KERN HEALTH SYSTEMS

REGULAR MEETING OF THE QI/UM COMMITTEE

Thursday, November 15, 2018
at
7:00 A.M.

at
9700 Stockdale Highway
1st Floor Conference Room
Bakersfield, CA 93311

The public is invited

For more information, call (661) 664-5000

AGENDA

QUALITY IMPROVEMENT (QI) / UTILIZATION MANAGEMENT (UM) COMMITTEE

KERN HEALTH SYSTEMS
1st Floor-Conference Room
9700 Stockdale Highway
Bakersfield, California 93311

Regular Meeting
Thursday, November 15, 2018

7:00 A.M.

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COMMITTEE MEMBERS: Jennifer Ansolabehere, PHN; Satya Arya, MD; Danielle C Colayco, PharmD, MS; Felicia Crawford, RN; Allen Kennedy; Philipp Melendez, MD; Chan Park, MD; Maridette Schloe MS, LSSBB; Martha Tasinga, MD, CMO

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])
3) Announcements
4) Closed Session
5) CMO Report

CA-6) QI/UM Committee Summary of Proceedings August 23, 2018 – RECEIVE AND FILE

7) Physician's Advisory Committee (PAC) Summary of Proceedings 3rd Quarter – APPROVE
   - August 2018
   - September 2018

CA-8) Pharmacy TAR Log Statistics 3rd Quarter 2018 – RECEIVE AND FILE
   - July 2018
   - August 2018
   - September 2018

9) QI Focus Review Report 3rd Quarter 2018 – APPROVE
   - Critical Elements Monitoring Ending September 30, 2018
   - IHEBA Monitoring Ending September 30, 2018
   - IHA Monitoring Ending September 30, 2018
   - KRC Monitoring Ending September 30, 2018
   - CCS Monitoring Ending September 30, 2018
   - Perinatal Care Monitoring Ending September 30, 2018

CA-10) QI Site Review Summary Report 3rd Quarter 2018 – RECEIVE AND FILE
CA-11) QI SHA Monitoring Report 3rd Quarter 2018 – RECEIVE AND FILE

VSP Reports

12) VSP Medical Data Collection Summary Reports – APPROVE
- September 2017-August 2018

13) VSP DER Effectiveness Report – APPROVE

Member Services

14) Grievance Operational Board Update - APPROVE
- 3rd Quarter 2018

15) Grievance Summary Reports – APPROVE
- 2nd Quarter 2018
- 3rd Quarter 2018

CA-16) Call Center Report – RECEIVE AND FILE
- 3rd Quarter 2018

CA-17) Comparative Tabulated Grievance Reports – RECEIVE AND FILE
- 2nd Quarter 2018

Provider Relations

CA-18) Re-credentialing Report 3rd Quarter 2018 – RECEIVE AND FILE

CA-19) Board Approved New Contracts – RECEIVE AND FILE
- Effective September 1, 2018
- Effective August 1, 2018

CA-20) Board Approved Providers Reports – RECEIVE AND FILE
- Effective August 1, 2018
- Effective September 1, 2018

CA-21) Access Monitoring Report 3rd Quarter 2018 – RECEIVE AND FILE

Disease Management

22) Disease Management 3rd Quarter 2018 Report – APPROVE

Policies and Procedures

23) QI/UM Policies and Procedures – APPROVE
- 2.11-I Group Needs Assessment
- 3.40-I Continuity of Care for New Members

Health Education Reports

CA-24) Health Education Activity Report 2nd Quarter 2018 – RECEIVE AND FILE

25) Health Education Activity Report 3rd Quarter 2018 – APPROVE

CA-26) Health Education Cultural and Linguistic Work Plan 2019 – RECEIVE AND FILE

UM Department Reports

27) Combined UM Reporting 3rd Quarter 2018 – APPROVE

ADJOURN TO THURSDAY, FEBRUARY 21, 2019 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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SUMMARY OF PROCEEDINGS

QUALITY IMPROVEMENT (QI) / UTILIZATION MANAGEMENT (UM) COMMITTEE

KERN HEALTH SYSTEMS
1st Floor-Conference Room
9700 Stockdale Highway
Bakersfield, California 93311

Regular Meeting
Thursday, August 23, 2018
7:00 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 9700 Stockdale Highway, Bakersfield, 93311 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.

Members Present: Satya Arya, MD; Danielle C Colayco, PharmD, MS; Felicia Crawford, RN; Allen Kennedy; Philipp Melendez, MD; Maridette Schloe MS, LSSBB; Martha Tasinga, MD, CMO

Members Absent: Jennifer Ansolabehere, PHN; Chan Park, MD

Meeting called to order by Dr. Martha Tasinga, M.D., C.M.O. @ 7:01 A.M.

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

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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]) **NO ONE HEARD.**

3) Announcements – **Jada Salamatian, KHS Quality Improvement Supervisor introduced Stephanie Kelly, HEDIS RN in Quality Improvement to committee. Dr. Martha Tasinga, KHS CMO introduced Dr. Maury Manliguis, our new Medical Director. He was previously a Medical Director with IEHP. Dr. Manliguis will provide support to UM, Grievance, Claims and Disputes. Committee did introductions.**

4) Closed Session – **N/A**

5) CMO Report – **Dr. Tasinga gave committee members an update on the Health Homes Program.**
   - **Final APL was received June 2018**
     (a) **Member identification**
     (b) **State criteria for funding vs. KHS current grant program**
   - **Operational requirements for HHP in JIVA Medical Management Program**
   - **New sites pending – (1) OMNI in Shafter (FQHC HHP) Q3 2018; (1) Premier Medical Group (at large HHP) Q3 2018; and (2) CSV sites pending 2019.**

CA-6) QI/UM Committee Summary of Proceedings May 24, 2018 – RECEIVED AND FILED
Melendez-Arya: All Ayes (Items CA-6 through CA-29)

CA-7) Physician's Advisory Committee (PAC) Summary of Proceedings 2nd Quarter – RECEIVED AND FILED

- April 2018
- May 2018
- June 2018

CA-8) Pharmacy TAR Log Statistics 2nd Quarter 2018 – RECEIVED AND FILED

- April 2018
- May 2018
- June 2018

CA-9) QI Focus Review Report 2nd Quarter 2018 – RECEIVED AND FILED

- Critical Elements Monitoring Ending June 30, 2018
- IHEBA Monitoring Ending June 30, 2018
- IHA Monitoring Ending June 30, 2018
- KRC Monitoring Ending June 30, 2018
- CCS Monitoring Ending June 30, 2018
- Perinatal Care Monitoring Ending June 30, 2018

CA-10) QI Site Review Summary Report 2nd Quarter 2018 – RECEIVED AND FILED

CA-11) QI SHA Monitoring Report 2nd Quarter 2018 – RECEIVED AND FILED

Kaiser Reports

CA-12) Kaiser KHS UM DME Authorization Denial Report – RECEIVED AND FILED

- 1st Quarter 2018

CA-13) Kaiser KHS Health Plan Dental Report– RECEIVED AND FILED

- 2nd Quarter 2018

CA-14) Kaiser KHS Mental Health Report – RECEIVED AND FILED

- 1st Quarter 2018

CA-15) Kaiser CBAS Reports – RECEIVED AND FILED

- 2nd Quarter 2018

CA-16) Kaiser APL Grievance Report – RECEIVED AND FILED

- 2nd Quarter 2018

CA-17) Kaiser Volumes Report – RECEIVED AND FILED

- 2nd Quarter 2018

VSP Reports

CA-18) VSP Medical Data Collection Summary Reports – RECEIVED AND FILED

- June 2017-May 2018

Member Services

CA-19) Call Center Report 2nd Quarter 2018 – RECEIVED AND FILED

- Kern Health Systems/Kaiser **– Amy Carrillo, Member Services Manager, went over Q2 Call Center Report with committee.**

CA-20) Comparative Tabulated Grievance Reports – RECEIVED AND FILED

- 1st Quarter 2018

CA-21) Grievance Summary Reports – RECEIVED AND FILED

- 1st Quarter 2018 – **Amy Carrillo went over all Grievance reports.**

Provider Relations

CA-22) Re-credentialing Report 2nd Quarter 2018 – RECEIVED AND FILED

CA-23) Board Approved New Contracts – RECEIVED AND FILED

- Effective June 1, 2018
- Effective July 1, 2018

CA-24) Board Approved Providers Reports – RECEIVED AND FILED

- Effective June 1, 2018
- Effective July 1, 2018

CA-25) Access Monitoring Report 2nd Quarter 2018 – RECEIVED AND FILED

Disease Management

CA-26) Disease Management 2nd Quarter 2018 Report – RECEIVED AND FILED

Policies and Procedures

CA-27) UM Policies and Procedures 3.05-3.73 – RECEIVED AND FILED

- 3.05-P Preventive Medical Care
- 3.13-P EPSDT Supplemental Services and Targeted Case Management (TCM)
- 3.22-P Referral and Authorization Process
- 3.23-P Provider Appeals Regarding Authorization
- 3.40-I Continuity of Care for New Members
- 3.72-P Behavioral Health Therapy and Behavioral Intervention Services
- 3.73-I Medical Decision Making

Health Education Reports

CA-28) Health Ed 2017 Program Evaluation – RECEIVED AND FILED

- **The 2017 Health Education Program Evaluation was an assessment of the past year's activities, achievements and challenges. Findings from the evaluation are used to generate the department's annual work plan and program plan, presented by Isabel Silva, Director of Health Education, and Cultural & Linguistics Services.**

CA-29) Health Ed 2018 Program Plan – RECEIVED AND FILED

UM Department Reports

30) Combined UM Reporting 2nd Quarter 2018 – APPROVED
Melendez-Crawford: All Ayes

Meeting adjourned by Dr. Martha Tasinga, M.D., C.M.O. @ 8:19 A.M.
to Thursday, November 15, 2018

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

KERN HEALTH SYSTEMS
9700 Stockdale Highway
1st Floor Board Room
Bakersfield, California 93311

Wednesday, August 1, 2018
7:00 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 9700 Stockdale Highway, Bakersfield, 93311 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.

PLEASE REMEMBER TO TURN OFF ALL CELL PHONES, PAGERS OR ELECTRONIC DEVICES DURING MEETINGS.

COMMITTEE RECONVENED

Members Present: Angela Egbikuadje, PD.MS, Ph.D; David Hair, M.D., Miguel Lascano, M.D., Raju Patel, M.D., Jacqueline Paul-Gordon, M.D.

Members Absent: Hasmukh Amin, M.D., Ashok Parmar, M.D.

Meeting called to order at 7:08 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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Dr. Ajitpal Tiwana appeared before the PAC during public presentation. Dr. Tiwana was given 2-minutes to provide the PAC members with information to support his request to perform procedures that are outside the primary care scope of practice for Family Practitioners.

Dr. Tiwana indicated he had been performing some procedures before the pre-authorization process; however, procedures are now being denied. Dr. Tiwana indicated he has been performing EGD's since 1988 and basic pain management services no pumps or spine cases and has provided his certifications multiple times. He further explained he obtained the required accreditation although his surgery center was already CMS certified.

Since the requested procedures are being denied he is referring patients to the ER for these "simple procedures" that can be performed at his surgery center. Dr. Tiwana is requesting to continue to perform the procedures he was previously performing.

Members of the committee were given the opportunity to pose questions to Dr. Tiwana. Dr. Paul-Gordon asked to which procedures Dr. Tiwana is requesting. Dr. Tiwana indicated pain management injections and epidurals, lumpectomy, external hemorrhoids, colonoscopy/EGDs, and vein ablations of which he states he has performed over 500 without complication.

Dr. Tiwana was thanked for his presentation and asked for a written response from the Physician Advisory Committee.

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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CA-3) Minutes for KHS Physician Advisory Committee meeting on June 6, 2018 – APPROVED
Hair-Patel: All Ayes

ADJOURNED TO CLOSED SESSION @ 7:18 A.M.

CLOSED SESSION

4) Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) – **BY A VOTE OF 5-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:29 A.M.

5) Review Policy 3.05-P Preventive Medical Care – RECEIVED AND FILED

6) Review Policy 3.22-P Referral and Authorization Process – RECEIVED AND FILED

7) Review Policy 3.23-P Provider Appeals Regarding Authorization – RECEIVED AND FILED

8) Review Policy 3.40-I Continuity of Care for New Members – RECEIVED AND FILED

9) Review Policy 3.72-P Behavioral Health Therapy and Behavioral Intervention Services – RECEIVED AND FILED

10) Review Policy 3.73-I Medical Decision Making – RECEIVED AND FILED

11) Physician Scope of Practice – DISCUSSION – (**HELD UNTIL NEXT MEETING)**

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 8:16 A.M.
TO WEDNESDAY, SEPTEMBER 12, 2018

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

KERN HEALTH SYSTEMS
9700 Stockdale Highway
1st Floor Board Room
Bakersfield, California 93311

Wednesday, September 12, 2018
7:00 A.M.

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COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Angela Egbikuadje, PD.MS, Ph.D; David Hair, M.D., Ashok Parmar, M.D., Raju Patel, M.D., Jacqueline Paul-Gordon, M.D., Martha Tasinga, M.D., C.M.O.

Members Absent: Miguel Lascano, M.D.

Meeting called to order at 7:01 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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 MEMBER OF THE COMMITTEE 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 CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

STAFF RECOMMENDATION SHOWN IN CAPS

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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CA-3) Minutes for KHS Physician Advisory Committee meeting on August 1, 2018 – APPROVED
Patel-Hair: All Ayes

ADJOURNED TO CLOSED SESSION @ 7:13 A.M.

CLOSED SESSION

3) Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) – **BY A VOTE OF 6-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

Members reviewed the letter submitted to the committee by provider PRV000383 with his formal request to perform procedures. Members discussed and commented on whether or not colonoscopies were performed by family practitioners. Dr. Tasinga asked for the committee's guidance on providers requesting procedures. Dr. Miller, KHS Medical Director, suggested that PRV000383 submit the procedure type and number of specific procedures performed in a given timeframe. Dr. Tasinga suggested that KHS run a report to see how many procedures PRV000383 has performed. It was further suggested that the cases then be sent to the designated specialists in that field to confirm PRV000383 is acceptable.

Jake Hall, PR Supervisor, reiterated to the committee that KHS is not a staff model in which KHS "grants privileges" to individual providers. The KHS Credentialing P&P states that all specialist must have completed an

accredited residency or accredited fellowship program. The certificates provided by PRV000383 do not appear to be from an Accreditation Council for Graduate Medical Education (ACGME) accredited training program, with the exception of the Flex Sigmoidoscopy, Colonoscopy and Colonscopic Polypectomy from the American Institute of Medical Education and Research, Inc. Discussion surrounding biopsies was confirmed that provider PRV000383 was performing biopsies. Dr. Amin suggested that an approved & credentialed GI doctor review the cases with biopsies to see if there are any issues. Dr. Paul advocated that our members should be able to have the same provider perform the colonoscopy as well as the biopsy and it should be an approved specialist. Dr. Miller informed the members that there is an industry "Position Statement" endorsing family practitioners, who have had experience and training, be allowed to do endoscopy/colonoscopy.

MOTION WAS MADE, SECONDED AND CARRIED: PRV000383 approved flex sig, colonoscopy and EGDs. All other requests for procedures to be reviewed by KHS approved & credentialed specialist to conduct sampling review of cases performed by provider PRV000383. Amin / Paul-Gordon.

COMMITTEE RECONVENED TO OPEN SESSION @ 8:03 A.M.

5) Use of Preventative Services Guidelines – APPROVE
(ITEM HELD UNTIL NEXT MONTH)

6) Physician Scope of Practice – DISCUSSION
(ITEM HELD UNTIL NEXT MONTH)

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D.,C.M.O. @ 8:15 A.M.
TO WEDNESDAY, OCTOBER 3, 2018 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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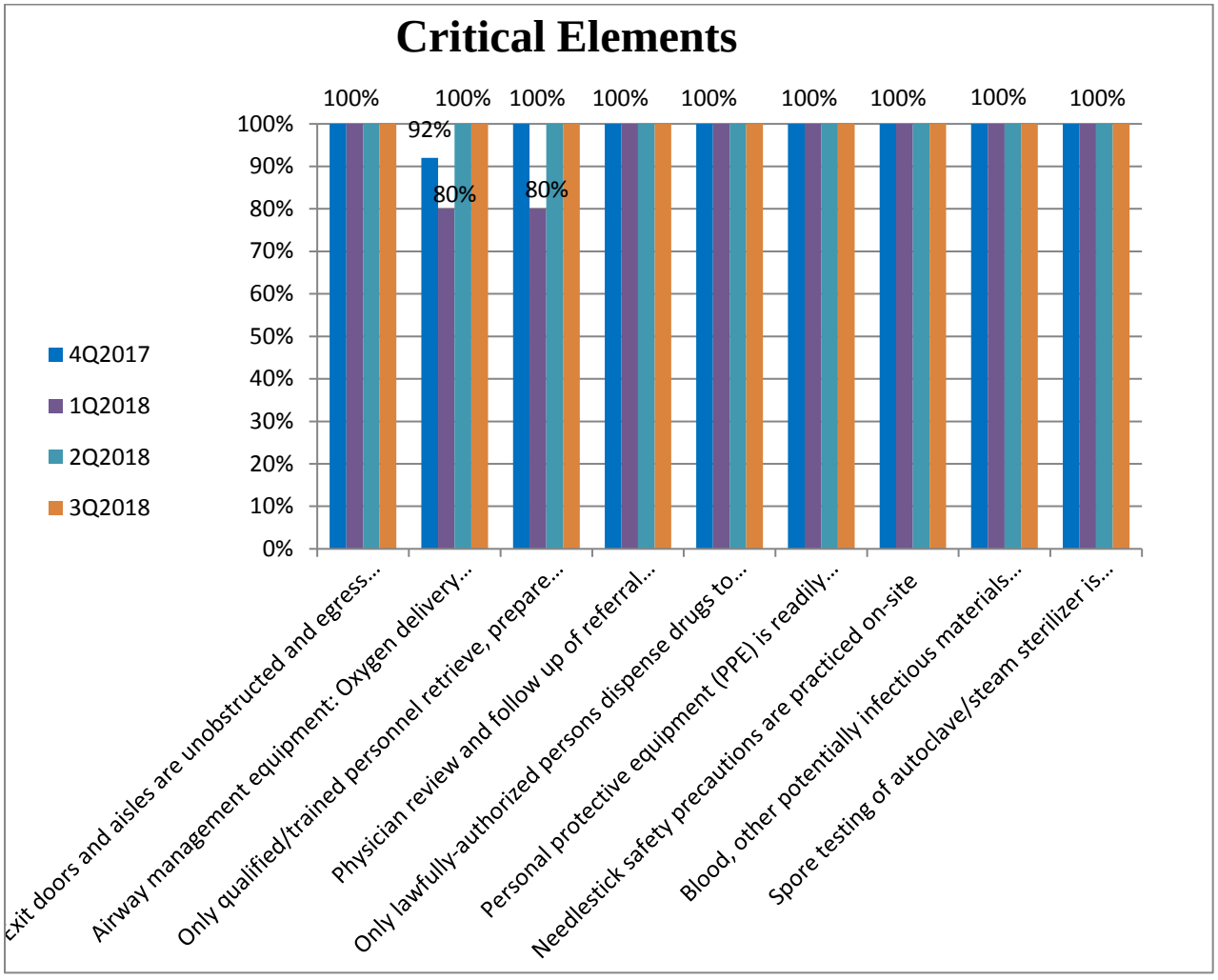
Quarter/Year of Audit	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018
Month Audited	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Total TAR's for the month	3359	3056	3812	3046	3831	3551	3293	3553	3145			
Compliant	100%	99%	99%	100%	100%	100%	99%	100%	100%			
APPROVED TAR'S												
Timeliness - Reviewed & Returned in 1 busines day	76/76	72/72	87/88	69/69	80/80	71/71	64/65	79/79	71/71			
Date Stamped	76/76	72/72	88/88	69/69	80/80	71/71	65/65	79/79	71/71			
Fax copy attached	76/76	72/72	88/88	69/69	80/80	71/71	65/65	79/79	71/71			
Decision marked	76/76	72/72	88/88	69/69	80/80	71/71	65/65	79/79	71/71			
DENIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	63/63	53/53	63/63	54/54	72/72	72/72	64/64	73/73	51/51			
Initally Denied - Signed by Medical Dir and/or Pharm	63/63	53/53	63/63	54/54	72/72	72/72	64/64	73/73	51/51			
Letter sent within time frame	63/63	53/53	63/63	54/54	72/72	72/72	64/64	73/73	51/51			
Date Stamped	63/63	53/53	63/63	54/54	72/72	72/72	64/64	73/73	51/51			
Fax copy attached	63/63	53/53	63/63	54/54	72/72	72/72	64/64	73/73	51/51			
Decision marked	63/63	53/53	63/63	54/54	72/72	72/72	64/64	73/73	51/51			
Correct form letter, per current policies used	63/63	53/53	63/63	54/54	72/72	72/72	64/64	73/73	51/51			
MODIFIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	0	0	0	0	0	0	0	0	0			
Date Stamped	0	0	0	0	0	0	0	0	0			
Fax copy attached	0	0	0	0	0	0	0	0	0			
Decision marked	0	0	0	0	0	0	0	0	0			
Correct form letter, per current policies used	0	0	0	0	0	0	0	0	0			
DUPLICATE TAR'S												
Timeliness - Reviewd & Returned in 1 business day	12/12	9/10	17/17	14/14	10/10	17/17	16/16	10/10	7/7			
Date Stamped	12/12	10/10	17/17	14/14	10/10	17/17	16/16	10/10	7/7			
Fax copy attached	12/12	10/10	17/17	14/14	10/10	17/17	16/16	10/10	7/7			

Kern Health Systems
Focus Review Summary Report

Critical Elements Reviews: Fourteen (14) providers were evaluated in 3rd Quarter 2018.

SUMMARY: KHS is responsible for systematic monitoring of all PCP sites between each regularly scheduled full scope site review surveys. This monitoring includes the nine (9) critical elements. Other performance assessments may include previous deficiencies, patient satisfaction, grievance, and utilization management data. The PCP and/or site contact are notified of all critical element deficiencies found during a full scope site survey, focused survey or monitoring visit. PCP and/or site contact are required to correct 100% of the survey deficiencies regardless of the survey score.

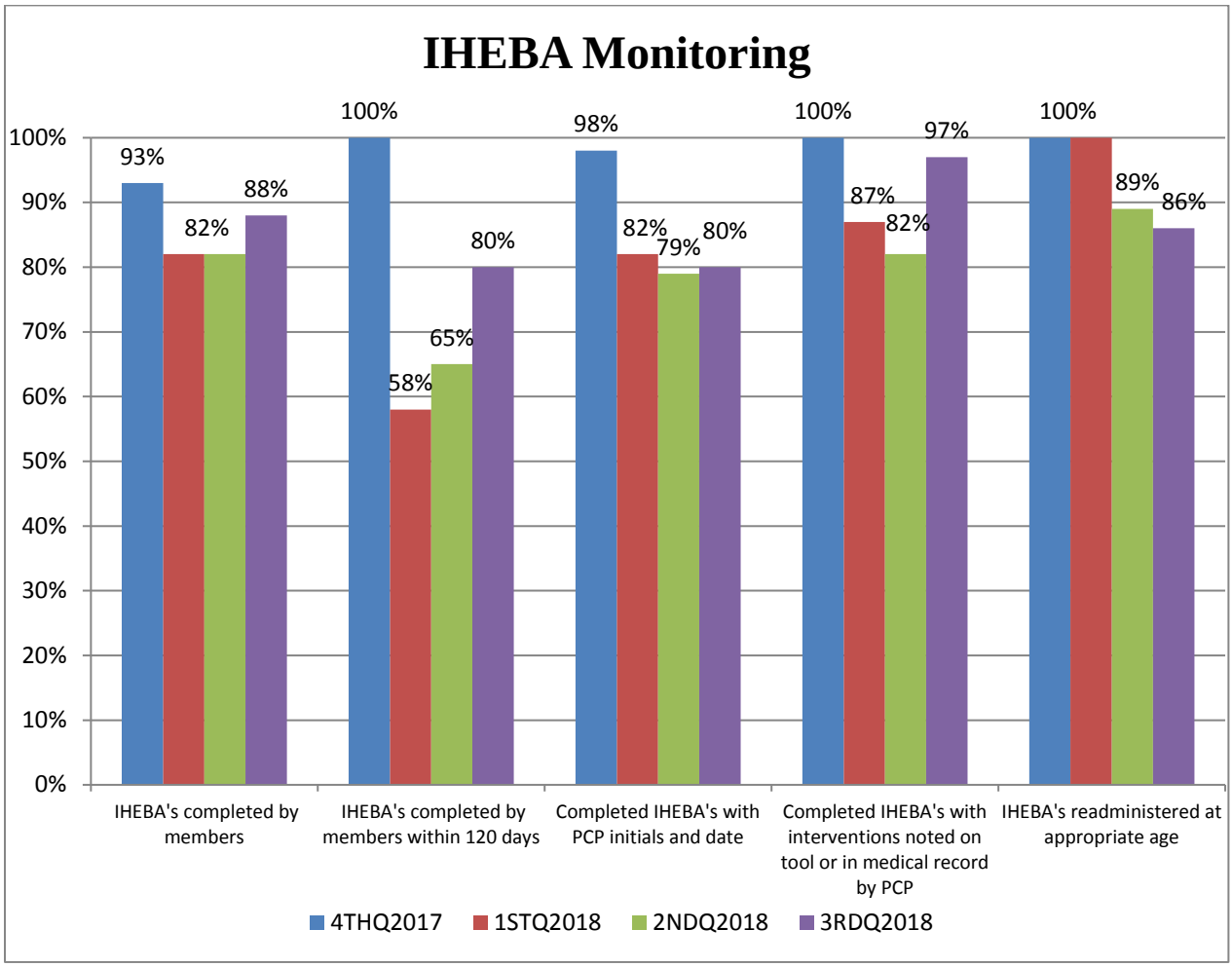


All providers evaluated over the last 4 Quarters scored 100% in all areas in 3 out of 4 Quarters. The two areas with opportunities for improvement in 1st Quarter 2018 were related to qualified personnel preparing and administering medications and Physician Review and Follow-up on referral and diagnostic test results. Correction Action Plans (CAPs) were issued and the deficiencies were corrected.

IHEBA Reviews: In 3rd Quarter 2018, 125 charts were reviewed from fourteen (14) providers. The areas for improvement noted were:

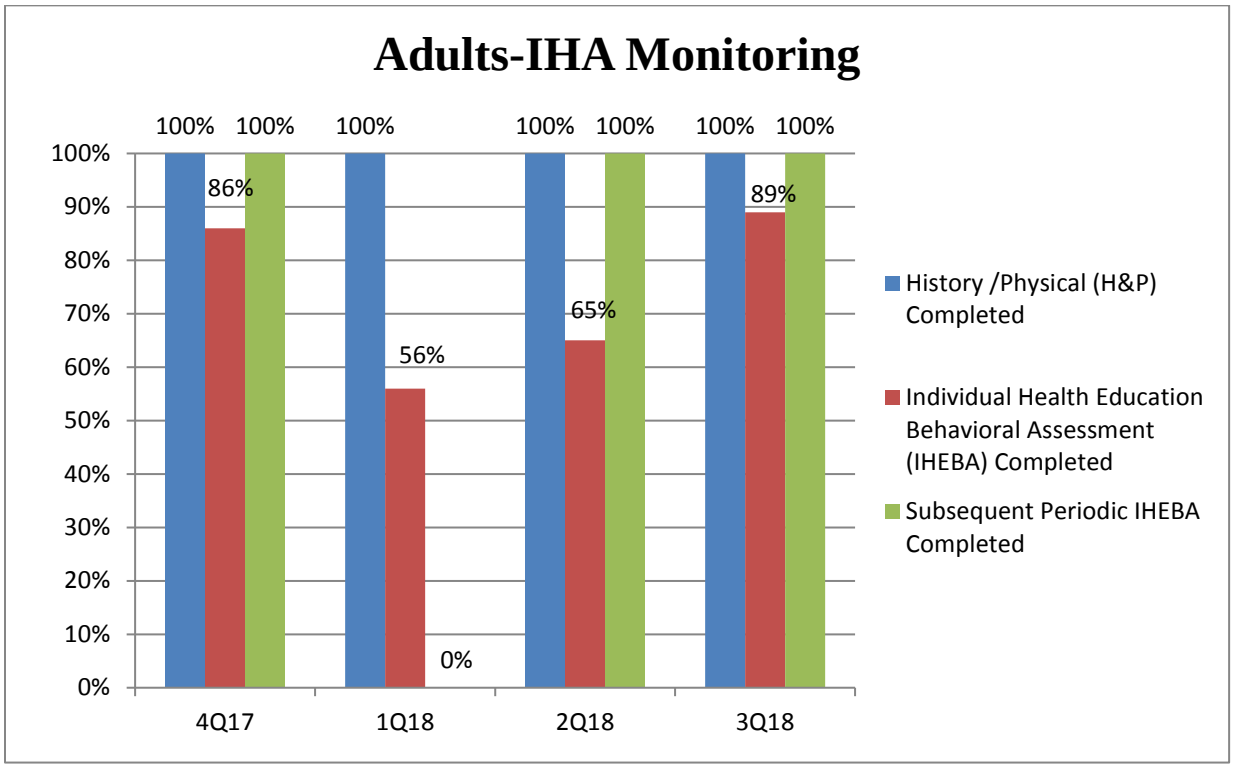
- member completion of IHEBAs,
- member completion of IHEBAs within 120 days,
- PCP initialing and dating of completed IHEBAs,
- PCP notation of IHEBA interventions in medical records.
- IHEBA's re-administered at appropriate age

SUMMARY: The initial Individual Health Education Behavioral Assessment (IHEBA), commonly referred to as the Staying Healthy Assessment, is performed during the Initial Health Assessment (IHA). Thereafter, the PCP must re-administer the IHEBA at the appropriate age intervals. This remains a problem prone process despite offering P4P for timely member engagement.



Initial Health Assessment Reviews: In the 3rd Quarter 2018, fourteen (14) providers were evaluated. There were forty-four (44) Adult records and forty-three (43) Pediatric records reviewed.

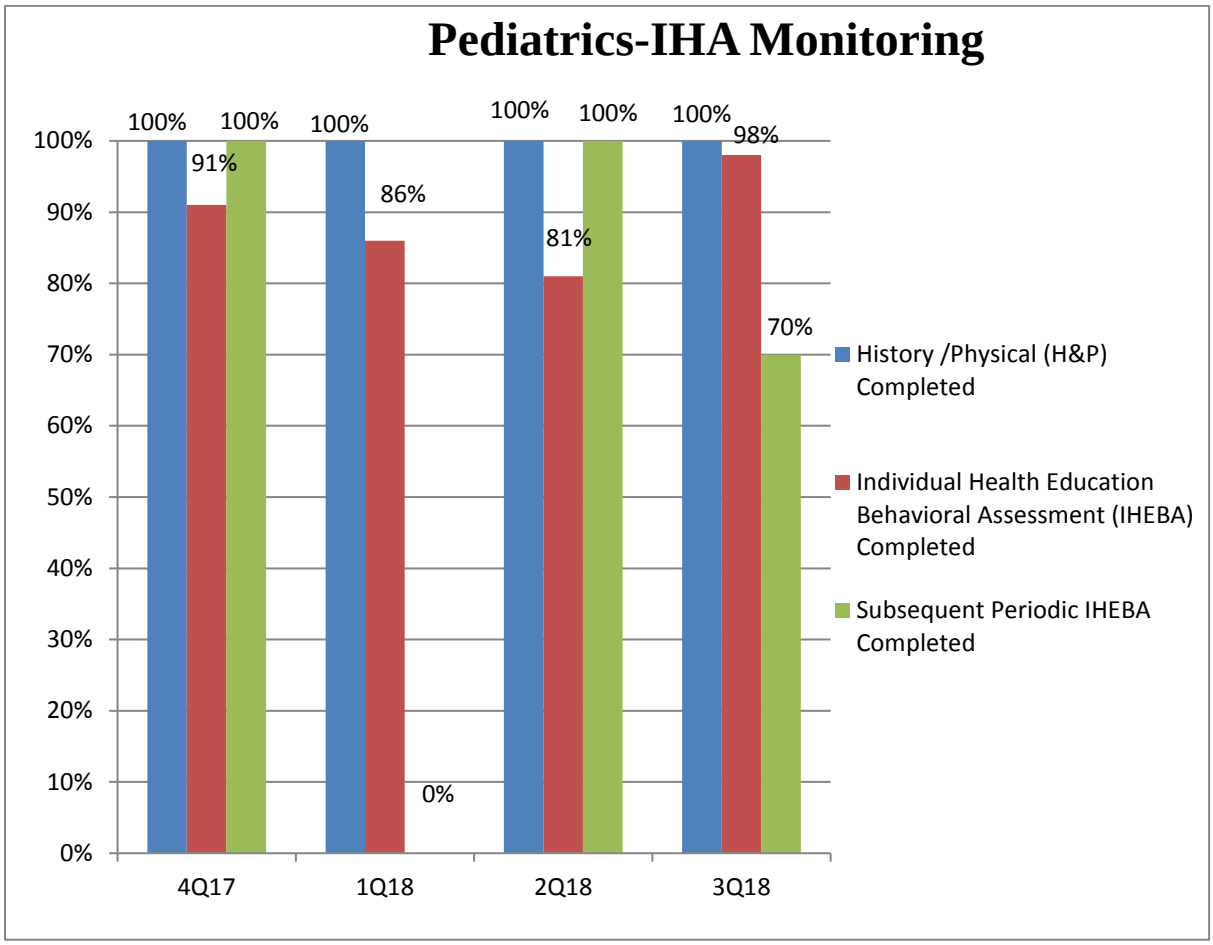
SUMMARY: An Initial Health Assessment (IHA) must be provided to each member within 120 days of enrollment. As PCP's receive their assigned panels, the Practitioner's office should contact members to schedule an IHA to be performed within the 120 day time limit. If the practitioner/staff is unable to contact the member, he/she should contact KHS Member Services Department for assistance. Contact attempts and results are documented by both the PCP and Member Services staff.



The fourteen (14) providers reviewed serving adults had all of the H&Ps and Subsequent IHEBAs completed in the 3rd quarter. And though 3rd Quarter totals are higher than 1st and 2nd Quarter 2018 totals, the Staying Healthy Assessment remains the area in most need of improvement for the Adult IHA completion rate.

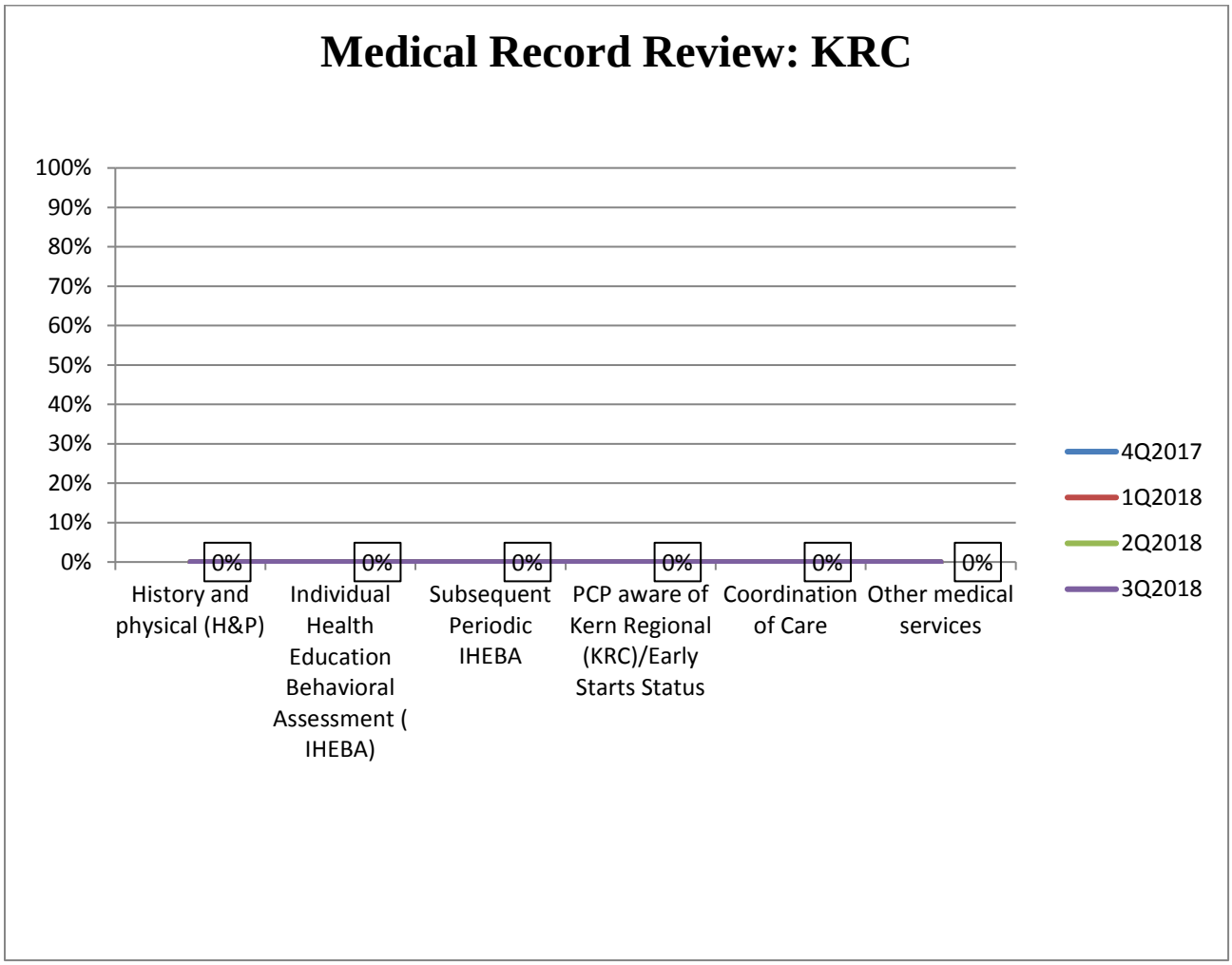
Both adult and pediatric providers perform H&Ps during the initial health assessment. The initial IHEBA/Staying Health Assessment should be performed during the IHA. Performance in Pediatric IHEBA use remains higher than in the adult population for all elements. Corrective Action Plans were implemented for all deficiencies and follow-up visits will be conducted.

This quarter, all fourteen providers surveyed scored 100% in completing the History/Physicals (H&P).Scores for Subsequent Periodic IHEBAs completed in the pediatric records reviewed were also high. The area most in need of improvement over the last 4 quarters was completion of the Staying Healthy Assessments during the IHA. Corrective Action Plans for deficiencies have been implemented and follow-up visits will be conducted.



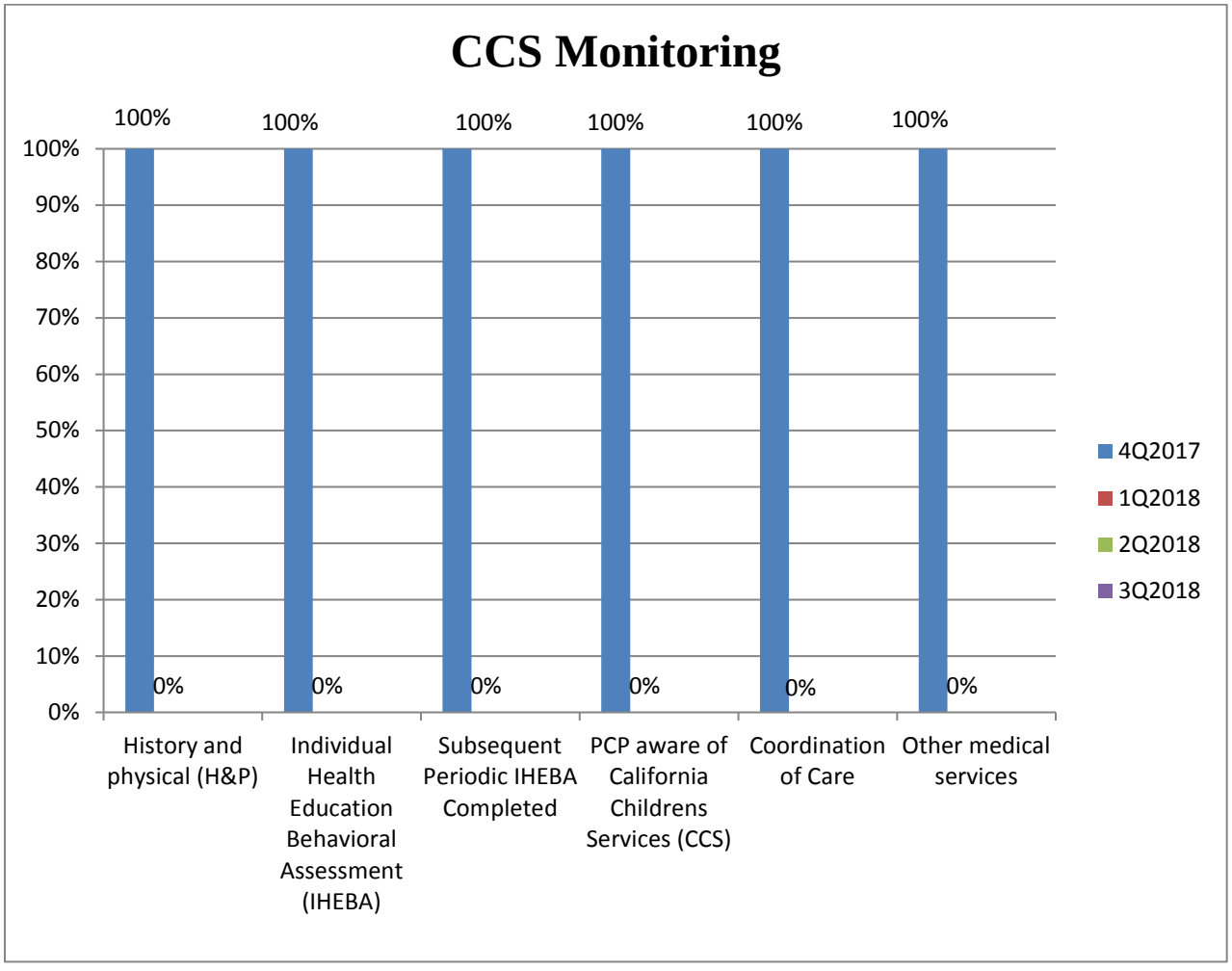
KRC Reviews: In 3rd Quarter 2018 there were no KRC charts reviewed.

