KERN HEALTH SYSTEMS

REGULAR MEETING OF THE QI/UM COMMITTEE

Thursday, February 20th , 2020
At
7:00 A.M.

At
2900 Buck Owens Boulevard
4th Floor Kern River Room
Bakersfield, CA 93308

The public is invited

For more information, call (661) 664-5000

AGENDA

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

KERN HEALTH SYSTEMS
4th Floor Kern River Room
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, February 20th, 2020

7:00 A.M.

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COMMITTEE MEMBERS: Jennifer Ansolabehere, PHN; Satya Arya, MD; Danielle C Colayco, PharmD; MS; 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

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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 November 14th, 2019 – APPROVE

7) Physician's Advisory Committee (PAC) Summary of Proceedings 4th Quarter – RECEIVE AND FILE
   - October 2019
   - November 2019
   - December 2019

CA-8) Pharmacy TAR Log Statistics 4th Quarter 2019 – RECEIVE AND FILE
   - October 2019
   - November 2019
   - December 2019

9) Quality Improvement Department Summary Reports 4th Quarter 2019- APPROVE
   - Potential Quality Issue (PQI) Notifications
   - Facility Site Reviews (FSRs)
     a. Initial Full Site Reviews
     b. Periodic Full Site Reviews
     c. Focus Reviews
        1. Critical Elements Monitoring
        2. IHEBA Monitoring
        3. IHA Monitoring
   - Quality Improvement Projects
     a. Performance Improvement Projects (PIPs)
     b. Improvement Projects (IPs)
   - MCAS Accountability Set (MCAS) Updates

Kaiser Reports

CA-10) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**

- KFHC APL Grievance Report-4th Quarter 2019 –RECEIVE AND FILE
- KFHC Volumes Report 4th Quarter 2019 – RECEIVE AND FILE

VSP Reports

11) VSP Reports

- Medical Data Collection Summary Report 2019– APPROVE
- VSP DER Effectiveness Report – APPROVE

Member Services

12) Grievance Operational Board Update - RECEIVE AND FILE

- 4th Quarter 2019

13) Grievance Summary Reports – RECEIVE AND FILE

- 4th Quarter 2019

Provider Relations

14) Re-credentialing Report 4th Quarter 2019 – RECEIVE AND FILE

CA-15) Board Approved New Contracts – RECEIVE AND FILE

- Effective November 1st, 2019
- Effective December 1st, 2019
- Effective January 1st, 2020

CA-16) Board Approved Providers Reports – RECEIVE AND FILE

- Effective November 1st, 2019
- Effective December 1st, 2019
- Effective January 1st, 2020

CA-17) Provider Relations Network Review Report 4TH Quarter 2019– RECEIVE AND FILE

Disease Management

18) Disease Management 4th Quarter 2019 Report – APPROVE

Policies and Procedures

19) QI/UM Policies and Procedures – APPROVE

- 3.10-P Alcohol and Substance Abuse Treatment
- 3.14-P Mental Health Services
- 3.77-P Palliative Care

Health Education Reports

CA-20) 2019 HECL Work Plan Evaluation- RECEIVE AND FILE

CA-21) 2020 HECL Work Plan - RECEIVE AND FILE

22) Health Education Activity Report 4th Quarter 2019 – APPROVE

UM Department Reports

23) Combined UM Reporting 4th Quarter 2019 – APPROVE

ADJOURN TO THURSDAY, May 21st, 2020 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
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Members Present: Jennifer Ansolabehere, PHN; Satya Arya, MD; Danielle C Colayco, PharmD; MS; Allen Kennedy; Chan Park, MD; Maridette Schloe; MS, LSSBB; Martha Tasinga; MD, CMO

Members Absent: Felicia Crawford, RN; Philipp Melendez, MD

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 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.

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3) Announcements – **None**

4) Closed Session – **N/A**

5) CMO Report – **Dr. Tasinga shared the following information with the committee:**

- **The HEDIS measures for 2020 have been revised and KHS will be accountable for 39 measures. The benchmark threshold for a subset of those measures has increased from 25% to 50% compliance requirement for KHS. If these thresholds are not met, KHS could face financial or other sanctions depending on the results submitted at the end of HEDIS 2020 in June.**

CA-6) QI/UM Committee Summary of Proceedings from August 22, 2019 – APPROVED
Kennedy-Park: All Ayes

7) Physician's Advisory Committee (PAC) Summary of Proceedings 3rd Quarter – APPROVED
- August 2019
- September 2019

Arya-Park: All Ayes

CA-8) Pharmacy TAR Log Statistics 3rd Quarter 2019 – RECEIVED AND FILED
- July 2019
- August 2019
- September 2019

Kennedy-Park: All Ayes

9) QI Focus Review Report 3rd Quarter 2019 – APPROVED
- Critical Elements Monitoring
- IHEBA Monitoring
- IHA Monitoring

Arya-Park: All Ayes

- **The PQI review process will be revised to accommodate the increased volume of Exempt classified grievances. Any grievance, regardless of status, if deemed potential QOC, will be reviewed by a Medical Director for final disposition.**

10) QI Site Review Summary Report 3rd Quarter 2019 – RECEIVED AND FILED
Park-Kennedy: All Ayes

11) QI SHA Monitoring Report 3rd Quarter 2019 – RECEIVED AND FILED
Park-Kennedy: All Ayes

Kaiser Reports

CA-12) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**
- KFHC APL Grievance Report-3rd Quarter 2019 –RECEIVE AND FILE
- KFHC Volumes Report 3rd Quarter 2019 – RECEIVE AND FILE

Park-Kennedy: All Ayes

VSP Reports

13) VSP Reports
- Medical Data Collection Summary Report 2019– APPROVED
- VSP DER Effectiveness Report – APPROVED

Park-Arya: All Ayes

Member Services

14) Grievance Operational Board Update - APPROVED
- 3rd Quarter 2019

15) Grievance Summary Reports – APPROVED
- 3rd Quarter 2019

CA-16) Call Center Report – RECEIVED AND FILED
- 3rd Quarter 2019

Park-Kennedy: All Ayes

Provider Relations

17) Re-credentialing Report 3rd Quarter 2019 – RECEIVED AND FILED

CA-18) Board Approved New Contracts – RECEIVED AND FILED

- Effective September 1st, 2019
- Effective October 1st, 2019

CA-19) Board Approved Providers Reports – RECEIVED AND FILED

- Effective September 1st, 2019
- Effective October 1st, 2019

CA-20) Provider Relations Network Review Report 3rd Quarter 2019– RECEIVED AND FILED

Park-Arya: All Ayes

Disease Management

21) Disease Management 3rd Quarter 2019 Report – APPROVED
Arya-Kennedy: All Ayes

Policies and Procedures

22) QI/UM Policies and Procedures – APPROVED

- 3.40 I Continuity of Care for New Members
- 3.65 I Utilization Management Nurse After Hours on Call Support
- 3.75 I Health Risk Assessment

Arya-Kennedy: All Ayes

Health Education Reports

23) Health Education Activity Report 3rd Quarter 2019 – APPROVED
Park-Kennedy: All Ayes

- **Discussed the requirements of the 2020 Population Needs Assessment (PNA) and Action Plan, which has replaced Group Needs Assessment per KHS' contract with DHCS. Committee members will be solicited for feedback in 2020 regarding the PNA findings and the Action Plan.**
- **Over 100 members participated in a 6 question Pregnancy Engagement Survey in 4th quarter. The survey assesses member satisfaction with prenatal care, and awareness of KHS member incentives and services. Findings will be shared at a future 2020 committee meeting.**

UM Department Reports

24) Combined UM Reporting 3rd Quarter 2019 – APPROVED
Park-Kennedy: All Ayes

- **Discussed the recent update regarding planned involvement with the Connected Community Network, (CCN Partnership.) This electronic platform brings in community based organizations within the county, so that a member can be referred for additional services that would support**

their needs. This platform will also help fill the gap in obtaining outcome data on these types of referrals and help to address members social determinants of health.

- **Information was provided to the committee regarding the new pilot program for members with COPD. This COPD program partners with one of the participating providers and a respiratory therapy equipment provider to provide evaluations and education to members in their home, also offers capacity for telemedicine monitoring and visits, as well as outpatient infusion or treatments when needed. The goal is that this program will help facilitate early intervention and treatment in hopes of preventing the need for hospital admissions or emergency visits for these high-risk members.**

Meeting adjourned by Dr. Martha Tasinga, M.D., C.M.O. @ 8:31 A.M.
to Thursday, February 20, 2020 at 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd.
4th Floor Conference Room – Kern River Room
Bakersfield, California 93308

Wednesday, October 2, 2019
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., Miguel Lascano, M.D., Ashok Parmar, M.D., Martha Tasinga, M.D., C.M.O.

Members Absent: Raju Patel, M.D., Jacqueline Paul-Gordon, M.D.

Meeting called to order at 7:00 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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ADJOURNED TO CLOSED SESSION @ 7:03 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.**

Dr. Tasinga discussed Provider # PRV000449 to review the past issues concerning this practitioner. The Medical Board of California issued a public letter of reprimand with recommendations for completion of a Medical Records and Ethics Course. Committee had discussion. Recommendation was to credential the provider for the normal period. Motion was made, seconded, and carried.

Dr. Tasinga spoke to committee regarding an anonymous complaint regarding Provider PRV006920 for allegedly exposing children to too much radiation through diagnostic studies.

Dr. Powell provided a summary of her findings regarding the alleged complaint and presented her analysis to the committee members. Dr. Powell's analysis compared PRV006920 to 3 similar specialty peers and panel size. The recommendation was:

- **Letter to be sent to PRV006920 requesting response to these findings;**
- **PRV006920 to define financial relationship with Stockdale Radiology; and**
- **Dr. Tasinga to provide provider education and track and trend radiology usage for 1-yr.**

Motion was made, seconded, and carried.

COMMITTEE RECONVENED TO OPEN SESSION @ 7:30 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on September 4, 2019 – APPROVED
Amin-Egbikuadje: All Ayes

CA-5) VSP Diabetic Exam Reminder Effectiveness Report – RECEIVED AND FILED
Amin-Egbikuadje: All Ayes

6) Health Dialog Delegated Oversight Report – APPROVED
Egbikuadje-Amin: All Ayes

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 7:35 A.M. TO WEDNESDAY, NOVEMBER 6, 2019 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd.
4th Floor Conference Room – Kern River Room
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Wednesday, November 6, 2019

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., Martha Tasinga, M.D., C.M.O.

Members Absent: Miguel Lascano, M.D., Raju Patel, M.D., Jacqueline Paul-Gordon, M.D.

Meeting called to order at 7:05 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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   - **HR 6 (plan requirements outlined in APL 19-012) was discussed with the committee and how it relates to the managed care plans.**

ADJOURNED TO CLOSED SESSION @ 7:24 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 5-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

   PRV033721 - Letter to be sent 11/06/19 with effective date of 12/06/19; with intent to terminate due to notification of no hospital privileges, which is an obligation of KHS contractual agreement with provider.

   PRV006940 – Letter to be sent 11/06/19 requesting a release of information in order to check hospital privileges. KHS will advise provider that we must be notified immediately if any restrictions were imposed.

   PRV033814 – KHS policy is to utilize only those specialties that are recognized by the American Board of Medical Specialties. This provider completed Internal Medicine Residency and is Internal Medicine board certified. Vascular Medicine and Endovascular Medicine were added to provider profile several years ago, and will be moved to specialty focus and Internal Medicine as the provider's designated specialty.

COMMITTEE RECONVENED TO OPEN SESSION @ 7:30 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on October 2, 2019 – APPROVED
Amin-Hair: All Ayes

CA-5) VSP Diabetic Exam Reminder Effectiveness Report – RECEIVED AND FILED
Amin-Hair: All Ayes

CA-6) VSP Medical Data Collection Summary Report – RECEIVED AND FILED
Amin-Hair: All Ayes

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 7:41 A.M. TO WEDNESDAY, DECEMBER 4, 2019 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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Members Present: Hasmukh Amin, M.D., Miguel Lascano, M.D., Ashok Parmar, M.D., Raju Patel, M.D., Martha Tasinga, M.D., C.M.O.

Members Absent: Angela Egbikuadje, PD.MS, Ph.D; David Hair, M.D., Jacqueline Paul-Gordon, M.D.

Meeting called to order at 7:03 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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ADJOURNED TO CLOSED SESSION @ 7:05 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 5-0, THE COMMITTEE APPRVOVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

- **Dr. Tasinga provided an update on physician PRV006940; Specific to correspondence received by the provider's attorney indicating the arrest and filing of criminal proceeding are not occurrences requiring notification to the plan. KHS attorneys will respond to the letter outlining the contractual requirements of meeting standards of a health care provider.**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:19 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on November 6, 2019 – APPROVED
Amin-Parmar: All Ayes

5) Peer to Peer Requests – APPROVED
Patel-Parmar: All Ayes

- **Review of the P2P internal criteria outlined the guidelines for KHS consideration to accept P2P request. Timelines were defined, including next steps if P2P decline.**

- **Restrictions applied to the specialty provider type and limited to the ordering provider, not the rendering provider, to avoid conflict of interest.**

6) CalAim Timeline – DISCUSSION

- **DHCS outlined the 5 year plan for the "Medi-Cal Healthier California for All" proposal for all Managed MCAL plans, and this was discussed with PAC committee.**

2020-
Submission plan for transitioning existing programs (WPC, HHP, TCM) into ECM and ILOS

2021-
LTC and TRANSPLANTS carved in
PHARMACY CARVE-OUT implementation
PHM implementation

2022-
FULL INTEGRATION RFP posted (Jan - July); full integration contracts announced (July)

2023-
Mandatory managed care enrollment for DUALS
All Medi-Cal managed care plans to operate D-SNPs

2024-
Full integration pilots GO-LIVE date

2025-
NCQA ACCREDITITATION for plans and delegates by 2025

2026-
Full implementation of LTSS, LTC, D-SNPs

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 7:57 A.M. TO WEDNESDAY, FEBRUARY 5, 2020 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the KHS Finance Committee may request assistance at the Kern Health Systems office, 9700 Stockdale Highway, Bakersfield, California or by calling (661) 664-5000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

Quarter/Year of Audit	2019	2019	2019	2019	2019	2019	2019	2019	2019	2019	2019	2019
Month Audited	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Total TAR's for the month	3359	2956	3287	3373	3661	3419	3453	3783	3180	3910	3209	3307
Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%
APPROVED TAR'S												
Timeliness - Reviewed & Returned in 1 busines day	76/76	75/75	69/69	74/74	87/87	67/67	75/75	83/83	65/65	88/88	72/72	73/73
Date Stamped	76/76	75/75	69/69	74/74	87/87	67/67	75/75	83/83	65/65	88/88	72/72	73/73
Fax copy attached	76/76	75/75	69/69	74/74	87/87	67/67	75/75	83/83	65/65	88/88	72/72	73/73
Decision marked	76/76	75/75	69/69	74/74	87/87	67/67	75/75	83/83	65/65	88/88	72/72	73/73
DENIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75	69/69	57/57	58/58
Initally Denied - Signed by Medical Dir and/or Pharm	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75	69/69	57/57	58/58
Letter sent within time frame	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75	69/69	57/57	58/58
Date Stamped	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75	69/69	57/57	58/58
Fax copy attached	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75	69/69	57/57	58/58
Decision marked	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75	69/69	57/57	58/58
Correct form letter, per current policies used	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75	69/69	57/57	58/58
NOA Commentary Met											57/57	54/58
MODIFIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	0	0	0	0	0	0	0	0	0	0	0	0
Date Stamped	0	0	0	0	0	0	0	0	0	0	0	0
Fax copy attached	0	0	0	0	0	0	0	0	0	0	0	0
Decision marked	0	0	0	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	0	0	0
NOA Commentary Met											0	0
DUPLICATE TAR'S												
Timeliness - Reviewd & Returned in 1 business day	12/12	12/12	16/16	17/17	15/15	8/8	19/19	20/20	10/10	18/18	13/13	15/15
Date Stamped	12/12	12/12	16/16	17/17	15/15	8/8	19/19	20/20	10/10	18/18	13/13	15/15
Fax copy attached	12/12	12/12	16/16	17/17	15/15	8/8	19/19	20/20	10/10	18/18	13/13	15/15

KERN HEALTH SYSTEMS
Quality Improvement Department Summary Reports
Q4 2019

The purpose of this report is to provide a summary of the quarterly activities and outcomes for the QI department. This provides a window into both compliance with regulatory requirements as well as identifying opportunities for improving the quality of care for our members. Areas covered in the report include:

I. Potential Quality Issue (PQI) Notifications

II. Facility Site Reviews (FSRs) and Medical Record Reviews (MRRs)

   a. Initial Full Site Reviews

   b. Periodic Full Site Reviews

   c. Focus Reviews

III. Quality Improvement Projects

   a. Performance Improvement Projects (PIPs)

   b. Improvement Projects (IPs)

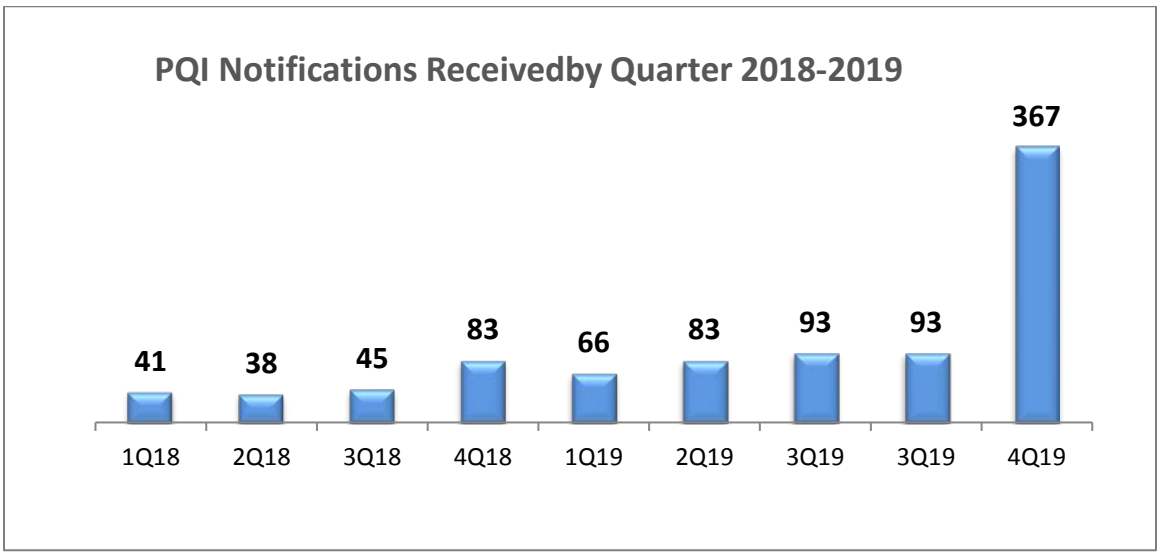
IV. MCAS Accountability Set (MCAS) Updates

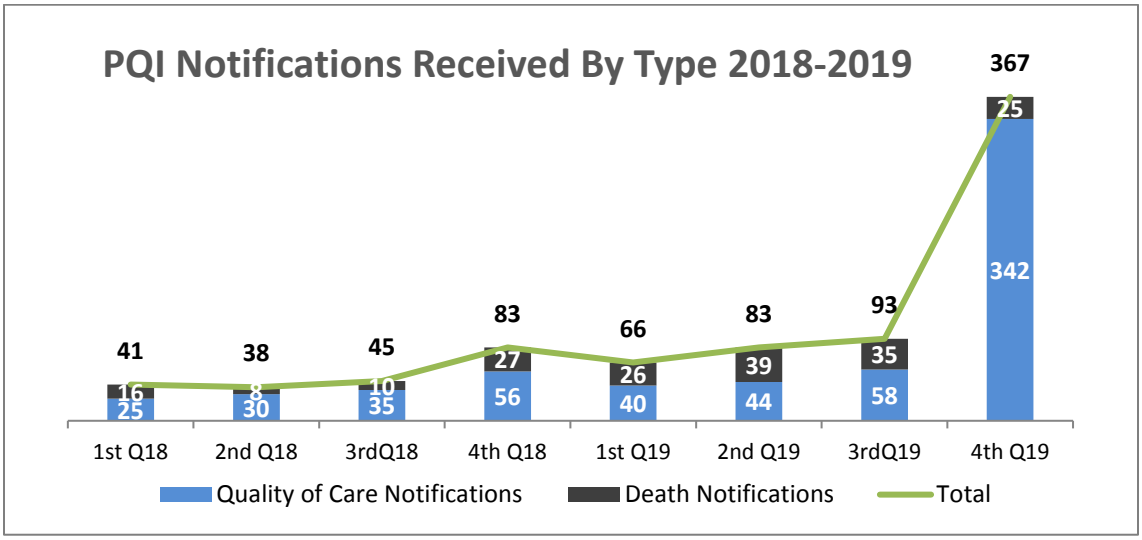
I. Potential Quality Issue (PQI) Notifications:

QI receives Notifications from various sources to review for potential quality of care issues.
On receipt of a potential quality of care issue, a high level review is completed by a QI RN to determine what level of Potential Quality Issue exists.
PQIs are assigned a level based on the outcome of the review. The levels assigned are as follows:

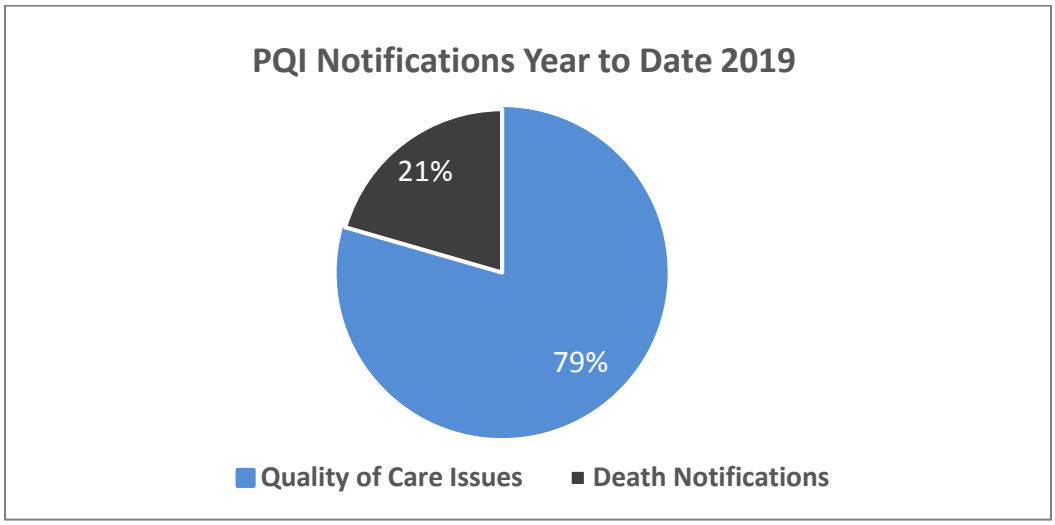
- Level 0 = No Quality of Care Concern
  - Follow-up = Track and Trend and/or Provider Education
- Level 1 = Potential for Harm
  - Follow-up = Track and trend the particular area of concern for the specific provider and the Medical Director or their designee may provide additional actions that are individualized to the specific case or provider.
- Level 2 = Actual Harm
  - Follow-up = Corrective Action Plan plus direction from Medical Director or their designee which is individualized to the specific case or provider
- Level 3 = Actual Morbidity or Mortality Failure
  - Follow-up = Corrective Action Plan plus direction from Medical Director or their designee which is individualized to the specific case or provider

Based on the feedback from DHCS during our annual audit, we have started closing exemptions with potential quality of care concerns and referring them to QI department to process them as PQIs. Because of this change we noticed a significant increase in the PQI notifications this 4th quarter.





If you look at the above charts, we received 367 notifications for the 4th Quarter of 2019, which increase nearly 4 fold compared to last quarters.



From previous quarter to this quarter the quality of care issues increased by 20% and death notifications decreased by 20%. This increase is expected due to the above mentioned change in the PQI policies.

Beginning of January, QI will stop working on PQI investigation of all Death notifications. Instead, we are working with Utilization Management team to refer only death notifications in which they think there may be a quality concern. Those referrals will be processed like any other PQI notifications.

II. Facility Site Reviews (FSR) and Medical Record Review (MRR) Description:

Certified Site Reviewers perform a Facility Site Review on all contracted primary care provider sites (including OB/GYNs and pediatricians) as well as providers who serve a high volume of SPD beneficiaries. Per PL 14-004, certified site reviewers complete FSRs and MRRs for providers credentialed per DHCS and MMCD contractual and policy requirements.

An Initial Full Site Review (IFSR) is completed as part of the credentialing process on new providers at sites that have not previously been reviewed before being added to the KHS provider network. An IFSR is also completed when an existing KHS provider moves to a new site location. Approximately 3 months after the completion of an IFSR, an Initial Medical Record Review (IMRR) is conducted on sites other than Urgent Care (UC) Facilities. A passing FSR score is considered "current" if it is dated within the last three (3) years.

Subsequent Periodic Full Site Reviews (PFSRs) are conducted as part of the re-credentialing process for providers three (3) years after completion of the IFSR and every three (3) years thereafter.

Critical Elements

There are nine critical elements related to the potential for adverse effect on patient health or safety and include the following:

- Exit doors and aisles are unobstructed and egress (escape) accessible.
- Airway management equipment, appropriate to practice and populations served, are present on site.
- Only qualified/trained personnel retrieve, prepare or administer medications.
- Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
- Only lawfully-authorized persons dispense drugs to patients.
- Personal protective equipment (PPE) is readily available for staff use.
- Needle stick safety precautions are practiced on-site.
- 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.
- Spore testing of autoclave/steam sterilizer is completed (at least monthly, with documented results).

Scoring and Corrective Action Plans

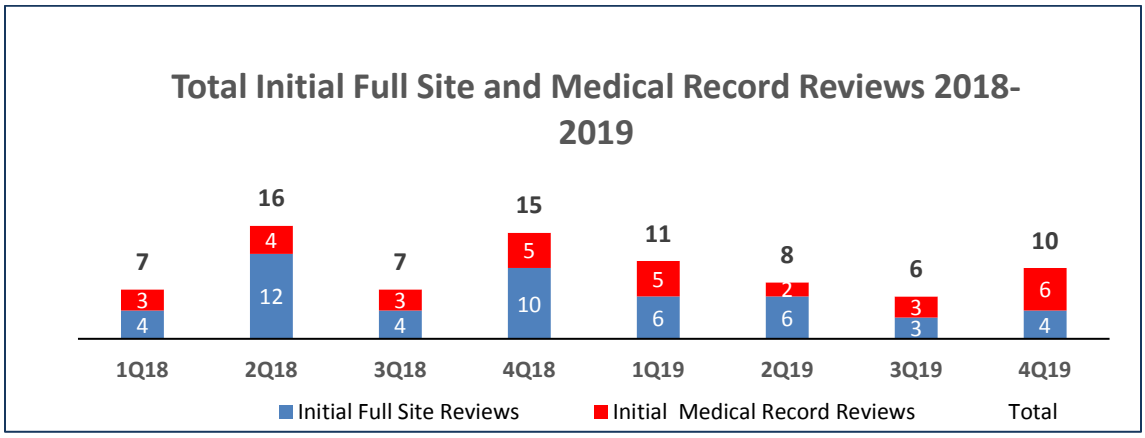
Provider sites that receive a FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are required to complete a CAP addressing each of the noted deficiencies. The compliance level categories for both the FSR and MRR are as listed below:

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

Corrective Action Plans (CAPs)

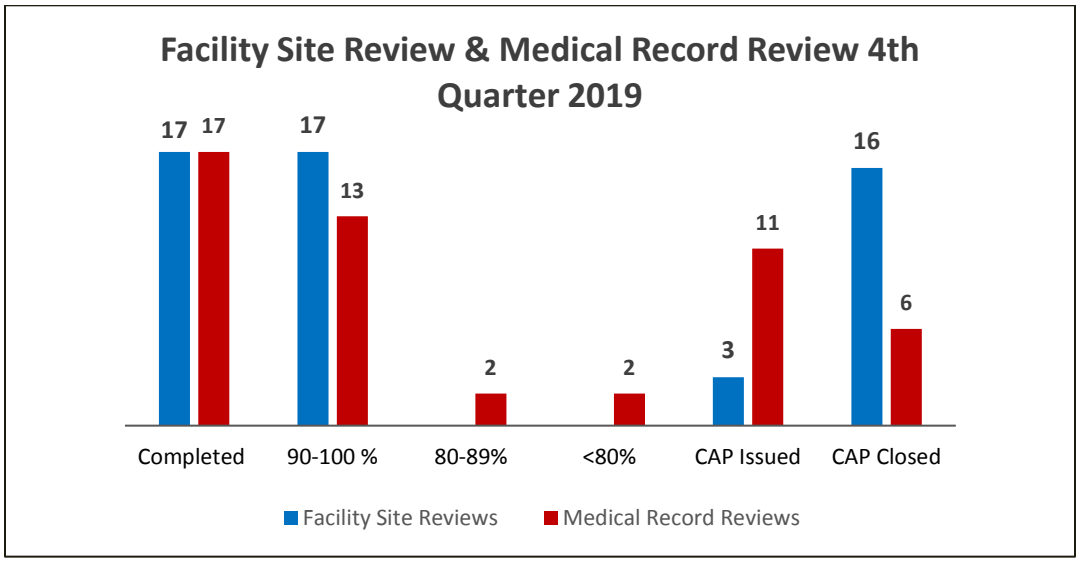
A CAP is issued when an initial, periodic, or focus review has deficiencies identified. DHCS requires follow up at 10 days for failure of any critical element, follow up for other failed elements at 45 days, and if not corrected by the 45 day follow up, at 90 days after a CAP has been issued. The majority of CAPs issued are corrected and completed within the 45 Day follow up period. Providers are encouraged to speak with us if they have questions or encounter issues with CAP completion. QI nurses provide education and support during the CAP resolution process.

Initial Facility Site Review and Medical Record Review Results:



No trends are identified, and this chart simply reflects the volume of new providers in KHS's Network. All the reviews due for the 4th Quarter were completed within the time frame required by DHCS.

