforts in the coming year. By strengthening partnerships, enhancing programs, and prioritizing equitable access to care, we are confident in our ongoing progress toward a healthier, more equitable future for all.

To: EQIHEC

From: Melinda Santiago, Director of Behavioral Health

Date: March 18, 2025

Re: Behavioral Health Advisory Committee (BHAC)

Background:
KHS has formed a Behavioral Health Advisory Committee to help us enhance the Behavioral Health services for our members. Subcommittee that is comprised of behavioral health practitioners. The committee will support, review, and evaluate interventions to promote collaborative strategic alignment between KHS and the County Behavioral Health Plan (BHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). Kern Behavioral Health and Recovery Services (KBHRS) administers both the BHP and DMC-ODS, treating KHS members with the goal to maintain continuity, reduce barriers to access, linkage to appropriate services, opportunities to integrate care with medical care, and provide resources for members with mental illness and/or substance use disorder. This report reflects activities and outcomes for the first quarter of 2025.

Meetings Held:
- January 15, 2025 (Quarter 1)

Discussion Items:
- National Committee for Quality Assurance (NCQA) Accreditation Standards
    - QI 4. A-B Continuity and Coordination Between Medical and Behavioral Health Care
    - ME 7E (BH) Grievance and Appeal – Review qualitative and quantitative analysis
    - ME 7E – Annual Assessment of Behavioral Healthcare and Services – Review (BH) Member Experience Surveys
- Welcome New Member -Tribal Liaison
- NSMHS O&E Plan
- BHAC Calendar

Fiscal Impact:
- None.

Requested Action:
- Review and approve.

KERN HEALTH SYSTEMS

BEHAVIORAL HEALTH ADVISORY COMMITTEE (BHAC) MEETING

Wednesday, January 15, 2025 at 12:00 pm

2900 Buck Owens Blvd.
Bakersfield, CA 93308
1st Floor – Board Room

For more information, call (661) 664-5000

KERN HEALTH SYSTEMS

Behavioral Health Advisory Committee (BHAC)
AGENDA – January 15, 2025

AGENDA ITEM	AGENDA TOPIC	PRESENTER	ACTION
CALL TO ORDER	Call meeting order / Attendance-Quorum	Dr. Martha Tasinga, CMO and Melinda Santiago, BH Dir	*N/A*
APPROVAL OF MINUTES	October 2024 Minutes Review, Discussion, Motion to Approve	***All Voting Members***	*Approve*
OLD BUSINESS	a. National Committee for Quality Assurance (NCQA) Accreditation Standards i. QI 4. A-B Continuity and Coordination Between Medical and Behavioral Health Care ii. ME 7E (BH) Grievance and Appeal – Review qualitative and quantitative analysis iii. ME 7E – Annual Assessment of Behavioral Healthcare and Services – Review (BH) Member Experience Surveys iv. Eating Disorder - Update	Melinda Santiago, BH Dir	*Informational*
NEW BUSINESS	a. Welcome New Member -Tribal Liaison b. NSMHS O&E Plan c. BHAC Calendar	Melinda Santiago, BH Dir	*Approve*
OPEN FORUM	Open Forum / Committee Members Announcements / Discussion	***Open to all Members***	*Discussion*
NEXT MEETING	Next meeting will be held Wednesday, **April 9, 2025, at 12:00-1:30**	Informational only	*N/A*
ADJOURNMENT	Meeting Adjournment	Dr. Martha Tasinga, CMO and Melinda Santiago, BH Dir	*N/A*

661-664-5000
661-664-5151
kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

KERN HEALTH SYSTEMS

COMMITTEE: **BEHAVIORAL HEALTH ADVISORY COMMITTEE**
DATE OF MEETING: **OCTOBER 16, 2024**
CALL TO ORDER: **12:04 PM BY MELINDA SANTIAGO, DIRECTOR OF BEHAVIORAL HEALTH - CHAIR**

Members Present On-Site:	Marissa Garcia Trebizo, LMFT- Director at CSV Heather Hornibrook, LMFT - Deputy Dir. KBHRS .	Mesha Muwanga, LMFT – Rhema Therapy Inc. Melinda Santiago, KHS Director of Behavioral Health	Martha Tasinga MD, KHS Chief Medical Officer
Members Virtual Remote:	Anuradha Rao, MD – Omni Matthew Beare, MD – Clinica Sierra Vista	Franco Song, MD – Psychiatric Wellness Center	
Members Excused=E Absent=A	Cherilyn Haworth, CSUB (A)		
Staff Present:	Amy Daniel, KHS Executive Health Services Coordinator Vanessa Hernandez, KHS Senior Support Clerk Yolanda Herrera, KHS Credentialing Manager	John Miller, QI Medical Director Courtney Morris, KHS Behavioral Health Supervisor Seve Pocasangre, NCQA Accreditation Specialist	Abdolreza Saadabadi, BH Medical Director Pam Thomsen, NCQA Program Manager Julianne Ybarra, KHS Behavioral Health Supervisor

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga, CMO and Melinda Santiago, KHS Director of Behavioral Health called the meeting to order at 12:04 AM.		N/A
Committee Minutes	**Approval of Minutes** Approval of Minutes from July 10, 2024 meeting.	☑ **APPROVED**: A motion was made by M. Muwanga, LMFT and seconded by Dr. A. Rao, to approve the minutes of July 10, 2024. Motion carried.	10/16/24
OLD BUSINESS	**Grievance Process** **NCQA ME 7E (BH) Grievance and Appeal – Review qualitative and quantitative analysis.**	☑ **PENDING: Held until next meeting.**	Pending

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Eating Disorders Follow-up Follow-up meeting with Dr. Sidhu, Dr. Tasinga and Dr. Rao to work on this suggested algorithm. Dr. Rao suggested including Marlena Tanner, RD in this meeting as she has guidelines for eating disorders.	☑ **PENDING: Held until next meeting.**	
NEW BUSINESS	**NCQA Standards QI 4.A-B** Melinda Santiago, Director of Behavioral Health presented qualitative and quantitative analysis report. Reviewed the targeted measures and methodology for data collection on the continuity of care coordination between medical care and behavioral health outcomes. Reviewed all six factors with activities listed that included exchange of information, Appropriate Diagnosis, Treatment, and Referral of Behavioral Health Disorders Commonly Seen in Primary Care, Appropriate Use of Psychotropic Medications, Management of Treatment Access and Follow-Up for Members with Co-Existing Medical and Behavioral Health Disorders, Primary or Secondary Preventive Behavioral Healthcare Program Implementation, and Special Needs of Members with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED). Reviewed the results qualitative analysis, quantitative analysis, reviewed barriers and opportunities, and planned interventions. KHS collaborates with the health plans core system of care with equitable and high-quality integrated care by collecting and analyzing the data to improve those opportunities that found between medical care and behavioral health care. Melinda reviewed with the members that data currently being collected through various targeted measures with data collection through MCAS, HEDIS, Survey results and claims data. Additional barriers identified contributing to low rates or failure to meet goals included lack of coordination between PCPs and Behavioral Health Specialist, especially due to PCPs not aware of the BH Referrals and the BH Providers don't have access to the provider platform to share information with the PCPs. Dr. Saadabadi suggested recommendation of the factors. **004**	☑ **ACTION**: Collectively committee agreed with recommendation. Marisa Garcia Trebizo-CSV motioned to approve these targeted areas of focus: AMM, ADD and SSD. Mesha Muwanga seconded, and motion carried.	10/16/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	BH Director selected opportunities where improvements could be made, were thoroughly discussed amongst the members with the following recommendation to target these areas of focus: 1. AMM 2. ADD 3. SSD		
	<u>NCQA Standards ME 7E1 & 7E2</u> Melinda presented the Behavioral Health Complaints and Appeals for Year 2023 per 1,000 Members. KHS has an overall behavioral health grievance goal of 10 per 1000 members per year and 2 -per members per year for each grievance category. The following highlights were noted: • 131 BH Complaints were filed – resulting in 0.04 complaints per 1000 members – KHS met our goal of <10 grievances per 1000 • 4 BH Appeals were filed – resulting in less than .01 appeals per 1000 members – KHS met our goal of <1 grievance per 1000 members.	☑ **Action –** Follow-up Agenda Item v. BH Director will present the NCQA Standards ME 7E1 Grievance and Appeal – Review qualitative and quantitative analysis • Discussion on selected opportunities vi. ME 7E – Annual Assessment of Behavioral Healthcare and Services – Review (BH) Member Experience Surveys • Discussion on selected opportunities	Pending
OPEN FORUM	**<u>Open Forum</u>** APL 24-012 (SB1019)	☑ **CLOSED**: Informational discussion only.	10/16/24
NEXT MEETING	Next meeting will be held January 15, 2025.	☑ **CLOSED**: Informational only.	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
ADJOURNMENT	The Committee adjourned at 1:29 am. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Behavioral Health Advisory Committee Minutes 10/16/2024

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

Behavioral Health Department

National Committee for Quality Assurance (NCQA)
Continuity and Coordination Between Medical and Behavioral Health Care

Date: 12/10/2024

Introduction:

Kern Health Systems' (KHS) Behavioral Health (BH) Department has the mission of ensuring members receive equitable, timely, appropriate, and integrated behavioral health services through referrals to appropriate BH providers, wellness and rehabilitative programs; collaborating with Provider Network Management to ensure adequacy and access to BH providers, integrating BH services with medical care when clinically indicated, and analyzing data to measure performances and outcomes of interventions.
KHS provide medically necessary Medi-Cal covered physical health care services to Plan members requiring specialty mental health services and substance use disorder services delivered by designated Kern County Medi-Cal programs for these services.
Non-Specialty Health Services (NSMHS) are those services that KHS must provide when they are medically necessary and provided by Primary Care Provider (PCP) or mental health network providers within their scope of practice. KHS is directly responsible for providing covered non-specialty mental health services for beneficiaries with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders.
At any time, members can choose to seek and obtain a mental health assessment from a licensed mental health provider within the KHS's provider network. PCPs are recommended to complete mental health screenings annually and as needed for their patients. Members with positive screening results should be further assessed. The member may be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP shall refer the member to a behavioral health provider, first attempting to refer within the KHS network.
To ensure the coordination of medically necessary Medi-Cal covered physical, mental health and substance use disorder services, KHS collaborates with Kern Behavioral Health and Recovery Services (Kern BHRS), the designated Mental Health Plan (MHP)and the County Drug Medi-Cal Organized Delivery System (DMC-ODS) to implement protocols to ensure care coordination, data sharing, and non-duplicative services with the Mental Health Plan through mutually agreed upon Memorandum of Understanding (MOU) between parties.
To promote collaboration, the MOU addresses policies and procedures for the management of member's care for both KHS and program providers, including the following:

i. KHS developed policies and procedures for the timely and frequent exchange of:
   a. Member information and data, including behavioral and medical health data.
   b. Maintaining the confidentiality of exchanged information and data
   c. Bi-directional monitoring of data exchange
   d. Process for obtaining member consent
ii. KHS implemented processes for establishing medical necessity determination, care coordination, creating closed loop referral systems, and exchange of medical information between KHS and the MHP and DMC-ODS.
iii. KHS and Kern BHRS institute policies and procedures to address and document QI activities for services covered under the MOU, including applicable performance measures, such as:
   a. QI initiatives and reports that track cross-system referrals, member engagement and service utilization.
   b. Facilitating member access to medically necessary services and network providers during non-business hours.
iv. KHS is implementing closed loop referral systems referrals.
v. KHS covers medical necessity Non-Specialty Mental Health Services (NSMHS)
   a. For individuals under 21 years of age, a service is medically necessary if the service meets the EPSDT standard set forth in Section 1396d(r)(5) of Title 52 of the United States Code. Services that sustain, support, improve, or make more tolerable a behavioral health condition is considered to ameliorate the condition, and are thus medically necessary and are covered as EPSDT services.

b. For individuals 21 years old and over, a service is medically necessary when it is reasonable and necessary to protect life, to prevent severe illness or disability, or to alleviate severe pain.

Non-Specialty Mental Health Services:

i. Mental health evaluation and treatment, including individual, group or family psychotherapy.
ii. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
iii. Outpatient services for the purpose of monitoring drug therapy.
iv. Psychiatric consultation.
v. Outpatient laboratory, drugs, supplies and supplements.
vi. Substance Use Disorder (SUD), including Drug and Alcohol Screening, Brief Intervention and Referral to Treatment (SABIRT) services. (P&P 21,03-P Alcohol and Substance Use Disorder Treatment Services.
vii. Coordination of care for maternal mental health

Care Coordination Activities:

The Director of Behavioral Health works with liaisons of Kern BHRS to facilitate member access to specialized programs and services to promote coordination and communication between specific County programs and services.
Procedures for accessing behavioral health services, referral processes and care coordination with Kern BHRS are outlined in KHS' policies and procedures.

KHS uses DHCS-approved Screening Tools for youth under age 21 and adults 21 and over to offer timely screening for all members. These tools are used for members who are not currently receiving mental health services to determine the most appropriate system of care for initial mental health assessment.

Care Management:

KHS retains responsibility for performing all BH care coordination activities related to direct BH-contracted providers. The medical management system is used to track and trend members needing care management and those with catastrophic or potential high-risk BH conditions to ensure appropriate follow-up and intervention. BH staff participate in Kern BHRS interdisciplinary care team (ICT) meetings for specific target populations for complex cases to ensure members are connected to appropriate services. On an as needed basis, BH staff attend ICT meetings with KHS's Population Health Management (PHM) for complex cases to ensure members are connected to medically necessary services.

Continuity of Care:

KHS' BH staff facilitates continuity and coordination of care for members accessing behavioral health care. BH staff follows procedures to coordinate the exchange of information between PCPs, inpatient admitting physicians, specialists, BH providers, surgical centers, home health agencies, Out of Network (OON) providers, and skilled nursing facilities to ensure continuity of care.

Transition of Care:

KHS reviews and processes the DHCS-approved Transition of Care Tools to support timely and coordinated care for members who are currently receiving mental health services from either the MCP or MHP. This tool is used when completing a transition of services to the other delivery system or when adding a service from the other delivery system to their existing mental health treatment.

Coordination of Care Between Medical and Behavioral Health Care:

Lack of communication and coordination between medical and behavioral health care can lead to poor quality and unsuccessful patient outcomes, while well-integrated care increases patient satisfaction and produces better clinical results. Gaps in care occur when a patient is admitted to mental health facility due to lack of

data sharing and coordination between the MHP and MCP.
Coordinating care for specialty mental health services, where they are carved-out to the MHP, presents challenges due to differences in systems, behavioral health structure, levels of authorities for contacts, and overall difficulties in communication between medical providers and behavioral health providers. Defining the scope of coverage of non-specialty mental health services versus specialty health services oftentimes add to the inconsistencies and confusion to the PCPs in determining what is appropriate referral and in navigating the financial payment systems.
The importance of training, education and collaboration are crucial to efficient care coordination. BH providers may not be familiar with the process of sharing protected health information (PHI) with primary care practitioners and vice versa. The issue of privacy and confidentiality, trusts and handling of sensitive records pose hesitancy on the part of BH practitioners to share records when it comes to treatment, case management, and coordination of care. The HIPAA standards allow for medication prescription and monitoring, the modalities and frequencies of treatment furnished, results of clinical tests, and summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.
At KHS, strategies were put in place to assure members receive quality behavioral health services while receiving medical care. Process improvement activities are being implemented to ensure open communication and coordinated care between medical and behavioral health care providers, as well as with the MHP facilities.

Population Assessment:

Kern County, the 11th largest county in California, has 49% of the population living in poverty. Kern County consistently ranks low in major health indicators from birth outcomes, mortality, communicable and chronic diseases, air quality, healthcare coverage, and food insecurity.

Opportunities for Coordination Between Medical and Behavioral Health Care

KHS collaborates with the MHP System of Care to provide members with equitable and high-quality integrated care, to collect and analyze data, and to improve coordination between medical care and behavioral health care.

QI 4 Element A Factors 1-6

The data on the opportunities below were collected from 2023, so this report is a baseline study.

Element A	Targeted Measures	Methodology for Data Collection
Exchange of Information	Provider Satisfaction Survey	Survey results
Appropriate Diagnosis, Treatment, and Referral of Behavioral Health Disorders Commonly Seen in Primary Care	Anti-depression Medication Management	HEDIS, Encounter data, claims, pharmacy data
Appropriate Use of Psychotropic Medications	Pharmacy Drug Utilization Review for Patients With ADHD	HEDIS, Encounter data, claims, pharmacy data
Management of Treatment Access and Follow-Up for Members with Co-Existing Medical and Behavioral Health Disorders	Multiple Medical Conditions at Risk for Behavioral Health Issues	Encounter data, claims data

Element A	Targeted Measures	Methodology for Data Collection
Special Needs of Members with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED)	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Claims data

QI 4 Element A Factor 1

Exchange of Information

A. Activity

Provider Satisfaction Survey

B. Description and Relevance:

Complete and timely exchange of medical information is essential to the treating practitioner, whether it is behavioral health clinician or a primary care physician.

Studies show that inadequate continuity of care between BH providers and PCPs is a particular concern for providers, especially the lack of integrated BH and medical care for those whom mental health services are carved out. In this case, there is no standardized communication protocols between behavioral health specialists and PCP, and real and perceived barriers affect the transfer of information between behavioral health services and medical care services.

The Provider Satisfaction Survey is a means of assessing the primary care practitioner's experience and satisfaction with continuity and coordination of care with behavioral health specialists and vice versa.

C. Goal:

The immediate goal is to achieve a 5% year over year improvement on the selected criteria on the provider satisfaction survey tool. The ultimate goal is to achieve 80% rating on the selected criteria.

D. Methodology:

The Provider Satisfaction Survey was conducted by the Press Ganey Group, a nationally recognized vendor for developing and distributing patient satisfaction surveys. The providers surveyed were a mixture of PCPs, specialists, behavioral health, and others. The 'others' respondents were not defined.

There are two attributes related to behavioral health:

1. Timeliness of feedback/reports from BH providers.
2. Access to BH non-urgent care

E. Results

a. Quantitative Analysis:

QI 4 Element B Factor 2

(1) Survey Response:

Respondents	# Who Responded	2023 Response Rates	2022 Response Rates
PCPs	41	7.9%	13.0%
Specialists	80	14.1%	15.4%
Behavioral Health	20	9.5%	10.5%
Others	41	20.3%	24.3%
Total	182		
Sample Size	1500	12.1%	14.6%

Overall, there was a decrease in the number of PCP respondents in 2023. The response rate was 5.1 percentage points lower in 2023 compared to 2022. A slight decrease for specialists and behavioral health was noted. Respondents called "Others" were not identified, and a four-percentage point decrease was also noted in 2023.

(2) Criteria:

Questions	2022 Result	2023 Result	Percentage -Point Change	Percent Change
Timeliness of feedback/reports from BH provider	45.1%	47.6%	2.5	+ 5.54 %
Timeliness of feedback/reports from Specialists to BH provider	48.00%	57.14%	9.14	+ 19.73%
Access to BH non-urgent care	39.2%	48.8%	9.6	+ 24.49 %

The 2023 result showed an increase of 5.47 % on the timeliness of feedback/reports from BH provider from 2022. Similarly, access to BH non-urgent care showed an increase of 24.49% in 2023 compared to 2022. **The ultimate goal of 80% satisfaction was not met.**
However, the immediate goal of increasing year over year improvement of selected criteria by 5% was met for both criteria.

QI 4 Element B Factor 2

b. Qualitative Analysis:

The primary reason for the dissatisfaction with the exchange of information may be influenced by the following factors:

i. There is no clear process for effective practitioner communication
ii. PCP is not aware of BH referral
iii. PCP has no contact information for the BH practitioner
iv. BH practitioner is hesitant to share information because of confidentiality, privacy and trust
v. BH practitioner lacks understanding of regulatory and ethical standards for care coordination
vi. BH practitioner is hesitant to share any information because the member refuses to give consent for his/her record to be shared with the PCP.
vii. There is insufficient coordination and communication among internal departments within KHS.
viii. Information exchange systems between providers are not optimal for ease of sharing member information. Many practitioners don't have access to the Health Information Exchange (HIE). This can be a major barrier in cases where a member switches providers and medical history is not shared in a timely manner.
ix. The BH practitioners and medical practitioners are rarely on the same EMR system which means that they are not able to see the relevant clinical information needed to better manage their patient.

a. In cases where external EMRs are not accessible, a practitioner must rely on the member or family for information.
b. School districts with BH practitioners can't record member information into accessible EMRs.
c. External BH provider EMRs are typically not accessible as they it is a closed EMR system that does not allow access to external EMR systems.

Conclusion Based on Qualitative Analysis

The Behavioral Health Advisory Committee (BHAC) convened on October 16, 2024, to review target measure for the Exchange of Information. The committee reviewed the opportunities, interventions, and barriers related to the Exchange of Information measure, which focuses on improving communication and coordination of care between Behavioral Health (BH) providers and Primary Care Providers (PCPs). A committee member who is a BH network provider raised concerns about the difficulty of coordinating care when there is no contact or established communication with the assigned PCP. The member suggested that having a platform to facilitate this contact would be a significant improvement and an opportunity to enhance collaboration between providers. There was a discussion about the ongoing barrier of confusion around the need for patient consent to release and exchange information. This misunderstanding is an obstacle to care coordination. The committee emphasized the continuous need for education among providers on the regulations that allow for the exchange of information for care coordination purposes. One member discussed the complexities associated with the treatment of substance use disorders (SUD), especially considering the federal regulations under 42 CFR. These regulations impose specific restrictions on the sharing of patient information related to SUD treatment, which can create challenges in coordinating care across providers. The committee proposed an opportunity to ask BH providers to rate their satisfaction with PCPs in the next survey. This could help identify areas where communication and coordination between BH and PCPs can be improved. After careful consideration, the committee members decided not to select the Provider Satisfaction Survey measure as one of the opportunities for improvement. However, they acknowledged that the survey would still be conducted on an annual basis as part of the regular activities to assess provider satisfaction with the coordination of care.

F. Opportunities for Improvement and Interventions

QI 4B Factor 3

QI 4 Element B Factor 5

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
There is no pathway of communication between medical practitioners and behavioral health practitioners	There is an opportunity to develop a process that will facilitate exchange of information between medical and BH practitioners.	KHS will leverage the enhancement of the Provider Portal to promote the exchange of information between the primary care practitioners and behavioral health providers. a. The Care Coordination	Ongoing	

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
		Form will be posted on the portal to be used by the PCPs when making referrals to the BH practitioner. In the same manner, the BH practitioner can use the form to provide update and/or plan of care once referral is done. The goal is for all PCPs and contracted specialty providers to utilize the Provider Portal not only for updates and directives from KHS but be a source of member information that is beneficial to all clinicians involved in the member's care. b. Continue to promote the Provider Portal to all practitioners via i. newsletters		

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
		ii. joint operations meetings with KHS provider network and primary practitioners iii. provider meetings and forums iv. quarterly provider dinners c. Promote the Care Coordination of Care Forms by introducing and disseminating to offices, educating the office staff and providers on the objective and purpose of the Continuity of Care (CoC) form. d. Provide other tools, such as behavioral tool kits, Healthcare Effective Data and Information Set (HEDIS) information resources to increase physicians' knowledge about the		

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
		requirements of specific HEDIS measures.		
Lack of education regarding the importance of collaboration among providers involved in patient care.	There is an opportunity to provide training and education to practitioners.	KHS will leverage the enhancement of the Provider Portal to promote the exchange of information between the primary care practitioners and behavioral health providers. a. The Care Coordination Form will be posted on the portal to be used by the PCPs when making referrals to the BH practitioner. In the same manner, the BH practitioner can use the form to provide update and/or plan of care once referral is done. The goal is for all PCPs and contracted specialty providers to utilize the Provider Portal not only for updates and directives from KHS but		

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
		be a source of member information that is beneficial to all clinicians involved in the member's care. b. Continue to promote the Provider Portal to all practitioners via i. newsletters ii. joint operations meetings with KHS provider network and primary practitioners iii. provider meetings and forums iv. quarterly provider dinners c. Promote the Care Coordination of Care Forms by introducing and disseminating to offices, educating the office staff and providers on the objective and purpose of the Continuity of		

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
		Care (CoC) form. d. Provide other tools, such as behavioral tool kits, Healthcare Effective Data and Information Set (HEDIS) information resources to increase physicians' knowledge about the requirements of specific HEDIS measures.		
Lack of interdepartmental collaboration	There is an opportunity to integrate efforts to provide quality care and service to members and providers.	Continue to gather the departments that are most likely to impact the provider satisfaction survey and improve the exchange of information between providers. Establish a cadence of meetings with business owners to discuss survey results and develop strategies to improve exchange of information among practitioners and increase their satisfaction.		
		Emphasize to the members the importance of collaboration		

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
		between practitioners involved to provide continuity of care in a safe and efficient manner. These activities would be through member newsletters, providing updates to the website, the use of social media with content specific to member engagement, community engagement efforts and partnerships with local organizations and health fairs. By implementing these outreach and education strategies, we aim to foster a collaborative relationship between patients and providers, ultimately leading to better continuity of care and improved health outcomes. Presenting the benefits of exchanging information between providers to help with preventative care, determining risk factors, treatment planning, and empowering the individual to engage actively in monitoring their own care.		

QI 4 Element A Factor 2

Appropriate Diagnosis, Treatment, and Referral of Behavioral Health Disorders Commonly Seen in Primary Care

A. Activity

Antidepressant Medication Management (AMM)

B. Description and Relevance

Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects.

Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated, as well. (NCQA)

Studies revealed that the need to monitor treatment adherence and condition severity across providers, further supports the critical importance of communication between MHPs/KHS BH practitioners and PCPs. Evidence suggests that persons with mental illnesses are less likely to receive appropriate testing and adequate intervention and monitoring.

C. Methodology -

KHS uses HEDIS data collection for the methodology:

a. HEDIS Data

The HEDIS AMM measure assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. (NCQA)

Two rates are reported:

- Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks).
- Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months).

b. Pharmacy Process

KHS will utilize claims, encounter and HEDIS data or provider profile to identify those members who were prescribed antidepressants. These data will be reconciled with the pharmacy data to determine who refilled the prescription for at least 12 weeks during the acute phase, and those who continue to refill the medication for at least six months for the continuing phase.

To promote communication among providers and continuity of care, KHS pharmacy will collaborate with the BH Department, notify the PCPs and treating behavioral health practitioners of the utilization patterns of their members who are on antidepressants and identify those who are outliers.

The pharmacy department will send utilization data of the prescription to the members' respective practitioners.

D. Goals

1. Achieve the 50th percentile of NCQA's Quality Compass (QC) benchmark for the AMM measure.
2. Send notification to PCPs and BH practitioners regarding their patients' utilization patterns of prescribed antidepressants.
    - **a.** Identify outliers

QI 4 Element B Factor 2

E. Results

Quantitative Analysis:

1. **HEDIS Data:**

Name	MY 2023 Rate	HEDIS 2022 Benchmark	2022 Rate	2021
(AMM) Antidepressant Medication Management – acute phase	65.03% (1294/1990)	60.9	55.79	52.05
(AMM) Antidepressant Medication Management – continuation phase	47.29% (941/1990)	43.9	40.71	34.58

The rate for MY 2023 showed improvement for the acute and continuation phases over two years. The rate in MY2023 surpassed the established goal and national benchmark.

Qualitative Analysis:

i. KHS has no mechanism for tracking members who were referred to BH providers for depression, were prescribed medications and who were compliant with antidepressant medications.

   a. BH practitioners and PCPs are not aware of the drug utilization patterns of their patients. Non-compliance is common to those members who fail to see their doctors regularly

ii. The exchange of information between healthcare providers may not be fully effective, impacting the sharing of member details. Many practitioners lack access to Health Information Exchanges (HIE), creating challenges when a member changes providers and their medical history is not promptly transferred. This issue is particularly problematic if the initial prescription was given by a behavioral health provider, as primary care providers who later care for the member might not receive crucial medical information. Consequently, they may either not continue necessary medication or inadvertently duplicate prescriptions, disrupting treatment and diminishing care effectiveness.

iii. Primary care providers (PCPs) may not know that a member is taking depression medications because they have not received this information from behavioral health (BH) providers. A key obstacle is the

need for a completed release of information form, which is often misunderstood in relation to HIPAA regulations and remains a significant barrier.

iv. PCPs sometimes discontinue medication if a member experiences side effects or seems to have improved, without consulting the BH practitioners.

v. Members' perceptions of their treatment's effectiveness can also affect their adherence to antidepressant therapy. If members believe their medications are not working, they might stop taking them. Alternatively, if they feel their condition has improved too quickly, they may discontinue treatment. Additionally, side effects from antidepressants can be bothersome, leading members to stop treatment altogether.

vi. Behavioral health and medical practitioners frequently use different Electronic Medical Record (EMR) systems, preventing them from accessing each other's relevant clinical information, which is essential for effective patient management.

vii. Although stigma around mental health has decreased, some members may still feel judged by their medical providers or communities, leading them to discontinue treatment to avoid perceived judgment.

Conclusion Based on Qualitative Analysis

The Behavioral Health Advisory Committee (BHAC) convened on October 16, 2024, to review target measure for the Appropriate Diagnosis, Treatment, and Referral of Behavioral Health Disorders Commonly Seen in Primary Care. The committee members reviewed and discussed the opportunities, interventions, and barriers to measure. The committee members agreed upon the identified barriers, including continuity and coordination of care issues, have been recognized as significant factors contributing to the low rates and failure to meet the goals for the AMM measure. The committee members did not provide additional recommendations on barriers. Not additional changes proposed.

F. Opportunities for Improvement and Interventions

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
Lack of collaboration between PCPs and BH specialists.	There is an opportunity to facilitate communication between PCPs and BH specialists.	Team Collaboration, such as workgroup meetings a. Gather the business owners that are most likely to contribute to the improvement of the AMM measure, e.g., QI dept, pharmacy, Medical Director, provider network, and PHM dept to discuss root causes for low rates and	Ongoing	Y

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
		develop strategies to improve performance.		
	There is an opportunity to educate PCPs and BH providers regarding the importance of collaboration to promote equitable care for members.	Continue to collaborate with the pharmacy department to keep primary care practitioners aware of the utilization of prescribed medications for their members.		
PCPs are not aware of the BH referrals	There is an opportunity to promote the provider portal among PCPs where member information is available. There is an opportunity for departmental collaboration to develop strategies in promoting communication between PCPs and BH specialists.	Consistently collaborate with PHM department to improve tracking of PHQ9 forms and tracking the follow of the referrals to appropriate BH providers.		
MHP providers do not have access to provider platform to share information to PCP.	There is an opportunity to create data exchange with MCP with coordination information that includes BH Dx, Members referred to BH, Members linked to BH Provider, last appointment and next	Make available the standards of practice, i.e., clinical practice guidelines for use in primary care settings.		

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
	appointment, Name of Assigned BH Provider, list of psychotropic meds, and Rx provider.			

QI 4 Element A Factor 3

Appropriate Use of Psychotropic Medications

A. Activity

Follow-Up Care for Children Prescribed with ADHD Medication (ADD)

B. Description and Relevance

Attention-deficit/hyperactivity disorder (ADHD) is one of the most common mental disorders affecting children. Eleven percent (11%) of American children have been diagnosed with ADHD. The main features include hyperactivity, impulsiveness and an inability to sustain attention or concentration. Of these children, 6.1% are taking ADHD medication.

When managed appropriately, medication for ADHD can control symptoms of hyperactivity, impulsiveness and inability to sustain concentration. To ensure that medication is prescribed and managed correctly, it is important that children be monitored by a pediatrician with prescribing authority. (NCQA)

Studies revealed that the need to monitor treatment adherence and condition severity across providers further supports the critical importance of communication between MHPs and PCPs. Evidence suggests that persons with mental illnesses are less likely to receive appropriate testing and adequate intervention and monitoring.

C. Methodology

HEDIS Data:

The two rates of this HEDIS measure assess follow-up care for children prescribed an ADHD medication:

- *Initiation Phase*: Assesses children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.
- *Continuation and Maintenance Phase*: Assesses children between 6 and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days and had at least two follow-up visits with a practitioner in the 9 months after the Initiation Phase.

D. Goal

The goal is to achieve the 50th percentile of NCQA's Quality Compass benchmark for the ADD measure:

QI 4 Element B Factor 2

E. Results

Quantitative Analysis:

Name	MY 2023 Rate	HEDIS 2022 Benchmark	2022 Rate	2021
(ADD) Follow-Up Care for Children Prescribed with ADHD Medication Management – initiation phase	**43.83%** (174/397)	43.6	40.50	31.27
(ADD) Follow-Up Care for Children Prescribed with ADHD Medication Management – continuation and maintenance phase	**41.64%** (112/269)	53.1	41.60	28.00

Compared to the rates in 2022 and 2021, there has been a steady increase in MY 2023 for both initiation and continuation/maintenance phases. The MY 2023 rate did not meet the established and national benchmark for the continuation/maintenance phase.

Qualitative Analysis:

i. KHS has no mechanism for tracking members who were referred to BH providers for ADHD, were prescribed medications and who were compliant with ADHD medications.

ii. BH practitioners and PCPs are not aware of the drug utilization patterns of their patients. Non-compliance is common to those members who fail to see their doctors regularly

a. The exchange of information between healthcare providers may not be fully effective, impacting the sharing of member details. Many practitioners lack access to Health Information Exchanges (HIE), creating challenges when a member changes providers and their medical history is not promptly transferred. This issue is particularly problematic if the initial prescription was given by a behavioral health provider, as primary care providers who later care for the member might not receive crucial medical information. Consequently, they may either not continue necessary medication or inadvertently duplicate prescriptions, disrupting treatment and diminishing care effectiveness.
b. Primary care providers (PCPs) may not know that a member is taking ADHD medications because they have not received this information from behavioral health (BH) providers. A key obstacle is the need for a completed release of information form, which is often misunderstood in relation to HIPAA regulations and remains a significant barrier.
c. PCPs sometimes discontinue medication if a member experiences side effects or seems to have improved, without consulting the BH practitioners.
d. Members' perceptions of their treatment's effectiveness can also affect their adherence to therapy. If members believe their medications are not working, they might stop taking them. Alternatively, if they feel their condition has improved too quickly, they may discontinue treatment.
e. Behavioral health and medical practitioners frequently use different Electronic Medical Record (EMR) systems, preventing them from accessing each other's relevant clinical information, which is essential for effective patient management.

f. Although stigma around mental health has decreased, some members may still feel judged by their medical providers or communities, leading them to discontinue treatment to avoid perceived judgment.

Conclusion Based on Qualitative Analysis

The Behavioral Health Advisory Committee (BHAC) convened on October 16, 2024, to review target measure for Appropriate Use of Psychotropic Medications. The committee members reviewed and discussed the opportunities, interventions, and barriers to measure. The committee members agreed upon the identified barriers, including continuity and coordination of care issues, have been recognized as significant factors contributing to the low rates and failure to meet the goals for the ADD measure. Primary care providers (PCPs) are not effectively coordinating care with behavioral health (BH) practitioners, which can lead to inadequate management of patients with ADHD.

- Some PCPs discontinue ADHD medications if patients experience side effects or show symptom improvement, without consulting BH practitioners.
- PCPs might not be as comfortable with certain ADHD medications as BH practitioners.
- PCPs may be unsure about the appropriate frequency of follow-ups or may lack time to conduct them due to heavy workloads.
- Some PCPs believe they can manage ADHD on their own and may consider further follow-up with BH practitioners unnecessary or burdensome for their counterparts.

The committee members did not provide additional recommendations on barriers. Not additional changes proposed.

F. Opportunities for Improvement and Interventions:

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
Not all children are screened for behavioral health services	Ensure provision of all screening, preventive and medically necessary diagnostic and treatment services for members under 21 years of age.	Proactively promote EPSDT and AAP Bright Futures preventive services to members and families. Connect with First 5 and other organizations that promote preventative screenings.	Ongoing	Y
PCPs are not aware of BH services	There is opportunity to promote the availability of provider portal to gather member information. Upgrades to the provider portal to include BH	Educate the BH practitioners to use a **Coordination Letter**. This is to be prepared by a BH practitioner. This provides information about the diagnosis and the medications they are taking to any other provider following up on the member and can assist them in ordering follow up care.		

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
	information on Provider Practice. All providers have assigned members to them. Adding have BH diagnosis, members referred to BH, members linked to BH provider, name of assigned BH provider, list of psychotropic medications, and Rx provider.			
	There is an opportunity for team collaboration to find ways to improve communication among practitioners.	Conduct ongoing training, at least once every two years for network providers on required preventive healthcare services (SS 3.2.5.A) to ensure full utilization of EPSDT services.		
MHP providers do not have access to provider platform to share information to PCP.	There is an opportunity to create data exchange with MCP with coordination information that includes BH Dx, Members referred to BH, Members linked to BH Provider, last appointment and next appointment, Name of Assigned BH Provider, list of	Create data element files for inbound and outbound to be exchanged between MCP and MHP.	In Production by end of March 2025.	Y

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
	psychotropic meds, and Rx provider.			
		Continue to educate the PCPs and BH specialists regarding the importance of communicating to share plan of care for the benefit of the members.		

QI 4 Element A Factor 4

Management of Treatment Access and Follow-Up for Members with Co-Existing Medical and Behavioral Health Disorders

A. Activity

Multiple Medical Conditions at Risk for Behavioral Health Issues

B. Description and Relevance

Research findings have shown that patients seeking mental health care have considerable unmet needs, and patients with mental illness are more likely than other patients to have multiple medical illnesses.

C. Methodology

With the understanding that members with multiple chronic conditions are considered high risk for behavioral health disorders, these members are stratified and based on criteria for high-risk conditions, KHS will outreach patients and link to PCPs and BH practitioners (identify gaps in care).

Using the John Hopkins Adjusted Clinical Groups (ACG) System and Predictive Modeling for stratification of members with co-existing medical and behavioral health conditions are referred to complex case management. The objective is to evaluate treatment accessibility and follow-up of the care provided.

Members identified with co-existing medical and behavioral health conditions are offered complex case management services. Members are given the option to opt out of the service.

Criteria:
Denominator:
Number of members identified through the ACG model who have co-existing medical condition and behavioral health diagnosis

Numerator:
Number of members identified through the ACG model who were enrolled in complex case management (CCM) program.

D. Goal -

The goal is to increase enrollment of the identified members to CCM by 10%.

E. Results

Quantitative Analysis:

Eligible Population	# enrolled in CCM	Rate (%)	# stayed in program >=3 mos.	Retention Rate >=3 mos.

Data Analysis:

- Out of the 588 members listed,
- 173 are enrolled in Complex Case Management (CCM),
- Of the 173 members enrolled in CCM,
  - 24 members = ages 6-20 yrs old
  - 79 members = ages 21-40
  - 41 members = ages 41-60
  - 20 members = ages 61-70
  - 9 members = ages 71-89
- Majority of the members are Hispanics, followed by Caucasians, there were those identified as Asian descent. At least 17 members are of unknown origin.
- Members are assigned to individual practitioners but most of them are assigned to CSV Care Centers (27) and Omni Health Centers (50).

Qualitative Analysis:

This is a baseline study. The data revealed that 70% of the members who were enrolled in CCM are in the 21-60 age group, while those who were not enrolled are also high in the same age bracket but are dispersed throughout ages 5-70. The data showed that 80% of members enrolled in CCM had a behavioral health diagnosis, 84% of those members had a visit with a PCP and only 53% had a behavioral health visit. **The goal of 90% of enrolled members completing a PCP visit a minimum of one time a year was not met. The goal of 70% of enrolled members completing a BH visit a minimum of one time a year was not met.** While many enrolled members have seen a PCP, a smaller proportion has accessed behavioral health services, suggesting potential gaps in care or barriers to behavioral health visits.

Because the data is limited, there is a need to understand the medical conditions that are commonly seen among our members with behavioral/mental problems. For those who opted for the service, we need to understand the outcomes of their care under complex case management. We may also need to survey those members under CCM care to evaluate their satisfaction and to assess the effectiveness of our programs.

Conclusion Based on Qualitative Analysis

The Behavioral Health Advisory Committee (BHAC) convened on October 16, 2024, to review target measure for Management of Treatment Access and Follow-Up for Members with Co-Existing Medical and Behavioral Health Disorders. The committee reviewed the Multiple Medical Conditions at Risk for Behavioral Health Issues measure, which aims to address individuals who have both medical and behavioral health disorders, ensuring they receive appropriate management and follow-up care for both aspects of their health. The committee discussed the potential opportunities for improving treatment access and follow-up care for members with co-existing medical and behavioral health disorders. They also examined the interventions that

could be implemented to address these opportunities, as well as any barriers that might hinder progress in this area.
After considering the measure, the committee members decided not to select the Multiple Medical Conditions at Risk for Behavioral Health Issues measure as one of the two opportunities for improvement.

F. Opportunities for Improvement and Interventions:

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
Limited data	There is an opportunity for collaboration with CCM staff /PHM Dept to explore more criteria and identify areas that can be improved.	BH will continue to collaborate with Case Management in the PHM Department to ensure high risk members are offered the option to be referred to BH.		
Lack of knowledge among members	There is an opportunity to educate members about the benefits of enrolling in CCM program.	Continue workgroup meetings to eliminate silos and provide coordinated care for the members.		
Lack of knowledge of providers	There is an opportunity to promote member benefits and programs to practitioners	Promote CCM program to the members, its benefits, process for enrolling, available resources via member newsletters, or leaflets in physicians' offices.		
		Promote CCM program and strategies among practitioners.		
		Improve data collection process including gathering related data from other internal and external sources.		

QI 4 A Factor 6

Special Needs of Members with Serious Mental Illness or Serious Emotional Disturbance

A. Activity

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

B. Description and Relevance:

Individuals with serious mental illness who use antipsychotics are at risk for diabetes. Diabetes is the seventh leading cause of death in the United States. Diabetes screening for members with schizophrenia, schizoaffective disorder or bipolar disorder who take antipsychotic medications is important for early detection and management.

NCQA states that challenges to measuring the quality of behavioral healthcare include lack of standardization in treatment protocols, limited standardized data sources to capture outcomes and lack of linked electronic health information.

Collaboration and care coordination are crucial in transitioning patients from the inpatient services back to the community. Communication between behavioral health and PCPs is equally important, especially when requesting test results or scheduling an appointment for testing.

The government recognizes the complex needs of SMI/SED/SUD members. Section 1115 Demonstration Waiver was instituted to address the complexity of care and services required to provide these members.

C. Methodology:

HEDIS Data:

The HEDIS measure for SSD requires annual diabetes screening for members 18 to 64 years old with schizophrenia, schizoaffective disorder or bipolar disorder, if they receive an antipsychotic medication at any time during the year. The HEDIS measure recommends screening with either glucose or HgbA1c test and documenting the result.

Criteria:

Numerator:

Members who had glucose test or HBA1c test during the measurement year.

Denominator:

Members 18-64 years of age with schizophrenia or bipolar disorder and dispensed an antipsychotic medication.

D. Goal:

Achieve the 50th percentile of NCQA's Quality Compass benchmark for the total SSD measure.

The internal goal is to achieve an aggregate goal of 80% compliance on each of the private clinics and community health centers that take care of these members.

E. Results

QI 4 Element B Factor 2

Quantitative Analysis:

easure	igible Population enominator)	mpliant umerator)	Y 2023 Rate	EDIS 2022 Benchmark

D	23	86	87%	%

This is a baseline study.

Organization-wide, the rate for the SSD measure was 77.8%. The MY 2023 rate did not meet the established and national benchmark.

From the HEDIS data, there were 348 providers and facilities who had eligible members for SSD. The membership was widely dispersed, and the majority of the practitioners have very minimal members. We focused our attention on the Omni Community Health Centers, which had a total of 559 members. The average compliance score from these facilities was 71%.