SUMMARY: KHS ensures the provision of primary care interventions and other medically necessary covered services unrelated to the KRC and/or Early Starts eligible condition. Medical record review showed appropriate primary care and other necessary intervention although historically, the denominator for this measure is small.



CCS Reviews: Out of the fourteen (14) providers surveyed in 3rd Quarter 2018, there were no CCS charts reviewed.

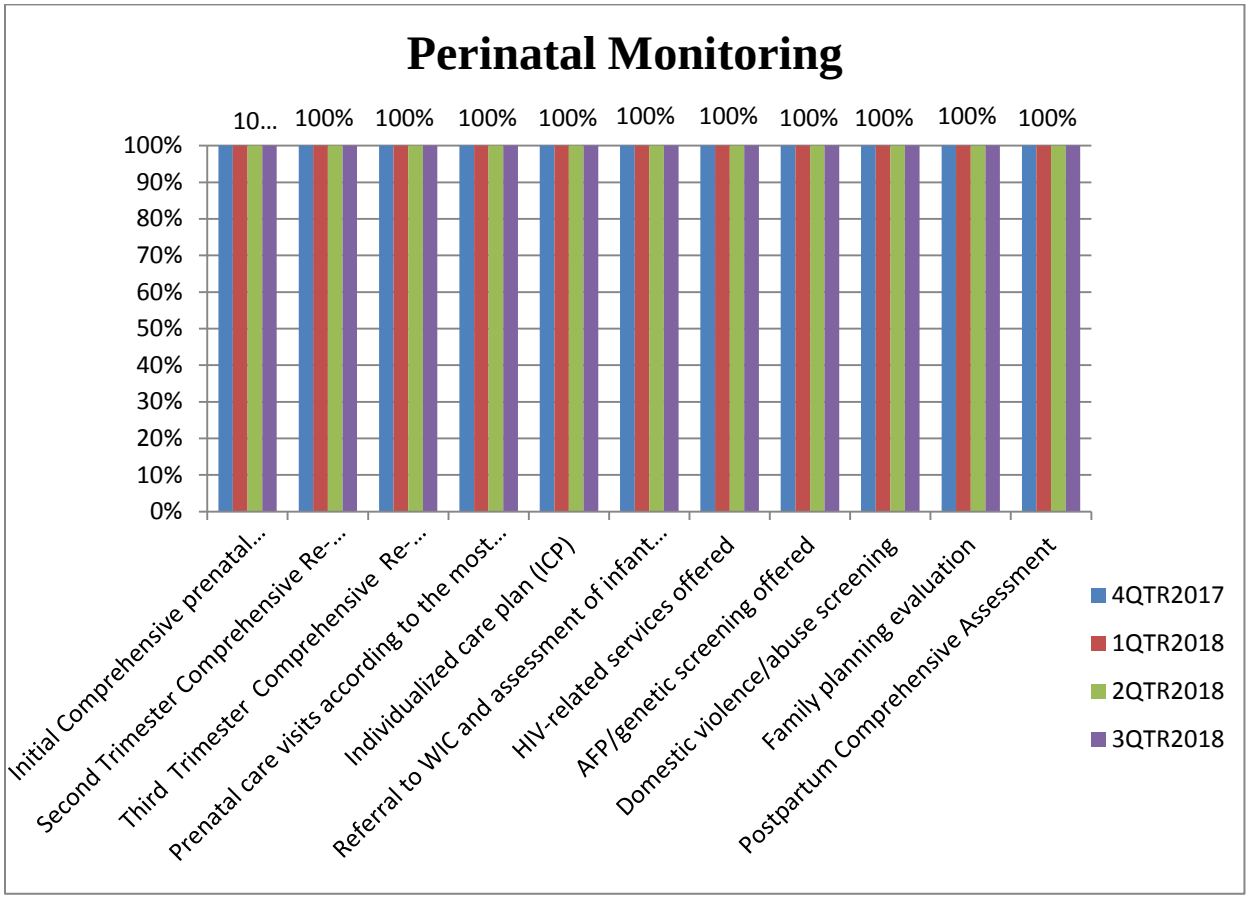
SUMMARY: KHS ensures the provision of primary care interventions and other medically necessary covered services unrelated to the CCS eligible condition through medical record review evidenced by appropriate primary care and other necessary intervention. KHS collaborates with CCS, the CCS Specialist, and the PCP as necessary to ensure continuity of the member's care.



Perinatal Reviews: Out of the fourteen (14) providers surveyed in 3rd Quarter 2018 there were 17 perinatal charts reviewed.

SUMMARY: KHS encourages optimum maternity care as appropriate for all pregnant members. Maternity care includes prenatal care, delivery, postpartum care, education, high risk interventions, and genetic counseling, screening, and referral. All pregnancy providers shall utilize a multi-disciplinary approach to perinatal care. All pregnant KHS members will receive case coordination of Obstetric and Comprehensive Perinatal Services to the degree warranted by the State Department of Healthcare Services (DHCS) combined standardized risk assessment tools. Maternity care will be provided in accordance with the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG).

OB patients are routinely monitored through the QI Department's medical record reviews. Timeliness of prenatal and postpartum care is monitored for HEDIS. When appropriate, the QI nurse implements a CAP for the KHS provider and notifies Provider Relations for follow-up. The QI department collects data on these members and reports the aggregate findings to the QI/UM Committee on a regular basis in order to determine necessary interventions. There is a variance from quarter to quarter depending on the number of providers reviewed. In 3Q18 all Providers scored 100% in all areas.

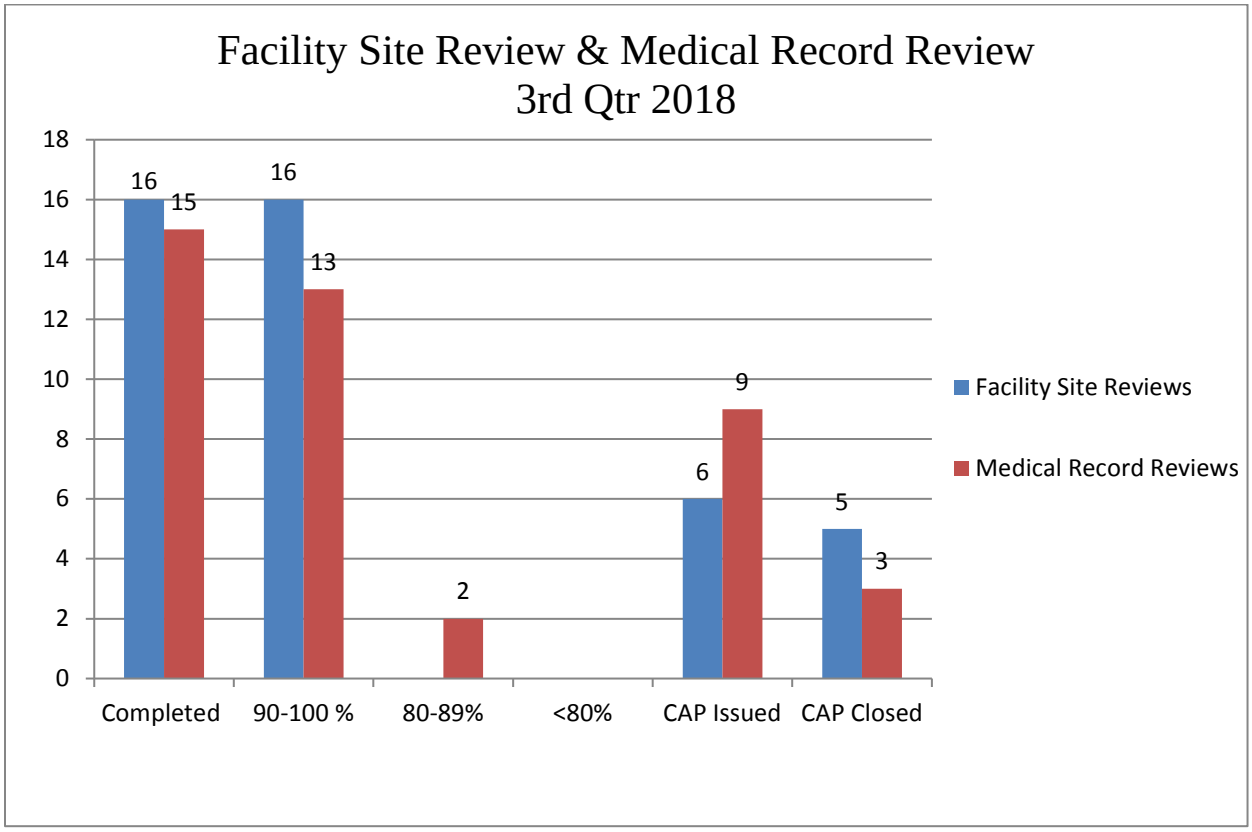


Kern Health Systems
Site Review Summary Report

Disciplinary Involvement: Quality Improvement and Provider Relations
Data Retrieval Method: Chart Review, Observation, Interview/Survey, Physical Inspection
Department: Quality Improvement
Monitoring Period: July 1, 2018- September 30, 2018

A total of sixteen (16) Office Site Reviews were completed in the 3rd Quarter of 2018. Out of the sixteen (16) completed, four (4) were Initial Reviews and twelve (12) were Periodic Reviews. One (1) out of the sixteen (16) performed was for Urgent Care Centers.

A total of fifteen (15) Medical Record Reviews were completed in the 3rd Quarter of 2018. Three (3) were Initial Medical Record Reviews, and twelve (12) were Periodic Medical Record Reviews. There were six (6) Facility Site Review CAPs and nine (9) Medical Record Review CAPs issued. Five (5) Full Site Review CAPs were closed, and three (3) Medical Record Review CAPs were closed.



Description of Process: Certified Site Reviewers perform a facility site review on all contracted primary care providers (including OB/GYNs and pediatricians) as well as providers who serve a high volume of SPD beneficiaries. Per APL 15-023, APL 16-002 and PL 14-004, certified site reviewers complete site and medical record reviews for providers credentialed per DHCS and

MMCD contractual and policy requirements. A site review shall be completed as part of the initial Credentialing process if a new provider at a site that has not previously been reviewed is added to a contractor's provider network.

A site review need not to be repeated, as part of the initial Credentialing process if a new provider is added to a provider site that has a current passing site survey score. A site review survey need not to be repeated as part of the re-credentialing process if the site has a current passing site survey score. A passing Site Review Survey shall be considered "current" if it is dated within the last 3 years, and need not to be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the plan

Scoring and Corrective Action Plans

QI/UM Committee approved Policy #CP232 and #CP233 as the Scoring and Corrective Action Plan Policies for all Provider Site Reviews

Facility sites that receive an Exempted Pass (90% or above, without deficiencies in critical elements) will not be required to complete a corrective action plan (CAP), unless required by the plan or local plan collaborative. All sites that receive a Conditional Pass (80-89%, or 90% or above with deficiencies in critical elements) will be required to establish a CAP that addresses each of the noted deficiencies. The compliance level categories for both the facility site review and medical record review are the same as listed below:

Exempted Pass: 90% or above
Conditional Pass: 80-89%
Not Pass: below 80%

Facility sites that receive an Exempted Pass (90% or above) for medical record review will not be required to complete a CAP for medical record review. On-site CAP follow up visits are intended to verify that processes are in place to remedy deficiencies.

Nine critical survey elements related to the potential for adverse effect on patient health or safety have a scored "weight" of two points. All other survey elements are weighted at one point. All critical element deficiencies found during a full scope site survey, focused survey, or monitoring visit shall be corrected by the provider within 10 business days of the survey date. Sites found deficient in any critical element during a Full Score Site Survey shall be required to correct 100% of the survey deficiencies, regardless of survey score. Critical elements include the following nine criteria:

1. Exit doors and aisles are unobstructed and egress (escape) accessible.

2. Airway management equipment, appropriate to practice and populations served, are present on site.
3. Only qualified/trained personnel retrieve, prepare or administer medications.
4. Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
5. Only lawfully-authorized persons dispense drugs to patients.
6. Personal protective equipment (PPE) is readily available for staff use.
7. Needlestick safety precautions are practiced on-site.
8. Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collections, processing, storage, transport or shipping.
9. Spore testing of autoclave/steam sterilizer is completed (at least monthly, with documented results).

Top Facility Site Review CE Deficiencies

- Airway Management Equipment appropriate to practice and present on site.
- Needle-stick safety precautions are practiced on-site.
- Infectious materials and wastes being appropriately collected and stored.
- Spore testing of autoclave/steam sterilizer completed monthly and documented.

Top Medical Record Review Deficiencies

- Cervical Cancer Screening
- Colorectal Screening
- TB Screening
- Adult Immunizations

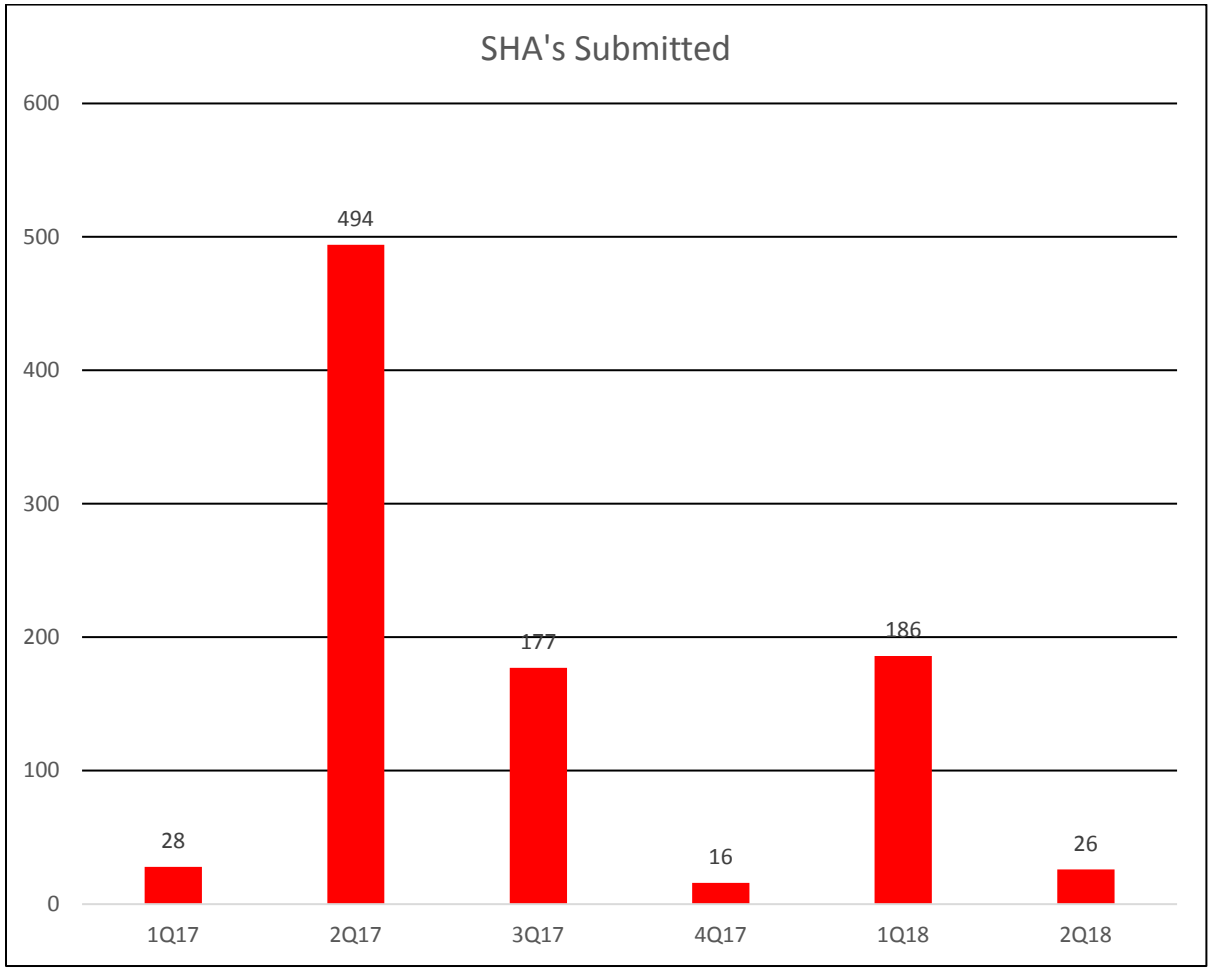
Providers are responsible for coming into compliance with the full site review criteria. If a site remains out of compliance and/or has a recurrent failing score through subsequent follow-up visits, disciplinary action may be imposed.

Kern Health Systems
Staying Healthy Assessments Monitoring

SUMMARY: KHS works to identify members with unmet health needs. During the course of P4P and HEDIS audits QI nurses identify members with positive Staying Healthy Assessments in their medical record. These positive SHAs are shared with Health Education to evaluate clinical follow-up and to assist them in developing their curriculum. The QI department collects data (shown below) on these members and reports the aggregate findings to the QI/UM Committee on a regular basis. There is a variance from quarter to quarter depending on the records reviewed.

Staying Healthy Assessment Monitoring

During routine audits of medical records, QI RNs validate that a Staying Healthy Assessment was completed yearly. During 1st Quarter 2018, there were 186 positive SHAs sent to Health Education. This increase was related to the number of records reviewed for HEDIS. 2nd Quarter 2018 saw a decrease though with only 26 SHAs submitted as the Medical Record Review drew to a close at the end of HEDIS. There were no SHA's submitted to Health Education in 3rd Quarter 2018.



Medical Data Collection Summary Report

Period Covered: September, 2017 through August, 2018
Prepared for: KERN HEALTH SYSTEMS - (12049397)

Overview

This report shows an aggregate view of your members who have received an eye exam during the reporting period. It also shows the number and percentage of your members that have one or more of the health conditions listed below, as reported by VSP doctors. VSP focuses on the six conditions listed below because they represent some of the most frequent and costly health conditions for which early detection and treatment can reduce or prevent vision loss as well as potentially avoid more costly treatment. VSP can work with your health plan or disease management company by providing them with patient-specific information upon request.

Summary of Findings

The left section below shows how many of your members received an eye exam during the reporting period as well as how many of them had each of the conditions listed (as reported by VSP doctors). The percentages represent the number of people with the respective conditions divided by the total number that received an eye exam. The right section below shows the estimated number of cases in your member population. We use health and demographic statistics provided by the Centers for Disease Control and the US Census. Also, because prevalence rates vary by age, we incorporate patient age data from your VSP eye exam claims for the reporting period.

The estimates for diabetes and hypertension are expected to be higher than the reported rates because approximately 30% of people with diabetes and 50% of people with hypertension are unaware of their condition and would not report it to their VSP doctor. The percentages represent the estimated number of people with the conditions divided by your total membership. Note that diabetes and hypertension are self-reported while the other conditions are reported based on the VSP doctor's findings. This report does not indicate if cases are newly diagnosed or existing.

Reported Cases

	Members	
Received Eye Exam:	21,257	
Diabetes?:	1,197	5.6%
Diabetic Retinopathy:	169	.8%
Glaucoma:	204	1.0%
Hypertension:	919	4.3%
High Cholesterol	279	1.3%
Macular Degeneration:	37	.2%

Estimated Number of Cases

Total Members:	245,446	
Diabetes?:	5,615	2.3%
Diabetic Retinopathy:	482	.2%
Glaucoma:	933	.4%
Hypertension:	24,509	10.0%
High Cholesterol	37,051	15.1%
Macular Degeneration:	302	.1%

? Patients managing their diabetes can avoid medical costs from $2,000 to over $4,000 annually versus those not managing it.

Diabetic Exam Reminder Effectiveness Report

Client: - 12049397

Reminder Year:	Reminder Month:	Reminders Sent	Received Exam Within 0-90 Days	Received Exam Within 91-180 Days	Total Exams Within 180 Days
2017	October	374	8	1	9
	November	641	49	70	119
	December	10,512	324	360	684
2018	January	740	34	30	64
	February	0	0	0	0
	March	0	0	0	0
	April	0	0	0	0
	May	0	0	0	0
	June	0	0	0	0
	July	0	0	0	0
	August	4,743	56	0	56
	September	557	7	0	7
Totals		**17,567**	**478**	**461**	**939**

LTM Effectiveness* : 5 %

12-Month Effectiveness (Apr 2017 - Mar 2018) : 8 %

* This figure does not include an estimate of those patients who will return within 90 or 180 days.
It solely calculates based upon the patients who have returned to date for letters sent within the last twelve months.

Grievance Report

- The DMHC requires KHS Management report/review quarterly grievances with the KHS Board of Directors.

Category	Q3 2018	Trend	Issue	Q2 2018	Q1 2018	Q4 2017	Q3 2017
Access to Care	59		Appointment Availability	42	34	25	26
Coverage Dispute	21		Authorizations and Pharmacy	37	45	37	44
Medical Necessity	267		Questioning denial of service	297	121	67	53
Other Issues	7		Miscellaneous	1	0	0	2
Quality of Care	30		Questioning services provided. All cases forwarded to Quality Dept.	27	31	26	46
Quality of Service	2		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	3	5	44	178
Total Grievances	386			407	236	199	349

KERN HEALTH SYSTEMS
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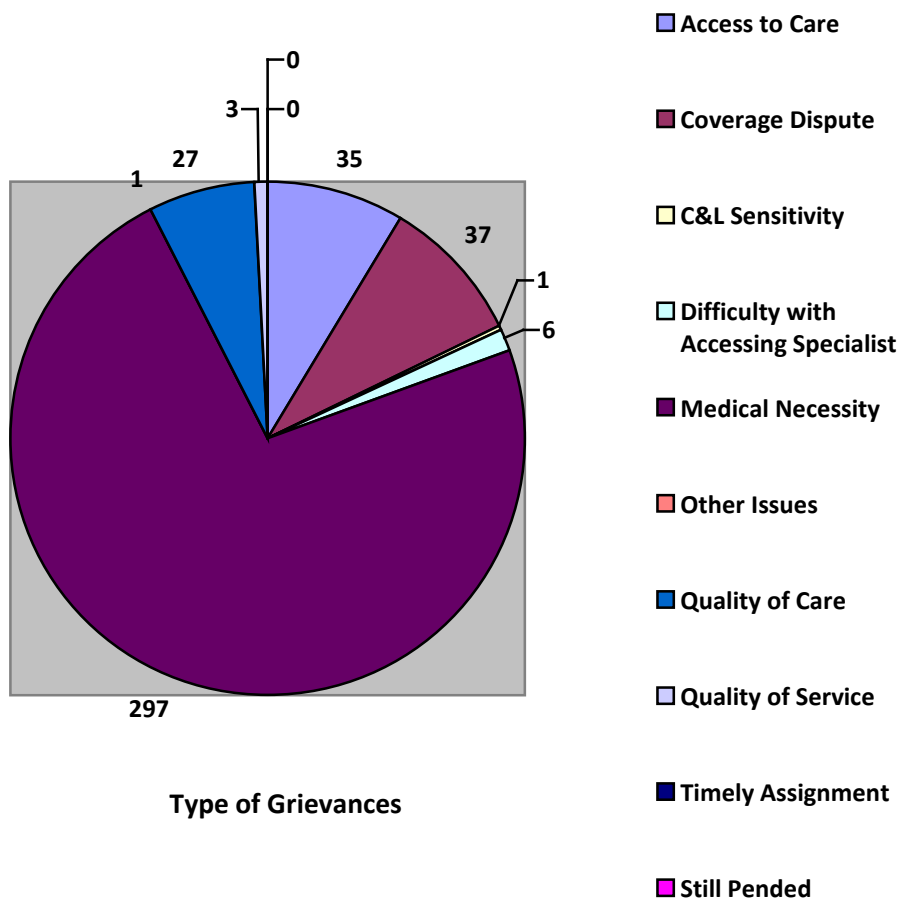
Additional Insights-Grievance Detail

Issue	3rd Quarter Grievances	Upheld Plan Decision	Overturned Ruled for Member	Still Under Review
Access to Care	52	41	8	3
Coverage Dispute	21	17	0	4
Specialist Access	7	5	0	2
Medical Necessity	267	142	92	33
Other Issues	7	2	1	4
Quality of Care	30	17	5	8
Quality of Service	2	0	2	0
Total	386	224	108	54

2nd Quarter 2018 Grievance Summary

Issue	Number	In Favor of Health Plan	In Favor of Enrollee
Access to care	35	29	6
Coverage dispute	37	37	0
Cultural and Linguistic Sensitivity	1	1	0
Difficulty with accessing specialists	6	4	2
Medical necessity	297	245	52
Other issues	1	0	1
Quality of care	27	19	8
Quality of service	3	2	1
Timely assignment to provider	0	0	0
Still under review	0	0	0



Type of Grievances

Grievances per 1,000 Members = 1.59

During the second quarter of 2018, there were four hundred and seven grievances received. Seventy cases were closed in favor of the Enrollee and three hundred and thirty seven were closed in favor of the Plan. All of the cases closed within thirty days. One hundred and five cases were received from SPD (Seniors and Persons with Disabilities) members. One hundred and fifty three were received from Medi-Cal Expansion members.

2nd Quarter 2018 Grievance Summary

Access to Care

There were thirty five grievances pertaining to access to care. Twenty nine cases closed in favor of the Plan. Six cases closed in favor of the Enrollee. The following is a summary of these issues.

Sixteen members complained about the lack of available appointments with their Primary Care Provider (PCP). Thirteen of the cases closed in favor of the Plan after the responses indicated the office provided appropriate access to care based on the Access to Care Standards for PCP appointments. Three of the cases closed in favor of the Enrollee after the responses indicated the office may not have provided appropriate access to care.

Nineteen members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Sixteen cases closed in favor of the Plan after the responses indicated the member was seen within the appropriate wait time for an appointment or the member was there as a walk-in, which are not held to Access to Care standards. Three cases closed in favor of the Enrollee after the response indicated the member was not seen within the appropriate wait time for an appointment.

Coverage Dispute

There were thirty seven grievances pertaining to a Coverage Dispute issue. All of the cases closed in favor of the Plan. The following is a summary of these issues:

Twenty three members complained about the denial of a TAR for non-formulary or restricted medications. All of these cases were found in favor of the Plan. Upon review it was determined that the TARs were appropriately denied as not a covered benefit under the KFHC Drug Formulary.

Fourteen members complained about the denial of a referral authorization request. Thirteen of these cases were closed in favor of the Plan and the decisions were upheld after it was determined that the requests were appropriately denied as the requested services were not a covered benefit or the requested providers were not contracted under KFHC. One of the cases closed in favor of the Plan as it was determined the request was appropriately denied; however, upon review of new information it was determined an exception would be made and the denial was overturned and approved.

Cultural and Linguistic Sensitivity

There was one grievance pertaining to Cultural and Linguistic Sensitivity. The case closed in favor of the Plan. The following is a summary of this case.

One member's mother complained about the lack of an in person American Sign Language (ASL) interpreter for a scheduled appointment. This case closed in favor of the Plan after it was determined that an ASL interpreter was offered via video phone for the appointment; however, member's mother declined the service.

Difficulty with Accessing a Specialist

2nd Quarter 2018 Grievance Summary

There were six grievances pertaining to Difficulty Accessing a Specialist. Four cases closed in favor of the Plan. Two cases closed in favor of the Enrollee. The following is a summary of these issues.

Four members complained about the lack of available appointments with a specialist. Two cases closed in favor of the Plan after the responses indicated the offices provided appropriate access to care based on the Access to Care Standards for specialty appointments. Two cases closed in favor of the Enrollee after the responses indicated the office did not provide appropriate access to care based on the Access to Care Standards for specialty appointments.

Two members complained about the wait time to be seen for a specialist appointment. All of the cases closed in favor of the Plan after the responses indicated the member was seen within the appropriate wait time for an appointment.

Medical Necessity

There were two hundred and ninety seven grievances pertaining to Medical Necessity. Two hundred and forty five of the cases were closed in favor of the Plan. Fifty two of the case closed in favor of the Enrollee. The following is a summary of these issues.

Two hundred and forty three members complained about the denial or modification of a referral authorization request. One hundred and thirty eight of the 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 of the requested specialist or DME item and the denials were upheld. Fifty four cases were closed in favor of the Plan as it was determined the initial denial or modification of a referral authorization request was appropriate; however, upon review of additional new information, medical necessity was met and the denial was overturned. Fifty of the cases closed in favor of the Enrollee after it was determined the authorization may have been denied inappropriately and the denials were overturned. One of the cases closed in favor of the Enrollee as member was not notified no prior authorization is needed for local specialty provider; however, the denial was upheld to send member to tertiary facility.

Fifty four members complained about the denial or modification of a TAR. Forty nine of the cases were closed in favor of the Plan as it was determined there was no supporting documentation submitted with the TAR to support the criteria for medical necessity of the requested medication and the denial was upheld. Four cases were closed in favor of the Plan as it was determined the initial denial or modification of a TAR was appropriate; however, upon review of additional new information, medical necessity was met and the denial was overturned. One of the cases closed in favor of the Enrollee after it was determined the TAR may have been denied inappropriately.

Other Issues

There was one grievance pertaining to Other Issues. This case closed in favor of the Enrollee. The following is a summary of this issue:

One member complained about what she felt was inappropriate behavior from a hospital staff member. This case closed in favor of the enrollee due to lack of response; and was left open to the plan for response. Once response was received it was determined there was no inappropriate behavior from the hospital staff member.

Quality of Care

There were twenty seven grievances involving Quality of Care issues. Nineteen cases were closed in favor of the Plan. Eight cases were closed in favor of the Enrollee. The following is a summary of these issues:

Thirteen members complained about the quality of care received from a Primary Care Provider (PCP). Nine cases were closed in favor of the Plan after it was determined that the provider or their staff provided the member with the appropriate care. Four cases closed in favor of the Enrollee after review of all medical documents and written responses received indicated that appropriate care may not have been provided.

Six members complained about the quality of care received from a specialty provider. Five of the cases were closed in favor of the Plan after it was determined that the specialist provided the member with the appropriate care. One case closed in favor of the Enrollee after review of all medical documents and written responses received indicated that appropriate care may not have been provided.

Seven members complained about the quality of care received from the provider or staff with a hospital or urgent care. Five cases closed in favor of the Plan after review of medical records and written responses received indicated that the members were provided appropriate care. Two cases closed in favor of the Enrollee after review of medical records and written responses received indicated that appropriate care may not have been provided.

One member complained about the quality of care received from the staff with a pharmacy. This case closed in favor of the Enrollee after review of medical records and written responses received indicated that appropriate care may not have been provided.

All cases were forwarded to the Quality Improvement (Q.I.) Department for review to determine if further investigation was necessary.

Quality of Service

There were three grievances pertaining to Quality of Service. Two of the cases were closed in favor of the Plan. One case closed in favor of the Enrollee. The following is a summary of these issues:

One member complained about the service they received from a provider. This case was closed in favor of the Plan after the written response was reviewed and it was determined that the service the member received was appropriate.

One member complained about the service they received from a provider and staff. This case was closed in favor of the Enrollee after the written response was reviewed and it was determined that the service the member received may not have been appropriate.

One member complained about the service they received from staff with a provider. This case was closed in favor of the Plan after the written response was reviewed and it was determined that the service the member received was appropriate.

Timely Assignment to Provider

There were no grievances pertaining to Timely Assignment to Provider received this quarter.

Kaiser Permanente Grievances

During the second quarter of 2018, there were forty one grievances and appeals received by KFHC members assigned to Kaiser Permanente. Thirty nine cases were closed in favor of the Enrollee, while two cases closed in favor of the Plan.

Access to Care

There were three grievances pertaining to Access to Care. The following is a summary of these issues.

Two members complained about the excessive wait time to be seen for an appointment. Both of these cases closed in favor of the Enrollee.

One member complained about the lack of PCP appointments available. This case closed in favor of the Enrollee.

Coverage Dispute

There were three appeals pertaining to Coverage Dispute. The following is a summary of these issues:

Three members complained about a non-covered or out-of-network service they requested; however, were not being covered. Three cases closed in favor of the Enrollee and services were provided.

Medical Necessity

There were six appeals pertaining to Medical Necessity. The following is a summary of these issues:

Six members complained about a requested service that was denied, delayed or otherwise modified. Five cases closed in favor of the Enrollee and services were provided. One case was closed in favor of the Plan.

Quality of Care

2nd Quarter 2018 Grievance Summary

There were four grievances pertaining to Quality of Care. The following is a summary of these issues:

Four members complained about the care they received from their providers or non-clinical staff. All of these cases were closed in favor of the Enrollee.

Quality of Service

There were fourteen grievances pertaining to Quality of Service. The following is a summary of these issues:

Fourteen members complained about the service they received from their providers, non-clinical staff, or the condition of a facility. Thirteen cases were closed in favor of the Enrollee. One case is still open at the time of this report.

Other Issues

There were eleven grievances pertaining to Other Issues. The following is a summary of this issue:

Two members complained about operations or policy issues. All of the cases closed in favor of Enrollee.

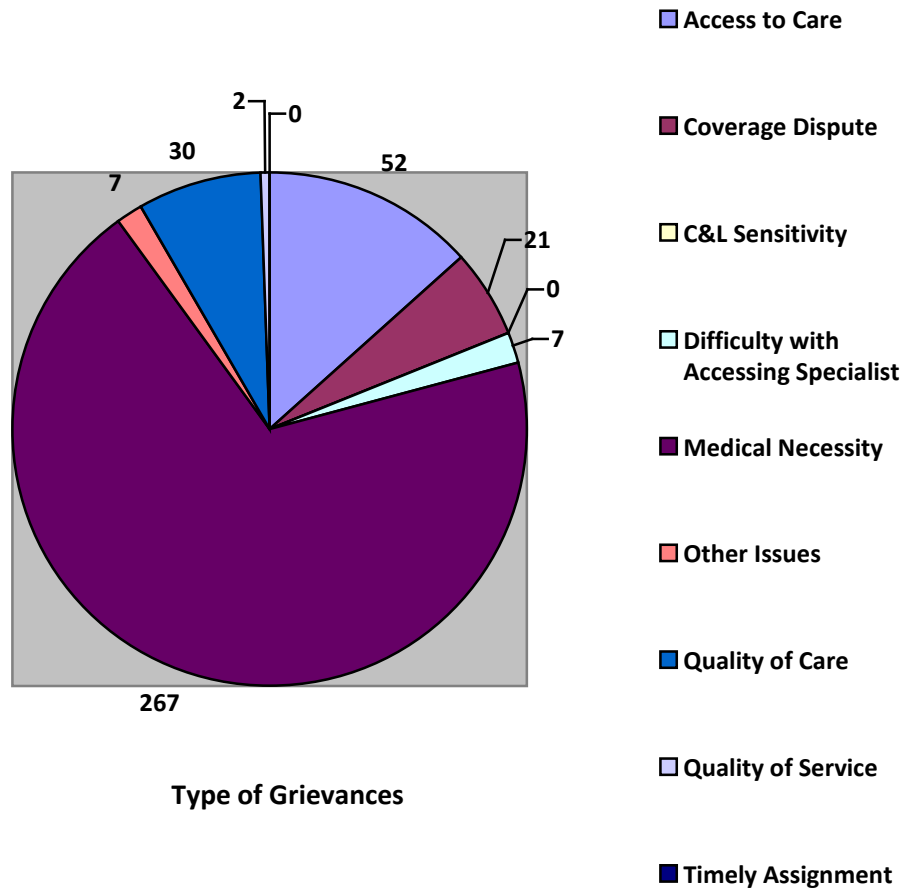
One member complained about a billing issue. This case closed in favor of the Enrollee.

Five members complained about their benefits. Four of these cases closed in favor of the Enrollee. One case closed in favor of the Plan.

Three members complained about other issues. All of these cases closed in favor of the Enrollee.

3rd Quarter 2018 Grievance Summary

Issue	Number	In Favor of Health Plan	In favor of Enrollee	Still under review
Access to care	52	41	8	3
Coverage dispute	21	17	0	4
Cultural and Linguistic Sensitivity	0	0	0	0
Difficulty with accessing specialists	7	5	0	2
Medical necessity	267	142	92	33
Other issues	7	2	1	4
Quality of care	30	17	5	8
Quality of service	2	0	2	0
Timely assignment to provider	0	0	0	0



Type of Grievances

Grievances per 1,000 Members = 1.51

During the third quarter of 2018, there were three hundred and eighty six grievances received. One hundred and eight cases were closed in favor of the Enrollee, two hundred and twenty four cases were closed in favor of the Plan and fifty four cases are still open, pending response and/or records from a provider. There was one case that was not closed within thirty days of receipt and had to be pended for further review. One hundred and seven cases were received from SPD (Seniors and Persons with Disabilities) members. One hundred and thirty six were received from Medi-Cal Expansion members.

3rd Quarter 2018 Grievance Summary

Access to Care

There were fifty two grievances pertaining to access to care. Forty one cases closed in favor of the Plan. Eight cases closed in favor of the Enrollee. Three cases are still open pending a response from the provider. The following is a summary of these issues.

Twenty six members complained about the lack of available appointments with their Primary Care Provider (PCP). Twenty three of the cases closed in favor of the Plan after the responses indicated the office provided appropriate access to care based on the Access to Care Standards for PCP appointments. Two of the cases closed in favor of the Enrollee after the responses indicated the office may not have provided appropriate access to care. One case is still open pending a response from the provider.

Twenty four members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Seventeen cases closed in favor of the Plan after the responses indicated the member was seen within the appropriate wait time for an appointment or the member was there as a walk-in, which are not held to Access to Care standards. Five cases closed in favor of the Enrollee after the response indicated the member was not seen within the appropriate wait time for an appointment. Two of the cases are still open pending a response from the provider.

Two members complained about telephone access with Primary Care Provider's (PCP) office. One of the cases closed in favor of the Plan after the response indicated the office provided appropriate telephone access. One of the cases closed in favor of the Enrollee after the response indicated the office did not provide appropriate telephone access.

Coverage Dispute

There were twenty one grievances pertaining to a Coverage Dispute issue. Seventeen of the cases closed in favor of the Plan. Four cases are still open pending records and/or review. The following is a summary of these issues:

Nine members complained about the denial of a TAR for non-formulary or restricted medications. Eight of these cases were found in favor of the Plan. Upon review it was determined that the TARs were appropriately denied as not a covered benefit under the KFHC Drug Formulary. One case is still open pending records and/or review.

Twelve members complained about the denial of a referral authorization request. Six of these cases were closed in favor of the Plan and the decisions were upheld after it was determined that the requests were appropriately denied as the requested services were not a covered benefit or the requested providers were not contracted under KFHC. Three of the cases closed in favor of the Plan as it was determined the request was appropriately denied; however, upon review of new information it was determined an exception would be made and the denial was overturned and approved. Three of the cases are still open pending records and/or review.

3rd Quarter 2018 Grievance Summary

Cultural and Linguistic Sensitivity

There were no grievances pertaining to Cultural and Linguistic Sensitivity.

Difficulty with Accessing a Specialist

There were seven grievances pertaining to Difficulty Accessing a Specialist. Five cases closed in favor of the Plan. Two cases are open pending a response from the provider. The following is a summary of these issues.

Four members complained about the lack of available appointments with a specialist. All of the cases closed in favor of the Plan after the responses indicated the offices provided appropriate access to care based on the Access to Care Standards for specialty appointments.