Facility Site Review and Medical Record Review Results:

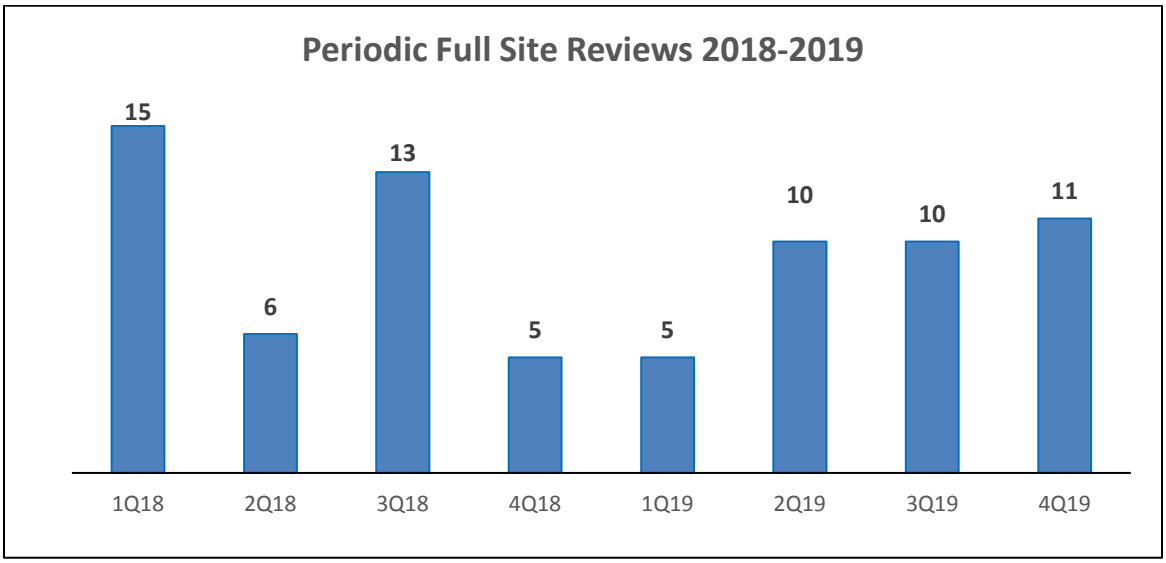


Above chart:

- A total of 17 Site Reviews were completed in the 4th Quarter of 2019. Out of these 4 were initial site reviews and 13 were periodic site reviews.
- A total of 17 Medical Record Reviews were completed out of which 7 were initial medical record reviews and 10 were Periodic Medical Record Reviews.
- For the medical record reviews that scored less than 80%, CAP were issued with a 45 day follow up scheduled.
- The total CAPS issued were 3 for Facility Site Review and 11 for Medical Record Review.
- There were 16 Full Site Review CAPs closed and 6 Medical Record Review CAPs closed.

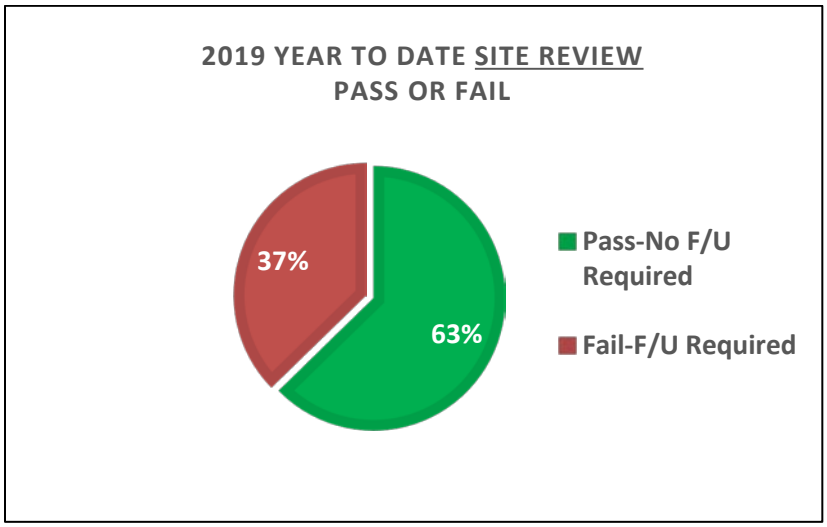
Periodic Full Site Reviews

Periodic Full Site Reviews are required every 3 years. The due date for Periodic FSRs is based on the last Initial or Periodic FSR that was completed. The volume of Periodic Reviews is not controlled by KHS. It is based on the frequency dictated by DHCS.

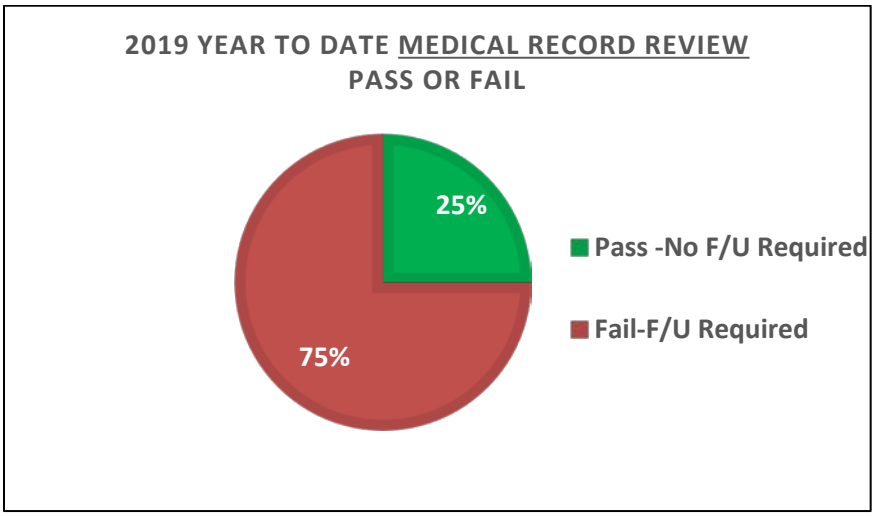


This above chart simply reflects the number of Periodic Full Site Reviews that were due and completed for each quarter. All the periodic Full Site Reviews due in 4th Quarter were completed within the time frame required by DHCS

Year to Date (YTD) Initial and Periodic FSR Pass or Fail Rate:



In 2019 YTD 63% of the Initial and Periodic site reviews performed passed on the first visit and 37% required follow-up. Compared to last quarter, full site review pass rate increased by 9% and fail rate decreased by 9%.



For 2019 YTD medical record reviews, 25% of the Medical Records Reviews performed passed on the first visit and 75% required additional follow-up. Compared to last quarter medical record review pass rate decreased by 1% and fail rate increased by 1%. Typically, there are more follow-ups required for Medical Record Reviews.

Quality Improvement explores opportunities to improve areas on a broader basis for areas with consistent non-compliance. For 4th Quarter there are no deficiencies identified for Opportunities for improvement in facility site reviews.

Medical Record Review opportunities for improvement during quality audits for 4th quarter are listed below.

Pediatrics:

1. Vision and Hearing Screening
2. Dental Assessment,
3. Adolescent Immunizations

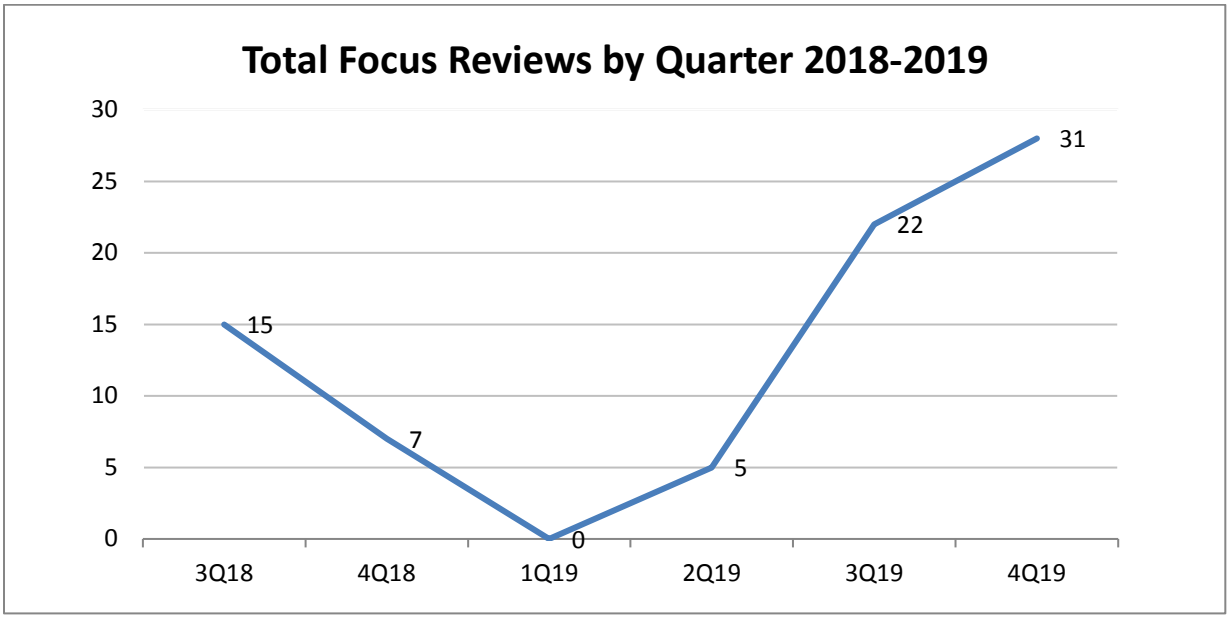
Adults:

1. Adult Immunizations,
2. Staying healthy assessment,
3. Pap smear and Chlamydia Screening

Focus Reviews:

Focus Reviews are conducted between Initial and first Periodic Full Site Reviews or between two Periodic Full Site Reviews. Typically they occur once every 18 months. These reviews are intended to be

a check-in to ensure the provider is compliant with the 9 critical elements and as a follow up for any areas found to be non-compliant in the previous Initial or Periodic Full Site Review.

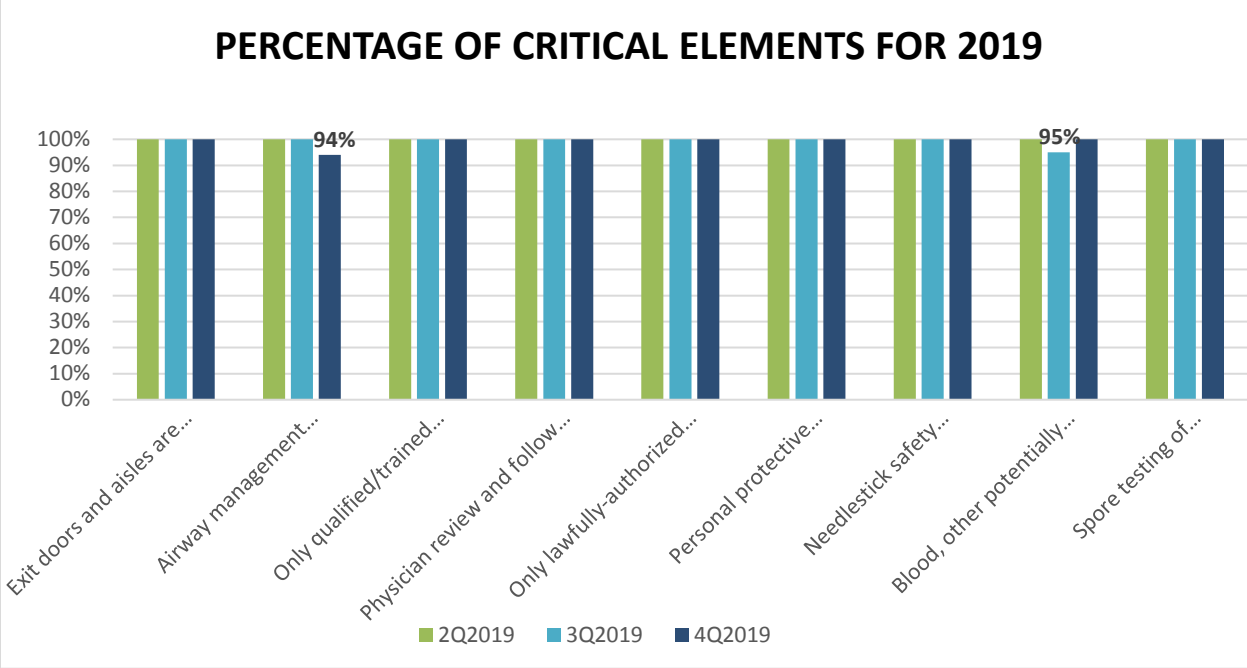


Note There is no data for the 1st Quarter of 2019 due to HEDIS Review Activity.

Focus reviews were put on hold during Q1 of 2019 because of HEDIS but resumed in the latter part of Q2 of 2019 as HEDIS came to a close. By the end of 4th Quarter, they were 31 focus reviews completed.

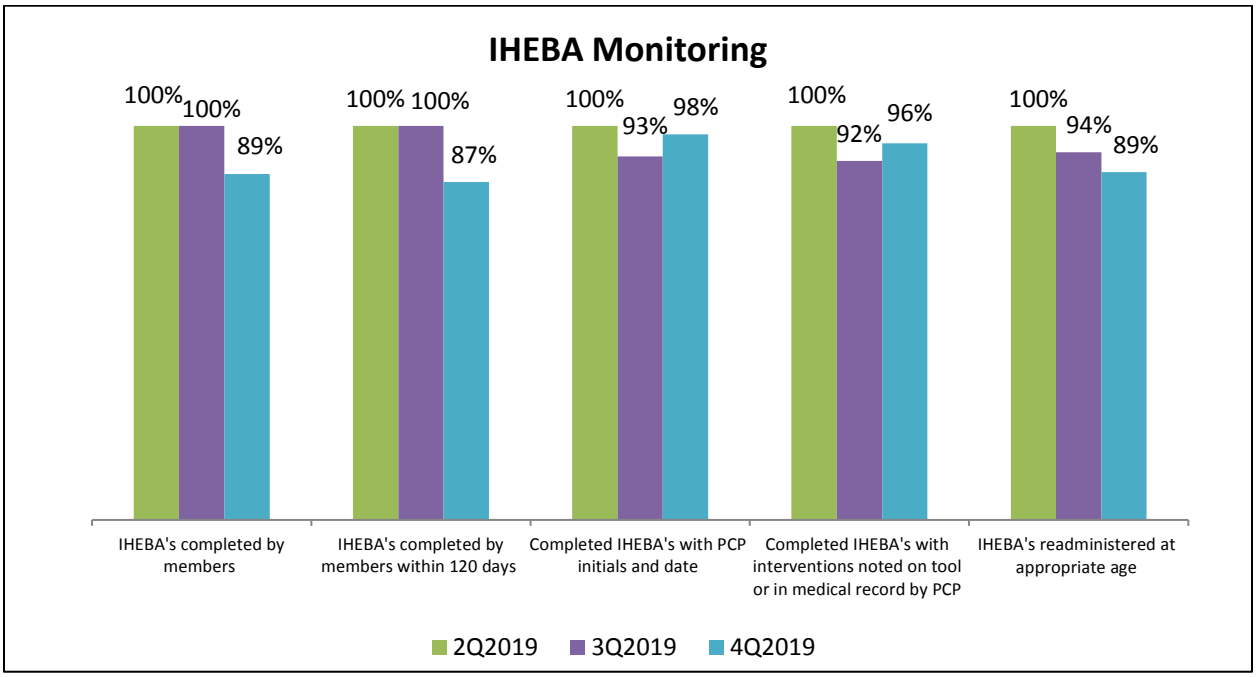
KHS is responsible for systematic monitoring of all PCP and OB/GYN sites between each regularly scheduled, full scope site review surveys. This monitoring includes the nine (9) critical elements. These nine critical survey elements are related to the potential for adverse effect on patient health or safety which 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 review or monitoring visit must be corrected by the provider within 10 business days of the survey date. Sites found deficient in any critical element during a Focus Review are required to correct 100% of the survey deficiencies, regardless of survey score.

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 survey or monitoring visit. The PCP and/or site contact are required to correct 100% of the survey deficiencies regardless of the survey score.



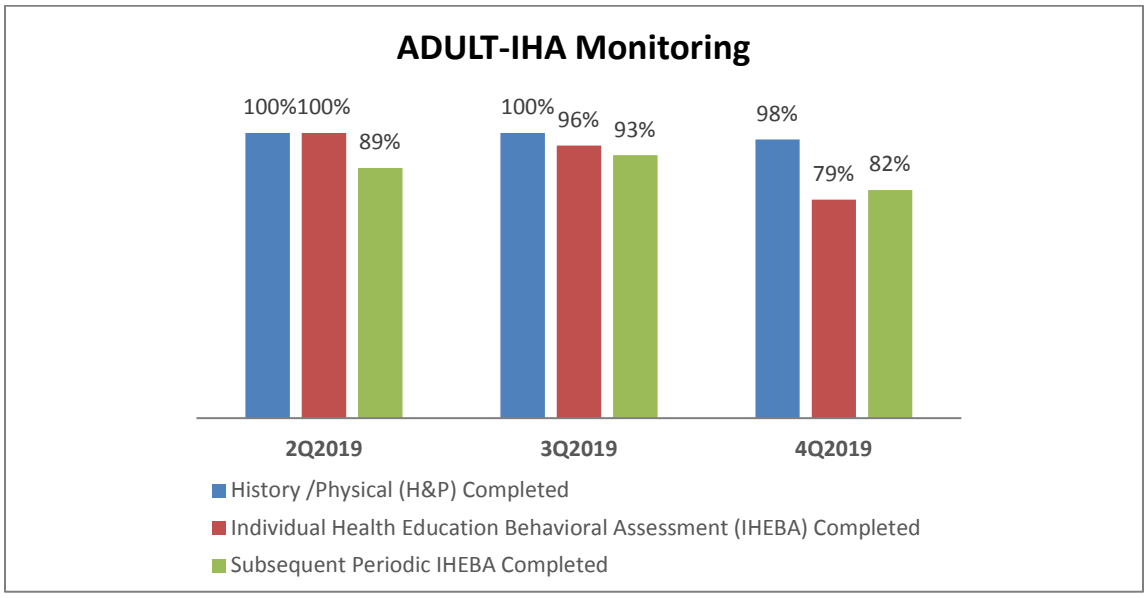
Analysis for Critical Elements: The area with an opportunity for improvement in the 4th Quarter of 2019 is Airway Management: Oxygen delivery system, oral airways, nasal cannula or mask Ambu Bag. A Corrective Action Plan (CAP) was issued and the deficiency was corrected.

Individual Health Education Behavioral Assessment (IHEBA) Description: The 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. The minimum performance level (MPL) is 80%.

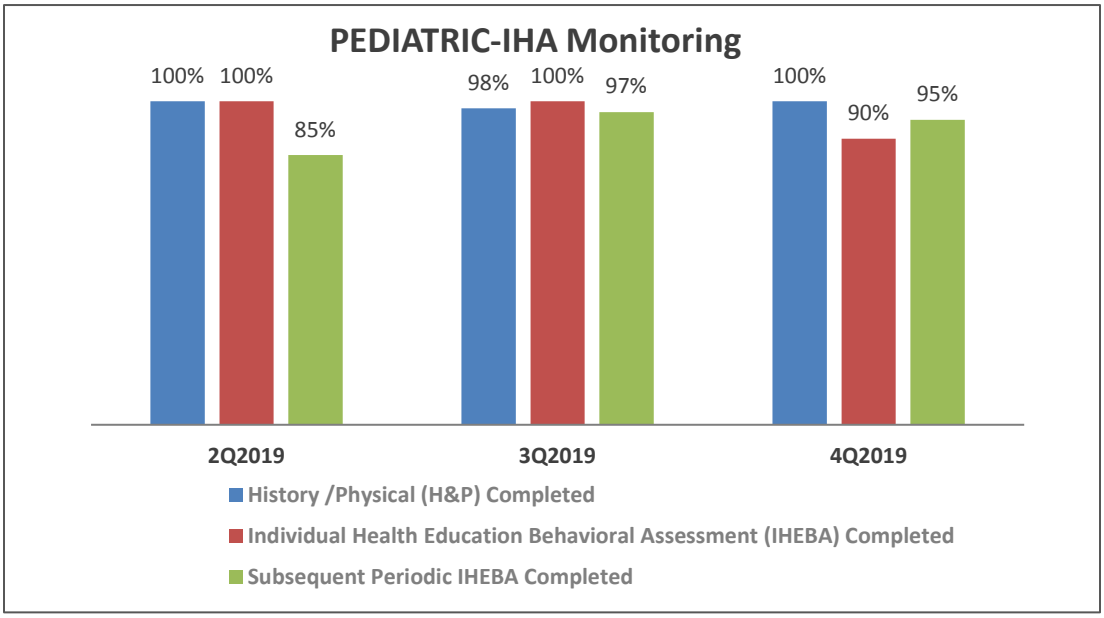


IHEBA Results: In the 4th Quarter of 2019, 252 records were audited from 29 different providers. This quarter providers surveyed scored less compared with previous quarters, we had a provider who had no SHA done for all ten patients reviewed and there were five other providers who scored below MPL and that could have been the primary source to this decrease. Corrective Action Plans (CAPS) were issued and follow up reviews were done.

Initial Health Assessment (IHA) Description: An IHA must be provided to each member within 120 days of enrollment. As PCP's receive their assigned members, the practitioner's office contacts the member to schedule an IHA to be performed within the 120 day time limit. If the practitioner is unable to contact the member, he/she contacts the KHS Member Services Department for assistance. Contact attempts and results are documented by both the PCP and member services staff. The MPL is 80% for this measure, and IHAs are performed on both adult and child members.

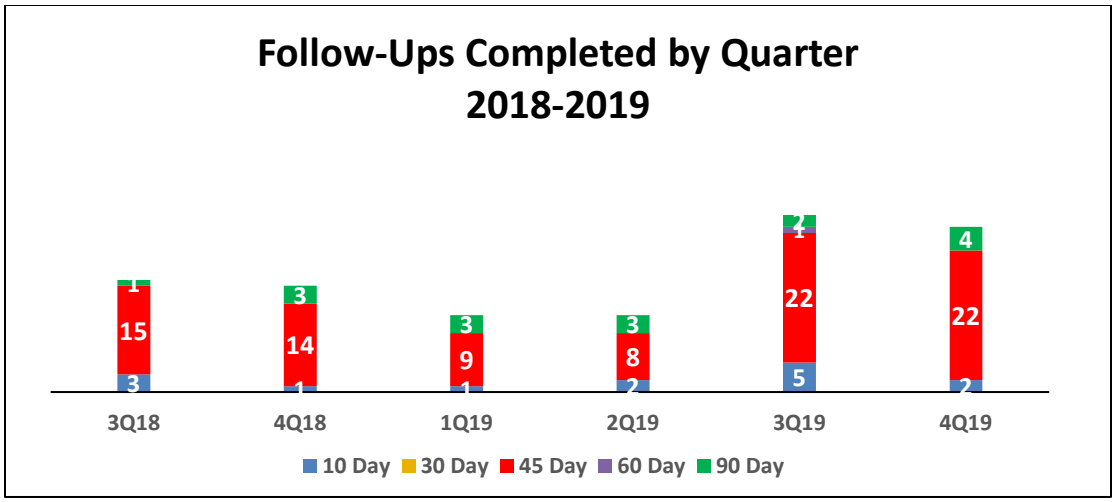


ADULT IHA Results: In the 4th Quarter of 2019, there were 31 providers evaluated out of which 24 providers had adult IHA records. We had 104 Adult-IHA records reviewed for these 24 providers. Six providers among the 24 scored below MPL for Individual Health Education Behavioral Assessment (IHEBA) that rendered overall score of IHEBA. Corrective Action Plans (CAPS) were issued and the deficiencies were corrected.



PEDIATRIC IHA Results: For the 4th Quarter of 2019, out of 31 providers, 27 of them had pediatric IHA records. Among these 27 providers, we had 106 Pediatrics-IHA records reviewed. Surveyed scored 100% in History /Physical (H&P) Completed. The areas most in need of improvement were IHEBA Completed and Subsequent Periodic IHEBA Completed. Corrective Action Plans (CAPS) were issued and the deficiencies were corrected.

Facility Site Review and Focus Review Corrective Action Plans (CAPs):



In the 4th Quarter of 2019 there were two 10-Day Follow-ups, twenty-two 45-Day Follow-ups, four 90-Day Follow-ups completed. The majority of CAP's issued were corrected within the 45 Days follow-Up period except for one provider who has not corrected their deficiencies for greater than 90-day follow up. Our CMO will be addressing this issue with the provider in the next Quarter.

III. Quality Improvement Projects

Performance Improvement Projects (PIPs)

Based on the final rates of HEDIS, two of the measures that KHS is held accountable to meet the MPL (Minimum Performance Level) were not met. Those two measures are the Asthma Medication Ratio (AMR) and the W34 Well-Child visits (ages 3-6 years old). Improvement projects (IP) are required for both of these measures and are being incorporated into the 2019-2021 PIPs. DHCS has approved this approach. For 2019-2021, KHS has chosen the following PIP topics:

Disparities in W34 (Well child Visits on ages 3-6 years old)

The proposal for the KHS' Disparities W34 (Well Child Visits on ages 3-6 years old) PIP got accepted by DHCS for 2019-2021 on August 15th, 2019. Kern Pediatrics has accepted to partner with us on this PIP

to improve member care. Our PIP team is working closely with providers to identify gaps in care and act appropriately to address them.

During this 4th Quarter Module 1 was submitted and was accepted by HSAG. KHS will be submitting Module 2, Intervention Determination by January 17, 2021. Once the Module is approved by DHCS we will start implementing one intervention at a time, every 4 months, to improve our SMART Aim (Specific, Measureable, Attainable, Relevant, Time-bound) which in turn improves our overall HEDIS score.

Child/Adolescent Health AMR PIP

The proposal for the KHS Child/Adolescent AMR PIP was accepted by DHCS for 2019-2021 on August 30, 2019. Riverwalk Pediatrics and Bakersfield Pediatrics has accepted the invitation to partner with KHS on this PIP project. We will be working with these two Pediatric Providers to identify common areas for improvement in their processes, in order to improve our overall HEDIS AMR number. Module 1 was submitted on November 22, 2019. We received feedback from HSAG for some corrections to be made and resubmission is due on January 24, 2020 for Module 1.

IV. MCAS Updates

MCAS (also referred to as HEDIS

HEDIS/MCAS audit for 2020 has been initiated with the receipt of roadmap forms from HSAG. First deliverable of roadmap was due on Jan 31st 2020 and we went ahead and submitted it on December 5th 2019 to HSAG.

On Dec 19th we received a feedback from HSAG stating Attachment 4.3 (MRR abstraction tool documentation) portion of the roadmap was approved with no issues identified. Internally we started working on abstraction training for all the QI nurses for the hybrid measures we are held accountable to. Our Business Intelligence team will be uploading administrative data into Cotiviti software for all the measures to go into production in January so we can start our chases for hybrid measures. HSAG onsite audit is scheduled for March 20th 2020.

KERN HEALTH SYSTEMS

CA-10) Kaiser Reports

Kaiser Reports (Proprietary and Confidential)

661-664-5000
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kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

Medical Data Collection Summary Report

Period Covered: February, 2019 through January, 2020
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:	28,534	
Diabetes?:	1,534	5.4%
Diabetic Retinopathy:	197	.7%
Glaucoma:	290	1.0%
Hypertension:	1187	4.2%
High Cholesterol	459	1.6%
Macular Degeneration:	48	.2%

Estimated Number of Cases

Total Members:	246,100	
Diabetes?:	5,742	2.3%
Diabetic Retinopathy:	509	.2%
Glaucoma:	963	.4%
Hypertension:	24,993	10.2%
High Cholesterol	37,225	15.1%
Macular Degeneration:	316	.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
2019	January	8,557	327	341	668
	February	8,910	414	315	729
	March	265	24	14	38
	April	1,012	61	50	111
	May	553	40	32	72
	June	729	60	29	89
	July	591	40	28	68
	August	541	39	11	50
	September	4,151	228	13	241
	October	525	42	0	42
	November	0	0	0	0
	December	1,916	12	0	12
Totals		**27,750**	**1,287**	**833**	**2,120**

LTM Effectiveness* : 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/discuss quarterly grievances with the KHS Board of Directors.

Category	Q4 2019	Status	Issue	Q3 2019	Q2 2019	Q1 2019	Q4 2018
Access to Care	**56**		Appointment Availability	34	32	41	32
Coverage Dispute	**0**		Authorizations and Pharmacy	3	9	14	12
Medical Necessity	**187**		Questioning denial of service	214	244	228	240
Other Issues	**14**		Miscellaneous	16	13	9	10
Quality of Care	**323**		Questioning services provided. All cases forwarded to Quality Dept.	65	26	29	22
Quality of Service	**0**		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	0	1	6	3
Exempt	**1140**		Member Grievances that are calls of dissatisfaction, that are not regarding a coverage or medical necessity issue, resolved within one business day.	1515	1321	1216	1082
Total Grievances, Appeals and Exempt Cases	**1720**			1847	1646	1543	1401

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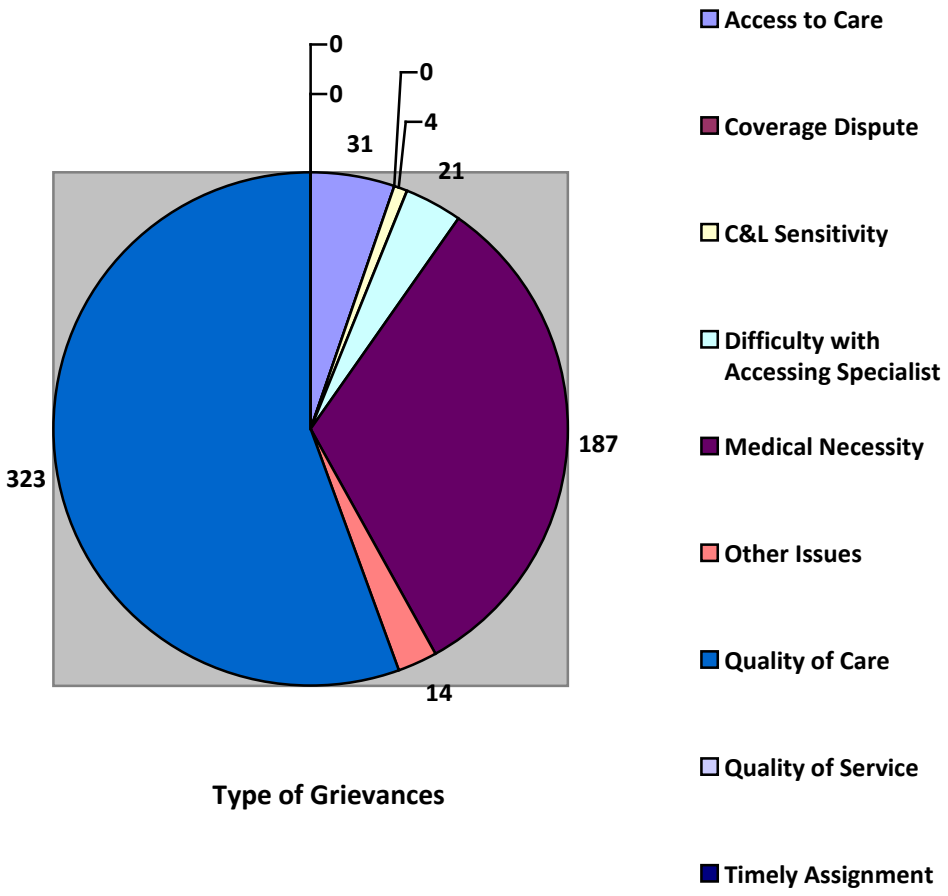
Additional Insights-Grievance & Appeal Detail

Issue	4th Quarter Grievances	Upheld Plan Decision	Overturned Ruled for Member	Still Under Review
Access to Care	31	22	7	2
Coverage Dispute	0	0	0	0
Specialist Access	25	10	14	1
Medical Necessity	187	128	48	11
Other Issues	14	13	1	0
Quality of Care	323	54	269	0
Quality of Service	0	0	0	0
Total	580	227	339	14

4th Quarter 2019 Grievance Summary

Issue	Number	In Favor of Health Plan	In favor of Enrollee	Still under review
Access to care	31	23	8	0
Coverage dispute	0	0	0	0
Cultural and Linguistic Sensitivity	4	1	3	0
Difficulty with accessing specialists	21	9	12	0
Medical necessity	187	137	50	0
Other issues	14	13	1	0
Quality of care	323	54	269	0
Quality of service	0	0	0	0
Timely assignment to provider	0	0	0	0



Grievances per 1,000 Members = 2.33

During the fourth quarter of 2019, there were five hundred and eighty formal grievances and appeals received. Three hundred and thirty nine cases were closed in favor of the Enrollee; two hundred and twenty seven cases were closed in favor of the Plan. Five hundred and seventy nine cases closed within thirty days; one case closed past thirty days. Fifty eight cases were received from SPD (Seniors and Persons with Disabilities) members. Sixty nine cases were received from Medi-Cal Expansion members.