			Eligible Pop	Compliant	Rate
SSD	SSD	OMNI - BRIMHALL COMMUNITY HEALTH CENTER	68	52	76%
SSD	SSD	OMNI - BRIMHALL TWO COMMUNITY HEALTH CENTER	8	8	100%
SSD	SSD	OMNI - BUTTONWILLOW HEALTH AND DENTAL CENTER	3	1	33%
SSD	SSD	OMNI - CALIFORNIA AVE	19	12	63%
SSD	SSD	OMNI - DELANO #2 COMMUNITY HEALTH CENTER	7	6	86%
SSD	SSD	OMNI - H STREET	1	0	0%
SSD	SSD	OMNI - LOST HILLS COMMUNITY HEALTH CENTER	2	2	100%
SSD	SSD	OMNI - MALL VIEW ROAD	6	6	100%
SSD	SSD	OMNI - MING AVENUE HEALTH CENTER	46	35	76%
SSD	SSD	OMNI - NILES	1	1	100%
SSD	SSD	OMNI - NORTH CHESTER COMMUNITY HEALTH CENTER	131	100	76%
SSD	SSD	OMNI - OILDALE COMMUNITY HEALTH CENTER	32	24	75%
SSD	SSD	OMNI - RIDGECREST COMMUNITY MEDICAL AND DENTAL CEN	19	13	68%
SSD	SSD	OMNI - ROSEDALE COMMUNITY HEALTH CENTER	21	15	71%
SSD	SSD	OMNI - TAFT COMMUNITY MEDICAL CENTER	21	16	76%
SSD	SSD	OMNI - WHITE LANE COMMUNITY HEALTH CENTER	18	14	78%
SSD	SSD	OMNI FAMILY HEALTH - PANAMA	80	54	68%
SSD	SSD	OMNI- MEXICALI DRIVE	24	18	75%
SSD	SSD	OMNI SHAFTER 2 MEDICAL AND BH	1	0	0%
SSD	SSD	OMNI SHAFTER COMMUNITY MEDICAL AND DENTAL CENTER	8	6	75%
SSD	SSD	OMNI TEHACHAPI COMMUNITY MEDICAL AND DENTAL CENTE	31	21	68%
SSD	SSD	OMNI WASCO MEDICAL AND DENTAL CENTER	12	11	92%

QI 4 Element B Factor 2

Qualitative Analysis:

One of the possible reasons for low performance is the lack of awareness of PCPs regarding the treatment provided by the behavioral health specialist. Non-communication of clinicians involved is likely to produce an unfavorable outcome in the care of the members. On the other hand, the member may have stopped going to the PCP because he/she is now under the care of behavioral specialist. The BH specialist may not be aware of the recommended screening for diabetic members taking antipsychotic medications.

Primary care providers (PCPs) and other behavioral health (BH) providers are often unaware if their members

are taking antipsychotics due to insufficient communication from prescribing BH providers. This lack of information sharing can lead to missed opportunities for necessary diabetes screenings.

Several factors contribute to the inadequate sharing of information from BH practitioners to PCPs and other BH providers:

- **Low SSD Rates**: PCPs are often not informed that a member is on antipsychotics, so they do not order essential tests to monitor diabetes.
- **Assumptions about Responsibility**: Psychologists and psychiatrists may assume that members are seeing a PCP and believe it is the PCP's responsibility to conduct glucose and LDL monitoring.
- **Communication Gaps**: Due to ineffective communication between practitioners, members may not receive the necessary metabolic monitoring tests.

• Understanding of HIPAA Regulations:

- **Misinterpretation**: BH office staff often misunderstand HIPAA regulations, leading to reluctance to share information with PCPs without a signed release of information form from the member.
- **Uncertainty Without Release Forms**: Without a release form, BH staff may be unsure about their ability to share information and with whom it should be shared.
- **Confidentiality Concerns**: Staff might believe that a BH diagnosis requiring antipsychotic treatment is protected information that cannot be shared without explicit consent from the member.
- **Training Deficiencies**: HIPAA regulations can be complex, and staff often lack adequate training to fully understand the requirements. Although information can be shared without consent for continuity of care, staff may not know whom to send it to without the proper release form.

• Staffing Challenges:

- **Turnover Issues**: High staff turnover at BH facilities can disrupt processes and negatively impact care coordination. The healthcare industry is facing a significant shortage of BH staff, which exacerbates these issues.

Conclusion Based on Qualitative Analysis

The Behavioral Health Advisory Committee (BHAC) convened on October 16, 2024, to review target measure for Special Needs of Members with Serious Mental Illness or Serious Emotional Disturbance. The committee members reviewed and discussed the opportunities, interventions, and barriers to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) measure. One of the significant barriers identified was the lack of effective coordination between primary care providers (PCPs) and behavioral health (BH) practitioners. This lack of collaboration is contributing to low screening rates and the failure to meet targets for the SSD measure. There was agreement that this issue is critical, as inadequate care coordination often leads to missed opportunities for diabetes screening in individuals with serious mental illnesses (SMI).

The committee did not provide any new recommendations or additional changes to address these barriers. It appears that the barriers identified were considered significant enough, but no further interventions were proposed at this time. The committee also decided not to make any changes to the existing approaches for addressing these issues. The committee agreed to select the SSD measure as the third opportunity for improvement, alongside AMM (Antidepressant Medication Management) and ADD (Follow-Up Care for Children Prescribed with ADHD Medication), which had already been chosen for the first two opportunities. While it was not required to select the SSD measure, it was considered an important area for continued focus.

F. Opportunities for Improvement and Interventions:

QI 4 Element B Factor 4

QI 4 Element B Factor 6

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
PCPs' lack of knowledge about the importance of screening diabetic patients with mental illness.	There is an opportunity to educate practitioners on the recommended screening of diabetic members who were on antipsychotic medications for mental illness.	Continue to educate and train practitioners regarding the requirements of the SSD measure.	Ongoing	Y
PCPs are not aware of BH services	There is opportunity to promote the availability of provider portal to gather member information. Upgrades to the provider portal to include BH information on Provider Practice. All providers have assigned members to them. Adding have BH diagnosis, members referred to BH, members linked to BH provider, name of assigned BH provider, list of psychotropic medications, and Rx provider.	Encourage collaboration among practitioners – make available the names and titles of all clinicians involved in the member's care.		

Barriers	Opportunity	Intervention(s):	Intervention(s) Timeframe:	Intervention(s) Selected and Prioritized:
	There is an opportunity for team collaboration to find ways to improve communication among practitioners.	Train the practitioners to use the provider portal as it may provide more information about the member.		
MHP providers do not have access to provider platform to share information to PCP.	There is an opportunity to create data exchange with MCP with coordination information that includes BH Dx, Members referred to BH, Members linked to BH Provider, last appointment and next appointment, Name of Assigned BH Provider, list of psychotropic meds, and Rx provider.	Utilize data exchange systems to deliver lab result notifications to the PCPs and BH practitioners.	Live at end of March 2025.	Y
		Educate the BH practitioners to use a Coordination Letter. This is to be prepared by a BH practitioner. This provides information about the diagnosis and the medications they are taking to any other provider following up on the member and can assist them in ordering follow-up care. This encourages members to share glucose monitoring results with other practitioners managing their care.		

Conclusion:

The Behavioral Health Advisory Committee (BHAC) convened on October 16, 2024, to review and discuss QI

4AB opportunities for improving the Continuity and Coordination between medical and behavioral healthcare. The committee reviewed five key factors in element A, aimed at improving data collection and facilitating collaboration between these two healthcare sectors. The factors discussed included: Exchange of Information, Appropriate Diagnosis, Treatment, and Referral of Behavioral Health Disorders Commonly Seen in Primary Care, Appropriate Use of Psychotropic Medications, Management of Treatment Access and Follow-Up for Members with Co-Existing Medical and Behavioral Health Disorders, and Special Needs of Members with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED.

The committee also reviewed both qualitative and quantitative analyses, identifying barriers and opportunities for improvement in the collaboration between medical and behavioral healthcare providers. Strategies for overcoming these barriers and enhancing care coordination were discussed. After considering these factors, the committee members identified key areas for improvement and agreed on the following targeted areas of focus: (AMM) Antidepressant Medication Management and (ADD) Follow-Up Care for Children Prescribed with ADHD Medication Management. Additionally, the committee agreed to include a third measure focused on Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).

The committee concluded by approving these three targeted areas for focus, with plans to implement interventions that will address identified barriers and promote better collaboration between medical and behavioral healthcare providers.

List of Committee Members:

Name	Title / Department	Agency
Martha Tasinga, MD	Chief Medical Officer	Kern Health System
Melinda Santiago, LMFT	Director of Behavioral Health	Kern Health System
Marissa Garcia Trebizo, LMFT	Sr. Director of BH	Clinica Sierra Vista, Network Provider
Heather Hornibrook, LMFT	Deputy Director	Kern Behavioral Health & Recovery Services (MHP)
Mesha Muwanga, LMFT	Licensed Therapist	Rhema Therapy, Inc. Network Provider
Anuradha Rao, MD	Pediatric PCP	OMNI, Network Provider
Matthew Beare, MD	Adult PCP	Clinica Sierra Vista, Network Provider
Franco Song, MD	Chief Medical Officer/ Psychiatrist	Psychiatric Wellness Center, Network Provider
Abdolreza Saadabadi, MD	Medical Director BH/Psychiatrist	Kern Health System

Opportunity 1:

Address the opportunities for improvement in Antidepressant Medication Management (AMM) in the context of Appropriate Diagnosis, Treatment, and Referral of Behavioral Health Disorders commonly seen in primary care. The opportunity to facilitate effective communication between PCPs and BH specialists is crucial for the appropriate diagnosis, treatment, and management of behavioral health disorders, particularly for patients on antidepressant medications. Improving communication can enhance coordination of care by ensuring that both PCPs and BH specialists have access to the same patient information, care goals, and treatment plans helps provide more comprehensive care and reduces duplication of efforts. Support more informed treatment decisions by sharing insights from both a medical and behavioral health perspective improves the overall quality of care and optimizes the use of antidepressant medications. Ensure timely referrals and follow-ups with improved communication can prevent delays in referrals to BH specialists when necessary and allow for regular updates and feedback loops. By increasing patient engagement and adherence, patients are more likely to stay engaged in their care when they see that their healthcare providers are collaborating, which can

positively impact treatment adherence, including antidepressant medication management.

Opportunity 2:

Address the opportunities for improvement in Appropriate Use of Psychotropic Medications Follow-Up Care for Children Prescribed with ADHD Medication Management (ADD). Managing ADHD in children under 21 years of age requires comprehensive, coordinated care across multiple healthcare providers, including primary care providers (PCPs), behavioral health specialists, pediatricians, and sometimes psychiatrists. Ensuring appropriate medication management for ADHD and necessary follow-up care requires collaboration, ongoing monitoring, and timely interventions, particularly when psychotropic medications such as stimulants and non-stimulants are prescribed. There are several key opportunities for improvement to enhance the appropriateness of ADHD medication use and ensure that children receive all necessary diagnostic, treatment, and follow-up services, as well as the required screening and preventive services. These opportunities are primarily centered around improving communication, enhancing data exchange, and upgrading the provider portal to better support coordinated care.

Describe the Barriers

Addressing the opportunities for improvement in Antidepressant Medication Management (AMM) and Appropriate Use of Psychotropic Medications (ADD) requires overcoming several barriers to enhancing continuity and coordination of care between Primary Care Providers (PCPs) and Behavioral Health (BH) specialists. These opportunities will require investment in training, technology, and cross-departmental collaboration but has the potential to significantly improve patient outcomes by fostering a more connected, coordinated care environment between primary care and behavioral health providers.

1. There is often minimal communication between PCPs and BH specialists, resulting in fragmented care. This is exacerbated by cultural differences in how both sectors view patient care, with medical providers focusing on physical health and BH providers focusing on mental health, leading to a siloed approach.
2. Referral processes between PCPs and BH specialists are often not standardized, leading to missed opportunities for comprehensive care. Follow-up from BH providers to PCPs may be inconsistent, meaning PCPs may not know if their patients are engaging in behavioral health services or making progress in treatment.
3. PCPs often have time constraints and may focus primarily on physical health issues, leaving little room for addressing behavioral health concerns. BH specialists, on the other hand, may be focused on mental health treatment without considering the broader medical context.
4. Many PCPs lack access to behavioral health records, treatment plans, and progress updates from BH specialists, which hinders their ability to make informed decisions about antidepressant or ADHD medication management. While both sectors may use Electronic Health Records (EHRs), these systems are often not designed to share patient data efficiently between PCPs and BH specialists, leading to incomplete or delayed information sharing.
5. In primary care settings, there is often a lack of standardized screening for behavioral health conditions, especially for conditions like depression or ADHD. Without proper screening, patients may not be referred to BH specialists in a timely manner, leading to delayed treatment.
6. Financial limitations and lack of resources can hinder the ability of both PCPs and BH specialists to provide comprehensive care. Both sectors may be underfunded and may face reimbursement barriers for services that integrate behavioral health into primary care.
7. Patient reluctance to engage in behavioral health care or adhere to prescribed antidepressant or ADHD medication regimens is a significant barrier. Mental health stigma, lack of awareness of the importance of medication management, and difficulties navigating the healthcare system can deter patients from seeking or continuing care.

Action Plan:

Opportunity 1:
For Appropriate Diagnosis, Treatment, and Referral of Behavioral Health Disorders Commonly Seen in Primary Care Antidepressant Medication Management (AMM).

i. **Educate Providers on the Importance of Collaboration**:
   a. Organize educational sessions or workshops for PCPs and BH providers about the value of interdisciplinary collaboration, focusing on improved outcomes for patients with depression or other behavioral health conditions.
   b. Include case studies and evidence-based practices that highlight the benefits of joint management of antidepressant medications and other psychiatric treatments.

ii. **Promote the Use of the Provider Portal**:
   a. Increase awareness and usage of the provider portal among PCPs and BH specialists to facilitate better communication. This portal should allow for easy sharing of patient information (medication history, treatment plans, referrals).

iii. **Standardize Communication Protocols**:
   a. Develop and implement standardized communication protocols (e.g., shared care plans, regular check-ins, case conferences) between PCPs and BH specialists.

iv. **Create a Feedback Loop for Medication Management**:
   a. Establish a system where PCPs and BH specialists can share feedback about a patient's response to antidepressant medications and other treatments. This might include scheduled follow-up appointments to discuss treatment progress, side effects, or changes in patient status.
   b. Set up a regular feedback mechanism that encourages ongoing collaboration, such as through shared patient outcome tracking or electronic communication tools.

v. **Departmental Collaboration and Strategy Development**:
   a. Form Behavioral Health Advisory Committee composed of representatives from both PCP and BH practitioners to develop strategies aimed at improving communication and collaboration.
   b. Set goals for bidirectional coordination, such as shared clinical guidelines, and communication tools.

vi. **Monitor Progress and Evaluate Outcomes**:
   a. Regularly assess the effectiveness of the communication strategies through quality improvement audits, patient satisfaction surveys, and performance metrics (e.g., antidepressant medication adherence, referral timeliness, and patient outcomes).
   b. Use this data to make continuous improvements in the communication and collaboration process.

Opportunity 2:
For Appropriate Use of Psychotropic Medications Follow-Up Care for Children Prescribed with ADHD Medication Management (ADD).

1. **Educate Providers**: Implement educational campaigns to inform providers about the benefits of using the portal, ensuring they understand its role in streamlining communication and improving care quality.
2. **Encourage Portal Utilization**: Make the portal user-friendly, accessible, and comprehensive, with easy navigation for all types of providers. Highlight key features, such as access to medication lists, past diagnoses, and upcoming follow-up appointments.
3. **Monitor Use**: Track provider engagement with the portal and provide additional training or incentives for providers who do not frequently use it.
4. **Add Behavioral Health Features to the Portal**: Upgrade the portal so it includes relevant BH data, such as:
   a. **Behavioral health diagnosis** (e.g., ADHD, co-occurring conditions such as anxiety or depression).

b. **Referrals to BH specialists** (including the name of the assigned provider and referral dates).
c. **List of prescribed psychotropic medications** and monitoring requirements.
d. **Current treatment plans** for ADHD and any related behavioral issues.

5. **Ensure Real-Time Updates**: Ensure that when information is updated (e.g., a new medication is prescribed or a follow-up appointment is scheduled), it is automatically reflected in the portal in real time.

Subject matter experts were involved throughout the process. All barrier analysis had a combination of the following subject matter experts present throughout discussions:

Name	**Title / Department**
Martha Tasinga, MD	Chief Medical Officer
Melinda Santiago	Director of Behavioral Health
John Monahan	Business Intelligence Analyst IV
Bruce Wearda	Director of Pharmacy
Kailey Collier	Director of Quality Performance
Michelle Curioso	Director of Population Health Management
James Winfrey	Deputy Director of Provider Network

Resources:
MOU Requirements KHS and Specialty Substance Use Disorder, # 21.07-P
W&I Codes, 14059.5 and 141.84.402
BH Program Description
Policy and Procedure, Care Coordination and Care Management, # 21.02-P
Policy and Procedure, Scope of Services, #21.05
Policy and Procedure, Adult and Youth Screening and Transition of Care, # 21.01-P
American Psychiatric Association, 2018

NCQA Qualitative Data Analysis Report

Behavioral Health Complaints and Appeals

Introduction

This report summarizes the analysis of behavioral health complaints and appeals received during the 2023 calendar year. The data, covering January 1, 2023, through December 31, 2023, was gathered and evaluated by the Grievance Department and Behavioral Health leadership to identify trends, areas of improvement, and opportunities for quality enhancement in behavioral health services. The analysis combines both quantitative and qualitative data to gain a comprehensive understanding of the complaints and appeals process.

Methodology

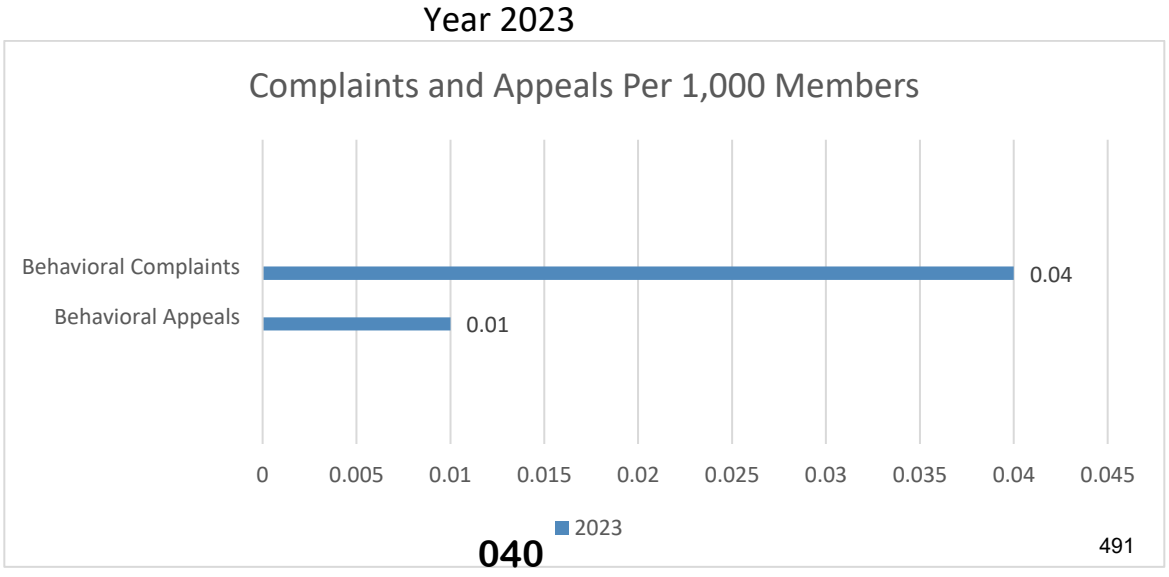
The analysis was conducted in two parts:

- **Quantitative Analysis:** Involves the numerical tracking of complaints categorized by issue type, frequency, and resolution status.
- **Qualitative Analysis:** A detailed review of the nature and context of complaints and appeals, identifying underlying themes and patterns. This analysis was performed by Behavioral Health leadership to gain insights into the experiences of members and to understand the root causes of the complaints.

Complaint Categories

The Grievance Department tracks complaints within the following five categories:

1. Access to Care: Complaints related to difficulties in obtaining timely appointments, finding appropriate providers, or issues with care accessibility (e.g., geographic barriers, availability of services).
2. Attitude and Services: Complaints regarding the interpersonal aspects of care, including issues with the attitudes, behaviors, or professionalism of behavioral health staff, or dissatisfaction with the quality of customer service.
3. Billing and Financial Issues: Complaints related to problems with billing, insurance coverage, out-of-pocket costs, or financial assistance for behavioral health services.
4. Quality of Care: Complaints concerning the perceived quality, effectiveness, or appropriateness of the behavioral health services provided, including concerns about treatment plans, therapy, and outcomes.
5. Quality of Practitioner Office Site: Complaints regarding the physical environment of the practitioner's office, including cleanliness, comfort, accessibility, or safety concerns.



Behavioral Healthcare Complaints

The following tables provides data on behavioral healthcare complaints filed in 2023. Kern Health Systems (KHS) has an overall behavioral health grievance goal of 10 per 1000 members per year and 2 per 1000 members per year for each grievance category.

Table 1: Complaint Volume Report – Behavioral Healthcare

Category	2023			
	Complaints Total	**Complaints per 1,000 members**	**Performance Goals**	**Performance Goals Met?**
Access	49	0.01	<2	Yes
Attitude and Service	65	0.02	<2	Yes
Billing and Financial Issues	0	0	<2	Yes
Quality of Care	17	<0.01	<2	Yes
Quality of Practitioner Office Site	0	0	<2	Yes
Total	**131**	**0.04**	**<10**	**Yes**

Quantitative Analysis: In 2023, a total of 131 behavioral healthcare complaints were filed, totaling 0.04 complaints per 1000 members. KHS met our goals of <10 grievances per 1000 members per year and <2 grievances per 1000 members per grievance category for the year. Overall, Kern Health Systems maintained the overall category and per category performance goal.

Behavioral Healthcare Appeals

The following tables provides data on non-behavioral healthcare appeals filed in 2023. Kern Health Systems has overall category goal of 10 per 1000 members per year and 2 per 1000 members per year for each grievance category.

Table 1: Appeal Volume Report – Behavioral Healthcare

Category	2023			
	Appeals Total	**Appeals per 1,000 members**	**Performance Goals**	**Performance Goals Met?**
Access	0	0	<2	Yes
Attitude and Service	0	0	<2	Yes
Billing and Financial Issues	0	0	<2	Yes

Quality of Care	4	<.01	<2	Yes
Quality of Practitioner Office Site	0	0	<2	Yes
Total	**4**	**.01**	**<10**	**Yes**

Quantitative Analysis: In 2023, there were 4 behavioral healthcare appeals filed, totaling less than .01 appeals per 1000 members per year, with <1 grievance per 1000 members per grievance category per year. Overall, Kern Health Systems met the overall grievance and per category performance goal.

Qualitative Analysis: In 2023, the top three categories for grievances and appeals were Access, Attitude and Service and Quality of Care. When reviewed against the 2024 ECHO Member Satisfaction Survey, we found common deficiencies in these categories. KHS has increased provider capacity working with Provider Network Management (PNM). PNM has a Provider Recruitment Specialist to assist with ongoing recruitment efforts. Grants and Special Programs launched the Provider Recruitment & Retention Grant (R&R) to improve access and increase provider capacity/ appointment within BH. BH has increased providers by 11.85% between Q4 2023 to Q3 2024.

The qualitative analysis revealed the following key themes:

- **Access to Care:** Many complaints centered around long wait times for appointments, particularly for specialized behavioral health services. Issues with limited provider availability and difficulties in scheduling were also commonly cited.
- **Attitude and Services:** Complaints in this category typically focused on negative experiences with staff behavior, including perceived unprofessionalism, lack of empathy, or communication challenges with providers.
- **Quality of Care:** Complaints in this area frequently involved concerns about the adequacy of treatment, including dissatisfaction with the effectiveness of therapy or the alignment of treatment plans with individual needs.

While KHS has made significant progress in increasing provider capacity, working closely with Provider Network Management (PNM), and launching the Provider Recruitment & Retention Grant (R&R), several barriers remain that could impact the success of these opportunities and actions. While telehealth options have expanded access for many members, there remains a subset of patients who prefer or require in-person visits for their care. The availability of in-person appointments may not fully meet the demand, especially in more rural areas or for specialized services where telehealth may not be as effective. This disparity between telehealth and in-person options can create friction for members seeking care and may contribute to dissatisfaction in terms of accessibility. Even with the addition of more providers, appointment availability may still not align with member demand, especially during peak times or for urgent care needs. Long wait times or difficulty securing timely appointments could result in frustration and negatively affect member satisfaction. Additionally, members may experience challenges navigating the scheduling process, particularly if they face issues with online booking systems, lack of clarity in provider availability, or communication gaps between administrative staff and patients.

Recommendations

Based on the findings of the quantitative and qualitative analysis, the following recommendations are proposed:

1. **Improve Access to Care:**
   - Increase the availability of appointments, particularly for specialized care, and explore expanding telehealth services to address accessibility challenges.
   - Ensure that providers are trained in best practices for conducting effective and engaging telehealth sessions. This includes clear communication, maintaining a personal connection, and addressing any concerns members may have about the virtual format.
   - Implement member education on the benefits of telehealth, such as convenience, reduced wait times, and access to specialists that might not be available locally. Highlighting the effectiveness of telehealth as in-person visits for many mental health services.
2. **Attitude and Services:**
   - Provide additional training for staff in customer service, empathy, and professionalism to address complaints regarding attitudes and service quality.
   - Introduce a feedback loop for members to provide real-time input about their experiences with behavioral health professionals.
   - Regional Advisory Committees (RAC) meetings. Engaging a gathering of members and community residents who share their personal experiences with health care in their region.
   - Discover opportunities for ways to improve member and provider communication through technology using multiple modalities.

3. **Improve the Quality of Care:**
   - Review and refine treatment protocols to ensure that care is aligned with member needs and expectations. Ensure that members are receiving the appropriate level of care and follow-up.
   - Offer regular training for practitioners to keep them updated on best practices and evidence-based treatment approaches.

Conclusion

Kern Health Systems met the goals for both complaints and appeal categories. The analysis of complaints and appeals in 2023 has highlighted several key challenges within behavioral health services. Notably, issues with access to care, particularly in terms of appointment availability and timeliness, continue to be a significant concern. Complaints related to staff attitudes, billing discrepancies, and the quality of physical office environments also point to areas that require attention and improvement.

Report prepared and reviewed by
Melinda Santiago, Director of Behavioral Health

1. Executive Summary

Dedicated to improving the business of health care satisfaction, Press Ganey (PG) is pleased to provide your health plan with this Executive Summary, an overview of significant survey results from the Kern Family Health Care (Child)'s ECHO® Member Satisfaction Survey. The remainder of this report is dedicated to specific analyses in order to assist you in developing a more comprehensive plan for improving and maintaining member satisfaction.

PG followed a mixed mode survey methodology to administer the ECHO® Member Satisfaction Survey from July through September of 2024. A total of 84 surveys were collected, yielding a response rate of 18.7%.

The chart below presents 2024 Summary Rate Scores[1] for Kern Family Health Care (Child)'s composites, item-specific attributes, and the rating of counseling or treatment. In addition, trend data (if applicable) and the 2023 Press Ganey ECHO® Book of Business benchmark is provided so that you may assess how your member satisfaction scores compare with those of other plans.[2]

Composites	2024 Summary Rates	2023 PG ECHO® Aggregate BoB	**
Getting Treatment Quickly	52.8%	64.1%	↓
How Well Clinicians Communicate	83.8%	89.5%	
Item-Specific Attributes/Rating Item			
Office Wait Time (Q5)	70.7%	78.7%	
Informed about Medication Side Effects (Q11)	75.6%	80.6%	
Rating of Counseling or Treatment (Q16)	74.4%	74.9%	

*↓↑ Indicates a significant difference when compared to previous years.
**↓↑ Indicates a significant difference when compared to the 2023 Press Ganey ECHO® Book of Business.

ECHO® Satisfaction Report Highlights

Kern Family Health Care (Child)

Summary Rate Scores	Highest and Lowest Performing Composite Key Attributes	2024		2023 PG Agg. B.o.B.**		
		n*	SRS*	PG B.o.B.	25th percentile	75th percentile
	Highest Scoring Questions					
	Q12. In the last 12 months, how often were you involved as much as you wanted in your child's counseling or treatment?	84	89.3%	88.0%	83.2%	92.4%
	Q8. In the last 12 months, how often did the people your child saw for counseling or treatment show respect for what you had to say?	84	85.7%	93.1%	90.4%	95.7%
	Q6. In the last 12 months, how often did the people your child saw for counseling or treatment listen carefully to you?	84	84.5%	89.8%	85.9%	93.2%
	Lowest Scoring Questions					
	Q3. In the last 12 months, not counting the times your child needed counseling or treatment right away, how often did your child get an appointment for counseling or treatment as soon as you wanted?	83	62.7%	77.6%	67.8%	80.5%
	Q2. In the last 12 months, when your child needed counseling or treatment right away, how often did he or she see someone as soon as you wanted?	81	58.0%	65.9%	55.9%	74.3%
	Q1. In the last 12 months, how often did you get the professional counseling your child needed on the phone?	82	37.8%	51.8%	41.7%	57.9%

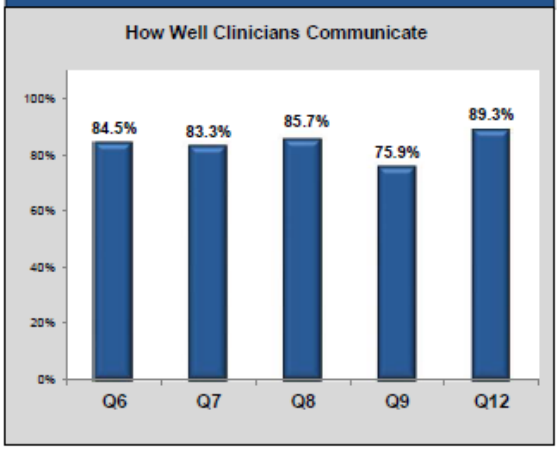
Priority Matrix

Composite	Correlation***	BOB Percentile Ranking
Strength: No composites are considered Strengths.		
Top Priority		
How Well Clinicians Communicate	*0.853*	*13th*

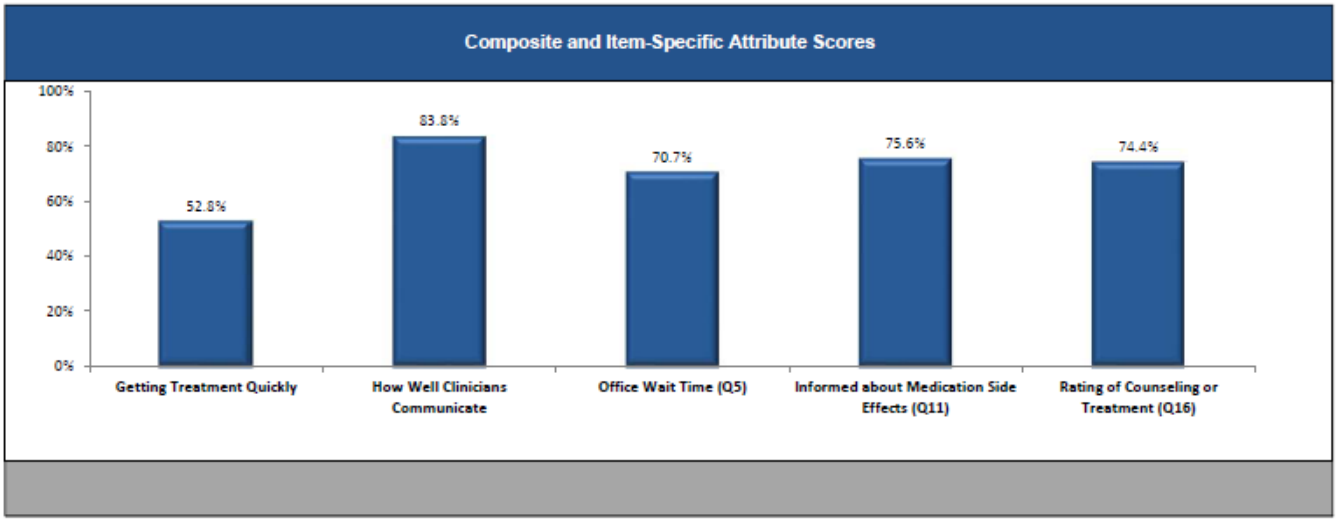
Strength: Composite is highly correlated with Rating of Counseling and Treatment and ranks at or above the 75th percentile when compared to the PG ECHO Aggregate Book of Business benchmark.

Top Priority: Composite is highly correlated with Rating of Counseling and Treatment and ranks below the 75th percentile when compared to the PG ECHO Aggregate Book of Business benchmark.

Highest Performing Composite



Composite and Item-Specific Attribute Scores



* The Valid n represents the number of responses to the question. Summary Rate Scores (SRS) represent the most favorable response percentages ("Usually" and "Always;" "Yes;" "None;" "8-10;" and "Not a problem").

** The Press Ganey 2023 ECHO Book of Business benchmark consists of data from 117 plans representing 26439 adult and child respondents, including 16753 Behavioral Health Service Users. See Technical Notes for more information.

*** A correlation coefficient approaching a value of 1.000 represents an increasing association of the composite with the rating of counseling or treatment (Q29).

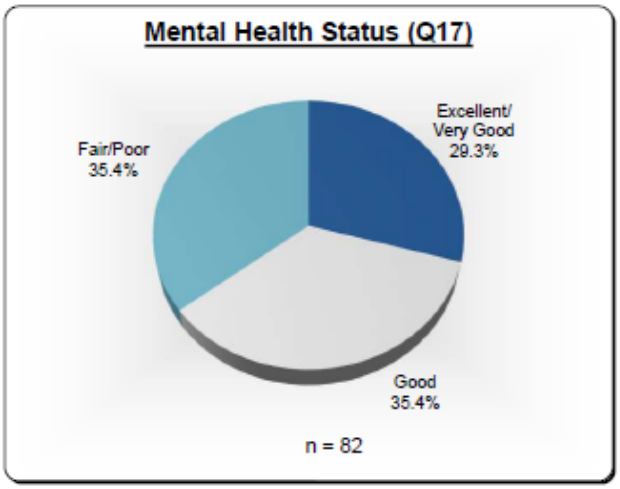
Note: Significance Testing - Cells highlighted in red denote current year plan percentage is significantly lower when compared to benchmark data; cells highlighted in green denote current year plan percentage is significantly higher when compared to benchmark data; no shading denotes that there was no significant difference between the percentages, there is no comparable data, or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level.

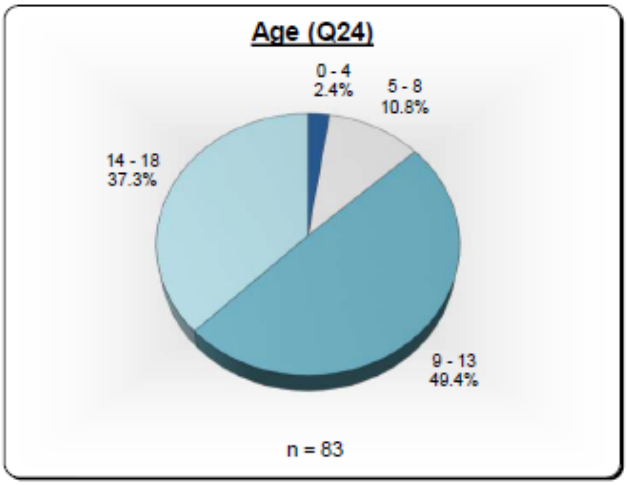
Profile of Survey Respondents

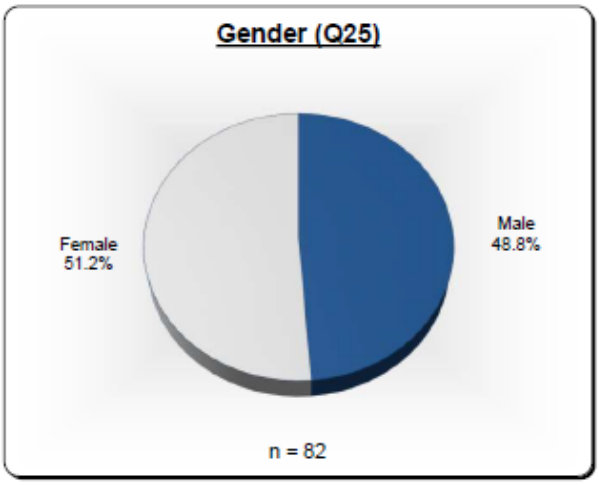
Survey Demographics

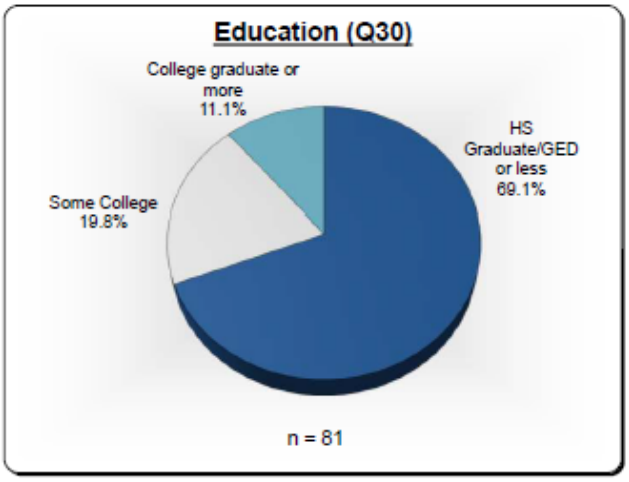
84 Total Respondents

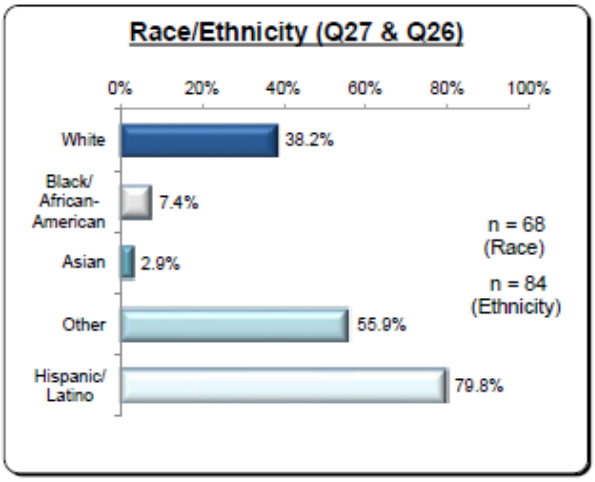
Kern Family Health Care (Child)
ECHO® Member Satisfaction Survey











Note 1: Mental Health Status (Q31) and Overall Health Status (Q59) are defined by the member.
Note 2: Race/Ethnicity (Q63 & Q62) figures may not equal 100% because they are separate questions. "Other" includes Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, and respondents who chose Other.

Summary of Trend and Benchmark Comparisons

Kern Family Health Care (Child)

Composites and Attributes - Summary Rate Scores

ECHO® Member Satisfaction Survey

84 Total Respondents

Composites and Key Questions	Current		
	2024		2023 PG Book of Business Benchmark Aggregate**
	Valid n	Summary Rate*	
Getting Treatment Quickly		52.8%	64.1%
Q1. In the last 12 months, how often did you get the professional counseling your child needed on the phone?	82	37.8%	51.8%
Q2. In the last 12 months, when your child needed counseling or treatment right away, how often did he or she see someone as soon as you wanted?	81	58.0%	65.9%
Q3. In the last 12 months, not counting the times your child needed counseling or treatment right away, how often did your child get an appointment for counseling or treatment as soon as you wanted?	83	62.7%	77.6%
How Well Clinicians Communicate		83.8%	89.5%
Q6. In the last 12 months, how often did the people your child saw for counseling or treatment listen carefully to you?	84	84.5%	89.8%
Q7. In the last 12 months, how often did the people your child saw for counseling or treatment explain things in a way you could understand?	84	83.3%	91.6%
Q8. In the last 12 months, how often did the people your child saw for counseling or treatment show respect for what you had to say?	84	85.7%	93.1%
Q9. In the last 12 months, how often did the people your child saw for counseling or treatment spend enough time with you?	83	75.9%	88.8%
Q12. In the last 12 months, how often were you involved as much as you wanted in your child's counseling or treatment?	84	89.3%	88.0%
Office Wait Time (Q5)	82	70.7%	78.7%
Informed about Medication Side Effects (Q11)	41	75.6%	80.6%
Rating of Counseling or Treatment (Q16)	82	74.4%	74.9%

* Summary Rates represent the most favorable response percentage(s).

** The 2023 Press Ganey ECHO Aggregate Book of Business benchmark consists of data from 117 plans representing 26439 adult and child respondents, including 16753 Behavioral Health Service Users. See Technical Notes for more information.

Note: Significance Testing - Cells highlighted in red denote current year plan percentage is significantly lower when compared to benchmark data; Cells highlighted in green denote current year plan percentage is significantly higher when compared to benchmark data; No shading denotes that there was no significant difference between the percentages, there is no benchmark, or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level.

Summary of Benchmark Comparisons

PG 2023 Book of Business Percentiles

Kern Family Health Care (Child)

ECHO® Member Satisfaction Survey

84 Total Respondents

Composites and Key Questions	Summary Rate*	Kern Family Health Care (Child) Percentile Ranking**	2023 PG Agg. Book of Business Benchmark***	2023 PG Agg. BoB Percentiles			
				25th	50th	75th	90th
Getting Treatment Quickly	52.8%	<10th	64.1%	57.9%	62.6%	69.2%	77.1%
Q1. In the last 12 months, how often did you get the professional counseling your child needed on the phone?	37.8%	15th	51.8%	41.7%	50.0%	57.9%	65.6%
Q2. In the last 12 months, when your child needed counseling or treatment right away, how often did he or she see someone as soon as you wanted?	58.0%	28th	65.9%	55.9%	66.1%	74.3%	81.9%
Q3. In the last 12 months, not counting the times your child needed counseling or treatment right away, how often did your child get an appointment for counseling or treatment as soon as you wanted?	62.7%	<10th	77.6%	67.8%	73.6%	80.5%	86.1%
How Well Clinicians Communicate	83.8%	13th	89.5%	86.6%	89.6%	93.6%	96.9%
Q6. In the last 12 months, how often did the people your child saw for counseling or treatment listen carefully to you?	84.5%	19th	89.8%	85.9%	88.8%	93.2%	97.3%
Q7. In the last 12 months, how often did the people your child saw for counseling or treatment explain things in a way you could understand?	83.3%	<10th	91.6%	88.5%	91.7%	95.0%	98.4%
Q8. In the last 12 months, how often did the people your child saw for counseling or treatment show respect for what you had to say?	85.7%	<10th	93.1%	90.4%	93.0%	95.7%	98.7%
Q9. In the last 12 months, how often did the people your child saw for counseling or treatment spend enough time with you?	75.9%	<10th	88.8%	83.3%	88.2%	93.2%	96.3%
Q12. In the last 12 months, how often were you involved as much as you wanted in your child's counseling or treatment?	89.3%	62nd	88.0%	83.2%	87.1%	92.4%	96.9%
Office Wait Time (Q5)	70.7%	27th	78.7%	70.5%	77.8%	86.9%	92.1%
Informed about Medication Side Effects (Q11)	75.6%	24th	80.6%	75.9%	80.9%	84.8%	89.9%
Rating of Counseling or Treatment (Q16)	74.4%	57th	74.9%	67.9%	73.2%	78.6%	85.0%

At or above the 90th percentile.
At or above the 75th percentile, but below the 90th percentile.
At or above the 50th percentile, but below the 75th percentile.
At or above the 25th percentile, but below the 50th percentile.
Below the 25th percentile.

* Summary Rates represent the most favorable response percentage(s).

** Ranking indicates where your plan's Summary Rate ranks when compared to all other plans in the 2023 ECHO Book of Business. Summary Rates that are below the 10th percentile are shown as '<10th.'

*** The 2023 Press Ganey ECHO Aggregate Book of Business benchmark consists of data from 117 plans representing 26439 adult and child respondents, including 16753 Behavioral Health Service Users. See Technical Notes for more information.

1. Executive Summary

Dedicated to improving the business of health care satisfaction, Press Ganey (PG) is pleased to provide your health plan with this Executive Summary, an overview of significant survey results from the Kern Family Health Care (Adult)'s ECHO® Member Satisfaction Survey. The remainder of this report is dedicated to specific analyses in order to assist you in developing a more comprehensive plan for improving and maintaining member satisfaction.

PG followed a mixed mode survey methodology to administer the ECHO® Member Satisfaction Survey from August through September of 2024. A total of 221 surveys were collected, yielding a response rate of 13.0%.