Three members complained about the wait time to be seen for a specialist appointment. One of the cases closed in favor of the Plan after the responses indicated the member was seen within the appropriate wait time for an appointment. Two of the cases are open pending a response from the provider.

Medical Necessity

There were two hundred and sixty seven grievances pertaining to Medical Necessity. One hundred and forty two of the cases were closed in favor of the Plan. Ninety two of the case closed in favor of the Enrollee. Thirty three of the cases are still open pending records and/or review. The following is a summary of these issues.

Two hundred and twenty seven members complained about the denial or modification of a referral authorization request. One hundred and eleven of the 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 of the requested specialist or DME item and the denials were upheld. Eighty eight of the cases closed in favor of the Enrollee after it was determined the authorization may have been denied inappropriately or additional information was received and the denials were overturned. Twenty eight of the cases are still open and pending records and/or review.

Forty members complained about the denial or modification of a TAR. Thirty one of the cases were closed in favor of the Plan as it was determined there was no supporting documentation submitted with the TAR to support the criteria for medical necessity of the requested medication and the denial was upheld. Four cases were closed in favor of the Enrollee as upon review of additional new information, medical necessity was met and the denial was overturned. Five of the cases are still open pending records and/or review.

3rd Quarter 2018 Grievance Summary

Other Issues

There were seven grievances pertaining to Other Issues. Two of the cases closed in favor of the Plan. One case closed in favor of the Enrollee. Four of the cases are still open pending response and/or records for review. The following is a summary of this issue:

One member complained that she felt her Primary Care Provider (PCP) misdiagnosed her. This case closed in favor of the Enrollee after the provider failed to send a response or records to the Plan.

One member complained that she felt staff with a Primary Care Provider (PCP) office was releasing her PHI. This case closed in favor of the Plan after the response from the provider indicated all staff is properly trained to keep PHI files confidential.

One member complained that he felt he was being discriminated against by staff with a clinic. This case closed in favor of the Plan after the response from the provider indicated the clinic does not discriminate and all patients are welcome to go in for any medical access.

One member complained that she felt staff with a transportation company was negligent during her transport. This case is still open pending response from the transportation company.

One member complained that a provider released her PHI while her family was present. This case is still open pending response from the provider.

One member's guardian complained that the staff with a clinic is not reporting abuse and mistreatment to the appropriate agencies. This case is still open pending response from the provider.

One member complained about the staff with a mental health provider not following HIPAA guidelines. This case is still open pending a response from the provider.

Quality of Care

There were thirty grievances involving Quality of Care issues. Seventeen cases were closed in favor of the Plan. Five cases were closed in favor of the Enrollee. Eight cases are still open pending a response and records from the provider. The following is a summary of these issues:

Fourteen members complained about the quality of care received from a Primary Care Provider (PCP). Nine cases were closed in favor of the Plan after review of the responses and medical records received indicated that there were no quality of care concerns identified. Three cases closed in favor of the Enrollee after review of all medical documents and written responses received indicated that the care received may have been below standard. Two cases are still open pending a response and records from the provider.

Eleven members complained about the quality of care received from a specialty provider. Four of the cases were closed in favor of the Plan after review of the responses and

medical records received indicated that there were no quality of care concerns identified. Two case closed in favor of the Enrollee after review of all medical documents and written responses received indicated that the care received may have been below standard. Five cases are still open pending a response and records from the provider.

Five members complained about the quality of care received from the provider or staff with a hospital or urgent care. Four cases closed in favor of the Plan after review of medical records and written responses received indicated that there were no quality of care concerns identified. One case is still open pending a response and records from the provider.

All cases were forwarded to the Quality Improvement (Q.I.) Department for review to determine if further investigation was necessary.

Quality of Service

There were two grievances pertaining to Quality of Service. Both of the cases were closed in favor of the Enrollee. The following is a summary of these issues:

One member complained about the service they received from a provider and their staff. This case was closed in favor of the Enrollee after the written response was reviewed and it was determined that the service the member received may have been below standard.

One member complained about the service they received from the staff of a provider. This case was closed in favor of the Enrollee after the written response was reviewed and it was determined that the service the member received may have been below standard.

Timely Assignment to Provider

There were no grievances pertaining to Timely Assignment to Provider received this quarter.

Call Center Q3 2018
Screenshot

A	B	C	D	E	F	G	H	I	J	K
Plan Name	Reporting Quarter	Number of Calls Received Do not fill in	Number of Calls Abandoned	Number of Calls Answered	Average Wait Time (H:MM:SS)	Average Talk Time (H:MM:SS)	Abandonment Rate = D/C Do not fill in	Service Level (0-100)	Member Only Calls (Y/N)	Medi-Cal Only Calls (Y/N)
KERN HEALTH SYSTEMS	Q3 2018	59900	1683	58217	0:00:39	0:07:36	2.8%	79%	Y	Y

2016-2017 COMPARATIVE TABULATED GRIEVANCES

Kern Family Health Care Grievances	1st Quarter 2018	2nd Quarter 2018	2nd Quarter 2017
Access to Care (PCP)	**25**	**35**	**7**
Difficulty Accessing Specialist	**8**	**6**	**3**
Quality of Care	**32**	**27**	**38**
Quality of Service	**2**	**3**	**163**
Medical Necessity	**127**	**297**	**14**
Coverage Dispute	**38**	**37**	**13**
Cultural and Lingustic Dissatisfaction	**3**	**1**	**1**
Other Issue	**1**	**1**	**4**
Total Grievances	**236**	**407**	**243**
MCAL (NonSPD) Grievances	**97**	**149**	**129**
SPD Grievances	**46**	**105**	**50**
Expansion Grievances	**93**	**153**	**64**
Cases Upheld by Plan	**210**	**337**	**198**
Cases Found in Favor of the Enrollee	**26**	**70**	**45**
Pending at the time of report	**0**	**0**	**0**
State Fair Hearings			
Coverage Dispute	**1**	**0**	**2**
Medical Necessity	**0**	**4**	**4**
Quality of Care	**0**	**0**	**0**
Access to Care	**0**	**0**	**0**
Quality of Service	**0**	**0**	**0**
Other Issues	**0**	**0**	**0**
Total	**1**	**4**	**6**
Cases Found in Favor of the Plan	**0**	**2**	**2**
Cases Found in Favor of the Enrollee	**0**	**0**	**0**
Waiting on Decision or Case not Heard Yet	**1**	**2**	**4**
DMHC Complaints			
Coverage Dispute	4	0	1
Medical Necessity	2	4	3
Quality of Care	0	0	0
Access to Care	0	0	0
Quality of Service	0	0	0
Other Issues	0	1	1
Total	**6**	**5**	**5**
DMHC Complaints Found in Favor of the Plan	4	3	4
DMHC Complaints Found in Favor of the Enrollee	1	2	1
Decisions Pending at the time of report	1	0	0

LEGEND OF CATEGORIES
Access to Care (PCP) - Issues related to long wait times or difficulty scheduling PCP appointments.
Difficulty Accessing Specialist - Issues related to difficulty scheduling specialty appointments.
Quality of Care - Dissatisfied with care received from provider, staff or facility staff.
Quality of Service - Dissatisfied with serive received from provider, staff or facility staff.
Medical Necessity - Appeals for denied authorization or medication requests that are denied based on medical necessity.
Coverage Dispute - Appeals for denied authorization or medication requests that are not a covered benefit under KFHC and/or FFS Medi-Cal.
Cultural and Linguistic Dissatisfaction - Issues related to a language barrier or interpretation services.
Other Issue - Any other dissatisfaction not related to any of the above categories.

2016-2017 COMPARATIVE TABULATED GRIEVANCES

Independent Medical Reviews	1st Quarter 2018	2nd Quarter 2018	2nd Quarter 2017
Delay of Services	0	0	0
Modification of Services	1	0	0
Denial of Services	7	5	4
Total	**8**	**5**	**4**
IMR Cases Found in Favor of the Plan	6	3	2
IMR Cases Found in Favor of the Enrollee	1	2	1
Decisions Pending at the time of report	1	0	1
Enrollment Counts vs Grievances Received Per Quarter - Total Enrollment			
Total Enrollment	253,166	255,611	249,461
Grievances per 1,000 Members	0.93	1.59	0.97
Percentage of Grievances	0.093%	0.159%	0.097%
Enrollment Counts vs Grievances Received Per Quarter - MCAL (Non SPD) Members			
Total Enrollment	238,732	240,837	235,456
Grievances per 1,000 Members	0.80	0.62	0.85
Percentage of Grievances	0.080%	0.062%	0.085%
Enrollment Counts vs Grievances Received Per Quarter - SPD Members			
Total Enrollment	14,434	14,774	14,005
Grievances per 1,000 Members	3.19	7.11	3.57
Percentage of Grievances	0.31%	0.71%	0.36%
Enrollment Counts vs Grievances Received Per Quarter - Expansion Members			
Total Enrollment	60,008	61,182	58,690
Grievances per 1,000 Members	1.55	2.50	1.09
Percentage of Grievances	0.16%	0.25%	0.10%

KERN HEALTH SYSTEMS
3rd Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: October 1, 2018

Department: Provider Relations

Monitoring Period: July 1, 2018 through September 30, 2018

Population:

Providers	Credentialed	Recredentialed
MD's	50	39
DO's	8	1
AU's	0	0
DC's	1	0
AC's	0	0
PA's	7	5
NP's	9	4
CRNA's	0	1
DPM's	1	2
OD's	1	0
ND's	0	0
RD's	0	0
BCBA's	5	0
Mental Health	3	0
Ocularist	0	0
Ancillary	4	7
OT	0	0
TOTAL	**89**	**59**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	0	0	0	0
Allergy & Immunology	0	0	0	0
Anesthesiology / CRNA	0	1	1	0
Audiology	0	0	0	0
Autism / Behavioral Analyst	5	0	5	0
Cardiology	0	1	1	0
Chiropractor	1	0	1	0
Colon & Rectal Surgery	0	0	0	0
Critical Care	0	1	1	0
Dermatology	4	7	11	0
Emergency Medicine	0	2	2	0
Endocrinology	3	1	4	0
Family Practice	11	1	12	0
Gastroenterology	1	0	1	0
General Practice	2	1	3	0
General Surgery	2	4	6	0
Genetics	0	0	0	0
Gynecology	0	0	0	0

KERN HEALTH SYSTEMS
3rd Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Gynecology/Oncology	0	0	0	0
Hematology/Oncology	0	0	0	0
Hospitalist	0	0	0	0
Infectious Disease	1	0	1	0
Internal Medicine	22	4	26	0
Mental Health	3	0	3	0
Mid Wife	0	0	0	0
Naturopathic Medicine	0	0	0	0
Neonatology	0	0	0	0
Nephrology	1	2	3	0
Neurological Surgery	0	3	3	0
Neurology	4	3	7	0
Obstetrics & Gynecology	1	1	2	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	0	3	3	0
Optometry	1	0	1	0
Orthopedic Surgery / Hand Surg	0	1	1	0
Otolaryngology	1	0	1	0
Pain Management	1	3	4	0
Pathology	0	0	0	0
Pediatrics	5	2	7	0
Physical Medicine & Rehab	1	1	2	0
Plastic Sugery	0	1	1	0
Podiatry	1	2	3	0
Psychiatry	7	1	8	0
Pulmonary	0	2	2	0
Radiation Oncology	0	0	0	0
Radiology	6	3	9	0
Registered Dieticians	0	0	0	0
Rheumatology	2	2	4	0
Sleep Medicine	0	1	1	0
Thoracic Surgery	0	0	0	0
Vascular Medicine	0	0	0	0
Vascular Surgery	0	0	0	0
Urology	0	0	0	0
KHS Medical Directors	0	0	0	0
TOTAL	**86**	**54**	**140**	**0**

KERN HEALTH SYSTEMS
3rd Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Ambulance	0	0	0	0
Cardiac Sonography	0	0	0	0
Comm. Based Adult Services	0	0	0	0
Dialysis Center	0	0	0	0
DME	1	0	1	0
Hearing Aid Dispenser	0	0	0	0
Home Health	0	0	0	0
Home Infusion/Compounding	0	0	0	0
Hospice	0	0	0	0
Hospital	0	1	1	0
Laboratory	1	0	1	0
Lactation Consultant	0	0	0	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	2	2	4	0
Pharmacy/DME	0	1	1	0
Physical / Speech Therapy	0	0	0	0
Prosthetics & Orthotics	0	0	0	0
Radiology	0	1	1	0
Skilled Nursing	0	0	0	0
Sleep Lab	0	1	1	0
Surgery Center	0	0	0	0
Transportation	0	0	0	0
Urgent Care	0	1	1	0
TOTAL	**4**	**7**	**11**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS
3rd Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

KERN HEALTH SYSTEMS
3rd Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

	A	B	C	D	E	F
1	NAME	LEGAL NAME AND ADDRESS	Specialty	Provider #	Pay To #	Effective
2	***NEW CONTRACTS***					
3	Healthquest Esoterics, Inc.	Healthquest Esoterics Inc 9805 Research Drive Irvine CA 92618	Laboratory	PRV046037	PRV046037	**Yes** **Eff 9/1/18**
4	Optimal Health Pharmacy, Inc	Optimal Health Pharmacy, Inc. DBA: Optimal Pharmacy 700 Airport Drive Unit C Bakersfield CA 93308	Pharmacy	PRV046747	PRV046747	**Yes** **Eff 9/1/18**
5	Penrose, James DO	Hospitalist Medicine Physicians of California, Inc. dba: Sound Physicians of California III 2615 Chester Avenue Bakersfield CA 93301	Hospitalist / IM	PRV044680	PRV014433	**Yes** **Retro Eff 8/1/18**
6	ZOLL Services, LLC	ZOLL Services, LLC 121 Gamma Drive Pittsburgh PA 15238	DME Supplier	PRV001866	PRV001866	**Yes** **Eff 9/1/18**
7	Americare Corporation	5301 Office Park Drive Ste. 305 Bakersfield CA 93309	Imaging Center	Pending	Pending	**Yes** **Eff 9/1/18**
8	***EXISTING CONTRACTS***					
9	Al Shaer, Adnan MD	Central California Hospitalists 1401 Garces Highway Bakersfield CA 93215	Hospitalist / IM	PRV001478	PRV013660	**Yes** **Eff 9/1/18**
10	Aw, Than MD	Omni Family Health *Floats at all Omni Locations 210 N. Chester Avenue Bakersfield CA 93306	Internal Medicine	PRV044479	PRV000019	**Yes** **Eff 9/1/18**
11	Banta, Brady MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Drive Bakersfield CA 93309	Diagnostic Radiology	PRV046224	ALL SITES	**Yes** **Eff 9/1/18**
12	Caprioli, Pamela NP, PA	Sumeet Bhinder, MD Inc. 6001-A Truxtun Avenue Ste. 160 Bakersfield CA 93309	Rheumatology	PRV006640	PRV000285	**Yes** **Eff 9/1/18**
13	Cesar, Analene NP-C	LAGS Spine and Sportscare Medical Centers, Inc. 3550 Q Street Ste. 103-105,201,202 Bakersfield CA 93301	Physical Medicine & Rehab	PRV046842	PRV000403	**Yes** **Eff 9/1/18**
14	Dains, Bruce PA	Centric Health dba: Jasleen Duggal, MD 3008 Sillect Avenue Ste. 220 Bakersfield CA 93308	Endocrinology	PRV004600	PRV000503	**Yes** **Eff 9/1/18**
15	Franke, Ryan MD	Renaissance Imaging Medical Assoc Inc *All locations 44105 W. 15th Street Ste. 100 Lancaster CA 93534	Diagnostic Radiology	PRV046651	PRV000324	**Yes** **Eff 9/1/18**
16	Gabrillo, Josephine NP-C	Kern County Neurological Medical Group 1705 28th Street Bakersfield CA 93301	Neurology	PRV046462	PRV000308	**Yes** **Eff 9/1/18**
17	Garbell, Gina PsyD	Omni Family Health 210 N. Chester Avenue Bakersfield CA 93308	Psychology	PRV045848	PRV000019	**Yes** **Eff 9/1/18**
18	Gonzalez, Sara BCBA	MAPSS 2225 E Street Ste. 100 Bakersfield CA 93301	Behavior Analyst / Qualified Autism Services Provider	PRV045342	PRV014034	**Yes** **Eff 9/1/18**

	A	B	C	D	E	F
19	Goraya, Nadeem MD	West Side Family Health Care dba: West Side Family Health Care - Primary Care 100 E. North Street Taft CA 93268	Family Practice	PRV044121	PRV000306	**Yes** **Eff 9/1/18**
20	Gunda, Sateesh MD	Omni Family Health 4600 Panama Lane Ste. 102B 210 N. Chester Avenue 1014 Calloway Drive Bakersfield CA 93313, 93308, 93312	Psychiatry	PRV046135	PRV000019	**Yes** **Eff 9/1/18**
21	Hayes, Joseph DO	Omni Family Health *Floats at all Omni Locations 210 N. Chester Avenue Bakersfield CA 93306	Internal Medicine & Pediatrics	PRV045987	PRV000019	**Yes** **Eff 9/1/18**
22	Hettinger, Heather BCBA	Behavior Frontiers, LLC 5401 Business Park South Ste. 210 Bakersfiel d CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV046844	PRV046025	**Yes** **Eff 9/1/18**
23	Jacques, Thomas MD	The Pain Institute of California 9802 Stockdale Highway Ste. 105 Bakersfield CA 93311	Pain Medicine	PRV012141	PRV000510	**Yes** **Eff 9/1/18**
24	Javdan, Parviz MD	Advanced Gastro Medical Associates dba: Institute Of Advanced Gastroenterology 9802 Stockdale Highway Ste. 102 Bakersfield CA 93311	Gastroenterology	PRV001668	PRV000330	**Yes** **Eff 9/1/18**
25	Mader, Helen BCBA	Behavior Frontiers, LLC 5401 Business Park South Ste. 210 Bakersfiel d CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV046843	PRV046025	**Yes** **Eff 9/1/18**
26	Manzer, Ferwa PA-C	LA Laser Center PC 5600 California Avenue Ste. 101 & 103 Bakersfield CA 93309	Dermatology	PRV044384	PRV013922	**Yes** **Eff 9/1/18**
27	Michalak, John, PA-C	Emergency Physicians Urgent Care, Inc. Accelerated Urgent Care *All Locations 9500 Stockdale Highway Ste. 100 Bakersfield CA 93311	Family Practice / Urgent Care	PRV046845	ALL SITES	**Yes** **Eff 9/1/18**
28	Mitchell, Dana NP-C	Kern County Hospital Authority dba: Kern Medical 1111 Columbus Street 1700 Mt Vernon Avenue Bakersfield CA 93305	OB/GYN	PRV045613	ALL SITES	**Yes** **Eff 9/1/18**
29	Momtahen, Amir MD	Renaissance Imaging Medical Assoc Inc *All locations 44105 W. 15th Street Ste. 100 Lancaster CA 93534	Diagnostic Radiology	PRV046846	PRV000324	**Yes** **Eff 9/1/18**
30	Muchinyi, Stephen PA-C	Emergency Physicians Urgent Care, Inc. Accelerated Urgent Care *All Locations 9500 Stockdale Highway Ste. 100 Bakersfield CA 93311	Family Practice / Urgent Care	PRV037922	ALL SITES	**Yes** **Eff 9/1/18**
31	Rizkalla, Wedad MD	Kern County Hospital Authority dba: Kern Medical 1111 Columbus Street Bakersfield CA 93305	Pediatrics	PRV000549	ALL SITES	**Yes** **Eff 9/1/18**

	A	B	C	D	E	F
32	Schmidt, Keilla MD	Kern County Hospital Authority dba: Kern Medical 1700 Mt Vernon Avenue Bakersfield CA 93306	General Surgery / Surgical Critical Care	PRV044933	ALL SITES	**Yes** **Eff 9/1/18**
33	Singh, Atam MD	Centric Health dba: Jasleen Duggal, MD 3008 Sillect Avenue Ste. 220 Bakersfield CA 93308	Endocrinology	PRV045986	PRV000503	**Yes** **Eff 9/1/18**
34	TerKonda, Raj MD	Kern County Hospital Authority dba: Kern Medical 1700 Mt Vernon Avenue Bakersfield CA 93306	Otolaryngology	PRV046134	ALL SITES	**Yes** **Eff 9/1/18**

Kern Health Systems
Board Approved Effective 08/01/18 and 09/01/18

Name	DBA	Address	Provider #	Pay To #	Contract Effective Date
Americare Corporation	Acoustic Imaging Services	5301 Office Park Drive Ste. 305 Bakersfield CA 93309			09/01/2018
Healthquest Esoterics, Inc	Healthquest Esoterics, Inc	9805 Research Drive Irvine CA 92618	PRV046037	PRV046037	09/01/2018
Hospital Medicine Physicians of California, Inc.	Sound Physicians	2615 Chester Avenue Bakersfield CA 93301	PRV044680	PRV014433	Retro-Eff 8/1/2018
Optimal Health Pharmacy	Optimal Pharmacy	700 Airport Drive Unit C Bakersield CA, 93308	PRV046747	PRV046747	09/01/2018
Zoll Services, LLC	Zoll Lifecor Corp.	121 Gamma Drive Pittsburg, PA 15238	PRV001866	PRV001866	09/01/2018

KERN HEALTH SYSTEMS
3rd Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: October 1, 2018

Department: Provider Relations

Monitoring Period: July 1, 2018 through September 30, 2018

Population:

Providers	Credentialed	Recredentialed
MD's	50	39
DO's	8	1
AU's	0	0
DC's	1	0
AC's	0	0
PA's	7	5
NP's	9	4
CRNA's	0	1
DPM's	1	2
OD's	1	0
ND's	0	0
RD's	0	0
BCBA's	5	0
Mental Health	3	0
Ocularist	0	0
Ancillary	4	7
OT	0	0
TOTAL	**89**	**59**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	0	0	0	0
Allergy & Immunology	0	0	0	0
Anesthesiology / CRNA	0	1	1	0
Audiology	0	0	0	0
Autism / Behavioral Analyst	5	0	5	0
Cardiology	0	1	1	0
Chiropractor	1	0	1	0
Colon & Rectal Surgery	0	0	0	0
Critical Care	0	1	1	0
Dermatology	4	7	11	0
Emergency Medicine	0	2	2	0
Endocrinology	3	1	4	0
Family Practice	11	1	12	0
Gastroenterology	1	0	1	0
General Practice	2	1	3	0
General Surgery	2	4	6	0
Genetics	0	0	0	0
Gynecology	0	0	0	0

KERN HEALTH SYSTEMS
3rd Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Gynecology/Oncology	0	0	0	0
Hematology/Oncology	0	0	0	0
Hospitalist	0	0	0	0
Infectious Disease	1	0	1	0
Internal Medicine	22	4	26	0
Mental Health	3	0	3	0
Mid Wife	0	0	0	0
Naturopathic Medicine	0	0	0	0
Neonatology	0	0	0	0
Nephrology	1	2	3	0
Neurological Surgery	0	3	3	0
Neurology	4	3	7	0
Obstetrics & Gynecology	1	1	2	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	0	3	3	0
Optometry	1	0	1	0
Orthopedic Surgery / Hand Surg	0	1	1	0
Otolaryngology	1	0	1	0
Pain Management	1	3	4	0
Pathology	0	0	0	0
Pediatrics	5	2	7	0
Physical Medicine & Rehab	1	1	2	0
Plastic Sugery	0	1	1	0
Podiatry	1	2	3	0
Psychiatry	7	1	8	0
Pulmonary	0	2	2	0
Radiation Oncology	0	0	0	0
Radiology	6	3	9	0
Registered Dieticians	0	0	0	0
Rheumatology	2	2	4	0
Sleep Medicine	0	1	1	0
Thoracic Surgery	0	0	0	0
Vascular Medicine	0	0	0	0
Vascular Surgery	0	0	0	0
Urology	0	0	0	0
KHS Medical Directors	0	0	0	0
TOTAL	**86**	**54**	**140**	**0**

KERN HEALTH SYSTEMS
3rd Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Ambulance	0	0	0	0
Cardiac Sonography	0	0	0	0
Comm. Based Adult Services	0	0	0	0
Dialysis Center	0	0	0	0
DME	1	0	1	0
Hearing Aid Dispenser	0	0	0	0
Home Health	0	0	0	0
Home Infusion/Compounding	0	0	0	0
Hospice	0	0	0	0
Hospital	0	1	1	0
Laboratory	1	0	1	0
Lactation Consultant	0	0	0	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	2	2	4	0
Pharmacy/DME	0	1	1	0
Physical / Speech Therapy	0	0	0	0
Prosthetics & Orthotics	0	0	0	0
Radiology	0	1	1	0
Skilled Nursing	0	0	0	0
Sleep Lab	0	1	1	0
Surgery Center	0	0	0	0
Transportation	0	0	0	0
Urgent Care	0	1	1	0
TOTAL	**4**	**7**	**11**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS
3rd Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

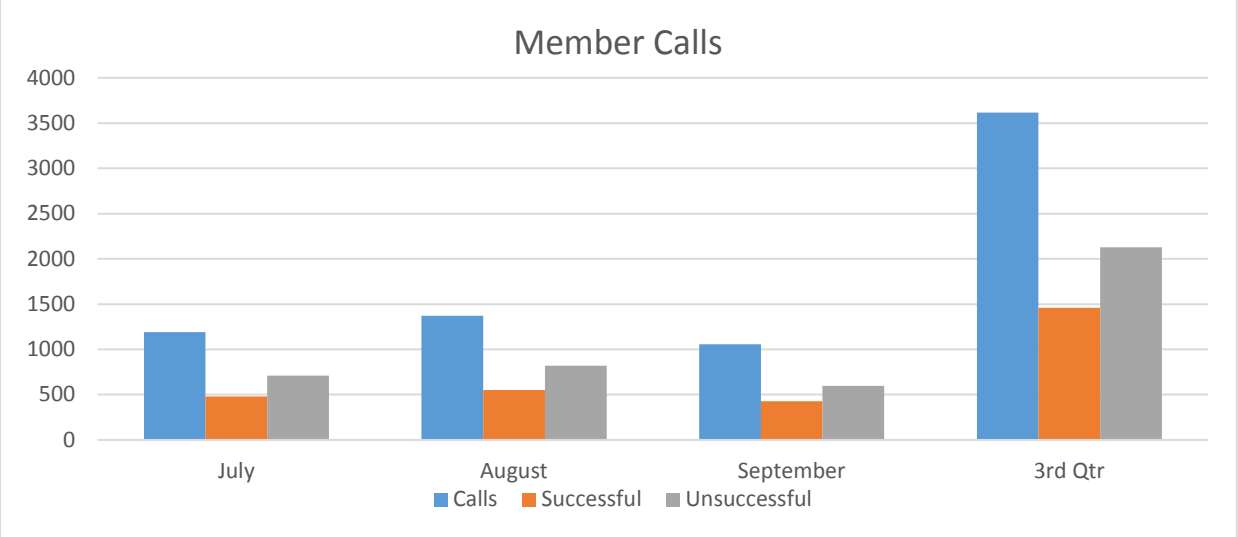
KERN HEALTH SYSTEMS
3rd Quarter 2018
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Disease Management Monthly Report

3rd Quarter 2018

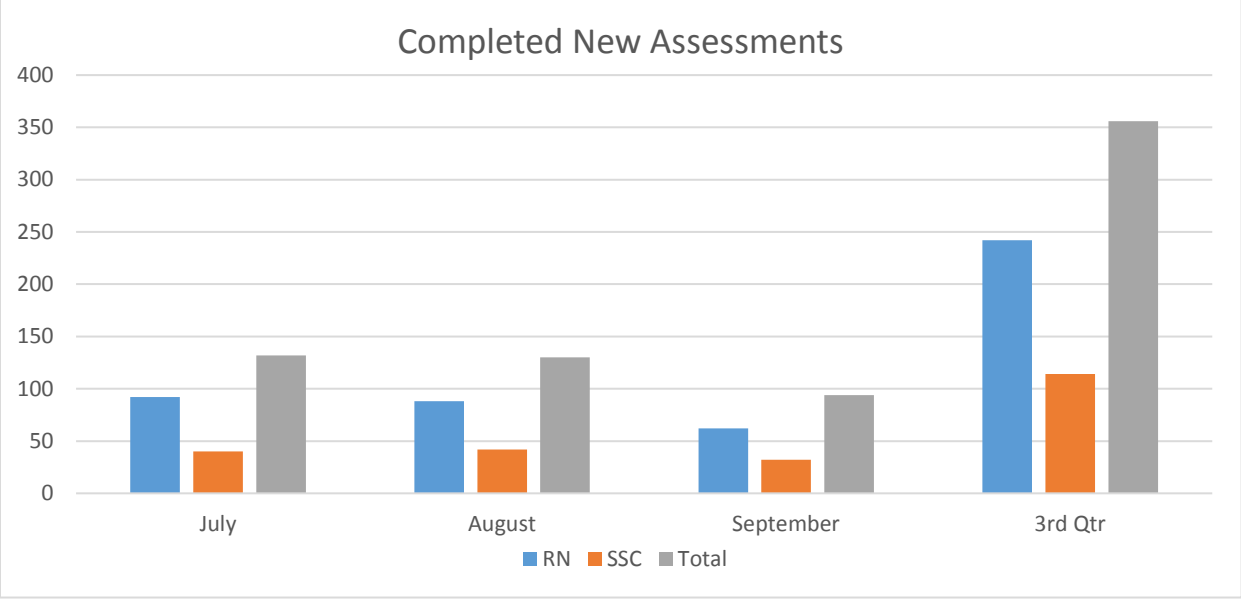
Member Calls: 3RD Quarter, 2018. 3,587 calls were made to 1,722 members.

Calls Attempted	Successful Calls	Unsuccessful Calls	Total Calls	% Contacted
RN	905	1,379	2284	40%
SSC	554	749	1.303	43%
Total	**1,459**	**2,128**	**3,587**	**41%**



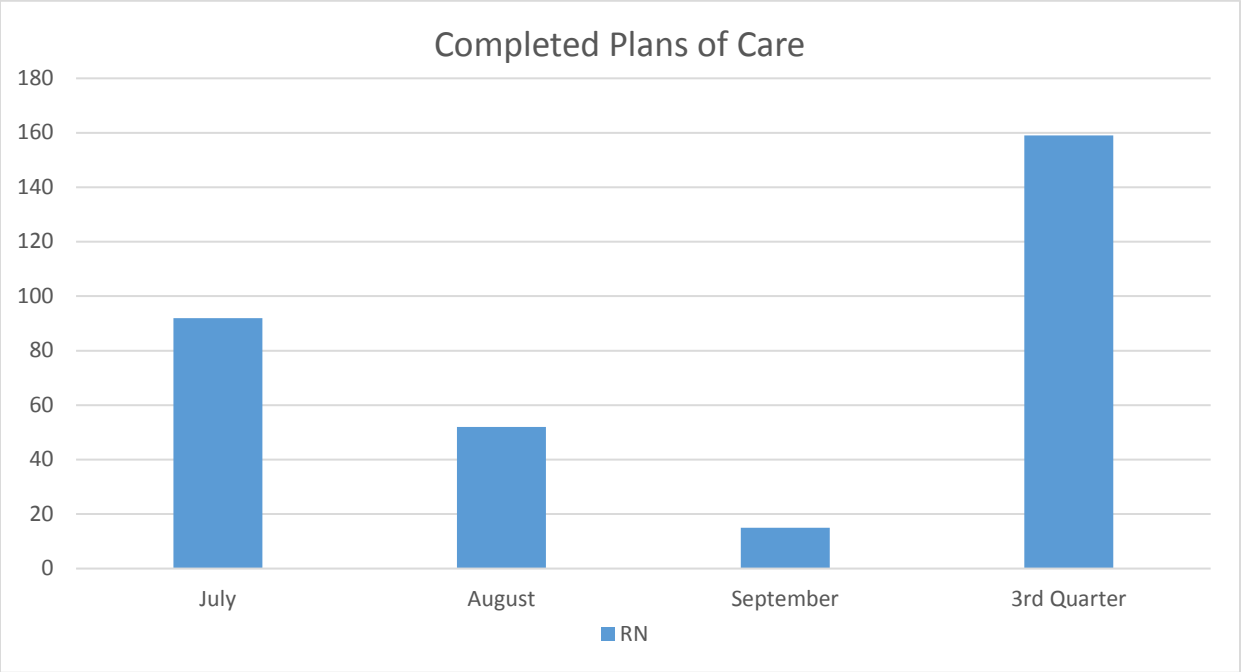
New Assessments Completed: 3RD Quarter, 2018

RN	SSC	Total
242	114	356



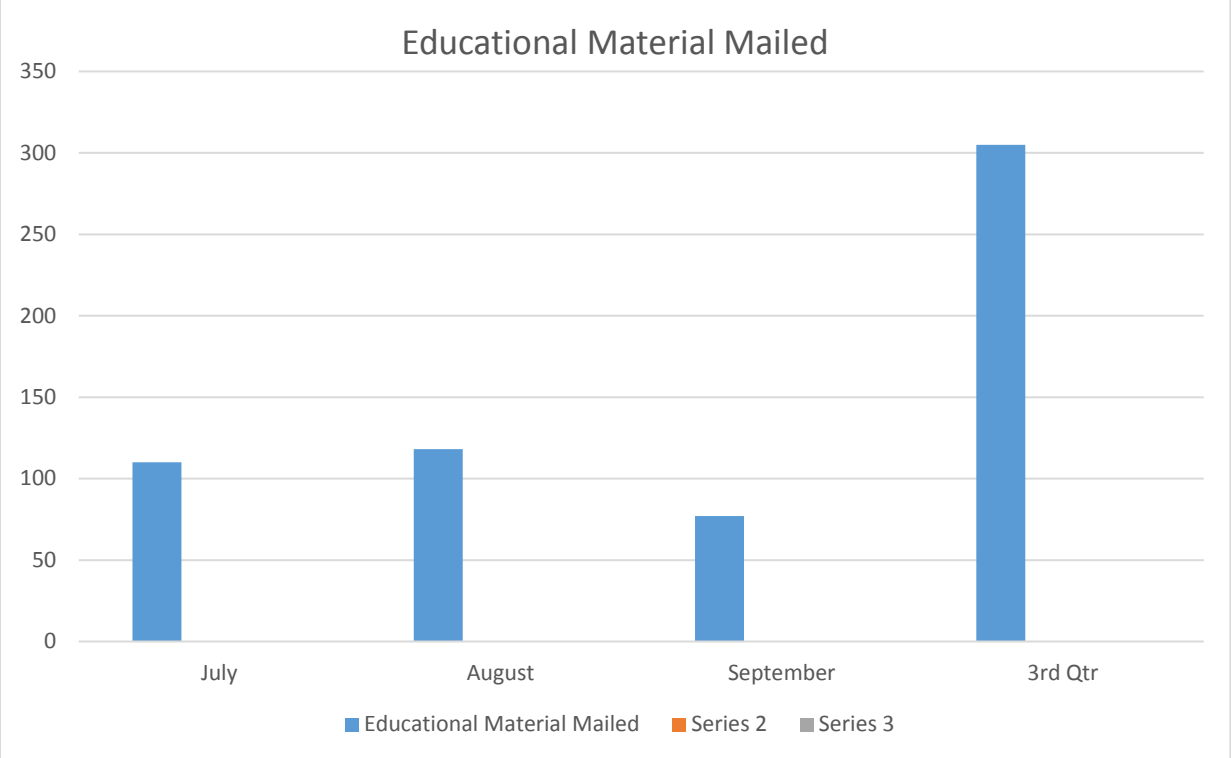
Plans of Care Completed & Closed: 3rd Quarter, 2018

RN
159



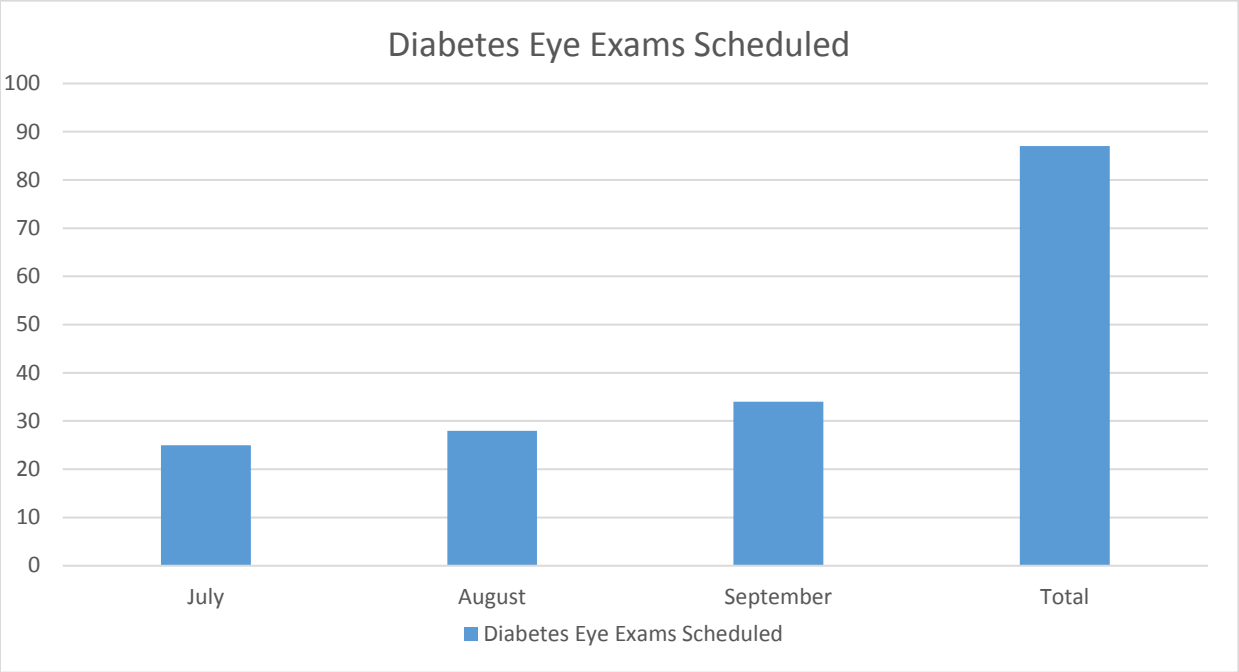
Educational Material Mailed: 3ed Quarter, 2018

305



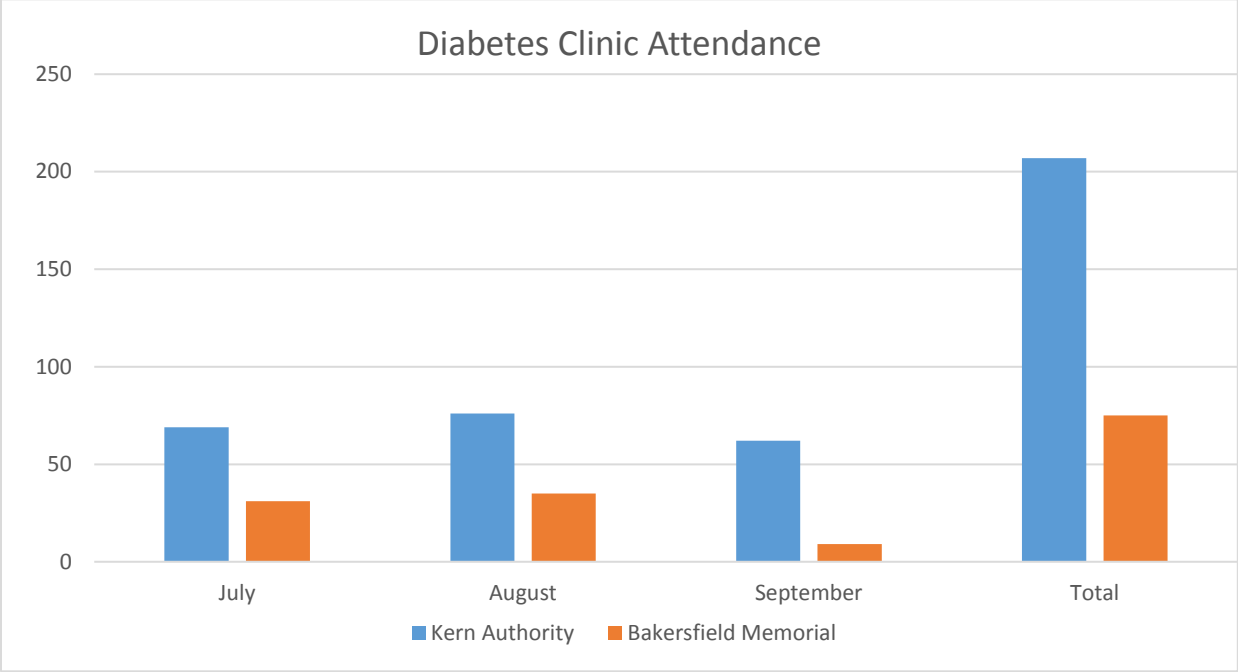
Diabetes Eye Exams Scheduled: 3rd Quarter, 2018

87



Diabetes Clinic Attendance: 3rd Quarter, 2018.