4th Quarter 2019 Grievance Summary

Access to Care

There were thirty one grievances pertaining to access to care. Twenty three cases closed in favor of the Plan. Eight cases closed in favor of the Enrollee. The following is a summary of these issues:

Thirteen members complained about the lack of available appointments with their Primary Care Provider (PCP). Nine 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. Four of the cases closed in favor of the Enrollee after the response indicated the office may not have provided appropriate access to care.

Fifteen members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Thirteen 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. Two cases closed in favor of the Enrollee after the response indicated the member was not seen within the appropriate wait time for an appointment.

Three members complained about the telephone access with their Primary Care Provider (PCP). One case closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access. Two cases closed in favor of the Enrollee after the response indicated the office may not have provided appropriate telephone access.

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

There were four grievances pertaining to Cultural and Linguistic Sensitivity. One case closed in favor of the Plan. Three cases closed in favor of the Enrollee. The following is a summary of these issues:

One member complained about lack of interpreting service to assist completing paperwork. The case closed in favor of the Enrollee after the response indicated the office may not have assisted coordinate interpreter.

One member complained about provider not coordinating American Sign Language (ASL) interpreter for upcoming appointment. The case closed in favor of the Enrollee after the response indicated the office may not have assisted coordinate service.

Two members complained about lack of interpreting service to assist during appointment. One case closed in favor of the Plan after the response indicated the member was provided with the appropriate interpreting service. One case closed in favor of the Enrollee after the response indicated the office may not have assisted coordinate interpreter.

4th Quarter 2019 Grievance Summary

Difficulty with Accessing a Specialist

There were twenty one grievances pertaining to Difficulty Accessing a Specialist. Nine cases closed in favor of the Plan. Twelve cases closed in favor of the Enrollee. The following is a summary of these issues:

Fourteen members complained about the lack of available appointments with a specialist. Seven cases closed in favor of the Plan after the response indicated the offices provided appropriate access to care based on the Access to Care Standards for specialty appointments. Seven cases closed in favor of the Enrollee after the responses indicated the member may not have been provided appropriate access to care based on the Access to Care Standards for specialty appointments.

Five members complained about the wait time to be seen for a specialist appointment. Two cases closed in favor of the Plan after the response indicated the member was seen within the appropriate wait time for an appointment based on the Access to Care Standards. Three cases closed in favor of the Enrollee after the responses indicated the member may not have been seen within the appropriate wait time for an appointment based on the Access to Care Standards.

Two members complained about the telephone access with their specialist. The cases closed in favor of the Enrollee after the responses indicated the member may not have been provided appropriate telephone access based on the Access to Care Standards.

Medical Necessity

There were one hundred and eighty seven appeals pertaining to Medical Necessity. One hundred and thirty seven of the cases were closed in favor of the Plan. Fifty of the cases closed in favor of the Enrollee. The following is a summary of these issues:

One hundred and forty nine members complained about the denial or modification of a referral authorization request. Ninety nine 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. One case was closed in favor of the Plan and modified. Forty nine cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned.

Thirty eight members complained about the denial or modification of a TAR. Thirty seven 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. One case was closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned.

Other Issues

There were fourteen grievances pertaining to Other Issues. Thirteen of the cases were closed in favor of the Plan. One case closed in favor of the Enrollee.

4th Quarter 2019 Grievance Summary

Quality of Care

There were three hundred and twenty three grievances involving Quality of Care issues. Thirty four cases were closed in favor of the Plan. Two hundred and sixty nine cases were closed in favor of the Enrollee. The following is a summary of these issues:

Two hundred and thirty eight members complained about the quality of care received from a Primary Care Provider (PCP). Thirty eight cases were closed in favor of the Plan. Two hundred cases closed in favor of the Enrollee. All records/responses were sent to QI for further review and investigation.

Sixty six members complained about the quality of care received from a specialty provider. Eleven cases were closed in favor of the Plan. Fifty five cases closed in favor of the Enrollee. All records/responses were sent to QI for further review and investigation.

Nineteen members complained about the quality of care received from providers staffed by an urgent care, hospital, or non-hospital affiliated clinic. Five cases closed in favor of the Plan. Fourteen of the cases closed in favor of the Enrollee. All records/responses were sent to QI for further review and investigation.

Quality of Service

There were no grievances pertaining to Quality of Service.

Timely Assignment to Provider

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

Kaiser Permanente Grievances

During the fourth quarter of 2019, there were seventy nine grievances and appeals received by KFHC members assigned to Kaiser Permanente. Two cases closed in favor of the Plan. Seventy seven cases were closed in favor of the Enrollee.

Access to Care

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

Three members complained about the excessive wait time to be seen for an appointment. All three cases closed in favor of the Enrollee.

Two members complained about the lack of appointment availability for a Primary Care Provider. Both of the cases closed in favor of the Enrollee.

Coverage Dispute

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

Twenty four members complained about a service they requested; however, the request was not covered. One case closed in favor of the Plan and the service was not covered. Twenty three of the cases closed in favor of the Enrollee and the services were provided.

Medical Necessity

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

One member complained about a service they requested; however, the request was not approved. The case closed in favor of the Plan and the service was not provided.

One member complained about a delay of a service they requested. The case closed in favor of the Enrollee and the requested service was provided.

Quality of Care

There were ten grievances pertaining to quality of care. The following is a summary of this issue:

Nine members complained about the quality of care they received from a provider. All nine cases closed in favor of the Enrollee.

One member complained about a provider denying treatment. This case closed in favor of the Enrollee.

Quality of Service

There were thirty eight grievances pertaining to Quality of Service. The following is a summary of these issue.

Twenty six members complained about the services being inadequate at a facility. All twenty six cases closed in favor of the Enrollee.

Twelve members complained about the poor attitude from a provider and/or staff. All twelve cases closed in favor of the Enrollee.

KERN HEALTH SYSTEMS
4th Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: January 3, 2020

Department: Provider Relations

Monitoring Period: October 1, 2019 through December 31, 2019

Population:

Providers	Credentialed	Recredentialed
MD's	55	85
DO's	5	3
AU's	0	0
DC's	0	0
AC's	0	0
PA's	12	9
NP's	15	12
CRNA's	0	4
DPM's	1	2
OD's	1	1
ND's	0	0
RD's	0	0
BCBA's	3	1
Mental Health	6	3
Ocularist	0	0
Ancillary	4	23
OT	0	0
TOTAL	**102**	**143**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	0	0	0	0
Allergy & Immunology	0	1	1	0
Anesthesiology / CRNA	0	7	7	0
Audiology	0	0	0	0
Autism / Behavioral Analyst	3	1	4	0
Cardiology	3	8	11	0
Chiropractor	0	0	0	0
Colon & Rectal Surgery	0	1	1	0
Critical Care	0	1	1	0
Dermatology	4	1	5	0
Emergency Medicine	2	1	3	0
Endocrinology	1	1	2	0
Family Practice	17	12	29	0
Gastroenterology	2	4	6	0
General Practice	0	3	3	0
General Surgery	3	3	6	0
Genetics	1	0	1	0
Gynecology	0	0	0	0

KERN HEALTH SYSTEMS
4th Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Gynecology/Oncology	2	0	2	0
Hematology/Oncology	0	4	4	0
Hospitalist	0	1	1	0
Infectious Disease	0	3	3	0
Internal Medicine	13	18	31	0
Mental Health	6	3	9	0
Mid Wife	0	0	0	0
Naturopathic Medicine	0	1	1	0
Neonatology	0	0	0	0
Nephrology	0	3	3	0
Neurological Surgery	0	2	2	0
Neurology	2	2	4	0
Obstetrics & Gynecology	3	5	8	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	2	2	4	0
Optometry	1	1	2	0
Orthopedic Surgery / Hand Surg	2	2	4	0
Otolaryngology	0	2	2	0
Pain Management	2	3	5	0
Pathology	0	1	1	0
Pediatrics	6	14	20	0
Physical Medicine & Rehab	6	1	7	0
Plastic Sugery	2	0	2	0
Podiatry	1	2	3	0
Psychiatry	8	2	10	0
Pulmonary	0	2	2	0
Radiation Oncology	1	1	2	0
Radiology	6	9	15	0
Registered Dieticians	0	0	0	0
Rheumatology	1	0	1	0
Sleep Medicine	0	0	0	0
Thoracic Surgery	0	1	1	0
Vascular Medicine	0	0	0	0
Vascular Surgery	0	0	0	0
Urology	1	0	1	0
KHS Medical Directors	0	0	0	0
TOTAL	**101**	**129**	**230**	**0**

KERN HEALTH SYSTEMS
4th Quarter 2019
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	1	1	0
DME	1	2	3	0
Hearing Aid Dispenser	0	0	0	0
Home Health	1	0	1	0
Home Infusion/Compounding	0	0	0	0
Hospice	1	0	1	0
Hospital	0	2	2	0
Laboratory	0	0	0	0
Lactation Consultant	0	0	0	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	0	7	7	0
Pharmacy/DME	0	2	2	0
Physical / Speech Therapy	0	1	1	0
Prosthetics & Orthotics	0	0	0	0
Radiology	0	1	1	0
Skilled Nursing	1	1	2	0
Sleep Lab	0	1	1	0
Surgery Center	0	3	3	0
Transportation	0	1	1	0
Urgent Care	0	1	1	0
TOTAL	**4**	**23**	**27**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS
4th Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

KERN HEALTH SYSTEMS
4th Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Kern Health Systems
Board Approved Effective 11/01/19

LEGAL NAME DBA NAME	SPECIALTY	PROVIDER #	GROUP #	ADDRESS	CONTRACT EFFECTIVE DATE
Ararat Hospice Care, Inc	Hospice	PRV031631	PRV031631	1601 New Stine Rd. Ste. 185 Bakersfield CA 93309	11/1/2019
Delano PostAcute Care LLC dba: Delano PostAcute Care	SNF	PRV042584	PRV042584	729 Browning Rd Delano CA 93215	11/1/2019
Respiratory Technologies, Inc. dba: RespirTech	DME (Assistive Device)	PRV008324	PRV008324	5905 Nathan Lane North Ste 200 Plymouth MN 66442	11/1/2019

Kern Health Systems
Board Approved Effective 12/01/19

Legal Name DBA Name	Specialty	Provider #	Group #	Address	Contract Effective Date
Crystal Rose Home Health, Inc	Home Health	PRV036542	PRV036542	44841 Date Avenue Bakersfield CA 93534	12/1/2019
David Horovitz, MD, Inc	Urology	PRV057103	PRV057103	3838 San Dimas St, Ste B-231 Bakersfield CA 93301	12/1/2019
Sound Physicians Emergency Medicine of Southern California, PC	ER Group	PRV047457	PRV047457	2615 Chester Avenue Bakersfield CA 93301	12/1/2019
Mansukh Ghadiya MD, Inc	PCP / Family Practice	PRV006642	PRV049314	2201 Mt Vernon Suite 211A Bakersfield CA 93306	12/1/2019

Kern Health Systems
Board Approved Effective 01/01/20

Legal Name DBA Name	Specialty	Provider #	Group #	Address	Comments	Contract Effective Date
Raman Talwar, MD	General Surgery	PRV008374	PRV008374	20111 W Valley Blvd Tehachapi CA 93561	*Existing Provider	1/1/2020

Kern Health Systems
Board Approved Effective 11/01/19

	NAME	LEGAL NAME/ADDRESS	Provider #	Group #	SPECIALTY	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
	Ararat Hospice Care, Inc	Ararat Hospice Care, Inc. 1601 New Stine Rd. Ste. 185 Bakersfield CA 93309	PRV031631	PRV031631	Hospice	New Contract	Yes Eff 11/1/19
	Delano PostAcute Care	Delano PostAcute Care, LLC 729 Browning Rd Delano CA 93215	PRV042584	PRV042584	Skilled Nursing Facility	New Contract	Yes Eff 11/1/19
	RespirTech	Respiratory Technologies, Inc. Dba: RespirTech 5905 Nathan Lane North Ste 200 Plymouth MN 66442	PRV008324	PRV008324	Assistive Device / DME	New Contract	Yes Eff 11/1/19
	Chu, John MD	Priority Urgent Care 4821 Panama Lane Ste. A-C Bakersfield CA 93313	PRV056453	PRV038192	Emergency Medicine	Existing	Yes Eff 11/1/19
	Nath, Mahendra MD	LAGS Spine and Sportscare Medical Centers, Inc. 3550 Q St Ste 105 Bakersfield CA 93301	PRV052522	PRV000403	Physical Medicine & Rehabilitation	Existing	Yes Eff 11/1/19
	Outlaw, Edward MD	LAGS Spine and Sportscare Medical Centers, Inc. 3550 Q St Ste 105 Bakersfield CA 93301	PRV056454	PRV000403	Physical Medicine & Rehabilitation	Existing	Yes Eff 11/1/19
	Bawa, Anudeep NP-C	Ashok Parmar, MD, Inc. Lamont Primary Care Clinic Brimhall Primary Care Center Ming Primary Care Clinic **Additional Affiliations:** Universal Urgent Care, PC *All Locations	PRV056408	PRV056408 PRV051864 PRV051865 PRV045444 PRV036257 PRV012894	Family Practice	Existing	Yes Eff 11/1/19
	Bryan, Paul LCSW	Omni Family Health 912 Fremont St Delano 210 N Chester Ave Bakersfield 1701 Stine Rd Bakersfield	PRV055838	PRV000019	Clinical Social Worker	Existing	Yes Eff 11/1/19
	Ding, Shao-Zheng MD	Clinica Sierra Vista 2000 Physicians Blvd Bakersfield CA 93301	PRV054976	PRV000002	Family Practice	Existing	Yes Eff 11/1/19
	Gavilan Yodu, Ronald MD	Clinica Sierra Vista 8787 Hall Road Lamont CA 93241	PRV045223	PRV000002	Family Practice	Existing	Yes Eff 11/1/19
	George, John MD	Universal Urgent Care, PC *All Locations 8325 Brimhall Rd Bakersfield CA 93312	PRV056463	PRV045444 PRV036257 PRV012894	Internal Medicine	Existing	Yes Eff 11/1/19
	Khosrovi-Eghbal, Arash MD	Clinica Sierra Vista 1305 Bear Mountain Blvd Arvin CA 93203	PRV054592	PRV000002	Internal Medicine	Existing	Yes Eff 11/1/19

	Lashgari, Ali MD	Ridgecrest Regional Hospital-RHC 1111 N China Lake Blvd Ste 190 Ridgecrest CA 93555	PRV035093	PRV029495	Dermatology	Existing	**Yes** **Eff 11/1/19**
	Linares Valderrama, Maria MD	Clinica Sierra Vista 2000 Physicians Blvd Bakersfield CA 93301	PRV054634	PRV000002	Internal Medicine / Endocrinology	Existing	**Yes** **Eff 11/1/19**
	Madhanagopal, Nandhini MD	Kern County Hospital Authority Kern Medical-1700 Mt Vernon Ave. Grow Clinic - 820 34th St Bakersfield CA 93306	PRV054977	ALL KM	Psychiatry	Existing	**Yes** **Eff 11/1/19**
	Mendoza, Marilou NP-C	LAGS Spine and Sportscare Medical Centers, Inc. 3550 Q St Ste 105 Bakersfield CA 93301	PRV049740	PRV000403	Physical Medicine & Rehabilitation	Existing	**Yes** **Eff 11/1/19**
	Montecillo, Theresa NP-C	LAGS Spine and Sportscare Medical Centers, Inc. 3550 Q St Ste 105 Bakersfield CA 93301	PRV056464	PRV000403	Physical Medicine & Rehabilitation	Existing	**Yes** **Eff 11/1/19**
	Nair, Narayanan MD	California Institute of Cosmetic and Reconstructive Surgery 2901 Sillect Ave Ste 201 Bakersfield CA 93308	PRV054044	PRV000688	Plastic Surgery	Existing	**Yes** **Eff 11/1/19**
	Nandhagopal, Thiagarajan MD	Kern County Hospital Authority Kern Medical 1700 Mt Vernon Ave. 820 34th St Bakersfield CA 93306	PRV054291	ALL KM	Pediatrics	Existing	**Yes** **Eff 11/1/19**
	Person, Nanouli NP-C	Omni Family Health 210 N Chester Ave Bakersfield CA 93309	PRV055632	PRV000019	Family Practice	Existing	**Yes** **Eff 11/1/19**
	Perumalsamy, Kumaravel MD	Adventist Health Medical Center Tehachapi 105 West E St Tehachapi CA 93561	PRV008081	ALL KM	Gastroenterology	Existing	**Yes** **Eff 11/1/19**
	Quillatupa Valencia, Norka MD	Kern County Hospital Authority Kern Medical 1700 Mt Vernon Ave. 820 34th St Bakersfield CA 93306	PRV054043	ALL KM	Internal Medicine / Geriatric Medicine	Existing	**Yes** **Eff 11/1/19**
	Rosales, Maria Cecilia NP-C	Clinica Sierra Vista 2000 Physicians Blvd Bakersfield CA 93301	PRV054590	PRV000002	Family Practice	Existing	**Yes** **Eff 11/1/19**
	Sheikh, Aisha PA-C	San Joaquin Valley Health Group, Inc. Dba: 1st Choice Urgent Care 6515 Panama Lane Ste 106-107 Bakersfield CA 93313	PRV004561	PRV042402	Family Practice	Existing	**Yes** **Eff 11/1/19**

Kern Health Systems
Board Approved Effective 12/01/19

	NAME	LEGAL NAME/ADDRESS	Provider #	Group #	SPECIALTY	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
	Crystal Rose Home Health Care, Inc.	Crystal Rose Home Health Care, Inc. 44841 Date Ave Lancaster CA 93534	PRV036542	PRV036542	Home Health	New Contract	Yes Eff 12/1/19
	Ghadiya, Mansukh MD	Mansukh Ghadiya, MD, Inc. Dba: Primary and Immediate Care Clinic 2201 Mt Vernon Ave Ste 211A Bakersfield CA 93306	PRV006642	PRV049314	Family Practice	New Contract	Yes Eff 12/1/19
	Horvitz, David MD	David Horovitz MD Inc. 3838 San Dimas Street, Ste B-231 Bakersfield CA 93301	PRV057103	PRV057103	Urology	New Contract	Yes Eff 12/1/19
	Ezell, Dorinda NP-C	Pain Institute of California 9802 Stockdale Hwy Ste 105 Bakersfield CA 93311	PRV057095	PRV000510	Pain Medicine	Existing	Yes Eff 12/1/19
	Fuentes, Felma MD	Omni Family Health 912 Fremont St Delano CA 93215	PRV056796	PRV000019	Pediatrics	Existing	Yes Eff 12/1/19
	Perez, Hugo DPM	Stockdale Podiatry Group Inc. 110 New Stine Rd Bakersfield 1519 Garces Hwy Ste 107 Delano	PRV056955	PRV000332	Podiatry	Existing	Yes Eff 12/1/19
	Sun, Julie MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV003879	PRV000324	Diagnostic Radiology /Neuroradiology	Existing	Yes Eff 12/1/19
	Tyagi, Vivaik MD	Adventist Health Tehachapi 105 West E St Tehachapi CA 93561	PRV001087	ALL SITES	Gastroenterology	Existing	Yes Eff 12/1/19
	Agbor-Etang, Brian MD	Oak Hills Medical Corporation 5020 Commerce Dr Bakersfield CA 93309	PRV055839	PRV000310	Cardiovascular Diseases	Existing	Yes Eff 12/1/19
	Beach, Kourtney LCSW	Omni Family Health 912 Fremont St Delano 1701 Stine Rd Bakersfield 210 N Chester Ave Bakersfield 1215 Jefferson St Delano 1001 Main St Delano	PRV055839	PRV000019	Clinical Social Worker	Existing	Yes Eff 12/1/19
	Bekarev, Mikhail MD	Kern County Hospital Authority 3551 Q St Ste 100 Bakersfield CA 93301	PRV055367	ALL SITES	Orthopedic Surgery	Existing	Yes Eff 12/1/19
	Bhandohal, Janpreet MD	Kern County Hospital Authority Sagebrush - 1111 Columbus St Kern Medical - 1700 Mt Vernon St Bakersfield CA	PRV054597	ALL SITES	Internal Medicine	Existing	Yes Eff 12/1/19
	Bost, Neal MD	Kern Radiology Medical Group, Inc. * All Locations 2301 Bahamas Dr Bakersfield CA 93309	PRV056967	ALL SITES	Diagnostic Radiology / Nuclear Medicine	Existing	Yes Eff 12/1/19

Kern Health Systems
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	Cendana, Luigi DO	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV041945	PRV029495	Pediatrics	Existing	**Yes** **Eff 12/1/19**
	Chu, Clarence PA-C	LA Laser Center PC 5600 California Ave Ste 101 & 103 Bakersfield CA 93309	PRV039598	PRV013922	Dermatology	Existing	**Yes** **Eff 12/1/19**
	Cruz, Marc NP	Ravi Patel, MD Inc. Dba: Comprehensive Blood & Cancer Center 6501 Truxtun Ave Bakersfield CA 93309	PRV057097	PRV013881	Gynecologic Oncology	Existing	**Yes** **Eff 12/1/19**
	Currie, Aaron "Scott" PA-C	Clinica La Victoria 2303 S Union Ave Ste C2 Bakersfield CA 93307	PRV032480	ALL SITES	Family Practice	Existing	**Yes** **Eff 12/1/19**
	Esters, Latavia PA-C	LAGS Spine & Sportscare Medical Centers 3550 Q St Ste 201 Bakersfield CA 93301	PRV046506	PRV000403	Physical Medicine & Rehabilitation	Existing	**Yes** **Eff 12/1/19**
	Franco, Cristina BCBA	Behavior Frontiers, LLC 5060 California Ave Ste 610 Bakersfield CA 93309	PRV057098	PRV046025	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 12/1/19**
	Garn, Karen PA-C	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA 93306	PRV054237	ALL SITES	General Surgery	Existing	**Yes** **Eff 12/1/19**
	Gauvin, Wali MD	Pediatric Heart Center, LLC 500 Old River Road Ste. 105 Bakersfield CA 93311	PRV046594	PRV000237	Pediatric Cardiology	Existing	**Yes** **Eff 12/1/19**
	Hinman, Timothy MD	Emergency Physicians Urgent Care, Inc. Accelerated Urgent Care * All Locations 212 Coffee Road Bakersfield CA 93309	PRV057099	ALL SITES	Emergency Medicine	Existing	**Yes** **Eff 12/1/19**
	Jones, Kendall LCSW	Omni Family Health 912 Fremont St Delano 1701 Stine Rd Bakersfield 1215 Jefferson St Delano	PRV057100	PRV000019	Clinical Social Worker	Existing	**Yes** **Eff 12/1/19**
	Kelly, Nancy NP-C	Comprehensive Medical Group 1230 Jefferson St Delano CA 93215	PRV054046	PRV000258	Internal Medicine	Existing	**Yes** **Eff 12/1/19**
	Kotwal, Neville MD	Clinica Sierra Vista 2000 Physicians Blvd Bakersfield 7800 Niles St Bakersfield 8787 Hall Rd Lamont 1508 Garces Hwy Ste 1 Delano	PRV055425	PRV000002	Psychiatry	Existing	**Yes** **Eff 12/1/19**
	McLaughlin, Patrick DO	Infusion & Clinical Services Dba: Premier Valley Medical Group 5401 White Lane 611 Airport Dr Bakersfield CA	PRV055654	PRV055842 PRV047600	Psychiatry	Existing	**Yes** **Eff 12/1/19**

Kern Health Systems
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	Mongar, Samantha DO	Kern Valley Healthcare District 6410 Laurel Ave Lake Isabella CA 93240	PRV005510	PRV046034	Internal Medicine / Hospitalist	Existing	**Yes** **Eff 12/1/19**
	Nalls, Gail MD	Kern Radiology Medical Group, Inc. * All Locations 2301 Bahamas Dr Bakersfield CA 93309	PRV057074	ALL SITES	Diagnostic Radiology	Existing	**Yes** **Eff 12/1/19**
	Nguyen, Tim OD	Ace Eyecare, Inc 1721 Westwind Dr Ste B Bakersfield CA 93301	PRV057101	PRV041736	Optometry	Existing	**Yes** **Eff 12/1/19**
	Obanor, Femi NP-C	LAGS Spine & Sportscare Medical Centers 3550 Q St Ste 201 Bakersfield CA 93301	PRV057102	PRV000403	Physical Medicine & Rehabilitation	Existing	**Yes** **Eff 12/1/19**
	Palispis, Winnie MD	Kern County Hospital Authority 3551 Q St Ste 100 Bakersfield CA 93301	PRV055426	ALL SITES	Orthopedic Surgery	Existing	**Yes** **Eff 12/1/19**
	Ramzan, Amin MD	Kern County Hospital Authority Sagebrush - 1111 Columbus St Kern Medical - 1700 Mt Vernon St Bakersfield CA	PRV055633	ALL SITES	OB/GYN / Gynecologic Oncology	Existing	**Yes** **Eff 12/1/19**
	Redon, Kenneth NP-C	Carlos A. Alvarez, MD Inc. 8929 Panama Rd Lamont 801 Santa Fe Way Shafter	PRV057104	PRV055424	Internal Medicine	Existing	**Yes** **Eff 12/1/19**
	Reznik, Jacob MD	Charles D. Fritch, MD, Inc. Dba: Fritch Eye Care Medical Center 8501 Brimhall Rd Ste 401 & 402 Bakersfield CA 93312	PRV057105	PRV000176	Ophthalmology	Existing	**Yes** **Eff 12/1/19**
	Sandhu, Gurpreet MD	Infusion & Clinical Services Dba: Premier Valley Medical Group 5401 White Lane 611 Airport Dr Bakersfield CA	PRV056131	PRV055842 PRV047600	Psychiatry	Existing	**Yes** **Eff 12/1/19**
	Sexton, Gloria PA-C	Priority Urgent Care 4821 Panama Ln Ste A-C Bakersfield CA 93313	PRV048895	PRV038192	Family Practice	Existing	**Yes** **Eff 12/1/19**
	Sherman, Judith MD	Telehealthdocs Medical Corporation 2215 Truxtun Ave Bakersfield 100 E North St Taft 1017 Ellington St Delano	PRV057106	ALL SITES	Psychiatry	Existing	**Yes** **Eff 12/1/19**
	Tate, Matthew PA-C	Pain Institute of California 9802 Stockdale Highway Ste. 105 Bakersfield CA 93311	PRV001606	PRV000510	Pain Medicine	Existing	**Yes** **Eff 12/1/19**
	Thompson, Marcher MD	San Joaquin Community Hospital Dba: Adventist Health Bakersfield 2620 Chester Ave Bakersfield CA 93301	PRV056812	PRV000207	Radiation Oncology	Existing	**Yes** **Eff 12/1/19**
	Wang, Yawen MD	Kern County Neurological Med Grp 1705 28th Street Bakersfield CA 93301	PRV057157	PRV000308	Pediatric Neurology	Existing	**Yes** **Eff 12/1/19**

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	Watson, Stefany BCBA	Autism Learning Partners, LLC 1201 24th St Ste B110 Bakersfield CA 93301	PRV057107	PRV055002	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 12/1/19**
	Ziaei, Salman MD	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV055736	PRV029495	Internal Medicine	Existing	**Yes** **Eff 12/1/19**

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	NAME	LEGAL NAME/ADDRESS	Provider #	Group #	SPECIALTY	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
	McCarron, Audrey MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV057660	PRV000324	Diagnostic Radiology	Existing	Yes Eff 1/1/20
	Rojas, Rodrigo MD	Centric Health Dba: Sillect Urgent Care 4500 Morning Dr Ste 101 Bakersfield CA 93306	PRV002495	PRV046020	Pediatrics	Existing	Yes Eff 1/1/20
	Awadalla, Farah MD	LA Laser Center PC 5600 California Ave Ste 101 Bakersfield 1200 N China Lake Blvd Ste A Ridgecrest 20111 W Valley Blvd Tehachapi	PRV057654	PRV013922	Dermatology	Existing	Yes Eff 1/1/20
	Ayala-Rodriguez, Irving MD	Clinica Sierra Vista 1611 1st St Bakersfield CA 93304	PRV056682	PRV000002	Family Practice	Existing	Yes Eff 1/1/20
	Baughman, Ethan MD	Grossman Medical Group, Inc. 420 34th Street Bakersfield CA 93301	PRV057655	PRV000405	Plastic & Reconstructive Surgery	Existing	Yes Eff 1/1/20
	Blanks, Marci NP-C	Clinica Sierra Vista 9001 South H Street Bakersfield CA 93307	PRV056286	PRV000002	Pediatrics	Existing	Yes Eff 1/1/20
	Coleman, Jeffrey MD	Kern County Hospital Authority 1111 Columbus St Bakersfield CA 93305	PRV042241	ALL SITES	Internal Medicine	Existing	Yes Eff 1/1/20
	Collier, Stephanie PA-C	Adventist Health Medical Center Tehachapi 105 West E St Tehachapi 2041 Belshaw St Mojave 9350 N Loop Blvd California City	PRV057659	ALL SITES	Internal Medicine	Existing	Yes Eff 1/1/20
	Cranor, Todd PA-C	Emergency Physicians Urgent Care, Inc. Accelerated Urgent Care * All Locations 212 Coffee Road Bakersfield CA 93309	PRV057656	ALL SITES	Family Practice	Existing	Yes Eff 1/1/20
	De Jesus, Julie NP-C	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste 190 Ridgecrest, CA 93555	PRV055840	PRV029495	Family Practice	Existing	Yes Eff 1/1/20
	Fernandez, Carlos MD	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA 93306	PRV056143	ALL SITES	Psychiatry	Existing	Yes Eff 1/1/20