The chart below presents 2024 Summary Rate Scores[1] for Kern Family Health Care (Adult)'s composites, item-specific attributes, and the rating of counseling or treatment. In addition, trend data (if applicable) and the 2023 Press Ganey ECHO® Book of Business benchmark is provided so that you may assess how your member satisfaction scores compare with those of other plans.[2]

Composites	2024 Summary Rates	2023 PG ECHO® BoB	**
Getting Treatment Quickly	64.8%	65.4%	
How Well Clinicians Communicate	81.4%	90.3%	↓
Item-Specific Attributes/Rating Item			
Office Wait Time (Q6)	69.3%	78.6%	↓
Informed about Medication Side Effects (Q12)	67.5%	79.8%	↓
Informed about Patient Rights (Q14)	83.9%	84.3%	
Ability to Refuse Medication and Treatment (Q15)	68.8%	82.2%	↓
Rating of Counseling or Treatment (Q16)	69.0%	76.0%	↓

*↓↑ Indicates a significant difference when compared to previous years.
**↓↑ Indicates a significant difference when compared to the 2023 Press Ganey ECHO® Book of Business.

ECHO® Satisfaction Report Highlights

Kern Family Health Care (ADULT)

Summary Rate Scores	Percentile Ranking	Highest and Lowest Performing Composite Key Attributes	2024 n*	2024 SRS*	2023 PG B.o.B.** PG B.o.B.	25th percentile	75th percentile
	Highest Scoring Questions						
	<10th	Q9. In the last 12 months, how often did the people you went to for counseling or treatment show respect for what you had to say?	218	87.2%	93.4%	90.7%	96.3%
	10th	Q7. In the last 12 months, how often did the people you went to for counseling or treatment listen carefully to you?	219	84.0%	90.5%	86.6%	94.1%
	<10th	Q8. In the last 12 months, how often did the people you went to for counseling or treatment explain things in a way you could understand?	219	80.8%	92.0%	89.2%	95.8%
	Lowest Scoring Questions						
	<10th	Q4. In the last 12 months, not counting the times you needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted?	214	64.5%	78.6%	69.2%	81.9%
	26th	Q3. In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted?	210	58.1%	66.5%	57.6%	75.0%
	#REF!	Q18. In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called customer service?	72	56.9%	52.7%	42.0%	60.4%

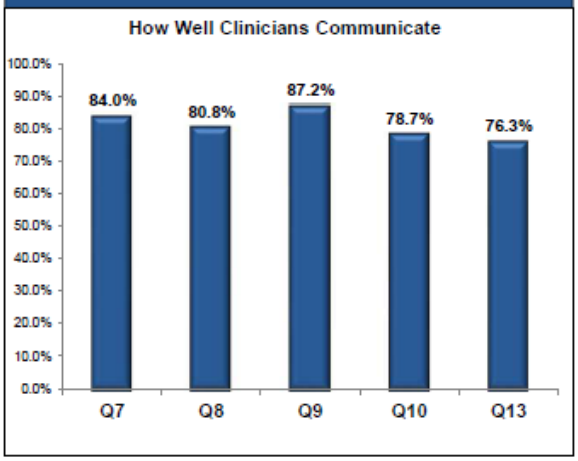
Priority Matrix

Composite	Correlation***	BOB Percentile Ranking
Strength: No composites are considered Strengths.		
Top Priority: No composites are considered Top Priorities.		

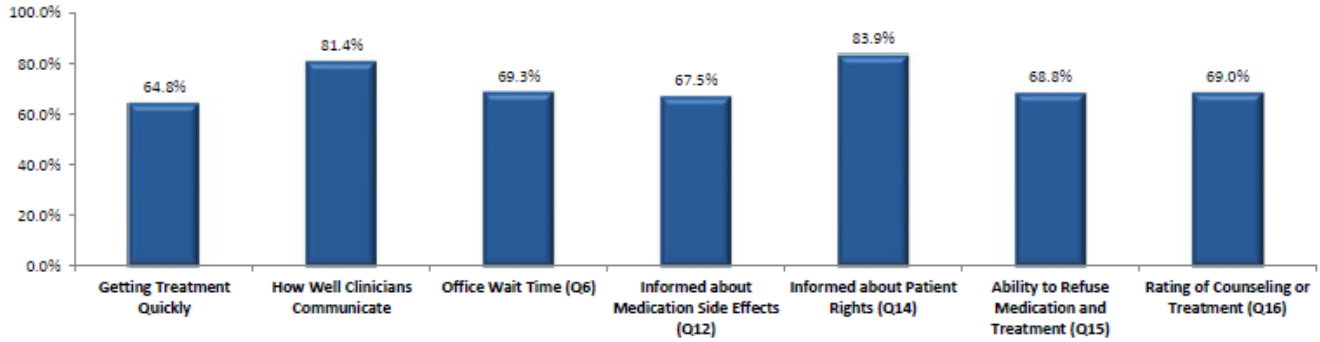
Strength: Composite is highly correlated with Rating of Counseling and Treatment and ranks at or above the 75th percentile when compared to the PG Book of Business benchmark.

Top Priority: Composite is highly correlated with Rating of Counseling and Treatment and ranks below the 75th percentile when compared to the PG Book of Business benchmark.

Highest Performing Composite



Composite and Item-Specific Attribute Scores



* The Valid n represents the number of responses to the question. Summary Rate Scores (SRS) represent the most favorable response percentages ("Usually" and "Always"; "Yes"; "2 days or less"; "3 days or less"; "None"; "8-10"; "Not a problem"; "Excellent" and "Very good".)

** The PG 2023 ECHO Book of Business benchmark consists of data from 92 plans representing 21,863 adult respondents, including 14,387 Behavioral Health Service Users. See Technical Notes for more information.

*** A correlation coefficient approaching a value of 1.000 represents an increasing association of the composite with the rating of counseling or treatment (Q16).

Note: Significance Testing - Cells highlighted in red denote current year plan percentage is significantly lower when compared to benchmark data; cells highlighted in green denote current year plan percentage is significantly higher when compared to benchmark data; no shading denotes that there was no significant difference between the percentages, there is no comparative data, or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level.

Profile of Survey Respondents

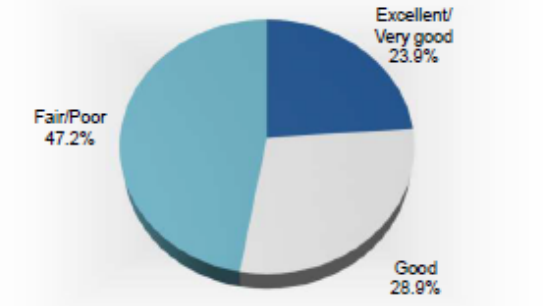
Survey Demographics

Kern Family Health Care (ADULT)

ECHO® Member Satisfaction Survey

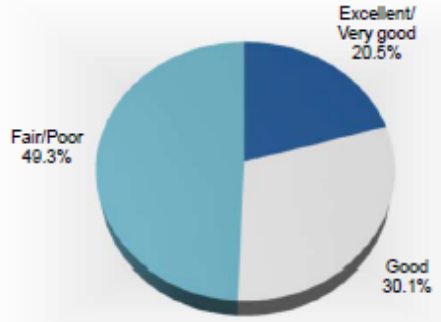
221 Total Respondents

Mental Health Status (Q20)



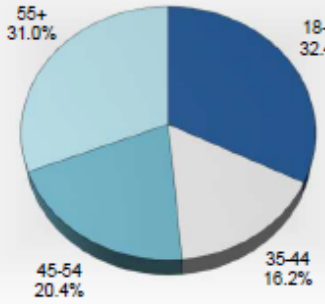
n = 218

Physical Health Status (Q21)



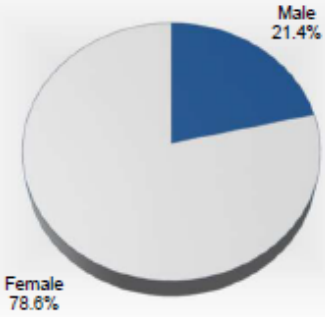
n = 219

Age (Q22)



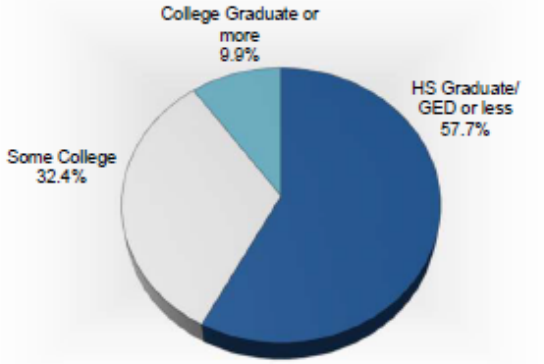
n = 216

Gender (Q23)



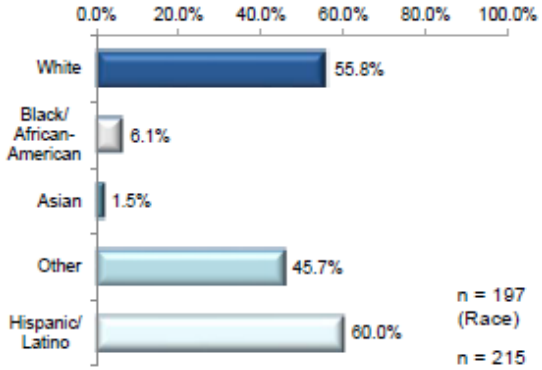
n = 220

Education (Q24)



n = 213

Race/Ethnicity (Q26/Q25)



n = 197 (Race)

n = 215 (Ethnicity)

Note 1: Mental Health Status (Q20) and Physical Health Status (Q21) are defined by the member.

Note 2: Race/Ethnicity (Q26/Q25) figures may not equal 100% because they are separate questions and (Q26) includes multimark responses. 'Other' includes Native Hawaiian or other Pacific Islander, American Indian or Alaska Native, and respondents who chose Other.

Summary of Trend and Benchmark Comparisons

Composites and Attributes - Summary Rate Scores

Kern Family Health Care (ADULT)

ECHO® Member Satisfaction Survey

221 Total Respondents

Composites and Key Questions	Current 2024 Valid n	Current 2024 Summary Rate*	2023 PG Book of Business Benchmark**
Getting Treatment Quickly		64.8%	65.4%
Q2. In the last 12 months, how often did you get the professional counseling you needed ?	139	71.9%	53.5%
Q3. In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted?	210	58.1%	66.5%
Q4. In the last 12 months, not counting the times you needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted?	214	64.5%	78.6%
How Well Clinicians Communicate		81.4%	90.3%
Q7. In the last 12 months, how often did the people you went to for counseling or treatment listen carefully to you?	219	84.0%	90.5%
Q8. In the last 12 months, how often did the people you went to for counseling or treatment explain things in a way you could understand?	219	80.8%	92.0%
Q9. In the last 12 months, how often did the people you went to for counseling or treatment show respect for what you had to say?	218	87.2%	93.4%
Q10. In the last 12 months, how often did the people you went to for counseling or treatment spend enough time with you?	216	78.7%	89.8%
Q13. In the last 12 months, how often were you involved as much as you wanted in your counseling or treatment?	211	76.3%	88.2%
Office Wait Time (Q6)	215	69.3%	78.6%
Informed about Medication Side Effects (Q12)	166	67.5%	79.8%
Informed about Patient Rights (Q14)	211	83.9%	84.3%
Ability to Refuse Medication and Treatment (Q15)	215	68.8%	82.2%
Rating of Counseling or Treatment (Q16)	216	69.0%	76.0%

* Summary Rates represent the most favorable response percentage(s).

** The PG 2023 ECHO Book of Business benchmark consists of data from 92 plans representing 21,863 adult respondents, including 14,387 Behavioral Health Service Users. See Technical Notes for more information.

Note 1: Significance Testing - Cells highlighted in red denote current year plan percentage is significantly lower when compared to benchmark data; Cells highlighted in green denote current year plan percentage is significantly higher when compared to benchmark data; No shading denotes that there was no significant difference between the percentages, there is no benchmark, or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level.

Summary of Benchmark Comparisons

PG 2023 Book of Business Percentiles

Kern Family Health Care (ADULT)

ECHO® Member Satisfaction Survey

221 Total Respondents

Composites and Key Questions	Summary Rate*	Kern Family Health Care (ADULT) Percentile Ranking**	2023 PG Book of Business Benchmark***	2023 PG BoB Percentiles***			
				25th	50th	75th	90th
Getting Treatment Quickly	64.8%	53rd	65.4%	59.5%	63.9%	70.8%	79.6%
Q2. In the last 12 months, how often did you get the professional counseling you needed ?	71.9%	95th	53.5%	45.9%	52.3%	58.6%	66.3%
Q3. In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted?	58.1%	26th	66.5%	57.6%	66.2%	75.0%	82.5%
Q4. In the last 12 months, not counting the times you needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted?	64.5%	<10th	78.6%	69.2%	74.6%	81.9%	86.4%
How Well Clinicians Communicate	81.4%	<10th	90.3%	87.0%	90.0%	94.4%	97.1%
Q7. In the last 12 months, how often did the people you went to for counseling or treatment listen carefully to you?	84.0%	10th	90.5%	86.6%	89.3%	94.1%	97.4%
Q8. In the last 12 months, how often did the people you went to for counseling or treatment explain things in a way you could understand?	80.8%	<10th	92.0%	89.2%	91.9%	95.8%	98.7%
Q9. In the last 12 months, how often did the people you went to for counseling or treatment show respect for what you had to say?	87.2%	<10th	93.4%	90.7%	93.1%	96.3%	100.0%
Q10. In the last 12 months, how often did the people you went to for counseling or treatment spend enough time with you?	78.7%	<10th	89.8%	84.5%	88.5%	94.3%	96.7%
Q13. In the last 12 months, how often were you involved as much as you wanted in your counseling or treatment?	76.3%	<10th	88.2%	83.1%	87.1%	92.6%	96.2%
Office Wait Time (Q6)	69.3%	24th	78.6%	69.6%	77.7%	88.1%	93.0%
Informed about Medication Side Effects (Q12)	67.5%	<10th	79.8%	75.5%	79.9%	83.3%	86.5%
Informed about Patient Rights (Q14)	83.9%	44th	84.3%	79.7%	84.6%	89.0%	91.5%
Ability to Refuse Medication and Treatment (Q15)	68.8%	<10th	82.2%	76.2%	85.7%	89.0%	97.7%
Rating of Counseling or Treatment (Q16)	69.0%	23rd	76.0%	70.5%	73.9%	79.1%	85.7%

At or above the 90th percentile.
At or above the 75th percentile, but below the 90th percentile.
At or above the 50th percentile, but below the 75th percentile.
At or above the 25th percentile, but below the 50th percentile.
Below the 25th percentile.

* Summary Rates represent the most favorable response percentage(s).

** Ranking indicates where your plan's Summary Rate ranks when compared to all other plans in the PG 2023 ECHO Book of Business. Summary Rates that are below the 10th percentile are shown as '<10th.'

*** The PG 2023 ECHO Book of Business benchmark consists of data from 92 plans representing 21,863 adult respondents, including 14,387 Behavioral Health Service Users. See Technical Notes for more information.

KERN HEALTH SYSTEMS

Non-Specialty Mental Health Services | Member and Provider Outreach and Education Plan

DECEMBER 2024

MELINDA SANTIAGO

Table of Contents

Introduction

KHS MISSION STATEMENT AND OVERVIEW

Our Mission:

Kern Health Systems is dedicated to improving the health status of our members through an integrated managed health care delivery system.

General Overview:

Kern Health Systems, known as Kern Family Health Care, was established in 1993 as a managed care health plan, and is the largest health plan in Kern County. Kern Health Systems (KHS) is committed to providing quality health care to our members. It is important to ensure good health through continuity of care by connecting each member to a provider of their choice within our provider network. Our extensive provider network includes the Traditional and Safety-Net Providers that historically delivered care to Medi-Cal recipients and private providers throughout Kern County and some parts of Los Angeles County. We believe good patient/physician relationships and effective preventive care are true indicators of our success. We also offer a continuum of care that extends beyond doctor visits. With a full range of health education classes and Care/Disease Management programs, we provide quality educational and preventive services to the population we serve. We are able to achieve this through partnerships with our providers and community-based organizations within Kern County. The difference is clear: We hold the standard high when it comes to quality health care for our members.

KHS Behavioral Health Department:

The mission of the KHS Behavioral Health department is to provide equitable, effective, and integrated behavioral health services to its members. The department aims to ensure that individuals have timely access to high-quality behavioral health and substance use services. These services are designed to improve overall health outcomes by addressing the comprehensive needs of members, fostering a holistic approach to their well-being.

KHS, through a network of licensed Mental Health Care Providers, provides Non-Specialty Behavioral Health Services (NSMHS) to Medi Cal Members with Mild to Moderate impairment of behavioral, cognitive, and emotional functioning resulting from a mental condition in the current Diagnostic and Statistical Manual. NSMHS include services such as individual/group mental health evaluation and treatment (psychotherapy), testing when clinically indicated to evaluate a mental health condition, and outpatient services for the purpose of monitoring drug therapy, and psychiatric consultation for medication management for all age groups.

The KHS Behavioral Health Department (BHD) plays a vital role in care management and utilization management for mental health and autism services. KHS ensures care coordination between the Primary Care Provider (PCP) network and the Behavioral Health Provider network to ensure that members receive seamless, integrated care. The Behavioral Health Department is overseen by the Director of Behavioral Health. The Behavioral Health Department Care

Management team is staffed by licensed mental health clinicians including LCSWs and LMFTs, and bachelors level care coordinators.

Education and Outreach Plan:

The KHS Outreach and Education Plan is designed to comply with the All-Plan Letter (APL) 24-012 issued by the California Department of Health Care Services (DHCS), a guideline aimed at improving access to mental health services within managed care plans (MCPs). The initiative, which is a response to Senate Bill (SB) 1019, addresses existing gaps in the utilization of mental health services by ensuring that both members and their primary care providers are informed annually about the covered mental health services available under the plan. This initiative aligns with the state's California Advancing and Innovating Medi-Cal (CalAIM) initiative, which emphasizes the concept of "no wrong door" for accessing essential mental health services. CalAIM aims to make mental health care more accessible and ensure that individuals understand how to navigate and access the services they need for their well-being.

The following plan outlines the activities undertaken and planned by Kern Health System's Behavioral Health department to achieve the goals of the outreach and education plan.

Stakeholder & Tribal Partner Engagement:

Community Engagement Overview

Kern Health Systems (KHS) actively participates in community events to engage with members, provide educational opportunities on health-related topics, and increase visibility in the community. These efforts aim to foster stronger connections with community members, improve awareness of healthcare services, and empower individuals to make informed healthcare decisions.

Regional Advisory Committees (RAC)
The KHS Regional Advisory Committees (RAC), launched in 2024, serve as a platform for community members to share personal healthcare experiences and provide feedback on regional healthcare services. RAC meetings are held quarterly to discuss various healthcare topics, gather input, and tailor services to meet community needs.

Objectives of RAC:

- Provide a forum for community engagement and input.
- Facilitate discussions on health equity and access.
- Gather insights to shape health policies and programs.

RAC operates as a subset of the Health Equity Steering Transformation Committee (HESTC),

which implements organization-wide initiatives promoting social and racial justice and health equity through internal and external activities.

In 2025, the Behavioral Health Department will join RAC to present the NSMHS (Network of Support for Mental Health Services) Outreach and Education Plan. These discussions will focus on:

- Improving access to behavioral health services.
- Providing culturally sensitive care.
- Addressing barriers to care.
- Developing effective outreach and education strategies.
- Raising awareness about mental health resources available through KHS.

Community Advisory Committee:

The KHS Community Advisory Committee (CAC) provides a structured mechanism for member input on how KHS operations impact care delivery.

Key Features:

- Membership complies with 22 CCR Section 53876(c) and primarily consists of KHS members.
- Open to public participation, with meeting information posted on the KHS website 30 days in advance (or at least 72 hours prior).
- Meets quarterly, with additional meetings as needed.
- Includes subcommittees and ad hoc workgroups as directed.

Behavioral Health Director presented to CAC on December 10, 2024, held at Kern Health Systems 2900 Buck Owens Boulevard Bakersfield, California 93308 1st Floor Board Room.

Key Discussions:

- Presentation on SB 1019 and the Behavioral Health Department overview.
- Differentiation between NSMH and SMH services and their coverage by KHS.
- Feedback gathered on the NSMHS Outreach and Education Plan.
- Discussion of roles for Behavioral Health staff (Case Managers, Care Coordinators, Community Health Workers).
- Addressing DHCS requirements for an outreach plan.
- Strategies for increasing stakeholder and Tribal engagement.
- Use of population health surveys and stratification data to address behavioral health needs.
- Aligning NSMH education and outreach with CLAS (Culturally and Linguistically Appropriate Services) standards.

Questions and Key Recommendations:

Question	Key Recommendation	Rationale & Solutions
Stigma/outreach/engagement/best practices	Directly engage individuals at community events.	Provide stress/anxiety resources at health fairs, have dedicated mental health booths, and actively approach attendees rather than waiting for them to engage.
Barriers to spreading information	Broaden CHW outreach strategies.	Expand community engagement to rural areas and online platforms, offer flexible hours for group sessions, and create more localized outreach initiatives.
Awareness of mental health benefits	Improve PCP engagement with mental health providers.	Use tools like PHQ-9 screenings to identify needs and link members to appropriate levels of care. Ensure proper follow-up after referrals.
Homeschool family engagement	Use social media and direct outreach strategies.	Develop specific processes and ensure alignment with the "no wrong door" policy to facilitate access.
Access standards and workforce challenges	Strengthen infrastructure and reduce barriers.	Address workforce shortages, promote flexible access standards, and integrate CHWs into PCP locations to enhance care coordination.

Tribal Partner Engagement:

On November 7, 2024, the Behavioral Health Department met with the Bakersfield American Indian Health Project (BAIHP) liaison to enhance health outcomes for American Indian and Alaska Native (AI/AN) communities. Topics included:

1. **Cultural Competency and Trust Building**:
    - Integrating cultural sensitivity into healthcare delivery.
    - Establishing trust through advocacy, mutual respect, and inclusive planning.

2. **Tailored Health Solutions and Interventions**:
    - Designing interventions to address chronic diseases, mental health, and addiction.
    - Raising awareness through targeted education initiatives.
3. **Promoting Inclusive Healthcare Environments**:
    - Creating welcoming environments that respect AI/AN traditions.
    - Training staff to provide culturally competent care.
4. **Addressing Social Determinants of Health**:
    - Tackling economic disparities, high suicide rates, and gaps in insurance coverage.
    - Developing trauma-informed care and violence prevention programs.
5. **Improving Health Outcomes**:
    - Focusing on reducing preventable diseases and increasing life expectancy.
    - Targeting leading causes of death through focused interventions.
6. **Tribal Identification and Support**:
    - Ensuring proper identification within healthcare systems.
    - Building partnerships with Tribal organizations for better service delivery.

Action Steps for 2025:

- Partner with BAIHP to host a Tribal Stakeholder Meeting on January 21, 2025.
- Focus on increasing engagement in mental health services among AI/AN populations.
- Implement cultural competency training for KHS staff.
- Engage AI/AN communities in shaping health policies and interventions.
- Collaborate on data sharing to address health disparities.

Through these initiatives, KHS aims to strengthen its connections with community members, enhance access to care, and ensure equitable, culturally appropriate healthcare for all. Community input and engagement remain central to shaping health policies, programs, and outreach efforts, ensuring that services meet the unique needs of diverse populations.

KHS Executive Quality Improvement Health Equity Committee (EQIHEC)

On December 10, 2024, the Behavioral Health Director presented the NSMHS Outreach and Education Plan to EQIHEC. The session covered key components such as stakeholder engagement, cultural competency, and improving access to mental health services.

Agenda Highlights:

1. **Overview of the O&E Plan:**
    - Purpose: Improve member access and awareness of NSMHS.
    - Alignment with best practices in stigma reduction and culturally competent care.
2. **Key Requirements for the O&E Plan:**
    - Stakeholder and Tribal Partner Engagement.
    - Population Needs Assessment integration.
    - Utilization assessment of NSMHS.
    - Compliance with Cultural and Linguistic Appropriateness Standards (CLAS).

- Multiple access points for NSMH services.
- Primary Care Provider (PCP) outreach and education.

3. **Feedback Mechanism:**
   - Dissemination of the All-Plan Letter (APL) for review by stakeholders before implementation.
   - Emphasis on provider feedback and engagement to ensure informed decision-making and service delivery improvements.
4. **Committee Discussion Points:**
   - Challenges faced by PCPs in navigating bifurcated systems for NSMH and SMH.
   - Recommendations for improving communication and follow-up processes between PCPs and Kern Behavioral Health and Recovery Services (KBHRS).
   - Proposal for enhanced PCP office resources, including staff for follow-ups and outreach.

MOU with the Mental Health Plan (MHP):

Behavioral Health Director discussed the requirement for an MOU with the designated MHP for Kern County, emphasizing:

- Coordinated care across NSMH and SMH services.
- Addressing gaps through data sharing, process automation, and closed-loop referrals.

Partnership with Mental Health Plan:

KHS maintains a strong, well-established partnership with the Mental Health Plan Kern Behavioral Health and Recovery Services (Kern BHRS) and maintains a standing executed Memorandum of Understanding (MOU) and participates with Kern BHRS through regular collaborative meetings. KHS will continue collaborating with the MHP to develop and share materials to guide how County Members can more effectively access NSMHS when medically necessary. Kern BHRS and the KHS Behavioral Health department met on December 18, 2024.

Behavioral Health Advisory Committee:

In 2024, KHS formed a Behavioral Health Advisory Committee (BHAC) to enhance the Behavioral Health services provided to your members and ensure that these services are aligned with both community needs and regional behavioral health programs. This committee, comprised of behavioral health practitioners, plays a vital role in guiding, reviewing, and evaluating interventions, with a focus on promoting collaboration between KHS and the County Behavioral Health Plan (BHP), as well as the Drug Medi-Cal Organized Delivery System (DMC-ODS). Kern Behavioral Health and Recovery Services (KBHRS) administers both the BHP and DMC-ODS, treating KHS members with the goal to maintain continuity, reduce barriers to access, linkage to appropriate services, opportunities to integrate care with medical care, and provide resources for members with mental illness and/or substance use disorder.

The activities of the Behavioral Health Advisory Committee include the following, but not limited to the following:

1. Review quality monitoring activities conducted by the Plan to measure compliance for network providers, corrective actions, and regulatory requirements regarding behavioral health services, network accessibility and delegation oversight.
2. Provide feedback on implementation of BH clinical guidelines and UM criteria, new BH technology, quality monitoring tools, site/chart review(s), tracking access to care standards, and treatment innovations.
3. Review Plan's adherence and achievement of Medi-Cal Managed Care Accountability Set (MCAS) targets focused on BH.
4. Review Plan's adherence to the quantitative and qualitative analysis for the Evaluation of BH member complaints, appeals, and experience.
5. Review Plan's process for continuity and coordination medical and behavioral health services, methods to exchange information.
6. Review and approve the BH Program Description annually.
7. Review Plan's compliance with overseeing MOU with KBHRS.
8. Provides support to KHS management based on their regular and direct interactions with KHS Members receiving BH Services.

In 2025, KHS will partner with Mental Health Service Act (MHSA) Coordinator in stakeholder engagement activities.

KHS Population Needs Assessment

Kern Health Systems maintains a singular, Medi-Cal line of business. The Plan's service area is entirely of Kern County.

According to KHS' membership statistics, 392,166 Medi-Cal managed care members enrolled in the plan in 2023.[1] This was an 11.7% increase in total annual membership compared to 350,984 members in 2022. KHS member enrollment in 2023 was over one third of the population of Kern County.[2] Although males account for a slightly larger share of the population than females at the state and county levels, females account for a larger share of the KHS member population than males. The table and chart below provide a comparison of the KHS member population with the county and state.

The goal of the 2024 KHS Population Needs Assessment (PNA) is to improve health outcomes for KHS members and ensure that KHS is meeting the needs of its members through:

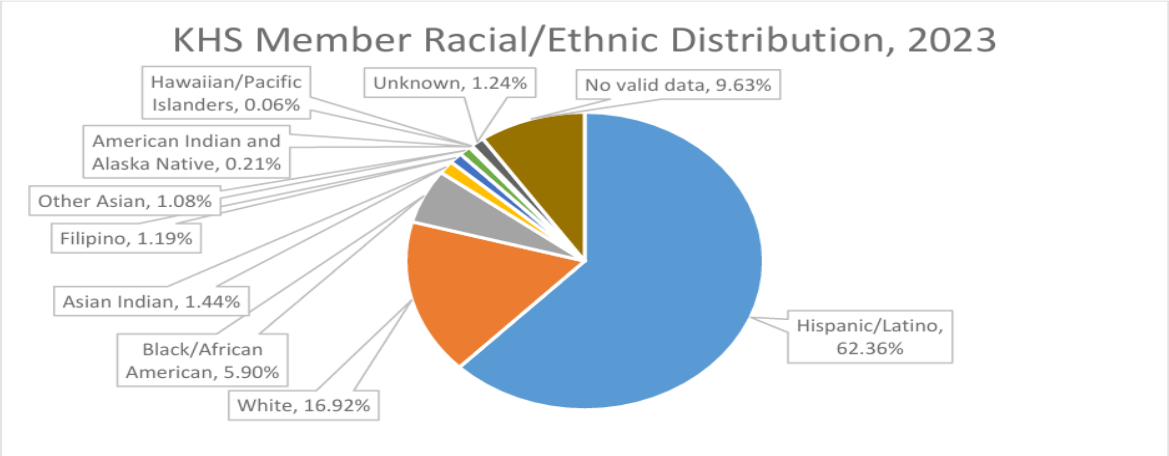
1. Identification of member health needs and health disparities.
2. Evaluation of current KHS activities and available resources to address identified concerns; and
3. Implementation of targeted strategies to address member needs. The KHS 2024 PNA builds upon previous needs assessments and uses various data collection methods and sources.

Key Statistics:

The KHS 2024 PNA builds upon previous needs assessments and uses various data collection

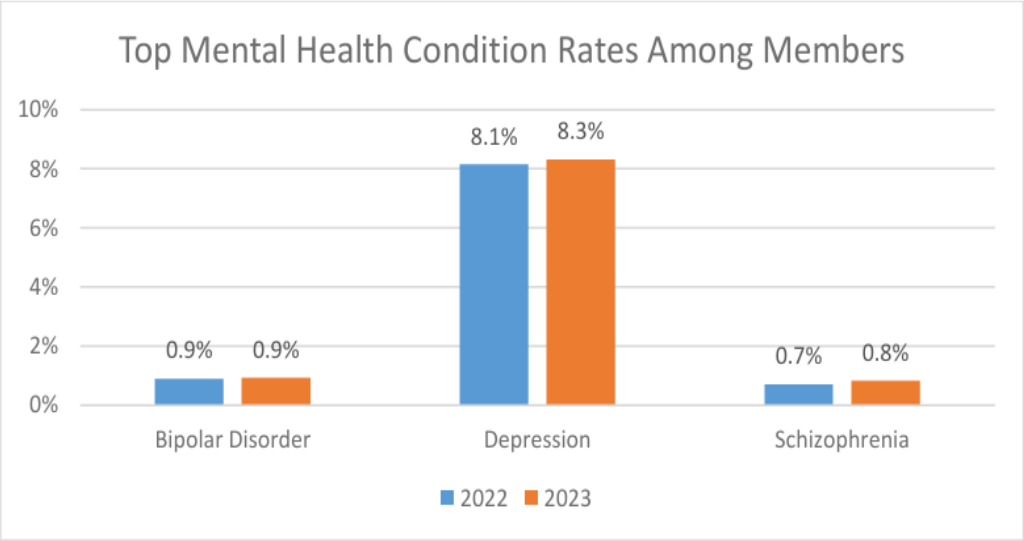
methods and sources. Total KHS membership and demographics in 2023 changed slightly compared to 2022 data. KHS membership grew by 11.7%. The adult share of KHS membership grew slightly from 58.0% in 2022 to 61.1% in 2023. The female shares of members decreased slightly from 53.9% to 53.8%. Hispanic/Latinos represent most members (63.0%), and English is the most common primary language (69.2%). Most members live in Bakersfield (54.5%) where the highest concentration of members is in the 93307-zip code (11.9%). The share of Seniors and Persons with Disabilities (SPD) increased from 6.5% in 2022 to 7.5% in 2023. The population of members who were identified as homeless increased to 15,595 in 2023, up 12.6% compared to the previous year.

Hispanic/Latinos continue to be the largest racial/ethnic group among KHS members, accounting for most of the membership (62.4%). They are followed by Whites (16.9%), Black/African Americans (5.9%), Asians/Pacific Islanders (3.8%), and other races/ethnicities. The racial/ethnic makeup of KHS members in 2023 was very similar to 2022. In comparison, data reported in the U.S. Census Bureau in 2022 shows that 56.8% of Kern County and 40.3% of California residents are Hispanic/Latino, followed by White (KC-30.4%, CA-38.9%), Black/African American (KC 5.1%, CA-5.4%), Asian/Pacific Islander (KC-5.1%, CA-15.9%), and Native American (KC-.6%, CA-1.6%).

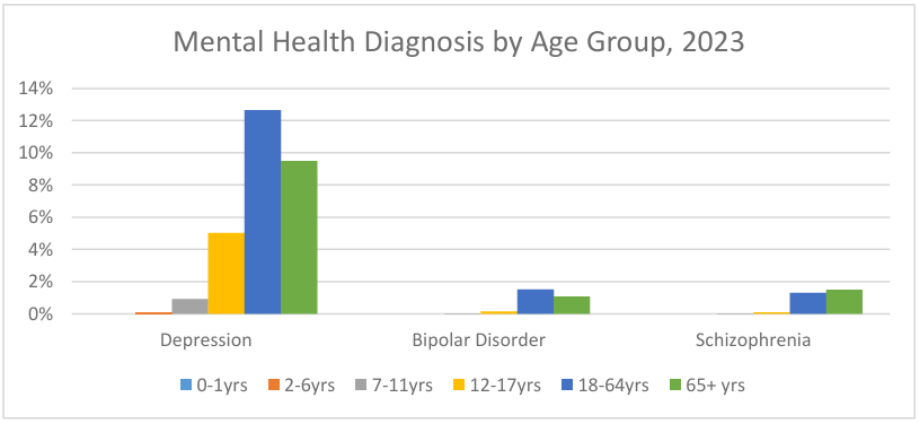


Source: KHS Member Demographics Data Report

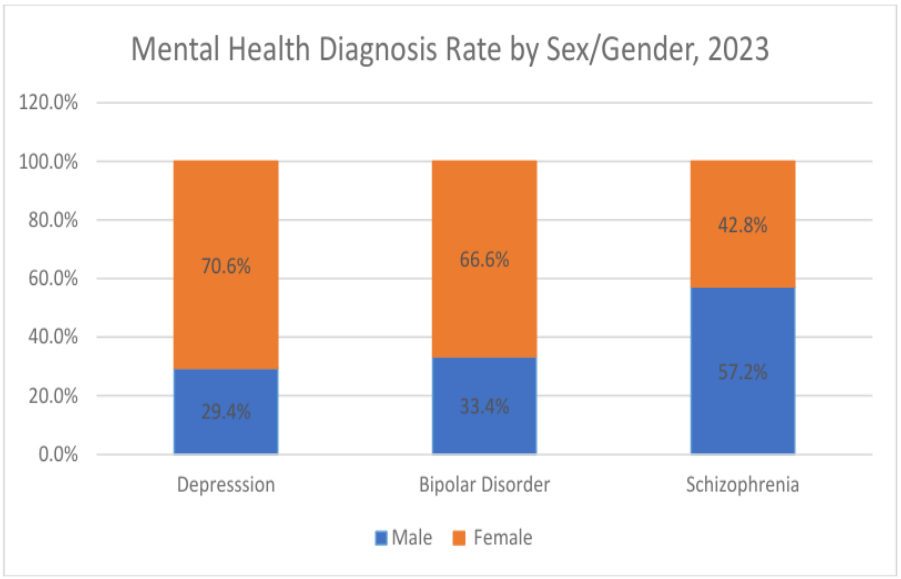
Assessment of Members with Mental Health Illness or Serious Emotional Disturbance In 2023, 8.3% of KHS members were identified to have had a depression diagnosis, 0.9% with a bipolar disorder, and 0.8% with schizophrenia.13 The 2023 rates for these mental health conditions increased slightly compared to the 2022 rates.



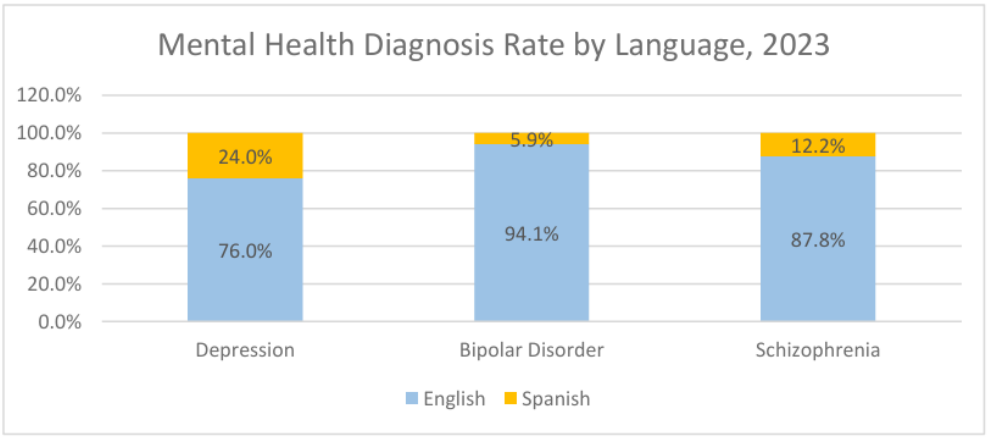
In 2023, depression and bipolar disorder were more common among female members than male members. Schizophrenia was more common among male members. When looking at language, these conditions were most common among English speaking members. When looking at age groups, depression and bipolar disorder were most common among members 18-64 years old. Schizophrenia was most common among members 65 years and older. When comparing racial/ethnic groups, depression and bipolar disorder were most common among White members. Schizophrenia was most common Native American members.



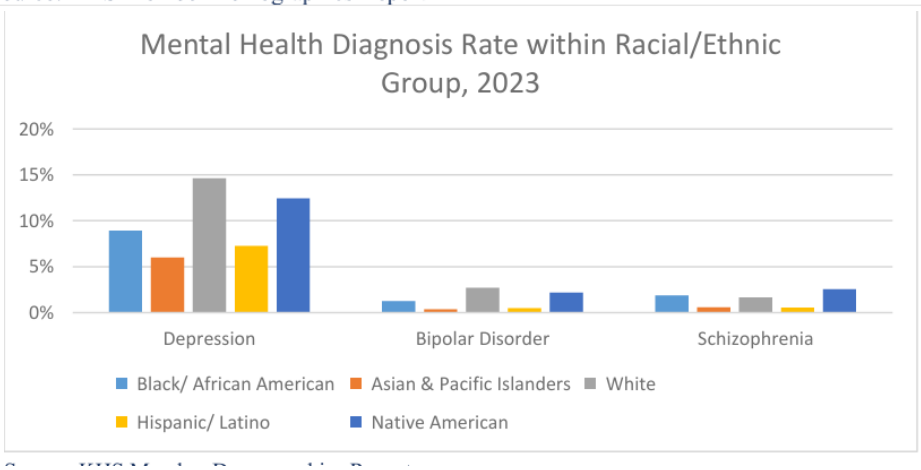
Source: KHS Member Demographics Report



Source: KHS Member Demographics Report



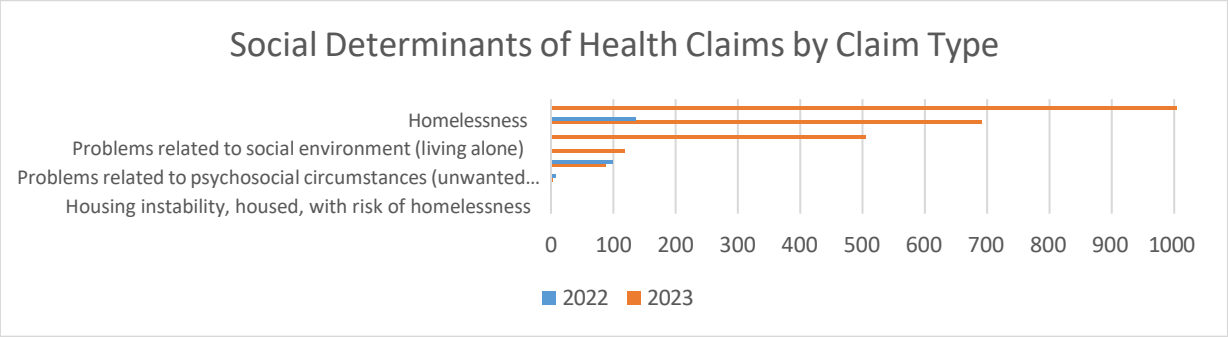
Source: KHS Member Demographics Report



Social Determinants of Health

KHS collects social determinants of health (SDoH) data with SDoH codes that KHS providers use

when submitting claims. Collection of SDoH data is part of the Population Health Management (PHM) initiative of CalAIM that identifies and manages member risk and need through whole person care approaches. SDoH claims increased by 956.8% from 241 in 2022 to 2547 in 2023.[6] Food insecurity was the top SDoH claim type in 2023, followed by homelessness, problems related to social environment (life cycle transitions), problems related to social environment (living alone), and inadequate housing.



Source: 2022 and 2023 KHS SDoH Claims Reports

Summary of Needs of Members with Serious Mental Illness or Emotional Disturbance

1. The 2023 member rates for bipolar disorder, depression, and schizophrenia increased slightly compared to the 2022 rates.
2. Depression is the most common mental health condition among members by far. Access to depression treatment services is a key mental health need among members.
3. Depression and bipolar disorder rates are highest among English speakers, females, and White members, and adult members 18-64 years old.
4. Schizophrenia is most prevalence among Native Americans when comparing racial and ethnic groups.
5. KHS covers behavioral health treatment (BHT) for autism spectrum disorder (ASD), non specialty outpatient mental health services, and alcohol misuse screening services. BHT includes applied behavior analysis (ABA) and other evidence-based services. Crisis response services and resources and substance use disorder treatment are offered by the county mental health agency and other community resources.
6. Behavioral Health (BH) community health worker (CHW) referral and member outreach data indicate CHW services are needed among members with BH or mental health conditions.
7. Feedback from KHS staff has indicated that a strategic approach, staff, and resources are needed to improve member access to and utilization of behavioral health treatment (BHT) and mental health services.
8. BHT provider recruitment is needed to increase the BHT provider network and access among members. Marketing and member outreach would result in member awareness and needed utilization of BHT services.
9. Member outreach is also needed to help keep members engaged with their BHT provider or team. Peer support groups would help reduce destigmatization associated with mental health illness and BHT services.

The following mental health needs are met with a combination of KHS benefits and community resources:

1. BHT for ASD
2. Non-specialty outpatient mental health services
3. Alcohol misuse screening services
4. BH CHW referrals and member outreach
5. Substance use disorder treatment services.
6. Severe mental health and crisis services and resources, such as 988 Crisis Hotline, crisis response, and mobile evaluation team
7. Transportation assistance

Resources from Health Education

Behavioral Health Resources:
KHS provides members with access to behavioral health resources through the **KHS Website**: Behavioral Health Resources.

http://www.kernfamilyhealthcare.com/members/behavioral-health/

Information Available:

- Types of treatments and services covered for various mental health conditions.
- Materials and messaging tailored to the diversity of the KHS enrollee population, as outlined in the Outreach and Education Plan.

Planned Website Enhancements for 2025:

The Behavioral Health website will be redesigned in 2025 to improve accessibility, user experience, and the availability of essential behavioral health resources. The enhanced website will serve as a centralized resource for members, providers, and the community.

Key Planned Updates

1. **Publication of Key Documents:**
    - **2025 Member and Provider Outreach and Education Plans** will be available to provide transparency and guidance on outreach strategies.
    - **2023-2024 Utilization Assessment of Non-Specialty Mental Health Services (NSMHS)** will be shared to inform stakeholders of service usage trends and improvement efforts.
2. **Resource Integration:**
    - Direct links to external organizations such as:
        - **National Alliance on Mental Illness (NAMI)**
        - **CalHOPE**

- Expanded access to community training resources, including:
    - **Mental Health First Aid (MHFA)**
    - **Cultural Competency Training**

3. **Engaging Features:**
    - **Personal Testimonies:** Stories highlighting member experiences with behavioral health services to reduce stigma and foster community connection.
    - **Calendar of Community Events:** Listings of behavioral health and recovery-related activities, training, and workshops to encourage community engagement.
4. **Support and Resources:**
    - Direct access to information on the **County Mental Health Plan (MHP)** and **Drug Medi-Cal Organized Delivery System (DMC-ODS)** to help members navigate available services.
    - Sponsorship and promotion of community events related to behavioral health and recovery.