Kern Authority	Bakersfield Memorial	Total
207	75	282



KHS POLICIES & PROCEDURES MANUAL
October 2018 – Notice of Changes

Electronic copies of all policies are available on the KHS website.

REVISED TABLE OF CONTENTS

The *Table of Contents* has been updated and is available on the KHS website.

REVISED DOCUMENTS

The following policies were added to the Policy & Procedures website. The old version of the policy was replaced with the new version.

Policy No.	Revision No.	Replaces	Changes of Interest to Staff
2.11-I Group Needs Assessment	07/2018	2017-02	Policy updated to comply with APL 17-002 Health Education and Cultural and linguistic Group Needs Assessment.
3.40-I Continuity of Care for New Members	08/2018	2018-05	New section added to comply with APL 18-008. New language regarding transition.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Group Needs Assessment				POLICY #: 2.11-I	
DEPARTMENT: Health Services - Quality Improvement					
Effective Date:	Review/Revised Date:	DMHC		PAC	
04/2005	07/25/2018~~02/07/2017~~	DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date_____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Administrative Director of Health Services ~~Director of Health Education, Cultural and Linguistics~~

_____ Date _____
Director of Health Education, Cultural and Linguistics ~~Administrative Director of Health Services~~

~~–~~POLICY:

Kern Health System (KHS) will identify health education and cultural/linguistic needs of members through a group needs assessment process. The needs assessment will facilitate the development and implementation of effective health education and promotion programs as well as cultural/linguistic services. Additionally, KHS will identify community health education and promotion resources, which will assist in the delivery of culturally competent and linguistically appropriate programs and services.

GNA that will be used for the continuous development and improvement of contractually required health education and cultural/linguistic programs and services.

PROCEDURES:

1.0 INITIAL PLANNING

The timeline for completion of the GNA are as indicated below or more frequently as required for contract compliance.

A. October 15, 202~~1~~1, and every five years thereafter. If October 15 falls on a weekend, the due date will be the following Monday.

1. ~~1.~~ Health Education and Cultural Linguistics Work Plan - ~~GNA Update~~-annually, except in the year the full GNA is due.

Oversight and administration of the GNA is conducted by a full-time health educator with a master's degree in community or public health education (MPH).

2.0 NEEDS ASSESSMENT DESIGN AND INFORMATION COLLECTION

For each specific needs assessment, a needs assessment team is assembled which includes, but is not limited to department representatives from Health Education, Cultural and Linguistics, Marketing, Member Services, Quality Improvement, Disease Management, Health Services, and IT. Additionally, input is solicited from the Public Policy/Community Advisory Committee (PP/CAC).

The needs assessment identifies the following for KHS members:

A. Demographic profile
B. Member health status and behaviors
C. Member cultural and linguistic need
D. Community health education and cultural and linguistic program and resources
E. Health disparities and gaps in services
F. Unique needs of KHS member, including:
   - Seniors and Persons with disabilities
   - Members with special healthcare needs
   - Members with limited English proficiency
   - Members from diverse cultural and linguistic backgrounds

In addition the GNA assesses the internal systems in place to address the cultural and linguistic needs of members, including but not limited to, assessing KHS's capacity to provide linguistically appropriate services.

Quantitative, qualitative, primary, secondary, analyzed, and in "raw" form data sources are used. The methodology used for the GNA includes research, surveys, and analysis of data.

The Health Education department conducts research on census data, such as demographic characteristics, geographic distribution, health status indicators and existing data of our membership. State, county and KHS comparisons are made.

Previously completed community needs assessments are collected to supplement the development of the GNA. Existing needs assessment and reports are reviewed for health indicators, priority needs and gaps in health service for low-income populations. National objectives such as, Healthy People 2020, are used as a source of information on areas of health

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promotion, health protection and preventative services. The membership database is used to profile member's age, gender, race, and language. Top five~~ten~~ inpatient and outpatient claims diagnoses for members are assessed through analysis of claims data. Top five~~ten~~ medications for members is also assessed through analysis of pharmacy data. HEDIS and CAHPS data are used to identify areas of improvement and health indicators in relation to member's care.

Community input is obtained through the ~~-~~PP/CAC survey. The PP/CAC survey solicits information of health needs and barriers to services for members. (See Attachment C).

When possible KHS will make a good faith effort to work in close collaboration with policy level committees, the public health department and community based organizations in implementing the needs assessment.

2.1 Member Surveys

Standardized questions have been developed by DHCS and the statewide Health Education and Cultural Linguistics Workgroup. DHCS will ensure that surveys are translated into all threshold languages and made available to KHS. KHS may include additional questions at the end of the standardized survey. KHS must complete a minimum of 411 GNA Member Surveys. A completed survey is any survey with five or more DHCS developed questions answered. Additionally, the 411 Member Surveys must only be completed by members who have been enrolled in KHS for at least six continuous months. ~~These questions are incorporated in the cultural/linguistic and health education member survey to identify the health education and cultural and linguistic needs of KHS members. (See Attachment B).~~ Survey participants who meet the aforementioned criteria are drawn from the membership database. A representative random sample is drawn based on the suggested sampling method provided by DHCS as well as the ethnic and language characteristic of our members~~.~~ (See Attachment B). ~~Accommodations, such as translation of the survey and identification of bilingual surveyors, are implemented.~~

2.2 Additional Consumer/Member Input

Additional member input is obtained through the KHS contracted 24-hour nurse advice and triage service. The contracted 24-hour nurse advice and triage service submits monthly reports of all calls received from members, the reason for the call and the call disposition. This information is indicative of the health needs of KHS members.

3.0 INFORMATION TABULATION AND ANALYSIS

Once all the survey tools have been completed, the Health Education department~~Manager and staff~~ tabulates and analyzes the data.

4.0 PRIORITY SETTING AND PROGRAM DEVELOPMENT

The GNA and the subsequent annual updates provide the substantive foundation for key decisions which become the basis for continuous program planning in Health Education and Cultural/Linguistic services. The GNA team convenes and decides on steps or actions to be planned based on the GNA findings. Input from the PP/CAC is also solicited at this planning stage.

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The results of the GNA will also be considered in the development of any Marketing materials prepared by KHS.

5.0 PROVIDER TRAINING

Provider education and training regarding the GNA findings and how KHS proposes to address the identified needs is available through provider bulletins and ~~,~~ provider portal ~~and the KHS website~~. KHS staff trainings will be provided as necessary.

6.0 REPORTING

Upon completion of the GNA, an Executive Summary of the GNA Report (See Attachment A) and Excel Survey Data Template ~~is~~are submitted to DHCS (See Attachment D~~A~~). KHS will have the complete GNA Report available for DHCS review upon request. The Executive Summary of the GNA Report shall consist of no more than five~~two~~ pages and include the following:

A. Data sources and methods
B. Member demographics
C. Member health status, disease prevalence, gap analysis
D. Understanding the cultural/linguistic and health education member needs
E. Conclusions and planned actions, including comparison to the previous and current activities.

The Excel Survey Data templated uses the Code Books developed by DHCS to report information (See Attachment E). ~~KHS' annual work plan shall incorporate and reflect findings from the GNA Report and annual GNA Update. The work plan shall include implementation activities, timelines with milestones, responsible individuals, and the individual with overall responsibility.~~

The Executive Summary and~~,~~ GNA Report ~~and work plan~~ is distributed to KHS administrators and management, and committee members.

6.1 Annual Work Plan~~Updates~~

Beginning in 2017, KHS will submit ~~an~~ annual work plan ~~GNA report~~ to DHCS health education mailbox on an annual basis~~in November of each year~~ on October 15th ~~of each year, except in the year the full GNA report is due.~~. KHS' annual work plan shall incorporate and reflect findings from the GNA Report and from annual and ongoing review of data, such as beneficiary demographics, claims and encounter data, HEDIS rates, CAHPS data, and beneficiary health status. The annual work plan will include goals and objectives, implementation activities, timelines, and responsible individuals. The work plan may be a standalone document or the information can be submitted as part of the QI programs description and/or QI evaluation.

~~The update will include the following information on our members:~~

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~~A. Demographic changes~~
~~B. New health disparities or changes in health outcomes~~
~~C. Changes in HEDIS, CAHPS or other survey findings~~
~~D. New health education, quality improvement and cultural/linguistic programs and resources~~
~~New program needs and how they will be addressed~~

~~Additionally, KHS will maintain documentation of program priorities, target populations, and program goals/objectives as they are revised to meet the identified and changing need of our membership.~~

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ATTACHMENTS:

- Attachment A: GNA Report format
- Attachment B: GNA Member Survey and Randomization Methodology
- Attachment C: Public Policy/Community Advisory Committee Survey
- Attachment D: GNA Excel Survey Data Template
- Attachment E: GNA Code Books for Mail and Phone Surveys

REFERENCE:

Revision 2018~~87~~-06~~1~~: Policy updated to comply with APL 17-002. **Revision 2017-01:** Policy updated by Health Education & Disease Management Manager. **Revision 2013-07:** Major revision provided by Quality Improvement Department. Policy should be reviewed in its entirety. **Revision 2010-05:** Routine review provided by Director of Quality Improvement, Health Education and Disease Management. **Revision 2009-07:** Revised by Director of Quality Improvement, Health Education and Disease Management. **Revision 2008-04:** Routine revision. Not reviewed by the AIS Department. **Revision 2005-04:** Revised to comply with DHS Contract 03-76165 (Effective May 1, 2004). Formulary #30.01renumbered to fit in new numbering scheme. **Revision 2002-02:** Created for NCQA compliance.

[1] References: DHS Contract §6.7.7.7; MMCD Policy Letter 99-02; and MRMIB Contract § III C (3)

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Continuity of Care for New Members				POLICY #: 3.40-I	
DEPARTMENT: Health Services - Utilization Management					
Effective Date: 01/1996	Review/Revised Date: 08/23/2018~~08/01/2018~~~~05/03/2018~~	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date

Douglas A. Hayward
Chief Executive Officer

_____ Date

Chief Medical Officer

_____ Date

Chief Operating Officer

_____ Date

Director of Provider Relations

_____ Date

Administrative Director of Health Services

POLICY:
Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care health plan (MCP) have the right to request continuity of care in accordance with state law and the KHS contract~~s~~, with some exceptions. All KHS members with pre-existing provider relationships who make a continuity of care request to KHS must be given the option to continue treatment for up to 12 months with an out-

of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another ~~MCP~~managed care plan.

For COC pertaining to terminated provider are described in Policy 3.39-P.

KHS will provide information to members about their continuity of care rights as well as to providers (both in and out-of-network). KHS will, at a minimum, include information about continuity of care in provider training and new member orientation materials.

KHS is not required to provide continuity of care for services not covered by Medi-Cal. In addition, provider continuity of care protections do not extend to the following ~~providers~~:

1. durable medical equipment,
2. transportation,
3. other ancillary services, and
4. carved-out service providers.
4.

COC does not apply to members who had an option to remain with their previous health plan.[i]

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COC for drugs and medications is addressed in *KHS Policy and Procedure #13.01-P: Drug Treatment and Non-Formulary Treatment Request.*

DEFINITIONS:

Acute condition[ii]	Medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.
Existing Relationship	The member has seen a primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment unless otherwise specified in this policy.
Individual Provider[iii]	A person who is licensed as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.
Medical Exemption Request (MER)	A request to the Department of Health Care Services (DHCS) for temporary exemption from Managed Care Plan (MCP) enrollment until the Medi-Cal beneficiary's condition has stabilized to enable a transfer to an MCP provider of the same specialty without deleterious medical effects.
New Member	A new member is an enrollee who has transitioned from FFS Medi-Cal or another qualifying government program and is assigned a mandatory aid code.

Provider[iv]	Any professional person, organization, health facility (including a hospital), or other person or institution licensed by the state to deliver or furnish health care services.
Provider group[v]	Includes a medical group, independent practice association, or any other similar organization.
Quality of Care Issue	A quality of care issue means KHS can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other KHS beneficiaries.
Serious chronic condition[vi]	Medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following: A. Persists without full cure or worsens over an extended period of time B. Requires ongoing treatment to maintain remission or prevent deterioration
Terminal Illness[vii]	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Terminated Provider[viii]	A practitioner, provider group, or hospital whose contract to provide services for KHS is terminated or not renewed by any of the contracting parties.

PROCEDURES:

1.0 QUALIFYING FOR CONTINUITY OF CARE[ix]

KHS will provide continuity of care with an out-of-network provider when:

1. KHS is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider);
   a. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment with KHS for a non-emergency visit, unless otherwise specified in the All Plan Letter (APL18-008).

2. The provider is willing to accept the higher of KHS's contract rates or Medi-Cal ~~FFS~~ FFS rates;
3. The provider meets KHS's applicable professional standards and has no disqualifying quality of care issues (for the purposes of this APL, a quality of care issue means KHS can document its concerns with the

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provider's quality of care to the extent that the provider would not be eligible to provide services to any other KHS members);
4. The provider is a California State Plan approved provider; ~~and~~
5. The provider supplies KHS with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

If a member changes health plans, the 12-month continuity of care period may start over one time. If the member changes health plans a second time (or more), the continuity of care period does not start over, ~~meaning that~~as the member does not have the right to a new 12 months of continuity of care. If the member returns to Medi-Cal FFS and later reenrolls with KHS, the continuity of care period does not start over. If a member changes health plans, this continuity of care policy does not extend to providers that the member accessed through their previous health plan.

1.2 Continuity of Care Process

Members, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to KHS for continuity of care. When this occurs, KHS will begin to process the request ***within five working days*** following the receipt of the request.

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However, as noted below, the request must be ***completed in three calendar days*** if there is a risk of harm to the member. For the purposes of this APL, "risk of harm" is defined as an imminent and serious threat to the health of the member. The continuity of care process begins when KHS starts the process to determine if the member has a pre-existing relationship with the provider.

KHS will accept requests for continuity of care over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a telephone request, KHS may take any necessary information from the requester over the telephone.

1.2.1 Retroactive Requests for COC

KHS will ~~accept and approve~~ retroactively approve a ~~requests for~~ continuity of care request and reimburse providers for services that were already provided if the request meets that meets all continuity of care requirements ~~noted~~ described above, and ~~it~~in ~~1-3 below. The~~ the services that are the subject of the request ~~must have occurred after the member's enrollment into KHS, and KHS will demonstrate that there was an existing relationship between the member and provider prior to the member's enrollment into KHS.~~ meet the following requirements:

~~KHS will only approve retroactive requests that meet the following requirements:~~

- ~~1.~~ Occurred after the member's enrollment into the

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MCP,

- Have dates of services ~~that occur~~ after ~~the effective~~ March 2, ~~2018~~December 29, 2014;

~~2.~~

- ~~2.~~ Have dates of services that are within 30 calendar days of the first ~~date of~~ service for which the provider ~~is requesting, or has previously requested,~~requests retroactive continuity of care retroactive reimbursement; ~~and~~
- ~~3.~~ Retroactive continuity of care reimbursement requests must be ~~Are~~ submitted within 30 calendar days of the first service ~~for~~ to which ~~retroactive continuity of care is being requested~~the request applies.

KHS will determine if a relationship exists through use of data provided by DHCS to KHS, such as Medi-Cal FFS utilization data. A member or ~~his or her~~their provider may also provide information to KHS ~~which~~ that demonstrates a pre-existing relationship with ~~a~~ the provider.

A member's self attestation of ~~may not attest to~~ a pre-existing relationship is not sufficient proof (instead, actual documentation must be provided), unless KHS makes this option available to ~~him or her~~ the member. Following identification of a pre-existing relationship, KHS determine if the provider is an in-network provider. If the provider is not an in-network provider, KHS will contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a continuity of care relationship for the member.

1.3 Request Completion Timeline

Each continuity of care request must be completed within the following timelines:

- Thirty calendar days from the date KHS receives the request;
- Fifteen calendar days if the member's medical condition requires more Immediate attention, such as upcoming appointments or other pressing care needs; or,
- Three calendar days if there is risk of harm to the member.

A continuity of care request is considered completed when:

- ~~T~~ KHS notifies the member, in the manner outlined above, that the request has been approved;~~he member is informed of his or her right of continued access~~;
- KHS and the out-of-network Medi-Cal FFS ~~or prior health plan~~ provider are unable to agree to a rate;
- KHS has documented quality of care issues with the Medi-Cal FFS provider; or
- KHS makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

1.4 Post Request Process Requirements

If KHS and the out-of-network Medi-Cal FFS provider are unable to reach an agreement because they cannot agree to a rate or KHS has documented quality of care issues with the provider, KHS will offer the member an in-network alternative.

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If the member does not make a choice, the member will be referred or assigned to an in-network provider. If the member disagrees with the result of the continuity of care process, the member maintains the right to ~~pursue~~ file a grievance ~~and/or appeal~~.

If a provider meets all of the necessary requirements including ~~concurring with~~entering into a letter of agreement or contract with KHS, KHS will allow the member to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with KHS for a shorter timeframe. In this case, KHS will allow the member to have access to that provider for the shorter period of time.

At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, KHS will work with the provider to establish a care plan for the member.

Upon approval of a continuity of care request, KHS will notify the member of the following within seven calendar days:

- The request approval;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the member's care at the end of the continuity of care period; ~~and~~
- The member's right to choose a different provider from KHS's provider network.

KHS will notify the member 30 calendar days before the end of the continuity of care period about the process that will occur to transition ~~his or her~~the member's care to an in-network provider at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

1.5 Extended Continuity of Care

KHS may choose to work with ~~the~~ a member's out-of-network provider past the 12-month continuity of care period; however, ~~, but~~ KHS is not required to do so to fulfill ~~its~~ the obligations under this APL or KHS's contract.

1.6 Member and Provider Outreach

KHS will inform members of their continuity of care protections and will include information about these protections in member information packets and handbooks. This information will include how the member and provider initiate a continuity of care request with KHS. KHS will translate these documents into threshold languages and make ~~t~~them available in alternative formats, upon request. KHS will provide training to call center and other staff who come into regular

contact with members about continuity of care protections.

1.7 Out of Network Provider Referral

An approved out-of-network provider must work with KHS and its contracted network and will not refer the member to another out-of-network provider without authorization from KHS. In such cases, KHS will make the referral, if medically necessary, and if KHS does not have an appropriate provider within its network.

2.0 NON-SPECIALTY MENTAL HEALTH SERVICES – CONTINUITY OF CARE FOR APPROVED PROVIDER TYPES:

KHS is required to cover outpatient mental health services, as outlined in APL 17- 018, for members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition, as defined by the current Diagnostic and Statistical Manual. County Mental Health Plans (MHPs) are required to provide specialty mental health services (SMHS) for members who meet the medical necessity criteria for SMHS. DHCS recognizes that the medical necessity criteria for impairment and intervention for SMHS differ between children and adults. Under the Early and Periodic Screening, Diagnostic, and Treatment benefit, the impairment component of the SMHS medical necessity criteria for members under 21 years of age is less stringent than it is for adults. Therefore, children with a lower level of impairment may meet medical necessity criteria for SMHS.

KHS will provide continuity of care with an out-of-network SMHS provider in instances where a member's mental health condition has stabilized such that the member no longer qualifies to receive SMHS from the MHP and instead becomes eligible to receive non-specialty mental health services from KHS. In this situation, the continuity of care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services (referred to in the State Plan as "Psychology").

KHS will allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network MHP provider in accordance with the requirements in this APL. After the continuity of care period ends, the member must choose a mental health provider in KHS's network for non-specialty mental health services. If the member later requires additional SMHS from the MHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to KHS for non-specialty mental health services, the 12-month continuity of care period may start over one time. If the member requires SMHS from the MHP subsequent to the continuity of care period, the continuity of care period does not start over when the member returns to KHS or changes KHSs (i.e., the member does not have the right to a new 12 months of continuity of care).

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~~2~~3.0 COVERED CALIFORNIA TO MEDI-CAL TRANSITION

This section specifies requirements for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a member's eligibility circumstances that may occur at any time throughout the year. These requirements are limited to these transitioning members.

To ensure that continuity of care and coordination of care requirements are met, KHS will ask these members if there are upcoming health care appointments or treatments scheduled and assist them, if they choose to do so, in initiating the continuity of care process at that time according to the provider and service continuity rights described below or other applicable continuity of care rights. When a new member enrolls in Medi-Cal, KHS will contact the member by telephone, letter, or other resources no later than 15 days after enrollment. The requirements noted above in this paragraph must be included in this initial member contact process. KHS will make a good faith effort to learn from and obtain information from the member so that it is able to honor active prior treatment authorizations and/or establish out-of-network provider continuity of care as described below.

KHS will honor any active prior treatment authorizations for up to 60 days or until a new assessment is completed by KHS. A new assessment is considered completed by KHS if the member has been seen by a KHS-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The prior treatment authorizations must be honored without a request by the member or the provider.

KHS will, at the member's or provider's request, offer up to 12 months of continuity of care with out-of-network providers, in accordance with the ~~DHCS policy~~ requirements ~~for other transitioning populations regarding out-of-network continuity of care.~~in this APL.

~~3~~4.0 SENIORS AND PERSONS WITH DISABILITIES FFS TREATMENT AUTHORIZATION REQUEST CONTINUITY UPON ENROLLMENT

For a newly enrolled Seniors and Persons with Disabilities (SPDs), KHS will honor any active FFS Treatment Authorization Requests (TARs) for up to 60 days or until a new assessment is completed by KHS. A new assessment is considered completed by KHS if the member has been seen by a KHS-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The FFS TAR must be honored as outlined above without a request by the member or the provider.

~~4~~5.0 BEHAVIORAL HEALTH TREATMENT FOR MEMBERS UNDER THE AGE OF 21 UPON TRANSITION

KHS is responsible for providing Early and Periodic Screening, Diagnostic, and Treatment services for members under the age of 21. Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. In accordance with existing contract requirements and the requirements listed in this APL and APL 18-006, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, KHS will offer members continued access to out-of-network BHT providers (continuity of care) for up to 12 months if all ~~policy~~ requirements in this APL are met.

For BHT, an existing relationship means a member has seen the out-of-network BHT provider at least

one time during the six months prior to either the transition of services from a Regional Center (RC) to KHS or the date of the member's initial enrollment with KHS if enrollment occurred on or after July 1, 2018. Further, if the member has an existing relationship, as defined above, with an in-network provider, KHS will assign the member to that provider to continue BHT services.

Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a member's transition date into KHS, or the date of the member's enrollment into KHS, if the enrollment date occurred after the transition.

KHS will continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.

45.1 Transition of BHT Services from Regional Center (RC) to KHS

At least 45 days prior to the transition date, DHCS will provide KHS with a list of members for whom the responsibility for BHT services will transition from the Regional Center to KHS, as well as member-specific utilization data. KHS will consider every member transitioning from an RC as an automatic continuity of care request. DHCS will also provide KHS with member utilization and assessment data from the RC prior to the service transition date. KHS is required to use DHCS-supplied utilization data to identify each member's BHT provider(s) and proactively contact the provider(s) to begin the continuity of care process, regardless of whether a member's parent or guardian files a request for continuity of care. If the data file indicates that multiple providers of the same type meet the criteria for continuity of care, KHS will attempt to contact the member's parent or guardian to determine their preference. If KHS does not have ~~contact the member's parent or guardian to determine his or her~~their preference. If KHS does not have access to member data that identifies an existing BHT provider, KHS will contact the member's parent or guardian by telephone, letter, or other resources, and make a good faith effort to obtain information that will assist KHS in offering continuity of care. If the RC is unwilling to release specific provider rate information to KHS, then KHS may negotiate rates with the continuity of care provider without being bound by the usual requirement that KHS offer at least a minimum FFS-equivalent rate. If KHS is unable to complete a continuity of care agreement, KHS will ensure that all ongoing services continue at the same level with a KHS in-network provider until KHS has conducted an evaluation and/or assessment, as appropriate, and established a treatment plan.

KHS may refer to the Continuity of Care section of APL 18-006 for additional requirements and information regarding continuity of care for transitioning members receiving BHT.

6.0 HEALTH HOMES PROGRAM – MEDI-CAL FFS TO MANAGED CARE TRANSITION

KHS will provide continuity of care with an out-of-network provider, in accordance with the requirements of this APL, for Medi-Cal FFS beneficiaries who voluntarily transition to an MCP to enroll in the Health Homes Program (HHP).~~7~~ Because HHP services are provided only through the

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managed care delivery system, continuity of care with out-of-network-providers is not available for HHP services.

~~5~~7.0 EXISTING CONTINUITY OF CARE PROVISIONS UNDER CALIFORNIA STATE LAW

In addition to the protections set forth above, KHS members also have rights to protections set forth in current ~~State~~ state law pertaining to continuity of care. In accordance with Welfare and Institutions Code Section (§) 14185(b), KHS will allow members to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the member immediately prior to the date of enrollment, whether or not the drug is covered by KHS, until the prescribed therapy is no longer prescribed by the KHS-contracting provider.

Additional requirements pertaining to continuity of care are set forth in Health and Safety (H~~&~~SC) Code § 1373.96 and require health plans in California to, at the request of a member, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under HSC §1373.96, health plans are required to complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and performance of a surgery or other procedure that is authorized by KHS as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member.. This APL does not alter KHS's obligation to fully comply with the requirements of HSC §1373.96. In addition to the requirements set forth in this APL, KHS will allow for completion of covered services as required by §1373.96, to the extent that doing so would allow a member a longer period of treatment by an out-of-network provider than would otherwise be required under the terms of this this APL. KHS will allow for the completion of these services for certain timeframes which are
specific to each condition and defined under ~~H&S Code~~HSC § 1373.96.

~~6~~8.0 PREGNANT AND POST-PARTUM BENEFICIARIES

As noted above, ~~H&S Code~~HSC §1373.96 requires health plans in California to, at the request of a member, provide for the completion of covered services relating to pregnancy, during pregnancy and immediately after the delivery (the post-partum period), and care of a newborn child between birth and age 36 months, by a terminated or nonparticipating health plan provider. These requirements will apply for pregnant and post-partum members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to ~~H&S Code~~HSC §1373.96 for additional information about applicable circumstances and requirements.

Pregnant and post-partum Medi-Cal members who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into KHS have the right to request out-of-network provider continuity of care for up to 12 months in accordance with KHS's contract~~s~~ and the general requirements listed in this APL. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of this APL (continuity of care for members transitioning from FFS to managed care).

~~7~~9.0 MEDICAL EXEMPTION REQUESTS

A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into KHS only until the ~~Medi-Cal~~ member's medical condition has stabilized to a level that would enable

the member to transfer to a KHS provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from KHS enrollment that only applies to members transitioning from Medi-Cal FFS to KHS. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above in this paragraph. KHS is required to consider MERs that have been denied as ~~an~~ automatic continuity of care requests to allow ~~the~~ members to complete ~~a~~ courses of treatment with ~~a~~ Medi-Cal FFS providers in accordance with APL ~~13-013~~17-007.

~~8~~10.0 REPORTING

KHS may be required to report on metrics related to any continuity of care provisions outlined in this APL, ~~State~~ state law and regulations, or other ~~State~~ state guidance documents at any time and in a manner determined by DHCS.

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, and ~~Dual Plan~~Policy Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

REFERENCE:

Revision 2018-08: Policy to comply with APL 18-008. **Revision 2018-04:** Policy revised to comply with DHCS Deliverable BHT 10E. **Revision: 2018-04:** Policy revised by Administrative Director of Health Services to comply with APL 18-008. **Revision 2017-07:** Policy revised to comply with APL 17-007 new reporting requirements. Reporting changed from quarterly to monthly beginning July 2017. Instructions and templet provided by DHCS. **Revision 2017-01:** Policy revised to included new attachments; Initial Contact letter provided by Member Services Department and the MER Workflow Process

[1] Deleted 30 days from enrollment deadline. Per M. Punja @ DMHC we can include a deadline only if we include an exception for "good cause". DMHC position is that since the statute doesn't impose a deadline, the plan cannot limit a member's rights by imposing a deadline. As a compromise with the Plans, an exception for "good cause" was determined to be acceptable. (See DMHC Comments 061A (04/16/04)).

[1] Process to review request must be included in policy (HSC §1373.95(a)(2)(D)).

[1] HSC §1373.96 (e)(1) and (2)

[1] HSC §1376.96 (f)

[1] HSC §1373.95© Per M. Punja of DMHC 6/29/04.

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[i] HSC §1363.96(j). Language result of AB1596(2004).

[ii] HSC §1373.96(c)(1)

[iii] HSC §1373.96(k)(1)

[iv] HSC §1345(i) and 1373.96(k)(3). Clarification of "hospital" requested by DMHC comment 061A (04/16/04).

[v] HSC §1373.65(g)

[vi] HSC §1373.96(c)(2)

[vii] HSC §1373.96(c)(4)

[viii] Definition requested by DMHC Comment 061A (04/16/04). Per M. Punja we cannot use the definition included in the Insurance Code. Although there is no definition included in the HSC, DMHC expectation is that terminated providers include those whose contract is terminated or not renewed by either party.

[ix] HSC §1373.96(c)

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KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Second Quarter 2018

Report Date: August 10, 2018

OVERVIEW

Kern Health Systems' Health Education department provides comprehensive, culturally and linguistically competent 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.

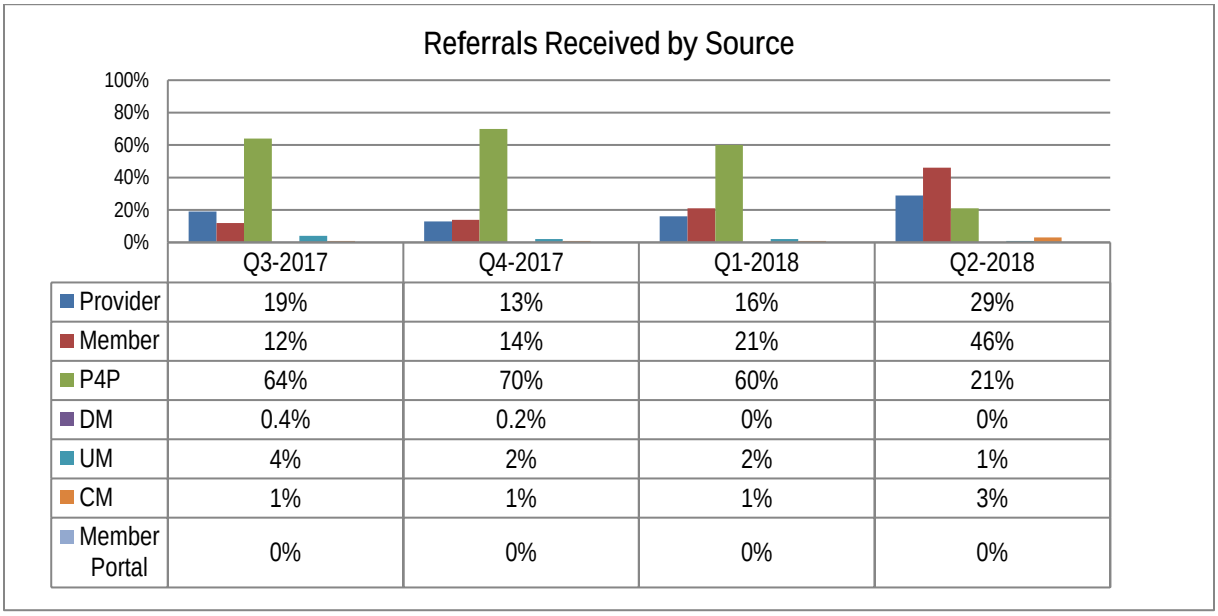
- Health Education in Jiva as of 6/11/18
- School Wellness Grant and Internship Programs ended in June 2018
- Fall/Winter Member Newsletter
- Health Education Member Focus Groups
- Community Wellness Program Contract ended 7/31/18
- Asthma education workshop series

The following pages reflect statistical measurements for the Health Education department detailing the ongoing activity for the 2nd quarter 2018.

Respectfully submitted,
Isabel Silva, MPH, CHES
Director of Health Education, Cultural and Linguistic Services

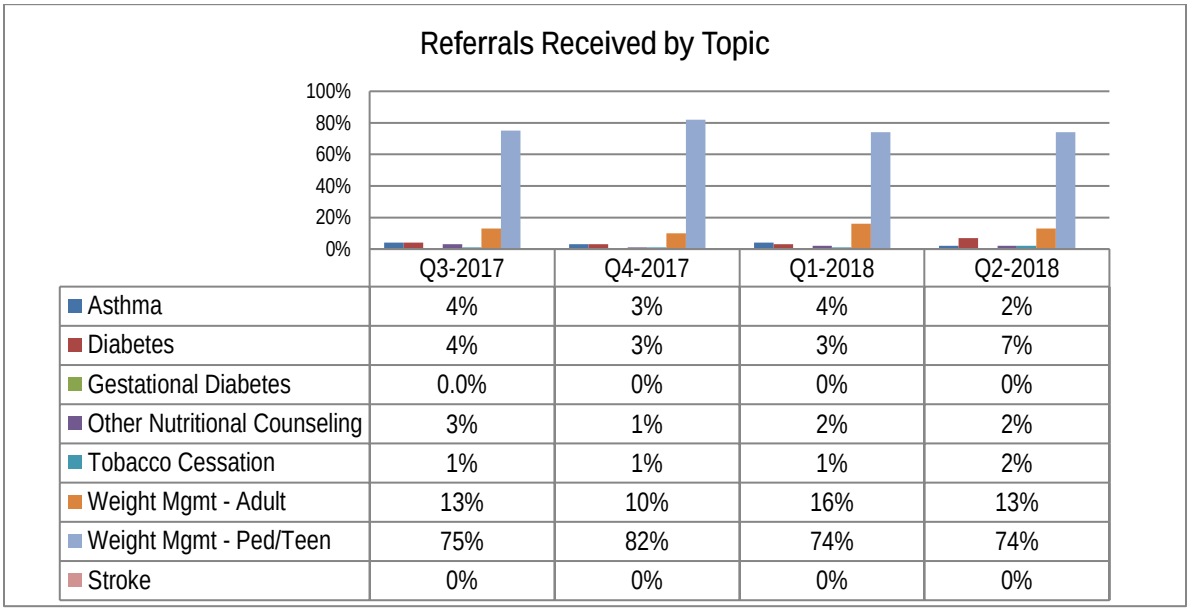
REFERRALS FOR HEALTH EDUCATION SERVICES

The Health Education Department (HE) receives referrals from various sources. Internal referrals are received from the Kern Health Systems (KHS) Utilization Management Department (UM), the Disease Management Department (DM), Case Management (CM), and the Provider Pay for Performance Program (P4P). Externally, KHS providers submit referrals for health education services according to the member's diagnosis. Kern Family Health Care (KFHC) members can also self-refer for health education services.



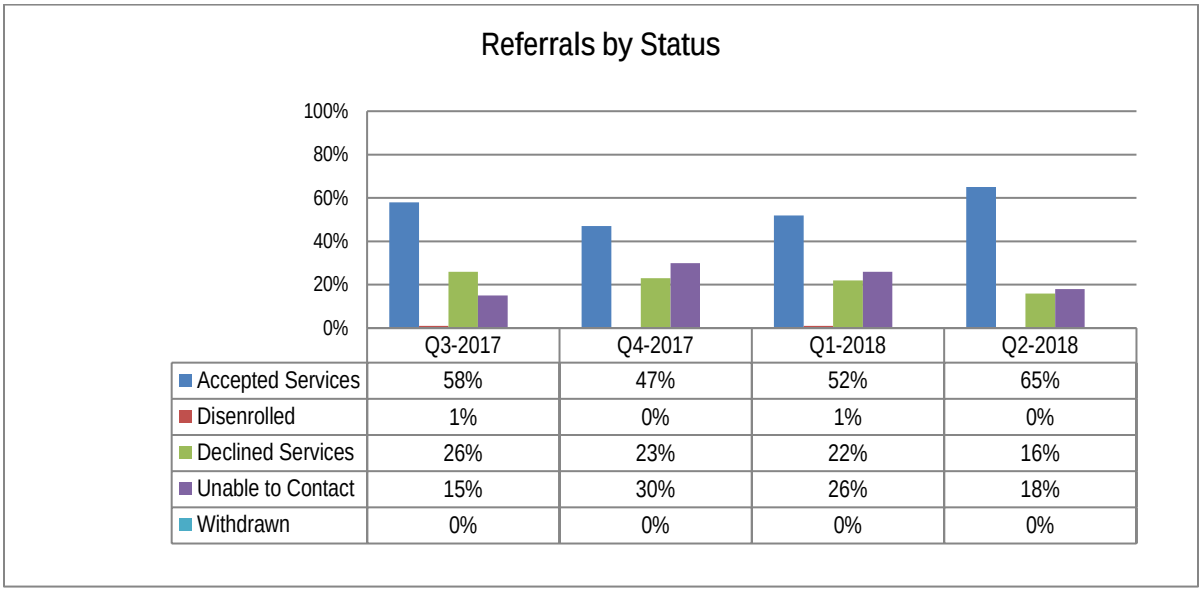
	Q3-2017	Q4-2017	Q1-2018	Q2-2018
Provider	19%	13%	16%	29%
Member	12%	14%	21%	46%
P4P	64%	70%	60%	21%
DM	0.4%	0.2%	0%	0%
UM	4%	2%	2%	1%
CM	1%	1%	1%	3%
Member Portal	0%	0%	0%	0%

During this quarter, 433 referrals were received which is a 41% decrease in comparison to the previous quarter. This decrease is attributed to the conclusion of the P4P weight management provider incentive program.



	Q3-2017	Q4-2017	Q1-2018	Q2-2018
Asthma	4%	3%	4%	2%
Diabetes	4%	3%	3%	7%
Gestational Diabetes	0.0%	0%	0%	0%
Other Nutritional Counseling	3%	1%	2%	2%
Tobacco Cessation	1%	1%	1%	2%
Weight Mgmt - Adult	13%	10%	16%	13%
Weight Mgmt - Ped/Teen	75%	82%	74%	74%
Stroke	0%	0%	0%	0%

The HE department receives referrals for various health conditions. Weight management education continues to be the most requested service for members. It accounted for 87% of all referrals received in the 2nd Quarter of 2018.



	Q3-2017	Q4-2017	Q1-2018	Q2-2018
Accepted Services	58%	47%	52%	65%
Disenrolled	1%	0%	1%	0%
Declined Services	26%	23%	22%	16%
Unable to Contact	15%	30%	26%	18%
Withdrawn	0%	0%	0%	0%

The rate of members who accepted to receive health education services increased from 52% in the 1st quarter to 65% in the 2nd quarter in 2018.

Member reasons for declining health education services were also collected. During this quarter, the top 3 reasons for referral refusal were due to the following:

1. The member prefers to be mailed educational material.
2. The member is not interested in the services.
3. Member unable to receive due to work/school schedule

HEALTH EDUCATION SERVICE PROVIDERS

The HE department offers various types of services through KHS or through community partnerships.