	Galoyo, Rubie NP	Shafter Pediatrics 501 Munzer St Ste C Shafter CA 93263	PRV053486	PRV035496	Pediatrics	Existing	**Yes** **Eff 1/1/20**
	Garcia, Carla LCSW	Bakersfield City School District Dba: Center Street Wellness Center 2951 Center St Bakersfield CA 93306	PRV057683	PRV000469	Clinical Social Worker	Existing	**Yes** **Eff 1/1/20**
	Gutzman, James PA	Kern Valley Healthcare District 6412 Laurel Ave Lake Isabella CA 93240	PRV057684	PRV000247	Internal Medicine / Hospitalist	Existing	**Yes** **Eff 1/1/20**
	Hazany, Salar MD	LA Laser Center PC 5600 California Ave Ste 101 Bakersfield 1200 N China Lake Blvd Ste A Ridgecrest 20111 W Valley Blvd Tehachapi	PRV057657	PRV013922	Dermatology	Existing	**Yes** **Eff 1/1/20**
	Khazai, Bahram MD	Advanced Cardiology Medical Associates 2601 16th St Bakersfield CA 93301	PRV055634	PRV013692	Interventional Cardiology	Existing	**Yes** **Eff 1/1/20**
	Kongara, Nanditha MD	Universal Urgent Care, Inc. * All Locations 8325 Brimhall Rd Bakersfield CA 93312	PRV009963	ALL SITES	Family Practice	Existing	**Yes** **Eff 1/1/20**
	Lewis, Alicia LMFT	Komin Medical Group 1150 Lerdo Hwy Ste C Shafter CA 93263 **Additional Affiliation:** S & T Professional Group	PRV057685	PRV013620 PRV000358	Marriage & Family Therapy	Existing	**Yes** **Eff 1/1/20**
	Li, Yi MD	Rheumatology Services Medical Group 8329 Brimhall Rd Ste 801 Bakersfield CA 93312	PRV057686	PRV014106	Rheumatology	Existing	**Yes** **Eff 1/1/20**
	Mack, Brittni PA-C	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA 93306	PRV055934	ALL SITES	General Surgery	Existing	**Yes** **Eff 1/1/20**
	Martinez Duenas, Yunior MD	Clinica Sierra Vista 7800 Niles St Bakersfield 2525 N Chester Ave Bakersfield	PRV045058	PRV000002	Family Practice	Existing	**Yes** **Eff 1/1/20**
	Mazzullo, Joseph NP-C	Kern Psychiatric Health and Wellness Center, Inc. 6313 Schirra Ct Ste 1 Bakersfield CA 93313	PRV057658	PRV046499	Psychiatry	Existing	**Yes** **Eff 1/1/20**
	McDermott, Roxanne MD	Clinica Sierra Vista 301 Brundage Lane Bakersfield CA 93304	PRV043181	PRV000002	OB/GYN	Existing	**Yes** **Eff 1/1/20**

	Murrain, Luis DO	Kern County Hospital Authority Sagebrush - 1111 Columbus St Kern Medical - 1700 Mt Vernon St Bakersfield CA	PRV055428	ALL SITES	OB/GYN / Clinical Genetics	Existing	**Yes** **Eff 1/1/20**
	Parish, Andrea BCBA	Bowcor Inc Dba: Special Explorers Center * All Locations 2401 M St Ste 300 Bakersfield CA 93301	PRV056681	ALL SITES	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 1/1/20**
	Reznik, Alena MD	Charles D. Fritch, MD, Inc. Dba: Fritch Eye Care Medical Center 8501 Brimhall Rd Ste 401 & 402 Bakersfield CA 93312	PRV010127	PRV000176	Ophthalmology	Existing	**Yes** **Eff 1/1/20**
	Saini, Rubby MD	Infusion & Clinical Services Dba: Premier Valley Medical Group 5401 White Lane Bakersfield 611 Airport Dr Bakersfield	PRV055655	PRV000404 PRV055842	Psychiatry	Existing	**Yes** **Eff 1/1/20**
	Saphiloff, Meghan NP	Centric Health Dba: Central Cardiology Medical Clinic 3008 Sillect Ave Ste 210 Bakersfield CA 93308	PRV052975	PRV000503	Neurology	Existing	**Yes** **Eff 1/1/20**
	Saremi, Farhood MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV005106	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 1/1/20**
	Sidhu, Ramanjeet MD	Kern County Hospital Authority Kern Medical - 1700 Mt Vernon Ave Sagebrush - 1111 Columbus St	PRV044478	ALL SITES	Internal Medicine / Hospitalist	Existing	**Yes** **Eff 1/1/20**
	Snyder, S. Faye PsyD	Integral Psychological Consulting Services 5251 Office Park Dr Ste 201 Bakersfield CA 93309	PRV056422	PRV000365	Psychology	Existing	**Yes** **Eff 1/1/20**
	Stone, Megan DO	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste 190 Ridgecrest CA 93555	PRV032705	PRV029495	Family Practice	Existing	**Yes** **Eff 1/1/20**
	Teran, Rafael NP	LAGS Spine & Sportscare Medical Centers 3550 Q St Ste 201 Bakersfield CA 93301	PRV056433	PRV000403	Physical Medicine & Rehabilitation	Existing	**Yes** **Eff 1/1/20**
	Van Ness, Brian PA-C	Kern County Hospital Authority Dba: Kern Medical 1700 Mt Vernon Ave Bakersfield CA 93306	PRV055701	ALL SITES	General Surgery	Existing	**Yes** **Eff 1/1/20**

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	Van Rompaey, Jason MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV056160	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 1/1/20**
	Ventura, Carlos MD	Emergency Physicians Urgent Care, Inc. Accelerated Urgent Care * All Locations 212 Coffee Road Bakersfield CA 93309	PRV055819	ALL SITES	Family Practice	Existing	**Yes** **Eff 1/1/20**
	Williams, Gregory MD	Emergency Physicians Urgent Care, Inc. Accelerated Urgent Care * All Locations 212 Coffee Road Bakersfield CA 93309	PRV051791	ALL SITES	Family Practice	Existing	**Yes** **Eff 1/1/20**

Provider Network Management
Network Review
Quarter 4, 2019

- **After Hours Calls**
- **Appointment Availability Survey**
- **Access Grievance Review** **(Q3, 2019)**
- **Geographic Accessibility**
- **Network Adequacy**
- **DHCS Quarterly Monitoring** **(Measurement Period – Q3, 2019)**
- **Provider Bulletin: DMHC Timely Access Survey Results**

KERN HEALTH SYSTEMS

After Hours Calls

Quarter 4, 2019

AFTER HOURS CALLS SURVEY

Q4, 2019

KERN HEALTH SYSTEMS

Introduction

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

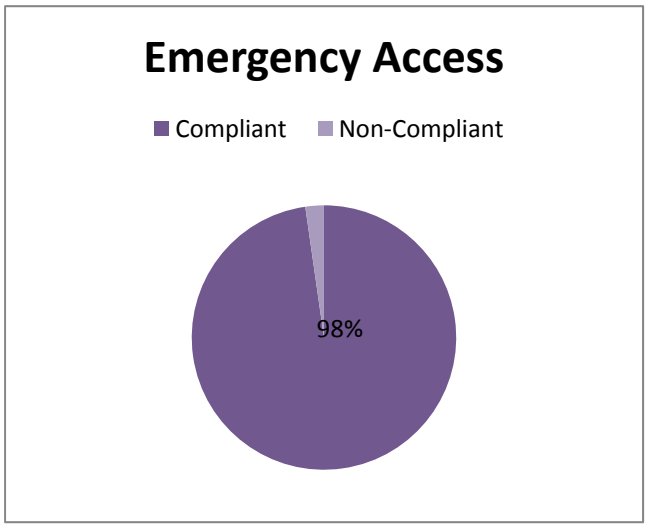
1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

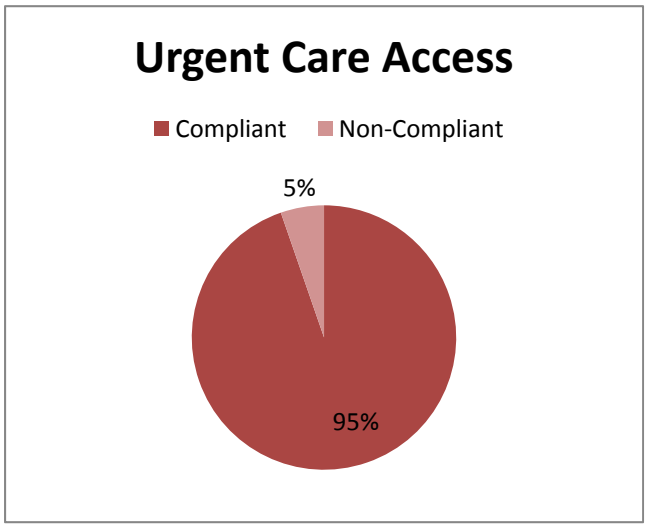
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

An initial survey is conducted by Health Dialog and then forwarded to the Plan's Provider Network Analysts who make additional calls each quarter based on the results received from the survey vendor. Results are to be reported to the KHS QI/UM Committees and to Executive Staff.

Results

132 provider offices were contacted during Q4 2019. Of those offices, 129 were compliant with the Emergency Access Standards and 125 were compliant with the Urgent Care Access Standards.





AFTER HOURS CALLS SURVEY

Q4, 2019

Trending / Follow –Up / Outreach

The Plan reviewed results against past quarters. The Plan identified three (3) provider groups with a repeated incident of non-compliance. In some cases, it appears that Plan outreach and education based on the prior quarter's results may have taken place concurrent with the Plan's survey vendor conducting the 4th quarter after-hours calls – which could be one potential reason for multiple providers remaining out of compliance.

The Plan's Provider Network Management Department made a series of secondary calls to provider groups found out-of-compliance in prior quarters, but who had since received education from the Plan; the results of these calls found that the majority of provider groups that received outreach were now compliant with the after-hours standard.

The Plan's Provider Network Management Department will conduct outreach and education to all identified non-compliant provider offices. In addition to sending out a letter (template attached), the results will be provided to each provider office's assigned Plan representative to reach out, inform them of the results, and provide additional coaching on the Plan's after-hours access standards.

KERN HEALTH SYSTEMS

[DATE]

[OFFICE NAME]
Attn: Office Manager
[ADDRESS]
[CITY], [STATE] [ZIP]

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

1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back within 30 minutes of call.

The purpose of this letter is to notify you of the identified non-compliance issues below.

During [QUARTER, YEAR], a call was placed to your office at [PHONE]. The results of that call found that your office was non-compliant with the [STANDARD] afterhours access standard as set forth in the KHS standards in policy 4.30-P *Accessibility Standards*.

For your convenience, I have attached a copy of our Policy related to access standards. Please review this policy with your staff to ensure compliance. Your office will remain on the list of providers to be surveyed for compliance with KHS access standards. In order to ensure member access, it is imperative these standards are regularly evaluated.

Please call me if you have any questions or concerns related to this policy. KHS will assist in any way possible to ensure compliance with these standards.

Sincerely,

Melissa Lopez
Provider Relations Manager
661-617-2642

if unavailable within the network, when medically necessary for the member's condition. This requirement does not prohibit a plan from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

3.8 Office Waiting Time - Maximum

Service	Required Care		
		Urgent	Routine
Primary Care Services (including OB/GYN)		1 hour	1 hour
Specialty Care Services		1 hour	1 hour
Diagnostic Testing		1 hour	1 hour
Mental Health Services		1 hour	1 hour
Ancillary Providers		1 hour	1 hour

Physicians are not held to the office waiting time standards for unscheduled non-emergent walk-in patients.

3.9 Facility Hours

A. Emergency Care - 24 hours per day, 7 days per week

B. After Hours Urgent and Emergency Care - Primary and specialty care providers must provide or arrange afterhours access for treatment of urgent and emergency conditions by telephone and/or personal contact.

C. Each contracted provider shall offer their KHS Medi-Cal members hours of operation that are no less than the hours of operation offered by the contracted provider to other patients or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal beneficiaries.

Office hours, including after-hours availability, should be posted on the outside entrance of the office with the office daytime and after hours phone numbers.

3.10 Telephone Accessibility

Providers and administrative personnel must maintain a reasonable level of telephone accessibility to KHS members. At minimum, the following response times are required:

Nature of Telephone Call	Response Time
Emergency medical or Kern County Mental Health Crisis Unit	Member should be instructed to call 9-1-1 or 661-868-8000
Urgent medical	30 Minutes
Non-urgent medical	By close of following business day
Non-Urgent Mental Health	By close of following business day

	Administrative	By close of following business day

Provider offices must provide procedures to enable patient access to emergency services 24 hours per day, seven days per week. Patients must be able to call the office number for information regarding physician availability, on call provisions or emergency services. An answering machine or service must be made available after normal business hours with direction in non-emergency and emergency situations.

Contracted providers must answer or design phone systems that answer phone calls within six rings. Providers should address each telephone call regarding medical advice or issues promptly and efficiently and must ensure that non-medical personnel do not give medical advice. Only PAs, NPs, RNs and MDs may provide medical advice. A sample policy that providers may incorporate into their own body of policies is included as Attachment A.

KHS provides or arranges for the provision of 24/7 triage screening services by telephone. KHS ensures that telephone triage or screening are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes. KHS provides triage or screening services through medical advice lines pursuant to section 1348.8 of the Health & Safety Code. Refer to KHS Policy 3.15-I 24-hour Telephone Triage Service.

4.0 MONITORING

The Provider Relations Department shall use the following sources to study and assure compliance with access standards:

A. Appointment Availability Survey Program
B. Access grievances/1000 member months
C. Member Services Call Center Data
D. Member Satisfaction Survey
E. Annual Provider Satisfaction Survey

4.1 Appointment Availability Survey Program

The Appointment Availability Survey Program assists with monitoring accessibility of care and quality of customer service. Calls are made to contracted primary care, mental health and specialist providers to assess their level of customer service and access compliance. The program also provides intervention and early feedback that identifies and facilitates resolution of access problems and prevents some member complaints.

The Plan will review and evaluate on a quarterly basis the accessibility, availability and continuity of care of PCP's, Specialists, and Mental Health Providers through the *member grievance process, After Hours Access Survey* and *quarterly DMHC reporting.*

4.1.1 Method and Frequency

Calls will be placed to contracted PCPs, mental health providers and specialists during regular business hours on an annual basis. Methodology for this survey will be based on the annually defined DMHC Survey Methodology. The Provider Appointment Availability Survey will be conducted annually.

KERN HEALTH SYSTEMS

Appointment Availability Survey

Quarter 4, 2019

Provider Network Management

Appointment Availability Survey

Q4, 2019

KERN HEALTH SYSTEMS

Introduction

As required by the Department of Health Care Services (DHCS) and Title 28 CCR Section 1300.67.2.2, Kern Health Systems (KHS) uses an appointment availability survey to assess compliance with access standards for Kern Family Health Care (KFHC) Members.

KHS policy and Department regulation require that members must be offered appointments within the following timeframes:

1) Non-urgent primary care appointments – **within ten (10) business days of request**.
2) Appointment with a specialist – **within fifteen (15) business days of request.**
3) First prenatal OB/GYN visit – **within the lesser of (10) business days or 2 weeks of request.**

The survey was conducted internally by KHS staff; compliance is determined using the methodology utilized by the DHCS during the 2017 Medical Audit in which they conducted a similar appointment availability survey. Results are to be reported to the KHS QI/UM Committee.

KHS also utilizes these quarterly calls to monitor contracted provider's **Phone Answering Timeliness.** KHS *Policy 4.30-P Accessibility Standards,* requires "contracted providers must answer or design phone systems that answer phone calls within six rings." In conducting the quarterly appointment availability survey, KHS staff count the rings prior to a provider answering to gauge compliance.

Appointment Availability Survey Results

A random sample of 15 primary care provider offices, 15 specialist offices, and 5 OBGYN offices were contacted during Q4 2019. Of the primary care providers surveyed, the plan compiled the wait time (in days) to determine the Plan's average wait time for a primary care appointment; for Q4 2019, the Plan's average wait time for a primary care appointment was **3.14 days**, and was found to be in-compliance with the 10 business day standard. Of the specialist providers surveyed, the plan compiled the wait time (in days) to determine the Plan's average wait time for a specialist appointment; for Q4 2019, the Plan's average wait time for a specialist appointment was **5.33 days**, and was found to be in-compliance with the 15 business day standard. Of OB/GYN providers surveyed for a first pre-natal visit, the plan compiled the wait time (in days) to determine the Plan's average wait time for a first prenatal visit with an OB/GYN; for Q4 2019 the Plan's average wait time for a first prenatal visit with an OB/GYN was **5.4 days**, and was found to be in-compliance with the 10 day/2 week standard.

While the Plan's average wait time for all appointment types was in-compliance with the required standards, during the course of the Q4 2019 survey, the Plan identified four provider offices not in-compliance with the required standard. The Plan is reaching out to these providers via letter to notify them of their non-compliant status and provide a copy of Plan's appointment availability policy and procedure.

Appointment Availability Survey

Q4, 2019

Non-compliant provider offices were compared against prior quarter's appointment availability surveys and access grievances. The Plan identified one provider office which was found noncompliant during the Q4 2019 appointment availability survey and had an "Access to Care" grievance for appointment availability found in favor of the enrollee during Q1 2019; while the Plan has made note of these occurrences, it is not considering this a trend at this time due to the time gap between the two incidents. All noncompliant provider offices will be logged for additional tracking and trending, and potential further outreach to measure compliance.

Phone Answering Timeliness Results

Utilizing the methodology outlined above, KHS conducts a phone answering timeliness survey in conjunction with the appointment availability survey. During Q4 2019, all calls were answered within six rings or less, with an average **1.35 rings** before a call was answered.

KERN HEALTH SYSTEMS

[OFFICE NAME]
[ADDRESS]
[CITY], [STATE] [ZIP]

[DATE]

Attn: Office Manager
RE: Appointment Availability

To Whom It May Concern:

Kern Health Systems (KHS) uses an appointment availability survey program to assess compliance with access standards for Kern Family Health Care (KFHC) Members. The Department of Health Care Services (DHCS), and KHS policy 4.30-P *Accessibility Standards* requires that patients be able to call an office for information regarding physician and appointment availability, on call provisions, or emergency services.

On [DATE] at [TIME], KHS contacted your office and conducted an appointment availability survey in regards to scheduling a [PROVIDER TYPE] appointment. Based on the results of the survey we found your office was not complaint with KHS availability standards. KHS policy requires non-urgent appointments should be within 10 business days for primary care services, 15 business days for specialty care services, 2 weeks for a first prenatal appointment, and 48 hours for urgent appointments.

The purpose of this letter is to notify you of the identified non-compliance and to remind you of your contractual obligations related to access standards. Please call me if you have any questions or concerns related to this policy. KHS will assist in any way possible to ensure compliance with these standards.

Sincerely,

Melissa Lopez
Provider Relations Manager
Kern Health Systems
(661) 617-2642
melissa.lopez@khs-net.com

KERN HEALTH SYSTEMS

Access Grievance Review

Quarter 3, 2019

Provider Network Management

Access Grievance Review

Q3, 2019

Introduction and KHS Policy

On a quarterly basis, KHS' Provider Network Management Department reviews all grievances from the previous quarter that were categorized as "Access to Care" or "Difficulty Accessing a Specialist".

The time standards for access to a primary care appointment, specialist appointment, and in-office wait time are outlined in KHS policy 4.30-P *Accessibility Standards.*

During Q3 2019, thirty-four (34) access-related grievances were received and reviewed by the KHS grievance committee. In twenty-five (25) of the cases, no issues were identified and were closed in favor of the plan. The remaining **nine (9) cases**, were closed in favor of the enrollee; these cases were forwarded to the Plan's Provider Network Management Department for further tracking and trending.

Tracking, Trending, and Provider Outreach

During the *Q3 2019 Access Grievance Review* meeting the nine (9) cases that were closed in favor of the enrollee were reviewed against all access grievances received in the previous year.

Of the nine (9) cases reviewed, two (2) grievances were classified as "Difficulty Accessing a Specialist", both for in-office wait time. One (1) of the grievances was against a group that had received one (1) other "Difficulty Accessing a Specialist" grievance within the past year for in-office wait time, but against a different provider/different specialty, within the same group; the Plan reviewed the group's response to the Q3 2019 grievance and does not identify this as a trend at this time, though will continue to monitor grievances received against this group. The other grievance was against a group that had also received two (2) other "Difficulty Accessing a Specialist" grievances within the past year for in-office wait time, but against different providers/different specialties, within the same group; based on the volume of members seen within this practice and variance in specialty type, the Plan does not identify this as a trend at this time, though will continue to monitor grievances received against this group.

The remaining seven (7) cases reviewed were classified as "Access to Care"; four (4) of the grievances were for in-office wait time, and three (3) were for appointment availability.

In regards to the four (4) "Access to Care" grievances for in-office wait time, they were all reviewed against grievances in the previous year to identify any potential trends. In three (3) grievances, no trends were identified.

The fourth grievance was against a group that had received an "Access to Care" grievance for in-office wait time in the past year. At this time the Plan is noting this as a potential trend and is forwarding the information to the Plan's Provider Relations Manager and the assigned Provider Relations Representative to conduct appropriate education. As part of their outreach, the Plan will require the provider to sign a letter (template attached), recognizing receipt of the education.

Access Grievance Review

Q3, 2019

The three (3) “Access to Care” grievances for appointment availability were reviewed against grievances received in the previous year and the Plan did not identify any trends. Two (2) of the grievances this quarter were against the same group, but due to no prior grievances against this group for this issue, the Plan does not identify this as a trend at this time, though will continue to monitor grievances received against this group.

Kern Family Health Care™

[DATE]

[OFFICE]
[ADDRESS]
[CITY], [STATE] [ZIP]

RE: Access Grievances

Dear [PROVIDER]:

Kern Health Systems (KHS) maintains in-office wait time standards for members receiving primary care and specialty services. Per KHS Policy 4.30-P *Accessibility Standards*, (included with this letter) a member's in-office wait time should not exceed 1 hour for a routine or urgent care visit.

KHS reviews grievances retrospectively and looks for trends in grievance type by provider. During [TIME PERIOD], KHS identified that your office received multiple access grievances related to in-office wait time. In each of these cases your office was given an opportunity to respond and upon review of the cases, the KHS Grievance Committee found your office did not meet the in-office wait time standard. As KHS' review is retrospective, this does not take into account any potential grievances received in [CURRENT QUARTER] in which KHS is in the process of reviewing.

This letter is to remind you that you are required to comply with all KHS policies and procedures, including the in-office wait time standard outline above. If you are uncertain as to what is expected of you as a provider in the KHS network, please contact me for clarification or further direction.

Further inability to comply KHS policy and procedures will result in future disciplinary actions, including but not limited to, corrective action plans and termination from the KHS provider network.

Sincerely,

Melissa Lopez
Provider Relations Manager
661-617-2642

KERN HEALTH SYSTEMS

Quarter 3, 2019 Access Grievances Review Agenda
Date: 2/4/2020

Discussion:

1. **Review access grievances for Q3, 2019**
   - **Identify any trends regarding access**
   - **Conduct file review for grievances closed in favor of the enrollee**

2. **Review Access Grievances for Q3, 2019 against last year of annual grievances**
   - **Identify any trends regarding access**

Name	Title	Date
[signature]	Network Analyst	2/04/2020
[signature]	PR Manager	2/4/2020
Yolanda Herrera	Cred Supervisor	2/4/2020
James Winfrey	Network Analyst	2/4/2020

KERN HEALTH SYSTEMS

Geographic Accessibility

Quarter 4, 2019

Provider Network Management

Geographic Accessibility

Q4, 2019

KERN HEALTH SYSTEMS

Background

As required by the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS), Kern Health Systems (KHS) is required to maintain time and distance standards for certain provider types.

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

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

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

DHCS Annual Network Certification – 2019 & 2020

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

As a part of the Annual Network Certification requirement outlined in APL 18-005 and 19-002, the Plan was required to submit geographic access analysis outlining compliance with the above-listed standards. For all zip codes in which the Plan was not compliant with the above standard, the Plan was able to submit alternative access standards to ensure compliance.

The Plan currently maintains a subcontract with Kaiser Permanente (KP) to provide services to a subset of KHS enrollees; DHCS Network Certification required KP contracted providers to be included in the geographic analysis conducted by the Plan. In reviewing the two plans combined provider data, KHS found that KP providers practice in the same geographic areas as KHS providers, and did not cause substantial change to KHS' compliance with geographic accessibility standards.

Geographic Accessibility

Q4, 2019

The Plan completed required network certification reporting in Q1 2019, including the submission of alternative access standard requests based on the results of the Plan's geographic accessibility analysis.

On July 9, 2019 KHS received notification to provide a corrective action plan in response to KHS's 2019 network adequacy evaluation submission to DHCS. DHCS found the Plan to be out of compliance with specialty/geographic area specific time and distance standards.

In response to the received request for a corrective action plan, on August 7, 2019 the Plan provided additional justification for previously submitted alternative access standards and requested the DHCS re-evaluate their original determination. Alternate access standards are granted to health plans that serve areas that include classifications such as Medically Underserved Areas (MUAs), Health Professional Shortage Areas (HPSAs), and rural and sparsely populated geographic areas. (These were the areas DHCS deemed access deficient).

On October 1, 2019, the KHS received notification from DHCS of their acceptance of our explanation of why the alternative access standard should apply and determined the matter closed.

During Q4 2019, the Plan reviewed the geographic analysis conducted during Q1 2019 against changes within the provider network during Q4 2019, and did not find any substantial changes that would affect the plan's current geographic accessibility. Additionally, the Plan began work on the mapping and geographic analysis components for the upcoming 2020 annual network certification requirement, to be finalized and submitted to the DHCS during Q1 2020.

KERN HEALTH SYSTEMS

Network Adequacy

Quarter 4, 2019

Network Adequacy

Q4, 2019

KERN HEALTH SYSTEMS

Introduction

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

During Q3/Q4 2018, KHS, in conjunction with guidance from the Department of Managed Health Care (DMHC), developed and adopted an updated methodology for determining full-time equivalency for contracted providers. KHS memorialized this methodology in Policy 4.30-P *Accessibility Standards;* this policy was submitted to the DMHC and received approval on 12/14/2018.

Per KHS policy, 4.30-P *Accessibility Standards, §4.5 Full-time equivalent (FTE) Provider to Member Ratios,* "Full-time equivalency shall be determined via an annual survey of KHS' contracted providers to determine the percentage of time allocated to Plan's beneficiaries. The results of the survey will be used to calculate an average FTE percentage which will be applied to the Plan's network of providers when calculating the physician-to-enrollee compliance ratios. The methodology for the survey, results of the survey, and network capacity review of above ratios, will be reported annually to the KHS QI/UM Committee. Due to a maximum member assignment of 1,000 Mid-level providers serving in the Primary Care capacity will be counted as .5 of a PCP FTE, prior to percentage calculation."

Survey Methodology and Results

In 2019, KHS contracted with SPH Analytics to conduct our annual Provider Satisfaction Survey; as a part of that survey, responding providers were asked, "*What portion of your managed care volume is represented by Kern Health Systems?"* Outreach for the survey was placed to every contracted provider within the Plan's network. Responses received, and FTE calculations based on those responses, do not account for providers who refuse to participate in the survey. KHS used the responses collected from Primary Care Providers to calculate the FTE for Primary Care Providers, and used the responses collected from Primary Care Providers and Specialists to calculate the FTE for Physicians.

KHS utilized SPH Analytics, an NCQA certified survey vendor, to conduct the survey for 2019. SPH's methodology involved two waves of mail and Internet, with a third wave of phone follow up to administer the survey; for 2019, the provider survey was conducted from March to May.

Based on the results of 2019 survey, KHS calculated a network-wide FTE percentage of **49.06% for Primary Care Providers** and **43.19% for Physicians.**

Network Adequacy

Q4, 2019

Full Time Equivalency Compliance Calculations

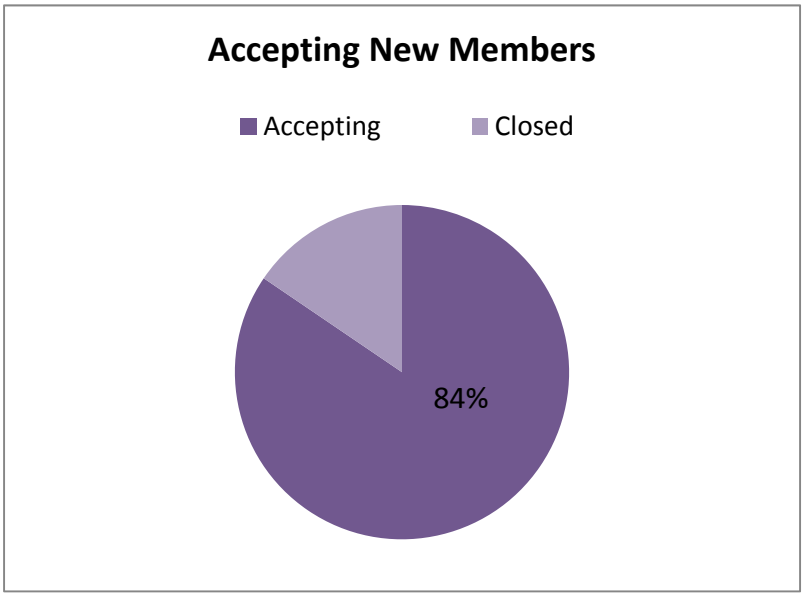
Of KHS' 258,147 membership at the close of Q4 2019, 8,995 were assigned and managed by Kaiser and did not access services through KHS' network of contracted providers; due to this, Kaiser managed membership is not considered when calculating FTE compliance.

As of the end of Q4 2019, the plan was contracted with 387 Primary Care Providers, a combination of 207 physicians and 180 mid-levels. Based on the FTE calculation process outlined above, with a 49.06% PCP FTE percentage, KHS maintains a total of **145.71 FTE PCPs**. With a membership enrollment of 249,152 utilizing KHS contracted PCPs, KHS currently maintains a ratio of **1 FTE PCP to every 1709.90 members**; KHS is compliant with state regulations and Plan policy.

As of the end of Q4 2019, the plan was contracted with 1103 Physicians. Based on the FTE calculation process outlined above, with a 43.19% Physician FTE percentage, KHS maintains a total of **476.34 FTE Physicians**. With a total membership enrollment of 249,152 utilizing KHS contracted Physicians, KHS currently maintains a ratio of **1 FTE Physician to every 523.06 members**; KHS is compliant with state regulations and Plan policy.

Accepting New Members

In addition to the Full Time Equivalency Compliance review conducted above, the Plan monitors adequacy of its Primary Care Network by reviewing the count/percentage of Primary Care Providers (PCP) who are accepting new members. At the end of Q4 2019 the plan maintained a network of 387 Primary Care Providers, a combination of 207 physicians and 180 mid-levels. At the time of this review, 327 Primary Care Providers were accepting new members at a minimum of one Plan-contracted location, a combination of 163 physicians and 164 mid-levels. **The Plan calculated that 84% of the network of Primary Care Providers is currently accepting new members at a minimum of one location**. The Plan will continue to monitor this percentage quarterly to ensure it maintains an adequate network of Primary Care Providers.



DHCS Quarterly Monitoring

Quarter 4, 2019

(Measurement Period – Quarter 3, 2019)

DHCS Quarterly Monitoring

Q4, 2019

Introduction

The Department of Health Care Services (DHCS) monitors specific areas of performance among Medi-Cal Managed Care Health Plans (MCPs) on a quarterly basis to identify trends which may indicate areas of concern. Each quarter, DHCS provides the Plan with the Quarterly Monitoring Report Template (QMRT), identifying potential performance deficiencies. The QMRT includes an overview of potential deficiencies, findings, and questions. Upon receipt, KHS reviews the provided findings and outlines timelines and strategies for correcting deficiencies and submits the response to the DHCS. One current effort by the Plan to remedy the identified deficiencies is to incorporate portions of the QRMT into the Plan's Quarterly Provider Network Management Network Review for additional tracking and trending.