KHS Utilization Assessment

Utilization Assessment of Non-Specialty Mental Health Services for Medi-Cal Members December 2024

Kern Health Systems (KHS) conducted a utilization assessment of non-specialty mental health services (NSMHS) provided to Medi-Cal members in 2023-2024. This report provides information on the number of unique utilizers of NSMHS stratified by race, ethnicity, language, age group, and sex.

NSMHS Utilization by Gender

Values	Percentage of Utilizers
Female	64.54%
Male	35.46%
TOTAL	**100.00%**

Table 1. NSMHS utilization by Gender

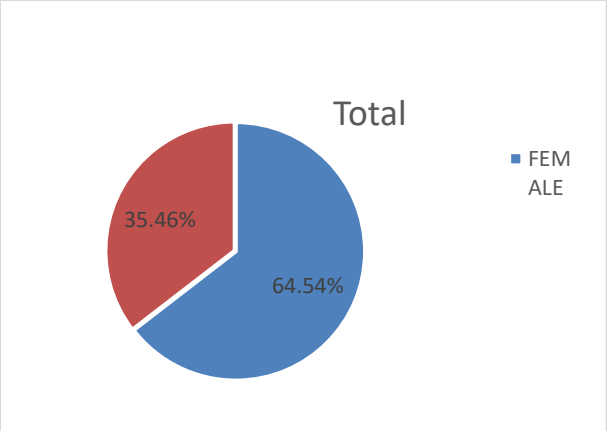


Figure 1. NSMHS utilization by Gender

NSMHS Utilization by Race

In Table 2 and Figure 2, the **Unknown** category accounts for **63.33%** of the total. This could indicate either incomplete data reporting or the absence of accurate racial/ethnic identifiers in the records. The high percentage of "unknown" users significantly skews the representation of utilization patterns and makes it difficult to accurately assess disparities in mental health service usage among known racial groups. It's crucial to address this data gap to improve the accuracy of future analyses.

Race	**Percentage of Utilizers**
AMERICAN INDIAN AND ALASKAN NATIVE	0.26%
ASIAN	1.71%
BLACK	7.14%
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0.04%
UNKNOWN	63.33%
WHITE	27.52%
TOTAL	100.00%

Table 2. NSMHS utilization by Race

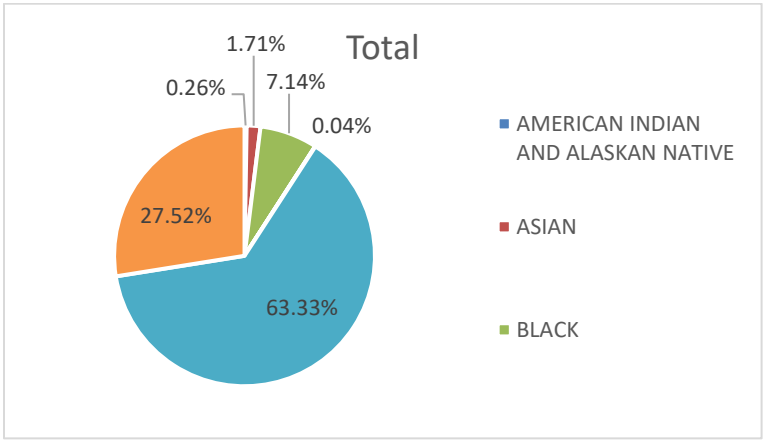


Figure 2. NSMHS utilization by Race

NSMHS Utilization by Ethnicity

In Table 3 and Figure 3, show **Hispanic** individuals represent the **largest group** of utilizers, accounting for **55.51%** of the total.

Ethnicity	Percentage of Utilizers
AFRICAN AMERICAN	7.14%
ALASKAN/AMER INDIAN	0.26%
ASIAN INDIAN	0.54%
ASIAN/PACIFIC	0.36%
CAMBODIAN	0.06%
CAUCASIAN	27.52%
CHINESE	0.08%
FILIPINO	0.57%
HAWAIIAN	0.01%
HISPANIC	55.51%
JAPANESE	0.03%
KOREAN	0.03%
LAOTIAN	0.01%
NO VALID DATA	6.92%
SAMOAN	0.03%
UNKNOWN	0.89%
VIETNAMESE	0.05%
TOTAL	**100.00%**

Table 3. NSMHS utilization by Ethnicity

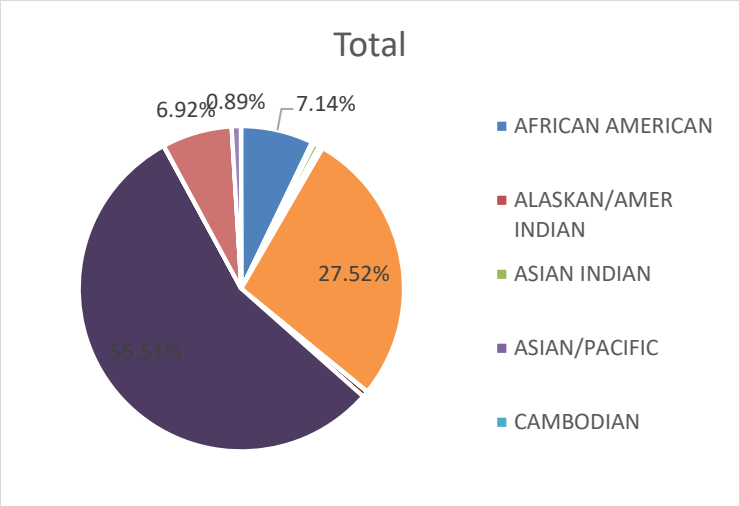


Table 3. NSMHS utilization by Ethnicity

NSMHS Utilization by Age Group

In Table 4 and Figure 4, show the 19 to 35 age group represents the largest proportion of utilizers, at 36.46%. This suggests that young adults are the most likely group to seek non-

specialty mental health services.

Age Group	Percentage of Utilizers
0 to 18	17.89%
19 to 35	36.46%
36 to 50	22.46%
51 to 65	17.65%
66 to 85	4.99%
Over 85	0.55%
TOTAL	**100.00%**

Table 4. NSMHS utilization by Age Group

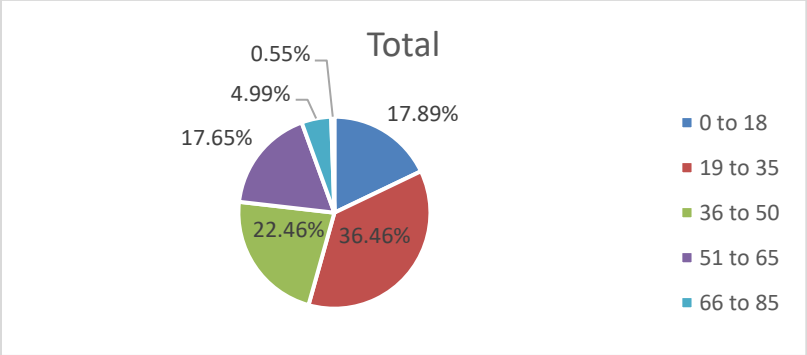


Figure 4. NSMHS utilization by Age Group

NSMHS Utilization by Spoken Language

In Table 5 and Figure 5, **Arabic (0.03%)**, **Punjabi (0.04%)**, **Tagalog (0.02%)**, **Vietnamese (0.01%)**, **Korean (0.01%)**, and **Russian (0.01%)** all have very low utilization rates, collectively representing a small fraction of total utilizers.

Spoken Language	Percentage of Utilizers
ARABIC	0.03%
ENGLISH	77.57%
KOREAN	0.01%
NO VALID DATA	0.23%
PUNJABI	0.04%
RUSSIAN	0.01%
SPANISH	22.03%
TAGALOG	0.02%
UNSPECIFIED	0.07%
VIETNAMESE	0.01%
TOTAL	**100.00%**

Table 5. NSMHS utilization by Spoken Language

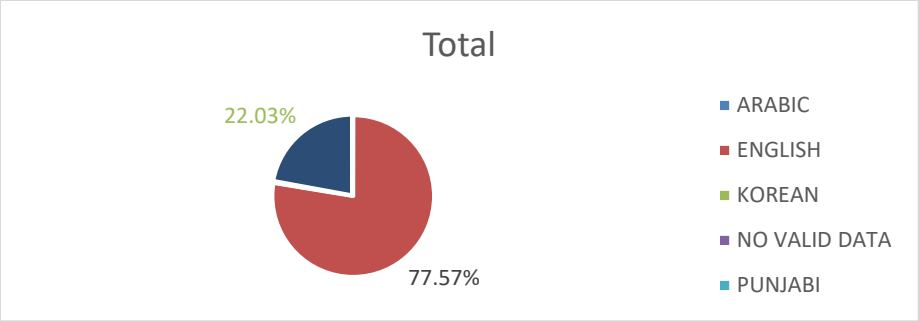


Figure 5. NSMHS utilization by Spoken Language

NSMHS Utilization by Geographic Distribution

In Table 6 and Figure 6, the low utilization in smaller rural areas could reflect the lack of accessible mental health services, transportation barriers, or less awareness of mental health issues.

Geographic Area	Percentage of Utilizers
Arvin, Lamont	3.49%
Bakersfield	73.83%
Delano, McFarland	6.24%
Lost Hills, Buttonwillow	0.32%
Mojave Desert - North	2.58%
Mojave Desert - South	2.70%
Outside Kern County	1.91%
Shafter, Wasco	4.38%
Southern Sierra Nevada	1.01%
Taft, Maricopa	1.53%
Tehachapi Mountains	1.64%
Tejon Communities	0.38%
TOTAL	**100.00%**

Table 6. NSMHS utilization by Geographic Distribution

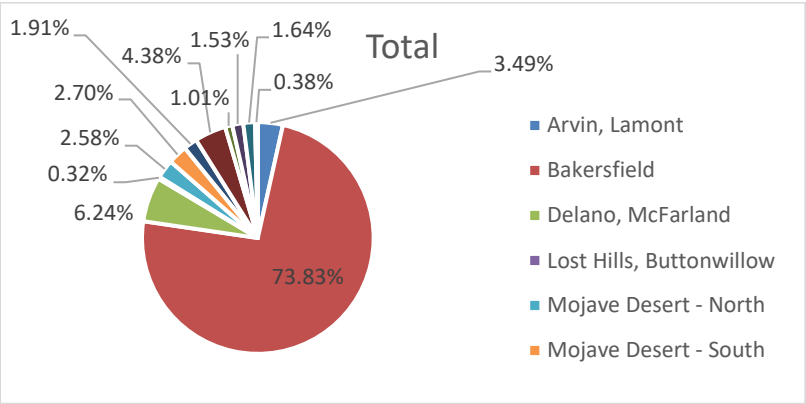


Figure 6. NSMHS utilization by Geographic Distribution

NSMHS Utilization by Aid Group

Aid Group	Percentage of Utilizers
Dual	9.38%
Expansion	38.49%
Family	40.79%
SPD	10.23%
Unknown	1.11%
TOTAL	**100.00%**

Table 7. NSMHS utilization by Aid Group

Utilization Assessment accounts for utilization of covered mental health benefits by race, ethnicity, language, age, sexual orientation, gender identity, and disability.

In 2025, Kern Health Systems (KHS) will implement a revised Health Risk Assessment (HRA) tool designed to collect Sexual Orientation and Gender Identity (SOGI) demographic data. This initiative is part of KHS's commitment to improving data reporting and ensuring equitable care for all members.

- MH Base Population
  - Members Currently enrolled with KHS
  - 1 or more ACG Modeler ECD Codes
    - PSY01 Anxiety, neuroses
    - PSY02 Substance use
    - PSY07 Schizophrenia and affective psychosis
    - PSY08 Personality disorders
    - PSY09 Depression
    - PSY12 Bipolar disorder
    - PSY13 Adjustment disorder
    - PSY14 Psychological disorders of childhood
    - PSY17 Psych-physiologic and somatoform disorders
    - PSY20 Major depression
  - Exclusions
    - Members with BH-CM Episode in Last 180 Days
    - Members receiving specialty mental health services through KBHRS
- Specialty Mental Health - Member has major depression, bipolar, or schizophrenia
- High Risk - Member has 6 or more chronic conditions
- Medium Risk - Member has 2 to 5 chronic conditions
- Low Risk - Member has 0 to 1 chronic condition

The Outreach and Education Plan provides strategies to reach Member groups with low utilization of Non- Specialty Mental Health Services, as identified in the utilization assessment.

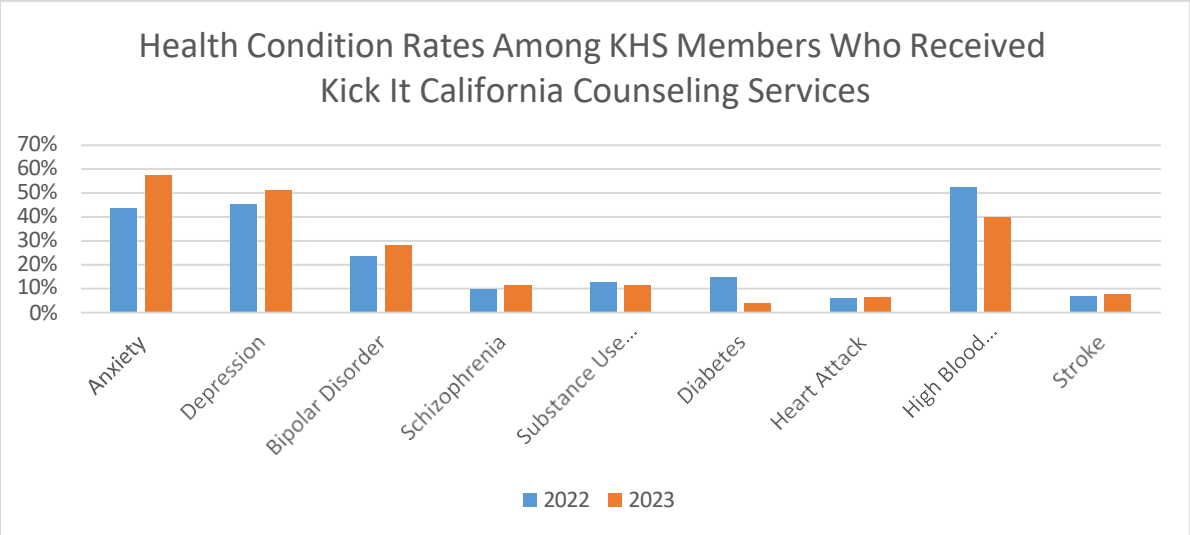
KHS Analysis of Members Utilizing NSMHS

Sample Report

Data Information Knowledge Action
Business Intelligence

KERN HEALTH SYSTEMS

Title:	Analysis of NSMH Services Among Kern Health Members
Prepared By:	Erica Zamora-Martinez, Stephen Wuertz
Contributor(s):	
Date Created:	December 2, 2024
Observation Period:	Claims DOS from 1/1/2023 through 10/31/2024 ACG months between January 2023 and October 2024
Purpose:	This report identifies KHS members who have received Non-Specialty Mental Health (NSMH) services. The NSMH services are determined by the following service codes: '90792', '90832', '90833', '90834', '90836', '90837', '90838', '90839', '90840', '90846', '90847', '90853', '96105', '96110', '96112', '96116', '96121', '96127', '96130', '96131', '96132', '96133', '96136', '96137', '96138', '96139', '96156', '96158', '97129', '97130', '99366', '99368', '99406', '99407', '99417', 'G0442', 'G9920', 'H0049', and 'H0050', as well as diagnosis codes starting with 'F'.



Source: Kick It California Reports: Kern Health Systems Member Data

Culturally and Linguistically Appropriate Services

Kern Health Systems' commitment is to provide quality healthcare to our culturally and linguistically diverse member population. To assist providers in better communicating with

Limited English Proficient (LEP) patients, the Cultural and Linguistics Services Department supports stigma reduction and utilizes resources to promote proper C&L approaches through the following:

1. **Language Support for Providers:**
    - Desktop Displays: Language Line ID displays for identifying preferred languages.
    - Preferred Language Labels: Tools for documenting language needs, including labels for language preference (yellow) and interpreter service usage/refusal (green).
2. **Provider Training and Tools:**
    - Toolkit: *Better Communication, Better Care*, developed by healthcare professionals, addresses operational and legal needs for diverse populations.
    - Online Courses: HRSA modules on health literacy, cultural competency, and LEP support. Topics include:
        - Effective use of interpreters.
        - Provider training on cultural competency and remote interpreting.
        - Provider access to language services guides.
3. **Professional Interpretation Services:**
    - Members have access to professional interpreters at no cost for medical appointments.
    - Qualified bilingual staff assist LEP members, meeting high proficiency and ethical standards.
4. **Translation Services:**
    - KHS ensures the accuracy of written materials through professional translators adhering to standardized processes and confidentiality protocols.
5. **Member Education and Stigma Reduction:**
    - Outreach Materials: Reviewed for readability and translated into relevant languages.
    - Inclusive Communication: Emphasizing person-first language to normalize mental health and eliminate stereotypes.
    - Community Engagement: Participation in events, health fairs, and workshops focused on mental health awareness.
    - Resource Sharing: Distribution of newsletters and multimedia materials, health libraries, and educational materials with inclusive, culturally resonant content.
6. **Cultural Competence:**
    - All communications align with the cultural backgrounds of members, aiming to foster understanding of mental health and improve access and outcomes.

Best Practices in Stigma Reduction

KHS is committed to implementing best practices in Stigma Reduction for Mental Health to create a more inclusive, supportive, and stigma-free environment for individuals seeking mental health services. By integrating these strategies, KHS aims to reduce barriers to care, foster understanding, and ensure that everyone has access to the necessary resources and support they deserve. The following approaches will guide these efforts:

1. **Collaboration with County Mental Health Plan (MHP) Partners**
    - KHS actively collaborates with Kern Behavioral Health and Recovery Services and other
      MHP partners to align efforts and ensure consistency in educating members on how to
      access mental and behavioral health services.
    - Partnership in the development of materials and campaigns tailored to the needs of the population, ensuring culturally sensitive and stigma-free messaging.
2. **Stigma Reduction Approaches**
    - **Collaborating with Kern NAMI:**
        - Participation in initiatives such as "Say It Out Loud" to normalize conversations about mental health.
        - Supporting peer support groups like "In Our Own Voices," which share personal testimonies to reduce stigma and promote empathy.
    - **Training Healthcare Providers:**
        - Promoting Mental Health First Aid (MHFA) and Cultural Competency Training
          to equip providers with tools to recognize and address stigma in clinical settings.
    - **Personal Testimonies:**
        - Linking real-life stories on the KHS website to humanize mental health experiences and reduce stereotypes.
    - **Community Engagement:**
        - Sponsoring events focused on behavioral health and recovery to engage the public, spread awareness, and foster inclusion.
        - Utilizing Community Health Workers (CHWs) to build trust and promote outreach in underserved communities.

KHS will utilize various methods of communicating stigma reduction to include:

1. **Education**
    - Disseminating knowledge through newsletters, brochures, and online resources to clarify misconceptions about mental health.
2. **Direct Contact**
    - Engaging with members and stakeholders through events, workshops, and support groups to build personal connections and understanding.
3. **Community Awareness**
    - Organizing campaigns to raise public awareness about mental health, its importance, and the impact of stigma.

4. **Workplace and Provider Education**
    - Conducting training programs for employers and providers to promote supportive environments and stigma-free care delivery.

Multiple Points of Contact for Member Access

KHS offers different ways members can access mental health services.

1. **Call Kern Family Health Care (KFHC) Behavioral Health (BH) Department**:
    a. Members can call KFHC at 1-800-391-2000 and request to be connected to the Behavioral Health Department.
2. **Primary Care Provider**:
    a. Member's Primary Care Provider (PCP) is a great resource for initial screenings to determine member's needs. Members with positive screening results should be further assessed. PCP shall refer the member to a behavioral health provider, first attempting to refer within the KHS network.
3. **KFHC Website**:
    a. Members can access https://www.kernfamilyhealthcare.com/members/behavioral-health/
    And click to find a mental health providers at KFHC through the online provider search tool. Alternatively, members can download a list of providers from the Publications / Member Materials webpage.
4. **KFHC email address:**
    a. kfhcmemberservices@khs-net.com
5. **Walk Into Any NSMHS Provider for an Appointment**:
    a. If members prefer an in-person option, members can walk into any Non-Specialty Mental Health Services (NSMHS) provider to schedule an appointment for an assessment.

These options provide flexibility in how you access mental health services, whether through direct outreach, referrals, online tools, or in-person visits.

Members can also reach out to the Medi-Cal Managed Care Division, Office of the Ombudsman at 1-888-452-8609.

Primary Care Provider Outreach Plan

KHS's Outreach and Education Plan ensures that Primary Care Providers (PCPs) are informed, supported, and equipped to provide Non-Specialty Mental Health Services (NSMHS) to members effectively. This plan is shaped by input from the Executive Quality Improvement and Health Equity Committee (EQIHEC) and aligns with DHCS contractual requirements, fostering a collaborative and informed care environment.

Annual Outreach and Education Initiatives

1. **Annual Behavioral Health Training for PCPs**

- Conduct comprehensive annual training sessions tailored to PCPs on NSMHS topics, including:
    - Covered services.
    - Referral processes.
    - Behavioral health screening tools.
    - Reducing stigma in care delivery.

2. **Provider Onboarding and Refresher Training**
    - Onboarding Orientation: New providers are introduced to KHS programs, policies, and processes through the KHS Provider Manual.
    - Annual Refresher Training: Includes updates to policies, resources, and best practices. Topics include:
        - Mental health referral workflows.
        - Integration of member feedback into care plans.
        - Changes in behavioral health policies and regulations.
3. **Behavioral Health Resource Repository**
    - Maintained at KHS Provider Training Library, this repository includes:
        - Behavioral health updates and guidelines.
        - Training resources on screening and referral.
        - Stigma reduction tools and materials.
        - Links to regulations, industry standards, and procedural criteria for coordinating care.

Alignment with QIHEC Recommendations

The PCP outreach and education strategies are informed by the QIHEC to:

- Identify and address gaps in knowledge or training for PCPs.
- Integrate equity-focused practices to meet the needs of diverse member populations.
- Promote collaboration between PCPs and Behavioral Health to improve care coordination and member outcomes.

Provider Communication Tools

KHS employs multiple communication channels to ensure PCPs stay informed:

1. **KHS Website Resources**
    - Centralized library of health service programs, policies, and procedures updated to reflect current standards.
    - Easily accessible behavioral health tools, referral guides, and training schedules.
2. **Provider Updates**
    - Bulletins, newsletters and email updates highlighting changes in services, training opportunities, and resources.
3. **Feedback Mechanisms**
    - Regular surveys and feedback sessions to capture PCP perspectives, ensuring training materials are responsive to real-world challenges.

KERN HEALTH SYSTEMS

Utilization Assessment of Non-Specialty Mental Health Services for Medi-Cal Members

December 2024

Kern Health Systems (KHS) conducted a utilization assessment of non-specialty mental health services (NSMHS) provided to Medi-Cal members in 2023-2024. This report provides information on the number of unique utilizers of NSMHS stratified by race, ethnicity, language, age group, and sex.

NSMHS Utilization by Gender

Values	Percentage of Utilizers
Female	64.54%
Male	35.46%
TOTAL	**100.00%**

Table 1. NSMHS utilization by Gender

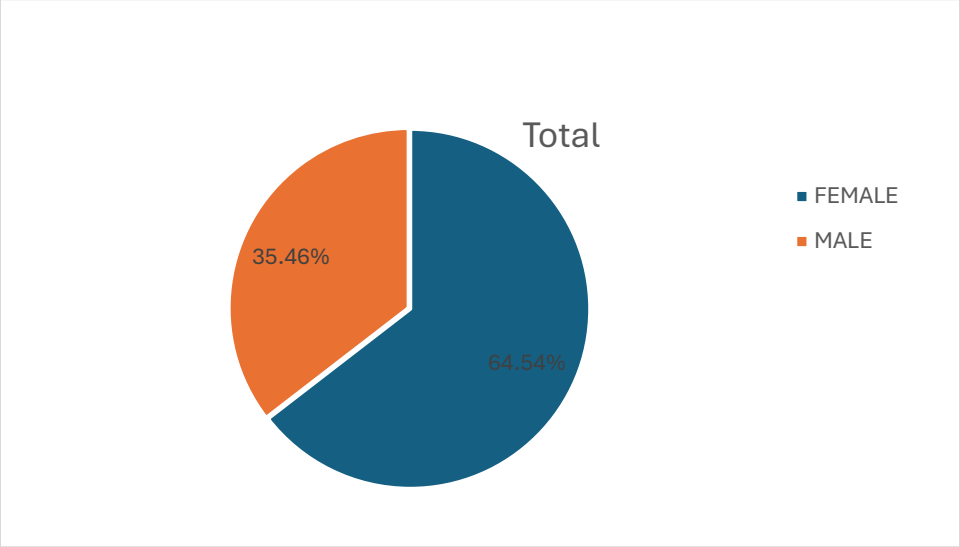


Figure 1. NSMHS utilization by Gender

NSMHS Utilization by Race

In Table 2 and Figure 2, the **Unknown** category accounts for **63.33%** of the total. This could indicate either incomplete data reporting or the absence of accurate racial/ethnic identifiers in the records. The high percentage of "unknown" users significantly skews the representation of utilization patterns and makes it difficult to accurately assess disparities in mental health service usage among known racial groups. It's crucial to address this data gap to improve the accuracy of future analyses.

Race	Percentage of Utilizers
AMERICAN INDIAN AND ALASKAN NATIVE	0.26%
ASIAN	1.71%
BLACK	7.14%
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0.04%
UNKNOWN	63.33%
WHITE	27.52%
TOTAL	100.00%

Table 2. NSMHS utilization by Race

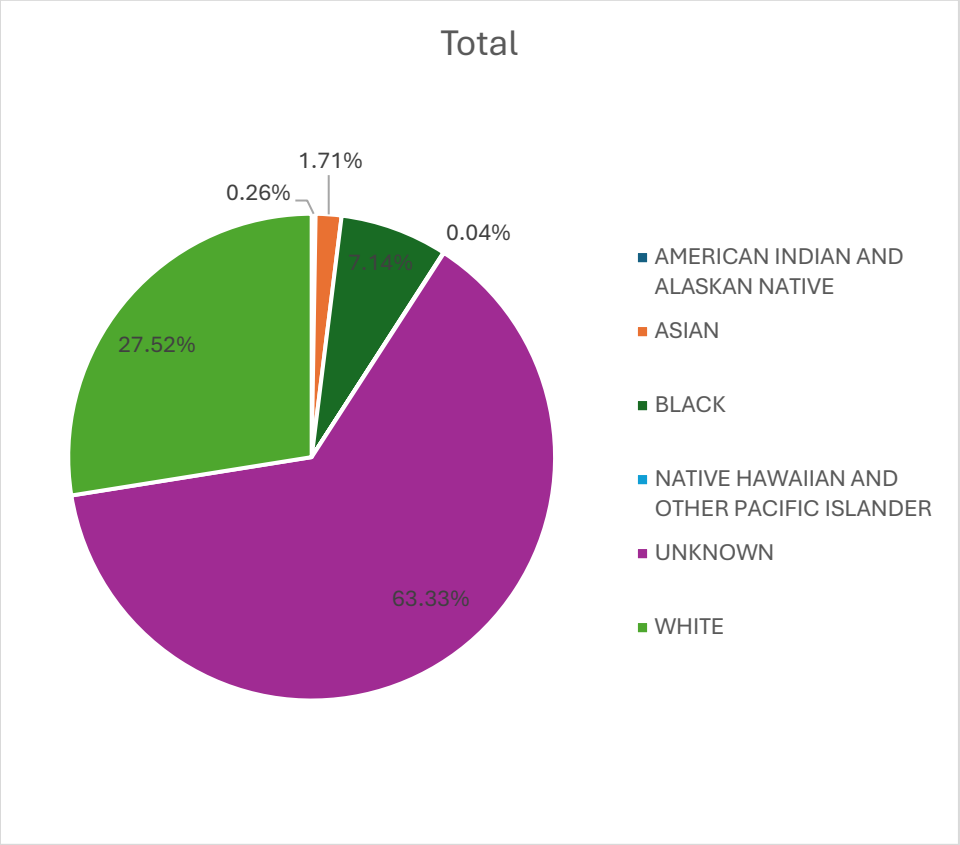


Figure 2. NSMHS utilization by Race

NSMHS Utilization by Ethnicity

In Table 3 and Figure 3, show **Hispanic** individuals represent the **largest group** of utilizers, accounting for **55.51%** of the total.

Ethnicity	Percentage of Utilizers
AFRICAN AMERICAN	7.14%
ALASKAN/AMER INDIAN	0.26%
ASIAN INDIAN	0.54%
ASIAN/PACIFIC	0.36%
CAMBODIAN	0.06%
CAUCASIAN	27.52%
CHINESE	0.08%
FILIPINO	0.57%
HAWAIIAN	0.01%
HISPANIC	55.51%
JAPANESE	0.03%
KOREAN	0.03%
LAOTIAN	0.01%
NO VALID DATA	6.92%
SAMOAN	0.03%
UNKNOWN	0.89%
VIETNAMESE	0.05%
TOTAL	**100.00%**

Table 3. NSMHS utilization by Ethnicity

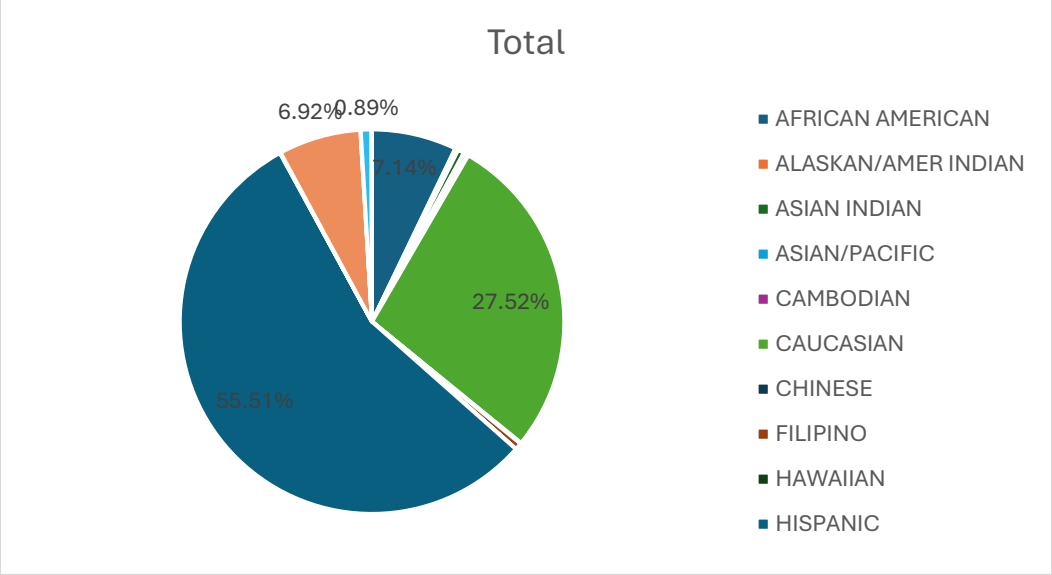


Figure 3. NSMHS utilization by Ethnicity

NSMHS Utilization by Age Group

In Table 4 and Figure 4, show the 19 to 35 age group represents the largest proportion of utilizers, at 36.46%. This suggests that young adults are the most likely group to seek non-specialty mental health services.

Age Group	Percentage of Utilizers
0 to 18	17.89%
19 to 35	36.46%
36 to 50	22.46%
51 to 65	17.65%
66 to 85	4.99%
Over 85	0.55%
TOTAL	**100.00%**

Table 4. NSMHS utilization by Age Group

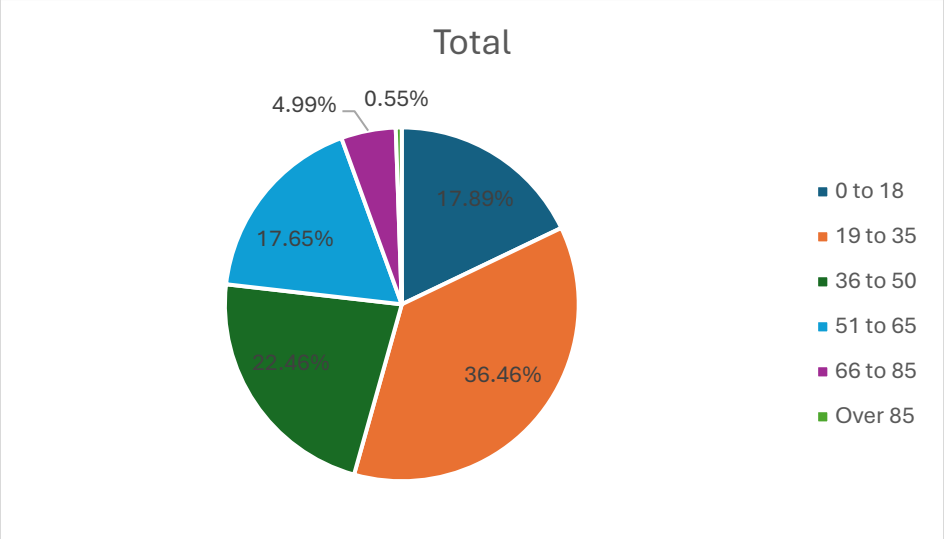


Figure 4. NSMHS utilization by Age Group

NSMHS Utilization by Spoken Language

In Table 5 and Figure 5, **Arabic (0.03%)**, **Punjabi (0.04%)**, **Tagalog (0.02%)**, **Vietnamese (0.01%)**, **Korean (0.01%)**, and **Russian (0.01%)** all have very low utilization rates, collectively representing a small fraction of total utilizers.

Spoken Language	Percentage of Utilizers
ARABIC	0.03%
ENGLISH	77.57%
KOREAN	0.01%

NO VALID DATA	0.23%
PUNJABI	0.04%
RUSSIAN	0.01%
SPANISH	22.03%
TAGALOG	0.02%
UNSPECIFIED	0.07%
VIETNAMESE	0.01%
TOTAL	**100.00%**

Table 5. NSMHS utilization by Spoken Language

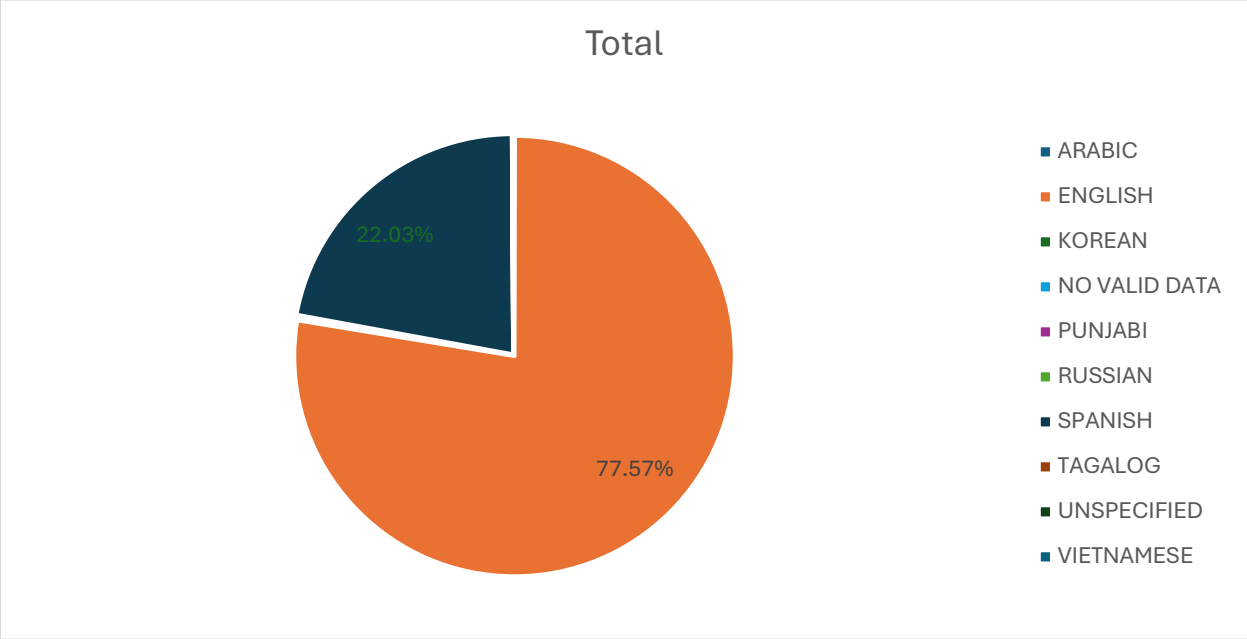


Figure 5. NSMHS utilization by Spoken Language

NSMHS Utilization by Geographic Distribution

In Table 6 and Figure 6, the low utilization in smaller rural areas could reflect the lack of accessible mental health services, transportation barriers, or less awareness of mental health issues.

Geographic Area	Percentage of Utilizers
Arvin, Lamont	3.49%
Bakersfield	73.83%
Delano, McFarland	6.24%
Lost Hills, Buttonwillow	0.32%

Mojave Desert - North	2.58%
Mojave Desert - South	2.70%
Outside Kern County	1.91%
Shafter, Wasco	4.38%
Southern Sierra Nevada	1.01%
Taft, Maricopa	1.53%
Tehachapi Mountains	1.64%
Tejon Communities	0.38%
TOTAL	**100.00%**

Table 6. NSMHS utilization by Geographic Distribution

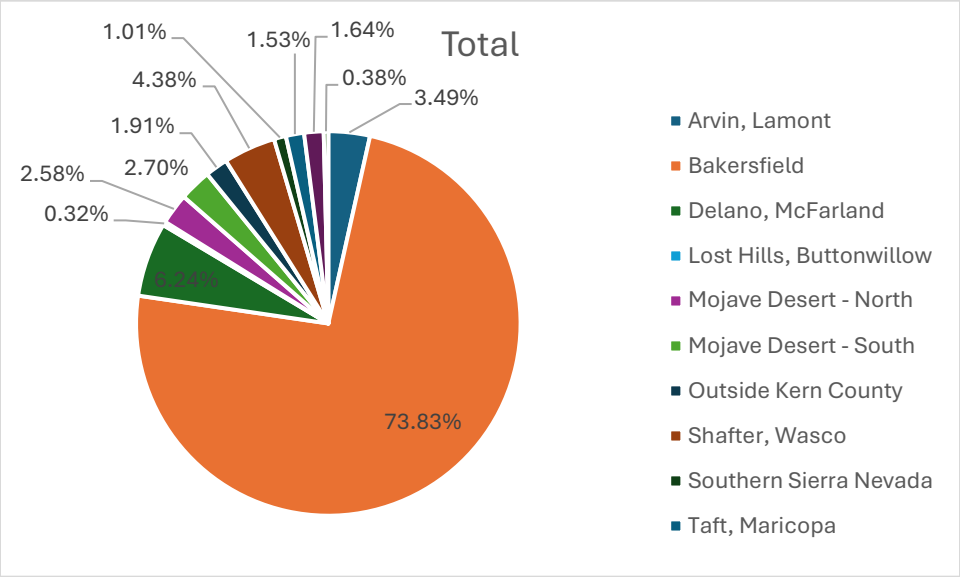


Figure 6. NSMHS utilization by Geographic Distribution

NSMHS Utilization by Aid Group

Aid Group	Percentage of Utilizers
Dual	9.38%
Expansion	38.49%
Family	40.79%
SPD	10.23%
Unknown	1.11%
TOTAL	**100.00%**

Table 7. NSMHS utilization by Aid Group

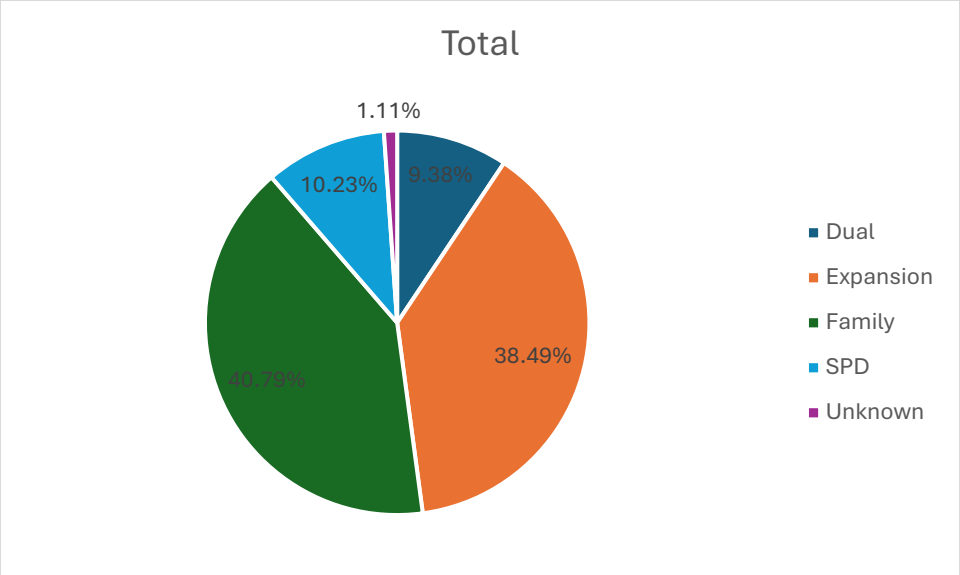


Figure 7. NSMHS utilization by Aid Group

KERN HEALTH SYSTEMS

Behavioral Health Advisory Committee

12:00pm-1:30pm

Calendar

Quarter 1 – January 15, 2025

Quarter 2 - April 9, 2025

Quarter 3 - July 16, 2025

Quarter 4 -October 15, 2025

Location:

KHS Board Room

2900 Buck Owens Blvd.

661-664-5000
661-664-5151
kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

KERN HEALTH SYSTEMS

To: EQIHEC

From: Nate Scott

Date: March 18, 2025

Re: Executive Summary for 4th Quarter 2024 Operational Board Update - Grievance Report

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Background

Executive Summary for 4th Quarter 2024 Operational Board Update - Grievance Report: When compared to the previous four quarters, the following grievance trends were identified during the 4th Quarter, 2024.

- There was a decrease in the Plan's grievance volume in the 4th quarter, 2024, compared to the previous four quarters. The overall volume of Grievances and Appeals dropped 10% from the 3rd to 4th quarter, 2024. Access to Care, Quality of Care, and Quality of Service grievances remained the three largest grievance categories. The volume of Exempt grievances continued to fall, dropping 25% from the previous quarter. No other significant trends were identified.

KHS Grievance and Appeals per 1,000 members = 2.22 per month.

Requested Action

Approve and file.

4th Quarter 2024 Operational Report

Alan Avery
Chief Operating Officer

4th Quarter 2024 Grievance Report

Category	4th Quarter 2024	Status	Issue	Q3 2024	Q2 2024	Q1 2024	Q4 2023
Access to Care	603		Appointment Availability	601	541	384	347
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	241		Questioning denial of service	290	357	385	423
Other Issues	134		Miscellaneous	106	118	64	39
Potential Inappropriate Care	476		Questioning services provided. All cases forwarded to Quality Dept.	532	538	572	522
Quality of Service	509		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	525	417	338	296
Discrimination (New Category)	71		Alleging discrimination based on the protected characteristics	62	81	60	40
Total Formal Grievances	2034			2116	2052	1803	1667
Exempt	644		Exempt Grievances	858	1177	1881	1620
Total Grievances (Formal & Exempt)	2678			2974	3229	3684	3287

KERN HEALTH SYSTEMS
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Additional Insights-Formal Grievance Detail

Issue	2024 4th Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	209	142	0	49	18
Coverage Dispute	0	0	0	0	0
Specialist Access	394	204	0	147	43
Medical Necessity	241	140	0	79	22
Other Issues	134	108	0	12	14
Potential Inappropriate Care	476	353	0	69	54
Quality of Service	509	370	0	82	57
Discrimination	71	64	0	1	6
Total	2034	1381	0	439	214

KERN HEALTH SYSTEMS

To: EQIHEC

From: Nate Scott

Date: March 18, 2025

Re: Executive Summary for 4th Quarter 2024 Grievance Summary Report

---

Background

Executive Summary for the 4th Quarter Grievance Summary Report:
The Grievance Summary Report supports the high-level information provided on the Operational Report and provides more detail as to the type of grievances KHS receives on behalf of our members.