Kern Family Health Care (KFHC):

- Healthy Eating and Active Lifestyle Workshop
- Breathe Well Asthma Workshop
- Intro to Gardening
- Rethink Your Drink

Bakersfield Memorial Hospital (BMH):

- Diabetes Management Classes (English only)
- Heart Healthy Classes
- Small Steps to a Healthier Weight (English only)
- Individual Nutrition Counseling

Community Wellness Program (CWP):

- In-home or group setting for Asthma, Diabetes, Nutrition or Stroke Prevention Education
- Freedom from Smoking Program

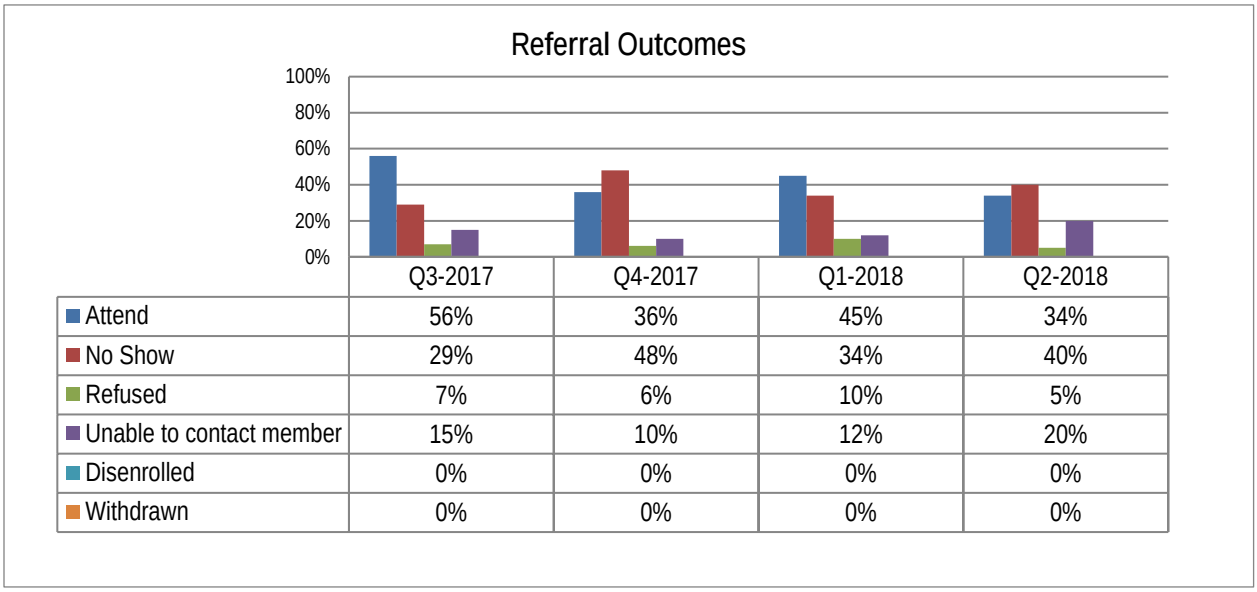
Clinica Sierra Vista (CSV) WIC:

- Diabetes Management Classes
- Heart Healthy Classes

California Smokers' Helpline (CSH):

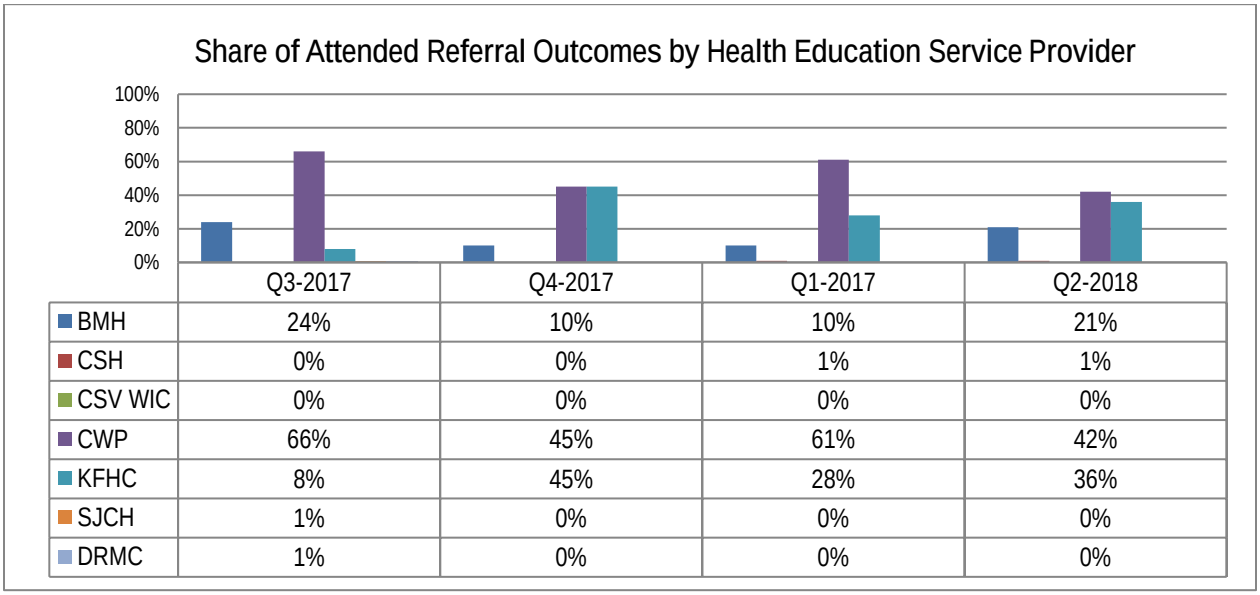
- Telephone Smoking Cessation Counseling

REFERRAL OUTCOMES



	Q3-2017	Q4-2017	Q1-2018	Q2-2018
Attend	56%	36%	45%	34%
No Show	29%	48%	34%	40%
Refused	7%	6%	10%	5%
Unable to contact member	15%	10%	12%	20%
Disenrolled	0%	0%	0%	0%
Withdrawn	0%	0%	0%	0%

During this quarter, the rate of members who attended or received health education services out of all members who accepted services decreased from a 45% to a 34%.

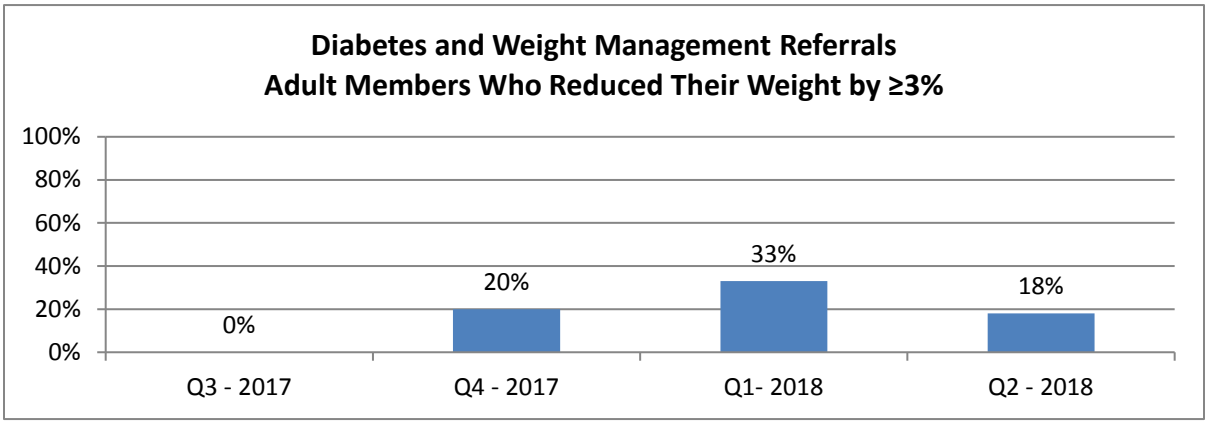


	Q3-2017	Q4-2017	Q1-2017	Q2-2018
BMH	24%	10%	10%	21%
CSH	0%	0%	1%	1%
CSV WIC	0%	0%	0%	0%
CWP	66%	45%	61%	42%
KFHC	8%	45%	28%	36%
SJCH	1%	0%	0%	0%
DRMC	1%	0%	0%	0%

Services through CWP continue to account for the largest share of referral outcomes. This quarter CWP showed a decrease from 61% in 1st quarter to a 42% in the 2nd Quarter of 2018.

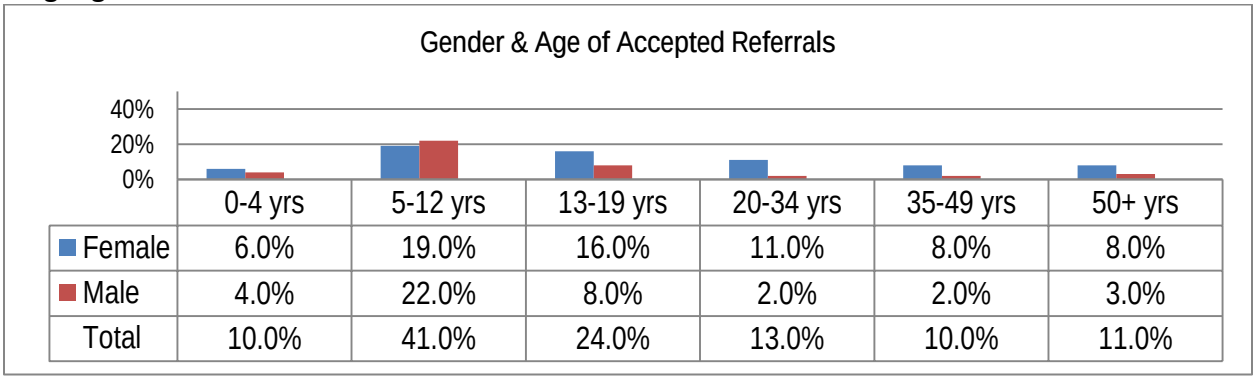
Effectiveness of Health Education Services

To evaluate the effectiveness of the diabetes and weight management health education services provided to members, a 3-month follow up call was conducted on members who received services during the prior quarter. The Health Education department was in the process of revising the evaluation metrics for its health education services which resulted in no follow up calls performed until December 2017. Follow up call findings revealed 18% of members had reduced their weight by 3% or greater during this quarter.



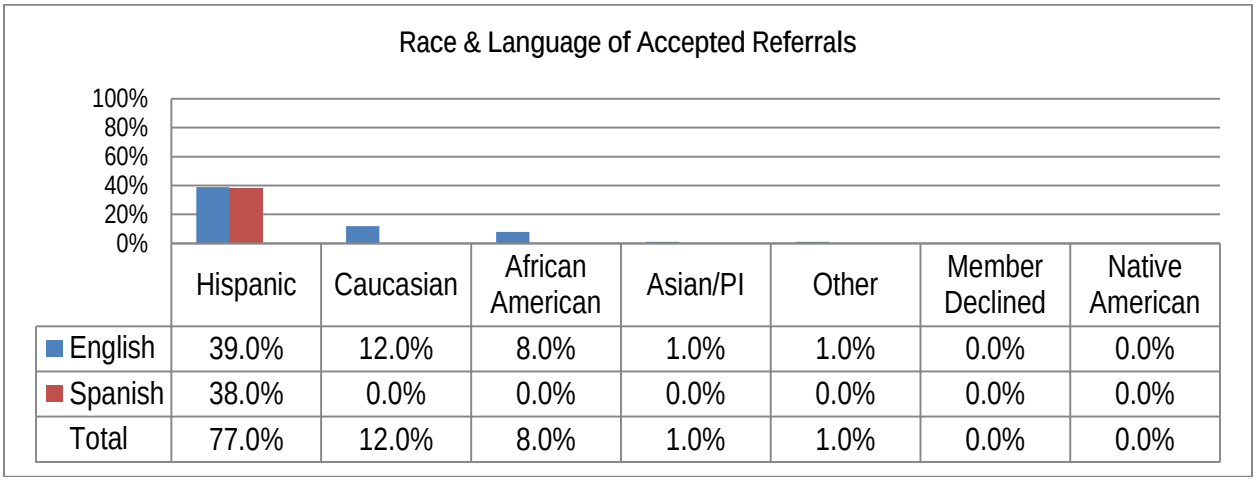
Demographics of Members Served

KHS' provides services to a culturally and linguistically diverse member population. KHS' language threshold is English and Spanish and all services and materials are available in these languages.



	0-4 yrs	5-12 yrs	13-19 yrs	20-34 yrs	35-49 yrs	50+ yrs
Female	6.0%	19.0%	16.0%	11.0%	8.0%	8.0%
Male	4.0%	22.0%	8.0%	2.0%	2.0%	3.0%
Total	10.0%	41.0%	24.0%	13.0%	10.0%	11.0%

Out of the members who accepted to receive health education services, the largest gender-age groups were male ages 5-12 years and female ages 5-12 years.



	Hispanic	Caucasian	African American	Asian/PI	Other	Member Declined	Native American
English	39.0%	12.0%	8.0%	1.0%	1.0%	0.0%	0.0%
Spanish	38.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	77.0%	12.0%	8.0%	1.0%	1.0%	0.0%	0.0%

A breakdown of member classifications by race and language preferences revealed that 77% of members who accepted services are Hispanic and prefer to speak English or Spanish.

Referrals Accepted by Top Bakersfield Zip Codes			
Q3-2017	**Q4-2017**	**Q1-2018**	**Q2-2018**
93307	93307	93307	93307
93306	93306	93306	93306
93304	93305	93304	93304
93301	93304	93305	93309

93305	93309	93309	93305

KHS serves members in the Kern County area. During this quarter, 78% of the members who accepted services reside in Bakersfield and the highest concentration of members were in the 93307 area.

Referrals Accepted by Top Outlying Areas			
Q3-2017	**Q4-2017**	**Q1-2018**	**Q2-2018**
Delano	Delano	Delano	Arvin
Wasco	Lamont	Wasco	Delano
Shafter	Shafter	Shafter	Wasco
Taft	Arvin	Arvin	Lamont
McFarland	McFarland	Lamont	McFarland
	Wasco	McFarland	Shafter

Additionally, 22% of the members who accepted services reside in the outlying areas of Kern County and the highest concentration of members continue to be in Arvin.

Health Education Mailings

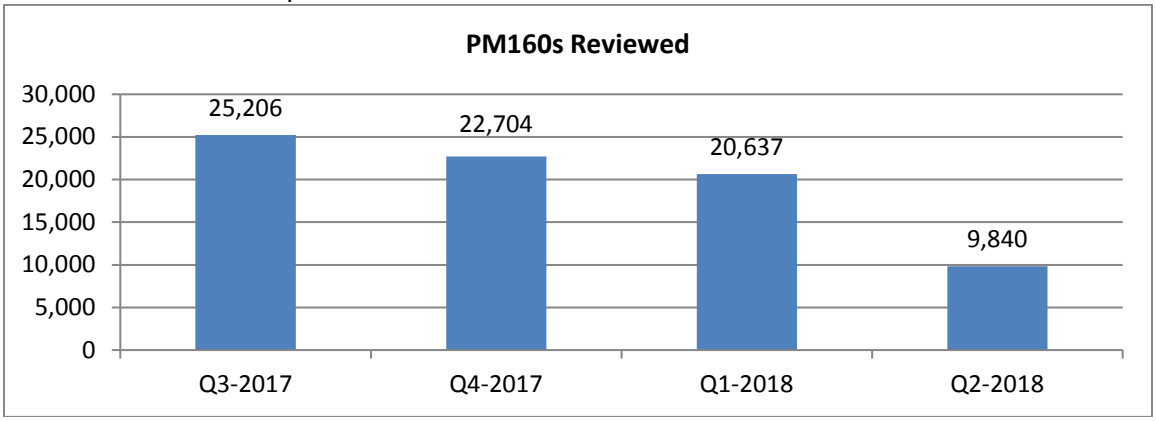
In addition to referrals, the HE department mails out a variety of educational material in an effort to assist members with gaining knowledge on their specific diagnosis or health concern. During this quarter, the HE department mailed 3,198 educational packets to members on the following health topics:

Educational Mailings				
	Q3-2017	**Q4-2017**	**Q1-2018**	**Q2-2018**
Anemia	0	0	0	0
Asthma	36	31	19	6
High Cholesterol	4	6	4	4
Diabetes	25	15	15	17
Gestational Diabetes	1	0	2	1
High Blood Pressure	19	20	14	18
Nutrition	0	0	0	0
COPD	0	0	0	0
Postpartum Care	953	408	14	52
Prenatal Care	241	254	8	11
Smoking Cessation	22	10,199	68	11
Weight Management	1472	893	674	496

Postpartum Incentive	0	275	275	852
WIC	0	2473	2360	1730
Total	**2773**	**14,574**	**3,178**	**3,198**

PM160 PROCESSING

KHS Primary Care Providers (PCP) are required to document pediatric preventive care services on a PM160 and submit these forms to KHS. On a daily basis, the HE department reviews these forms to evaluate for possible health education interventions.



INTERPRETER REQUESTS

Face-to-Face Interpreter Requests

During this quarter, there were 256 requests for face-to-face interpreting services received. KHS employs qualified staff interpreters in Spanish and contracts with the interpreting vendor, CommGap. The majority of these requests were for a Spanish interpreter.

Top Languages Requested			
Q3-2017	**Q4-2017**	**Q1-2018**	**Q2-2018**
Spanish	Spanish	Spanish	Spanish
Arabic	Arabic	Arabic	Cantonese
Cantonese	Cambodian	Cantonese	Vietnamese
		Punjabi	Punjabi

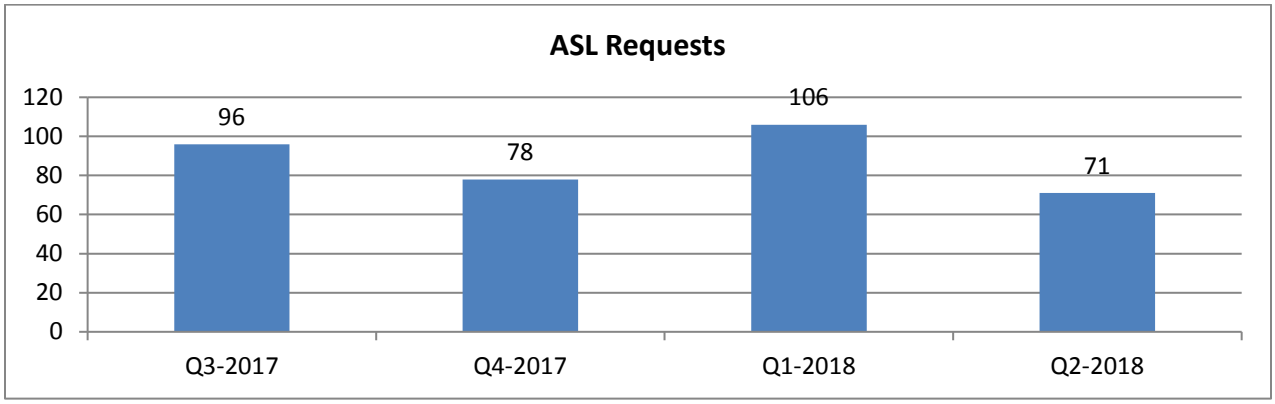
Telephonic Interpreter Requests

During this quarter, there were 693 requests for telephonic interpreting services through KHS' interpreting vendor, Language Line Solutions. The majority of these requests were for a Spanish interpreter.

Top Languages Requested			
Q3 - 2017	**Q4-2017**	**Q1-2017**	**Q2-2018**
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Arabic	Arabic	Arabic	Arabic
Tagalog	Tagalog	Tagalog	Tagalog
Vietnamese	Vietnamese	Vietnamese	Vietnamese

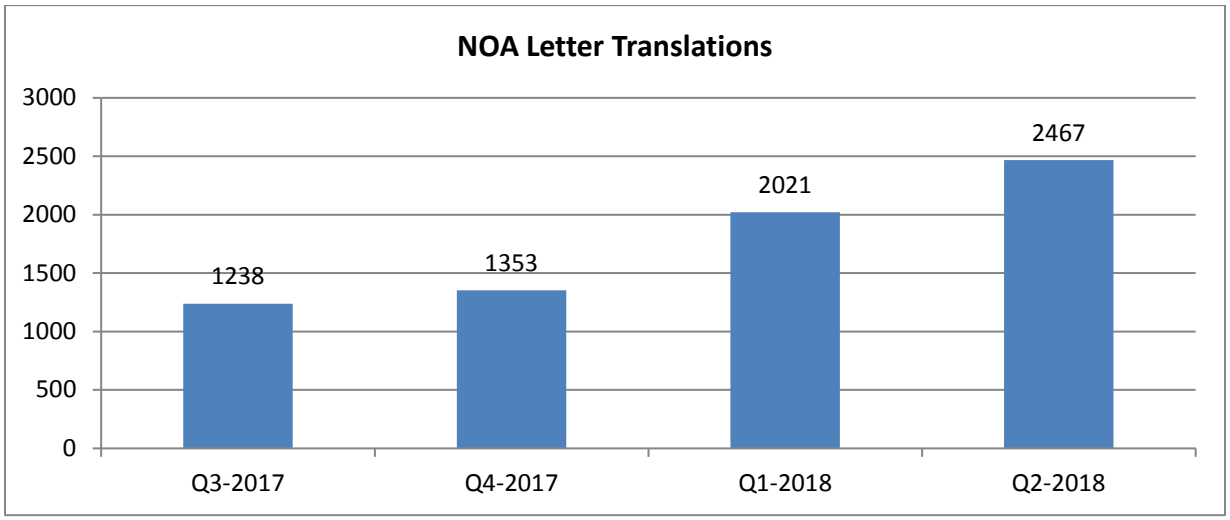
American Sign Language (ASL) Requests

During this quarter, there were a total of 71 requests received for an American Sign Language interpreter, which was a decrease in comparison to the previous quarter.



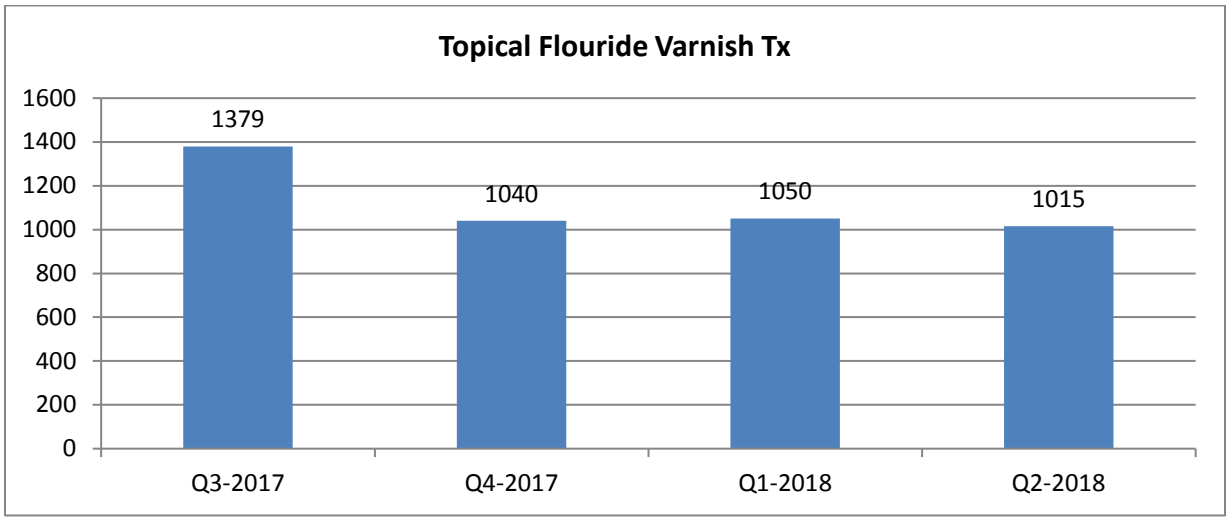
DOCUMENT TRANSLATIONS

The Health Education 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, 2,467 Notice of Action letters were translated into Spanish for the UM and Pharmacy departments.



TOPICAL FLUORIDE VARNISH TREATMENTS

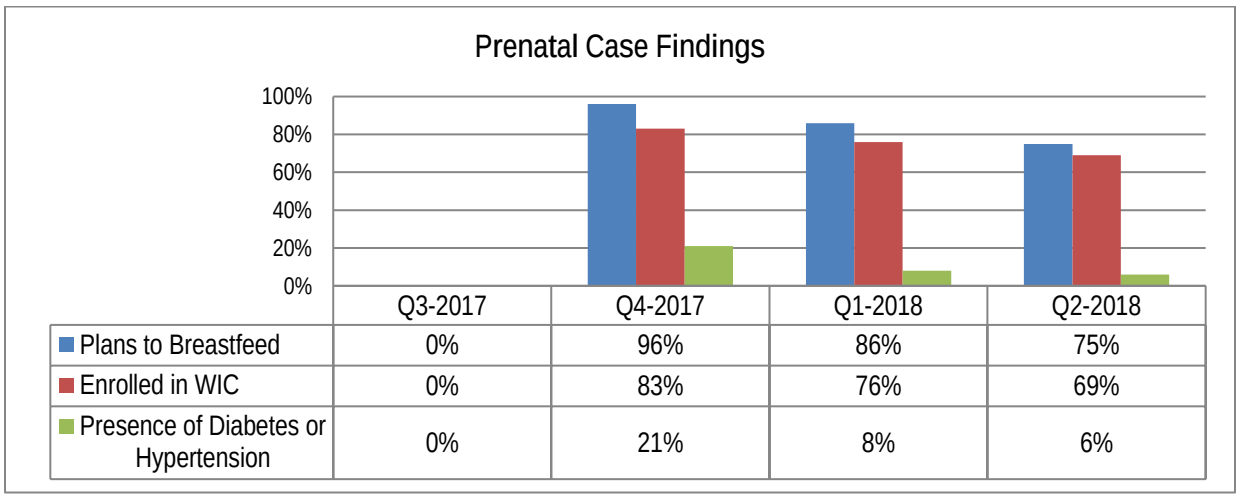
Fluoride varnish treatments are effective in preventing tooth decay and more practical and safer to use with young children. KHS covers up to three topical fluoride varnish treatments in a 12-month period for all members younger than 6 years.



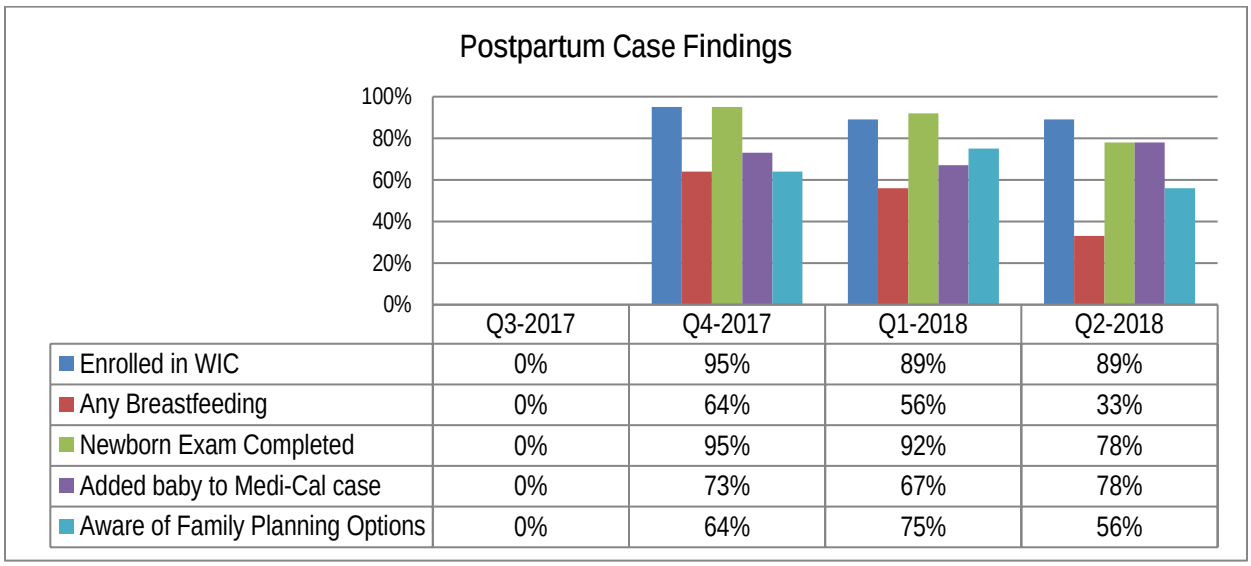
OB CASE MANAGEMENT PROJECT

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Second Quarter 2018

The HE department performs outreach education calls to all members identified as being pregnant in the 1st trimester, a pregnant teen (under age 18), or postpartum due to a c-section or teen pregnancy delivery. During the 2nd quarter, 11 pregnant and 9 postpartum members were successfully reached and provided education.



	Q3-2017	Q4-2017	Q1-2018	Q2-2018
Plans to Breastfeed	0%	96%	86%	75%
Enrolled in WIC	0%	83%	76%	69%
Presence of Diabetes or Hypertension	0%	21%	8%	6%



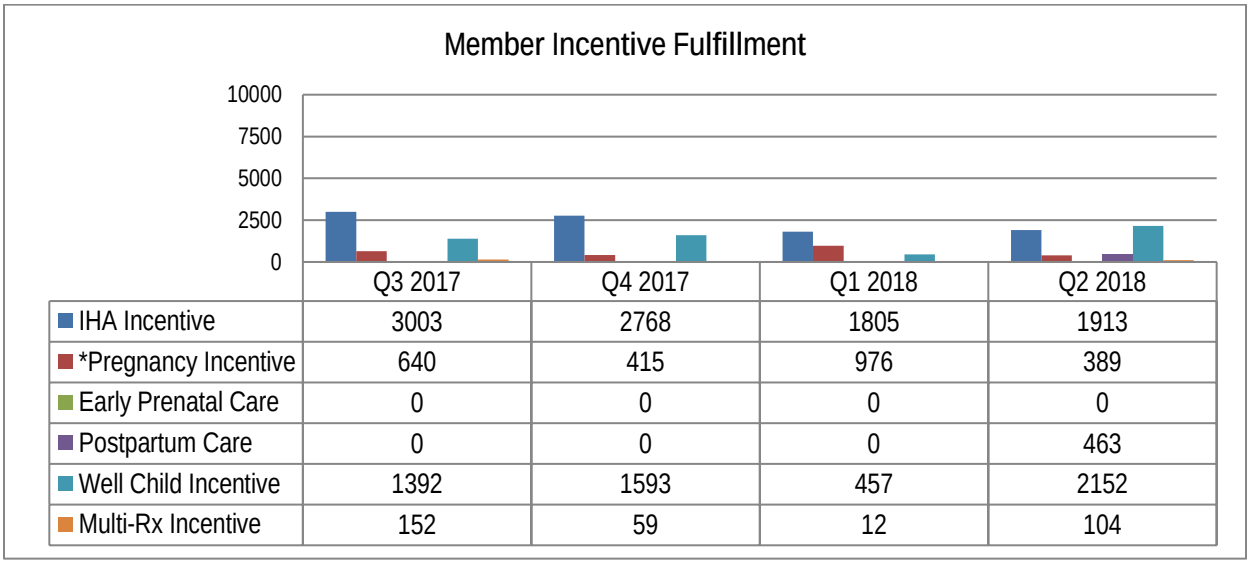
	Q3-2017	Q4-2017	Q1-2018	Q2-2018
Enrolled in WIC	0%	95%	89%	89%
Any Breastfeeding	0%	64%	56%	33%
Newborn Exam Completed	0%	95%	92%	78%
Added baby to Medi-Cal case	0%	73%	67%	78%
Aware of Family Planning Options	0%	64%	75%	56%

MEMBER WELLNESS AND CHRONIC CONDITION BASED INCENTIVES

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Second Quarter 2018

During the 2nd quarter of 2018, KHS continued to offer wellness based incentives and one chronic condition based incentive for members. Due to the bankruptcy closure of Toys R Us, the pregnancy and well child incentive programs were on hold during part of the 2nd Quarter until the transition to the new vendor, National Gift Cards, was completed. Incentive fulfillment recommenced in April. The initial pregnancy incentive program of 6 prenatal care visits and 1 postpartum visit also ended and was revised to focus on 1st trimester prenatal care and postpartum care.

- **Initial Health Assessment (IHA)** – newly enrolled members who complete the IHA visit within 120 days of enrollment are mailed a first aid kit. There is a limit of one incentive per household.
- **Early Prenatal Care** – pregnant members who complete prenatal care during the 1st trimester will receive a $30 Target gift card.
- **Postpartum Care** – members who complete the postpartum visit within 21-56 days following delivery will receive an additional $30 Target gift card.
- **Well Child** – members ages 12 -23 months who complete a well child visit are mailed a $25 Target gift card.
- **Multi-Medication** – members on multiple medications and would benefit from a pill box. KHS disease and case management departments identify and mail this incentive to members.



	Q3 2017	Q4 2017	Q1 2018	Q2 2018
IHA Incentive	3003	2768	1805	1913
*Pregnancy Incentive	640	415	976	389
Early Prenatal Care	0	0	0	0
Postpartum Care	0	0	0	463
Well Child Incentive	1392	1593	457	2152
Multi-Rx Incentive	152	59	12	104

**This program has been discontinued as of 3/15/18.*

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Third Quarter 2018

Report Date: October 10, 2018

OVERVIEW

Kern Health Systems' Health Education department provides comprehensive, culturally and linguistically competent 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.

- School Wellness Grant and Internship Program
- Fall/Winter Member Newsletter
- Annual Tobacco Education Campaign
- Reporting delays for 3rd quarter
- Increase in members declining health education services

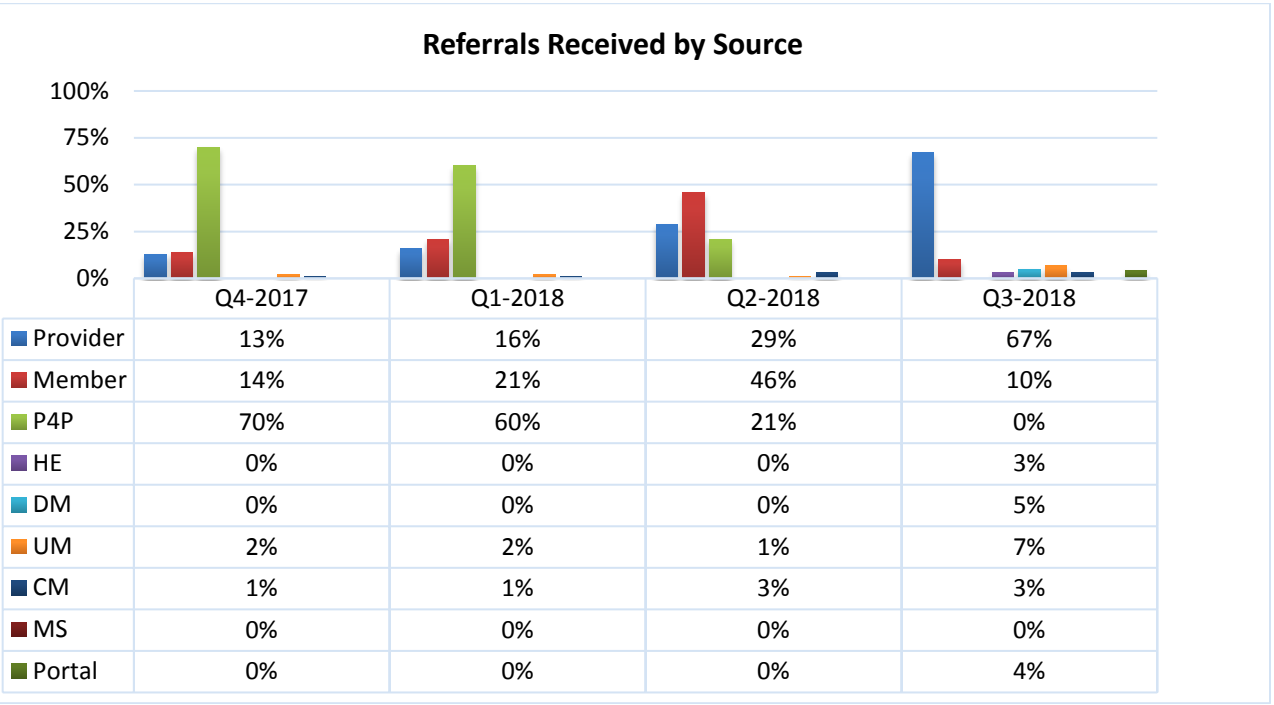
The following pages reflect statistical measurements for the Health Education department detailing the ongoing activity for the 3rd quarter 2018.

Respectfully submitted,
Isabel Silva, MPH, CHES
Director of Health Education, Cultural and Linguistic Services

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Third Quarter 2018

REFERRALS FOR HEALTH EDUCATION SERVICES

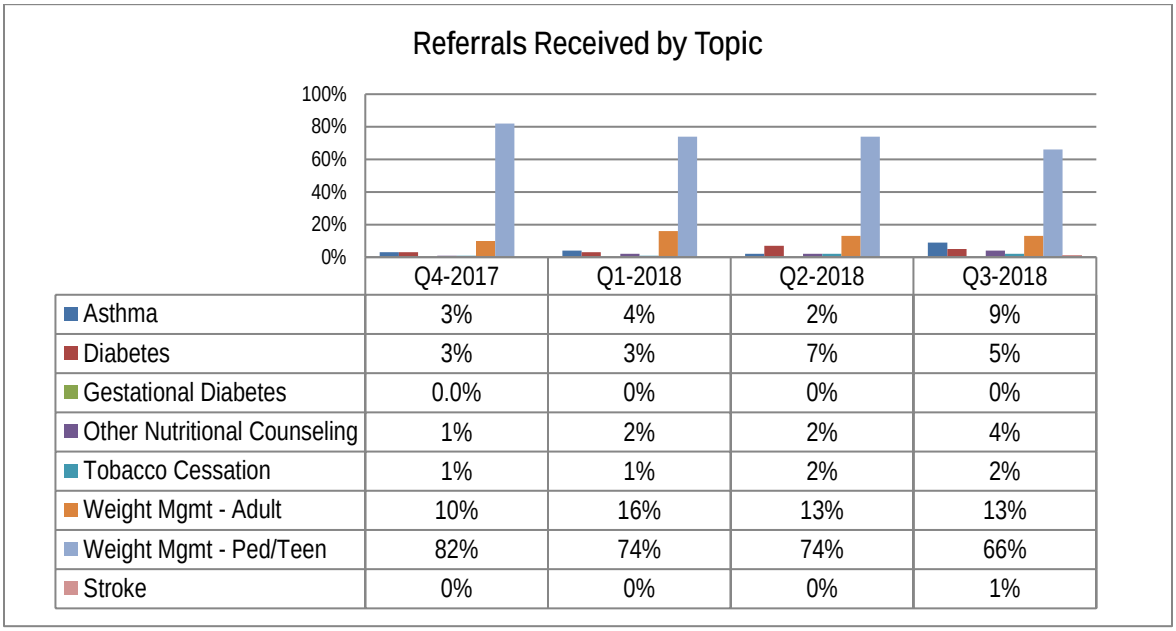
The Health Education Department (HE) receives referrals from various sources. Internal referrals are received from the Kern Health Systems (KHS) Utilization Management (UM), Disease Management (DM), Case Management (CM), and Member Services (MS). Externally, KHS providers submit referrals for health education services according to the member's diagnosis and members can also self-refer for health education services through the Member Portal or by calling the Member Services.



	Q4-2017	Q1-2018	Q2-2018	Q3-2018
Provider	13%	16%	29%	67%
Member	14%	21%	46%	10%
P4P	70%	60%	21%	0%
HE	0%	0%	0%	3%
DM	0%	0%	0%	5%
UM	2%	2%	1%	7%
CM	1%	1%	3%	3%
MS	0%	0%	0%	0%
Portal	0%	0%	0%	4%

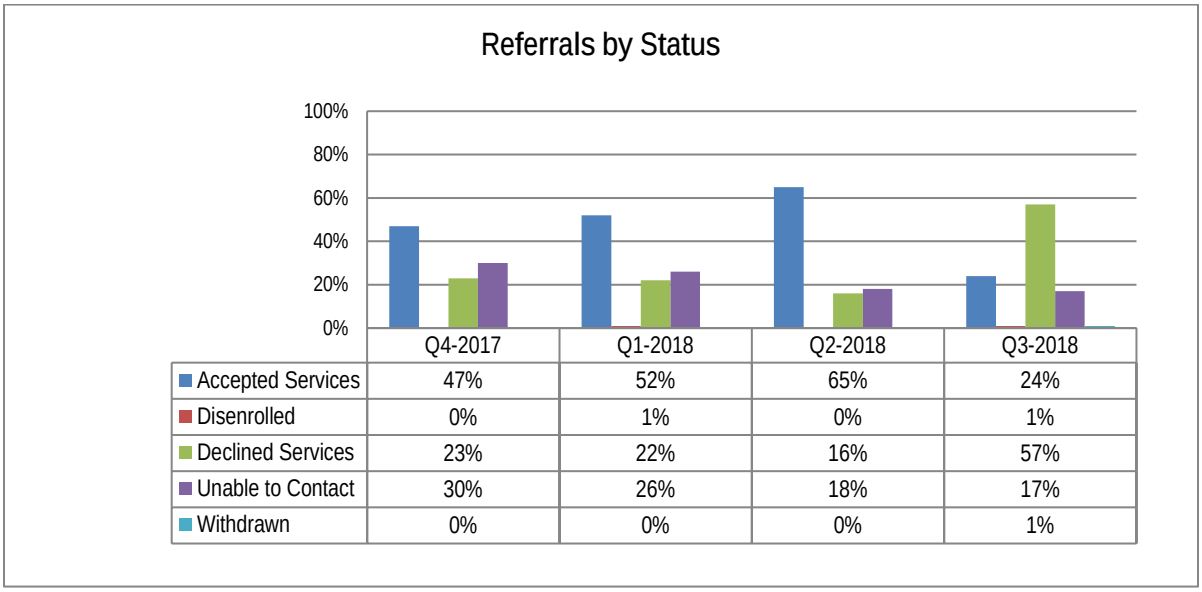
During this quarter, 788 referrals were received which is an 82% increase in comparison to the previous quarter. The increase is attributed to the HE department receiving more provider referrals.

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Third Quarter 2018



	Q4-2017	Q1-2018	Q2-2018	Q3-2018
Asthma	3%	4%	2%	9%
Diabetes	3%	3%	7%	5%
Gestational Diabetes	0.0%	0%	0%	0%
Other Nutritional Counseling	1%	2%	2%	4%
Tobacco Cessation	1%	1%	2%	2%
Weight Mgmt - Adult	10%	16%	13%	13%
Weight Mgmt - Ped/Teen	82%	74%	74%	66%
Stroke	0%	0%	0%	1%

The HE department receives referrals for various health conditions. Weight management education continues to be the most requested service for members. It accounted for 79% of all referrals received in the 3rd Quarter of 2018.