DHCS uses the Plan's 274 file submission to gather the provider data utilized for the following reporting categories. As a part of the subcontract relationship between Kaiser Foundation Health Plan and KHS, Kaiser provider data is included in the Plan's 274 file submission; the combined provider data was utilized to populate the counts found in the *FTE Provider to Member Ratios* and *Network Report* categories.

Applicable Quarterly Monitoring Categories/Elements – Network Access

Quarterly Monitoring Categories/Elements
Category A: Network Access
FTE Provider to Member Ratios
EQRO Timely Access Survey
Network Report

FTE Provider to Member Ratios

The Plan is required to meet fulltime equivalent (FTE) provider-to-member ratios for Primary Care Physicians (PCPs) of one FTE PCP to every 2,000 members and total network physicians of one FTE physician to every 1,200 members.

DHCS uses the Plan's 274 file submission to populate the total number of FTE PCPs and total network physicians. DHCS calculated the provider to member ratio using the total number of providers contracted with the MCPs divided by the enrollment in the 274 file submission noted above. The FTE provider count is based on the sum of FTE divided by 100 for all distinct providers at the plan parent. Each provider has a maximum FTE of 100% for each plan parent.

DHCS provided the Plan with an FTE Report (Attachment A) and upon review, the Plan did not identify any deficiencies with its current provider-to-member ratios; the Plan continues to monitor network adequacy through the *Network Adequacy* portion of Plan's Quarterly Provider Network Management Network Review.

DHCS Quarterly Monitoring

Q4, 2019

KERN HEALTH SYSTEMS

EQRO Timely Access Survey

DHCS' External Quality Review Organization (EQRO) conducts an annual timely access survey of all MCPs to ensure compliance with provider availability and wait time standards for urgent and non-urgent appointments among network provider types. The survey consists of calling a randomized sample of the Plan's network providers. The DHCS requested the Plan to review and respond to three 'measures': percentage of providers with collected appointment times, percentage of providers meeting the wait time standard, and average wait time. The Plan's overall compliance percentages, provided for review by the DHCS, are included as Attachment B.

The Plan reviewed the compliance percentage and raw data for providers in which an appointment was/wasn't able to be collected. The Plan found that its cumulative rate as of Q3 was +20% higher than the provided Medi-cal Statewide percentage in both the non-urgent and urgent categories. Additionally, while conducting the DMHC Provider Appointment Availability Survey and quarterly appointment availability surveys (both handled internally), the Plan has not found provider response to be a reoccurring issue. The Plan does not identify an issue with response percentage at this time.

The Plan reviewed the compliance percentage and raw data for providers who were/weren't able to meet wait time standards for first, second, and third appointments. The Plan compared the providers identified as non-compliant via the DHCS raw data, against the Plan's own quarterly surveys and access grievances for the past year and did not identify a trend amongst providers or their contracted groups. These noncompliant providers are being forwarded to the Plan's Provider Relations Manager for potential outreach/education. The Plan did not identify an issue with the overall compliance standards.

Utilizing the provided raw data, the Plan calculated the average wait time for all appointment types (Attachment C). The Plan found that for all but one appointment type, the average wait time for the 1st available appointment was within the regulatory standard. In review of appointment types in which the average was outside of the regulatory standard, specifically when reviewing the 3rd available appointment, the Plan found there was typically one provider offering a 3rd available appointment significantly outside the standard and in turn greatly increasing the average wait time. The Plan will continue to track average appointment wait time via this review, as well as the Plan's own internal quarterly appointment availability survey.

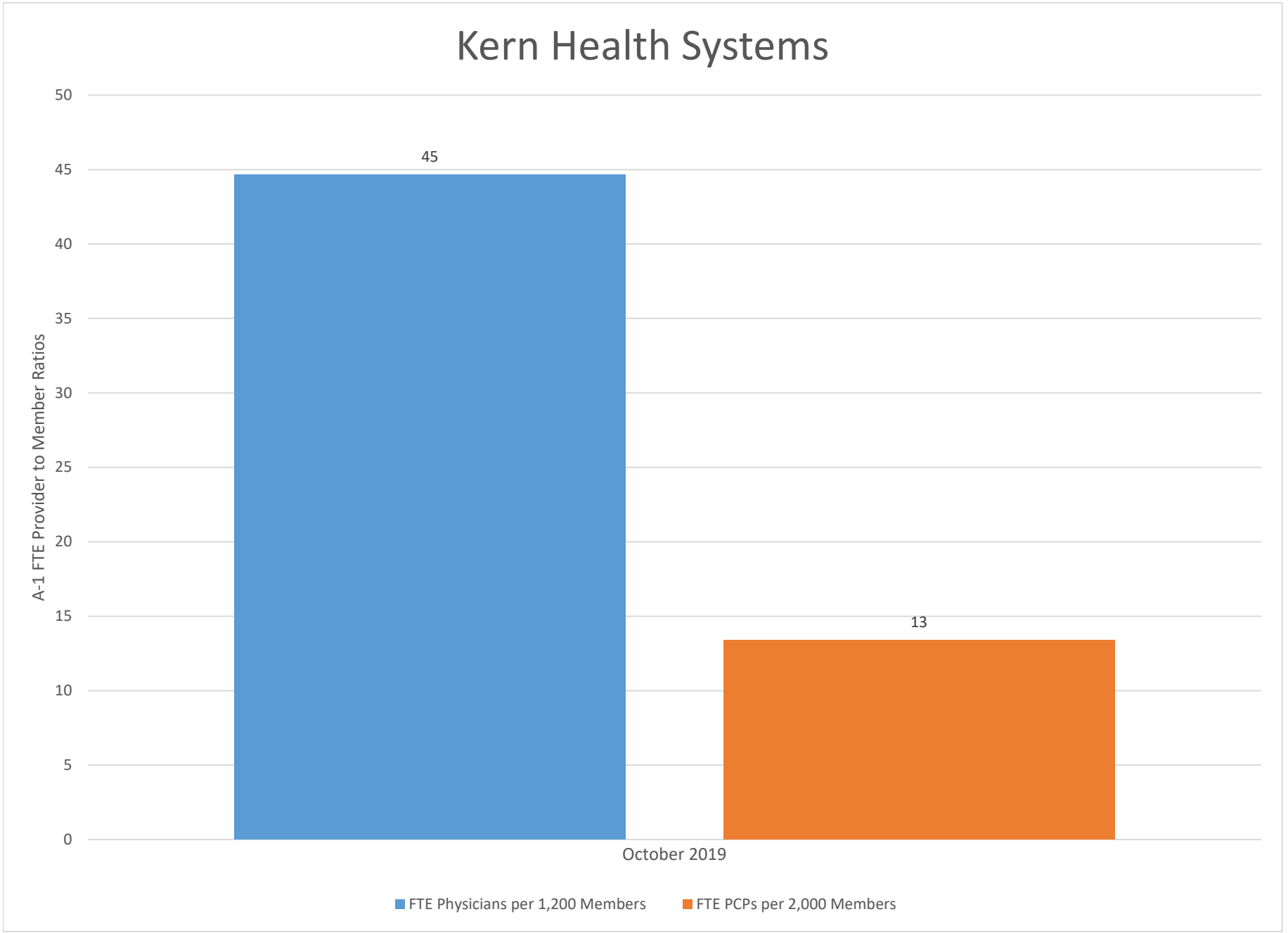
Network Report

Quarterly, the DHCS utilizes the Plan's 274 file submission to generate a Network Report (Attachment D); the Network Report compares provider to member ratios between each MCP by service area to other MCPs by service area across specific provider categories. The MCP and service area combination used to create the ratios take into account regional differences. Cells are highlighted to denote "No Data" or an "Outlier".

The Plan reviewed the DHCS Q3 Network Report against the other access monitoring processes employed as a part of the Plan's Quarterly Network Review. The Network Report highlighted 4 pediatric specialties as "No Data" and 3 pediatric specialties as "Outlier"; this is due to the DHCS categorization methodology that requires a provider to be reported with a specific pediatric taxonomy code to be included in count of

that pediatric specialty. Utilizing this methodology, the DHCS count does not include specialists who see children but do not have the appropriate taxonomy. Upon review of the Network Report the plan did not identify any issues at this time.

Attachment A



California Department of Health Care Services
Timely Access Focused Study—Quarter 3

Measure	Measure Description	Q3	
		Denominator	Rate
M5A1_NonUrgent	Percentage of providers meeting non-urgent visit wait time standards for the first collected appointment time	47	93.6%
M5A2_NonUrgent	Percentage of providers meeting non-urgent visit wait time standards for the second collected appointment time	47	91.5%
M5A3_NonUrgent	Percentage of providers meeting non-urgent visit wait time standards for the third collected appointment time	47	87.2%
M5A1_NonUrgent_Adult	Percentage of adult providers meeting non-urgent visit wait time standards for the first collected appointment time	26	96.2%
M5A2_NonUrgent_Adult	Percentage of adult providers meeting non-urgent visit wait time standards for the second collected appointment time	26	92.3%
M5A4_NonUrgent_Adult	Percentage of adult providers meeting non-urgent visit wait time standards for all collected appointment times.	26	88.5%
M5A1_NonUrgent_Child	Percentage of pediatric providers meeting non-urgent visit wait time standards for the first collected appointment time	24	95.8%
M5A2_NonUrgent_Child	Percentage of pediatric providers meeting non-urgent visit wait time standards for the second collected appointment time	24	91.7%
M5A3_NonUrgent_Child	Percentage of pediatric providers meeting non-urgent visit wait time standards for the third collected appointment time	24	87.5%
M5B1_Urgent	Percentage of providers meeting urgent visit wait time standards for the first collected appointment time	27	74.1%
M5B2_Urgent	Percentage of providers meeting urgent visit wait time standards for the second collected appointment time	27	70.4%
M5B3_Urgent	Percentage of providers meeting urgent visit wait time standards for the third collected appointment time	27	63.0%
M5B1_Urgent_Adult	Percentage of adult providers meeting urgent visit wait time standards for the first collected appointment time	24	83.3%
M5B2_Urgent_Adult	Percentage of adult providers meeting urgent visit wait time standards for the second collected appointment time	24	75.0%
M5B3_Urgent_Adult	Percentage of adult providers meeting urgent visit wait time standards for the third collected appointment time	24	66.7%
M5B1_Urgent_Child	Percentage of pediatric providers meeting urgent visit wait time standards for the first collected appointment time	22	81.8%
M5B2_Urgent_Child	Percentage of pediatric providers meeting urgent visit wait time standards for the second collected appointment time	22	77.3%
M5B3_Urgent_Child	Percentage of pediatric providers meeting urgent visit wait time standards for the third collected appointment time	22	68.2%

Attachment C

	Average Wait For Appointment											
	Urgent Appointment						Non-urgent Appointment					
	Adult			Child			Adult			Child		
	1st Available (Hours)	2nd Available (Hours)	3rd Available (Hours)	1st Available (Hours)	2nd Available (Hours)	3rd Available (Hours)	1st Available (Days)	2nd Available (Days)	3rd Available (Days)	1st Available (Days)	2nd Available (Days)	3rd Available (Days)
Primary Care	28.3	46.9	51	30.4	51.8	56.5	2	8	10	2	9	11
Specialist	72.2	240.1	276.9	258.9	277.8	311.8	10	11	12.3	11	12	13

	Average Wait For Appointment					
	Urgent Appointment			Non-urgent Appointment		
	1st Available (Hours)	2nd Available (Hours)	3rd Available (Hours)	1st Available (Days)	2nd Available (Days)	3rd Available (Days)
OBGYN	NA	NA	NA	2	3	4
Ancillary	NA	NA	NA	3	4	5
Mental Health	109.9	167.5	398.4	7	9	14

Attachment D

Department of Health Care Services

Kern

Data Used: Oct 2019

274 File Submission: Nov 2019

		Kern	
Category 1: Primary Care Physicians			
Provider Type	**Statewide Outlier (Members per FTE)**	**FTE Counts**	**FTE Ratio**
FTE Total PCPs[1]	1,465.61	1,736.31	149
FTE Adult Primary Care[2]	797.01	1,736.31	77
FTE Pediatric Primary Care[3]	775.58	1,236.18	102
Category 2: Core Specialists			
Provider Type	**Statewide Outlier (Members per Provider)**	**Counts**	**Ratio**
Total Specialists [1]	497	3,407	76
OB/GYN Specialty Care	3,230	656	395
Category 3: Adult Core Specialists			
Provider Type	**Statewide Outlier (Members per Provider)**	**Counts**	**Ratio**
Cardiologist/Interventional Cardiologist	3,065	242	549
Dermatologist	6,052	187	711
Endocrinologist	14,225	74	1,797
ENT/Otolaryngologist	7,863	155	858
Gastroenterologist	6,925	199	668
General Surgeon	1,807	564	236
Hematologist	7,753	129	1,031
HIV/AIDS Specialist/Infectious Diseases	14,343	65	2,046
Nephrologist	4,304	214	621
Neurologist	6,559	183	727
Oncologist	7,421	131	1,015
Ophthalmologist	3,242	538	247
Orthopedic Surgeon	4,142	33	4,030
Physical Medicine and Rehabilitation	8,857	138	964
Psychiatrist	6,173	331	402
Pulmonologist	8,293	139	957
Category 4: Pediatric Core Specialists			
Provider Type	**Statewide Outlier (Members per Provider)**	**Counts**	**Ratio**
Cardiologist/Interventional Cardiologist	11,809	9	**14,003**
Dermatologist	103,717	3	42,008
Endocrinologist	23,639	22	5,728
ENT/Otolaryngologist	37,448	0	No Data
Gastroenterologist	30,241	14	9,002
General Surgeon	23,383	8	15,753
Hematologist	13,252	19	6,633
HIV/AIDS Specialist/Infectious Diseases	50,352	10	12,602
Nephrologist	37,922	6	21,004
Neurologist	24,177	1	**126,023**
Oncologist	13,252	19	6,633
Ophthalmologist	242,455	0	No Data
Orthopedic Surgeon	46,137	0	No Data
Physical Medicine and Rehabilitation	96,741	0	No Data
Psychiatrist	27,170	131	962
Pulmonologist	36,947	3	**42,008**
Category 5: Outpatient Mental Health Providers			
Provider Type	**Statewide Outlier (Members per Provider)**	**Counts**	**Ratio**
Total Outpatient Mental Health Providers[1][4]	2,035	781	332
Adult Outpatient Mental Health Providers	1,180	781	170
Pediatric Outpatient Mental Health Providers	1,340	300	420

Key

FTE – Full Time Equivalent
PCP – Primary Care Physician
Counts – Provider counts are distinct NPI for the service area.
Ratio – Members per provider.
Red – No data based on 274 File Submission, or incorrect categorization for specified provider type.
Orange – Members per Provider ratio is greater than the statewide outlier Members per Provider.

FTE

- Only Total PCPs, Adult Primary Care and Pediatric Primary Care is based on FTE Providers.
- FTE is the percentage of time a provider spends with a specific MCP/county based on the amount of service areas the provider is assigned to a MCP. *(Example: MCP has contracts with Sacramento and Yolo counties. The provider serves Sacramento county 20% and Yolo 40% meaning the provider FTE is .60)*
- Each network provider has a maximum FTE of 100% for each MCP. DHCS calculates a network provider's FTE by taking the sum of the network providers FTE divided by 100 for all distinct NPIs at the MCP.

[1] Adult & Pediatric.
[2] Adult Primary Care includes Family Medicine, Geriatric Medicine, Internal Medicine and Preventive Medicine or any MD that is marked as a Primary Care Physician.
[3] Pediatric Primary Care includes Pediatrics or any MD that is marked as a Primary Care Physician.
[4] Outpatient Mental Health Providers include LCSW, LMFT, and Psychologists.

KERN HEALTH SYSTEMS

PROVIDER bulletin

January 29, 2020

Kern Health Systems Ranked #1 in All Categories Measuring Service Access in the California Department of Managed Health Care's Timely Access Report

Dear Provider,

In January 2020, the California Department of Managed Health Care (DMHC) released its Timely Access Report. Providing timely access to health care services is a health plan's fundamental duty to its enrollees. This report summarizes the Measurement Year 2018 provider appointment availability data submitted by health plans to the DMHC. For 2018, the DMHC required health plans to utilize external vendors to validate the plans' timely access data.

Health plans are required to ensure that each of its providers has the capacity to offer enrollees appointments within the established timely access standard. Health plans must also ensure that appointments meet the clinical appropriateness standard, which requires that services be provided in a timely manner that is appropriate for the nature of the individual enrollee's condition, consistent with good professional practice.

DMHC's annual review and reporting of timely access data demonstrates the State's commitment to protect consumers' right to receiving health care and ensure a stable health care delivery system by increasing and providing comparable timely access data to the public and other interested parties.

Standards are established by the State and each health plan is ranked on how they perform to each standard. Access measures are taken for Primary Care, Specialty Care, non-physician mental health and ancillary services (Chiropractic, Podiatry, Physical Therapy, etc.) for both urgent and non-urgent appointments.

When comparing Kern Health Systems' (KHS) performance with all health plans statewide (37) and Medi-Cal only health plans (20), KHS's performance was ranked against both groups for the following categories:

1. Full Service Health Plans combining urgent and non-urgent access to care
2. Full Service Health Plans (Medi-Cal only) combining urgent and non-urgent access to care
3. Full Service Health Plans measuring non-urgent appointments
4. Full Service Health Plans (Medi-Cal only) measuring non-urgent appointments
5. Full Service Health Plans measuring urgent appointments
6. Full Service Health Plans (Medi-Cal only) measuring urgent appointments

In all 6 categories measuring service access, Kern Health Systems ranked 1st in the State.

Of note, with 89%, KHS was number one in the percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent). For non-urgent appointments only, KHS was number one with 94% of providers surveyed showing appointment availability. For urgent appointments only, KHS was number one with 83% of providers surveyed showing appointment availability.

Doug Hayward, KHS Chief Executive Officer, says: "This accomplishment began several years ago with Kern Health Systems' grant programs providing over $50 million, earmarked for improving clinical service access for Kern Family Health Care members. The Physician Retention and Recruitment Grants, Facility Expansion Grants, ER Diversion Grants and Health Homes Program Grants (among others), all provided funding to launch and support bringing new providers to our community, expanding professional and outpatient services and creating new specialty care programs. Without which, this survey could have shown very different results."

According to Emily Duran, KHS Chief Network Administration Officer, "It cannot be overstated that, if not for the commitment of our contracted providers to do what was necessary to expand their practices in the face of rapid growth, we would not have achieved this outstanding performance." This accomplishment would not be possible without the collaboration of KHS and contracted providers to deliver high quality health care to Kern County residents.

The report is available using the following link:

http://dmhc.ca.gov/Portals/0/Docs/OPM/2018TAR-accessible.pdf
The charts within the report display, at the health plan level, the percentage of provider responses to appointment availability requests that were within the timely access standards.

Sincerely,

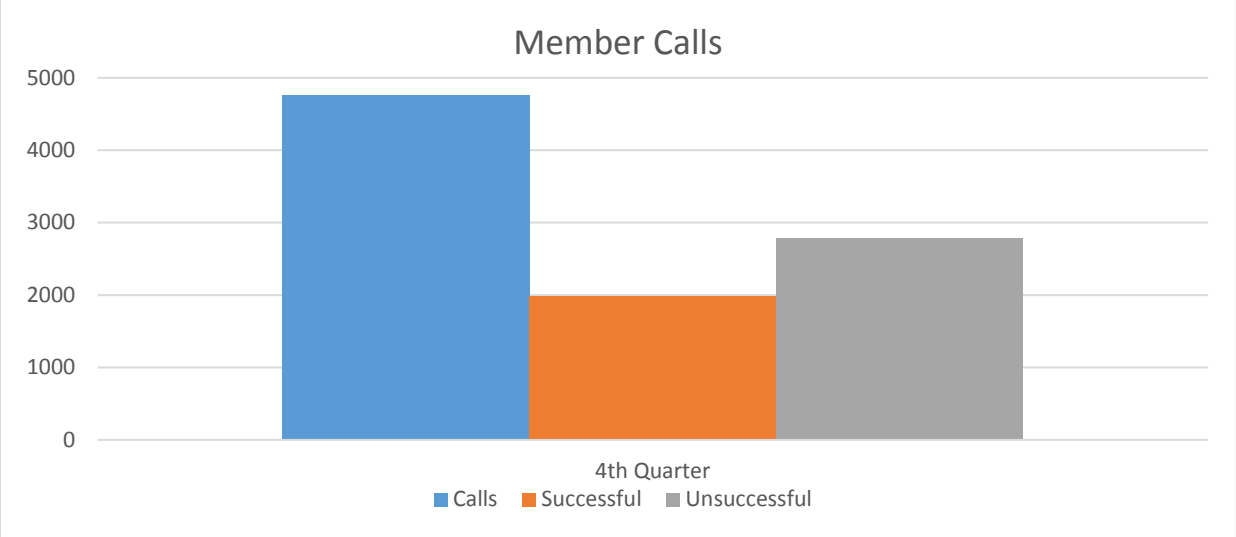
Jake Hall
Provider Network Manager
Kern Health Systems

Disease Management Quarterly Report

4th Quarter, 2019

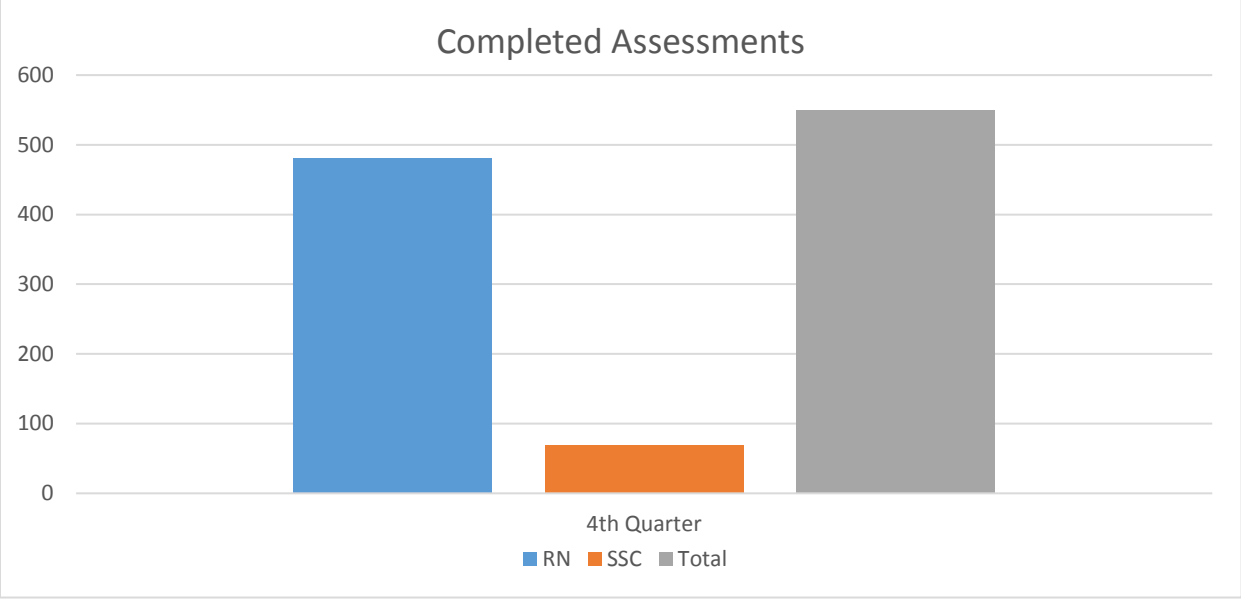
Telephone Calls: A total of 4,757 calls were made by the DM staff during the 4th Quarter, 2019.

Member Calls Attempted	Successful Calls	Unsuccessful Calls	Total Member Calls	% Contacted
RN	1,289	2,178	3,467	37%
SSC	693	597	1,290	54%
Total	**1,982**	**2,775**	**4,757**	**42%**



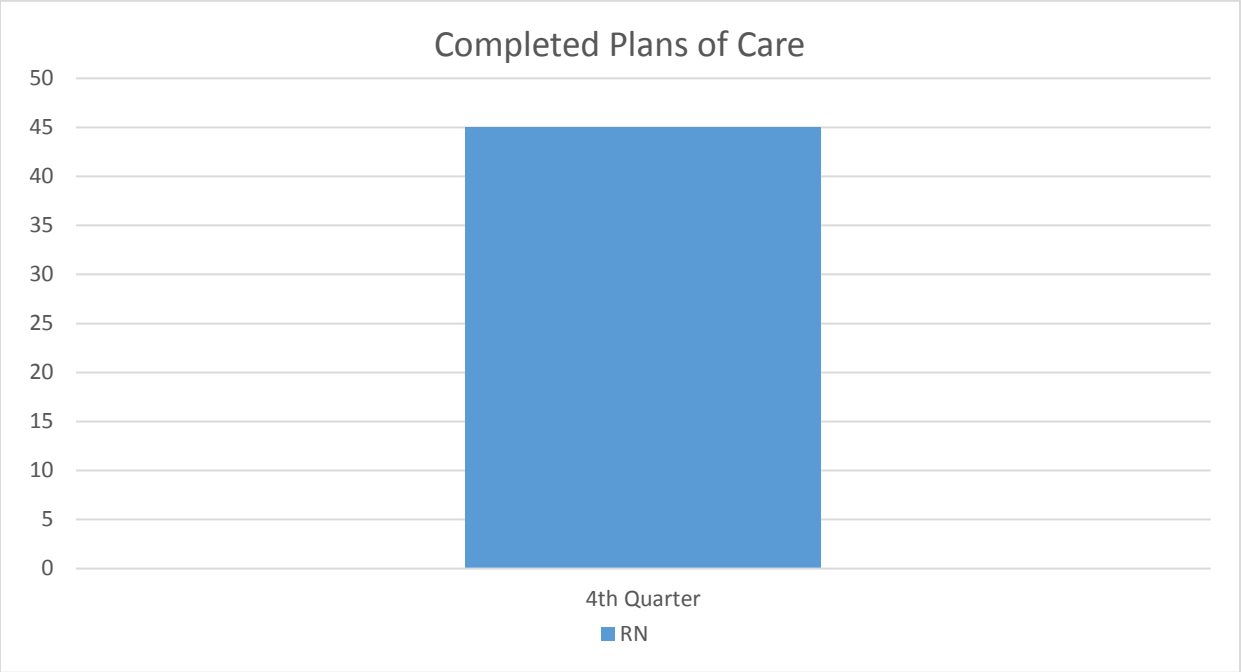
New Assessments Completed.

RN	SSC	Total
480	69	549



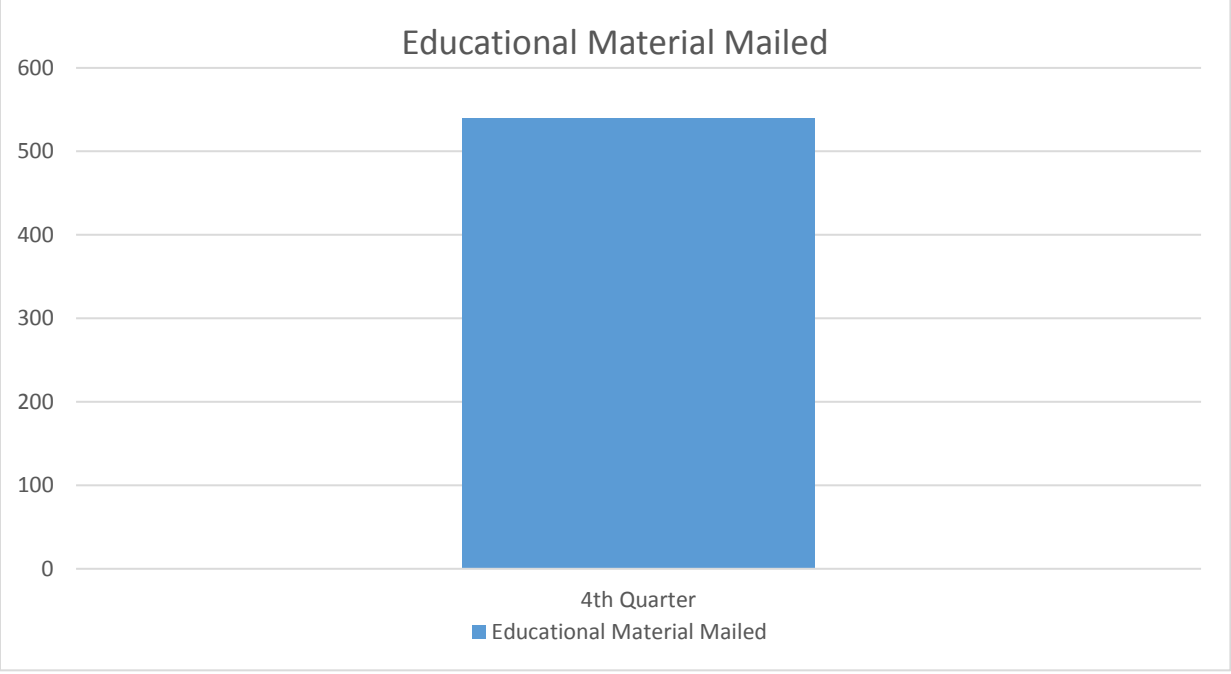
Plans of Care Completed & Closed.

RN
45



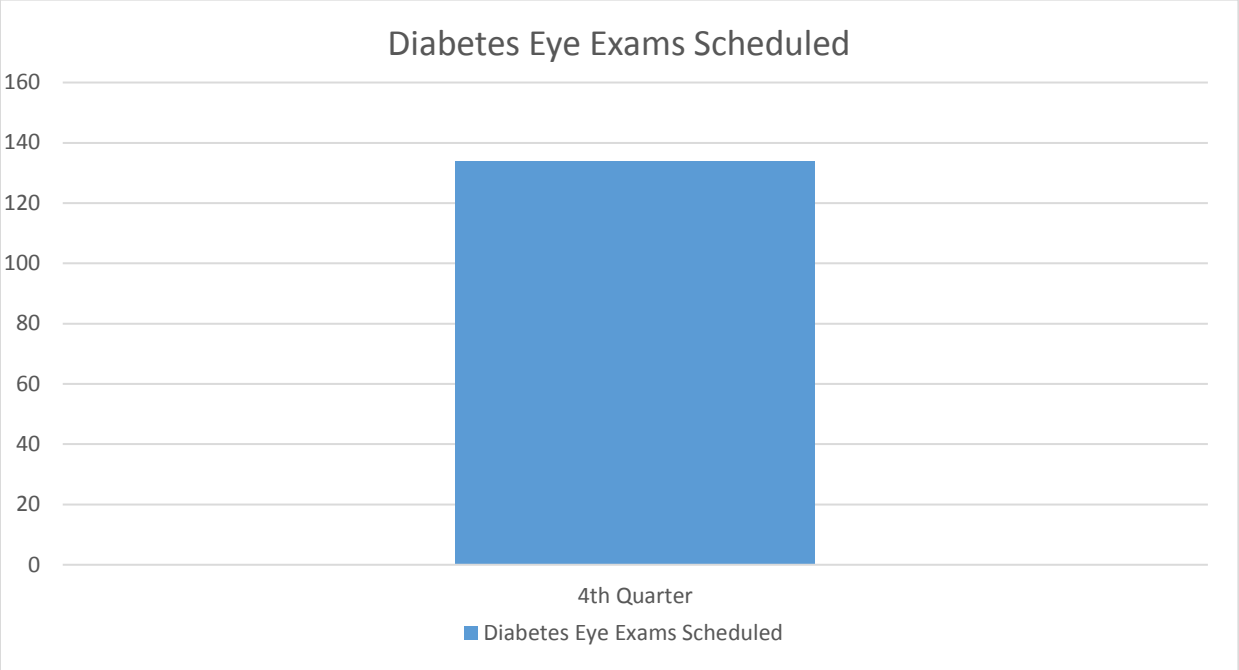
Educational Material Mailed.