For the 4th quarter, 2024, we had two thousand, six hundred, ninety-three (2,693) Grievances and Appeals (G&A) received. Here are the top three grievance categories:

- Access to Care/Difficulty Accessing Specialists at 32.2% of grievances received.
- Quality of Service at 31.8% of grievances received.
- Quality of Care at 17.8% of grievances received.

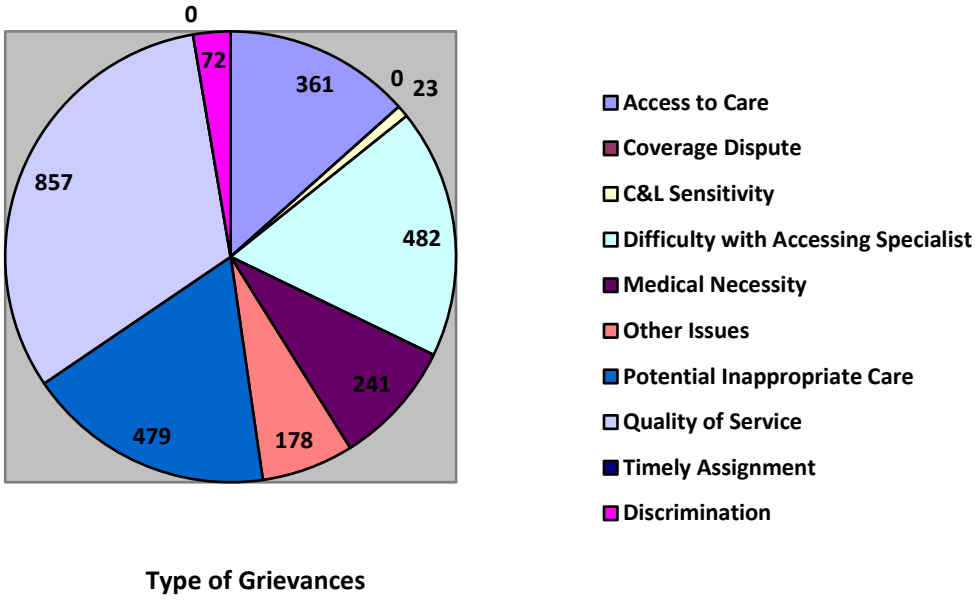
Of the 2,693 G&A received:

- 2,048 (76%) G&A were Standard Grievances and took up to 30 days to investigate and resolve.
- 645 (24%) G&A were Exempt Grievances and were resolved within one business day.
- 1,145 (42.5%) closed in Favor of the Enrollee
- 1,544 (57.3%) closed in Favor of the Plan/Provider
- 4 (.2%) are still open for review.

Requested Action

Approve and file.

Issue	Number	In Favor of Health Plan	In favor of Enrollee	Still under review
Access to care	361	156	205	0
Coverage dispute	0	0	0	0
Cultural and Linguistic Sensitivity	23	11	12	0
Difficulty with accessing specialists	482	212	270	0
Medical necessity	241	152	89	0
Other issues	178	121	56	1
Potential Inappropriate care	479	399	78	2
Quality of service	857	422	434	1
Timely assignment to provider	0	0	0	0
Discrimination	72	71	1	0



KHS Grievances and Appeals per 1,000 members = 2.22/month

During the fourth quarter of 2024, there were two thousand six hundred and ninety-three grievances and appeals received. Two thousand forty-eight cases were standard, and six hundred forty-five cases were exempt and closed within one business day. One thousand five hundred and forty-four cases were closed in favor of the Plan. One thousand one hundred and forty-five cases were closed in favor of the Enrollee. There are four cases still under review. Of the two thousand six hundred and ninety-three, two thousand two hundred and fifty-eight cases closed within thirty days; one hundred and ninety-four cases were pended and closed after thirty days.

Access to Care

There were three hundred and sixty-one grievances pertaining to access to care. Two hundred and thirteen cases were standard, and one hundred and forty-eight were exempt cases that closed within one business day. One hundred and fifty-six closed in favor of the Plan. Two hundred and five cases closed in favor of the Enrollee. There are no cases pending review. The following is a summary of these issues:

One hundred and seventy-two members complained about the lack of available appointments with their Primary Care Provider (PCP). Forty-nine cases closed in favor of the Plan after the responses indicated the offices provided the appropriate access to care based on the Access to Care standards. One hundred and twenty-three cases closed in favor of the Enrollee after the responses indicated the offices may not have provided appropriate access to care based on the Access to Care standards. There are no cases pending review.

Eighteen members complained about the wait time to be seen by a Primary Care Provider (PCP) appointment. Twelve closed in favor of the Plan after the responses indicated the members were seen within the appropriate wait time for a scheduled appointment or the members were at the offices to be seen as a walk-in, which are not held to the Access to Care standards. Six cases closed in favor of the Enrollee after the response indicated the member was not seen within the appropriate wait time for a scheduled appointment. There are no cases pending review.

Eighty-six members complained about the telephone access availability with their Primary Care Provider (PCP). Thirty-nine cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate telephone access availability. Forty-seven cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate telephone access availability. There are no cases pending review.

Eighty-one members complained about a provider not submitting a referral authorization request in a timely manner. Fifty-four cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Twenty-seven cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner. There are no cases pending review.

Two members complained about geographic access to a provider. Two cases closed in favor of the Enrollee after it was determined the geographic access provided may not have been appropriate.

Two members complained about physical access to a provider. Two cases closed in favor of the Plan after it was determined the physical access provided was appropriate.

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

There were twenty-three members that complained about the lack of available interpreting services to assist during their appointments. Fifteen were standard cases and eight were exempt cases that closed within one business day. Eleven cases closed in favor of the Plan after the responses from the providers indicated the members were provided with the appropriate access to interpreting services. Twelve cases closed in favor of the Enrollee after the responses from the providers indicated the members may not have been provided with the appropriate access to interpreting services. There are no cases under review.

Difficulty with Accessing a Specialist

There were four hundred and eighty-two grievances pertaining to Difficulty Accessing a Specialist. Three hundred and seventy-seven were standard cases and one hundred and five were exempt cases that closed within one business day. Two hundred and twelve cases closed in favor of the Plan. Two hundred and seventy cases closed in favor of the Enrollee. There are no cases still under review. The following is a summary of these issues:

Fifty-nine members complained about a provider not submitting a referral authorization request in a timely manner. Thirty cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Twenty-nine cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner. There are no cases under review.

One hundred and eleven members complained about experiencing difficulties in arranging, scheduling, or accessing transportation services. Fifty-six cases closed in favor of the Plan after the responses indicated the members were provided the appropriate services. Fifty-five cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate services. There are no cases under review.

Fifty-five members complained about the driver showing up outside of the scheduled pick-up time to transport the member to their appointment. Twenty-three cases closed in favor of the Plan after the response indicated the member was provided with the appropriate wait time for a scheduled appointment. Thirty-two cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate wait time for a scheduled appointment. There are no cases under review.

One hundred and forty members complained about the lack of available appointments with a specialist. Fifty-five cases closed in favor of the Plan after the responses indicated the members were provided the appropriate access to specialty care based on the Access to Care Standards. Eighty-five cases closed in favor of the Enrollee after the responses indicated the offices may not have provided the appropriate access to care based on the Access to Care standards. There are no cases under review.

One hundred and one members complained about the telephone access availability with a specialist office. Forty-one cases closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access availability. Sixty cases

closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate telephone access availability. There are no cases under review.

Sixteen members complained about the wait time to be seen for a specialist appointment. Seven cases closed in favor of the Plan after the response indicated the member was provided with the appropriate wait time for a scheduled appointment based on the Access to Care Standards. Nine cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate wait time for a scheduled appointment based on the Access to Care Standards. There are no cases under review.

Medical Necessity

There were two hundred and forty-one appeals pertaining to Medical Necessity. One hundred and fifty-two cases were closed in favor of the Plan as it was determined that there was no supporting documentation submitted with the referral authorization requests to support the criteria for medical necessity for the requested specialist or DME item; therefore, the denials were upheld. Of the cases that were closed in favor of the Plan, two were partially overturned. Eighty-nine were closed in favor of the Enrollee. There are no cases under review.

Other Issues

There were one hundred and seventy-eight grievances pertaining to Other Issues that are not otherwise classified in the other categories. One hundred and thirty-seven were standard cases and forty-one were exempt cases that closed within one business day. One hundred and twenty-one cases closed in favor of the Plan after the responses indicated the appropriate service was provided. Fifty-six cases closed in favor of the Enrollee after the responses indicated the appropriate service may not have been provided. One case is still open pending investigation and resolution.

Potential Inappropriate Care

There were four hundred and seventy-nine standard grievances involving Potential Inappropriate Care issues. These cases were forwarded to the Quality Improvement (QI) Department for their due process. Upon review, three hundred and ninety-nine cases were closed in favor of the Plan, as it was determined a quality-of-care issue could not be identified. Seventy-eight cases were closed in favor of the Enrollee as a potential quality of care issue was identified and appropriate tracking or action was initiated by the QI team. There are two cases still pending further review with QI.

Quality of Service

There were eight hundred and fifty-seven grievances involving Quality of Service issues. Five hundred and fourteen were standard cases and three hundred and forty-three were exempt cases that closed within one business day. Four hundred and twenty-two cases closed in favor of the Plan after the responses determined the members received the appropriate service from their providers. Four hundred and thirty-four cases closed in favor of the Enrollee after the responses determined the members may not have received the appropriate services. There is one case still under review.

Timely Assignment to Provider

There were no grievances pertaining to Timely Assignment to Provider received this quarter.

Discrimination

There were seventy-two standard grievances pertaining to Discrimination. Seventy-one cases closed in favor of the Plan as there was no discrimination found. One case closed in favor of the Enrollee. There are no cases still under review. All grievances related to Discrimination are forwarded to the DHCS Office of Civil Rights upon closure.

Email Quality & Accuracy

Audit Summary Report July 2024- December 2024			
Department:	Member Services		
Report Completion Date: 1/17/2025		**Review/Revised Date: 2/04/2025**	

List of Participants:

Participants listed were involved in the quantitative analysis, qualitative analysis and recommendations for actions and interventions related to the findings in this report.

Name	Title / Department
Nate Scott	Member Services Director
Amy Sanders	Member Services Manager
Maria Parra	Member Services Manager
Martha Quiroz	Member Services Manager
Mary Magana	Member Services Supervisor

A. Goal:

Audited emails must achieve a monthly average score of 90% or higher. 100% of audited emails must have a response within 1 business day.

B. Methodology:

All emails received are subject to routine audit.

Each month, the Member Services Auditors will select 10% (or a maximum of 10 whichever is less) of all email inquiries received via KFHCMEMBERSERVICES@KHS-NET.COM to audit.

KHS will evaluate the grammar, punctuation, response time and the quality and accuracy of information provided in the response.

The Auditor will collate the results of the monthly email audit and will share the results with Management.

C. Results:

1. Quantitative Analysis:

KFHC Email Audit Results							
E-mail Responses	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Year End Totals**
Emails Received	41	59	63	72	85	99	**419**
10% of Emails Received (formula)	4	6	6	7	9	10	**42**
The number of emails audited will be either 10% of the emails received or a max of 10, whichever is the lesser.	4	6	7	8	9	10	**44**

During this review period, a total of 419 member related emails were received. 44 emails were audited.

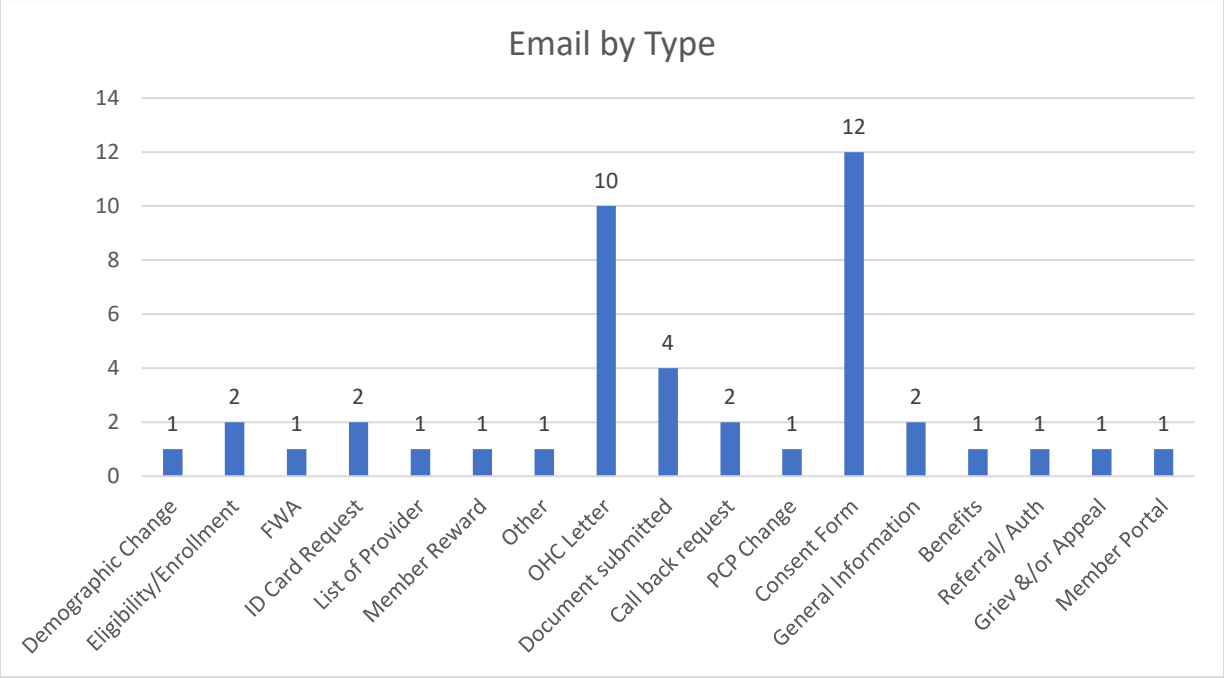
KFHC Email Audit Results								
Email Responses Met Monthly Audit Average Goal		**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Year End Totals**
Monthly Audit Average	**Standard 90%**	**100%**	**95%**	**99.29%**	**100.00%**	**100.00%**	**100.00%**	**99.05%**
Standard Met/Not Met		**Met**	**Met**	**Met**	**Met**	**Met**	**Met**	**Met**

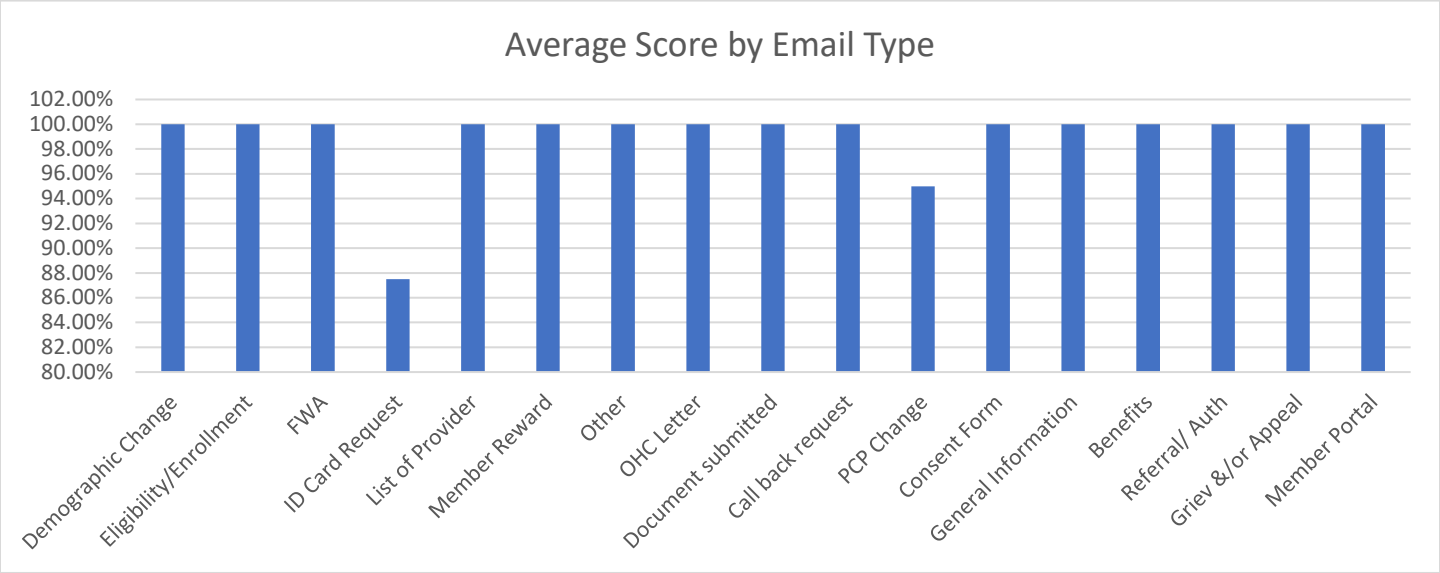
The total yearly audit average achieved was 99.05%, meeting the standard.

KFHC Email Audit Results							
Email Responses within 1 Business Day	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Year End Totals**
Total Emails Assessed	**4**	**6**	**7**	**8**	**9**	**10**	**44**
Total Emails with response within 1 business day	**4**	**6**	**7**	**8**	**9**	**10**	**44**
% Email responses within 1 business day (formula)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100.00%**
Standard Met/Not Met	**Met**	**Met**	**Met**	**Met**	**Met**	**Met**	**Met**

All 44 emails audited were responded to within 1 business day, meeting the standard.

Emails received by Type:





42 out of 44 of the emails audited scored at 100%. Only one email audited addressing an ID card request fell below the standard scoring at 75%.

Quantitative Analysis Conclusion: KHS met all goals for timeliness and quality and accuracy of emails. This indicates that members received accurate and quality emails in a timely manner.

2. **Qualitative Analysis**
   Although all goals were met, KHS completed a barrier analysis on these 44 email audits to identify areas of opportunity.
   a. There was only one email that fell below the standard. The deduction received was for not providing a response that was useful and understandable. The representative did not use the response template that best addressed the member's concern. This was an oversight and was addressed with the employee.

Qualitative Analysis Conclusion: The area to focus on is in question 2 on the audit score card impacting quality which measures if the staff are providing a response that is useful and understandable.

D. Opportunities & Interventions

1. During a scheduled meeting in February 2025, staff will be reminded:
   a. They must thoroughly review the email response templates and select the response that best fits the email inquiry.
   b. If they are unsure what to respond, they should reach out to a supervisor for guidance.

To: EQIHEC

From: Christine Pence, Senior Director of Health Services

Date: March 18, 2025

Re: Utilization Management Department Reporting Q4 2024

Background:

Utilization Management (UM) continues to be focused on ensuring KHS members receive medically necessary care at the right time in the most appropriate setting. To achieve this goal, UM works diligently to ensure all department processes are regulatorily compliant, staff is well trained, and all decision are made based on medical necessity and in accordance with regulatory directive and the Plan contract with DHCS.

Discussion:

This report contains a synopsis of both quantitative and qualitative analytics that reflect the performance of the Utilization Management Department's in the 4th quarter of 2024.

Also included is the 2024 UM Workplan Evaluation, 2025 UM Workplan, and UM Criteria.

Fiscal Impact:

None.

Requested Action:

Review and approve.

Utilization Management Executive Summary

The Utilization Management (UM) Department continues to focus on quality improvement to ensure UM services meet regulatory and accreditation standards.

The UM team has improved processes to ensure compliance with NCQA accreditation standards and continues to monitor key metrics using the Health Industry Collaboration Effort (HICE) tool. UM quality and compliance with regulatory standards are evaluated monthly through internal auditing. Internal audit results are distributed through the UM Committee and Compliance Committee.

In addition to the approval of the 2024 UM Workplan Evaluation, 2025 Workplan, and HICE annual review, the following policies were approved by the UM Committee on February 26, 2025

- Policy 3.16-P California Children's Services
- Policy 3.26 New Medical Technology
- Policy 30.55 Appropriate Non-Licensed UM Staff and Licensed Professional
- Policy 3.39-P Continuity of Care by Terminated Provider

The following report reflects Utilization Management performance through 4th quarter 2024.

Respectfully submitted,

Christine Pence, MPH, RN, RD
Senior Director for Health Services

Timeliness of Decision Trending

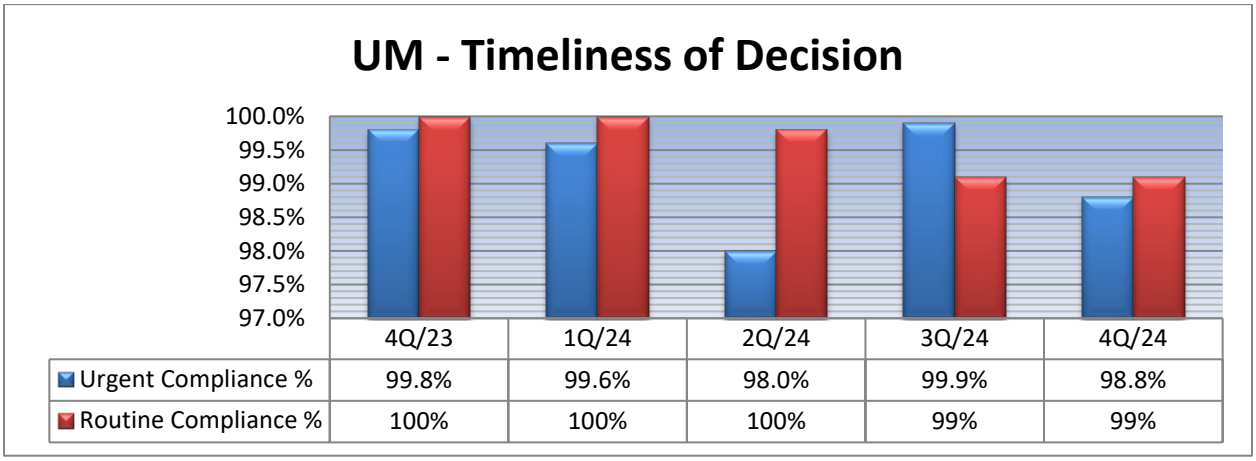
Summary:

Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

Providers may indicate 'Urgent' on the referrals indicating a decision needs to be made within 3 business days. Routine/non-emergent referrals must be processed within 5 business days. Once an urgent referral has been reviewed it may be downgraded for medical necessity at which time the provider will be notified via letter that the referral has been re-classified as a routine and nurse will clearly document on the referral "re-classified as routine". Random referrals are reviewed every quarter to observe timeliness. 10% of referrals received are reviewed monthly.

For those referrals that are found to be out of compliance with turn-around-timelines, the case manager and support staff are notified, and importance of timeframes discussed to help ensure future compliance.

Urgent: Response back to Provider in 3 business days
Routine: Response back to Provider in 5 business day



	4Q/23	1Q/24	2Q/24	3Q/24	4Q/24
Urgent Compliance %	99.8%	99.6%	98.0%	99.9%	98.8%
Routine Compliance %	100%	100%	100%	99%	99%

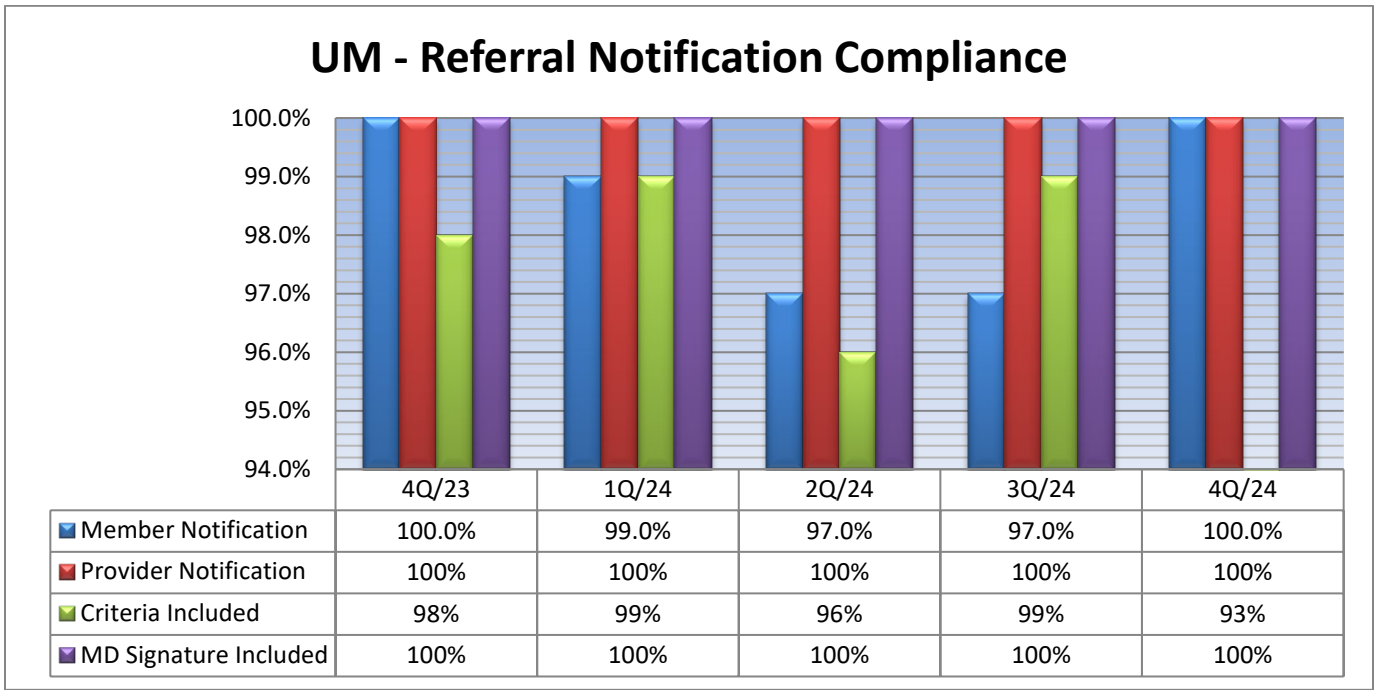
Referral Notification Compliance

Audit Criteria:

- Member Nofication: Letter of referral decision sent to member within 24 hours

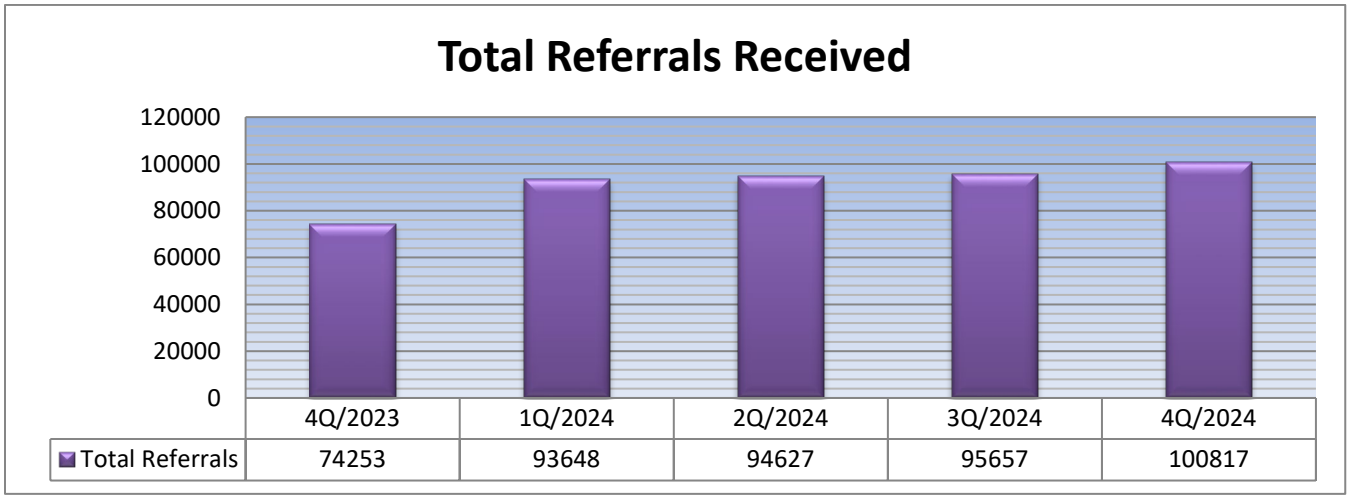
- Provider Notification: Referral is faxed back to the provider with 24 hours of decision
- Criteria Included: Criteria provided to provider on denial reason
- MD Signature: MD Signature included all referrals/NOA letters upon denial

Summary: Overall compliance rate from the 4th Qtr. of 2024 is 98.3% which increased from the 3rd Qtr. which was 98.0%

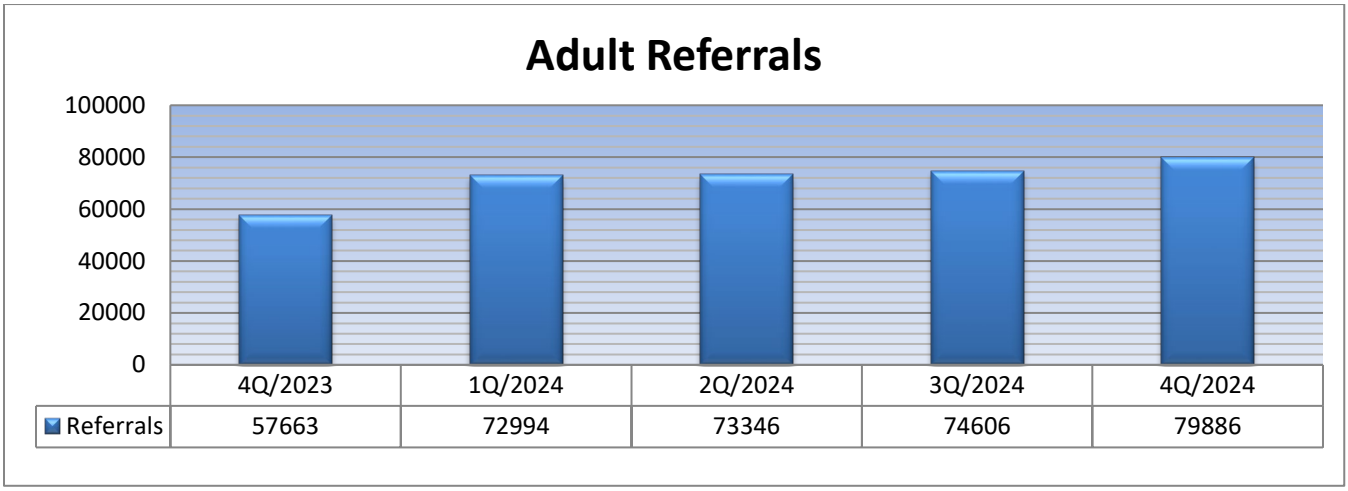


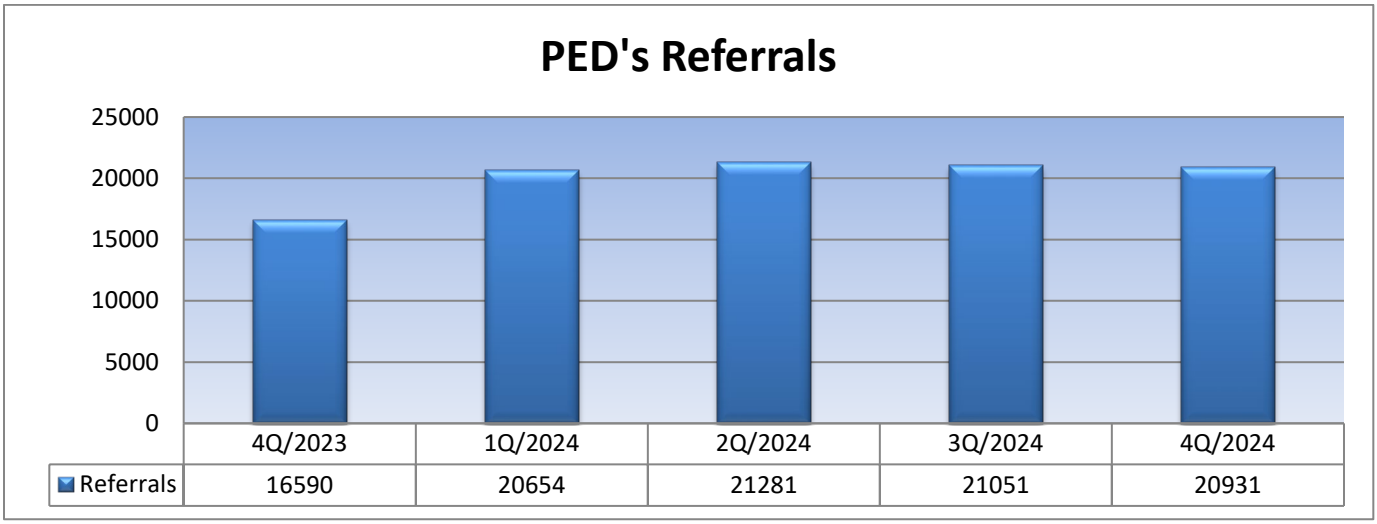
	4Q/23	1Q/24	2Q/24	3Q/24	4Q/24
Member Notification	100.0%	99.0%	97.0%	97.0%	100.0%
Provider Notification	100%	100%	100%	100%	100%
Criteria Included	98%	99%	96%	99%	93%
MD Signature Included	100%	100%	100%	100%	100%

Outpatient Referral Statistics



	4Q/2023	1Q/2024	2Q/2024	3Q/2024	4Q/2024
Total Referrals	74253	93648	94627	95657	100817

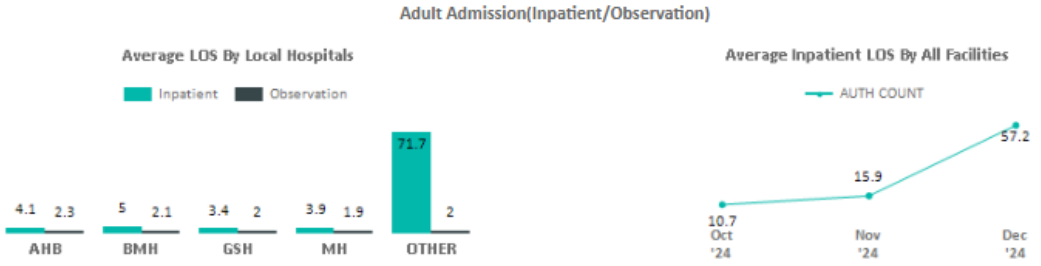




KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(Inpatient/Observation)

Dates of Discharge Between : 10/1/2024-12/31/2024

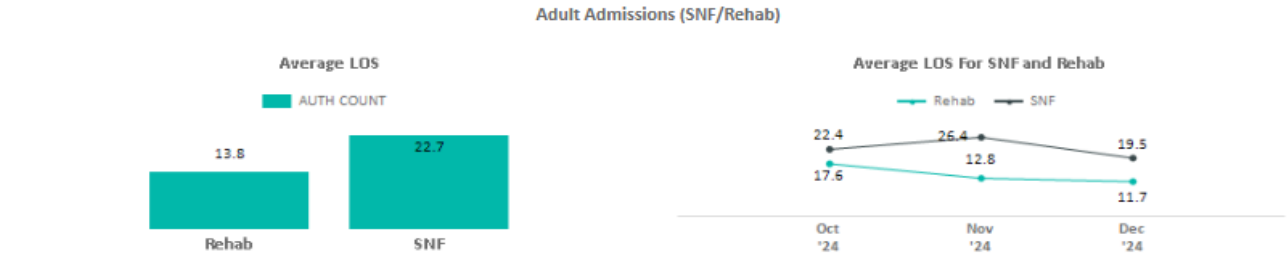


Post-Acute Statistics:

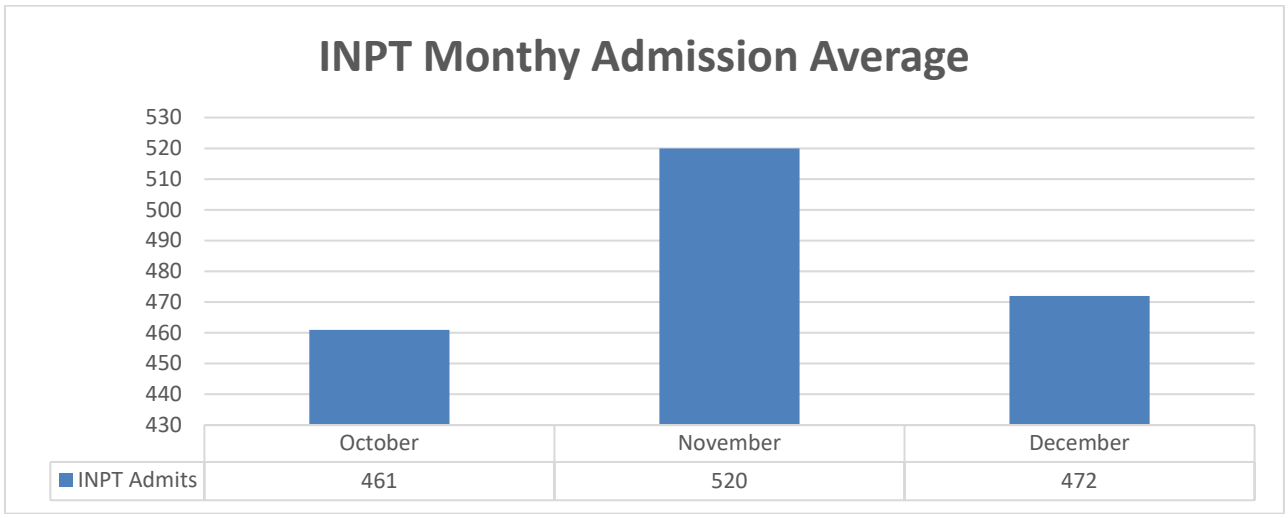
KHS Monthly Inpatient and LOS Report

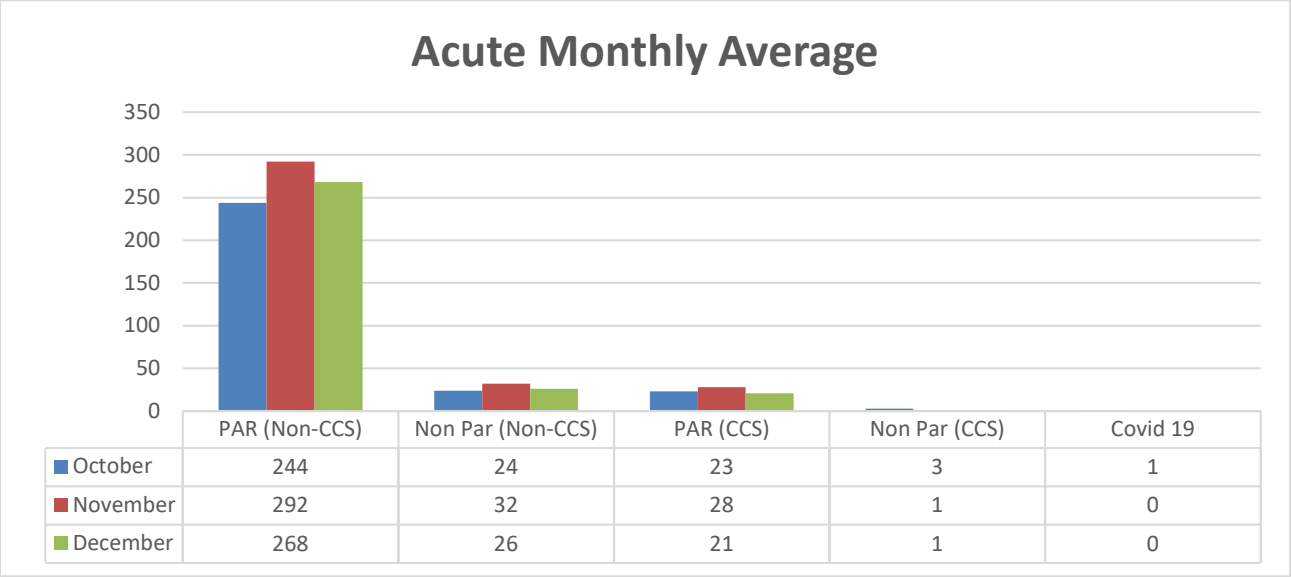
Report captures Adult Admissions(SNF/Rehabilitation)

Dates of Discharge Between : 10/1/2024-12/31/2024

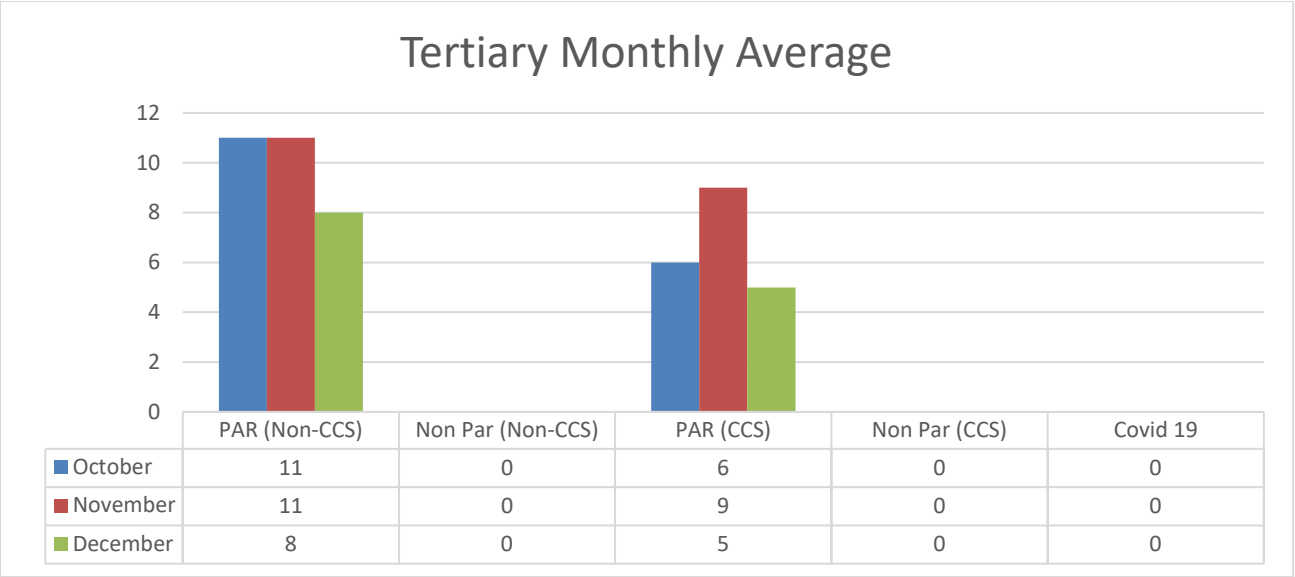


Inpatient Statistics Averages 4th Qtr. 2024

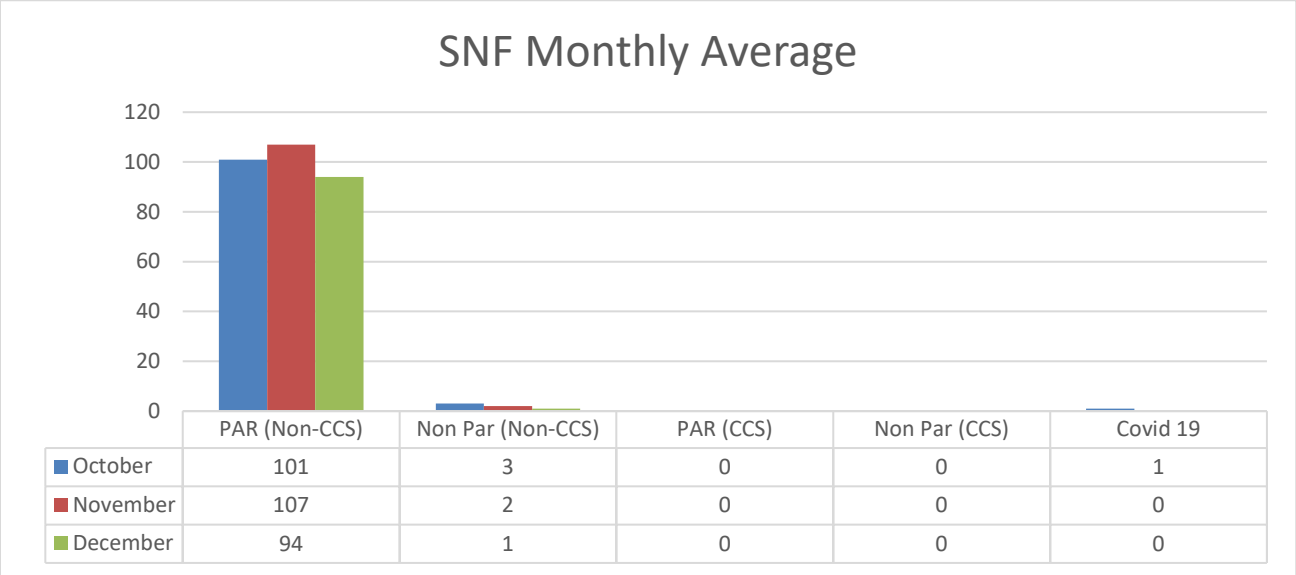




	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
October	244	24	23	3	1
November	292	32	28	1	0
December	268	26	21	1	0



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
October	11	0	6	0	0
November	11	0	9	0	0
December	8	0	5	0	0



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
October	101	3	0	0	1
November	107	2	0	0	0
December	94	1	0	0	0

Non-Clinical IRR Results

KHS - 2024 IRR Q4 Results

All Non-Clinical Staff in UM must successfully pass Quarterly IRR testing to demonstrate competency and understanding of the review process.