	Q4-2017	Q1-2018	Q2-2018	Q3-2018
Accepted Services	47%	52%	65%	24%
Disenrolled	0%	1%	0%	1%
Declined Services	23%	22%	16%	57%
Unable to Contact	30%	26%	18%	17%
Withdrawn	0%	0%	0%	1%

The rate of members who accepted to receive health education services decreased from 65% in the 2nd quarter to 24% in the 3rd quarter in 2018. This decrease is attributed to the termination

of in-home health education services previously provided through the CWP contract. The HE department is currently in the process of identifying and establishing other available services within the county.

HEALTH EDUCATION SERVICE PROVIDERS

The HE department offers various types of services through KHS or through community partnerships.

Kern Family Health Care (KFHC):
- Healthy Eating and Active Lifestyle Workshop
- Breathe Well Asthma Workshop
- Intro to Gardening
- Rethink Your Drink

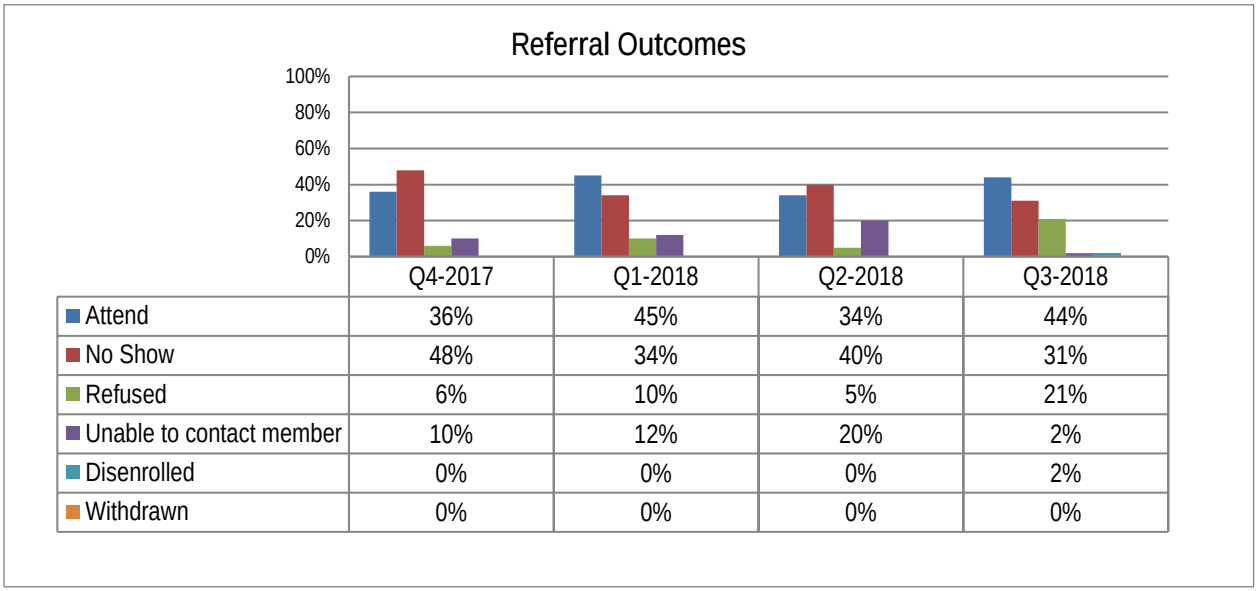
Bakersfield Memorial Hospital (BMH):
- Diabetes Management Classes (English only)
- Heart Healthy Classes
- Small Steps to a Healthier Weight (English only)
- Individual Nutrition Counseling

Community Wellness Program (CWP):
- In-home or group setting for Asthma, Diabetes, Nutrition or Stroke Prevention Education
- Freedom from Smoking Program

Clinica Sierra Vista (CSV) WIC:
- Diabetes Management Classes
- Heart Healthy Classes

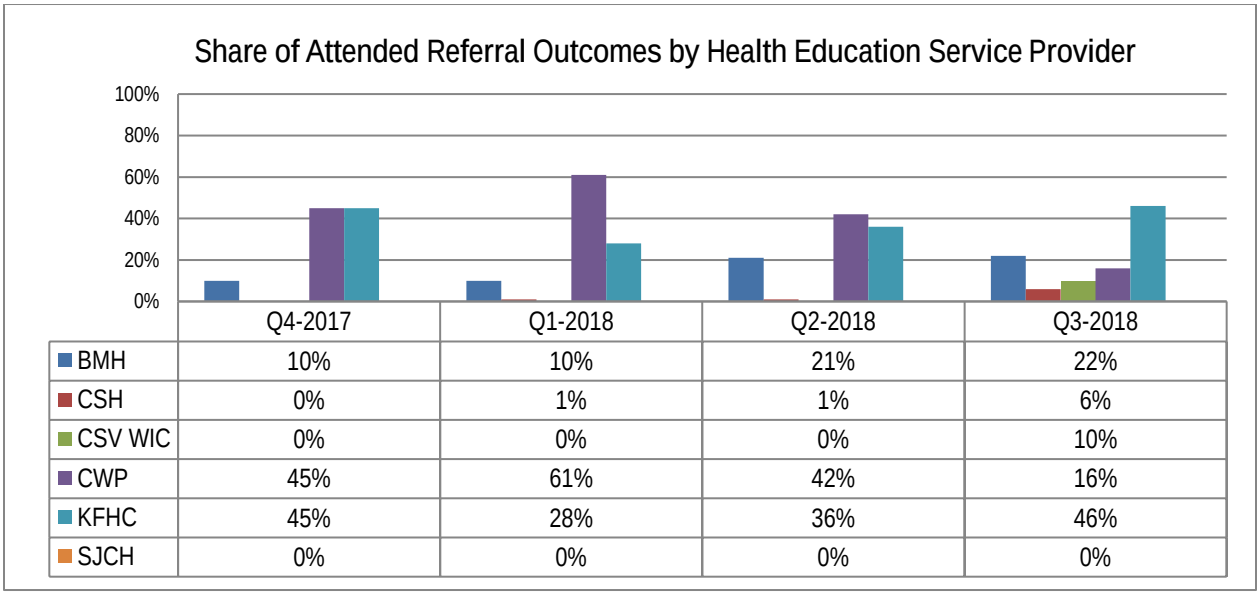
California Smokers' Helpline (CSH):
- Telephone Smoking Cessation Counseling

REFERRAL OUTCOMES



	Q4-2017	Q1-2018	Q2-2018	Q3-2018
Attend	36%	45%	34%	44%
No Show	48%	34%	40%	31%
Refused	6%	10%	5%	21%
Unable to contact member	10%	12%	20%	2%
Disenrolled	0%	0%	0%	2%
Withdrawn	0%	0%	0%	0%

During this quarter, the rate of members who received health education services out of all members who accepted services increased from 34% to 44%.



	Q4-2017	Q1-2018	Q2-2018	Q3-2018
BMH	10%	10%	21%	22%
CSH	0%	1%	1%	6%
CSV WIC	0%	0%	0%	10%
CWP	45%	61%	42%	16%
KFHC	45%	28%	36%	46%
SJCH	0%	0%	0%	0%

Services through KFHC demonstrates to be one of the largest share of referral outcomes. This quarter KFHC showed an increase from 36% in 2nd quarter to 46% in the 3rd Quarter of 2018.

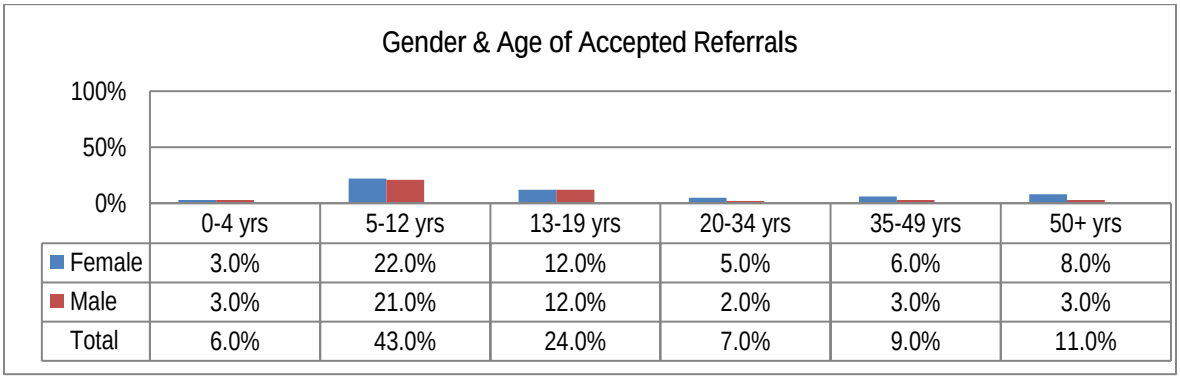
This increase is attributed to the termination of the CWP contract and encouraging members to participate in the KFHC workshops.

Effectiveness of Health Education Services

To evaluate the effectiveness of the health education services provided to members, a 3-month follow up call was conducted on members who received services during the prior quarter. Although 3 month follow up calls were performed for 121 members, reporting delays prevented the HE department from accessing the assessment findings from the calls performed in the 3rd quarter. Findings from the assessment are anticipated to be reported on starting in the 4th quarter.

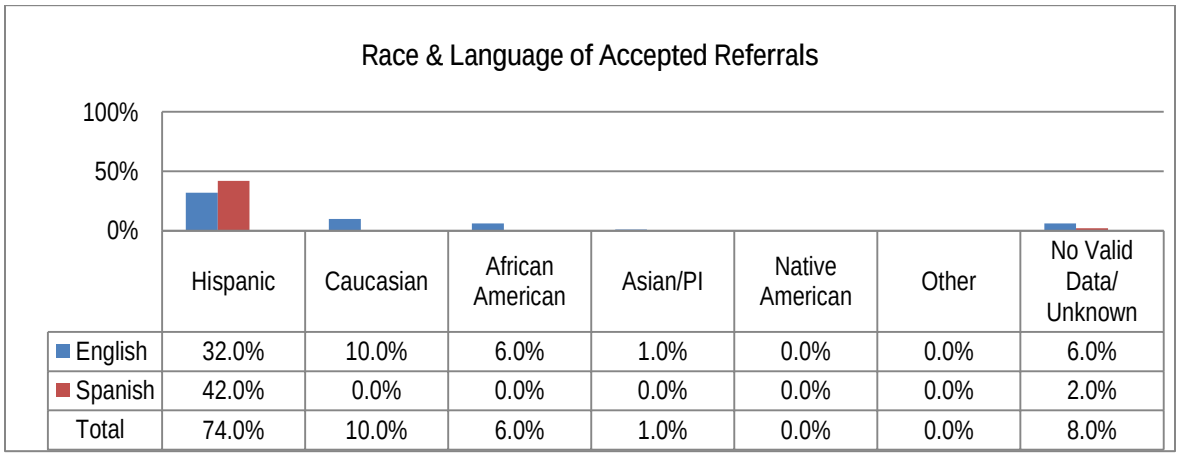
Demographics of Members

KHS' provides services to a culturally and linguistically diverse member population. KHS' language threshold is English and Spanish and all services and materials are available in these languages.



	0-4 yrs	5-12 yrs	13-19 yrs	20-34 yrs	35-49 yrs	50+ yrs
Female	3.0%	22.0%	12.0%	5.0%	6.0%	8.0%
Male	3.0%	21.0%	12.0%	2.0%	3.0%	3.0%
Total	6.0%	43.0%	24.0%	7.0%	9.0%	11.0%

Out of the members who were referred for health education services, the largest gender-age groups were male ages 5-12 years and female ages 5-12yrs.



	Hispanic	Caucasian	African American	Asian/PI	Native American	Other	No Valid Data/ Unknown
English	32.0%	10.0%	6.0%	1.0%	0.0%	0.0%	6.0%
Spanish	42.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.0%
Total	74.0%	10.0%	6.0%	1.0%	0.0%	0.0%	8.0%

A breakdown of member classifications by race and language preferences revealed that 74% of members who accepted services are Hispanic and prefer to speak English or Spanish.

Referrals Accepted by Top Bakersfield Zip Codes

Q4-2017	Q1-2018	Q2-2018	Q3-2018
93307	93307	93307	93306
93306	93306	93306	93307
93305	93304	93304	93305
93304	93305	93309	93304
93309	93309	93305	93309

KHS serves members in the Kern County area. During this quarter, 84% of the members who accepted services reside in Bakersfield and the highest concentration of members were in the 93306 area.

Referrals Accepted by Top Outlying Areas

Q4-2017	Q1-2018	Q2-2018	Q3-2018
Delano	Delano	Arvin	Delano
Lamont	Wasco	Delano	Arvin
Shafter	Shafter	Wasco	Lamont
Arvin	Arvin	Lamont	Shafter
McFarland	Lamont	McFarland	California City
Wasco	McFarland	Shafter	

Additionally, 16% of the members who accepted services reside in the outlying areas of Kern County and the highest concentration of members continue to be in Delano.

Health Education Mailings

In addition to referrals, the HE department mails out a variety of educational material in an effort to assist members with gaining knowledge on their specific diagnosis or health concern. During this quarter, the HE department mailed 3,198 educational packets to members on the following health topics:

Educational Mailings

	Q4-2017	Q1-2018	Q2-2018	Q3-2018
Asthma	31	19	6	25
High Cholesterol	6	4	4	15
Diabetes	15	15	17	92
Gestational Diabetes	0	2	1	0
High Blood Pressure	20	14	18	14
COPD	0	0	0	1
Postpartum Care	408	14	52	36
Prenatal Care	254	8	11	10
Smoking Cessation	10,199	68	11	136
Weight Management	893	674	496	57
WIC	2473	2360	1730	2444
Total	**14,574**	**3,178**	**3,198**	**2832**

PM160 PROCESSING

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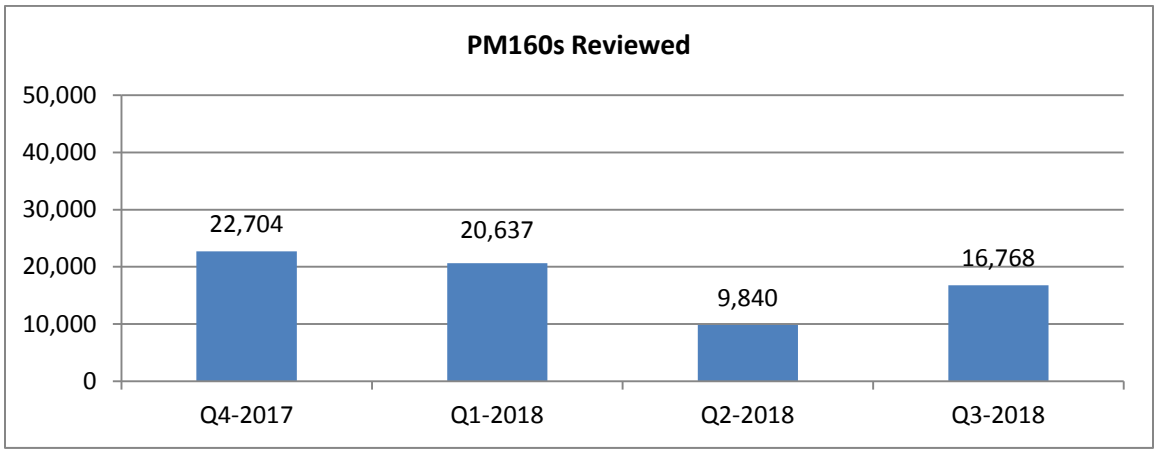


INTERPRETER REQUESTS

Face-to-Face Interpreter Requests

During this quarter, there were 161 requests for face-to-face interpreting services received. KHS employs qualified staff interpreters in Spanish and contracts with the interpreting vendor, CommGap. The majority of these requests were for a Spanish interpreter.

Top Languages Requested			
Q4-2017	**Q1-2018**	**Q2-2018**	**Q3-2018**
Spanish	Spanish	Spanish	Spanish
Arabic	Arabic	Cantonese	Cantonese
Cambodian	Cantonese	Vietnamese	Vietnamese
	Punjabi	Punjabi	Punjabi

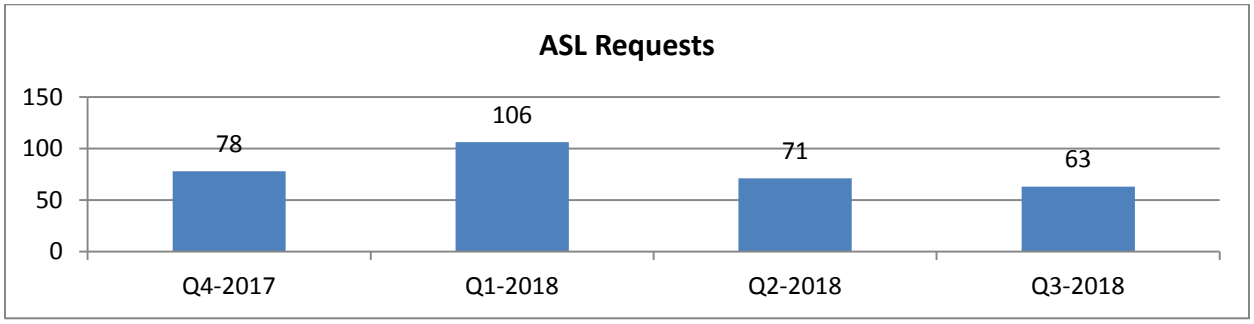
Telephonic Interpreter Requests

During this quarter, there were 413 requests for telephonic interpreting services through KHS' interpreting vendor, Language Line Solutions. The majority of these requests were for a Spanish interpreter.

Top Languages Requested			
Q4 - 2017	**Q1-2018**	**Q2-2018**	**Q3-2018**
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Arabic	Arabic	Arabic	Arabic
Tagalog	Tagalog	Tagalog	Tagalog
Vietnamese	Vietnamese	Vietnamese	Vietnamese

American Sign Language (ASL) Requests

During this quarter, there were a total of 63 requests received for an American Sign Language interpreter, which was a decrease in comparison to the previous quarter.



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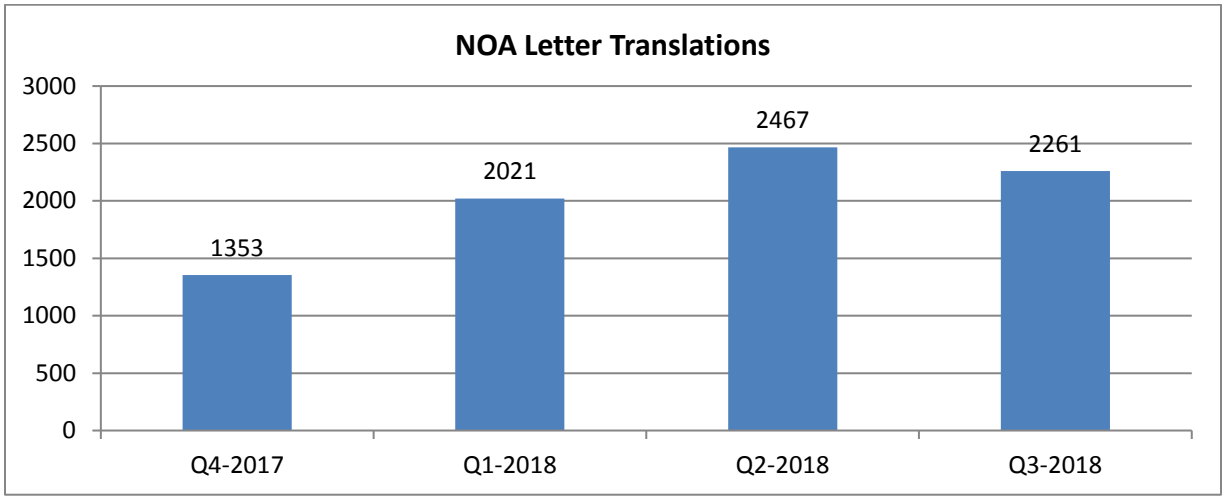

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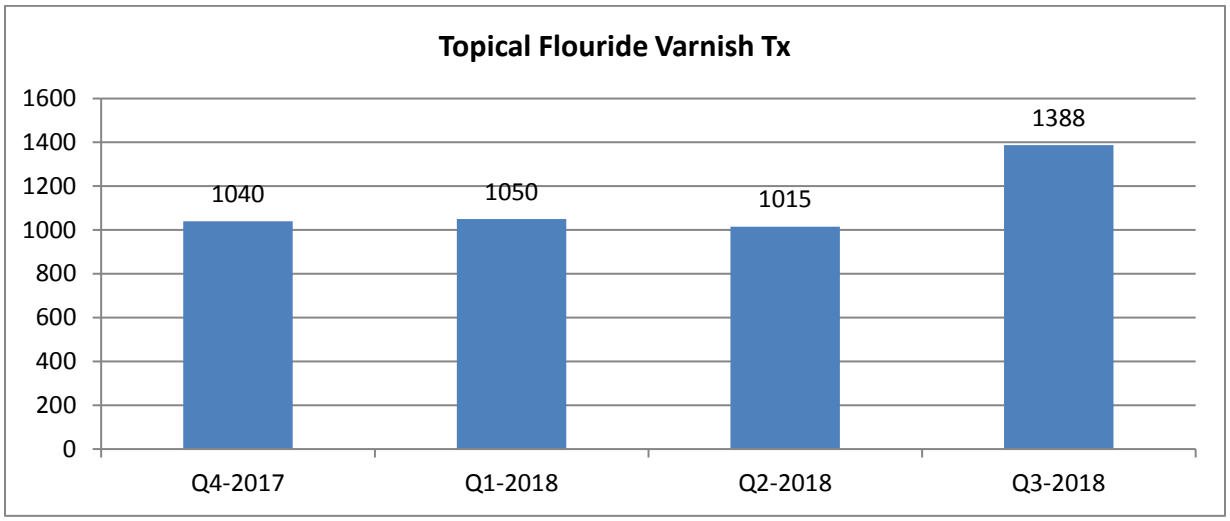

PERINATAL OUTREACH AND EDUCATION

The HE department performs outreach education calls to all members identified as being pregnant in the 1st trimester, a pregnant teen (under age 18), or postpartum due to a c-section or teen pregnancy delivery. During the 3rd quarter, 91 episodes for pregnant and 102 postpartum members were created. Although 17 prenatal and 63 postpartum were successfully reached, reporting delays prevented the HE department from accessing the assessment findings from these calls. Findings from the assessment are anticipated to be reported on starting in the 4th quarter.

MEMBER WELLNESS AND CHRONIC CONDITION BASED INCENTIVES

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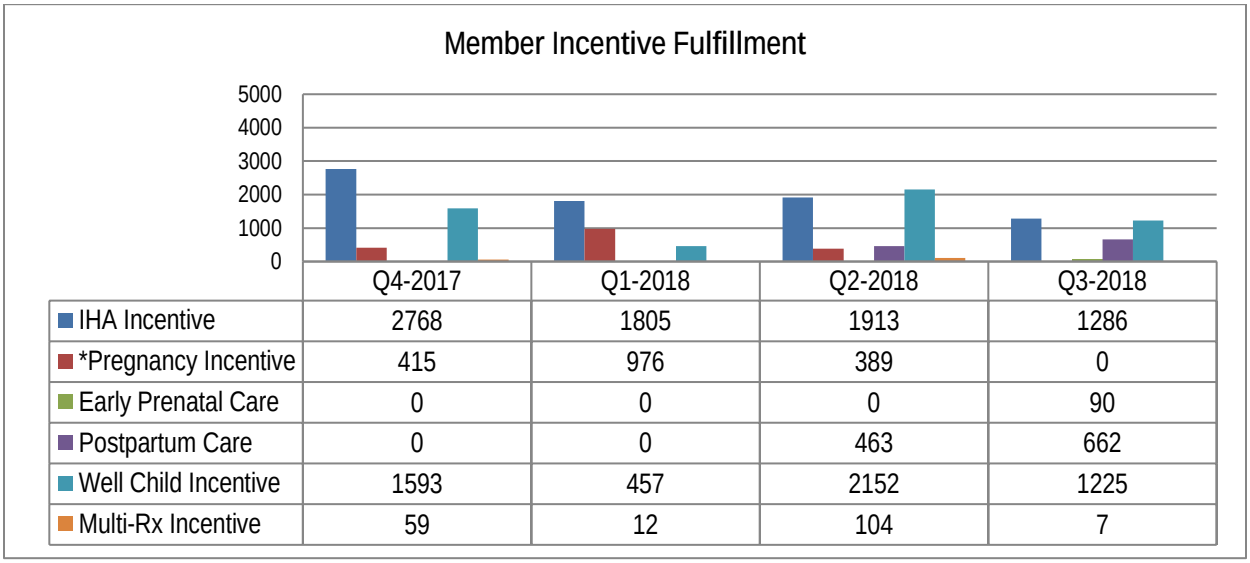
KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Third Quarter 2018



	Q4-2017	Q1-2018	Q2-2018	Q3-2018
IHA Incentive	2768	1805	1913	1286
*Pregnancy Incentive	415	976	389	0
Early Prenatal Care	0	0	0	90
Postpartum Care	0	0	463	662
Well Child Incentive	1593	457	2152	1225
Multi-Rx Incentive	59	12	104	7

**This program has been discontinued as of 3/15/18.*

2019 Health Education and Cultural and Linguistic Work Plan

	Goals	Objectives	Activities	Timeline	Responsible Department(s)
1	Promote access to free interpreting services among members and providers.	A. Educate members on the the availbility of free interpreting services. B. Educate providers on how to access KHS interpreting services and effectively communicate with LEP members. C. Offer video remote interpreting services as appropriate when in-person interpreters are not accessible.	1. Include language access taglines in the member newsletter issues and messages on IVR, member portal, KHS social media pages 2. Include information on free interpreting services in community presentations and health education workshops. 3. Distribute brochures and posters to provider offices on how to access KHS intepreting services. 4. Post annual provider bulletin to provider portal on C&L services. 5. Conduct provider in-services on process for requesting interpreters and how to effectively communicate with LEP members. 6. Maintain contract for VRI services.	12/31/2019	Health Education Member Services Provider Relations Marketing Quality Improvement

2	Improve member health literacy and communication skills with providers and KHS.	A. Educate members on how to communicate their health needs with their medical team and KHS using a variety of communication methods.	1. Message to members on IVR, member portal, KHS social media pages, and newsletter. 2. Continue the 3 Question"Ask Your Doctor" educational campaign targeted at specific chronic conditions. 3. Continue to make available educational tools for providers to distribute to KHS members on communicating health needs.	12/31/2019	Health Education Member Services Provider Relations Marketing Quality Improvement
3	Reduce the rate of unnecessary ED visits and increase the proper utilization of urgent care and preventive care services	A. Educate members on how to access and appropriately use the health plan benefits and health care services. B. Educate members on how the benefits of the 24 hour advice nurse line and how to access the service. C. Participate in community collaboratives targeting unecessary ED visits.	1. Message to members on portal, IVR, KHS social media pages, and newsletter. 2. Participate in community initiatives, that address ED, urgent care or accessing preventive care services. 3. Incorporate information on appropriate use of services in health education workshops. 4. Make available self-care materials to members that target prevention and home treatment of common illnesses that can be treated at home and prevented. 5. Make available educational tools to providers to distribute to KHS members.	12/31/2019	Health Education Member Services Provider Relations Marketing Quality Improvement

4	Increase member participation in KHS health education workshops.	A. Promote KHS health education services among members and providers. B.Evaluate the effectiveness of health education programs and incentives. C. Train staff to promote health education services and incentives. D. Train additional staff to aid in facilitatation of health education workshops. E. Identify additional locations to host health education workshops.	1. Provider bulletin reminder on health education services and incentives. 2. Conduct refresher staff training on service promotion 3. Provide copies of health education workshop flyer to provider offices and community events/meetings to distribute. 4. Message to members on portal, IVR, KHS social media pages, and newsletter. 5. Meet with key department heads on promotion of KHS workshops. 6. Revise follow up and evaluation plan for nutrition and asthma workshops. 7. Continue Public Health Internship partnership with Bakersfield College. 8. Offer at least 2 new site locations for health education workshops.	12/31/2019	Health Education Member Services Provider Relations Marketing Quality Improvement

5	Provide KHS members and providers access to health education materials, programs and resources.	A. Utilize KHS social media channels to provide health education. B. Offer health education workshops throughout the county. C. Enhance member experience in accessing health education services through the member portal. D. Enhance provider experience in requesting health education services for KHS members. E. Expand library of health education materials. F. Educate members and providers on available tobacco/smoking cessation services.	1. Produce social media postings. 2. Facilitate health education workshops within the identified top 3-5 high priority areas. 3. Make enhancements to member portal to allow members to view a schedule of health education workshops and sign up for specific workshops. 4. Make available additional health education materials and resources that target common childhood illnesses that can be prevented or self treated at home. 5. Continue to research the possibility of identifying or developing high demand health education material in non-threshold languages. 6. Provider bulletins on asthma and tobacco/smoking cessation programs and resources for KHS members. 7. Annual educational mailing to members on the KHS tobacco registry report.	12/31/2019	Health Education Member Services Provider Relations Marketing Quality Improvement

6	Improve the readability and member engagement of health education and promotion materials.	A. Evaluate the layout and images health education and promotion materials due for review in 2018. B. Increase staff knowledge in producing and identifying easy to read health education materials.	1. Review and recommend revisions or replacement of health education materials. 2. Research and identify additional health education material produced by vendors that is easy to read. 3. Conduct staff refresher training on improving readability of member material. 4. Participate in health literacy webinars, conferences, etc.	12/31/2019	Health Education Marketing Quality Improvement Member Services

7	Maintain and establish new relationships with community partners to help address policy, systems and environmental (PSE) factors of health.	A. Collaborate with schools and other community partners on programs and services that address community health. B. Support community partners on projects and programs that address PSE factors of health. C. Increase staff knowledge on best practices to address PSE factors of health.	1. Continue to partner with schools and districts to provide health education workshops that address asthma, obesity and other chronic conditions. 2. Implement 2nd cycle of School Wellness Grant program. 3. Provide letters of support, grant funding, donations, and/or staff time towards community projects and programs, as needed. 4. Participate in webinars, conferences, events and meetings that help address PSE factors of health. 5. Meet with City Parks and Recreation or County of Kern to discuss the PSE collaboration opportunities, combine health educaiton efforts, and discuss the possibility offering health education programs at parks or park facilities.	12/31/2019	Health Education Marketing

8	Promote programs and resources targeted for SPD members.	A. Collaborate with KHS Departments and community partners to address the needs of SPD members. B. Educate SPD members on new and existing programs and resources. C. Educate providers on the programs and resources available for SPD members.	1. Participate in community meetings and events that address the needs of SPD members. 2. Share new programs and resources with SPD members, as available. 3.Collaborate with Case and Disease Management Departments and community partners on the development of member newsletter articles. 4. Provide health education and promotion messages to SPD members through the member newsletter, IVR, member portal, and KHS social media sites. 5. Update the KHS community resource list, as needed. 6. Participate in media opportunities to promote health education programs. 7. Continue to promote health education programs on KHS social media sites and website.	12/31/2019	Health Education Case Management Disease Management Member Services Marketing

9	Improve member outreach and engagement strategies of the Pregnancy Management Program	A. Collaborate with Community Based Organizations to identify pregnant members and facilitate access to care. B. Evaluate effectiveness of new pregnancy incentive program C. Survey pregnant members to identify barriers to care and perceptions. D. Educate members on the importance of timely and regular care.	1.Establish additional community partners to promote pregnancy care and incentive programs. 2. Continue training outreach staff to include educational talking points. 3.Complete pregnancy incentive annual evaluation. 4. Participate in meetings and product demonstrations of pregnancy management programs offered by vendors.	12/31/2019	Health Education Quality Improvement Marketing Member Services

Health Services Quarterly Committee Reporting- Reporting Period July 1, 2018 to September 30, 2018

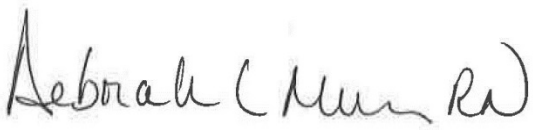
Health Services Overview

The 2018 membership enrollment remained stable at 252,000 in Q2 2018. Additional benefit coverage and broadening interdisciplinary collaboration to support the membership growth will continue through 2018.

- Diabetes Prevention Program-anticipated 1/1/19
- Partnership with Public Health- pregnancy related interventions
- Member engagement outreach vendor
- MCG Medical Criteria-provider interface 2019
- Health Home Program-DHCS mandate
- DHCS audit results-pending
- HEDIS 2019
- Telemedicine expansion-home interactions between member and provider
- Building move

The following pages reflect statistical measurements for Utilization Management, Case Management and Disease Management detailing the ongoing compliance activity for the 3rd Quarter 2018.

Respectfully submitted,



Deborah Murr RN, BS HCM
Administrative Director of Health Services
Kern Health System

Utilization Management Reporting

Timeliness of Decision Trending

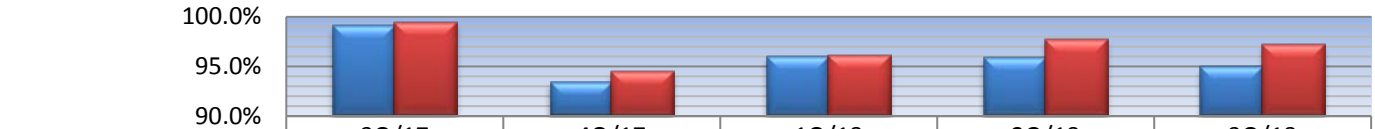
Summary:
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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

There were 47,859 referrals processed in the 3rd quarter 2018 of which 4,307 referrals were reviewed for timeliness of decision. In comparison to the 2nd quarters processing time, the routine referrals decreased from the 2nd quarter which was 97.7% to 97.2% and urgent referrals decreased from 2nd quarter which was 95.9% to 95.0%.

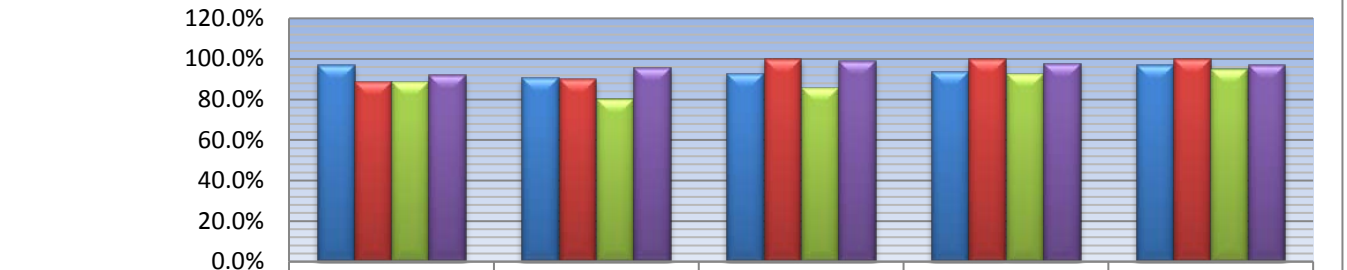


	3Q/17	4Q/17	1Q/18	2Q/18	3Q/18
Urgent Compliance %	99.1%	93.4%	96.0%	95.9%	95.0%
Routine Compliance %	99.4%	94.5%	96.1%	97.7%	97.2%

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

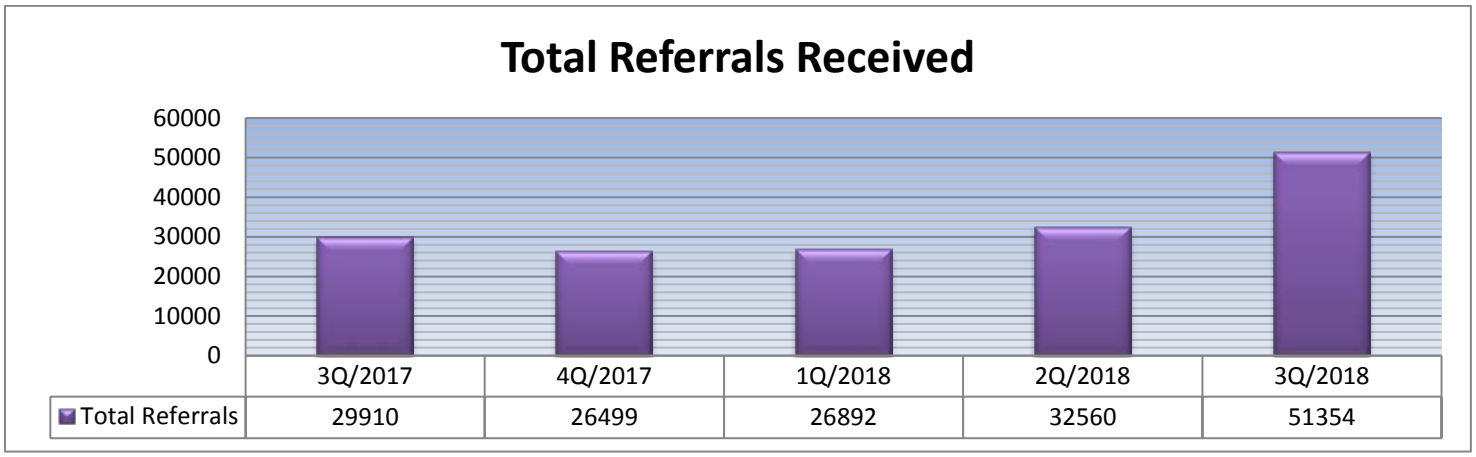
- MD Signature: MD Signature included all referrals/NOA letters upon denial

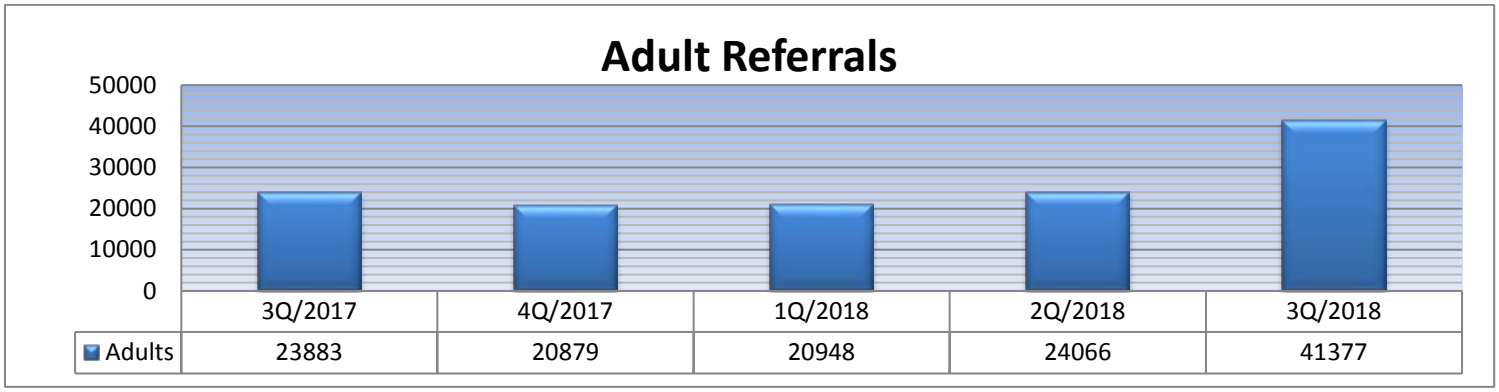


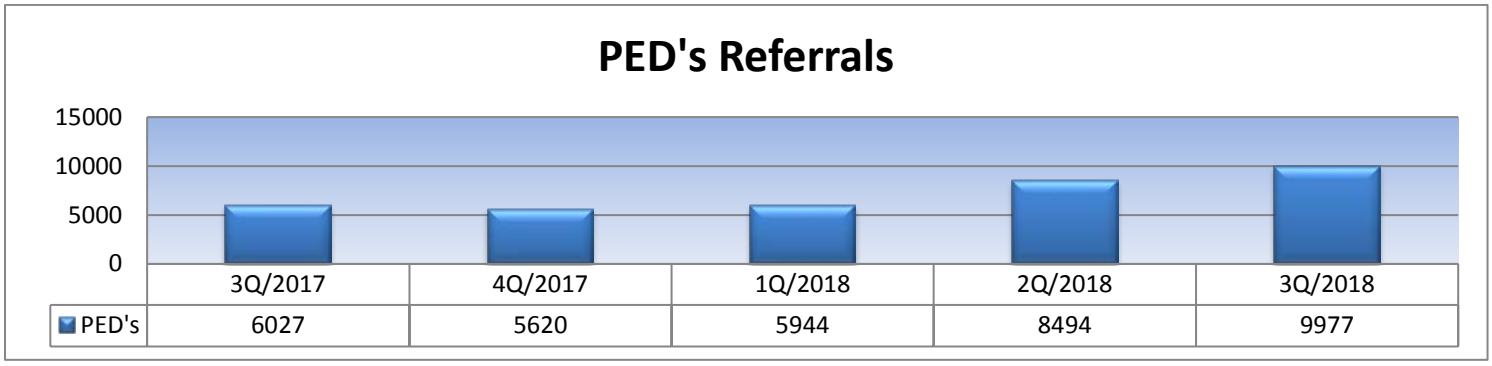
	3Q/17	4Q/17	1Q/18	2Q/18	3Q/18
Member Notification	97.0%	91.0%	93.0%	94.0%	97.0%
Provider Notification	89.0%	90.0%	100.0%	100.0%	100.0%
Criteria Included	89.0%	80.0%	86.0%	93.0%	95.0%
MD Signature Included	92.0%	96.0%	99.0%	98.0%	97.0%

Summary: Overall compliance rate from the 3rd Qtr of 2018 is 97.3% which increased from the 2nd Qtr which was 96.3%.