540



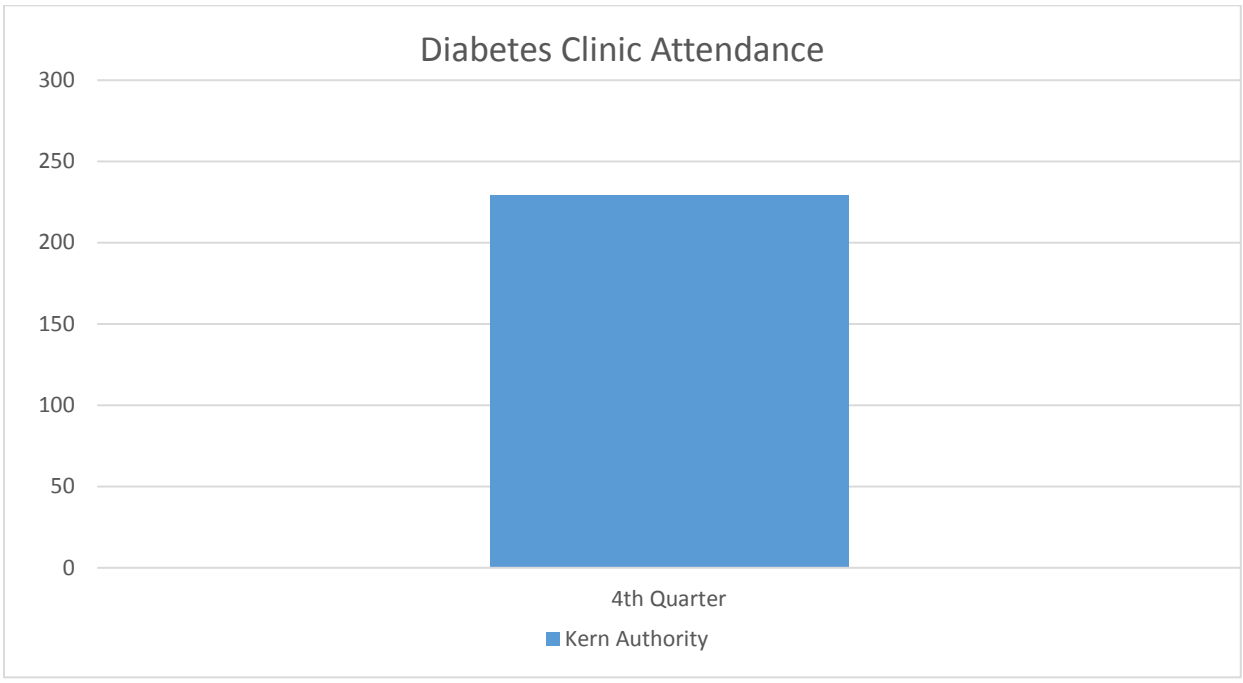
Diabetes Eye Exams Scheduled.

134



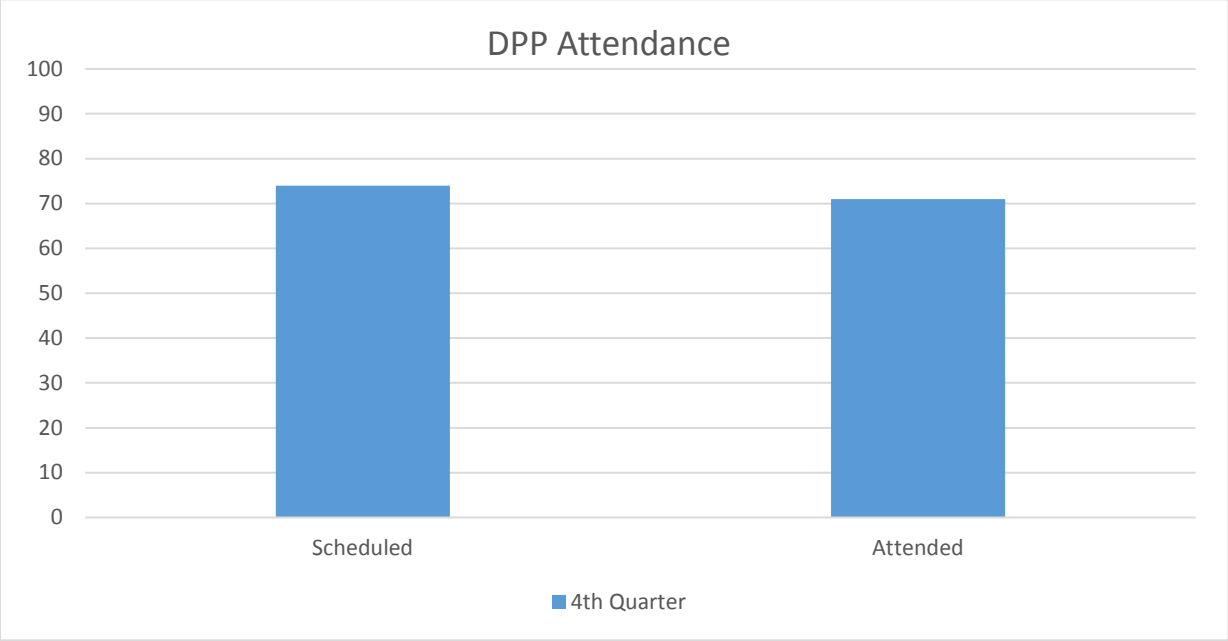
Diabetes Clinic Attendance.

Kern Authority
229



Diabetes Prevention Program: At the end of the 4th Quarter, 23 members remain enrolled in the program. Classes were held monthly during this reporting period

Sessions Scheduled to Attend	Actual Sessions Attended
74	71



KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Alcohol and Substance Abuse Treatment Services				POLICY #: 3.10-P	
DEPARTMENT: Health Services - Utilization Management					
Effective Date: 08/1997	Review/Revised Date: 11/21/2019	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A Hayward
Chief Executive Officer — Date 11/20/19

M Tasinga
Chief Medical Officer — Date 11/21/19

Chief Operating Officer — Date 11/14/19

Director of Claims — Date 11/11/19

Deborah L Munn
Senior Director of Health Services — Date 11/11/19

POLICY:

Alcohol and substance abuse treatment services available under the Short-Doyle Medi-Cal (SDMC) program as defined in Title 22, Section 51341.1, outpatient heroin detoxification as defined in Title 22, Section 51328 are excluded from the Kern Health Systems (KHS) Medi-Cal contract,[1] and the implementation of covered tobacco cessation services.

KHS is contractually required to provide all preventive services consistent with the United States Preventive Services Task Force (USPSTF) Grade A and B recommendations. USPSTF assigned a Grade B recommendation for Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care. The USPSTF recommends that clinicians screen adults ages 18 years or older for

alcohol misuse and pro[illegible]de persons engaged in risky or hazard[illegible]s drinking with brief behavioral counseling interventions to reduce alcohol misuse.

Consistent with USPSTF recommendations and the Preventive Services Medi-Cal Provider Manual, KHS must annually screen adult members 18 years of age and older for alcohol misuse. Although KHS must provide one alcohol misuse screening per year, additional screenings must be provided when medically necessary. Medical necessity must be documented by the member's PCP or primary care team.

KHS providers will make best efforts to identify members requiring alcohol, tobacco cessation or substance abuse treatment services. Providers will arrange their referral to the Kern County Behavioral and Recovery Services (KCBRS) for appropriate services provided through the Alcohol and Other Drugs Program, including outpatient heroin detoxification providers.[2]

To design and define systematic methods to identify and refer KHS plan members requiring alcohol and drug treatment services to KCBRS, and to identify, treat and refer KHS plan members for covered tobacco cessation services.

DEFINITIONS:

Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care means screening for alcohol misuse and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

Alcohol Use Disorder means that a patient meets the criteria in the DSM for a substance use disorder resulting from alcohol use.

Behavioral Counseling Interventions for Alcohol Misuse means activities delivered by primary care clinicians and related health care staff to assist patients in adopting, changing, or maintaining behaviors proven to affect health outcomes and health status including appropriate alcohol use.

PROCEDURE:

1.0 ACCESS

KHS, KHS Contracted Providers and KCBRS work collaboratively to coordinate referrals for chemical and alcohol dependency and tobacco cessation services. Primary Care Providers (PCPs) identify members requiring chemical dependency and tobacco cessation services through evaluations during office visits or during the initial health assessment. PCPs refer members to KHS, KCBRS or to community and volunteer organizations within the community as appropriate.

KCBRS referrals should be made to the following address and/or phone number:

Kern County Behavioral and Recovery Services
2001, 28th Street
Bakersfield, California 93301
(661) 868-6600

24 hour crisis intervention (661) 868-8. J

KHS assists members in locating available treatment service sites.[3] To the extent that treatment slots are not available in the KCBRS Alcohol and other Drugs Program, KHS pursues placement outside of Kern County.[4]

2.0 PROVISION OF SERVICES

2.1 Chemical Dependency

KHS covers psychotherapeutic medications, on the KHS formulary or approved with a TAR, prescribed by PCPs or KCBRS psychiatrists. Psychotherapeutic medications listed in Bulletin #420 are excluded from KHS coverage and should be billed to Fee-For-Service Medi-Cal.

KHS covers the History and Physical examination by a contract PCP if indicated prior to outpatient detoxification services and any associated laboratory studies.

Chemical dependency services are provided by and are the responsibility of KCBRS.

When KHS is aware of a member who is presenting in a general acute care hospital for Voluntary Inpatient Detoxification (VID) services who does not meet the medical necessity criteria above after clinical evaluation by a physician, KHS should refer the member to the county's behavioral health department for referral to other medically necessary substance use disorder (SUD) treatment services. KHS will provide care coordination to ensure members receive appropriate referrals to available county services.

Individual Health Education Behavioral Assessment (IHEBA) performed within 60 calendar days of enrollment for members under the age of 18 months and within 120 calendar days for members over the age of 18 months; and that all existing Members who have not completed an IHEBA, must complete it during the next preventative care office visit according to the Staying Healthy Assessment (SHA) periodicity .with annual reviews of the member's answers.

- KHS will allow each member at least one expanded screening, using a validated screening tool, every year. Additional screenings can be provided in a calendar year if medical necessity is documented by the member's provider. KHS will ensure that PCPs maintain documentation of the IHEBA and the expanded screening. When a member transfers to another PCP, the receiving PCP must obtain prior records. If no documentation is found, the new PCP must provide and document this service.
- Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs
- Direct communication between the provider and Member/family
- Member and family education, including healthy lifestyle changes when warranted; and
- Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

In addition to the SHA, the Primary Care Provider (PCP) must administer an Alcohol Use Disorder (AUD) questionnaire to determine if alcohol use requires additional treatment beyond the scope of the Primary Care Provider. The USPSTF considers the following three tools as the instruments of choice for screening for alcohol misuse in the primary care setting.

Accordingly, KHS must use one of these validated screening tools when screening members for alcohol misuse:

1. The Alcohol Use Disorders Identification Test (AUDIT);
2. The abbreviated AUDIT-Consumption (AUDIT-C); and
3. A single-question screening, such as asking, "How many times in the past year have you had 4 (for women and all adults older than 65 years) or 5 (for men) or more drinks in a day?"

If answers to specific questions indicate the need for expanded treatment modalities beyond the brief interventions of three 15 minute sessions in person or by phone by the PCP, a second screening test will be performed and can be billed separately as a screening tool. Coordination of services will follow guidelines outlined in the Memorandum of Understanding (MOU).

KHS must include alcohol misuse and behavioral counseling intervention services in their member-informing materials. KHS must also maintain policies and procedures to ensure that providers in primary care settings offer and document alcohol misuse screening services required by this APL and the Preventative Services Medi-Cal Provider.

KHS shall cover and pay for behavioral counseling intervention(s) for members who screen positively for risky or hazardous alcohol use or a potential alcohol use disorder or responds affirmatively to the alcohol question in the IHEBA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified. Any member identified with possible alcohol use disorders should be referred to the alcohol and drug program in the county where the member resides for evaluation and treatment. Treatment for alcohol use disorders is not a service covered under this health coverage.

KHS must offer members with brief behavioral counseling interventions, as specified by the Preventive Services Medi-Cal Provider Manual to reduce alcohol misuse when, during the screening process, a member is identified as being engaged in risky or hazardous drinking.

Behavioral counseling interventions for alcohol misuse vary in their specific components, administration, length, and number of interactions, but may include cognitive behavioral strategies, such as action plans, drinking diaries, stress management, or problem solving. Interventions may be delivered by face-to-face sessions, written self-help materials, computer- or Web-based programs, or telephone counseling. KHS must offer at least one, but may offer up to a maximum of three, behavioral counseling interventions for alcohol misuse per year. Providers may combine these sessions in one or two visits or administer the sessions as three separate visits. Additional behavioral counseling interventions must be authorized when medically necessary; however, medical necessity must be documented by the member's PCP.

Primary care providers (PCPs) may offer AUD interventions in the primary care setting as long as they meet the following requirements:
AUD services may be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider, including but not limited to, the following:

- Licensed Physician
- Physician Assistant
- Nurse Practitioner
- Psychologist

• At leas. one supervising licensed provider per c.. .ic or practice may take four hours of AUD training after initiating AUD services. The training is not required; however, it is recommended.

Chemical dependency services are provided by and are the responsibility of KCBRS. KHS must ensure that members who, upon screening and evaluation, meet the criteria for an AUD as defined by the current DSM (DSM-5, or as amended), or whose diagnosis is uncertain, are referred for further evaluation and treatment to the county department for alcohol and substance use disorder treatment services, or a DHCS-certified treatment program.

KHS must ensure that PCPs maintain documentation of the alcohol misuse screening of their members. When a member transfers from one PCP to another, the receiving PCP must obtain the member's prior medical records, including those pertaining to the provision of preventive services.

2.2 Tobacco Cessation

KHS covers comprehensive tobacco cessation services including Federal Drug Administration (FDA) approved medication and individual, group and telephone counseling.

2.2.1 FDA-Approved Tobacco Cessation Medication (for non-pregnant adults of any age)

KHS covers all FDA-approved tobacco cessation medications for adults who use tobacco products. This includes over-the-counter medications with a prescription from the provider per the below table. At least one FDA-approved tobacco cessation medication is available without prior authorization.

Medication	Prescription Needed
Buproprian SR	Yes
Varenicline	Yes
nicotine gum	No
nicotine inhaler	Yes
nicotine lozenge	No
nicotine nasal spray	Yes
nicotine patch	No*

*A prescription generic version is also available

- KHS will provide a 90-day treatment regimen of medications without other requirements, restrictions, or barriers.
- KHS will cover any additional medications once approved by the FDA to treat tobacco use.
- KHS will not require members to receive a particular form of tobacco cessation service as a condition of receiving any other form of tobacco cessation services.
- While counseling is encouraged, KHS will not require members to attend classes or counseling sessions prior to receiving a prescription for an FDA-approved tobacco cessation medication.

2.2.2 Individua., Group, and Telephone Counseling t. Members of Any Age Who Use Tobacco Products

KHS collaborates with county tobacco control program(s) to identify other local group tobacco cessation counseling resources.

According to and as required by APL 16-014, KHS will:

- Ensure that individual, group, and telephone counseling is offered to members who wish to quit smoking, whether or not those members opt to use tobacco cessation medications;
- Ensure that providers review the SHA's questions on tobacco use with members which will constitute individual counseling when the conditions in Policy Letter (PL) 13-001 are met;
- Encourage that providers or other office staff use the "5 A's" (**A**sk, **A**dvise, **A**ssess, **A**ssist, and **A**rrange), the "5 R's" (**R**elevance, **R**isks, **R**ewards, **R**oadblocks, and **R**epetition), or other validated behavior change models when counseling members;
- Ensure that a minimum of four (4) counseling sessions of at least ten (10) minutes in duration are covered for at least two separate quit attempts per year without prior authorization. MCPs must offer individual, group, and telephone counseling without cost to the members;
- Ensure that providers refer members to the California Smokers' Helpline (1-800-NO-BUTTS), a free statewide quit smoking service operated by the University of California San Diego (see below) or other comparable quit line services; and
- Encourage providers to use the Helpline's web referral, or if available, the e-referral systems.

2.2.3 Services for Pregnant Women

Because of the serious risk of smoking to the pregnant smoker and fetus, whenever possible, pregnant members should be offered tailored, one-on-one counseling exceeding minimal advice to quit smoking.

KHS will require that providers will, at a minimum:

- Ask all pregnant women if they use tobacco or are exposed to tobacco smoke. Pregnant members who smoke should get assistance with quitting throughout their pregnancy.
- Offer all pregnant smokers at least one face-to-face counseling session per quit attempt. Face-to-face tobacco-cessation counseling services may be provided by or under supervision of a physician, legally authorized to furnish such services under state law.
- Refer pregnant members who use tobacco to a tobacco cessation quit line, such as the Helpline. These tobacco cessation counseling services are covered for 60 days after delivery, plus any additional days needed to end the respective month.
- Refer to the tobacco cessation guidelines provided by the American College of Obstetrics and Gynecology (ACOG) before prescribing tobacco cessation medications during pregnancy. KHS shall post ACOG guidelines on the KHS website for providers.

2.2.4 Prevention of Tobacco Use in Children and Adolescents

KHS will cover medically necessary tobacco cessation services to members, including counseling and pharmacotherapy, as required for children up to age 21 under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Coverage includes the provision of anticipatory guidance and risk-reduction counseling regarding tobacco use.

KHS requires that primary care providers provide interventions, including education or counseling, in an attempt to prevent initiation of tobacco use in school-age children and adolescents. Services shall be provided in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule and anticipatory guidance, as periodically updated.

3.0 CASE MANAGEMENT AND COORDINATION OF CARE

KHS continues to cover and provide primary care and other services unrelated to the alcohol and substance abuse treatment.[5] KHS coordinates services between the PCP and the treatment programs.[6]

3.1 PCP and KCBRS Chemical Dependency Provider Responsibilities

KHS PCPs forward pertinent medical records/documentation to KCBRS. KCBRS providers are responsible for communicating with the member's PCP as needed and appropriate and for supplying the PCP with appropriate medical records/documentation.

KHS PCPs are responsible to monitor that the member is following up with chemical dependency appointments. KHS Case Mangers assist PCPs who are encountering difficulty referring members for services or who are having difficulty with non-compliant members, by contacting the member/KCBRS to determine the nature of the difficulty and intercede/facilitate as needed.

KHS Providers continue to provide care for the physical health of the member, and the PCP communicates with the member's chemical dependency provider as needed and appropriate.

After consultation with the member's PCP, the KCBRS chemical dependency provider refers the member back to the PCP for ongoing care at such time that it is determined that the member no longer requires care from the KCBRS provider. The PCP provides ongoing medical care and refers back to KCBRS for chemical dependency follow-up as needed.

3.1.2 Hospitalization of a Member

If a member is hospitalized for chemical dependency services and requires medical treatment, the admitting chemical dependency Provider will contact the PCP for consultation and development of treatment plan. Members who require transfer to a medical bed for treatment of a medical condition are transferred by the PCP to the appropriate level of acute care. The chemical dependency provider continues to consult with the PCP regarding treatment of the member. When medically stable, the member is either discharged by the PCP with appropriate follow-up by KCBRS chemical dependency provider and the PCP, or transferred back to the inpatient treatment facility by the chemical dependency provider. Upon discharge, the member is instructed to follow-up with the KCBRS chemical dependency provider and the PCP, as appropriate.

Medical criteria for inpatient admission for VID must include one or more of the following:

1. Delirium tre. .ens, with any combination of the fo. .wing clinical manifestations with cessation or reduced intake of alcohol/sedative:

- Hallucinations
- Disorientation
- Tachycardia
- Hypertension
- Fever
- Agitation
- Diaphoresis

2. Clinical Institute Withdrawal Assessment Scale for Alcohol, revised (CIWA-Ar) form score greater than 15.

3. Alcohol/sedative withdrawal with CIWA score greater than 8 and one or more of the following high-risk factors:

- Multiple substance abuse
- History of delirium tremens
- Unable to receive the necessary medical assessment, monitoring, and treatment in a setting with a lower level of care
- Medical co-morbidities that make detoxification in an outpatient setting unsafe
- History of failed outpatient treatment
- Psychiatric co-morbidities
- Pregnancy
- History of seizure disorder or withdrawal seizures

4. Complications of opioid withdrawal that cannot be adequately managed in the outpatient setting due to the following factors:

- Persistent vomiting and diarrhea from opioid withdrawal
- Dehydration and electrolyte imbalance that cannot be managed in a setting with a lower level of care

Detoxification of cannabinoids, stimulants, or hallucinogens alone does not require an inpatient level of medical intervention; however, multiple substance abuse with components of alcohol, opiates, or sedatives may be considered for inpatient admission.

To receive VID services, KHS will refer members to VID service providers in general acute care hospitals. The VID provider facility must not be a Chemical Dependency Treatment Facility or an Institution for Mental Disease. The VID service provider must submit a Treatment Authorization Request (TAR) to local Medi-Cal field offices for authorization. KHS will provide care coordination with the VID service provider as needed. Documentation that is submitted with the TAR should verify that admission criteria as outlined above are met as well as demonstrate the medical necessity for the inpatient stay.

3.1.3 KHS and KCBRS Liaisons

There is a designated liaison for KHS who serves as the liaison for KCBRS. Issues which require resolution are directed to these individuals for discussion and problem resolution

3.2.1 Identifying Tobacco Users

PCP's are responsible for identifying and tracking tobacco users. KHS will monitor provider compliance for identifying tobacco users and will utilize track tobacco users for better coordination of tobacco cessation benefits as required through the review of:

- PM160's
- The SHA during chart reviews
- The NME program

All reviews resulting in identified tobacco users are forwarded to the Health Education Department.

3.2.2 Tracking Treatment Utilization of Tobacco Users

KHS will track treatment utilization of tobacco use through the review of utilization data from the *Tobacco Registry Report* (See Attachment A) that includes internal data from provider and pharmacy claims encounters.

4.0 PROVIDER AND MEMBER EDUCATION

4.1 Chemical Dependency Provider Education

KHS providers are educated regarding chemical dependency carve-outs, PCP responsibilities, and referral procedures through Provider Orientations and the *Provider Administrative Manual.*

4.2 Tobacco Cessation Member Education

KHS will provide information to members who use tobacco about the availability of tobacco cessation services and identify those that are provided at no cost. Members are given the option of choosing which services to use. Additionally, KHS coordinates with the agency providing the tobacco cessation services to pay for the cost of the member to receive those services.

4.3 Tobacco Cessation Provider Education

KHS will use the USPHS "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update," for provider training on tobacco cessation treatments. This document informs and educates clinicians regarding effective strategies and approaches for providing tobacco cessation treatment for all populations, including specific recommendations for pregnant women. KHS will encourage providers to implement the USPHS' comprehensive tobacco use treatment recommendations.

KHS will include tobacco cessation training with other provider trainings as required in DHCS contracts. These trainings must include:

- Requirements for comprehensive tobacco cessation member services included in this policy in accordance with APL 16-014;
- Overview of the "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008";
- How to use and adopt the "5 A's", the "5 R's", or other validated model for treating tobacco use and dependence in the provider's clinic practice;

- Special requirements for providing services for pregnant tobacco users; and
- Advising providers about available online courses in tobacco cessation. These resources are posted on the KHS website.

5.0 CONFIDENTIALITY

KHS and KHS contracted providers will maintain and protect the confidentiality of members' medical information regarding inpatient and outpatient alcohol and drug services. Confidentiality of member information is described in *KHS Policy and Procedure #2.27 - Medical Records and Other Protected Health Information - Content, Maintenance, and Security and KHS Policy and Procedure #2.28-P: Medical Records and Other Protected Health Information – Privacy, Use, and Disclosure*.

6.0 DELEGATION OVERSIGHT

The KHS MHCM or delegated contractor actively coordinates all services between the member and providers. 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 Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors. Any problems identified in coordination of care are reported to the Chief Medical Officer and Senior Director of Health Services for intervention/resolution. The Chief Medical Officer and/or Senior Director of Health Services may submit the problem to the KHS QI/UM Committee for review and action, as appropriate.

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

ATTACHMENTS

- ❖ Attachment A: Tobacco Registry Report

REFERENCE:

Revision 2019-10: Policy revised to comply with APL 18-001 by Senior Director of Health Services. **Revision 2018-10:** Policy revised to comply with APL 18-014 by Administrative Director of Health Services. [1] **Revision 2018-02:** DHCS Approved 2/28/2018. Policy revised to comply with MIT 19K for the provision of Alcohol Misuse Screening and Counseling (AMSC). **Revision 2017-04:** Policy revised to comply with ALP 16-014. Titles updated. **Revision 2014-08:** Policy submitted as part of DMHC Mental Health Carve-In(12-2013) Material Modification. DMHC approval pending as of 08/2014. **Revision 2009-03:** Routine revision. **2005-11:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004).

[2] DHS Contract A-11 (6)
[3] DHS Contract A-11 (6)
[4] DHS Contract A-11 (6)
[5] DHS Contract A-11 (6)
[6] DHS Contract A-11 (6)

KERN HEALTH SYSTEMS

Governed Reporting System

Attachment A

Tobacco Registry Report

Report captures all members who meet criteria used to identify tobacco users on or after 1/1/16

Member Source ID	Tobacco User	Pregnant Tobacco User	Prior Tobacco User	Cessation Product	Cessation Counseling	Tobacco Exposure	Newborn Tobacco Exposure	New Member Question	Number of Conditions Met
MEMBER#	Y	N	Y	N	N	N	N	N	2
MEMBER#	N	Y	N	Y	Y	Y	N	Y	1
MEMBER#	Y	N	Y	N	N	N	N	N	3

KERN HEALTH SYSTEMS

Governor Reporting System

Tobacco Registry Report

Report captures all members who meet criteria used to identify tobacco users on or after 1/1/16

Member Source Id	Member Group Name	Entered Date	Language	Member Effective Date	Member Name	Date of Birth	Address	City	State	Zip	Current Age	Provider ID	Provider Name	Member Region	Home Phone	Number of Flags	First Date	Last Flag Updated	DOS	Last Update Paid
MEMBER#	EXPANSION	1/1/2015	ENGLISH	8/1/2014	MEMBER NAME	8/7/1987	123 SESAME ST	BAKERSFIELD	CA	93307	29	PRV000383	TIWANA,AJITPAL	TIWANA, AJITPAL	5555555555	1	1/13/2016	TOBACCO USER	1/1/2016	1/18/2016
MEMBER#	FAMILY/OTHERS	1/1/2016	SPANISH	10/1/2015	MEMBER NAME	7/18/1975	123 WONDER RD	BAKERSFIELD	CA	93306	41	PRV001174	BICHAI,WILLIAM	WILLIAM BICHAI MD INC	5555555555	46	1/21/2016	CESSATION PRODUCT	12/21/2016	1/10/2017
MEMBER#	SPD	1/1/2016	ENGLISH	1/1/2014	MEMBER NAME	4/1/1966	123 HEALTHY WAY	BAKERSFIELD	CA	93307	50	PRV000014	CSV - NORTH OF THE RIVER COMMUNITY HEALTH CENTER	CLINICA SIERRA VISTA	5555555555	9	2/23/2016	CESSATION PRODUCT	1/5/2017	1/18/2017

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Mental Health Services				POLICY #: 3.14-P	
DEPARTMENT: Health Services - Utilization Management					
Effective Date: 10/2000	Review/Revised Date: 10/31/2019	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A Hayward
Chief Executive Officer — Date 10/31/19

Chief Medical Officer — Date 10/28/19

Chief Operating Officer — Date 10-15-19

Director of Claims — Date 10/9/19

Deborah L Murray
Senior Director of Health Services — Date 10/9/19

POLICY[1]:

All specialty mental health services or Serious Emotional Disorders (inpatient and outpatient) are carved out of the Medi-Cal Product contract and are therefore excluded from Kern Health Systems (KHS) coverage.[2] KHS shall cover outpatient mental health services that are within the scope of practice of Primary Care Providers[3] or when performed for mild to moderate mental health conditions on an outpatient basis by a licensed mental health provider. Members who need specialty mental health services are referred to and are provided mental health services by an appropriate Medi-Cal Fee-For-Service (FFS) mental health provider or to the local mental health plan for specialty mental health services.[4]

Treatment for Serious Emotional Disturbances is provided by the Kern County Behavioral and Recovery Services (KCBRS).

KHS' responsibility to provide services related to mental health conditions is described in this policy and procedure. The KHS Utilization Management Department (UM) collaborates with the KCBRS in the delivery of mental and physical health services to KHS Plan members.

KHS is responsible for updating, amending, or replacing existing Memorandum of Understandings (MOUs) with KCBRS to delineate KHS and KCBRS responsibilities when covering mental health services. The existing MOUs between KHS and KCBRS are required based on Specialty Mental Health Services (SMHS) regulations and existing KHS contracts.

The MOU will include the following elements:
- Basic Requirements;
- Covered Services and Populations;
- Oversight Responsibilities of the KHS and KCBRS;
- Screening, Assessment, and Referral;
- Care Coordination;
- Information Exchange;
- Reporting and Quality Improvement Requirements;
- Dispute Resolution;
- After-Hours Policies and Procedures; and,
- Member and Provider Education.

The MOU is the primary vehicle for ensuring member access to necessary and appropriate mental health services. The MOU addresses policies and procedures for management of the member's care for both KHS and KCBRSs, including but not limited to:
- Screening, assessment and referral,
- Medical necessity determination, care coordination, and exchange of medical information.

MOU elements will promote local flexibility and acknowledge the unique relationships and resources that exist at the county level.

KHS's Utilization Management program does not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq

KHS will coordinate and/or provide mental health services as appropriate in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:
- California Health and Safety Code §1374.72; §1367.01
- 42 CFR 438.910(d)
- DHCS Contract Exhibit A – Attachment 10 (8)(E); Attachment 11 (6); and Attachment 12 (3) (Medi-Cal Product only)

PURPOSE:

To provide guidelines for the provision and/or coordination of mental health services.