Results:
All staff were able to complete 4th Quarter IRR Quiz for NCIC process review. Staff were given a total of 10 questions for NCIC review process to meet our passing standards of 95 percent or better.

All non-clinical staff members participated and has completed the required IRR testing in Learning Management System (LMS) with a passing score of 100 percent.

	Number of Staff	Percentage
Number of Total Staff	31	
Number of Staff Passed on First Attempt	30	99%
Number of Staff Needing to re-take	1	1%
Number of staff passed on Second Attempt	1	1% (% of number who re-took)

Refresher training conducted on demand as needed and upon hiring via LMS.

Clinical

Milliman Care Guidelines Interrater Reliability (IRR)

2024 - Quarter 4 Results

	# of Staff	Total # Questions	# of Attempts to Pass	% of staff that scored 95% or higher within 3 attempts
OP Nurse(s):	13	15	3	100%
IP Nurse(s):	17	24	3	100%
Medical Director(s):	6	24	3	100%
Manager(s):	2	24	3	100%
Trainer(s):	1	24	3	100%

Corrective Action Plan:

1. All clinical reviewers passed within the allotted three (3) attempts on their assigned IRR cases and no remediation was needed.
2. Refresher training and education will be provided quarterly and as needed at management's discretion.
3. Newly hired staff will participate in MCG IRR training during the onboarding process.

KERN HEALTH SYSTEMS

To: EQIHEC

From: Christine Pence, Senior Director of Health Services

Date: March 18, 2025

Re: Utilization Management Department 2024 Workplan Evaluation

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Background:

The Utilization Management (UM) Department develops an annual workplan. The 2024 Workplan was previously approved at the beginning of 2024. The attached provides an evaluation of the progress towards the UM goals and workplan.

Discussion:

All goals were met in the 2024 UM Workplan. A description of the interventions and associated evaluation for each workplan goal is provided.

- Goal 1: Ensure that qualified, licensed, healthcare professionals assess clinical information used for clinical decision making.
- Goal 2: Compliance with hierarchy of decision making, ensuring consistent application of medical necessity determination criteria.
- Goal 3: Ensure compliance with legislative and regulatory directives.
- Goal 4: Ensure separation of medical decisions from fiscal considerations.
- Goal 5: Ensure compliance of NOA with regulatory standards.
- Goal 6: Monitoring of the utilization management review process.
- Goal 7: Compliance with timeliness of processing. Turn Around Times (TAT)
- Goal 8: Consistency with which criteria are applied in UM decision-making and opportunities for improvement are acted upon.
- Goal 9: Appeals and distribute management compliance
- Goal 10: Monitoring of over and under utilization
- Goal 11: Consistent referral of members for specialty program consideration originating from UM
- Goal 12: Coordination of care with California Children's Services (CCS)

Fiscal Impact: None.

Requested Action: Review and approve.

KERN HEALTH SYSTEMS

2024 UTILIZATION MANAGEMENT WORKPLAN EVALUATION

INTRODUCTION:	The goal of the utilization management department is to ensure members we serve receive high quality care in the right setting at the right time. To ensure this goal is met, the utilization management department proposes the following interventions.
GOAL 1: MET	Ensure that qualified, licensed, healthcare professionals assess clinical information used for clinical decision making.

2024 INTERVENTIONS:	2024 GOAL(s):	RESPONSIBLE TEAM MEMBER:	COMPLETION DATE:
1. Ensure high quality new hire orientation training is provided to all new clinical staff. 2. Provide annual continuing education opportunities for the clinical staff. 3. Review and revise staff orientation materials, manuals and processes. 4. Implement verification process to validate continuing education completion and verification of certifications. 5. For medical necessity nationally recognized criteria, the UM nurses and physician reviewers will continue to utilize the MCG Guidelines. MCG guideline criteria sets offer **evidence-based care** guidelines for various care settings and conditions, developed by clinical editors, and based on peer-reviewed papers and research studies. The **care** guidelines are utilized by the KHS staff for outpatient referrals and procedures and inpatient concurrent hospital admission stays. The UM licensed staff reviewers will continue to undergo significant training as part of the new hire orientation process and then at regular intervals throughout the year to include, one-to-one training, UM inpatient concurrent review staff huddles, denied, modified case reviews, and inpatient denial reviews. Licensed staff UM reviews are monitored through a random selection of each reviewer's file reviews on a monthly basis as they apply to utilizing MCG guidelines. 6. A specialized training Inservice will be arranged in 2024. The training module included criteria access resource links, best practices, and hierarchical selection requirements in conformance with Medi-Cal regulations. Other	100% compliance with maintaining records of professional licenses and credentialing for staff that support clinical decision making to ensure KHS members receive medically necessary care at the right time in the most appropriate setting.	Utilization Review Manager	December 2024

aspects of the training covered application of benefits, how to locate and utilize the Medi-Cal Provider Manuals and specialized Medi-Cal Programs. 7. KHS UM medical leadership will ensure adherence to a designated Medical Criteria policy and procedure developed in 2023 to facilitate more detailed guidance with UM criteria selection process. The proficiency of staff adherence to application of medical necessity is also measured through the Inter-rater Reliability (IRR) audit process as defined in the following goal. **This function will continue for 2024 as part of the new staff onboarding process, ongoing hands-on licensed staff training, formal training modules, and updated procedural guides as needed.**			

2024 Evaluation

- Job specific training checklists have been prepared for the UM staff
- The following training guides and manuals have been updated:
    a. NCIC II-IV Auto Approval
    b. Activities in JIVA
    c. Call Process
    d. CCS Carve Out Training
    e. CCS Weekly Report
    f. Commentary vs. No Commentary
    g. CCS Approval Closed Out Process
    h. CCS Close Out Process
    i. ECM Approval Process
    j. ECM Cheat sheet
    k. ECM Denial- Termination Process
    l. Other Health Coverage Verification
    m. Provider Termination Process for NCIC
    n. Provider Termination Report Process
    o. Scanfinity Training Guide
- MCG guidelines were utilized when Medi-Cal does not have medical necessity criteria. They were and continue to be utilized for outpatient referrals, and inpatient concurrent hospital stays. MCG training was provided when the new edition was implemented. Staff were trained throughout the year on an individual and group basis depending on training needs.
- Quarterly reviews of staff MCG use were completed throughout the year.
- In addition to the quarterly reviews, all UM staff (licensed and non-licensed) completed Inter-rater Reliability (IRR) audits quarterly to ensure consistent application of criteria.

GOAL 2: MET	Compliance with hierarchy of decision making, ensuring consistent application of medical necessity determination criteria.		
2024 INTERVENTIONS:	**GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**

1. Quarterly completion of Milliman Care Guideline Inter Rater-Reliability (MCG IRR) 2. MCG training annual and as needed based on changes to the guidelines. 3. Annual review of Medi-Cal guideline training and for hire. 4. The Inter-rater-reliability compliance rate will continue to be 100% for licensed reviewers with a passing score of 80% or greater for each IRR Case Review and with the concession that if they failed a case they were educated and retrained and a retest of 2 cases will transpire after the retraining.	Inter-rater-reliability pass rate of **100%**	Utilization Review Manager	December 2024

2024 Evaluation

- Quarterly completion of Milliman Care Guidelines (MCG) Inter Rater-Reliability (IRR) for all licensed and non-licensed UM staff
- Provided MCG training when with the implementation of the new MCG edition
- The Inter-rater Reliability compliance rate was 100%, with a passing score of 80% or better for each IRR Case Review.

GOAL 3: MET	Ensure compliance with legislative and regulatory directives.		
2024 INTERVENTIONS:	**GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Participate in all appropriate legislative and regulatory workgroups and/or activities that may impact the UM department. 2. Update department policies and *procedures* to reflect these changes. 3. Implement a policy and procedure review plan to ensure directives are operationalized. 4. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards. 5. KHS will continue to demonstrate readiness with the DHCS 2024 Contract driven by the many CalAIM transformational goals to improve more coordinated person centered and equitable health care served. 6. KHS will adhere to the expanded health services committee structure with the creation of a Quality Improvement Health Equity Transformation Committee (QIHETC) as the umbrella committee for all health service	All new APLs will be reviewed, and policies updated to comply with new APL directives and other Federal and State regulations.	Utilization Management Director	December 2024

quality functions. The KHS internal existing health service committees as well as newly developed committees were converted to subcommittees to support, monitor and report the 2024 new contract requirements applying to each health services area to ensure compliance. In addition to the 2024 contract, multiple DHCS and Department of Managed Health Care (DMHC) APLs were released to guide operational and administrative requirements. 7. Continue to comply with 2024 NCQA Standards and Guidelines in preparation for the 2025 NCQA accreditation process. The most current 2024 NCQA Accreditation Standards will be cross-walked to KHS health services activities to ensure compliance. 8. Staff training will be continuous pertaining to the newly instituted documents and activities instituted through review of the policies and programs and collaborative meetings to facilitate best practices.			

2024 Evaluation

- UM Management and trainers participated in DHCS, DMHC, and NCQA meetings and workgroups to keep informed of legislative and regulatory activities that could impact the UM Department.
- The UM team continued to demonstrate DHCS Contract compliance as demonstrated by key performance indicators, and the December 2024 DHCS medical audit. The audit identified concerns with NOA language and turnaround times. The UM Management team addressed these issues prior to the audit but the audit samples were not reflective of the new processes.
- UM has devoted significant time and resources to ensure NCQA accreditation readiness. Improved processes, monitoring and documentation was developed to meet NCQA guidelines.
- The majority of the UM policies and procedures were reviewed, updated and submitted to compliance for processing. A full reconciliation of all UM policies to ensure review of all will be completed in the first quarter of 2025.
- A weekly reviews of policies that have not been recently updated was completed for half the year.
- UM participated in compliance committees and updated the UM compliance report to show trending of key performance indicators.
- All new APL's for 2024 were reviewed, assessed for UM impact, and communicated with the compliance team.

GOAL 4: MET	Ensure separation of medical decisions from fiscal considerations.		
2024 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**

1. Circulate to all Physician and Nurse reviewers an attestation that states: "Utilization Management decisions are based on medical necessity and medical appropriateness does not compensate physicians or nurse reviewers for denials. KHS does *not* offer incentives to encourage denials of coverage or service". 2. Ensure this education is provided to all Utilization Management staff. 3. UM Committee members will sign the attestation annually 4. The KHS website will be updated in 2024 with the affirmative statement under the Utilization Management section.	100% compliance with distribution and receipt of completion of affirmative statement about financial incentives.	Utilization Management Manager	December 2024
2024 Evaluation: 1. Affirmative Statement and policy reviewed and attested to by UM team members.			
GOAL 5: MET	Ensure compliance of NOA with regulatory standards.		
2024 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. File reviews to validate regulatory standards are met. 2. Education, both ongoing and remedial will be provided to staff on any issues revealed during the file review process 3. Clinical nurses will at least annually receive training consisting of best practices and compliance requirements for UM medical necessity and application of criteria and benefit review cases to include denial / delay / modified. Methodology will include a selection of 5 random cases from the universe for each staff being reviewed. The case documents, medical necessity criteria selected by the reviewer and the reviewers written rational and decision determinations will be cross referenced to the Notice of Action Letter as follows: a. Spelling/Grammar, Verbiage, and Format, b. Medi-Cal Criteria applied, c. Criteria indicated and attached, d. Recommendations to MD indicated.	Documented use of guidelines in medical necessity determinations will be in compliance with State, Federal and other regulatory requirements 95%	Utilization Review Manager/Trainor and Supervisor	December 2024

4. File review will ensure 95% compliance with referral decision making and member and provider notification timeliness standards in congruence with regulatory and accrediting standards. 5. Any deficiencies identified will be followed through with one-to-one continued training until they meet the threshold goal of 95%in 2024 (threshold was 85% in 2023). 6. Ongoing remedial training as needed will be provided throughout the year.			

2024 Evaluation

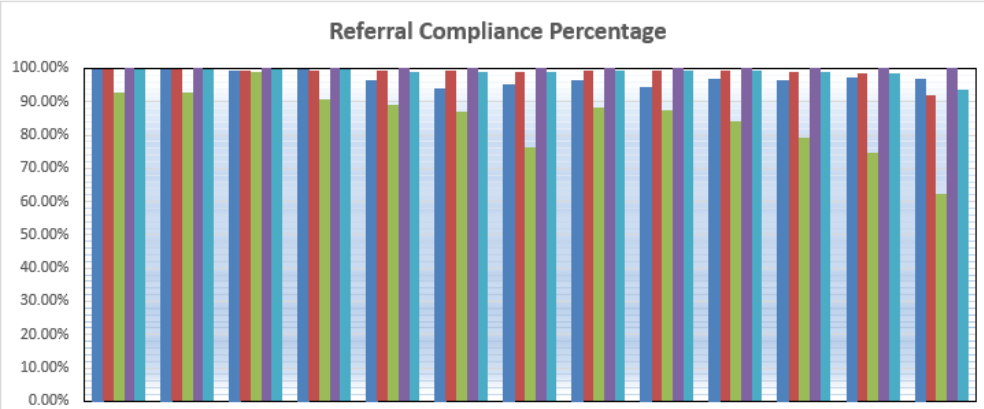
- Quarterly audits of 5 random cases for clinical staff were performed throughout the year. Results were shared with the UM Committee and Compliance Committee.
- Based on the NCQA mock audit and Compliance Department audit, the NOA language was revised to reflect clear and concise explanation of the reason for decision at or less than 6th grade readability, description of the criteria, a reference to the specific regulation and the clinical reasons for the decision. The structure for the NOA letters is based on the following:
  - Identifying the procedure/diagnostic test/treatment/consultation in 6th grade language with a description of why it was requested
  - Identifying what is needed for the request to be approved
  - Identifying why the request was not met
  - The decision
  - A statement of what the member can do next
  - Identification of the exact criteria used to make the decision
- Individual feedback was provided to each Physician to improve the NOA language.

GOAL 6: MET	Monitoring of the utilization management review process.		
2024 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Utilize business intelligence reports monthly and as needed as a tool for systematic oversight of the prior authorization process. 2. Assess staffing requirements to complete the prior authorization process timely and ensure an adequate budget is allocated to meet the staffing needs. 3. Multiple report monitoring activities will continue to be updated/ developed to support the management of authorization referral request processing during each business day serves as a means to effectively assess staff availability matched to volume demands.	Track and trend authorization activity on a monthly basis including: 1. Number of prior authorization requests submitted, approved, deferred, denied, modified and maintain compliance timeliness rate of	Utilization Management Director and Manager	December 2024

4. To mitigate any adverse TAT trends found in each given month, a monthly management UM huddle meeting will continue to transpire to review the processing results, with a drill down on the causation of any cases that failed to meet requirements. This process will be supported with ongoing training of staff and continued evaluation of work processes to identify opportunities for streamlining processes. 5. Ensure an adequate budget is allocated to meet the staffing needs. 6.	95 %. 2. Denials appealed and overturned compliance rate of 5 % or <.		

2024 Evaluation:

- Monthly reports include the following, which enable UM Management to provide oversight of the departments compliance with policies, procedures and regulatory requirements.
- Staffing adjustments were made to promote 95% compliance with turnaround times. The monthly turnaround times were



	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Urgent	99.62%	99.62%	99.12%	99.54%	96.12%	93.95%	94.87%	96.32%	94.22%	96.62%	96.08%	97.18%	96.86%
Routine	99.71%	99.71%	99.51%	99.55%	99.34%	99.34%	99.15%	99.50%	99.44%	99.34%	98.94%	98.58%	92.11%
Delayed	92.86%	92.86%	99.00%	90.67%	88.89%	87.04%	76.47%	88.24%	87.50%	84.21%	79.03%	74.58%	62.50%
Retropective	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
TAT Compliance	99.92%	99.92%	99.66%	99.78%	99.11%	99.02%	98.85%	99.30%	99.18%	99.25%	98.80%	98.64%	93.54%

- Turnaround times were discussed throughout the year and efficiencies implemented to improve compliance
- The budget was adequate to ensure staffing needs

GOAL 7: MET 11/12 Months	Compliance with timeliness of processing. Turn Around Times (TAT)		
2024 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**

1. Monitoring of the Turn Around Time (TAT) by type on a routine basis using business intelligence reporting tools. 2. Weekly evaluation to identify barriers to meeting utilization management timeline standards, 3. Develop action plans to address deficiencies. 4. Ongoing focus on meeting TAT requirements. 5. Routine request: the initial time is established from the day following receipt with a TAT of 5 business days to be completed in full. 6. For time stamped via the urgent the time frame will begin in at the hour, minute, and second of KHS receipt of request. i.e. date provider portal, fax, or call-in requests by which the time of the call in is recorded by the UM representative in receipt of the verbal request. The Turnaround time is 72 hours. Urgent requests will be prioritized. 7. The compliance goal is 95% for routine and urgent. 8. Monthly Management review or TAT results, with drill down on all cases that fail to meet TAT requirements. 9. Ongoing training or staff and evaluation of work processes to identify opportunities for streamlining process.	Compliance with DHCS/ DMHC/NCQA turn-around timeframes. >/= 95% by type of request.	Utilization Review Trainor/ Manager and Supervisor	December 2024

2024 Evaluation

- The Turnaround time is measured and monitored throughout the day with a summary provided monthly. The UM team has access to the daily aging report, that identifies the referrals due dates. Twice a day the daily aging report is emailed to the UM Management team. In addition, the UM Management team and UM staff can prepare the report at any time as it is available on demand.
- Evaluation of turnaround time subsequent action plans to address deficiencies occurred throughout the year. These action items included, but were not limited to, acquiring additional staff, improving JIVA processes, implementing JIVA due date and rules to ensure compliance, and daily oversight.

GOAL 8: MET	Consistency with which criteria are applied in UM decision-making and opportunities for improvement are acted upon.		
2024 INTERVENTIONS:	**2024 GOAL(s)**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Conduct quarterly interrater Reliability (IRR) testing of healthcare professionals involved in UM decision making. 2. For 2024 the IRR testing process will expand to non-licensed UM staff to evaluate and as needed to optimize UM efficiencies. The focus	Physician and nonphysician UM reviews 5 files achieving passing score on MCG IRR Tool.	Clinical Supervisor	December 2024

of the non-licensed IRR process will focus on administrative proficiency standards such as verification of benefits, checking the UM system to ensure a service is not duplicative or requested within the benefit period, ensuring medical necessity records are attached and following protocols to collect the records and so on. 3. The file review process will include application of the approved UM criteria.			

2024 Evaluation

- In 2024, non-licensed staff were added to the IRR process and evaluated on a quarterly basis
- All UM Staff passed IRR for each quarter

GOAL 9: MET	Appeals and Dispute Management Compliance		
2024 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Monthly analysis of UM Appeals by volume, number of upheld vs overturned, and associated turn-around times. 2. Analyze the UM appeal review to identify trends. 3. Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals data that are regularly overturned. 4. Ensure appeals are processed by specialty-matched physicians. **5.** Appeals will continue to be tracked and trended according to the number of Appeals cases overturned, upheld or partially upheld. 6. As a DHCS contractual requirement, KHS will continue to submit Appeals data routinely to the department to include an aging TAT. 7. When there is a specific provider trend of not complying with proper service request medical records and documentation submission in accordance with KHS policies and protocols, the Provider Network Department will be notified to assist in educating the provider and instituting steps to mitigate any adverse trends that may create a barrier to members receiving timely medically necessary services.	Ensure >/= 90% accuracy of all determinations TAT while complying with regulatory tum-around times	Utilization Review Manager and Supervisor	December 2024

2024 Evaluation

- Below is the analysis of the UM appeals. The percent overturned ranges from 32% to 59% with an average of 23 days TAT.

Month/Year	Closed - Appeal Overturned	% Overturned	Closed - Appeal Upheld	Grand Total	Average TAT Days
Jan-24	58	59.2%	40	98	17
Feb-24	56	44.1%	71	127	21
Mar-24	80	53.7%	69	149	26
Apr-24	40	32.5%	83	123	27
May-24	45	34.4%	86	131	25
Jun-24	32	32.7%	66	98	21
Jul-24	35	32.7%	72	107	21
Aug-24	36	34.0%	70	106	24
Sep-24	31	41.9%	43	74	25
Oct-24	31	32.0%	66	97	24
Nov-24	24	33.3%	48	72	24
Dec-24	19	47.5%	21	40	15
Grand Total	**487**	**39.9%**	**735**	**1222**	**23**

- KHS undertook a significant review of referrals to identify procedures, treatments, and DME that should be removed from the Prior Authorization list. This review included evaluating the approval/denial rates, and utilization compared to peers. The Prior Authorization analysis resulted in the removal of 418 codes and the addition of 24 codes.
- The AllMed implementation, which was scheduled for 2nd and 3rd quarter of 2024, was delayed due to the DMHC review. AllMed will provide specialty-matched physicians for all appeals.
- The UM team did not identify a specific provider(s) that were not complying with medical record requests.

GOAL 10:	Monitoring of over and under utilization		
INTERVENTIONS: MET	**GOAL (s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Conduct monthly review of the following UM metrics by AIDE code: Acute bed days per thousand, average length of stay. Acute care stay, ER visits per thousand. All-cause readmissions, readmissions within 30 days, C-Section ratio. 2. Aggregate LOS specialty referral review Assessments on a biannual basis. 1. Will continue to aggregate LOS specialty referral review Assessments on a biannual basis. 2. **For Underutilization:** a. The UM department will continue to perform the following activities and reports the results to the UM/QI Committee at least quarterly: - Letters to the member's PCP with a count of their assigned members who still need an IHA. These letters direct the PCP to the Provider Portal to review their list and perform outreach activities. - Letters are also mailed to the PCP	5% improvement of current statistical baseline.	Medical Director	December 2024

regarding members who have open authorizations. Open authorizations are defined as any auth that has not expired and has no claim attached to it. The auth does not need to be fulfilled to no longer be considered open. - Letters are mailed out to each PCP at each location where they have members assigned. b. The IHA process will continue in 2024. 3. **Overutilization** a. Track and identify members going to ER during regular PCP business hours for non-emergent conditions - Conduct PCP access and availability study during normal business hours. - Report of auditor findings will be sent to PCP identifying members who were not able to access PCP.			

2024 Evaluation:

- UM receives daily metrics that include acute bed days, length of stay and average length of stay, and readmissions
- Other measures evaluated at least quarterly include: CMO board report
  - Professional services utilization
  - Outpatient services utilization
  - Emergency service utilization
- Underutilization reports were sent monthly to PCPs to direct them to review their open referrals in the Provider Portal. The notifications identify the number of open referrals in their panel
- Overutilization of ER use is identified through stratification of claims data. Members that are high utilizers are stratified into the Enhanced Care Management program or Population Health Management provided care coordination.
- After evaluating for potential overutilization the Prior Authorization list was revised to evaluate medical necessity

GOAL 11: MET	Consistent referral of members for specialty program consideration originating from utilization management.		
2024 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**

1. Assessment of each member with an inpatient encounter with the purpose of Identifying a condition that would warrant additional specialty care management and *refer* for consideration prior to encounter closure. 2. Review of member encounter data via business intelligence reports to identify those with qualifying conditions or social determinants of health that may benefit from enhance care coordination services and refer. 3. The referral program strategy and intervention will be carried through to 2024. In 2023, a baseline was established for each service and will be measured and compared throughout 2024 on the reports. Additionally, follow through with the referral will be conducted and documented to provide further insight into the effectiveness of the increased referrals as it pertains to supporting the members with specific goals.	25% increase of referrals over current baseline each quarter until >/= 90% of eligible members are referred *for* specialty program consideration.	Utilization Review Manager and Supervisor	Ongoing

2024 Evaluation

- Members with inpatient encounters are evaluated for additional specialty care management and referred appropriately
- In Quarter 3, the risk stratification for Care Management services through the Population Health Management department was completed. This includes considerations of social determinants of health

GOAL 12: PARTIALLY MET	Coordination of care with California Children's Services (CCS).		
2024 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
4. Daily inpatient census will be reviewed, and any eligible member will be referred to CCS for service authorization request. 5. Weekly review of CCS business intelligence report to validate member's ambulatory referrals are authorized and encounters processed appropriately. 6. Quarterly review or reports to identify CCS eligible members that are near age out and referral to Case Management to facilitate smooth transition of provisions of care.	100% of eligible cases will be identified care will be coordinated with CCS as appropriate.	Utilization Review Manager and Supervisor	December 2024

2024 Evaluation

- The UM team utilizes BI reports to identify members with potential CCS conditions to ensure CCS referrals are tracked and appropriate authorizations are completed.
- All potential members with CCS conditions are submitted to CCS for review. If CCS accepts the condition, the medical services associated with that condition are carved-out to CCS and the member and provider are notified via writing. If CCS does not accept the condition, KHS provides the required medical services.

Additional Accomplishments for 2024:

- Added approximately 70,000 members on January 1st through members transitioning from HealthNet and Fee for Service. The team successfully complied with regulatory turnaround times, continuity of care, and other requirements even with this large increase in membership.
- Implemented additional Long Term Care processes to be compliant with the new managed care benefit while ensuring members have continuity of care.
- HICE template utilized to track and trend metrics to be consistent with industry standards
- The Inpatient RN and Physician team have daily rounds to discuss members that need additional care coordination and services.
- Although the UM team experienced staffing challenges while experiencing an increase in requests with the changes in PA list and seasonal variability, regulatory compliance continued.
- New policies were implemented for NCQA and for regulatory purposes. These include
    - UM Systems Control policy
    - UM Staff Access and Availability
    - Appropriate non- Licensed and Licensed Professionals
    - Specialty Referral and Use of Board-Certified Consultants
    - Care Transitions of Benefits and Services
    - Standing Referrals
    - Inter-Rater Reliability
- The Notice of Action letters were enhanced to meet NCQA standards
- Notice of Action language was improved to ensure the communication is clear and concise, written in 6th grade or lower language, and include a description of the criteria used for the determination
- The UM Management team implemented a daily monitoring process to ensure UM decisions are not changed after authorizations are processed
- Aligned our use of subacute and congregate facilities to regulatory requirements
- Identified, contracted and determined workflow process for AllMed, which will augment nursing and physician preservice reviews and appeals. Significant collaboration, training, workflow development and technical configuration occurred throughout the year to provide the infrastructure to have a successful delegation partnership.
- Completed a comprehensive review of KHS's prior authorization list and implemented a new prior authorization list
- JIVA improvements included
    - Automatically assigning inpatient reviews to the appropriate team member, to replace the manual process
    - Identifying providers with closed panels within JIVA to reduce errors with authorization approvals

    - Added the member's name and member identification number on concurrent notifications to replace the manual process
    - Added name, title, and licensure to NOA letter
    - Revised processing turnaround times to 72 hours for urgent, instead of 3 days to be consistent with regulatory requirements
    - Revised received date to remove the 3pm close of business rule to be consistent with regulatory requirements
    - Created UM note templates to improve efficiency of documentation and communication within the UM team
    - Created a peer-to-peer process within Jiva to document Peer to Peer interactions
- NCICs working weekends to improve weekend care coordination of inpatient services
- Revised poststabilization policies and procedures to align with DMHC audit findings

KERN HEALTH SYSTEMS

To: EQIHEC

From: Christine Pence, Senior Director of Health Services

Date: March 18, 2025

Re: Utilization Management Department 2025 Workplan

Background:

The Utilization Management (UM) Department develops an annual workplan. The workplan is developed to ensure the UM Department maintains high quality services that are compliant with regulatory and accreditation standards.

Discussion:

The 2025 Workplan has 5 goals. Each goal has planned interventions to support the success of the goal. The UM leadership team will monitor the progress towards each goal and report the evaluation of the 2025 Workplan in the 1st quarter of 2026.

- Goal 1: Meet NCQA UM standards. Obtain at least an 80% for UM standard reviews and pass all must-pass UM standards.
- Goal 2: Ensure consistent application of medically necessity determination criteria by maintaining an inter-rater reliability pass rate of 100%
- Goal 3: Ensure 100% of potentially eligible cases will be identified and referred to California Children's Services (CCS)
- Goal 4: Monitor UM review process to ensure compliance with regulatory standards. Maintain at least a 95% timeliness rate for regulatory required prior authorization requests.
- Goal 5: Improve over and underutilization management by 5% of current baseline.

Fiscal Impact: None.

Requested Action: Review and approve.

2025 UM Workplan

	Planned Interventions
Goal 1	**Meet NCQA UM standards. Obtain at least an 80% for UM standard reviews and pass all must-pass UM standards**
	Develop and implement policies and procedures to align with NCQA standards
	Monitor compliance with meeting NCQA standards through monthly auditing and tracking
	Develop an corrective action plan for any standards identified as deficient during the NCQA accreditation
Goal 2	**Ensure consistent application of medical necessity determination criteria by maintaining a Inter-rater reliability pass rate of 100%**
	Quarterly completion of Milliman Care Guideline Inter Rater-Reliability (MCG IRR) with 100% of reviewers receiving a passing score of 80% or greater. If a team member receives less than 80% in a case they will be educated, retrained and take a retest up to 2 times.
	MCG training annual and as needed based on changes to the guidelines.
	Annual review of Medi-Cal guideline training and upon hire
Goal 3	**Ensure 100% of potentially eligible cases will be identified and referred to California Children's Services (CCS)**
	Daily inpatient census will be reviewed, and any eligible member will be referred to CCS for service authorization request
	Outpatient UM team will evaluate preservice authorization requests for potential CCS conditions and refer to CCS as appropriate.
	UM team will track CCS referrals and notify member and provider of CCS acceptance. UM team will update JIVA with CCS SAR.
	All CCS approved cases, as identified with a CCS SAR, will be carved out from KHS financial responsibility.
	Meet with CCS representatives quarterly in Joint Operational Meetings

Goal 4	**Monitor UM review process to ensure compliance with regulatory standards.** **Maintain at least a 95% timeliness rate for regulatory required prior authorization requests.**

Complete file reviews to validate regulatory standards are met
Education, both ongoing and remedial, will be provided to staff on any issues revealed during the file review process
UM team review to ensure at least 95% compliance with referral decision making, member and provider notification timeliness standards.
Multiple TAT monitoring activities will continue to be updated/ developed to support the management of authorization referral request processing during each business day serves to effectively assess staff availability matched to volume demands
Assess staffing requirements to complete the prior authorization process timely and ensure an adequate budget is allocated to meet the staffing needs.
Participate in all appropriate legislative and regulatory workgroups and/or activities that may impact the UM department. These include DHCS, DMHC, NCQA meetings and workgroups
Review all new APLs and operationalize appropriate changes in policy and procedure to ensure compliance with regulatory standards.
Participate in the Executive Quality Improvement Health Equity Committee (EQIHEC)

Goal 5	**Improve over and utilization management by 5% of current baseline.**

Conduct quarterly review of the key UM metrics utilizing the HICE template
For underutilization: Letters are mailed to member's PCP with a count of their assigned members needing IHA and the number of open authorizations.
For overutilization: Use quadrant analysis to identify any services that have potential overutilization. Work with the Quality Improvement Department to further evaluate and appropriately communicate with providers.

To: EQIHEC

From: Christine Pence, Senior Director of Health Services

Date: March 18, 2025

Re: Utilization Management Department Hierarchy of Criteria

Background:

KHS establishes written criteria or guidelines for utilization review that are developed with actively practicing health care providers. The written criteria or guidelines must be based on sound clinical practices which are evaluated and updated at least annually and updated when necessary. Utilization review criteria are consistently applied.

Discussion:

Medi-Cal is KHS' primary criteria source. New technology reviews that do not have established criteria and guidelines are prioritized by the CMO, or his/her designee, and will be reviewed using HAYES. If the new technology has not been evaluated by HAYES, then KHS will send the specific case for independent medical review for appropriateness of use.

KHS discloses or provides for disclosure to the commissioner, contract providers, or enrollees, the process and criteria KHS uses to authorize, modify, or deny health care services under the benefits provided by the Plan, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities.

Fiscal Impact: None.

Requested Action: Review and approve.

UM Criteria Hierarchy

The list below is not exhaustive but written in order of criteria use.

1. Health Plan eligibility and coverage
2. Federal and state mandated criteria

    - California Code of Regulations Title 22,
    - California Code of Regulations Title 28,
    - CMS Code of Regulations Title 42,
    - California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16,
    - Medi-Cal Provider Manuals,
    - CA DHCS All Plan Letters (APL),
    - DMHC All Plan Letters,
    - CA DHCS Policy and Procedure Letters (PPL),
    - 42 CFR section 438.915, 438.206.
    - Standardized Behavioral Health criteria (Title 9, DSM-V)

3. Nationally recognized criteria set
    - MCG Health LLC (Milliman Care Guidelines,)

New technology reviews that do not have established criteria and guidelines are prioritized by the CMO, or his/her designee, and will be reviewed using HAYES. If the new technology has not been evaluated by HAYES, then KHS will send the specific case for independent medical review for appropriateness of use.

<u>Pharmacy Criteria for evaluating Off-Label use for Life Threatening or Chronic and Serious Conditions:</u>

1. Medi-Cal Product

    Section does not apply to the Medi-Cal product

2. Peer Reviewed Professional Society Endorsed Supporting Documentation

    If a physician or other provider wishes to prescribe a non-formulary or restricted FDA approved medication for an off-label use for a life threatening or chronic and debilitating condition, he/she may submit a referral or TAR to the Plan for the same. In the referral, the provider must demonstrate the medication is recognized for the treatment of that condition in one of the following sources:

    a. American Hospital Formulary Service's Drug Information.

    b. One of the following compendia, if recognized by the federal

    c. Centers for Medicare and Medicaid Services as part of an anticancer

    d. Chemotherapeutic regimen:

i. The Elsevier Gold Standard's Clinical Pharmacology.

ii. The National Comprehensive Cancer Network Drug and Biologics Compendium.

iii. The Thomson Micromedex DrugDex.

e. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

KERN HEALTH SYSTEMS

To: EQIHEC

From: James Winfrey, Deputy Director of Provider Network Management

Date: March 18, 2025

Re: Network Adequacy Committee, Q1 2025

Background:
The Network Adequacy Committee (NAC) shall advance the mission of Kern Health Systems (KHS) of improving the health status of our members through an integrated managed health care delivery system. The NAC will report to the KHS Executive Quality Improvement Health Equity Committee (EQIHEC) on KHS' monitoring activities, corrective actions, and regulatory requirements related to network access, availability, and adequacy.

The functions of the NAC are as follows:

1. **Establish Network Standards**: Ensuring network accessibility standards (capacity/adequacy, appointment availability, geographic accessibility, etc) align with Department Health Care Services (DHCS), Department of Managed Health Care (DMHC), and National Committee for Quality Assurance (NCQA) standards.
2. **Monitor Network Compliance:** Review monitoring activities conducted by the Plan to measure network compliance with established standards.
3. **Promote Health Equity**: Implement review processes that monitor network adequacy amongst diverse populations, focusing on equitable access to care across different demographic and geographic groups**.**
4. **Steer Continuous Improvement:** Provide feedback on proposed corrective actions and ensure they are appropriate to address identified issues. Track progress of active corrective action plans.

Discussion:
Enclosed is an overview of the Plan's network adequacy standards, monitoring activities, findings, and process improvements discussed during the 4th Quarter Network Adequacy Committee meeting, including minutes.

Fiscal Impact:
None.

Requested Action:
Approve and file.

Network Adequacy Committee, Q1 2025

Executive Quality Improvement Health Equity Committee

March 18, 2025

Network Adequacy Committee

The Network Adequacy Committee (NAC) is delegated by the Executive Quality Improvement Health Equity Committee (EQIHEC) to monitor and report on network adequacy.

Establish Network Standards	• Ensuring network accessibility standards align with regulatory and quality assurance standards
Monitor Network Compliance	• Review monitoring activities conducted by the Plan to measure network compliance with established standards
Promote Health Equity	• Implement review processes that monitor network adequacy amongst diverse populations, focusing on equitable access to care across different demographic and geographic groups.
Steer Continuous Improvement	• Provide feedback on proposed corrective actions and ensure they are appropriate to address identified issues

Q1 Committee Meeting

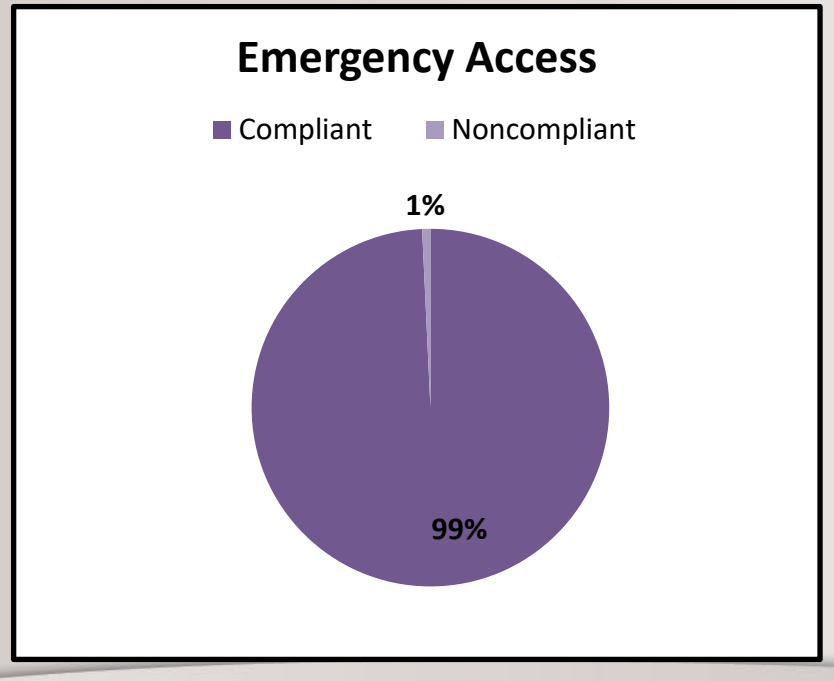
Quarter 1, 2025 Meeting – 2/27/2025

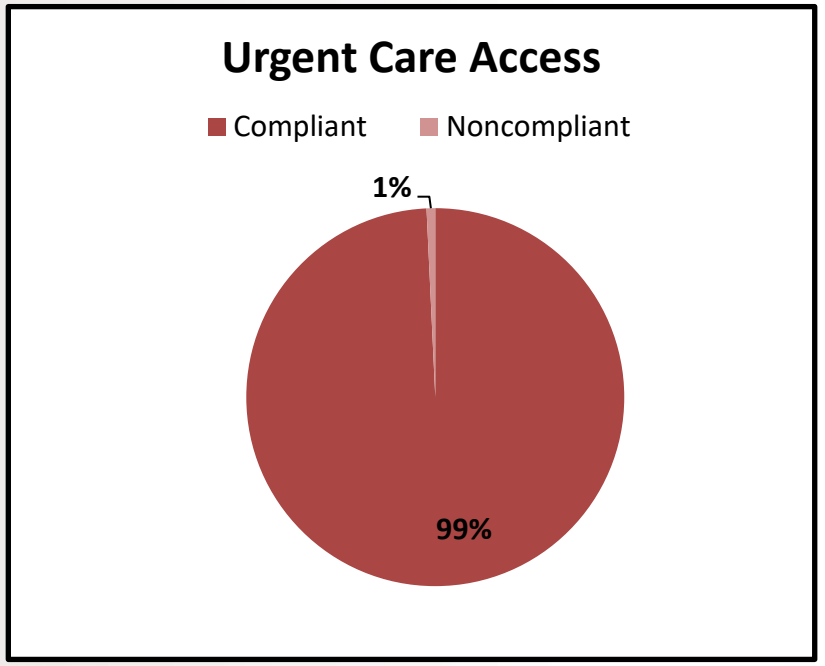
- Reviewed Quarter 4, 2024 Provider Network Management, Quarterly Network Review:
  - After Hours Survey Results
  - Provider Accessibility Monitoring Survey
  - Access Grievance Review
  - Geographic Accessibility & DHCS Network Certification
  - Network Adequacy & Provider Counts

After-Hours Survey Report

Results

During Q4 2024 **135** primary care provider offices were contacted. Of those offices, **134** were compliant with the Emergency Access Standards and **134** were compliant with the Urgent Care Access Standards.





After-Hours Survey Report

Action Taken

Singular provider office was identified as non-compliant with both standards; this was a first-time instance of non-compliance for this provider. Provider was educated via letter and Plan outreach.

Recommendation

Plan's ongoing outreach and education continues to be successful when instances of noncompliance are identified. Plan will continue to monitor quarterly, and no other action is needed at this time.

Provider Accessibility Monitoring Survey

- The Plan selected a random sample of 25 PCP and 25 Specialty providers by geographic location using the Health Equity Department's regional map -- 5 PCPs and 5 Specialists were select from each geographic region.

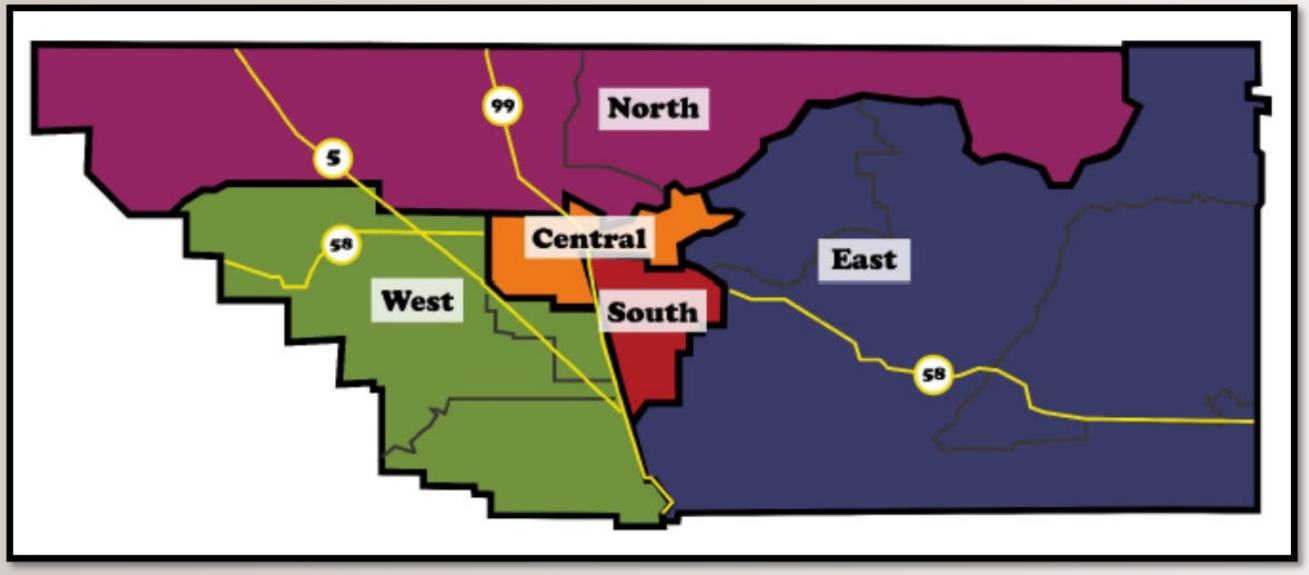
- A random sample of 5 non-physician mental health, 5 ancillary, and 5 OBGYN providers were also contacted to monitor network compliance with accessibility metrics.