Outpatient Referral Statistics







KHS Monthly Inpatient and LOS Report

Report captures how many members were inpatient during reporting month, excluding CCS denials

Dates of Discharge Between : 07/01/2018-09/30/2018

	20 and Under	Over 20	Totals
Total Inpatient:	877	5,358	**6,235**
Total LOS:	2,244	21,383	**23,627**
Average LOS:	2.6	4.0	**3.8**

PAR Facilities	Admits	LOS	Average LOS
Totals :	5,923	21,832	3.7
Adult Inpatient	4,034	15,261	3.8
Adult Observation	841	2,337	2.8
Adult Rehab/SNF	0	2,108	10.8
Pediatric Inpatient	850	2,111	2.5
Pediatric Rehab/SNF	3	15	5.0

NPAR Facilities	Admits	LOS	Average LOS
Totals :	312	1,795	5.8
Adult Inpatient	243	1,098	4.5
Adult Observation	10	20	2.0
Adult Rehab/SNF	35	559	16.0
Pediatric Inpatient	23	88	3.8
Pediatric Rehab/SNF	1	30	30.0

Activity by Facility	Total Inpatient	Total LOS	Average LOS
ADVENTIST HEALTH BAKERSFIELD	1137	4298	3.8
ADVENTIST HEALTH COMMUNITY CAR	5	9	1.8
ADVENTIST HEALTH MEDICAL CENTE	14	32	2.3
ADVENTIST MEDICAL CENTER	6	30	5.0
AHMC GREATER EL MONTE COMMUNIT	2	4	2.0
ANTELOPE VALLEY HOSP	56	272	4.9
ARROWHEAD REG MED CTR	2	14	7.0
BAKERSFIELD HEART HOSPITAL	205	622	3.0
BAKERSFIELD MEMORIAL HOSPITAL	1557	4961	3.2
BANNER BOSWELL MEDICAL CENTER	2	12	6.0
BARSTOW COMM HOSPITA	2	2	1.0

BELLAGIO IN THE DESERT	13	158	12.2
BROWARD HEALTH NORTH	2	16	8.0
CALIFORNIA HOSP MED-BACK	2	2	1.0
CEDARS SINAI MEDICAL CENTER	6	40	6.7
CHILDRENS HOSPITAL OF LOS ANGE	28	108	3.9
CHRISTIAN HOSPITAL NORTHEAST-	1	3	3.0
CITRUS VALLEY MEDICAL CENTER I	2	8	4.0
COMMUNITY MEMORIAL HOSPITAL OF	4	34	8.5
DEANCO HEALTHCARE LLC	2	4	2.0
DELANO REGIONAL MEDICAL CENTER	177	496	2.8
EMANUEL HOSPITAL	2	18	9.0
ENCORE HOSPICE	4	98	24.5
EVERGREEN AT ARVIN HEALTHCARE	6	151	25.2
EVERLASTING HEALTHCARE	4	56	14.0
FRESNO COMMUNITY HOSPITAL AND	19	103	5.4
GGNSC SHAFTER LP	15	193	12.9
GLENDALE ADVENTIST MEDCIAL GRO	2	6	3.0
GLENDALE MEMORIAL HO	2	2	1.0
GOLDEN LIVING CENTER - BAKERSF	10	101	10.1
GOOD SAMARITAN HOSPITAL	2	4	2.0
GOOD SAMARITAN HOSPITAL	137	536	3.9
HARBOR - UCLA MED FOUNDATION	2	2	1.0
HARBORVIEW MEDICAL CENTER	4	50	12.5
HAVASU REGIONAL MED	1	2	2.0
HEALTHBRIDGE CHILDREN'S HOSPIT	1	12	12.0
HEALTHSOUTH BAKERSFIELD REHABI	87	660	7.6
HEIGHT STREET SKILLED CARE	4	72	18.0
HENRY MAYO NEWHALL MEMORIAL HO	11	24	2.2
HOFFMANN HOSPICE OF THE VALLEY	23	213	9.3
JFK MEMORIAL HOSPITAL	2	4	2.0
KAISER FOUNDATION HOSPITALS	2	2	1.0
KAWEAH DELTA MEDICAL CENTER	5	17	3.4
KECK HOSPITAL OF USC	86	418	4.9
KERN COUNTY MEDICAL AUTHORITY	1079	3596	3.3
KERN VALLEY HEALTHCARE DISTRIC	40	107	2.7
KINDRED HOSPITAL - WESTMINSTER	4	24	6.0
KINGSTON HEALTHCARE CENTER	7	72	10.3
LAC USC MEDICAL CENTER	4	24	6.0
LAC/USC MEDICAL CENTER	4	14	3.5
LANCASTER HOSPITAL CORPORATION	15	50	3.3
LIFEHOUSE BAKERSFIELD OPERATIO	4	113	28.3
LIFEHOUSE HEALTH SERVICES	1	10	10.0
LOMA LINDA UNIVERSITY CHILDREN	2	6	3.0
LOMA LINDA UNIVERSITY MEDICAL	2	2	1.0
MARIAN REGIONAL MEDICAL CENTER	4	20	5.0
MARTIN LUTHER KING JR COMMUNIT	6	6	1.0
MEMORIAL MEDICAL CENTER	2	4	2.0

MERCY HOSPITAL	2	6	3.0
MERCY HOSPITAL	1001	3246	3.2
MERCY MEDICAL CENTER	4	22	5.5
MERCY SAN JUAN HOSPITAL	2	2	1.0
METHODIST HOSP SO CA	2	2	1.0
NAPOLI IN THE DESERT	20	279	14.0
NORTHRIDGE HOSPITAL MEDICAL CE	4	18	4.5
OLIVE VIEW MEDICAL CENTER	2	6	3.0
OPTIMAL HOSPICE	1	31	31.0
ORANGE COUNTY GLOBAL MED	6	6	1.0
PACIFICA HOSPITAL OF THE VALLE	4	87	21.8
PARKVIEW COMM HOSPITAL	2	4	2.0
PARKVIEW JULIAN CONVALESCENT H	6	61	10.2
PETERSEN	2	6	3.0
POMONA VALLEY HOSPITAL	2	6	3.0
PRIME HEALTHCARE SERVICES, INC	2	6	3.0
RENOWN REGIONAL	2	30	15.0
RIDGECREST REGIONAL HOSPITAL	1	2	2.0
ROSE DESERT CONGREGATE CARE IN	3	78	26.0
SAINT AGNES MEDICAL CENTER	2	10	5.0
SAINT FRANCIS HOSPITAL	2	8	4.0
SAN MARINO IN THE DESERT	14	208	14.9
SANTA MONICA UCLA MC AND ORTHO	8	42	5.3
SANTA PAULA HOSPITAL	2	2	1.0
SHASTA REGIONAL- PRIME HEALTHC	2	10	5.0
SIERRA VISTA REGIONAL MEDICAL	2	4	2.0
ST FRANCIS MEDICAL CENTER	4	24	6.0
ST MARY MEDICAL CENTER	6	28	4.7
ST VINCENT MED CTR	2	2	1.0
ST. JOSEPH HOSP-ORANGE	2	10	5.0
STANFORD MEDICAL CENTER	2	12	6.0
SUMMERLIN HOSPITAL MEDICAL CEN	1	6	6.0
SUN VALLEY SPECIALTY HEALTHCAR	1	30	30.0
SUNRISE MOUNTAINVIEW HOSPITAL,	5	12	2.4
SUTTER HEALTH SACRAMENTO SIERR	1	2	2.0
THE HOSPITALS OF PROVIDENCE SI	2	2	1.0
TORRANCE MEMORIAL MEDICAL CENT	2	18	9.0
TUCSON MEDICAL CENTER	2	4	2.0
UCI MEDICAL CENTER	2	4	2.0
UCLA MEDICAL CENTER	36	182	5.1
UCSD MEDICAL CENTER	2	2	1.0
UCSF MEDICAL CENTER	2	4	2.0
UNITED CARE FACILITIES	45	478	10.6
UNIVERSITY MEDICAL CENTER	4	34	8.5
UNIVERSITY OF CALIFORNIA DAVIS	2	2	1.0
UNIVERSITY OF UTAH HOSPITAL	2	6	3.0
USC NORRIS CANCERHOSPITAL	16	94	5.9

USC VERDUGO HILLS HOSPITAL	1	3	3.0
VALLEY CHILDRENS HOSPITAL	39	115	2.9
VALLEY CHILDREN'S HOSPITAL	116	381	3.3
VALLEY PRESBYTERIAN HOSPITAL	2	16	8.0
VFP HOMES	2	35	17.5

KHS Monthly Inpatient and LOS Report

Report captures how many members were inpatient at a rehab or skilled nursing facility during reporting month, excluding CCS denials

Dates of Discharge Between : 07/01/2018-09/30/2018

Total Inpatient:	233
Total LOS:	2,754
Average LOS:	11.8

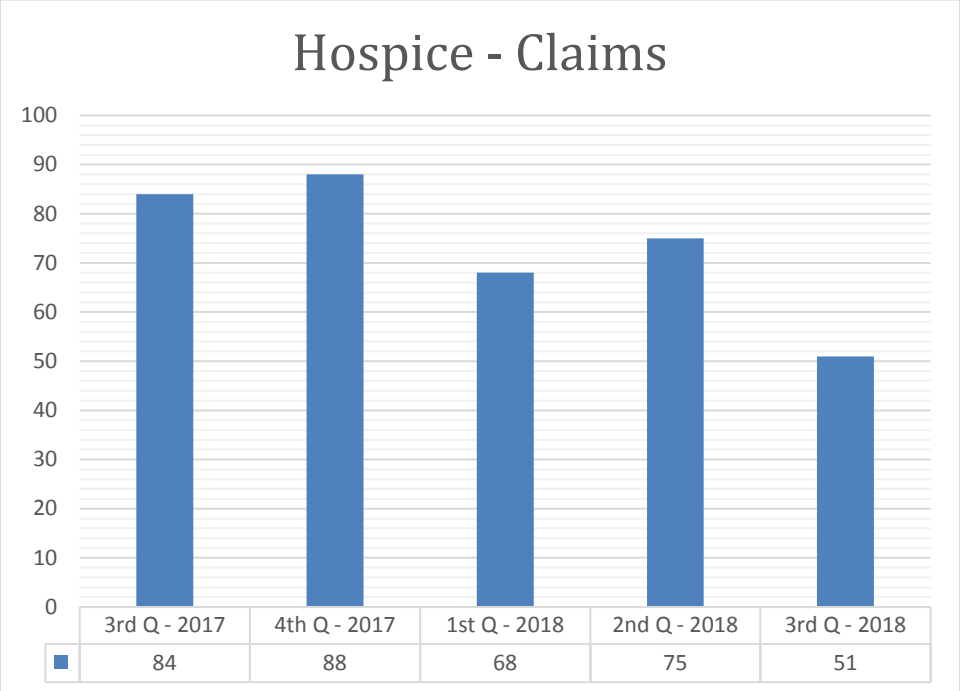
PAR Facilities	Admits	LOS	Average LOS
Totals :	197	2,159	11.0
Adult Rehab	14,184	556	0.0
Adult SNF	24,034	1,588	0.1
Pediatric Rehab	591	15	15.0
Pediatric SNF	0	0	0.0

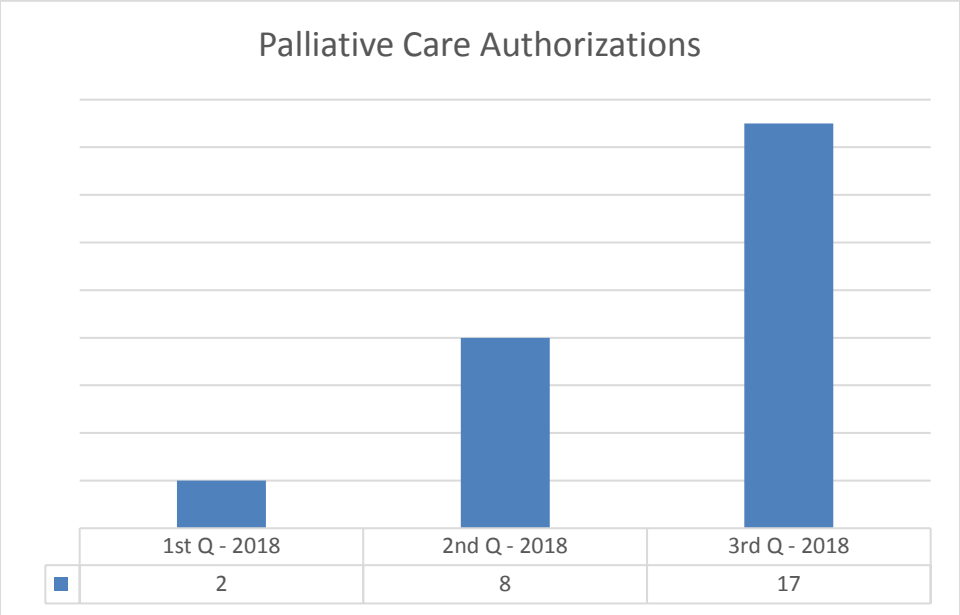
NPAR Facilities	Admits	LOS	Average LOS
Totals :	36	595	16.5
Adult Rehab	72	13	0.2
Adult SNF	1,188	552	0.5
Pediatric Rehab	0	0	0.0
Pediatric SNF	36	30	30.0

Activity by Facility	Total Inpatient	Total LOS	Average LOS
ADVENTIST HEALTH BAKERSFIELD	1	1	1.0
BAKERSFIELD HEART HOSPITAL	1	5	5.0
BAKERSFIELD MEMORIAL HOSPITAL	1	2	2.0
BELLAGIO IN THE DESERT	12	147	12.3
ENCORE HOSPICE	2	49	24.5
EVERGREEN AT ARVIN HEALTHCARE	6	151	25.2
EVERLASTING HEALTHCARE	3	43	14.3
GGNSC SHAFTER LP	12	173	14.4
GOLDEN LIVING CENTER - BAKERSF	9	96	10.7
HEALTHSOUTH BAKERSFIELD REHABI	68	516	7.6
HEIGHT STREET SKILLED CARE	3	56	18.7

HOFFMANN HOSPICE OF THE VALLEY	8	131	16.4
KERN VALLEY HEALTHCARE DISTRIC	2	5	2.5
KINDRED HOSPITAL - WESTMINSTER	2	14	7.0
KINGSTON HEALTHCARE CENTER	7	72	10.3
LIFEHOUSE BAKERSFIELD OPERATIO	3	82	27.3
LIFEHOUSE HEALTH SERVICES	1	10	10.0
MERCY HOSPITAL	3	13	4.3
NAPOLI IN THE DESERT	16	199	12.4
OPTIMAL HOSPICE	2	62	31.0
PACIFICA HOSPITAL OF THE VALLE	2	61	30.5
PARKVIEW JULIAN CONVALESCENT H	6	61	10.2
ROSE DESERT CONGREGATE CARE IN	3	78	26.0
SAN MARINO IN THE DESERT	13	195	15.0
SUMMERLIN HOSPITAL MEDICAL CEN	1	6	6.0
UNITED CARE FACILITIES	40	446	11.2
VFP HOMES	2	35	17.5

Hospice Claims has decreased in the 3rd Quarter 2018.

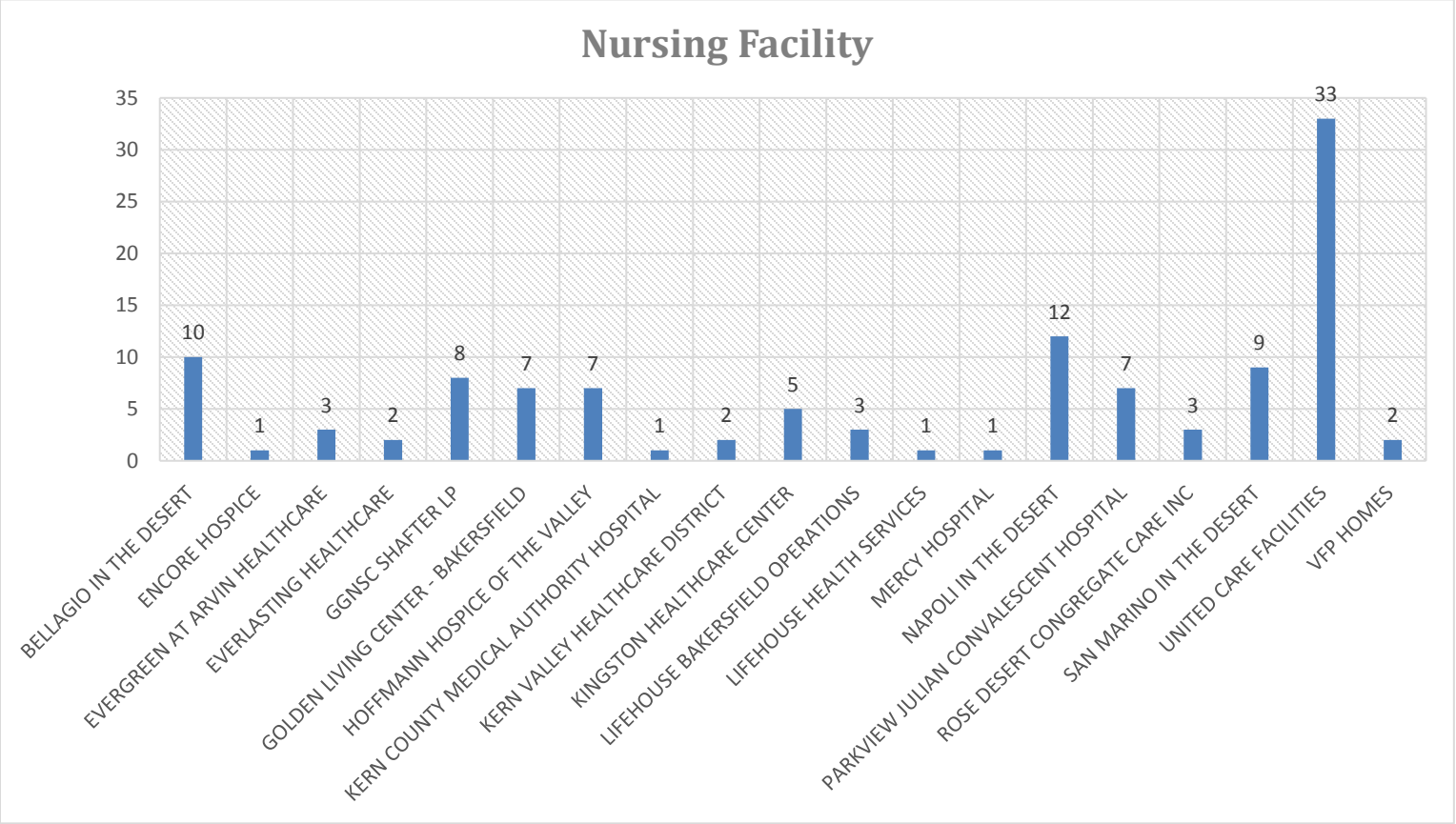



Palliative Care Authorizations
1st Q - 2018
2nd Q - 2018
3rd Q - 2018
2
8
17

Nursing Facility Services Report

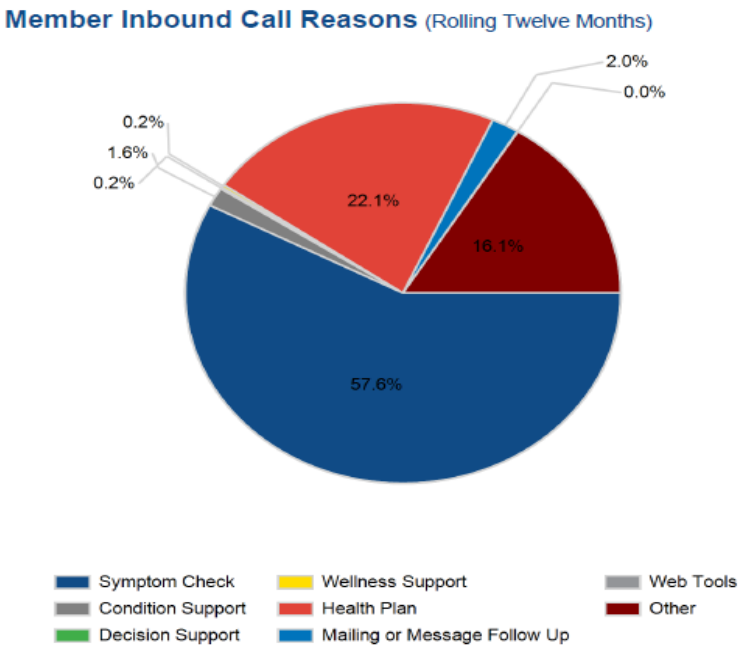
Purpose: Kern Health Systems covers medically necessary Nursing Facility Services for eligible members. KHS members requiring Nursing Facility Services are identified and placed in health care facilities, which provide the level of care most appropriate to the member's medical needs. For members requiring long-term care, KHS coordinates the members care and initiates disenrollment per DHCS criteria. Monthly and quarterly reporting is completed as per Policy 3.42, Sec. 5, for nursing facility services and to identify any current trends.

Summary: Summary: During the 3rd quarter 2018, there were 158 referrals for Nursing Facility Services. The average length of stay was 18.6 days for these members. During the 3rd quarter there were only 2 denials of the 158 referrals.

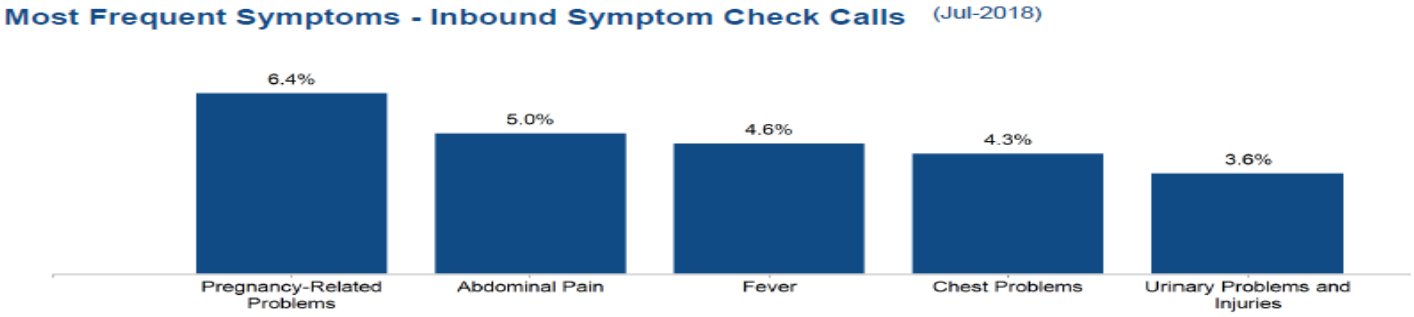


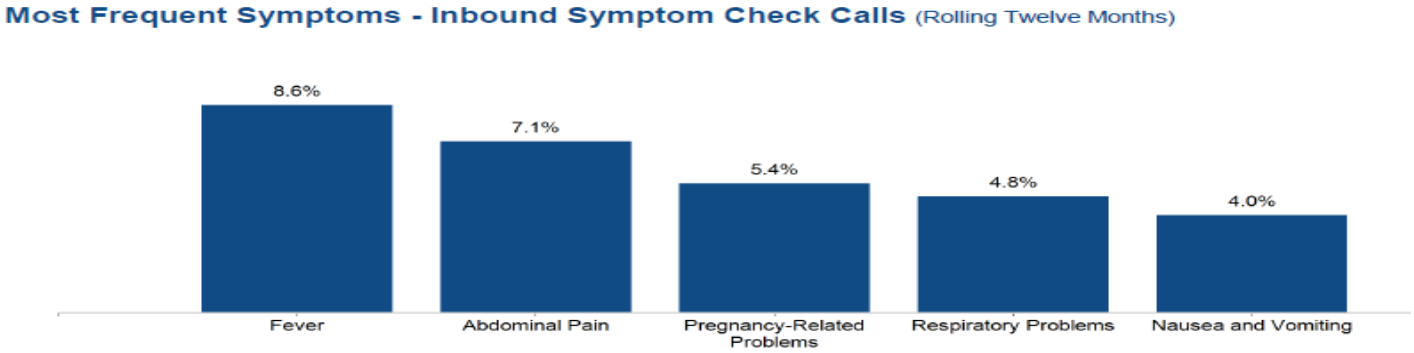
Health Dialog Report

July:



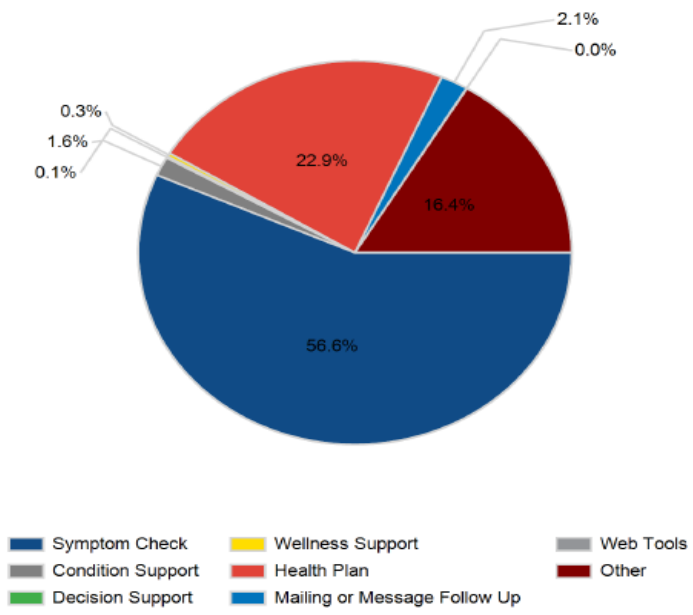
REASON	NUMBER
Symptom Check	2,938
Condition Support	82
Decision Support	8
Wellness Support	12
Health Plan	1,129
Mailing or Message Follow Up	104
Web Tools	2
Other	823





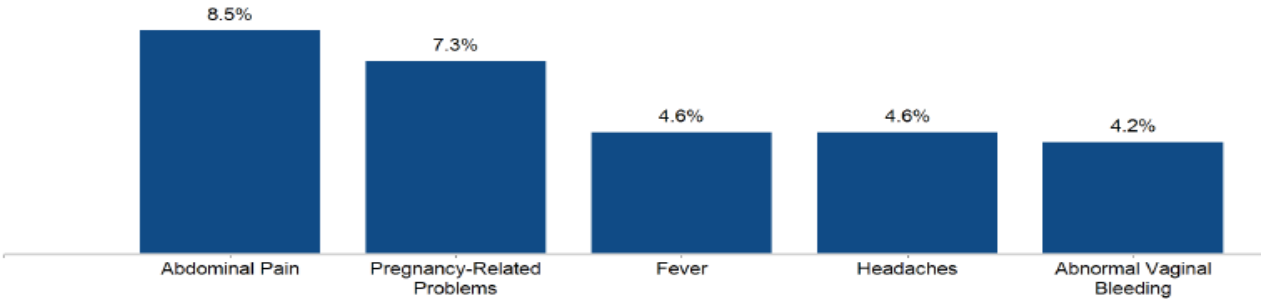
August:

Member Inbound Call Reasons (Rolling Twelve Months)

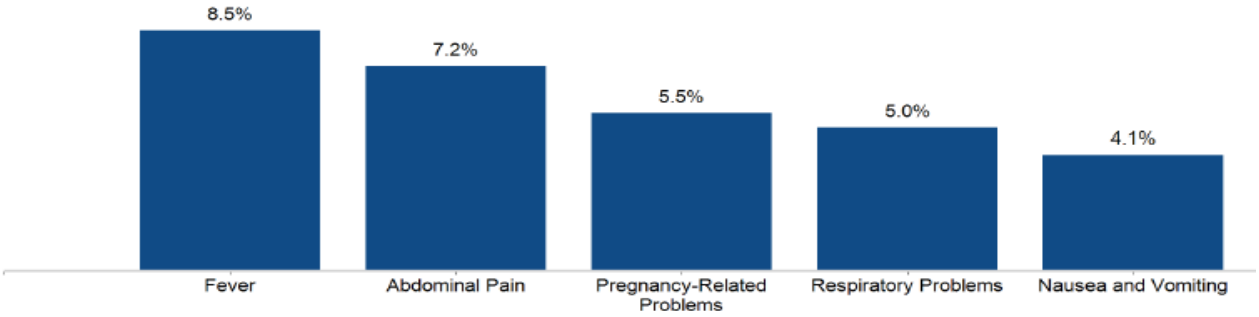


REASON	NUMBER
Symptom Check	2,898
Condition Support	82
Decision Support	7
Wellness Support	16
Health Plan	1,171
Mailing or Message Follow Up	105
Web Tools	2
Other	837

Most Frequent Symptoms - Inbound Symptom Check Calls (Aug-2018)

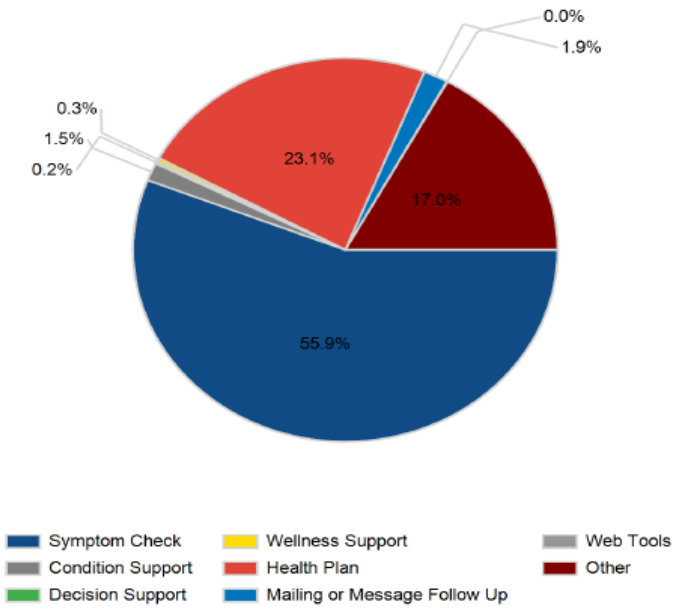


Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



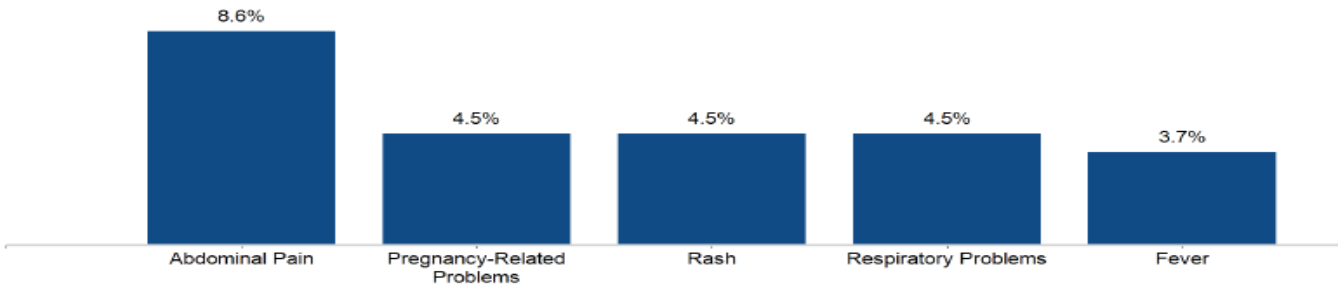
September:

Member Inbound Call Reasons (Rolling Twelve Months)

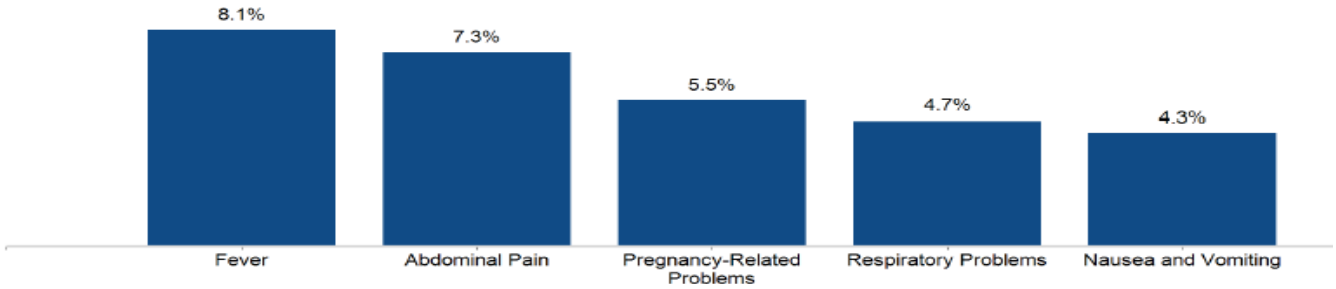


REASON	NUMBER
Symptom Check	2,849
Condition Support	77
Decision Support	10
Wellness Support	16
Health Plan	1,179
Mailing or Message Follow Up	95
Web Tools	2
Other	867

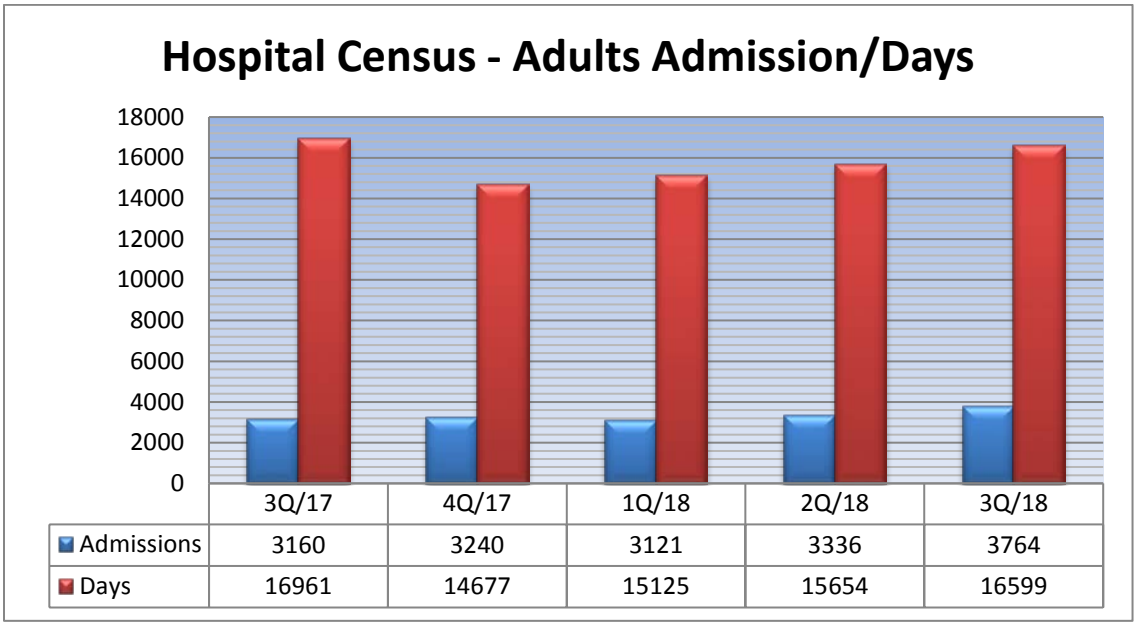
Most Frequent Symptoms - Inbound Symptom Check Calls (Sep-2018)



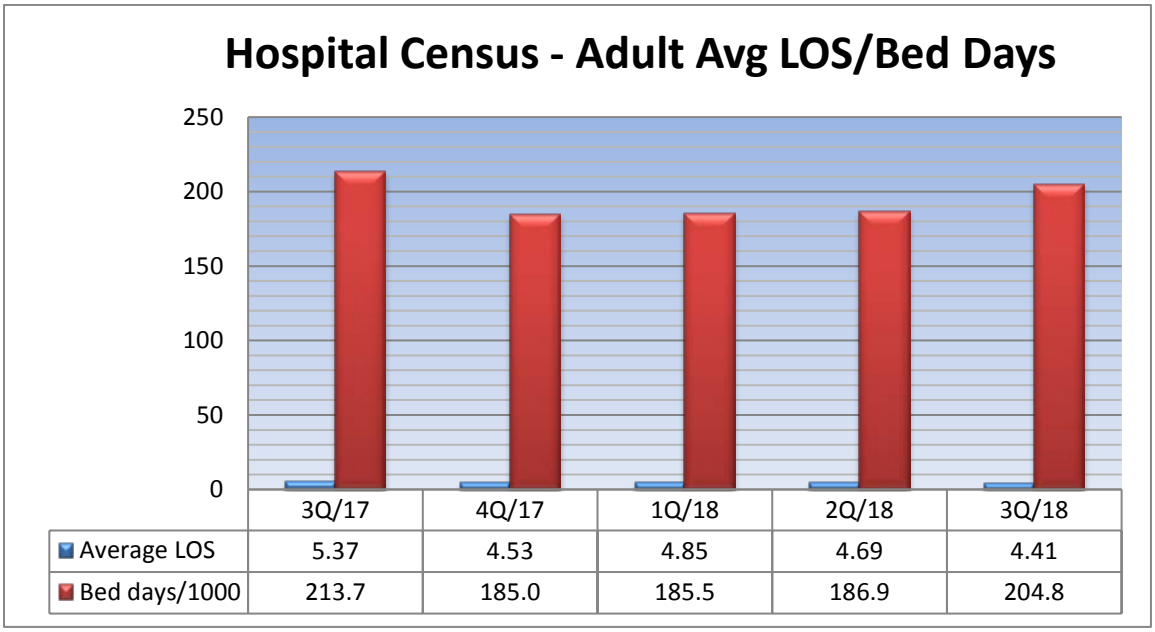
Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



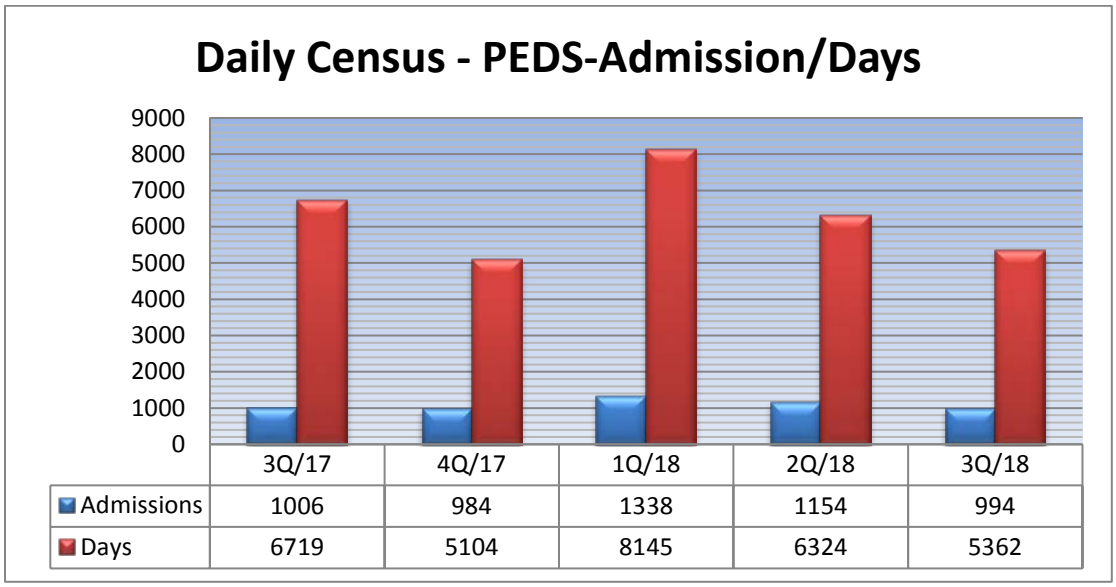
Inpatient 3rd Quarter Trending



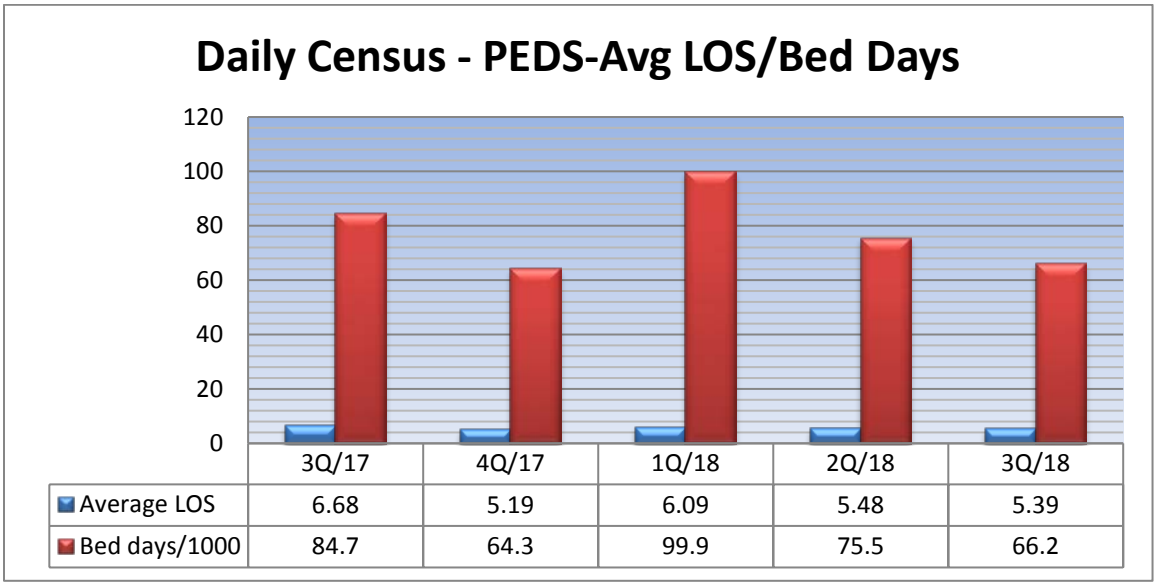
	3Q/17	4Q/17	1Q/18	2Q/18	3Q/18
Admissions	3160	3240	3121	3336	3764
Days	16961	14677	15125	15654	16599