DEFINITIONS

Serious Emotional Disturbance (SED)[5]	One or more of the mental disorders as identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance abuse disorder or developmental disorder, that result in behavior inappropriate to the child's age according to the expected developmental norms. Members of this target population shall meet one or more of the following criteria: A. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self care, school functioning, family relationships, or ability to function in the community; and either of the following occur: 1. The child is at risk of removal from home or has already been removed from the home 2. The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment B. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder C. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.
Severe Mental Illness (SMI)[6]:	Includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
Specialty Mental Health Services[7]	Mental health services outside the scope of practice of Primary Care Providers
Mild to Moderate Mental Health Services	Includes Mental Retardation, Learning Disorders, Motor Skills Disorders, Communication Disorders, Autistic or Pervasive Disorders, Developmental Disorders, Tic Disorders, Delirium, Dementia, and Amnestic and other Cognitive Disorders, Mental Disorders due to General Medical Condition, Substance Related Disorders, Sexual Dysfunctions, Sleep Disorders, Antisocial Personality Disorder, or Other Conditions that may be a Focus of Clinical Attention, except Medication-Induces Movement Disorders which are included

PROCEDURE:

1.0 ACCESS [8]

KHS and KCBRS work collaboratively to coordinate referrals for mental health services that are excluded from coverage by KHS.[9] Services that are the responsibility of KHS are subject to utilization management protocols as described in *KHS Policy and Procedure #3.22-P: Referral and Authorization Process* and other KHS policies specific to the type of service/supplies provided. KHS will continue to be responsible for the arrangement and payment of all medically necessary Medi-Cal physical health care services, not otherwise excluded by contract, to beneficiaries who require specialty mental health services.

Primary Care Providers (PCPs) are required to provide outpatient mental health services within their scope of practice.[10] These include services for members diagnosed with minor depression, minor anxiety, or uncomplicated grief reaction.

At any time, beneficiaries can choose to seek and obtain a mental health assessment from a licensed mental health provider within KHS's provider network. KHS is still obligated to ensure that a mental health screening of beneficiaries is conducted by network PCPs. Beneficiaries with positive screening results may be further assessed either by the PCP or by referral to a network mental health provider. The beneficiary may then be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP must refer the beneficiary to a mental health provider within the KHS network. For adults, the PCP or mental health provider must use a Medi-Cal-approved clinical tool or set of tools mutually agreed upon with the KCBRS to assess the beneficiary's disorder, level of impairment, and appropriate care needed. The clinical assessment tool or set of tools are identified in the MOU between KHS and KCBRS.

Primary care providers will identify the need for a mental health screening and refer to a specialist within the contracted network. Upon assessment, the mental health specialist can assess the mental health disorder and the level of impairment and refer members that meet medical necessity criteria to KCBRS for a Specialty Mental Health Services (SMHS) assessment. When a member's condition improves under SMHS and the mental health providers in the plan and the County System of care coordinate care, the member may return to the mental health provider in KHS network.

If a KHS beneficiary with a mental health diagnosis is not eligible for KCBRS services because they do not meet the medical necessity criteria for SMHS, then KHS is required to ensure the provision of outpatient mental health services as listed in the DHCS contract.

KHS will ensure its network providers refer adult beneficiaries with significant impairment resulting from a covered mental health diagnosis to the county KCBRS. Also, when the adult KHS beneficiary has a significant impairment, but the diagnosis is uncertain, the KHS must ensure that the beneficiary is referred to the KCBRS for further assessment. Services beyond the PCP's scope of practice should be referred as described below.

KHS will also cover outpatient laboratory tests, medications (excluding carved-out medications that are listed in the KHS's relevant Medi-Cal Provider Manual), supplies, and supplements prescribed by

the mental health providers in the KHS network, as well as by PCPs, to assess and treat mental health conditions. KHS may require that mild to moderate mental health services to adults are provided through KHS's provider network, subject to a medical necessity determination. KHS may contract with the KCBRS to provide these mental health services when the KHS covers payment for these services.

KHS will continue to be required to provide medical case management and cover and pay for all medically necessary Medi-Cal-covered physical health care services for KHS beneficiary receiving SMHS. KHS will coordinate care with the KCBRS. KHS is responsible for the appropriate management of a beneficiary's mental and physical health care, which includes, but is not limited to, the coordination of all medically necessary, contractually required Medi-Cal-covered services, including mental health services, both within and outside the KHS provider network.

Referrals for mental health services may be generated by the provider of care, KHS UM Case Managers, school systems, employers, or self referrals. To ensure confidentiality, KHS has a designated UM Mental Health Case Manager (MHCM) or Social Worker that is responsible for all aspects of the member's mental health care and the coordination of physical health care when indicated. Referrals for Medi-Cal members may be sent either directly to KCMHD or to KHS for forwarding to KCBRS.

Kern County Behavioral and Recovery Services
2151 College Ave.
Bakersfield, CA 93305
Fax: (661) 868-8087

OR

Kern Health Systems
Mental Health Case Manager
2900 Buck Owens Boulevard
Bakersfield, CA 93308
Fax: (661) 664-5190

Members needing immediate crisis intervention may self refer to the Crisis Stabilization Unit due to the availability of an on-site Mental Health staff 24 hours a day. The Memorandum of Understanding (MOU) with the county mental health plan allows Members in need of urgent and emergency care, including person-to-person telephone transfers, to be referred to the county crisis program during their call center hours.

1.1 Mental Health Parity

KHS will comply with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR, §438.930. KHS will also ensure direct access to an initial mental health assessment by a licensed mental health provider within KHS's provider network. KHS will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. KHS will notify beneficiaries of this policy, and KHS's informing materials must clearly state that referral and prior authorization are not required for a beneficiary to seek an initial mental health assessment from a network mental

health provider. KHS is required to cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

If further services are needed that require authorization, KHS is required to follow guidance developed for mental health parity, as follows:

KHS will disclose the utilization management or utilization review policies and procedures that KHS utilizes to DHCS, its contracting provider groups, or any delegated entity, uses to authorize, modify, or deny health care services via prior authorization, concurrent authorization or retrospective authorizations, under the benefits included in the KHS contract.

KHS policies and procedures must ensure that authorization determinations are based on the medical necessity of the requested health care service in a manner that is consistent with current evidence-based clinical practice guidelines. Such utilization management policies and procedures may also take into consideration the following:

- ☐ Service type
- ☐ Appropriate service usage
- ☐ Cost and effectiveness of service and service alternatives
- ☐ Contraindications to service and service alternatives
- ☐ Potential fraud, waste and abuse
- ☐ Patient and medical safety
- ☐ Other clinically relevant factors

The policies and procedures must be consistently applied to medical/surgical, mental health and substance use disorder benefits. KHS will notify contracting health care providers of all services that require prior authorization, concurrent authorization or retrospective authorization and ensure that all contracting health care providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

The disclosure requirements for KHS include making utilization management criteria for medical necessity determinations for mental health and substance use disorder benefits available to beneficiaries, potential beneficiaries and providers upon request in accordance with Title 42, CFR §438.915(a). KHS will also provide to beneficiaries, the reason for any denial for reimbursement or payment of services for mental health or substance use disorder benefits in accordance with Title 42, CFR, §438.915(b). In addition, all services must be provided in a culturally and linguistically appropriate manner.

1.2 Accessing Specialty Mental Health Care from KCBRS Practitioners

KCBRS reviews referrals and refers the member to the appropriate KCBRS mental health provider. KCBRS coordinates the care between the member and the designated mental health provider. Arrangements for appointments are per KCBRS established protocols.

KHS or the mental health provider may submit the request directly to KCBRS for review and approval/denial for outpatient treatment of Serious Emotional Disorders or Inpatient Mental Health Services. If the follow-up visits are denied, KCBRS will discuss alternatives with the mental health provider and follow established KCBRS protocol.

Services Provided by CKCBRS for Children and adults who meet medical necessity or EPSDT criteria for Medi-Cal Specialty Mental Health Services include:

Mental Health Services (assessments plan development, therapy, rehabilitation and collateral)
Medication Support
Day Treatment Services and Day Rehabilitation
Crises Intervention and Crises Stabilization
Targeted Case Management
Therapeutic Behavior Services

Residential Services Provided by CKCBRS
Adult Residential Treatment Services
Crises Residential Treatment Services

Inpatient Services
Acute Psychiatric Inpatient Hospital Services
Psychiatric Inpatient Hospital Professional Services
Psychiatric Health Facility services

Services Provided by County Alcohol or Other Drug Programs for: Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal Substance Use Disorder Services
Outpatient Drug Free
Intensive Outpatient (newly expanded to additional populations)
Residential Services (newly expanded to additional populations)
Narcotic Treatment Program
Naltrexone
Voluntary Inpatient Detoxification Services
If a beneficiary with a mental health diagnosis is not eligible for KCBRS services because the adult beneficiary's level of impairment is mild to moderate, or, for adults and children, the recommended treatment does not meet criteria for Medi-Cal specialty mental health services, then KHS will ensure the provision of the outpatient mental health services listed or other appropriate services within the scope of the KHS's covered services.

KH S will ensure its network providers refer beneficiaries with significant impairment resulting from a covered mental health diagnosis to KCBRS. Also, when the beneficiary has a significant impairment, but the diagnosis is uncertain, KHS will ensure that the beneficiary is referred to the KCBRS for further assessment.

2.0 COVERED SERVICES

The following outpatient mental health benefits will be available to KHS members:

1. Individual and group mental health evaluation and treatment (psychotherapy)
2. Psychological testing when clinically indicated to evaluate a mental health condition
3. Psychiatric consultation 4. Outpatient services for the purposes of monitoring drug therapy
5. Outpatient laboratory, supplies and supplements-
    - Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications.
    - Supplies may include laboratory supplies.
    - Supplements may include vitamins that are not specifically excluded in the Medi-Cal formulary and that are scientifically proven effective in the treatment of mental health disorders (although none are currently indicated for this purpose).
6. Drugs (excluding anti-psychotic drugs which are covered by Medi-Cal Fee-For-Service) See Attachment A.

PCPs are required to provide outpatient mental health services within their scope of practice.[11] KHS is responsible to provide emergency mental health services to all members.[12] 24 hour Mental Health Crisis services are available via the crisis hotline at (800) 991-5272. Member's will continue to have access to an existing relationship with a mental health provider in an emergency or urgent care situation and care will be coordinated through communications with the KCBRS and emergency room personnel. KHS Case Management Registered Nurses are available 24/7/365 at 661/331-7656 to provide support and coordination of services to providers involved in member's mental health evaluation and care. All specialty mental health services (inpatient and outpatient) are carved out of the KHS Medi-Cal LOB.

KHS will cover outpatient mental health services to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning (assessed by a licensed mental health professional through the use of a Medi-Cal-approved clinical tool or set of tools resulting from a mental health disorder, as defined in the current Diagnostic and Statistical Manual (DSM). The clinical tool will define the provisional diagnosis, functional impairment resulting from the mental disorder, probability of deterioration or other risk factors linked to the mental disorder, or if a alcohol drug dependence or abuse disorder is present.

KHS is responsible for the delivery of non-SMHS for children under age 21 and outpatient mental health services for adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by the current DSM.

The clinical assessment tools used will be specific for 2 age groups:

- Child 0-17 years of age (see Attachment B) and,
- Adult 18 years of age or older (see Attachment C).

The referral algorithm will determine which system of care is appropriate to deliver the necessary mental health services for maximum patient outcomes.

Conditions that the DSM identifies as relational problems (e.g. couples counseling, family counseling for relational problems) are not covered as part of the new benefit by KHS nor by KCBRS. All services must be provided in a culturally and linguistically appropriate manner.

Medically necessary services are defined as reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. These include services to:
1. Diagnose a mental health condition and determine a treatment plan;
2. Provide medically necessary treatment for mental health conditions (excluding couples and family counseling for relational problems) that result in mild or moderate impairment; and,
3. Refer adults to KCBRS for specialty mental health services when a mental health diagnosis covered by KCBRS results in significant impairment; or refer children under age 21 to KCBRS for specialty mental health services when they meet the criteria for those services.

The number of visits for mental health services is not limited as long as the beneficiary meets medical necessity criteria.

2.1 EPSDT Benefit

Pursuant to the EPSDT benefit, KHS is required to provide and cover all medically necessary services.

For adults, medically necessary services include all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

For children under the age 21, KHS will provide a broader range of medically necessary services that is expanded to include standards set forth under Title 22, CCR Sections 51340 and 51340.01 and "[such other necessary health care, diagnostic services, treatment, and other measures described in [Title 42, United States Code (US Code), Section 1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are covered under the state plan" (Title 42, US Code, Section 1396d(r)(5)).

However for children under the age 21, KHS is required to provide and cover all medically necessary service, except for SMHS listed in CCR, Title 9, Section 1810.247 for beneficiaries that meet the medical necessity criteria for SMHS as specified in to CCR, Title 9, Sections 1820.205, 1830.205, or 1830.210 that must be provided by KCBRS.

2.2 Health Home Program

KHS will be participating in the Health Homes Program (HHP) as required by the DHCS and will coordinate care for members enrolled in the HHP who also receive care through the KCBRS. The MOU is the vehicle for ensuring this coordination, as detailed in the MOU Template (Attachment 2).

2.3 Non -Mental Health Covered Services

The following medically necessary services remain the responsibility of KHS[13]:

A. Emergency room professional services to include services provided by psychiatrists, psychologists, licensed clinical social workers, marriage family and child counselors, or other specialty mental health provider for mild to moderated mental health diagnoses. See *KHS Policy and Procedure #3.31-P: Emergency Services* for additional information on emergency services.

B. Facility charges for emergency room visits which do not result in a psychiatric admission

C. All laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of a mental health condition. Services must be performed by a contracted provider whenever possible and are subject to utilization review as outlined in the applicable KHS scope of service policy.

D. Emergency medical transportation services necessary to provide access to emergency mental health services within KHS's mental health provider network.

E. All non-emergency medical transportation as described in *KHS Policy and Procedure #5.15 – Non-Medical Transportation* required to access Medi-Cal covered mental health services, subject to a written prescription by a KHS Mental Health Network Provider, Services must be performed by a contracted provider whenever possible and are subject to utilization review as outlined in the applicable KHS scope of service policy.

F. All Medi-Cal covered psychotherapeutic drugs not otherwise excluded that are prescribed by the member's PCP or a psychiatrist.[14] (See Attachment A for a list of excluded drugs.)

3.0 DOCUMENTATION

Hard copies of referrals received by KHS are filed in the member's KHS mental health chart for any follow-up or tracking purposes. This includes any referrals from mental health providers for medical services.

4.0 COORDINATION OF CARE, MONITORING, AND REPORTING[15]

KHS has established and maintains mechanisms to identify members who require non-covered psychiatric services and make appropriate referrals.[16] KHS continues to cover and facilitate the provision of primary care and other services unrelated to the mental health treatment and coordinate services between the Primary Care Practitioner and the psychiatric service provider(s).[17] KHS coordinates care with KCBRS in accordance with a Memorandum of Understanding that meets the requirements of DHCS Contract Exhibit A – Attachment 12 (3).[18]

Referrals for mental health services received by KHS or delegated contractor are reviewed for appropriateness then entered into the referral system and mailed to either the Contracted Behavioral Health provider or the KCBRS access supervisor. If for any reason the referral is not appropriate for mental health, the MHCM notifies the submitter to discuss the case for alternatives of care.

4.1 PCP Responsibilities

PCPs are responsible to monitor that the member is following up with mental health appointments. The KHS MHCM or delegated contractor assists the PCP in the coordination of the member's care when requested and upon verification of the release of mental health information from the member.

Basic Case Management Services are provided by the Primary Care Provider, in collaboration with KHS, and shall include:

- Initial Health Assessment (IHA) performed within 120 calendar days of enrollment
- California Child Health and Disability Prevention (CHDP) assessment and ensure immunization compliance
- Individual Health Education Behavioral Assessment (IHEBA) performed within 60 calendar days of enrollment for members under the age of 18 and within 120 calendar days for members over the age of 18; and that all existing Members who have not completed an IHEBA, must complete it during the next preventative care office visit according to the Staying Healthy Assessment (SHA) periodicity with annual reviews of the member's answers.
- KHS will allow each member at least one expanded screening, using a validated screening tool, every year. Additional screenings can be provided in a calendar year if medical necessity is documented by the member's provider. KHS will ensure that PCPs maintain documentation of the IHEBA and the expanded screening. When a member transfers to another PCP, the receiving PCP must obtain prior records. If no documentation is found, the new PCP must provide and document this service.
- Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs
- Direct communication between the provider and Member/family
- Member and family education, including healthy lifestyle changes when warranted; and
- Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

KHS will ensure that:

a) Primary Care Providers shall use the DHCS updated SHA questionnaires and forms, DHCS 7098 A through I, the AAP Bright Futures assessment tools, or a DHCS-approved alternative approved IHEBA, per MMCD Policy Letter PL 13-001.

b) The IHEBA is:

i) Administered and reviewed by the Primary Care Provider during a scheduled office visit, according to the SHA periodicity schedule: 0-6 months, 7-12 months, 1-2 years, 3-4 years, 5-8 years, 9-11 years, 12-17 years, and every 3-5 year for adults and seniors;

ii) Reviewed at least annually by the Primary Care Provider with Members during a scheduled office visit.

iii) Re-administered by the Primary Care Provider at the appropriate SHA periodicity age-intervals.

iv. Based on the Member's identified behavioral risks and willingness to make lifestyle changes, the Primary Care Provider shall provide tailored heath

education counseling, intervention, referral, and follow-up during the initial IHEBA administration, re-administration, and annual review of the assessment;

v. The Primary Care Provider must sign, print their name, and date the "Clinic Use Only" section of the SHA for newly administered, re-administered, or annually reviewed SHAs. The Primary Care Provider must check the appropriate boxes to indicate the specific behavioral topics and counseling, anticipatory guidance, referral, and follow-up provided to the Member; and

vi. Documentation equivalent to the SHA must be kept by Primary Care Providers who use AAP's Bright Futures or a DHCS-approved alternative IHEBA.

vii. In addition to the SHA, the Primary Care Provider (PCP) must administer a Alcohol Misuse Screening and Counseling (AMSC) questionnaire to adults ages 18 years or older to determine if alcohol misuse or have engaged in risky or hazardous drinking behavior that requires additional treatment beyond the scope of the Primary Care Provider. Each member is granted at least one expanded screening, using a validated screening tool, per year. If a member answers "yes" to the alcohol prescreen question in the SHA, a second screening test such as the AUDIT-C will be performed and can be billed separately as a screening tool. If the results of the expanded screening indicate a potential alcohol misuse problem, the PCP must offer (or refer) the member for brief intervention, one to three sessions (which may be combined). If the expanded screening indicates that a member might have an alcohol use disorder (whether or not the member definitely meets DSM criteria for alcohol use disorder), then the member must be referred to local alcohol and drug programs for further evaluation and treatment to receive expanded services covered under Medi-Cal Fee-For-Service. Expanded treatment modalities beyond the brief interventions of three 15 minute sessions maybe conducted in person, by telehealth, by phone, or by the PCP. Providers may provide brief intervention services on the same date of service as the expanded screen or on subsequent days. These sessions may also be combined in one or two visits or administered as three separate visits.

viii. KHS shall cover and pay for behavioral counseling intervention(s) for members who screen positively for risky or hazardous alcohol use or a potential alcohol use disorder or responds affirmatively to the alcohol question in the IHEBA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified. Any member identified with possible alcohol use disorders should be referred to the alcohol and drug program in the county where the member resides for evaluation and treatment. Treatment for alcohol use disorders is not a service covered under this health coverage.

ix. Primary care providers (PCPs) may offer AMSC (Alcohol Misuse Screening and Counseling) in the primary care setting as long as they meet the following requirements:

• AMSC services may be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider, including but not limited to, the following:
    - Licensed Physician
    - Physician Assistant
    - Nurse Practitioner
    - Psychologist
• At least one supervising licensed provider per clinic or practice may take four hours of AMSC training after initiating AMSC services. The training is not required; however, it is recommended.

xi. Behavioral counseling intervention(s) typically include one to three sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities. Providers may refer offsite for behavioral counseling interventions; however, KHS will encourage PCPs and their teams to offer the service within the primary care clinic, to increase the likelihood of members following through on the interventions.

xii. KHS will allow each member at least three behavioral counseling intervention sessions per year. Providers may combine these sessions in one or two visits or administer the sessions as three separate visits. Additional behavioral counseling interventions can be provided if medical necessity has been determined by the member's provider.

c) KHS shall provide Members with the following:

i. Information on the purpose of the IHEBA/SHA or AMSC and assurances that the IHEBA will be kept confidential in the Member's Medical Record, prior to the administration of the IHEBA/SHA or AMSC;

ii. Assistance in completing the SHA, IHEBA/SHA or AMSC translations, interpretation services, accommodation for any disability as needed; and

iii. Information on the Member's right to omit or not answer any assessment question, or to decline to complete the entire assessment.

iv. KHS will ensure that members who, upon screening and evaluation, meet criteria for an alcohol use disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM), or whose diagnosis is uncertain, are referred for further evaluation and treatment to the County Department for alcohol and substance use disorder treatment services or DHCS-certified treatment program.

v. KHS will include AMSC services in their member-informing materials and their procedures that address grievances and appeals regarding AMSC services.

4.2 Mental Health Provider Responsibilities

The mental health provider is required to directly refer members needing medical care to the KHS MHCM or delegated contractor. Referrals are processed in accordance with *KHS Policy and Procedure #3.22-P: Referral and Authorization Process*.

If a member requires medical treatment while admitted to a mental health treatment facility, the admitting mental health provider contacts the PCP for consultation and development of the treatment plan. Members who require transfer to a medical bed for treatment of a medical condition will be transferred by the PCP to the appropriate level of acute care. The KCBRS provider continues to consult with the PCP regarding treatment of the member. When the member is medically stable, the member will either be discharged by the PCP with appropriate follow-up by KCBRS and the PCP, or will be transferred back to the inpatient treatment facility by the KCBRS provider. Upon discharge, the member is instructed to follow-up with the KCBRS and the PCP, as appropriate.

KHS shall make appropriate referrals for Members needing Specialty Mental Health Services as follows:

i) For those Members with a tentative psychiatric diagnosis which meets eligibility criteria for referral to the County Mental Health Plan (CKCBRS), as defined in MMCD Mental Health Policy Letter 00-01 Revised, the Member shall be referred to KCBRS in accordance with the Memorandum of Understanding (MOU) between Contractor and KCBRS as stipulated in Exhibit A, Attachment 12, Provision 3, Local Health Department KCBRS Coordination for the coordination of Specialty Mental Health Services to Members.

ii) For those Members whose psychiatric diagnosis is not covered by KCBRS, but is a covered diagnosis, the Member shall be referred to an appropriate Medi-Cal mental health provider within KHS's provider network. KHS shall consult with KCBRS as necessary to identify other appropriate community resources and to assist the Member to locate available non-covered mental health services available through the Medi-Cal FFS program. Any time a member requires medically necessary Outpatient Mental Health Service that is not available within the provider network, KHS shall ensure access to out-of-network and Telehealth mental health providers as necessary to meet access requirements.

iii) KHS may negotiate with KCBRS to provide the outpatient mental health services when KHS covers payment for these services. Disputes between KHS and KCBRS regarding this section shall be addressed collaboratively within the Contract as specified by the MOU to achieve a timely and satisfactory resolution. If KHS and KCBRS cannot agree, disputes shall be resolved pursuant to Title 9, CCR, and Section 1850.505. Any decision rendered by DHCS regarding a dispute between KHS and KCBRS concerning provision of mental health services or Covered Services required under this Contract shall not be subject to the dispute procedures specified in Exhibit E, Attachment 2, Provision 18 regarding Disputes.

4.3 DELEGTION AND MONITORING

The KHS MHCM or delegated contractor actively coordinates all services

between the member and providers. 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 Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors. Any problems identified in coordination of care are reported to the Chief Medical Officer and Administrative Director of Health Services for intervention/resolution. The Chief Medical Officer and/or Administrative Director of Health Services may submit the problem to the KHS QI/UM Committee for review and action, as appropriate.

5.0 REIMBURSEMENT

Reimbursement for mental health services is made per contract agreement. Claims must be submitted in accordance with *KHS Policy and Procedure #6.01-P: Claims Submission and Reimbursement* and other KHS policies specific to the type of service/supplies provided.

KCBRS sub-contractors should not submit claims directly to KHS.

KCBRS must submit all DHCS required encounter data to KHS with transmitted claims.

6.0 PROVIDER REQUIREMENTS

Providers under contract with KHS must meet the requirements outlined in *KHS Policy and Procedure #4.01* – P, *Credentialing.*

KHS provides mental health services through health care providers who are acting within the scope of their licensure and acting within their scope of competence, established by education, training and experience.[19]

7.0 PROVIDER RESOURCES

KHS providers are educated regarding mental health carve-outs, PCP responsibilities, licensed mental health professionals responsibilities, and referral procedures through orientations and through this policy and procedure which is included in the *KHS Provider Manual.*

8.0 DISPUTES WITH KCBRS

Disputes between KHS and KCBRS shall be resolved pursuant to Title 9, CCR, Section 1850.505.[20]

ATTACHMENTS

- Attachment A – *Excluded Psychotherapeutic Drugs*
- Attachment B – *Child 0-17 Behavioral Health Screening form*
- Attachment C – *Adult Behavioral Health Screening form*

Revision 2019-10: Policy updated during retrospective review of APL 18-015. Minor revisions to correct references and address updated. **Revision 2018-1:** Policy revised to comply with APL 18-015. New section for updating, amending, or

replacing existing Memorandum of Understandings (MOUs). **Revision 2017-12:** Major revision to P&P to comply with APL 17-018.
Revision 2017-04: Section 5.0 Tobacco Cessation Services removed from policy. To be incorporated into policy 3.10-P. Titles updated. **Revision 2015-11:** Minor addition to reference on page 13 Section (i). No material change, revision date revised. **Revision 2015-03:** Tobacco Cessation Services added to comply with all plan Letter (APL) **14-006. Revision 2015-01: Minor** revisions incorporated due to internal audit of APL 13-021 Outpatient Mental Health Services. Attachments updated. **Revision 2014-03:** Revised to comply with SBIRT Deliverable AIR #1, training requirements added. **Revision 2014-02:** Major revision to policy for Mental Health and SBIRT. References to Healthy Families removed. Revisions provided by Director of Health Services. **Revision 2009-03:** Routine review. **Revision 2005-11:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). **Revision 2004-02:** Routine revision. Revised per DHS Comment 04/30/01. Reformatted according to scope of services template (sections simply moved from one part of the policy to another or to the associated internal policy are not marked as redline). Reviewed policy against AB88, DHS Contract, and MRMIB Contract and regulations to ensure compliance. **Revision 2001-02:** Changes requested by UM. **Revision 2000-10:** Routine revision.

[2] DHS Contract A-11 (6)(A)(1)
[3] DHS Contract A-10 (8)(E)(1)
[4] DHS Contract A-10 (8)(E)(3)
[5] Health and Safety Code §1374.72 (e)
[6] Health and Safety Code §1374.72 (d)
[7] DHS Contract A-10 (8)(E)(3)
[8] DHS Contract A-11 (6)(A)(2)
[9] DHS Contract §6.7.3.3(A)
[10] DHS Contract §6.7.3.3 (A)
[11] DHS Contract §6.7.3.3 (A)
[12] Health and Safety Code §1374.72. These services are not exempted per the DMHC Healthy Families exemption filing (024A).
[13] DHS Contract A-10 (8)(E)(2)
[14] DHS Contract A-10 (8)(E)(1)
[15] *Medical case management required as well as coordination of services with the Specialty Mental Health Provider 6.7.3.3B.*
[16] DHS Contract A-10 (8)(E)(4)
[17] DHS Contract A-10 (8)(E)(4)
[18] DHS Contract A-10 (8)(E)(4) and A-11 (6)(B) and MRMIB Contract §V(D)

[20] DHS Contract A-11 (5)(A)(3)

Psychiatric Drugs

The following psychiatric drugs are carved out under Kern Health Systems benefit coverage:

Amantadine HCl
Aripiprazole
Asenapine (Saphris)
Benztropine Mesylate
Biperiden HCl
Biperiden Lactate
Chlorpromazine HCl
Chlorprothixene
Clozapine
Fluphenazine Decanoate
Fluphenazine Enanthate
Fluphenazine HCl
Haloperidol
Haloperidol Decanoate
Haloperidol Lactate
Iloperidone (Fanapt)
Isocarboxazid
Lithium Carbonate
Lithium Citrate
Loxapine HCl
Loxapine Succinate
Lurasidone Hydrochloride
Mesoridazine Mesylate
Molindone HCl
Olanzapine
Olanzapine Fluoxetine HCl
Olanzapine Pamoate Monohydrate (Zyprexa Relprevv)
Paliperidone (Invega)
Paliperidone Palmitate (Invega Sustenna)
Perphenazine
Phenelzine Sulfate
Pimozide
Proclyclidine HCl
Promazine HCl
Quetiapine
Risperidone
Risperidone Microspheres
Selegiline (transdermal only)
Thioridazine HCl
Thiothixene
Thiothixene HCl
Tranylcypromine Sulfate
Trifluoperazine HCl
Triflupromazine HCl
Trihexyphenidyl
Ziprasidone
Ziprasidone Mesylate

Child 0-17 Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Patient Name: _____ Date of Birth: ____/____/____ ☐ M ☐ F

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (____) _____

Caregiver/Guardian: _____ Phone: (____) _____

Documents Included: ☐ **Required consent completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: _____

Primary Care Provider _____ Phone: (____) _____

Referring Provider Name: _____ Phone: (____) _____

Referring/Treating Provider Type: ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other _____

List A: Provisional Diagnosis/Diagnosis, if known	**List B:** Functional impairment in life domain resulting from mental disorder	**List C:** Probability of deterioration/Risk factors linked to mental disorder	**List D:** SUD
☐ Schizophrenia/Psychotic Disorder ☐ Bipolar Disorder ☐ Depression ☐ Anxiety Disorder ☐ Impulse Control Disorder ☐ Adjustment Disorder ☐ Personality Disorder (except Antisocial Personality Disorder) ☐ Eating Disorder ☐ Pervasive Development Disorder (except Autism) ☐ Disruptive Behavior/Attention Deficit D/O ☐ Feeding and eating, Elimination D/O ☐ Other disorders of infancy, childhood, adolescence ☐ Somatoform disorders ☐ Factitious Disorders ☐ Dissociative Disorders ☐ Paraphilias ☐ Gender Identity Disorder	☐ Independent living skills (e.g. notable difficulties dressing, grooming, cleaning, following parental instructions) ☐ Social relations (current interference that affects current relationships) ☐ Medical Self Care (notable difficulty following medical instructions) ☐ Educational/Vocational/Employment / Meaningful Activity (disruptive behavioral problems with school or other age appropriate activities)	☐ Psychiatric hospitalizations – 2 or more in last 6 months ☐ Suicidal/Violent Behaviors current or in the last 6 months. ☐ Self-injurious behaviors that required medical attention in last 6 months	☐ Alcohol Abuse ☐ Alcohol Dependence ☐ Drug Abuse ☐ Drug Dependence

	Referral Algorithm	
1	Remains in **PCP care/** Therapy only with **Kern Health Systems Contracted Provider**	☐ Diagnosis with none in List B or C
2	Refer to **Kern Health Systems Behavioral Health Utilization Management Department** Fax (661)664-5190	☐ Uncertain diagnosis or diagnosis not in List A ☐ ***Mild – Moderate*** impairment in List B and none in list C
3	Refer to **Kern County Mental Health** for assessment (661) 868-1554	☐ Diagnosis in List A and 1+ ***Significant*** impairment in List B ☐ Diagnosis in List A and 1+ in List C
4	Refer to **Kern County Mental Health Gate Team** Alcohol & Drug Program (661) 868-6453	☐ 1 from list D

Additional Relevant Clinical Information (medications, psychiatric/substance abuse history, trauma history):

_____

_____

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (____) _____

Date communicated assessment outcome with referral source: _____

Kern Health Systems
Kern County Mental Health

October 2014

Adult Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Patient Name: _____ Date of Birth: ___/___/___ ☐ M ☐F

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (____) _____

Caregiver/Guardian: _____ Phone: (____) _____

Documents Included: ☐ **Required consent completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: _____

Primary Care Provider _____ Phone: (____) _____

Referring Provider Name: _____ Phone: (____) _____

Referring/Treating Provider Type ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other _____

List A: Provisional Diagnosis/Diagnosis, if known	**List B:** Functional impairment in life domain below resulting from the mental disorder	**List C:** Probability of deterioration/Risk factors linked to mental disorder	**List D:** Substance Use Disorder
☐ Schizophrenia/Psychotic Disorder ☐ Bipolar Disorder ☐ Depression ☐ Anxiety Disorder ☐ Impulse control Disorder ☐ Adjustment Disorder ☐ Personality Disorder (except Antisocial Personality Disorder) ☐ Eating Disorder ☐ Disruptive Behavior/Attention Deficit D/O ☐ Somatoform Disorders ☐ Factitious Disorders ☐ Dissociative Disorders ☐ Paraphilias ☐ Gender Identity Disorder	☐ Independent living skills (e.g. notable difficulty cooking, cleaning, self-management, Activities of Daily Living, using transportation, residential instability/homelessness in last 30 days) ☐ Social Relations (current interference that affects current relationships) ☐ Medical Self Care (notable difficulty following medical instructions) ☐ Vocational/Employment/Meaningful Activities (disruptive behavior problems with work/education/volunteer performance)	☐ Persistent symptoms & impairments after 2 medication trials ☐ 2 or more psychiatric hospitalizations in the past 12 months ☐ Present LPS (Mental Health) Conservatorship ☐ Suicidal/Violent Behaviors current or in the last 6 months. ☐ Self-injurious behaviors that required medical attention in last 6 months	☐ Failed SBI (screening & brief intervention at primary care ☐ Alcohol Abuse (with failed SBI) ☐ Alcohol Dependence (with failed SBI) ☐ Drug Abuse ☐ Drug Dependence

	Referral Algorithm	
1	Remains in **PCP care/** Therapy only with **Kern Health Systems Contracted Provider**	☐ Diagnosis with none in List B or C
2	Refer to **Kern Health Systems Behavioral Health Utilization Department** Fax (661) 664-5190)	☐ Uncertain diagnosis or diagnosis not in List A ☐ ***Mild – Moderate*** impairment in List B and none in list C
3	Refer to **Kern County Mental Health** for assessment (661) 868-1554	☐ Diagnosis in List A and 1+ ***Significant*** impairment in List B ☐ Diagnosis in List A and 1+ in List C
4	Refer to **Kern County Mental Health Gate Team** Alcohol & Drug Program (661) 868-6453	☐ 1 from list D

Additional Relevant Clinical Information (medications, psychiatric history, substance abuse or trauma history): _____

_____

_____

_____

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (____) _____

Date communicated assessment outcome with referral source: _____

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Palliative Care				POLICY #: 3.77-I	
DEPARTMENT: Utilization Management					
Effective Date: 1/1/2018	Review/Revised Date: 10/02/2019	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Chief Executive Officer — Date 10/2/19

Chief Medical Officer — Date 10/1/19

Senior Director of Health Services — Date 9/11/19

Director of Provider Relations — Date 9/25/19

POLICY:

Policy is to establish standards for the delivery of palliative care as codified in the Welfare and Institutions Code (WIC) Section 14132.75.2. Palliative care does not require the beneficiary to have a life expectancy of six months or less and may be provided concurrently with curative care. A beneficiary with a serious illness who is receiving palliative care may choose to transition to hospice care if he/she meets the hospice eligibility criteria. A beneficiary may not be concurrently enrolled in hospice care and palliative care.