Average urgent wait time in hours	Standard	Q4 2024
Primary Care	48 Hours	20.0 Hours
Specialist	96 Hours	31.3 Hours

Average wait time in days	Standard	Q4 2024
Primary Care	10 Business	1.3 Days
Specialist	15 Business	3.5 Days
Non-Physician Mental Health	10 Business	3.6 Days
Ancillary	15 Business	0.8 Days
First Prenatal OB/GYN*	10 Business*	3.0 Days

*The lesser of 10 business days or within 2 weeks

Provider Accessibility Monitoring Survey



Region	Total Members
North	60,881
South	27,703
East	31,106
West	15,381
Central	265,553

	PCPs Surveyed	Urgent Compliant	Compliant Non-Urgent Compliant
North	5	100%	100%
South	5	80%	100%
East	5	80%	100%
West	5	100%	100%
Central	5	100%	100%

	Specialists Surveyed	Urgent Compliant	Compliant Non-Urgent Compliant
North	5	100%	100%
South	5	100%	100%
East	5	60%	100%
West	5	100%	100%
Central	5	80%	80%

Provider Accessibility Monitoring Survey

Analysis

- While instances of non-compliance were identified, at a county/network level the Plan was compliant with accessibility standards.
- Results from the specialty survey noted that noncompliant providers were located in the East and Central regions. This is inline with grievance data that will be discussed below.

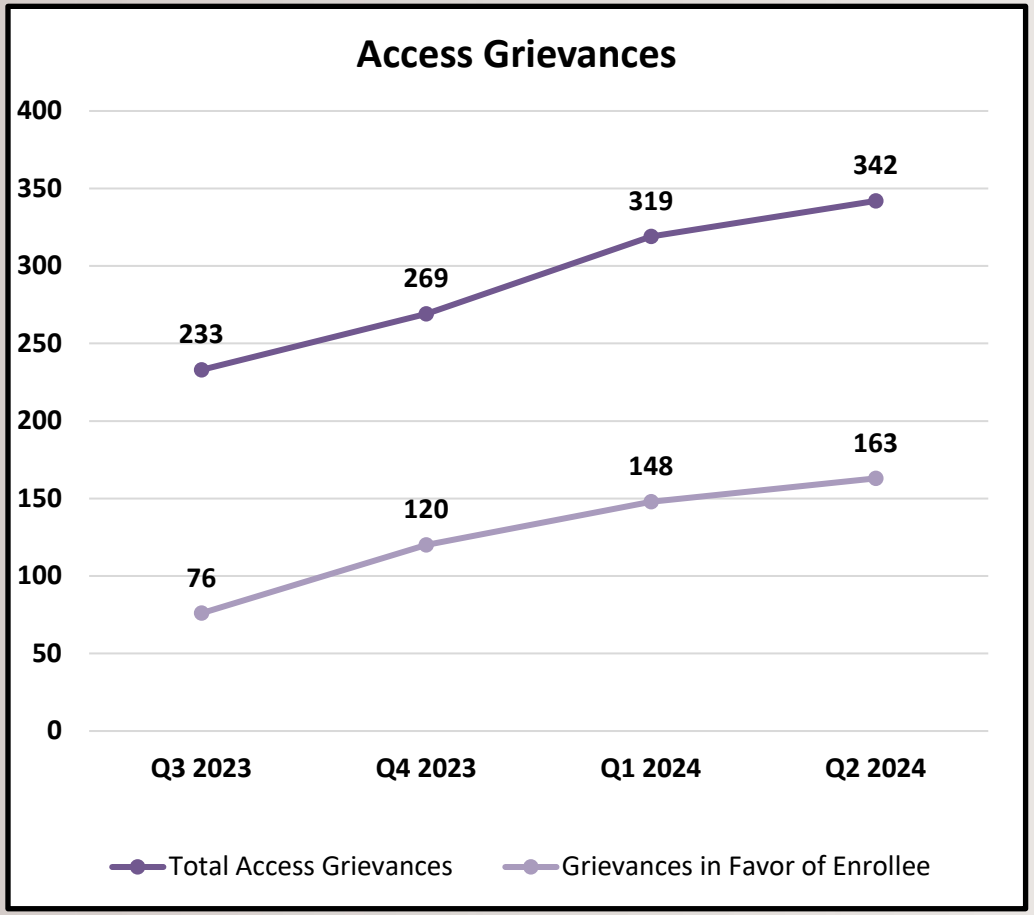
Action Taken

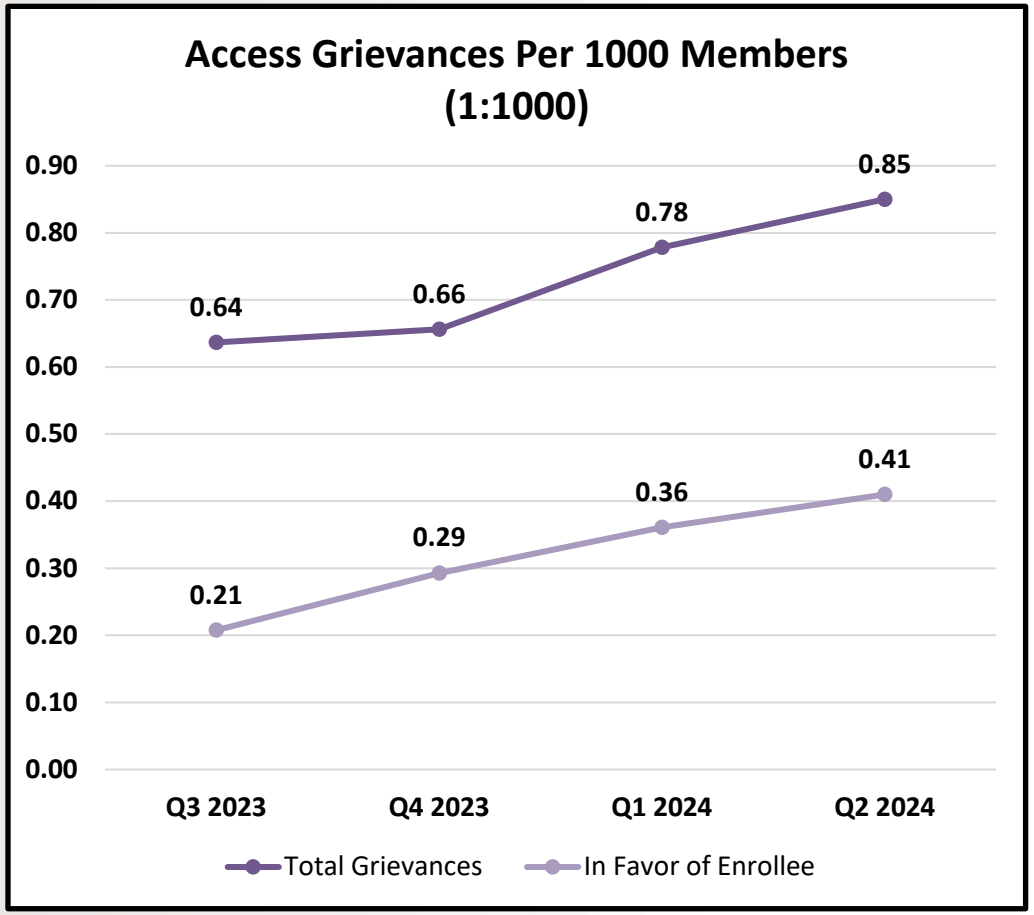
For all providers identified as noncompliant during Q4 2024, the Plan sent letters notifying the providers of the survey results and Plan policy.

Recommendation

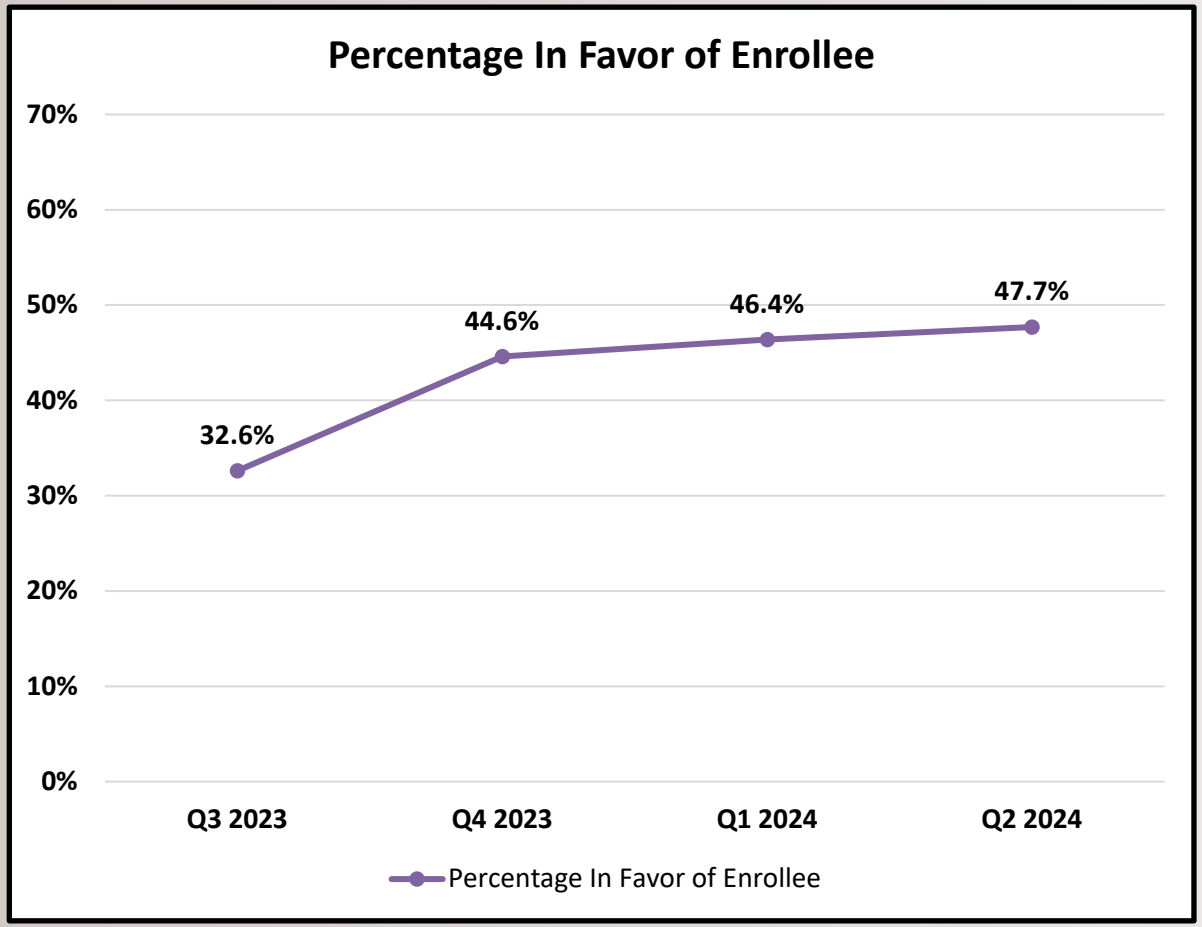
The Plan will resurvey all noncompliant providers in Q1 2024. Plan will continue to monitor quarterly, and no other action is needed at this time.

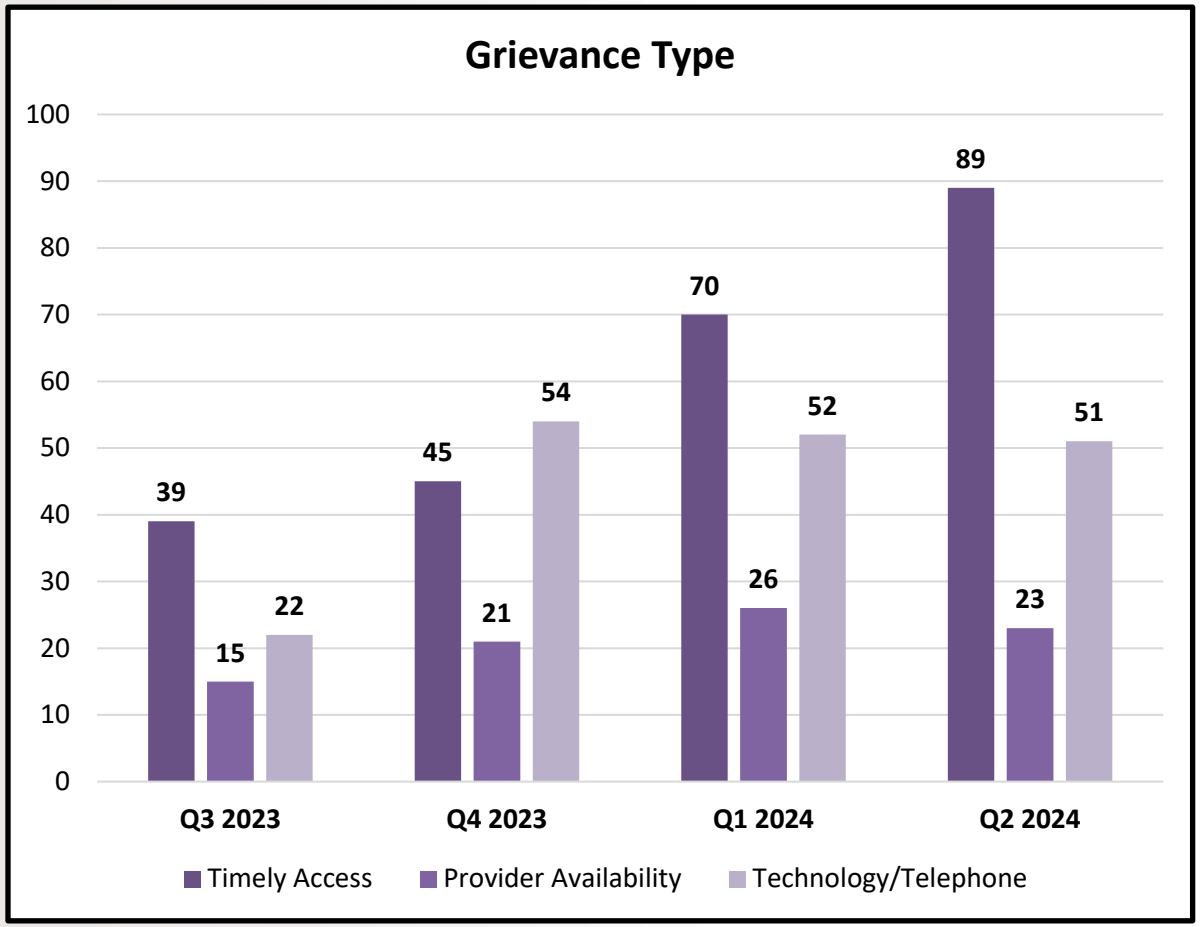
Access Grievance Review



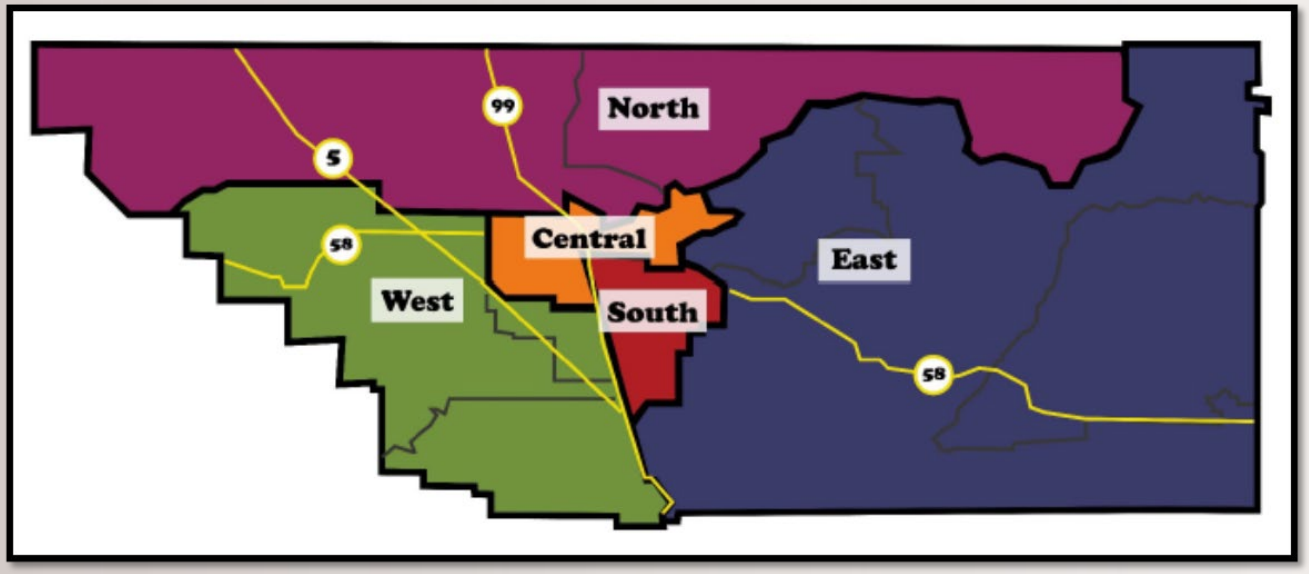


Access Grievance Review





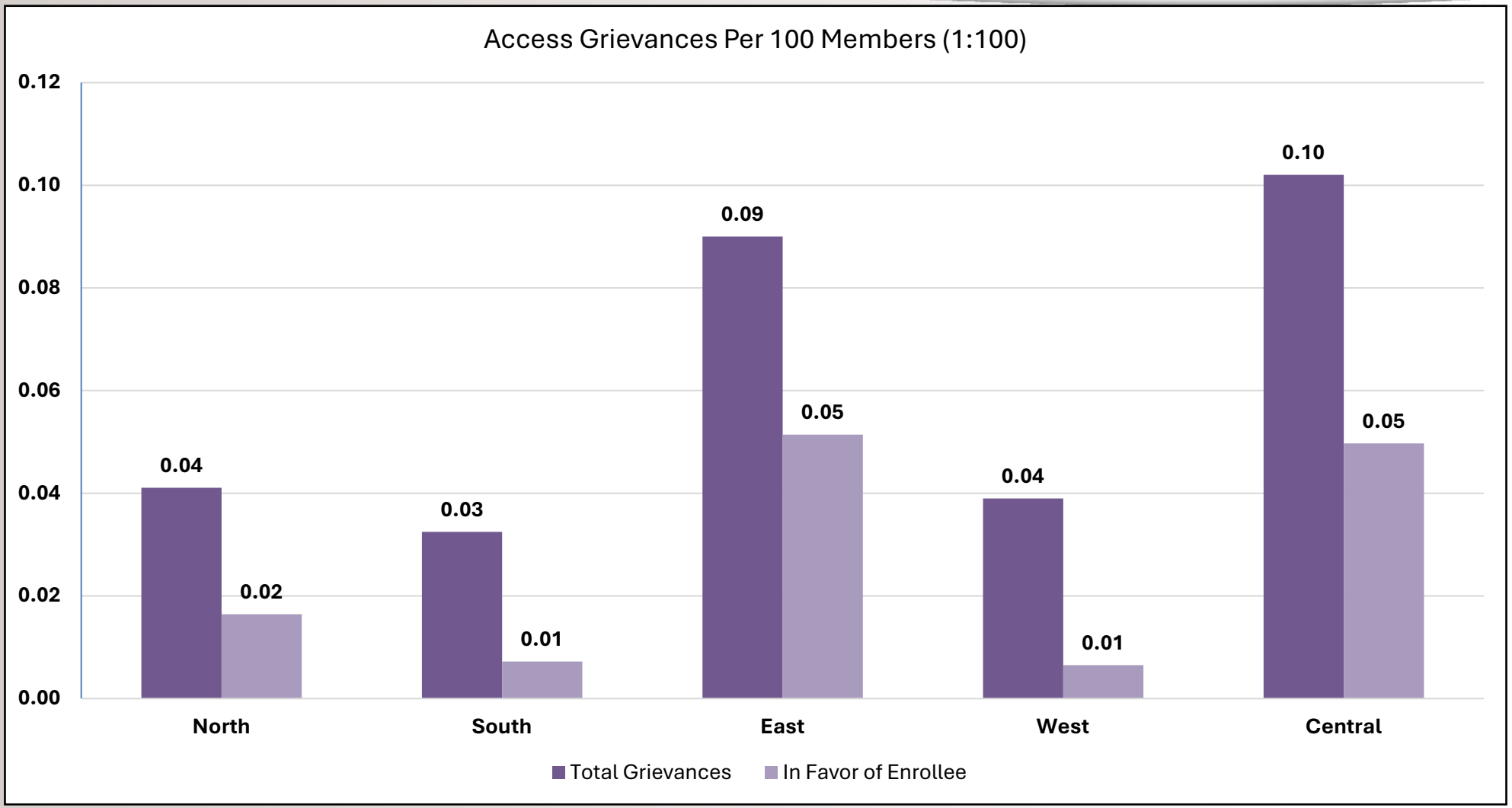
Access Grievance Review



Region	Total Members
North	60,881
South	27,703
East	31,106
West	15,381
Central	265,553

	North	South	East	West	Central	Out-of-Area
Provider	2	3	6	0	136	8
Member	10	9	16	1	132	N/A

Access Grievance Review



Access Grievance Review

Analysis

- The Plan has identified a continued increase in Access Grievances.
- One potential cause is the increase of members received by the Plan during the Q1 2024 health plan transition, though the increase began prior to the transition and continues after it.
- Based on grievance type review, increase appears to mainly be amongst Timely Access Grievances.
- Based on geographic review over past two quarters East and Central Region are most impacted.

Timely Access	Grievance related to timely access to a state plan approved provider within the timeframe requirements based on type of appointment and condition of member's health.

Recommendation

The Plan has an ongoing retention and recruitment grant (Nov 2023 - Nov 2025) to address accessibility issues. The Provider Network Analytics team will continue to monitor access grievances to identify potential access issues and gauge success of grant.

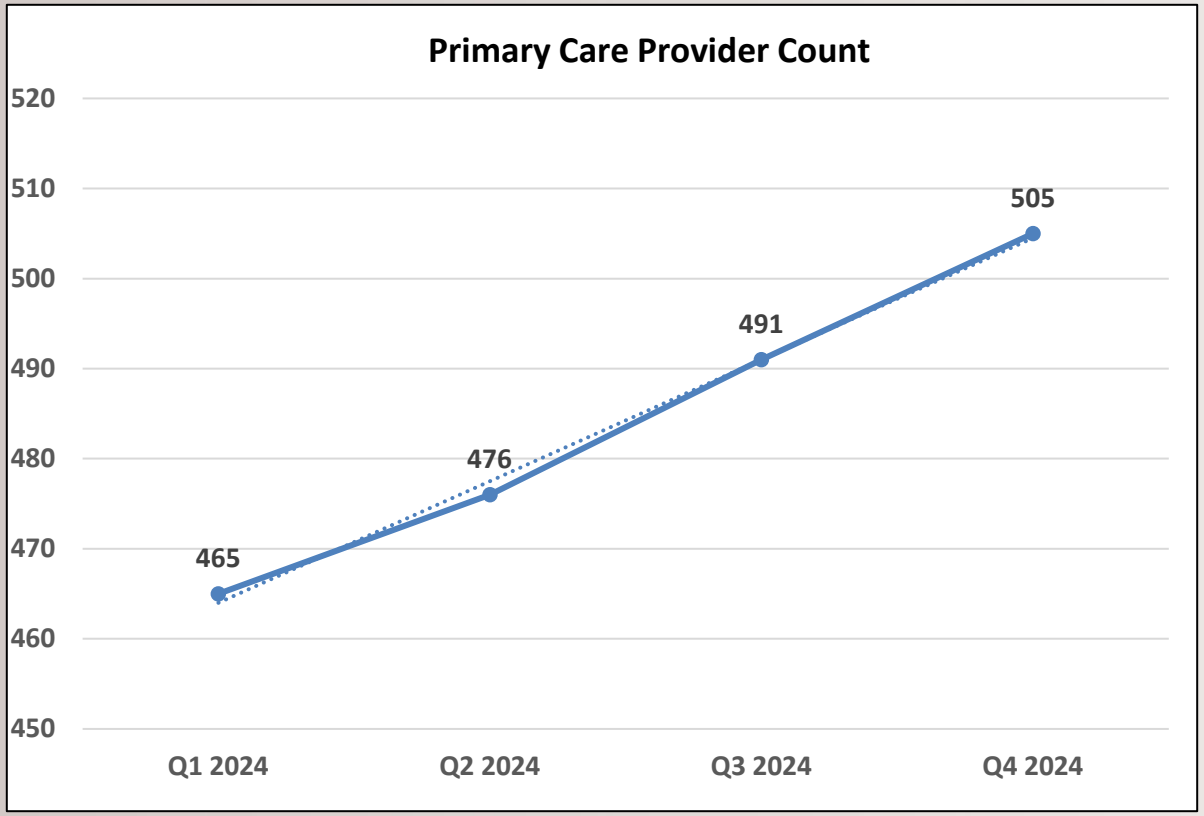
Geographic Accessibility & DHCS Network Certification

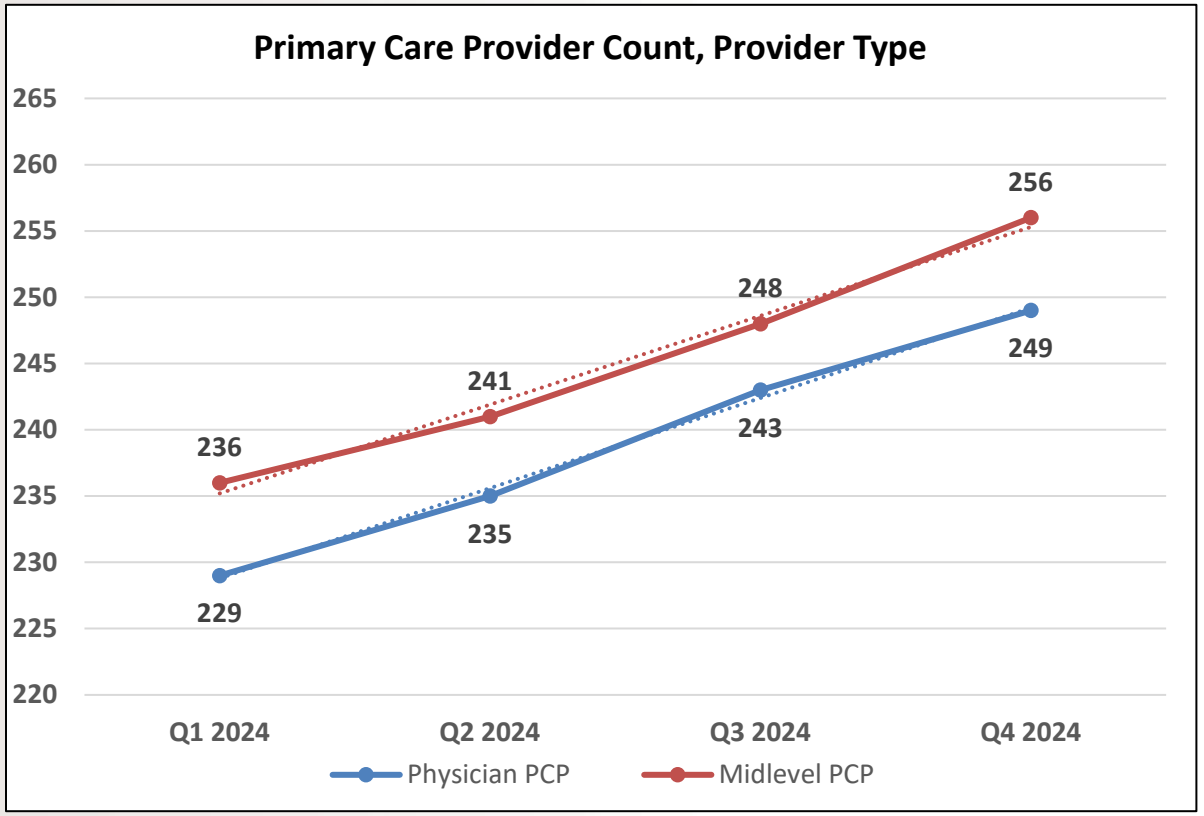
DHCS Annual Network Certification – 2023/2024

DHCS Network Adequacy Standards	
Primary Care (Adult and Pediatric)	10 miles or 30 minutes
Specialty Care (Adult and Pediatric)	45 miles or 75 minutes
OB/GYN Primary Care	10 miles or 30 minutes
OB/GYN Specialty Care	45 miles or 75 minutes
Hospitals	15 miles or 30 minutes
Non-Specialty Mental Health (Adult and Pediatric)	45 miles or 75 minutes

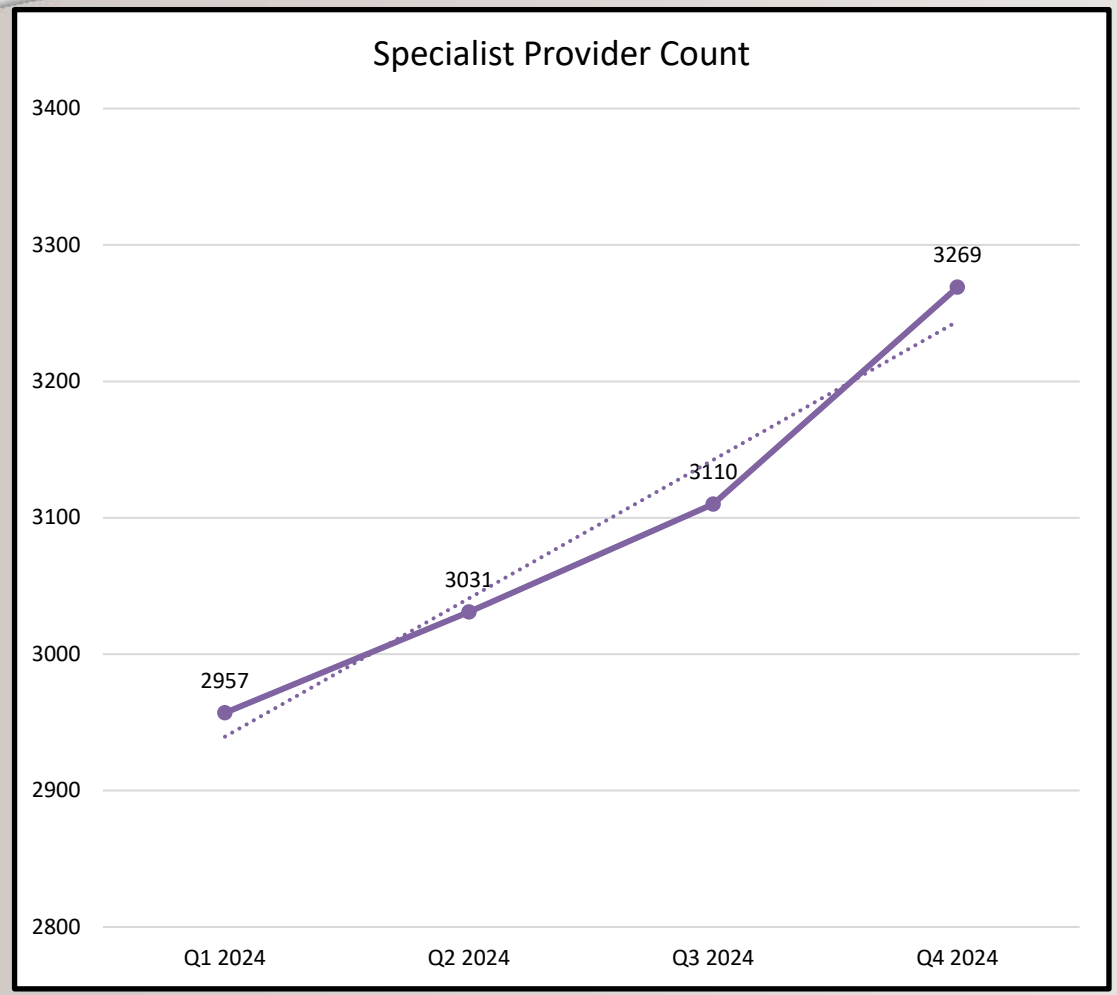
- The Plan submitted 343 AAS requests to the DHCS in Q1 2024. On November 15, 2024, the DHCS approved the Plan's submission of the AAS requests, identified no deficiencies, and deemed the Plan had passed the 2023 Annual Network Certification.
- The Plan reviews all network deletions and as of the end of Q4 2024, the Plan did not identify terminations any that impacted the Plan's geographic accessibility.
- **Analysis**: The Plan is now compliant with all geographic access standards or holds a regulatory-approved alternative access standard.
- **Recommendation**: The Plan will continue to monitor geographic access both ongoing and through the DHCS Network Certification process.

Network Adequacy & Provider Counts



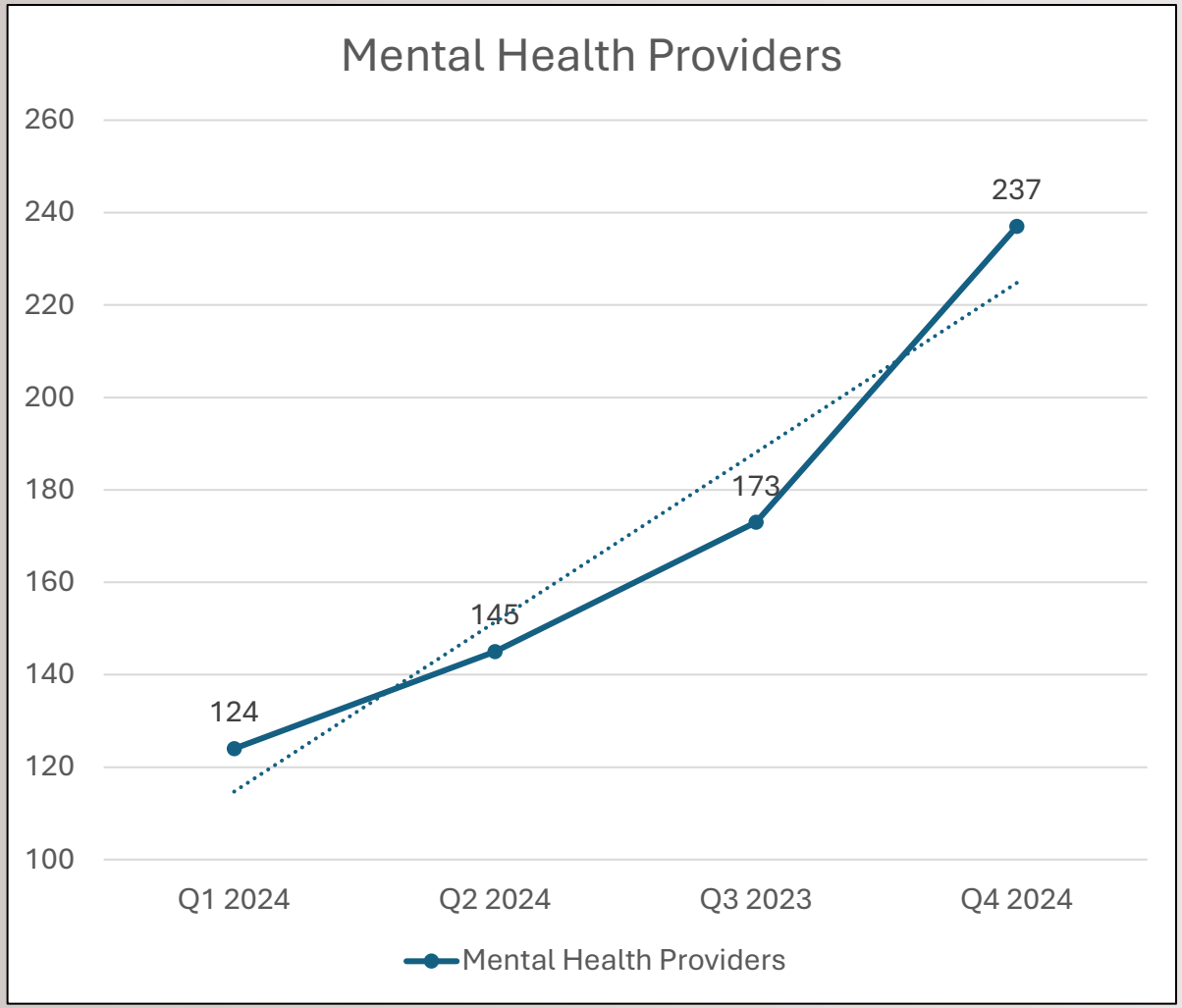


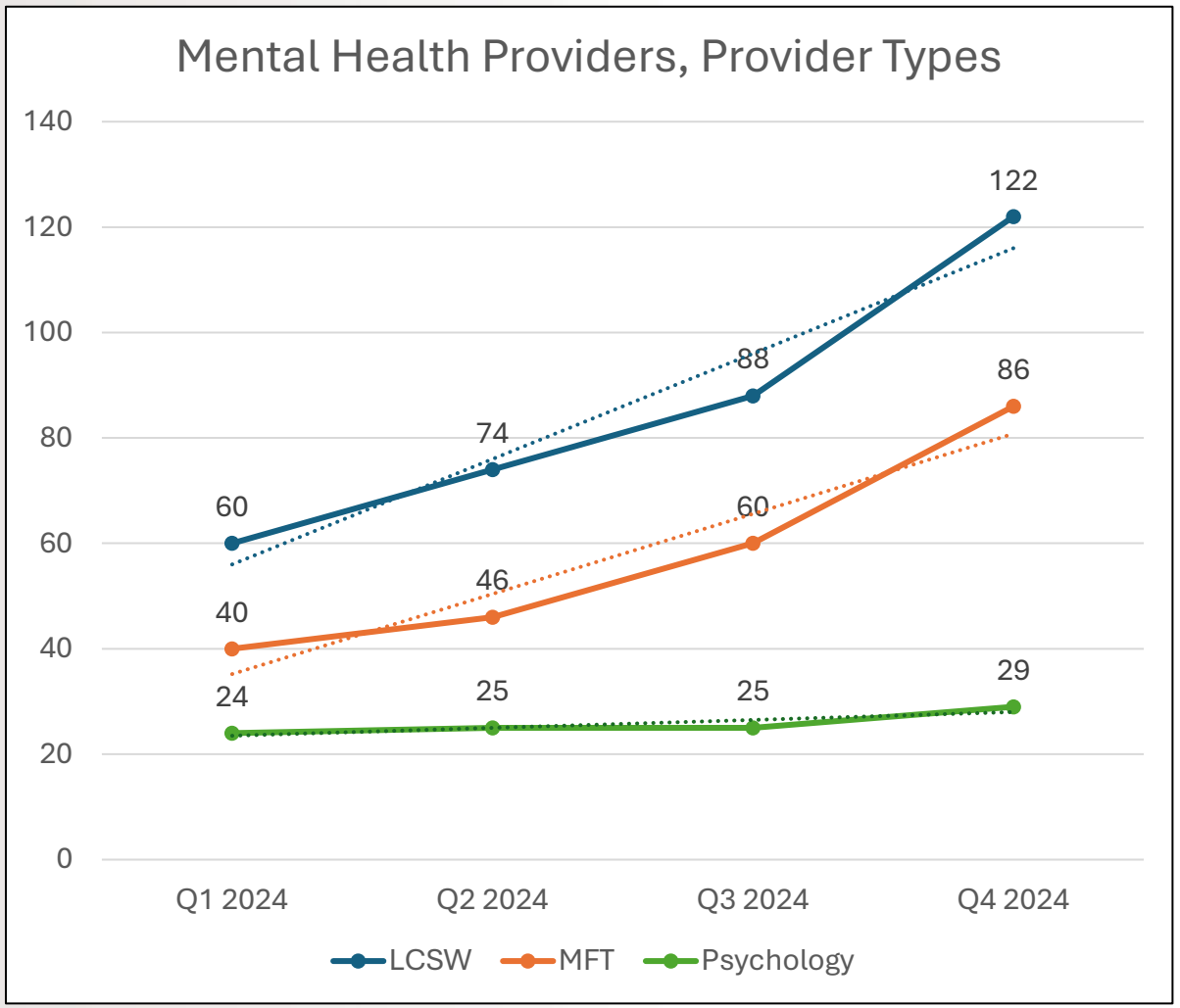
Network Adequacy & Provider Counts



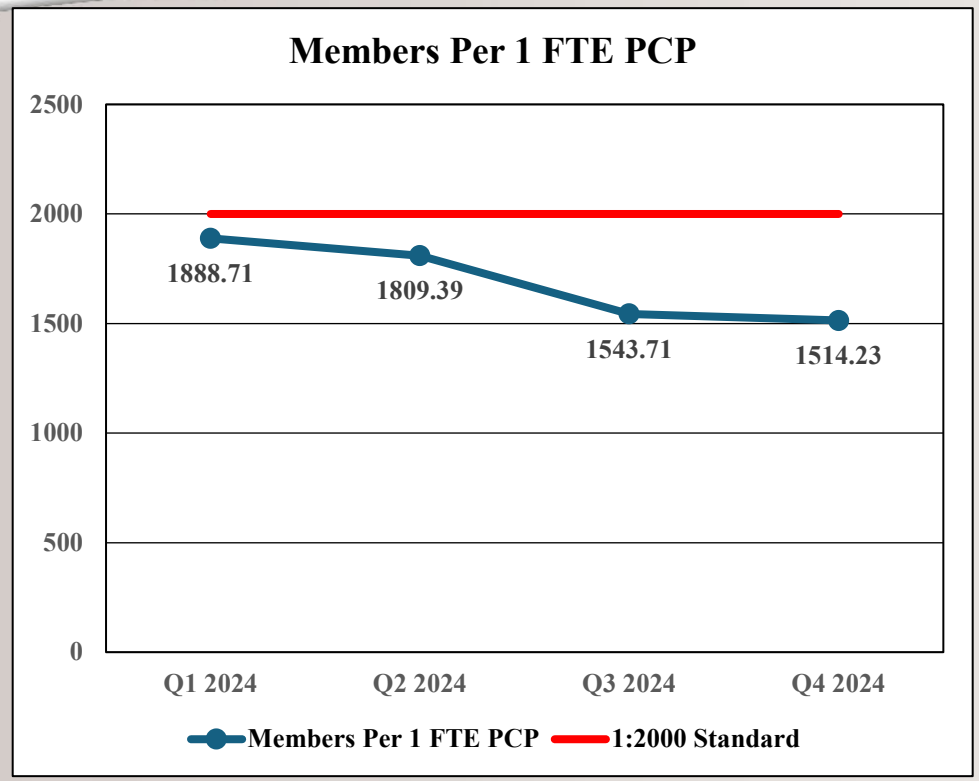
	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Cardiology	47	44	46	45
Dermatology	49	49	50	51
Endocrinology	28	29	29	29
Gastroenterology	36	35	35	36
General Surgery	66	63	63	68
Hematology	24	25	25	28
Infectious Disease	14	14	13	13
Nephrology	30	29	25	24
Neurology	34	33	31	33
Oncology	27	28	30	30
Ophthalmology	36	34	32	30
Orthopedic Surgery	33	31	30	29
Otolaryngology	17	16	15	16
Physical Med & Rehab	8	8	8	8
Psychiatry	90	91	90	95
Pulmonary Disease	25	26	26	24
	> 5% Increase		> 5% Decrease	
	≤ 5% Increase		≤ 5% Decrease	

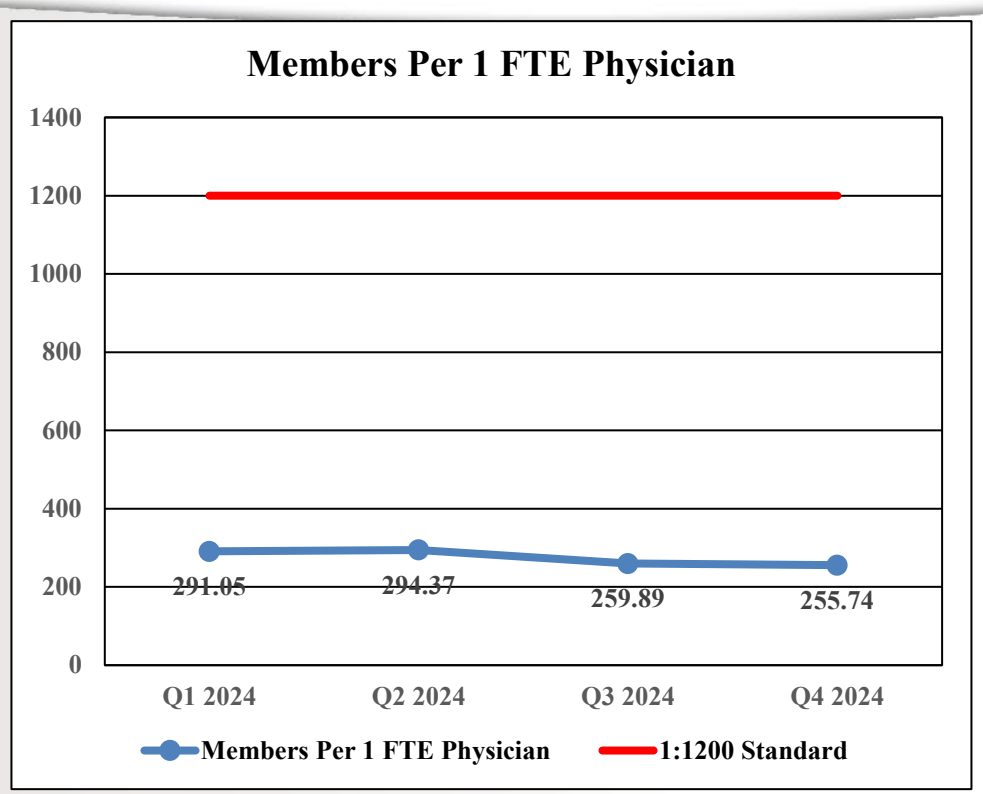
Network Adequacy & Provider Counts





Network Adequacy & Provider Counts





Analysis: Network growth illustrated in the slides above, has resulted in a positive impact on the Plans network adequacy goals. The Plan is hoping these increases (particularly those experienced in Q3 and Q4) will reflect a decrease in access grievances (reviewed retrospectively).