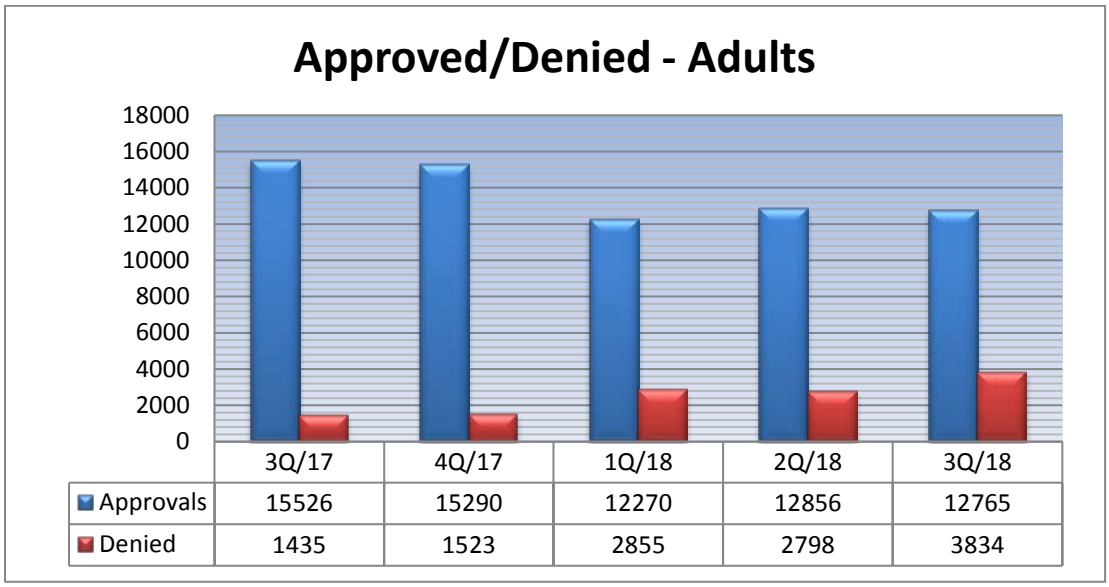
	3Q/17	4Q/17	1Q/18	2Q/18	3Q/18
Average LOS	5.37	4.53	4.85	4.69	4.41
Bed days/1000	213.7	185.0	185.5	186.9	204.8



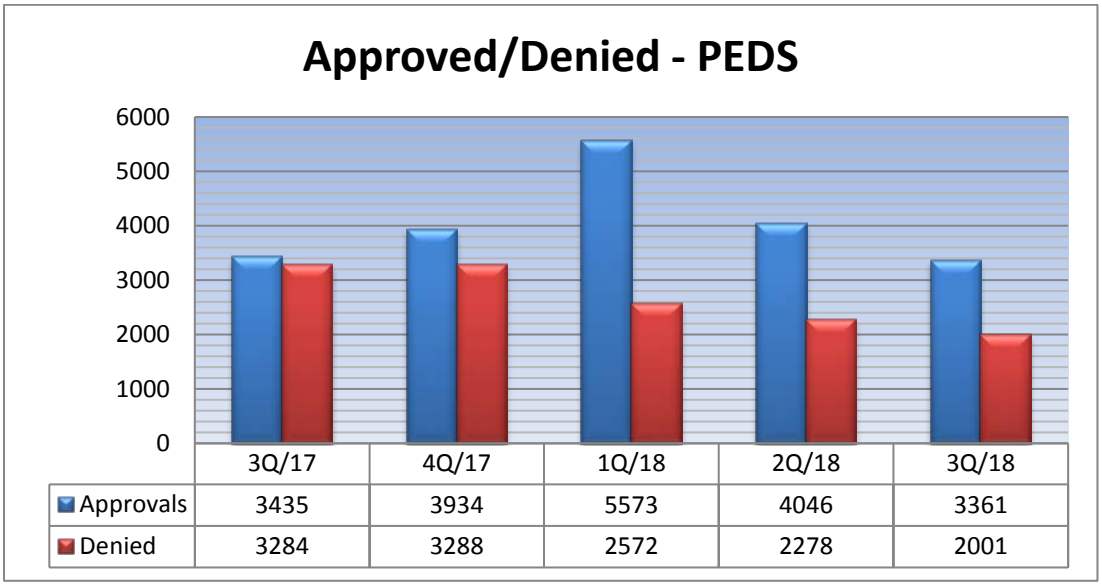
	3Q/17	4Q/17	1Q/18	2Q/18	3Q/18
Admissions	1006	984	1338	1154	994
Days	6719	5104	8145	6324	5362



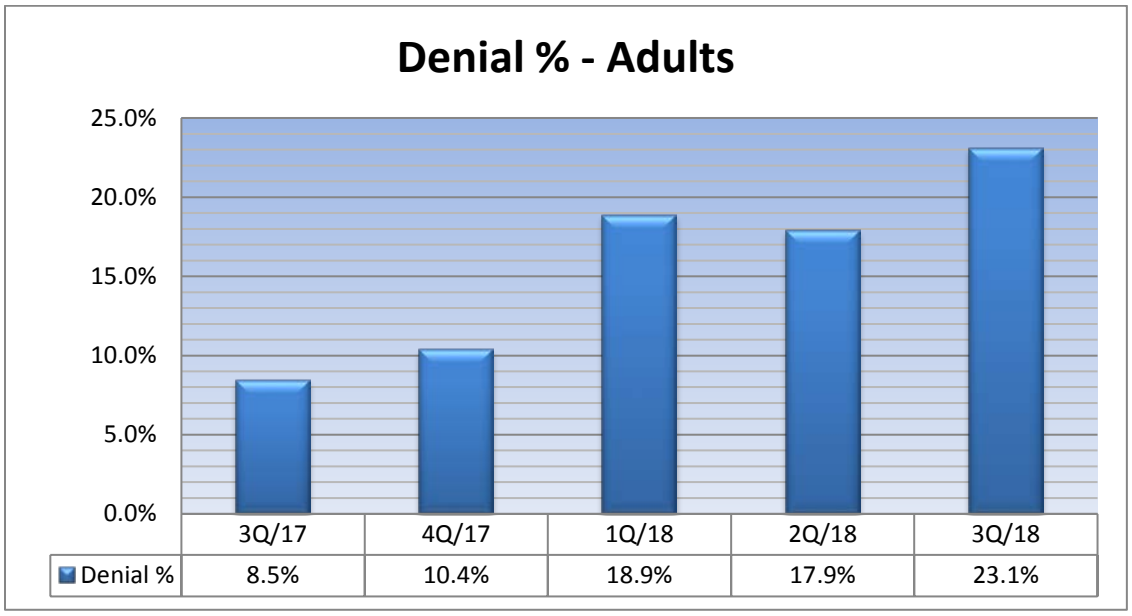
	3Q/17	4Q/17	1Q/18	2Q/18	3Q/18
Average LOS	6.68	5.19	6.09	5.48	5.39
Bed days/1000	84.7	64.3	99.9	75.5	66.2

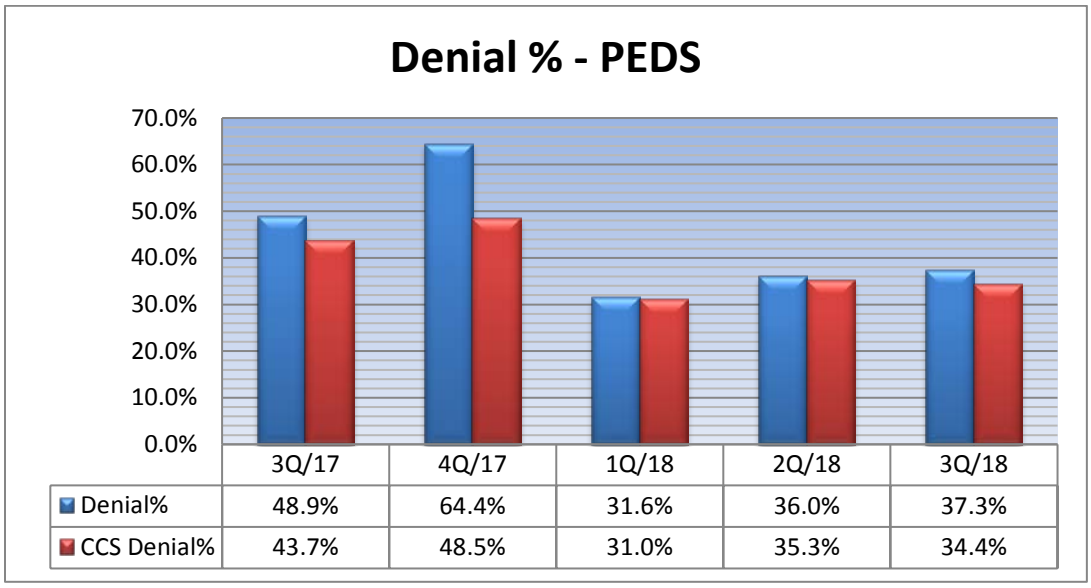


	3Q/17	4Q/17	1Q/18	2Q/18	3Q/18
Approvals	15526	15290	12270	12856	12765
Denied	1435	1523	2855	2798	3834



	3Q/17	4Q/17	1Q/18	2Q/18	3Q/18
Approvals	3435	3934	5573	4046	3361
Denied	3284	3288	2572	2278	2001


Denial % - Adults
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
3Q/17
4Q/17
1Q/18
2Q/18
3Q/18
Denial %
8.5%
10.4%
18.9%
17.9%
23.1%


Denial % - PEDS
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
3Q/17
4Q/17
1Q/18
2Q/18
3Q/18
Denial%
48.9%
64.4%
31.6%
36.0%
37.3%
CCS Denial%
43.7%
48.5%
31.0%
35.3%
34.4%

Continuity of Care

Total Referral – 31

Total Approval – 30

Total Denial - 1

Total SPD COC -11

UM Provider Disputes

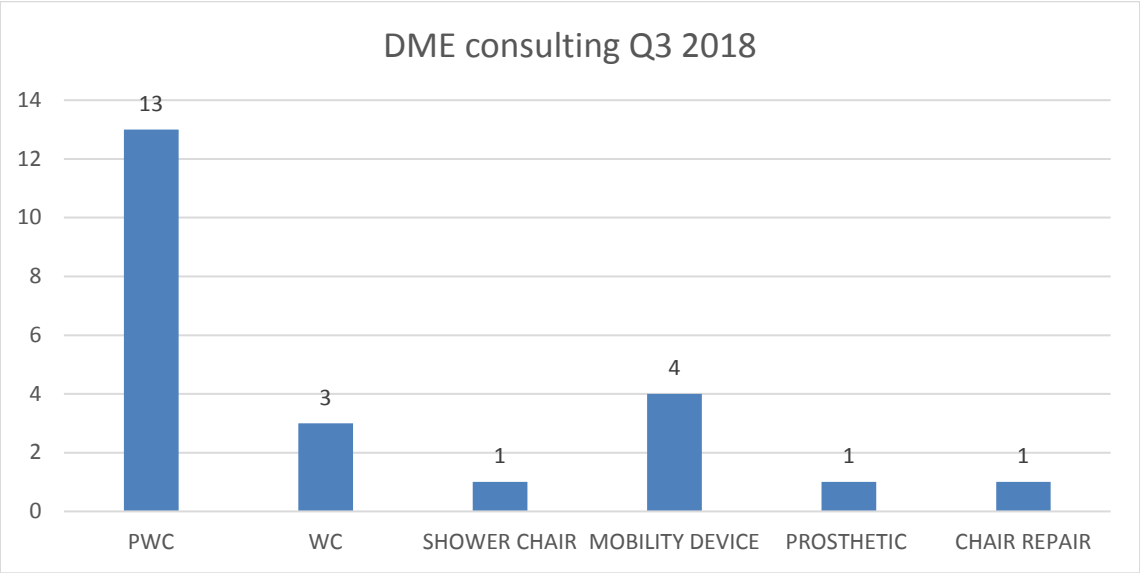
Total Disputes – 78

Favor of Provider -55

Favor of Plan – 23

Pending – 0

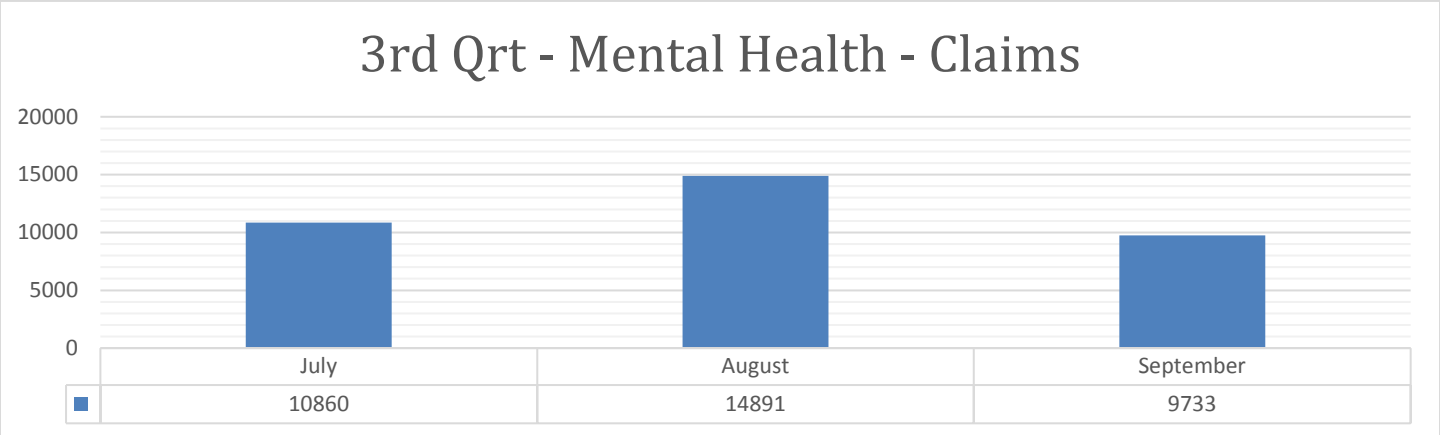
DME Consulting



Autism Reporting

UNIQUE CASES		Mild	Moderate	Severe	Total	Undetermined
MEMBER COUNT		33	88	24	210	65
Severity %		15.71%	41.90%	11.43%	69%	
SEVERITY	Jul	Aug	Sep	Total		
MILD	14	16	4	34		
MODERATE	33	24	35	92		
SEVERE	10	5	9	24		
Approved FBA	44	53	44	141		
Approved Treatment	64	53	48	165		
PENDING DX	20	30	17	67		
	Jul	Aug	Sep	Total		
AGE 7 OR LESS	43	48	33	124		
AGE 8 OR GREATER	34	27	32	93		
TOTAL	77	75	65	217		
% < 7	55.84%	64.00%	50.77%	57.14%		
% > 8	44.16%	36.00%	49.23%	42.86%		

Mental Health



Diabetic Exam Reminder Effectiveness Report

Client: - 12049397

Reminder Year:	Reminder Month:	Reminders Sent	Received Exam Within 0-90 Days	Received Exam Within 91-180 Days	Total Exams Within 180 Days
2017	October	374	8	1	9
	November	641	49	70	119
	December	10,512	324	360	684
2018	January	740	34	30	64
	February	0	0	0	0
	March	0	0	0	0
	April	0	0	0	0
	May	0	0	0	0
	June	0	0	0	0
	July	0	0	0	0
	August	4,743	56	0	56
	September	557	7	0	7
Totals		**17,567**	**478**	**461**	**939**

LTM Effectiveness* : 5 %

12-Month Effectiveness (Apr 2017 - Mar 2018) : 8 %

KERN HEALTH SYSTEMS
CASE MANAGEMENT DEPARTMENT MONTHLY REPORT

Reporting Period: July 1st, 2018- September 30th, 2018

During the months of July thru September, a total of 1,121 members were managed by the Case Management Department.

Episode Type	Closed Episodes	Open Episodes	Referral Episodes	Total
Case Management	620	90	41	751
Behavioral Health Case Management	323	43	4	370

Closure Reasons	Behavioral Health Case Management Episode	Case Management Episode
Deceased	1	8
Declined Services	41	23
Do Not Contact	2	0
Does not meet criteria	21	66
Medical Director Decision	11	73
Member Disenrolled	4	18
Member Goals Completed	62	49
Reassigned	4	4
Unable to Contact	225	387
(blank)	37	109

Members Closed and Referred to HHP	Behavioral Health Case Management Episode	Case Management Episode
HHP	28	116

Closed Episodes with Admits within 30 days after Closure	Total
Behavioral Health Case Management	11
Case Management	8
Percentage of closed cases Readmitted	0.02 Percent

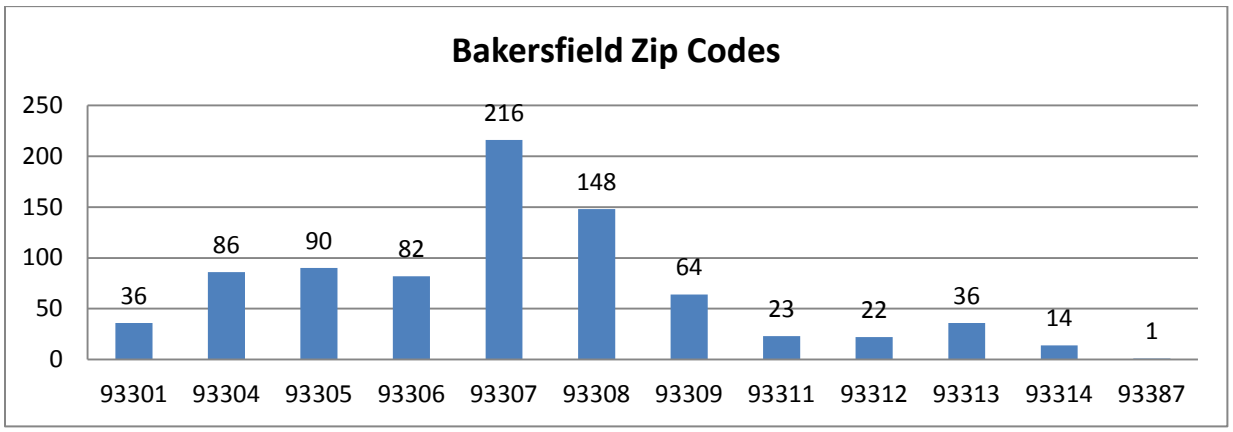
Assessments/Plan of Care	Behavioral Health Case Management Episode	Case Management Episode	Total
Assessments	81	211	292
Plan of Care	79	204	283

During the month of July thru September, 98% of the members managed were 65 years of age or younger.

Age	65 and under	Over 65	Total
Case Management	739	12	751
Behavioral Case Management	365	5	370

Of the 1,121 members managed during the months of July thru September, the majority of members were female at 70%. The majority of members' ethnicity was Caucasian at 43%., with Hispanic next at 38%.

Ethnicity	Female	Male	Total
AFRICAN AMERICAN	79	29	108
ALASKAN/AMER INDIAN	5	1	6
ASIAN INDIAN	5	3	8
ASIAN/PACIFIC	1	0	1
CAUCASIAN	331	154	485
FILIPINO	4	1	5
HISPANIC	306	118	424
KOREAN	0	1	1
NO VALID DATA	46	29	75
UNKNOWN	3	5	8



Outlying Areas

City	Total
ARVIN	20
BODFISH	9
BORON	3
BUTTONWILLOW	3
CALIENTE	1
CALIF CITY	13
DELANO	46
EDWARDS	1
FRAZIER PARK	5
KERNVILLE	1
LAKE ISABELLA	9
LAMONT	16
LEBEC	1
LOST HILLS	1
MARICOPA	3
MC FARLAND	6
MOJAVE	10
N/A	14
NORTH EDWARDS	1
PENNGROVE	1
QUARTZ HILL	1
RAYMOND	1
REEDLEY	1
ROSAMOND	4
SHAFTER	24
STOCKTON	1
STUDIO CITY	1
SUN VALLEY	1
TAFT	36
TEHACHAPI	37
TUPMAN	3
VALLEJO	1
WASCO	24
WELDON	2
WOFFORD HTS	2

Notes Completed

Note Source	Behavioral Case Management Episode	Case Management Episode
Activity Note	761	1672
Add Episode Note	96	123
Assessment Note	3	0
Call Tracking Note	0	2
Care Plan Problem Note	276	357
Change Status Note	1447	2406
Edit Episode Note	18	215
Episode Note	113	278
Goals	424	595
Interventions	231	667

Letters

Letter Template	Behavioral Health Case Management Episode	Case Management Episode
Appointment Letter English	39	63
Appointment Letter Spanish	13	13
Consent Form English	2	24
Consent Form Spanish	0	7
Discharge English	32	57
Discharge Spanish	4	7
Educational Material	7	296
Mental Health Alert to PCP	0	1
Suicide Hospital Letter to MD	1	1
Unable to Contact	345	736
Welcome Letter Bilingual	125	271

Activity Type

Activity Type	Behavioral Health Case Management Episode	Case Management Episode
Fax	103	252
Letter Contact	352	975
Member Services	29	49
Phone Call	1345	6400

(blank)	916	2624

Activities Completed

Activities Completed	Total
CMA's	2,971
Nurses	3,322
Social Workers	2,057

Activity Name

Activity Name	Behavioral Health Case Management Episode	Case Management Episode
Appointment Reminder Calls	1	32
Basic Needs	0	13
Centric Appointment	0	8
Close Episode for UTC	8	27
Community Resources	1	2
Contact Member	156	108
Contact Pharmacy	0	16
Contact Provider	128	461
Create Work Item	30	53
ER Utilization	1	0
HHP	28	116
HRA	23	93
ICT	15	24
Incoming Call	0	10
Inpatient Discharge Follow Up	3	4
Language Line	74	75
Mail Appointment Letter	38	41
Mail Authorization	0	3
Mail Consent Letter	5	27
Mail Discharge Letter	38	63
Mail Drug Formulary	1	0
Mail Educational Material	74	285
Mail Pill Box	27	91
Mail Pocket Calendars	33	116

Mail Provider Directory	8	13
Mail Unable to contact letter	83	147
Mail Urgent Care Pamphlet	18	37
Mail Welcome Letter	9	25
Plan of care	100	215
Provided Information	0	1
Request Medical Records	14	82
Return Mail	0	14
Schedule Physician Appointment	46	30
Transportation	4	31
Verbal consent to be received	862	5406
Plan of Care Interventions	493	1762
UTC Reminder Closures	423	862

Seniors and Persons with Disabilities (SPDs):

There were a total of 276 SPD members that were enrolled from July thru September, according to the risk stratification reports.

There are a total of 13,408 SPD members through September 2018

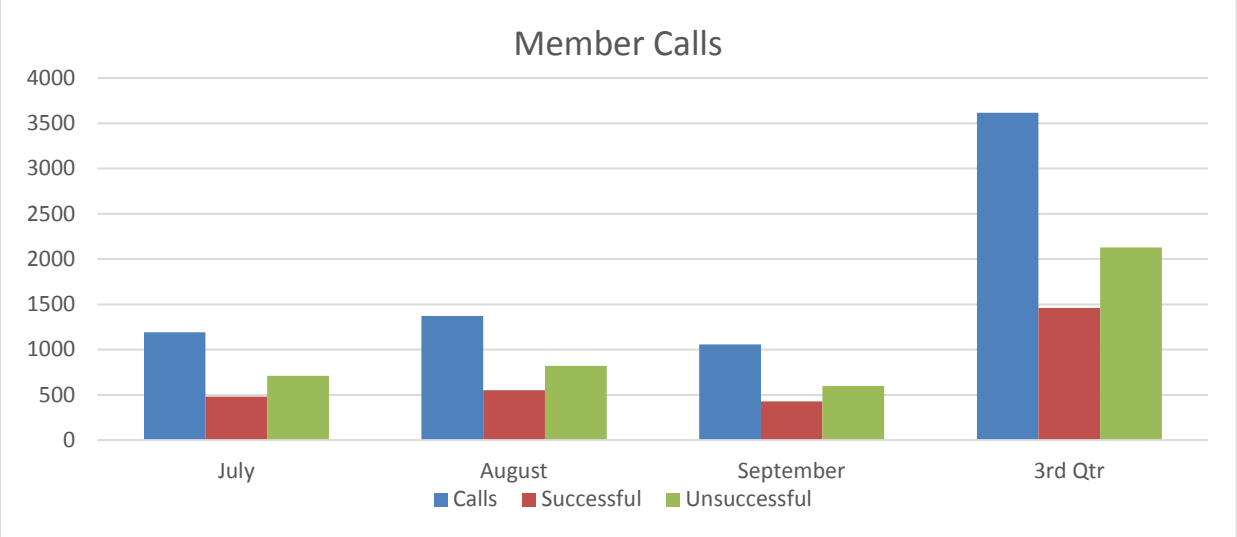
SPD Members are stratified into the Complex Case Management Group through use of the John Hopkins Predictive Modeler and represent 36 percent of the Complex Group from July thru September 2018.

Disease Management Monthly Report

3rd Quarter 2018

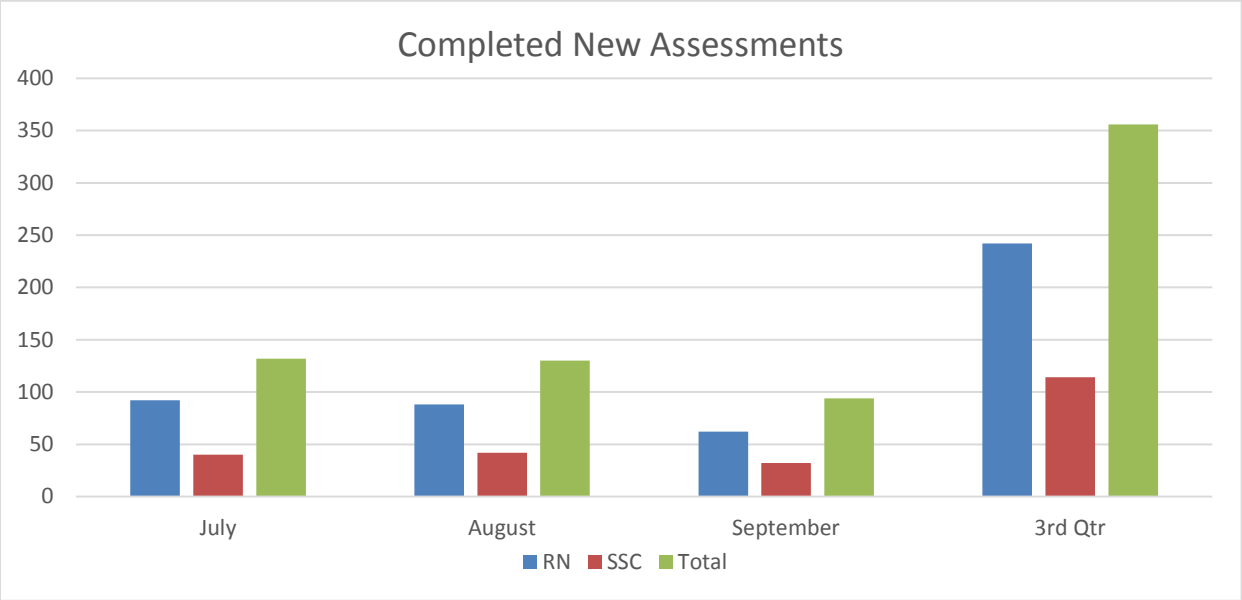
Member Calls: 3RD Quarter, 2018. 3,587 calls were made to 1,722 members.

Calls Attempted	Successful Calls	Unsuccessful Calls	Total Calls	% Contacted
RN	905	1,379	2284	40%
SSC	554	749	1.303	43%
Total	**1,459**	**2,128**	**3,587**	**41%**



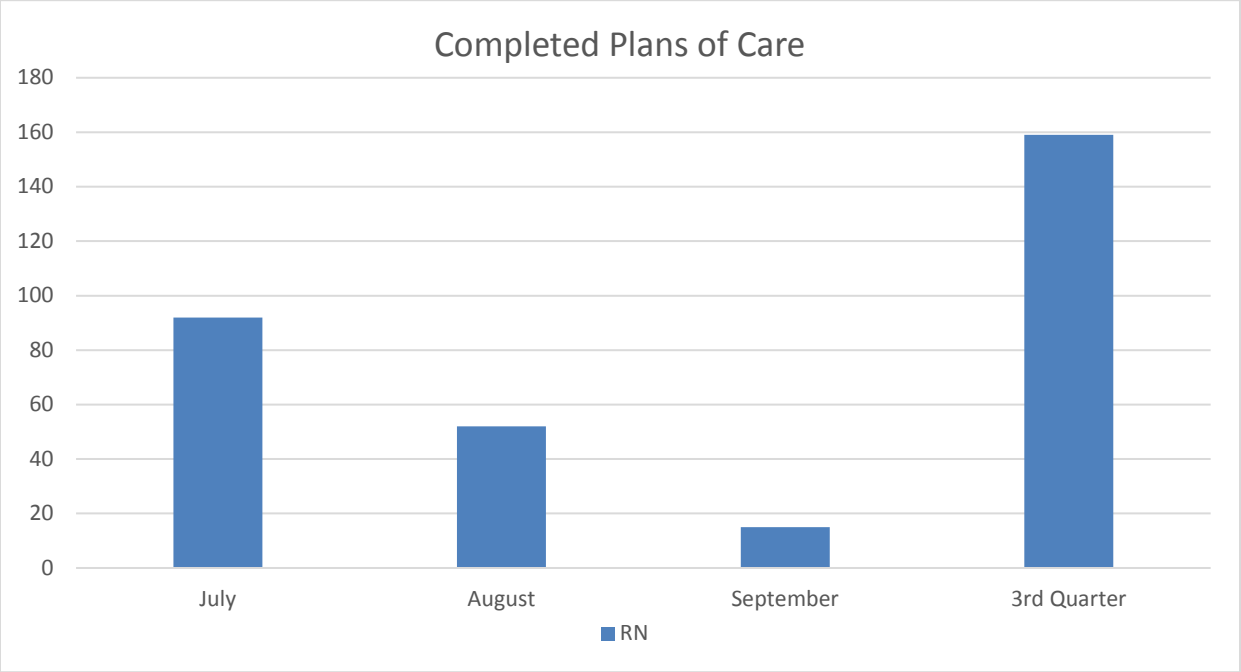
New Assessments Completed: 3RD Quarter, 2018

RN	SSC	Total
242	114	356



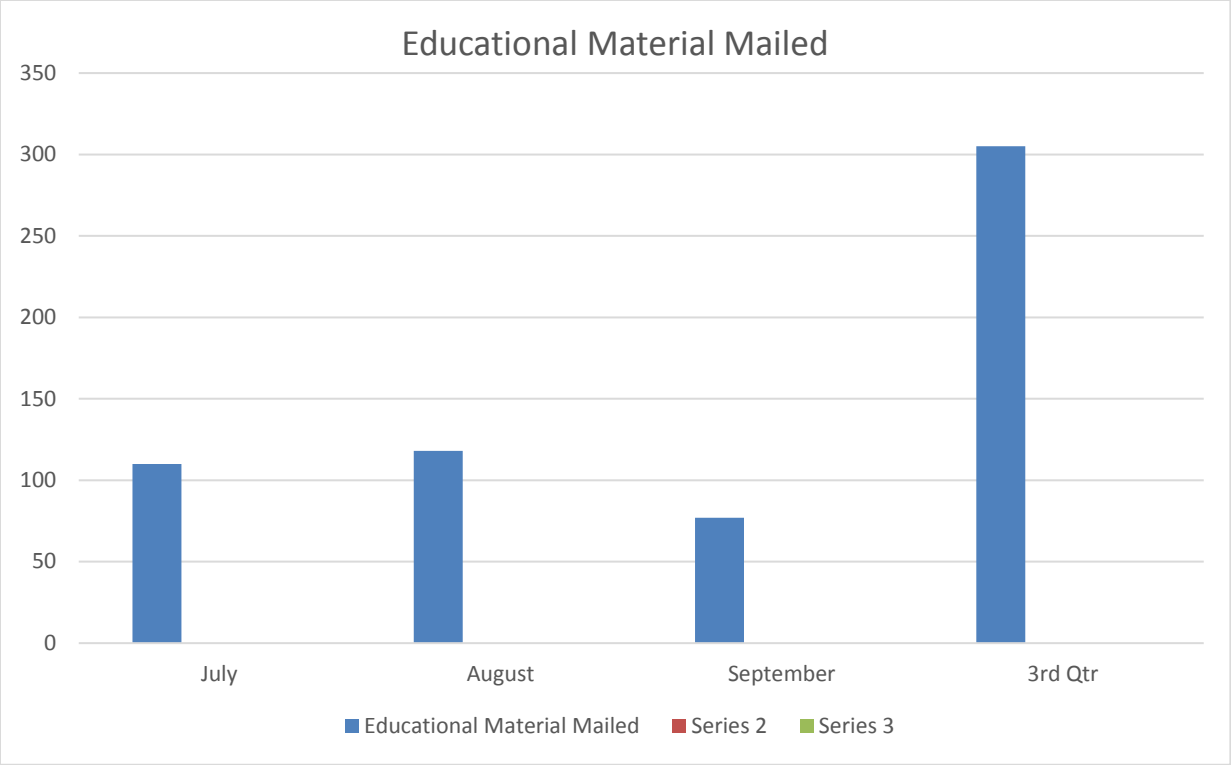
Plans of Care Completed & Closed: 3rd Quarter, 2018

RN
159



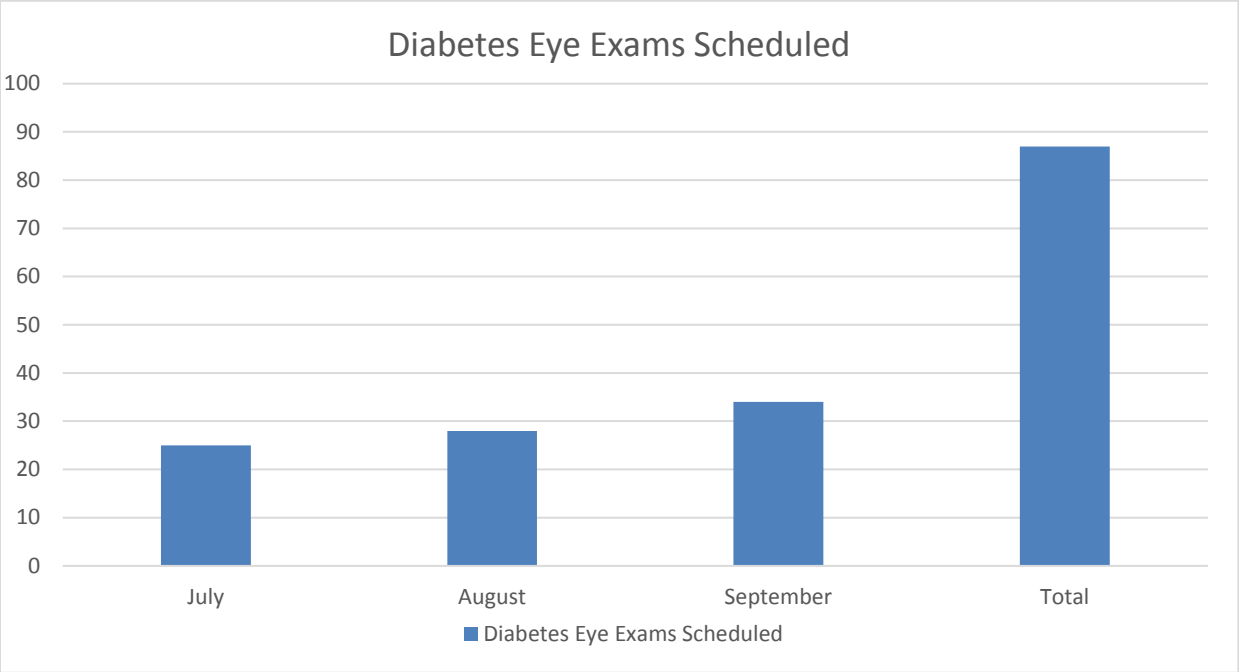
Educational Material Mailed: 3ed Quarter, 2018

305



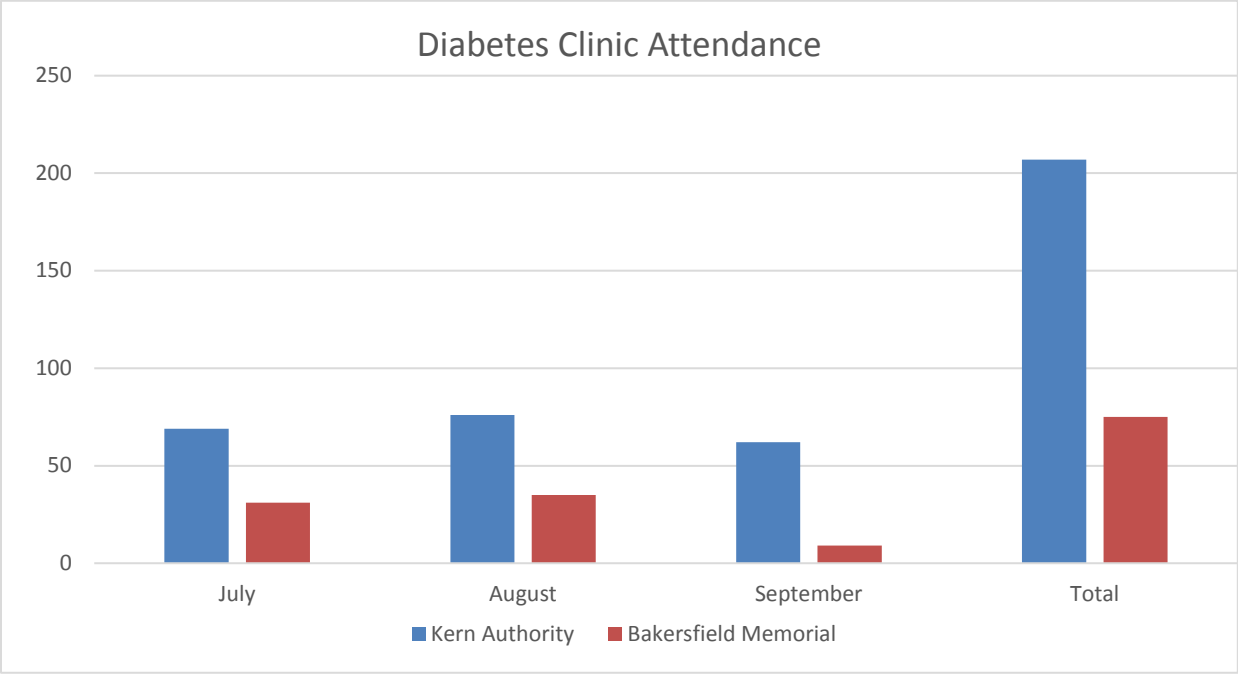
Diabetes Eye Exams Scheduled: 3rd Quarter, 2018

87



Diabetes Clinic Attendance: 3rd Quarter, 2018.

Kern Authority	Bakersfield Memorial	Total
207	75	282


Diabetes Clinic Attendance
250
200
150
100
50
0
July
August
September
Total
Kern Authority
Bakersfield Memorial