Recommendation: The Provider Network Analytics team will continue to monitor network adequacy and growth.

Network Adequacy & Provider Counts

Significant Network Change

As outlined in California Health and Safety Code, Section 1367.27, subdivision®: *Whenever a plan determines (…) that there has been a 10 percent change in the network for a product in a region, the plan shall file an amendment to the plan application with the department.*

On September 20, 2024, the Plan submitted the Significant Network Change to the Compliance department to submit to the DMHC. As of the end of Q4 2024, the Plan has not received any feedback from the DMHC regarding this filing.

East Kern OB/GYN Access

During the Q2 2024 Executive Quality Improvement and Health Equity Committee (EQIHEC) meeting, committee member, Jennifer Ansolabehere, raised concerns regarding access to OB/GYN services in East Kern.

In Q4 2024, Ridgecrest Regional Hospital reopened its Labor & Delivery Unit, and the Plan contracted with Northern Inyo Hospital in Bishop to offer labor and delivery services. The Plan believes these network changes with ensure appropriate access to these services for members within this geographic region.

To: EQIHEC

From: Michelle Curioso, Director of Population Health Management

Date: March 18, 2025

Re: Population Health Management: Improving Maternal Healthcare Access in East Kern County (Updates)

Background:

East Kern County, a rural area, faces significant challenges in providing maternal health care, especially labor and delivery due to geographic isolation, limited healthcare infrastructure, and socioeconomic factors. Despite these barriers, there are opportunities to improve healthcare access through collaboration, policy changes, and technology. A SWOT analysis revealed strengths such as existing healthcare resources, community engagement, and the recent addition of labor and delivery services at Ridgecrest Regional Hospital. However, weaknesses include healthcare provider shortages, logistical challenges, and limited access to care, contributing to high maternal and infant mortality rates. Recommendations to improve maternal healthcare include expanding infrastructure, increasing mobile and telehealth options, and addressing transportation and environmental issues.

Discussion:

The purpose of this report is to provide an update on the previous discussion regarding limited access to maternal healthcare in the East Kern area. It will present findings from the SWOT analysis, along with feedback gathered from both internal and external partners. Additionally, the report includes recommendations for improving maternal health outcomes and reducing disparities in access to care. By implementing these strategies, East Kern can make meaningful progress in improving maternal health, addressing care access disparities, and ultimately enhancing the health and well-being of the community.

Fiscal Impact: None.

Requested Action: Approve and file.

Kern Family Health Care™

Improving Maternal Healthcare Access in East Kern County: A SWOT Analysis and Strategic Recommendations

Michelle Curioso, MPA, PHN, RN
March 18, 2025

Improving Maternal Healthcare Access in East Kern County: A SWOT Analysis and Strategic Recommendations

Introduction

East Kern County, a predominantly rural area, faces significant challenges in providing adequate access to prenatal and postpartum care. These barriers stem from a combination of geographical isolation, limited healthcare infrastructure, and socioeconomic factors that hinder the delivery of essential maternal health services. Despite these challenges, there are opportunities to enhance healthcare access and quality in the region through community collaboration, targeted policy advocacy, and the strategic use of technology and mobile healthcare solutions.

This SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis examines the current state of maternal healthcare in East Kern, highlighting the key factors that shape the availability and quality of care. It identifies both the existing strengths within the community, such as local healthcare resources and the dedication of non-profit organizations, as well as the weaknesses that need to be addressed, including healthcare provider shortages and transportation challenges. The analysis also explores opportunities for growth and improvement, such as expanding telehealth services and leveraging state and federal programs to transform maternal health care delivery.

The findings of this analysis aim to inform decision-making and guide the development of targeted interventions that address the unique healthcare needs of East Kern's residents. By capitalizing on local strengths and addressing the challenges identified, there is a pathway to improving maternal health outcomes in the region.

A SWOT Analysis was conducted with input from Population Health Mangement (PHM) staff, including Registered Nurses and Certified Medical Assistants. Following this, a one-on-one interview was held with community partners to gather their feedback. The SWOT Analysis was shared with them to ensure all relevant information was captured and to provide an opportunity for them to add any missing details.

SWOT Analysis Summary: Limited Access to Prenatal and Postpartum Care in East Kern Area

Strengths

1. Available Healthcare Resources
    - WIC clinics and KHS services, such as care management and coordination, offer valuable support for maternal health.
    - Ridgecrest Regional Hospital now provides labor and delivery services (since January 2025).
    - New location of Bartz Altadonna Community Health Center in Boron for prenatal and postpartum care.
    - Local non-profit organizations such as Omni in Tehachapi and Clinica Sierra Vista in Ridgecrest can be leveraged to increase healthcare access.
2. Community Engagement
    - Local community awareness campaigns and maternal health advocacy efforts are helping raise attention to healthcare gaps.
    - Ongoing support from local organizations, such as WIC, Kern County Public Health Services, and local schools provides an additional layer of healthcare outreach.

Weaknesses

1. Geographical and Logistical Barriers
    - The rural location of East Kern makes it difficult for residents to access healthcare, especially when considering transportation issues and long distances.
    - There is only one hospital in the area, which may be inadequate to meet the increasing demand for maternity services.
2. Healthcare Shortages
    - Limited access to prenatal and postpartum services, including a shortage of doulas and pregnancy centers, exacerbates the care gap.
    - Understaffed healthcare facilities and limited specialized maternal health services reduce the quality and availability of care.
    - Cultural and provider inconsistency create trust issues for patients, making it difficult for them to build relationships with their healthcare providers.

        ✓ These inconsistencies arise in several ways, such as differences in language, values, beliefs, and communication styles between patients and providers.
        ✓ When these disparities exist, patients may feel misunderstood, unheard, or even discriminated against, which can weaken their confidence in the care they receive.
        ✓ For instance, cultural differences may affect how patients perceive illness, treatment, and medical advice. A provider who does not acknowledge or respect a patient's cultural beliefs may unintentionally dismiss their concerns, leading the patient to feel neglected or judged.
        ✓ Another example, if a provider frequently changes—such as in large hospital or understaffed clinics—patients may struggle to build rapport with any one doctor, making it harder for them to trust medical recommendations.

- ✓ Systemic issues, such as biases in healthcare delivery or differences in how providers approach treatment for different cultural groups, can further damage trust. If patients feel that their concerns are not taken seriously due to cultural misunderstandings or biases, they may be less likely to seek care, follow medical advice, or disclose important health information.
- ✓ Ultimately, these trust issues can lead to poorer health outcomes, lower patient satisfaction, and a greater reluctance to engage in preventive care.

- High maternal and infant mortality rates in Kern County highlight the severity of these challenges.

Opportunities

1. Infrastructure and Services Expansion
   - Establishing labor and delivery services at Tehachapi Hospital could alleviate strain on existing resources and provide more localized care.
   - The *Transforming Maternal Health (TmaH) Model* provides a funding opportunity to improve healthcare access, quality, and workforce infrastructure.
     - ✓ The Transforming Maternal Health (TMaH) Model is a funding initiative designed to enhance healthcare access, improve the quality of maternal care, and strengthen the healthcare workforce infrastructure.
     - ✓ This model addresses disparities in maternal health outcomes by supporting innovative strategies that expand services, promote equitable care, and ensure healthcare providers have the necessary resources and training.
     - ✓ Through this funding opportunity, healthcare organizations can implement programs that improve maternal health services, particularly for underserved and high-risk populations.
   - Exploring mobile healthcare units could bring prenatal and postpartum services directly to rural communities, bridging the transportation gap.
   - Growth in telehealth services could provide remote consultations, follow-ups, and maternal education, reducing the need for travel.
2. Community and Workforce Development
   - Strengthening relationships with local organizations and non-profits could enhance resource sharing and improve outreach.
   - Advocating for state and federal policy changes that allocate more resources to rural healthcare clinics and hospitals could improve access.
   - Targeted recruitment programs focused on hiring diverse healthcare professionals could help ensure that providers understand and connect with the community's needs.
   - Initiatives to retain and support diverse healthcare workers in rural areas will help ensure a sustainable workforce.
   - Increased emphasis on perinatal education and training will improve care delivery and empower patients.

Threats

1. Healthcare Provider Shortage

- The shortage of healthcare providers, particularly obstetricians and gynecologists, remains a significant barrier to accessing specialized maternal care.
- High provider turnover in rural areas makes it difficult to maintain consistency in patient care and relationships.

2. Infrastructure and Environmental Factors
   - Poor road conditions and limited public transportation make it challenging for residents without vehicles to attend appointments, further hindering access to care.
3. Cultural and Social Barriers
   - Cultural or language barriers, along with mistrust of medical systems, may discourage residents from seeking prenatal or postpartum care, leading to delayed treatment or missed visits.

Common Themes

1. Access to Care: A recurring theme throughout the analysis is the challenge of accessing maternal healthcare due to geographical, logistical, and transportation barriers. East Kern's rural location limits both the availability and accessibility of specialized care, making it difficult for residents to receive timely prenatal and postpartum services.
2. Provider and Workforce Shortages: Another critical theme is the shortage of healthcare providers, particularly specialists in maternal care. This shortage contributes to gaps in service delivery, long wait times, and difficulty in building trusting, consistent relationships between patients and healthcare professionals.
3. Cultural and Socioeconomic Factors: Addressing the cultural, socioeconomic, and language barriers is essential. There is a strong need for culturally competent care, where patients feel heard, understood, and respected, which can significantly impact their overall healthcare experience.
4. Community Support and Engagement: Leveraging local organizations, advocacy efforts, and community support networks plays a central role in addressing gaps and building a more comprehensive maternal healthcare infrastructure in the region.

Recommendations

Building on the findings from the SWOT Analysis, the following recommendations are proposed as next steps.

1. Expand Healthcare Infrastructure
   - Explore labor and delivery services at Tehachapi Hospital and consider further expanding maternal health services at local facilities to reduce strain on Ridgecrest Regional Hospital.
   - Advocate for funding through the *Transforming Maternal Health Model* and similar state and federal programs to enhance local infrastructure.
2. Mobile and Telehealth Solutions
   - Explore the use of mobile health units to bring prenatal and postpartum care directly to remote communities. This will help overcome transportation barriers and provide essential services to hard-to-reach areas.
   - Expand telehealth offerings to provide virtual consultations and follow-up care, allowing women to access healthcare without the burden of long travel.
3. Increase Cultural Competency and Provider Consistency

- Implement training programs that emphasize cultural competency, ensuring healthcare providers can relate to and understand the unique needs of the community.
- Work to establish consistency in the healthcare providers that patients see, allowing for stronger relationships and continuity of care.
- Develop mentorship and retention programs for healthcare providers, ensuring those who work in rural areas feel supported and valued.

4. Community and Workforce Development
    - Strengthen collaborations with local organizations, such as Omni, Clinica Sierra Vista, and WIC, to enhance service delivery and raise awareness about maternal health.
    - Focus on recruiting diverse healthcare providers who reflect the cultural background of the communities served, fostering trust and improving patient-provider relationships.
    - Consider offering incentives and training opportunities to attract healthcare professionals to rural areas, ensuring a sustainable workforce for the long term.
5. Address Transportation and Environmental Barriers
    - Partner with transportation providers to create more accessible and reliable options for residents who lack vehicles or face transportation issues.
    - Work on improving infrastructure, such as roads and public transit, to ensure better access to healthcare facilities.
6. Advocacy and Awareness Campaigns
    - Increase efforts to raise awareness about the importance of prenatal and postpartum care in East Kern. Support campaigns that highlight the available resources and address any cultural stigma surrounding healthcare services.
    - Encourage and facilitate the reporting of concerns or dissatisfaction with care, fostering a more open and responsive healthcare environment.

Conclusion

East Kern County, a predominantly rural area, faces significant challenges in accessing prenatal and postpartum care due to geographic isolation, limited healthcare infrastructure, and socioeconomic factors. Despite these hurdles, there are opportunities to improve healthcare access through community collaboration, policy advocacy, and mobile healthcare technologies. This SWOT analysis highlights regional strengths like local resources and non-profit support, while addressing weaknesses such as provider shortages and transportation barriers. It also explores opportunities, including expanding telehealth and leveraging state and federal programs. Implementing these strategies could improve care access, reduce maternal and infant mortality, and enhance community health overall.

Barriers to Accessing Maternal Health Care in East Kern

Michelle Curioso, Director of PHM

March 18, 2025

KERN HEALTH SYSTEMS

Access to Maternal Health Care Updates

- Conducted SWOT Analysis with Team
- One-On-One Interviews with Community Partners

Strengths

1. Available Healthcare Resources
   - ✓WIC clinics and KHS services, such as care management and coordination, offer valuable support for maternal health.
   - ✓Ridgecrest Regional Hospital now provides labor and delivery services (since January 2025).
   - ✓New location of Bartz Altadonna Community Health Center in Boron for prenatal and postpartum care.
   - ✓Local non-profit organizations such as Omni in Tehachapi and Clinica Sierra Vista in Ridgecrest can be leveraged to increase healthcare access.

SWOT Analysis

Weaknesses

1. Geographical and Logistical Barriers
   - ✓The rural location of East Kern makes it difficult for residents to access healthcare, especially when considering transportation issues and long distances.
   - ✓There is only one hospital in the area, which may be inadequate to meet the increasing demand for maternity services.
2. Healthcare Shortages
   - ✓Limited access to prenatal and postpartum services, including a shortage of doulas and pregnancy centers.
   - ✓Cultural and provider inconsistency create trust issues for patients, making it difficult for them to build relationships with their healthcare providers.

SWOT Analysis

Opportunities

1. Infrastructure and Services Expansion
   - ✓Establishing labor and delivery services at Tehachapi Hospital could alleviate strain on existing resources and provide more localized care.
   - ✓The Transforming Maternal Health (TMaH) Model provides a funding opportunity to improve healthcare access, quality, and workforce infrastructure.
   - ✓Exploring mobile healthcare units could bring prenatal and postpartum services directly to rural communities, bridging the transportation gap.
   - ✓Growth in telehealth services could provide remote consultations, follow-ups, and maternal education, reducing the need for travel.

SWOT Analysis

Opportunities

2. Community and Workforce Development
   - ✓Strengthening relationships with local organizations and non-profits could enhance resource sharing and improve outreach.
   - ✓Advocating for state and federal policy changes that allocate more resources to rural healthcare clinics and hospitals could improve access.
   - ✓Targeted recruitment programs focused on hiring diverse healthcare professionals could help ensure that providers understand and connect with the community's needs.
   - ✓Initiatives to retain and support diverse healthcare workers in rural areas will help ensure a sustainable workforce.

SWOT Analysis

Threats

1. Healthcare Provider Shortage
   - ✓The shortage of healthcare providers, particularly obstetricians and gynecologists.
   - ✓High provider turnover in rural areas makes it difficult to maintain consistency in patient care and relationships.
2. Infrastructure and Environmental Factors
   - ✓Poor road conditions and limited public transportation make it challenging for residents without vehicles to attend appointments.
3. Cultural and Social Barriers
   - ✓Cultural or language barriers, along with mistrust of medical systems, may discourage residents from seeking prenatal or postpartum care, leading to delayed treatment or missed visits.

Recommendations

1. Expand Healthcare Infrastructure
   - ✓Advocate for funding through the Transforming Maternal Health Model and similar state and federal programs to enhance local infrastructure.
2. Mobile and Telehealth Solutions
   - ✓Explore the use of mobile health units to bring prenatal and postpartum care directly to remote communities.
   - ✓Expand telehealth offerings to provide virtual consultations and follow-up care.

Recommendations

3. Increase Cultural Competency and Provider Consistency.
   - ✓Implement training programs that emphasize cultural competency, ensuring healthcare providers can relate to and understand the unique needs of the community.
   - ✓Work to establish consistency in the healthcare providers that patients see.
   - ✓Develop mentorship and retention programs for healthcare providers, ensuring those who work in rural areas feel supported and valued.
4. Community and Workforce Development
   - ✓Strengthen collaborations with local organizations, such as Omni, Clinica Sierra Vista, and WIC.
   - ✓Focus on recruiting diverse healthcare providers who reflect the cultural background of the communities served.
   - ✓Consider offering incentives and training opportunities to attract healthcare professionals to rural areas.

Recommendations

5. Address Transportation and Environmental Barriers
   - ✓Partner with transportation providers to create more accessible and reliable options for residents who lack vehicles or face transportation issues.
   - ✓Work on improving infrastructure, such as roads and public transit, to ensure better access to healthcare facilities.

To: EQIHEC

From: Isabel Silva, Senior Director of Wellness and Prevention

Date: March 18, 2025

Re: 2024 Annual Wellness & Prevention Department Report

Background:
KHS' contract with the DHCS requires that it implements evidence-based wellness and prevention programs inclusive of a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all members. The contract also requires that KHS have a Cultural and Linguistic Services Program and that KHS monitors, evaluates and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services.

Discussion:
Enclosed is the Annual Wellness and Prevention Department report summarizing the goals, objectives and activities performed during 2024 to meet KHS' contractual requirements with DHCS for wellness, prevention, health education and cultural and linguistic services.

Fiscal Impact:
None.

Requested Action:
Review and approve.

Wellness & Prevention Department 2024 Annual Review

March 17, 2025

KERN HEALTH SYSTEMS

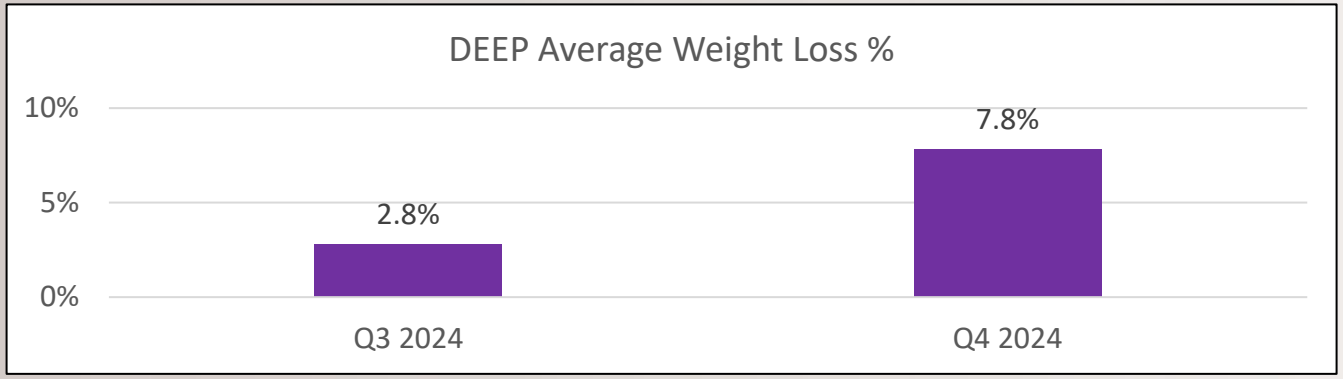
2024 Goals & Objectives

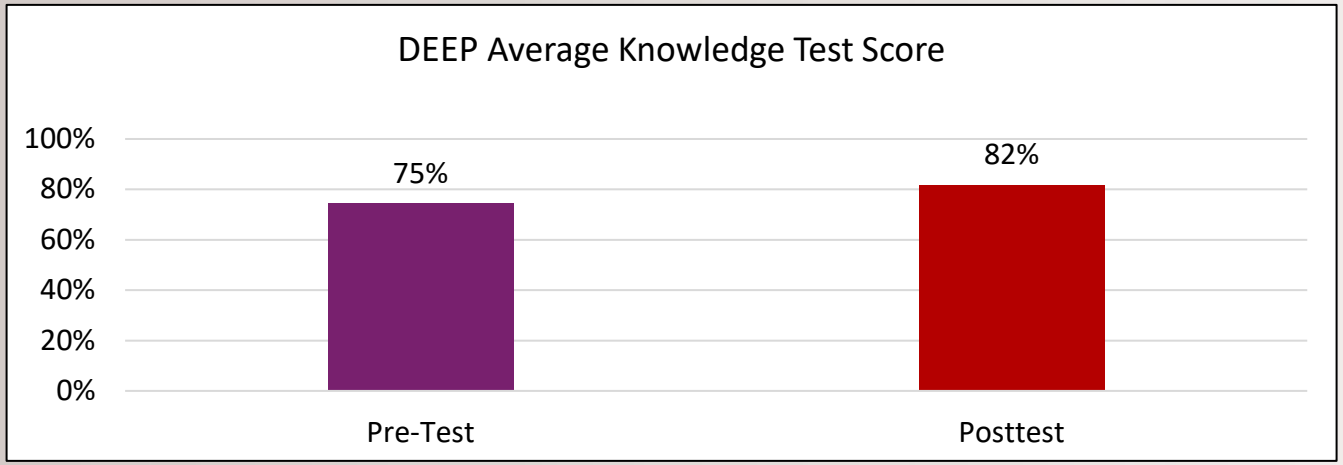
1. Expand Wellness & Prevention Programs
   - Restructure department and develop comprehensive strategy
   - Implement programs to support MCAS, members, providers, and the community
2. Ensure compliance with C&L requirements per DHCS contract
   - Implement and evaluate effectiveness of continuous monitoring plan
   - Update cultural competency training to align with Health Equity Department
   - Implement continuous monitoring of C&L services to members <21 years
3. Implement NCQA requirements
   - Prepare and submit all deliverables for Health Plan and Health Equity accreditation
4. Implement Year 3 of SBHIP Project Plan
   - Lead Kern county steering committee
   - Submit biquarterly and project outcomes reports to DHCS

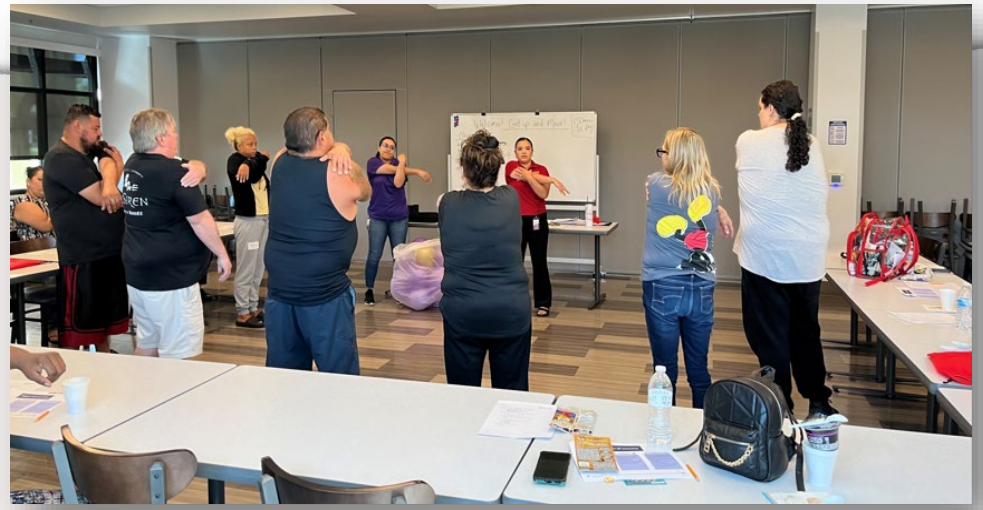
Goal 1 Results – Expand Wellness and Prevention Programs

1. Restructured Health Education Department to Wellness & Prevention Department with 4 Key Teams:
   - Member Wellness & Prevention
   - Community Health & Wellness
   - Cultural & Linguistic Services
   - Wellness & Prevention Partnerships
2. Developed strategy aimed at engaging targeted communities, advancing educational initiatives, building collaborative networks, enhancing knowledge and skills, educating community partners, shaping internal policies, and ensuring ongoing monitoring and evaluation.
   - ✓ Executed MOUs with Kern Public Health Department, Kern County Probations, CSV WIC and CAPK WIC
   - ✓ Contracted with Bakersfield American Indian Health Project to serve as KHS' Tribal Liaison
3. New programs and initiatives implemented:
   - ✓ Sponsored vision clinic through OneSight Foundation for 14 schools
   - ✓ Diabetes Empowerment Education Program (DEEP) launched in Q1.
   - ✓ California Health Collaborative contracted to offer DEEP and Diabetes Prevention Programs.
   - ✓ Live Better Program launched in Delano, Greenfield and Lake Isabella/Kernville.
   - ✓ Kernville Family Resource Center trained on Diabetes Prevention Program.
   - ✓ Partnered with First 5 Kern to revive the Kern Immunization Coalition and host a Child Passenger Safety Technician training and car seat check event.

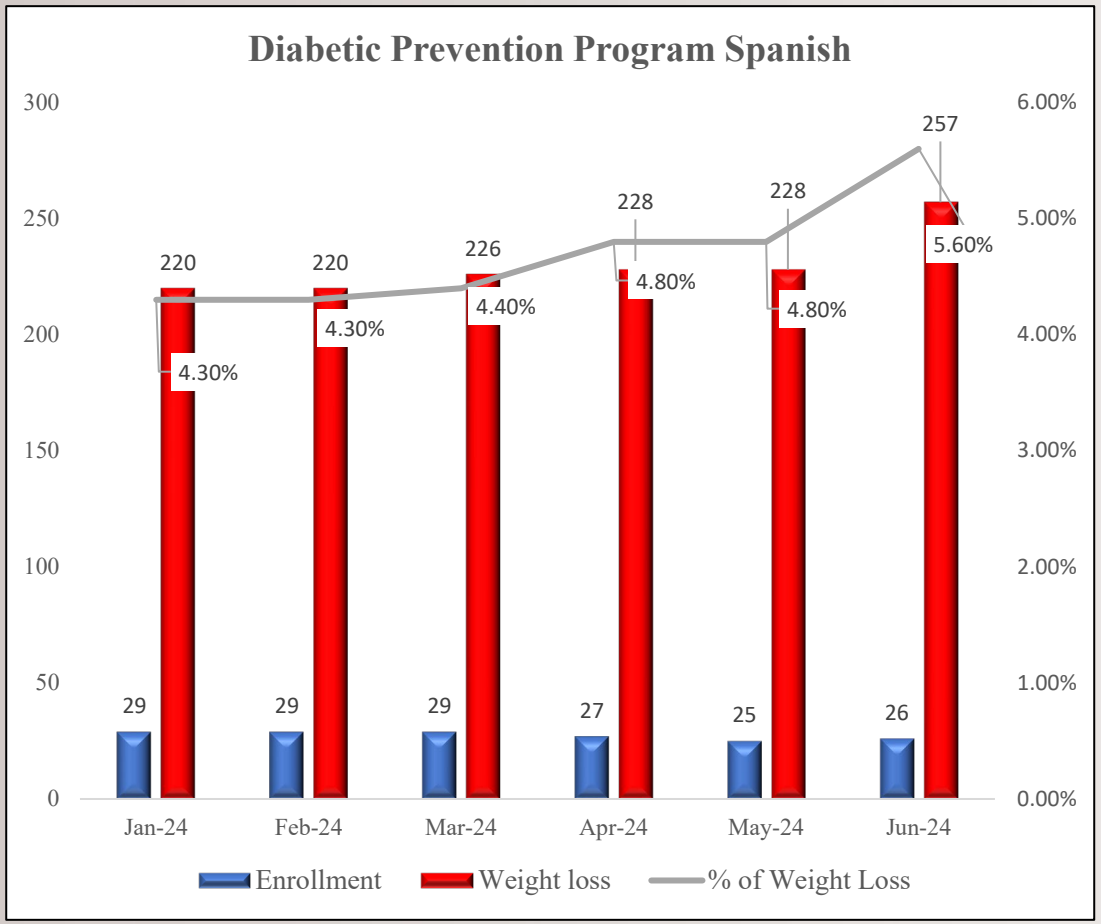
DEEP Effectiveness

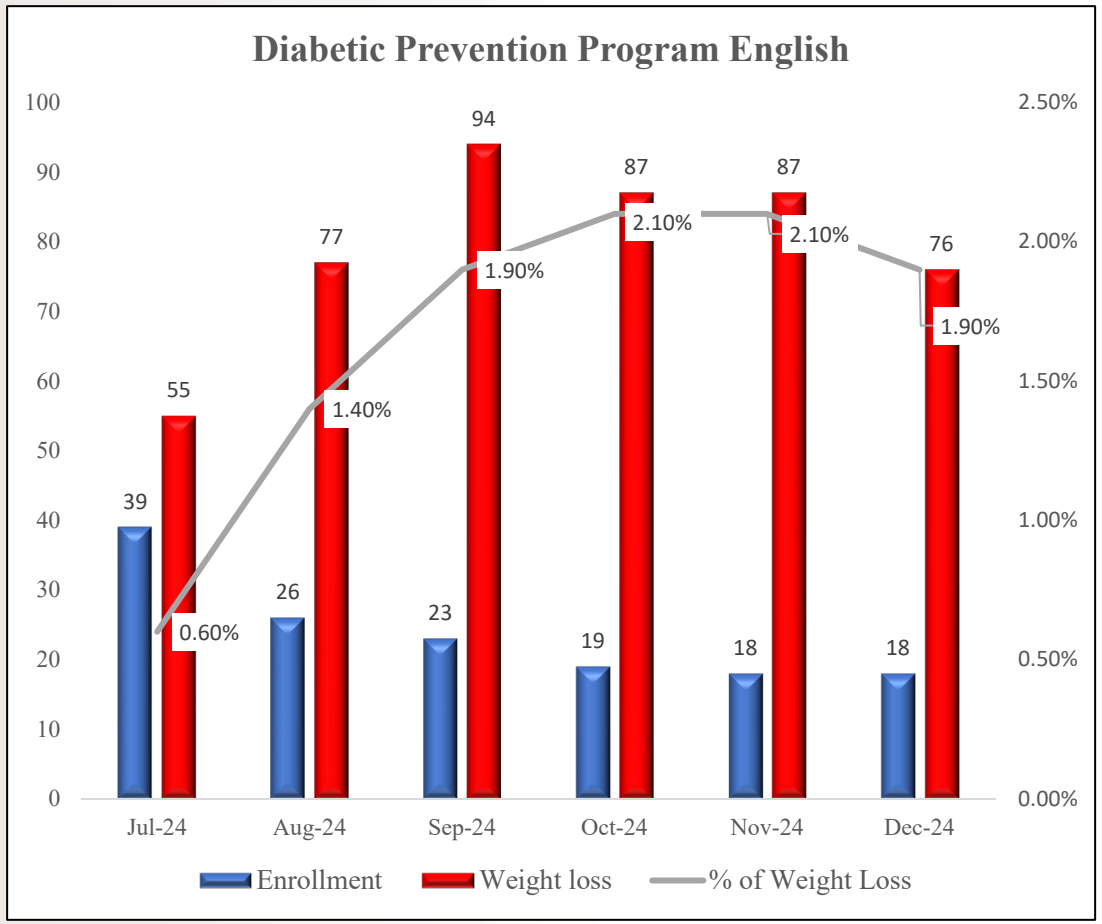




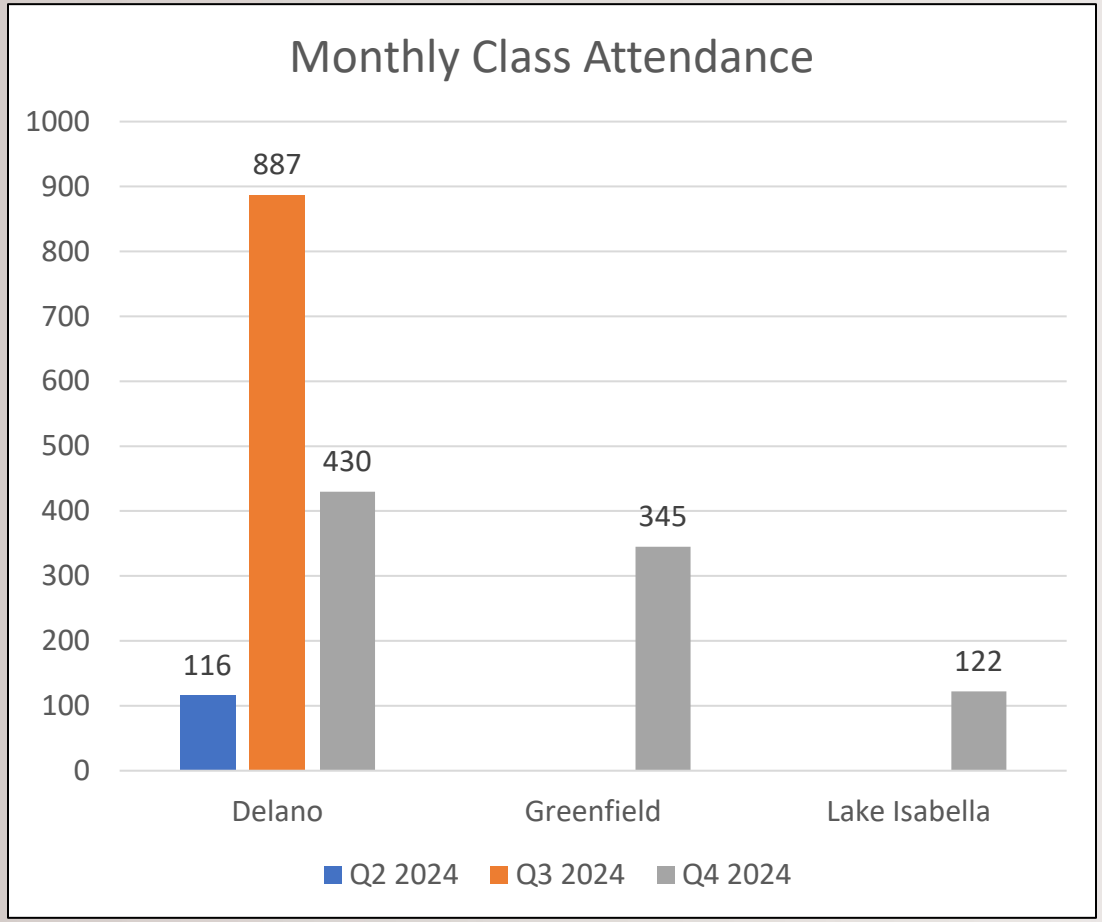


Diabetes Prevention Program Impact





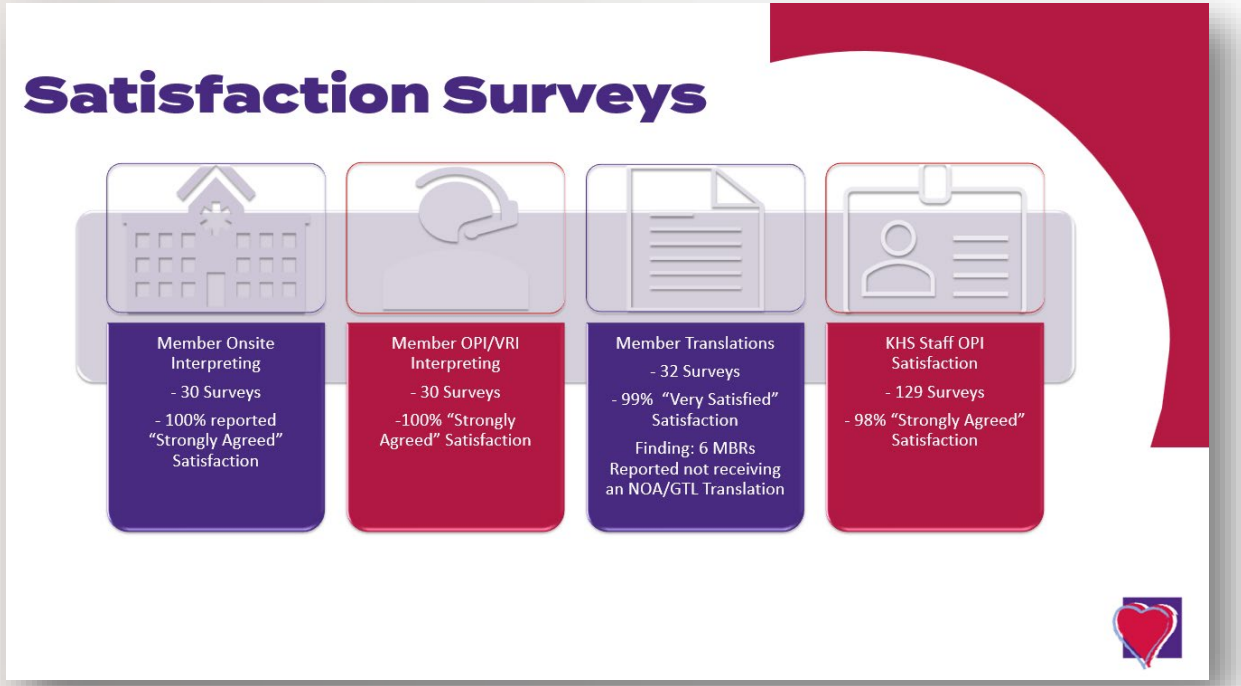
KFHC Live Better Program



- **Delano Parks & Recreation**
  - June 2024: Zumba and Yoga
  - January 2025: Live Better Kids (Zumba, Yoga, Pickleball, Fit Camp)
- **Greenfield Family Resource Center**
  - October 2024: Zumba
- **Lake Isabella/Kernville Family Resource Center and Danica's School of Dance**
  - November 2024:
    - Zumba, Hip-Hop and Yoga
    - Diabetes Prevention Program
- **McFarland Iron Valley Fitness**
  - 2nd Quarter 2025:
    - 3-month pilot for KFHC members only
    - Free gym membership & customized fitness plans

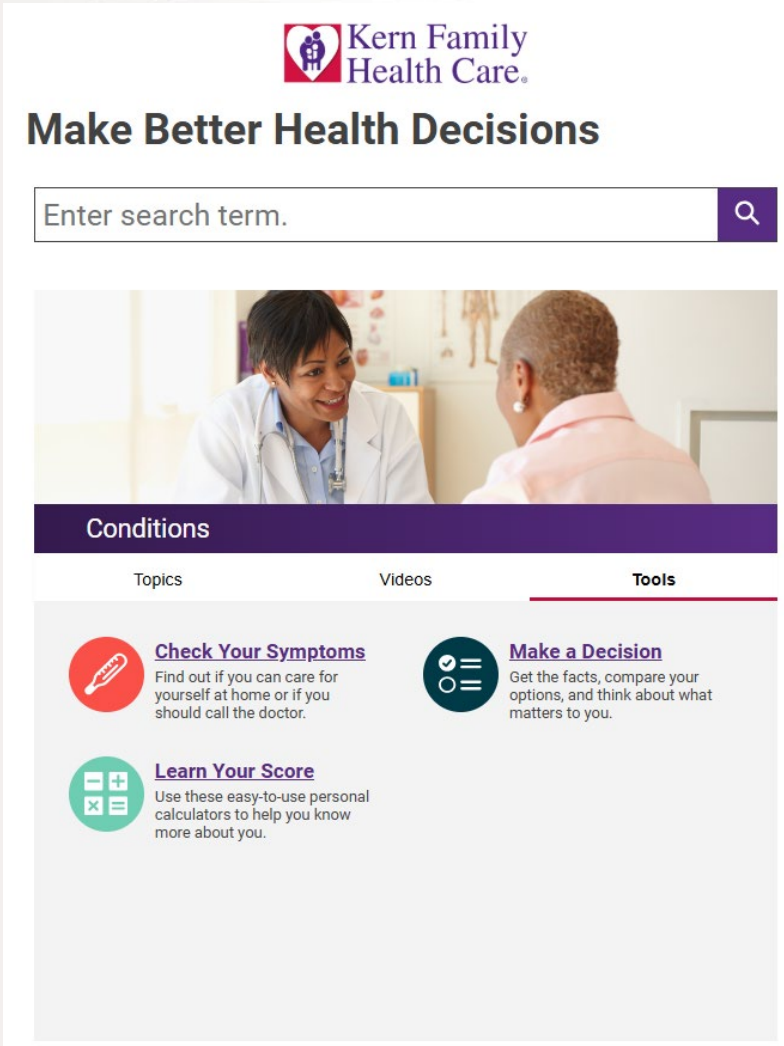
Goal 2 Results - Compliance with C&L DHCS requirements

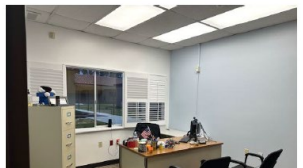
1. Implement and evaluate effectiveness of continuous monitoring plan
   - ✓ Monthly audio recording audits for Member Services and linguistic service vendors
   - ✓ Member satisfaction surveys on quality of translations, interpreters and bilingual staff (phone, in person, video remote)
   - ✓ KHS staff survey with phone interpreter vendor
   - ✓ Updated Spanish style guide and glossary. Facilitated basic Spanish translation classes
2. Update cultural competency training to align with Health Equity Department
   - ✓ Partnered with the Health Equity Department to enhance the cultural competency training to include additional courses on Diversity, Equity and Inclusion in the workplace.
3. Implement continuous monitoring of C&L services to members <21 years
   - ✓ Quarterly reports updated to include utilization section for members under 21 years of age
   - ✓ Flyer created and distributed at provider offices and community events on availability of free interpreting services



Goal 3 Results – Implement NCQA Requirements

1. Prepared and submitted deliverables for Health Plan and Health Equity accreditation
   - ✓ Purchased WebMD Ignite Solution for online Self Management Tools
   - ✓ Updated KHS Population Needs Assessment
   - ✓ Revised and operationalized Policy and Procedure changes:
     - 11.23-I Cultural and Linguistic Services
     - 11.26-I Translation of Written Member Information
   - ✓ Revised job description for Cultural and Linguistic Specialist
   - ✓ Developed new reports:
     - Culturally and Linguistically Appropriate Services (CLAS) Evaluation Report
     - Cultural and Linguistic Services Satisfaction Reports
   - ✓ Developed new provider training on Language Access Services
   - ✓ Updated vendor contracts for linguistic services:
     - Language Line Solutions
     - CommGap, Inc.
     - LifeSigns, Inc.
     - Independent Living Center for Kern County





Goal 4 Results – SBHIP Year 3 Implementation

- ✓ Received DHCS approval of 2nd BQR and April 2024 installment of funds ($1.2 million)
- ✓ Facilitated Kern county steering committee meetings among KHS, Anthem, Kaiser and KCSOS
- ✓ Prepared and submitted 3rd BQR to DHCS
- ✓ Received DHCS approval of 3rd BQR and Oct 2024 installment of funds ($1.3 million)
- ✓ Prepared and submitted Project Outcome Reports to DHCS
- ❑ DHCS approved Project Outcome Reports -
- ❑ Final funding installment (April 2025)

Thank you! Questions?

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