A beneficiary under age 21 years of age may be eligible for palliative care and hospice services concurrently with curative care through other existing programs such as the Section 1915(c) Home and Community Based Services waiver, known as Pediatric Palliative Care waiver, or concurrent care under Section 2302 of the Patient Protection and Affordable Care Act (ACA). Information regarding the concurrent care policy is available in APL 13-014, California Children's Services Numbered Letter 06-1011, and Managed Care Policy Letter 11-004.

DEFINITIONS:

Palliative care consists of patient- and family-centered care that optimizes quality of life by

anticipating, preventing, and treating suffering. The provision of palliative care shall not result in the elimination or reduction of any covered benefits or services under the KHS benefits and State contracts and shall not affect a beneficiary's eligibility to receive any services, including home health services, for which the beneficiary would have been eligible in the absence of receiving palliative care

PROCEDURES:

1.0 ELIGIBILTY CRITERIA

DHCS' minimum eligibility criteria requires a beneficiary to meet all requirements for the general eligibility criteria and at least one of the four disease-specific eligibility requirements.

A. General Eligibility Criteria:

1. The beneficiary is likely to or has started to use the hospital or emergency department as a means to manage his/her advanced disease. This refers to unanticipated decompensation and does not include elective procedures.
2. The beneficiary has an advanced illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. The beneficiary's death within a year would not be unexpected based on clinical status.
4. The beneficiary has either received appropriate patient-desired medical therapy or is a beneficiary for whom patient-desired medical therapy is no longer effective. Patient is not in reversible acute decompensation.
5. The beneficiary and, if applicable, the family/patient-designated support person, agrees to:
    a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
    b. Participate in Advance Care Planning discussions.

B. Disease-Specific Eligibility Criteria:

1. Congestive Heart Failure (CHF): Must meet (a) and (b)
    a. The beneficiary is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; and
    b. The beneficiary has an Ejection Fraction of less than 30 percent for systolic failure or significant co-morbidities.
2. Chronic Obstructive Pulmonary Disease (COPD): Must meet (a) or (b)
    a. The beneficiary has a Forced Expiratory Volume (FEV) 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
    b. The beneficiary has a 24-hour oxygen requirement of greater than or equal to three liters per minute.
3. Advanced Cancer: Must meet (a) and (b)
    a. The beneficiary has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
    b. The beneficiary has a Karnofsky Performance Scale (KPS) score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or

radiation therapy).

4. Liver Disease: Must meet (a) and (b) combined or (c) alone
    a. The beneficiary has evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, and
    b. The beneficiary has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
    c. The beneficiary has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

If a beneficiary continues to meet the above minimum eligibility criteria, he or she may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death. KHS will identify those beneficiaries eligible for palliative care using claims data and predictive modeling tool, which also includes referrals to providers to provide palliative care services. KHS will periodically assess the beneficiary for changes in his/her condition or palliative care needs at a minimum of 6-month intervals. KHS may discontinue palliative care that is no longer medically necessary or reasonable.

2.0 PALLIATIVE CARE SERVICES

Effective no sooner than January 1, 2018, when a beneficiary meets the minimum eligibility criteria for palliative care, KHS will authorize palliative care without regard to age. Palliative care must include, at a minimum, the following seven services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:

1. Advance Care Planning: Advance care planning for beneficiaries enrolled in Medi-Cal palliative care under SB 1004 includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms.

2. Palliative Care Assessment and Consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:
    - Treatment plans, including palliative care and curative care
    - Pain and medicine side effects
    - Emotional and social challenges
    - Spiritual concerns
    - Patient goals
    - Advance directives, including POLST forms
    - Legally recognized decision maker

3. Plan of Care: A plan of care should be developed with the engagement of the beneficiary and/or his or her representative(s) in its design. If a beneficiary already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A beneficiary's plan of care must include all authorized palliative care,

including but not limited to pain and symptom management and curative care. The plan of care must not include services already received through another Medi-Cal funded benefit program.

4. Palliative Care Team: The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of beneficiaries and their families and are able to assist in identifying sources of pain and discomfort of the beneficiary. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members must provide all authorized palliative care. DHCS recommends that the palliative care team includes, but is not limited to the following team members:
   - Doctor of medicine or osteopathy (Primary Care Provider if MD or DO),
   - Registered nurse,
   - Licensed vocational nurse or nurse practitioner (Primary Care Provider if NP),
   - Social worker, and
   - Chaplain. (Chaplain Services provided as palliative care are not reimbursable through the Medi-Cal program).

5. Care Coordination: A member of the palliative care team should provide coordination of care, ensure continuous assessment of the beneficiary's needs, and implement the plan of care.

6. Pain and Symptom Management: Adequate pain and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address beneficiary pain and other symptoms. The beneficiary's plan of care must include all services authorized for pain and symptom management.

7. Mental Health and Medical Social Services: Counseling and social services must be available to the beneficiary to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to: psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate. Provision of medical social services shall not duplicate specialty mental health services (SMHS) provided by county Mental Health Plans (MHPs) and does not change the KHS's responsibilities for referring to, and coordinating with, county MHPs as delineated in APL 13-021.

KHS will determine the type of palliative care that is medically necessary or reasonable for eligible beneficiaries. KHS will ensure a sufficient network of palliative care providers to meet the needs of their beneficiaries. *Refer to Policy 4.30 Access Standards for specialty appointments.*

Pediatric Palliative Care Waiver Transitions

DHCS' Pediatric Palliative Care (PPC) Waiver Program ended on December 31, 2018. Most services previously covered under the waiver are covered under EPSDT. For those individuals currently enrolled in KHS or transitioning from Medi-Cal FFS, KHS will provide continuity of care to out-of-network providers who provided Medi-Cal-covered PPC Waiver Program services to the member for services that are also covered by Medi-Cal under EPSDT. KHS is not required to provide continuity of care for services that were exclusive to the PPC Waiver Program and that are not also covered by Medi-Cal under EPSDT. 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 provider in accordance with the requirements in APL 18-008.

Furthermore, KHS may authorize additional palliative care that is not described above, at the KHS's discretion and cost. An example of an additional service that is offered by many community-based palliative care programs is a telephonic palliative care support line, separate from a routine advice line that is available twenty-four hours a day, seven days a week.

3.0 PROVIDERS

KHS may authorize palliative care to be provided in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based settings. KHS must utilize qualified providers for palliative care based on the setting and needs of a beneficiary so long as the KHS ensures that its providers comply with existing Medi-Cal contracts and/or APLs policy. DHCS recommends that KHS use providers with current palliative care training and/or certification to conduct palliative care consultations or assessments.

KHS may contract with hospitals, long-term care facilities, clinics, hospice agencies6, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care. KHS may contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. Palliative care provided in a beneficiary's home must comply with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans. KHS will inform and educate providers regarding availability of the palliative care benefit through the following:

- Provider bulletin
- Provider portal

4.0 POLICIES AND PROCEDURES

The written Policy and Procedures for palliative care describes KHS's policy to meet the requirements for the palliative care benefit as indicated within APL 17-015, including how KHS will monitor and collect palliative care enrollment, provider, and utilization data to report to DHCS as specified.

A. Disputes

Kern Health Systems (KHS) has established and maintains a fast, fair, and cost-effective appeals and dispute resolution mechanism to process and resolve Provider appeals/disputes. Contracting providers shall have the opportunity to appeal/dispute authorizations that have been denied or modified.

Appeals/Disputes submitted on behalf of an enrollee or a group of enrollees will be processed according to *KHS Policy and Procedure #5.01-P – Grievance Process and 3.23 Prior Authorization Provider Appeals/Disputes.* Disputes regarding claims payment will be processed according to *KHS Policy and Procedure #6.04 – Practitioner/Provider Disputes Regarding Claims Payment.* Disputes regarding all other issues will be processed according to *KHS Policy and Procedure #4.03 – Practitioner/Provider Disputes Regarding Issues Other*

than Authorization and Claims Payment.

B. Monitoring

Letters regarding authorization requests, including those sent by KHS to both members and providers, are retained as outlined in KHS Policy and Procedure #10.51-I: Records Retention.

KHS tracks all referral requests through the KHS computerized MIS system. Requests are entered into the system at the time of authorization. Members who have been enrolled into the Palliative program will be assessed at a minimum of every 6 months and will be re-determined for eligibility based on the medical documentation and recommendations from the Interdisciplinary Palliative Care Team. The UM Department maintains adequate staffing to manage referrals in a timely manner.

KHS will conduct random audits quarterly for purposes of compliance with the referral process and identifying any correspondence issues. Issues will be brought to the attention of the Administrative Director of Health Services for corrective action.

It is the PCPs responsibility to track referrals and follow-up care. To assist in this effort, KHS provides the PCP with access to view all submitted referrals through an online provider portal. Providers/vendors are able to monitor the referrals received, closed and decision dates. The PCP should investigate all open authorizations and follow up with the member as necessary. PCP follow-up and documentation is monitored by the Quality Improvement Department through facility site review.

5.0 DELEGATION OVERSIGHT

KHS will ensure that contracted delegates comply with all applicable state and federal law and regulations and other contractual requirements as well as DHCS guidance, including APLs and Dual Plan Letters. KHS will revise and update the Division of Financial Responsibility (DOFR) as necessary based on DHCS requirements. DHCS' readiness review process includes a review of KHS's delegation oversight. KHS will receive prior approval from DHCS for each delegate.

Revisions 08/2019: Language added to comply with APL 18-008 regarding Pediatric Palliative Care. **Policy Created**: 11/07/18 APL 17-015

20xx DHS Contract A-x(x)
20xx DHS Contract A-x(x)

2019 Health Education and Cultural and Linguistic Work Plan Evaluation

	Goals	Objectives	Activities	Timeline	Results
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. Language access taglines posted in the member newsletter issues and messages on IVR, member portal, KHS social media pages were posted. 2. Information on free interpreting services in community presentations and health education workshops continue to be included. 3. Brochures and posters to provider offices on how to access KHS intepreting services continue to be provided. 4. Annual provider bulletin to provider portal on C&L services posted in July. 5.Provider in-services on process for requesting interpreters and how to effectively communicate with LEP members completed with 6 sites. 6. Contract for VRI services with LLS continues to be maintained.	12/31/2019	Objectives Met
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 continue to be shared. 2. 3 Question"Ask Your Doctor" questions were included in the members newsletters. 3. Educational tools for members to communicate health needs with PCP are included as part of the HE classes.	12/31/2019	Objectives Met

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 IVR, KHS social media pages, and newsletter were posted. 2. The HE team participated in community health fairs to share brochures and benefit information with members.. 3. Information on appropriate use of services are included in the HE classes as part of the handouts or presentation. 4. Self care information continues to be shared with members via the members newsletter, audio health library and KHS website. 5. Brochures on "Is it an Emergency" continue to be shared with provider offices.	12/31/2019	Objectives Met

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 member incentives posted in July and Sept. 2. Refresher staff training on service promotion completed with HE team 3. Copies of health education workshop flyer to provider offices and community events/meetings continue to be distributed. 4. Message to members on IVR, KHS social media pages, and newsletter continue to be posted. 5. Met with PR, MS and QI on promotion of KHS workshops. 6. Follow up and evaluation of nutrition and asthma workshops was completed. 7. Continued Public Health Internship partnership with Bakersfield College. 8. New site locations for health education classes at new KHS building, Standard School District, Wallace Elementary, Williams Elementary, and Terrace Elementary.	12/31/2019	Objectives Met

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. Calendar of social media postings was created and validated. 2. Health education classes continue to be held in 93308 , 93307 and 93306 areas. 3. Members can sign up for health education class topics and staff will reach out by phone to register the member. New KHS website launched and includes calendar of HE classes. Membe portal enhancements were not implemented. 4. Self care information made available through members newsletter, KHS website and audio health library. 5. We continue to research availability of high demand health education material in non-threshold languages. 6. Provider bulletins on new asthma guidelines posted in December. Postcards on accessing tobacco cessation aids provided by CA Smokers Helpline continue to be distributed in the comnunity. Asthma class promotion in Summer member newsletter.	12/31/2019	Objectives Met

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.Health education material continues to be reviewed every 3 years for content updates. 2. Research continues to be performed to identify additional health education material produced by vendors that is easy to read. 3. Health literacy training provided to key Marketing and Member Engagement staff in March. 4. Participated in Health Literacy conference in May and webinar in October.	12/31/2019	Objectives Met

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. Continued to partner with schools and districts to provide health education workshops that address asthma, obesity and other chronic conditions. 2. Implemented 2nd cycle of School Wellness Grant program. 6 sites were awarded funding. 3. Provide letters of support to Tobacco Free Kern Coalition, onesie donations to Black Infant Help and staff participation in Asthma Summit, Asthma Camp. 4. Continued to participate in webinars, conferences, events and meetings that help address PSE factors of health. 5. Met with MLK Park and Pocket Park representatives on hosting HE classes at the site. Classes will be held once dates and times have been secured and have gone through approval process.	12/31/2019	Objectives Met

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. Continued to participate in community meetings and events that address the needs of SPD members. 2. Continued to share new programs and resources with SPD members, as available. 3.Continued to collaborate with Case and Disease Management Departments and community partners on the development of member newsletter articles. 4. Continued to provide health education and promotion messages to SPD members through the member newsletter, IVR, member portal, and KHS social media sites. 5. Continued to update the KHS community resource list, as needed. 6. Continued to participate in media opportunities to promote health education programs. 7. Continued to promote health education programs on KHS social media sites and website.	12/31/2019	Objectives Met

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.Partnered with schools, retail stores, parks, grocery stores and other CBOs to promote pregnancy education, services and incentive programs. 2. Continued to meet with staff on performing outreach calls to the perinatal population. Began referring members to BHCM for further maternal mental health screening. 3.Submitted pregnancy incentive annual evaluation tp DHCS with change to pospartum incentive timeframe to align with MCAS. 4. Participate in Pregnancy Engagement Project and viewed pregnancy demonstration solutions for case management and education via text message, mobile application, IVR and live agent.	12/31/2019	Objectives Met

2020 Health Education and Cultural and Linguistic Work Plan

	Goals	Objectives	Activities	Timeline	Responsible Department(s)
1	Increase promotion of access to free interpreting services among members and providers.	A. Implement at least one new communication method to promote interpreting services. B. Meet with at least 4 new provider offices to educate on how to access KHS interpreting services and effectively communicate with LEP members. C. Establish a process for requesting use of video remote interpreting services at provider office.	1. Research and identify other communication modes to promote access to interpreting services. 2. Continue to distribute brochures and posters to provider offices on how to access KHS interpreting services. 3. Post provider bulletins to provider portal on C&L services. 4. Coordinate with PR/QI to conduct provider in-services on process for requesting interpreters and how to effectively communicate with LEP members. 5. Create process for accessing video remote interpreting services. 6. Research additional interpreting vendors that serve Kern County. 7. Perform staff refresher in-service on C&L services	12/31/2020	Health Education Member Services Provider Relations Marketing Quality Improvement Case & Disease Management
2	Increase member participation in KHS health education services.	A. 3% increase in member awareness of health education classes B.3% increase in member interest in health education services C. 10% increase in attendance rate D. Identify at least one agency to contract for health education services.	1. Provider bulletin reminder on health education services and incentives. 2. Conduct refresher staff training on service promotion 3. Provide copies of health education class flyer to provider offices and community events/meetings. 4. Message to members on portal, IVR, KHS social media pages, and newsletter. 5. Meet with key department heads on promotion of KHS classes. 6. Evaluate success of member incentive programs. 7. Leverage school wellness grant sites as potential class locations. 8. Research agencies interested in contracting for health education services. 9. Work with the local mass media to increase awareness about KFHC health education services and programs. 10. Coordinate with PR/QI to conduct provider in-services on promotion of HE classes.	12/31/2020	Health Education Member Services Provider Relations Marketing Quality Improvement Case & Disease Management
3	Increase tobacco cessation promotion and education among members.	A. 5% increase in referrals for tobacco cessation. B. Leverage all member communication channels for tobacco education.	1. Participate in community meetings, events and media opportunities on tobacco cessation. 2. Research evidence-based incentive programs around tobacco cessation 3.Annual mailing on tobacco cessation. 4. Provide health education and promotion messages on tobacco cessation through the member newsletter, IVR, member portal, community events, and KHS social media sites. 5. Work with the QI department on monitoring tobacco users and counseling at the provider level. 6. Provider bulletin on recommended web-based trainings.	12/31/2020	Health Education Member Services Provider Relations Marketing Quality Improvement Case & Disease Management
4	Increase asthma management education among members and improve asthma outcomes.	A. 5% increase in asthma class attendance rates. B. Enroll 40 members in the Asthma Impact Model with at least 50% participation at the end of the pilot program. C. Leverage all member communication channels for asthma education. D.Evaluate the asthma education and training needs of KHS contracted providers	1. Participate in community meetings, events and media opportunities on asthma. 2. Continue to host asthma education services in the community. 3.Evaluate and modify asthma class incentive program. 4.Monitor and support efforts of the Asthma Impact Model program. 5. Provide health education and promotion messages on asthma through the member newsletter, IVR, member portal, community events, and KHS social media sites. 6. Work with the QI/PR departments on other asthma management education initiatives at the member and provider level. 7. Encourage schools to apply for KFHC grants to address student asthma management.	12/31/2020	Health Education Member Services Provider Relations Marketing Quality Improvement Case & Disease Management

5	Increase member outreach and engagement in the Perinatal Management and Engagement Program	A. 5% increase in member awareness of incentive programs. B. At least 10% of pregnant members will have signed up for Text 4 Baby C. 1% increase in members identified as compliant with prenatal care visits. D. Implement postpartum incentive programs that align with new MCAS meaures	1.Educate and inform members on perinatal care and available incentive programs through social media channels, mail, phone, and community outreach. 2. Continue to train outreach staff to include talking points on pregnancy care and incentives. 3.Mail out pregnancy and postpartum healthcare guides. 4. Implement member surveys. 5. Post bulletins on the provider portal to reminder provider network on available incentive programs and services to support pregnant members. 6. Revise postpartum incentive programs to align with new MCAS measures 7. Screen & refer members who participate in outreach calls for maternal mental health KHS BHCM. 8. Encourage member participation in Text4Baby.	12/31/2020	Health Education Member Services Provider Relations Marketing Quality Improvement Case & Disease Management
6	Encourage members to be more active participants in their health care through member rewards programs	A. Evaluate the effectiveness and impact of all member incentives programs B. Create a plan-wide member rewards strategy plan.	1. Create inventory of all current member incentive programs. 2.Meet with key department stakeholders that engage with members and providers. 3. Identify potential member rewards vendors. 4. Obtain member feedback through surveys, focus groups or key informant interviews. 5. Identify targeted member groups and health actions to be impacted.	12/31/2020	Health Education Member Services Provider Relations Marketing Quality Improvement Case & Disease Management
7	Complete the DHCS Population Needs Assessment	A. Identify member health needs and health disparities B. Evaluate health education, C&L and QI activities and available resources to address identified concerns C. Implement targeted strategies for health education, C&L and QI programs and services.	1. Collect and analyze required and recommended data sources for KHS, Kern County and California. 2. Create PNA Report and Action Plan. 3. Submit PNA Report and Action Plan to DHCS for approval by 6/30/2020. 4. Share PNA Report findings and action plan with KHS management, CAC and providers.	12/31/2020	Health Education Member Services Provider Relations Marketing Quality Improvement Case & Disease Management

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Fourth Quarter 2019

Report Date: January 6, 2020

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.

- Member Incentive Program Changes
- Health Education Class Curriculum Changes
- Spring 2020 Member Newsletter

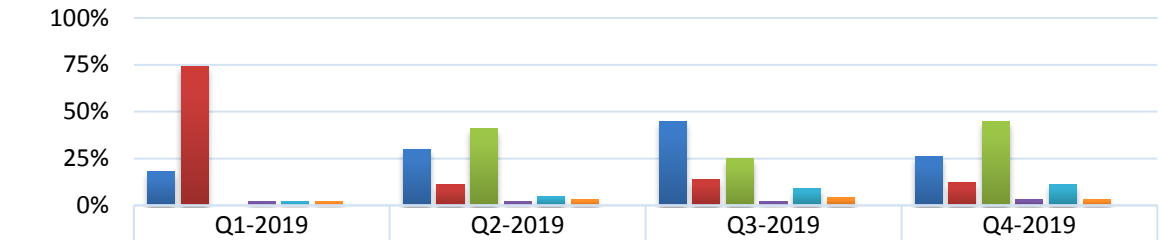
The following pages reflect statistical measurements for the Health Education department detailing the ongoing activity for the 4th quarter 2019.

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

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Fourth Quarter 2019

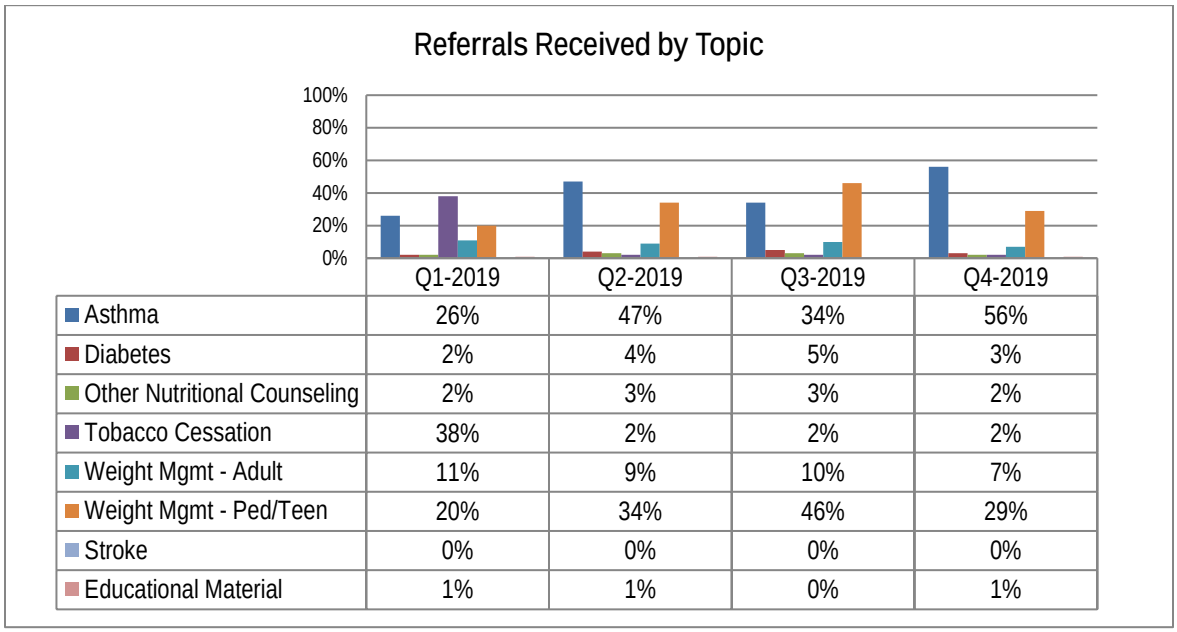
REFERRALS FOR HEALTH EDUCATION SERVICES

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), Member Services (MS), and Member Portal. 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 Member Services.



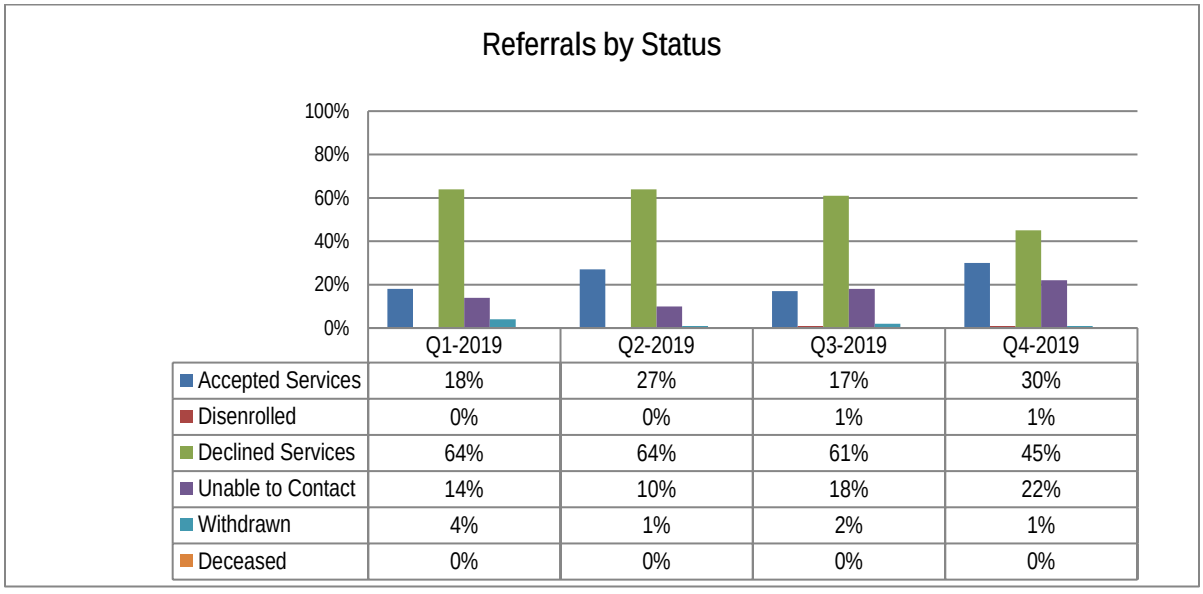
	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Provider	18%	30%	45%	26%
Member	74%	11%	14%	12%
HE	0%	41%	25%	45%
DM	2%	2%	2%	3%
UM	2%	5%	9%	11%
CM	2%	3%	4%	3%
MS	0%	0%	0%	0%

During this quarter, 825 referrals were received which is a 3% decrease in comparison to the previous quarter.



	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Asthma	26%	47%	34%	56%
Diabetes	2%	4%	5%	3%
Other Nutritional Counseling	2%	3%	3%	2%
Tobacco Cessation	38%	2%	2%	2%
Weight Mgmt - Adult	11%	9%	10%	7%
Weight Mgmt - Ped/Teen	20%	34%	46%	29%
Stroke	0%	0%	0%	0%
Educational Material	1%	1%	0%	1%

The HE department receives referrals for various health conditions. This quarter, referrals for asthma education were still significantly higher than the prior quarter due to targeted outreach calls performed by the HE department.



	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Accepted Services	18%	27%	17%	30%
Disenrolled	0%	0%	1%	1%
Declined Services	64%	64%	61%	45%
Unable to Contact	14%	10%	18%	22%
Withdrawn	4%	1%	2%	1%
Deceased	0%	0%	0%	0%

The rate of members who accepted to receive health education services increased from 17% in the 3rd quarter to 30% in the 4th quarter of 2019

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
  - Intro to Gardening
  - Rethink Your Drink
  - Funxercise
  - Healthy Cooking
- Breathe Well Asthma Workshop

Bakersfield Memorial Hospital (BMH):

- Diabetes Management Classes (English only)
- Heart Healthy Classes
- Individual Nutrition Counseling

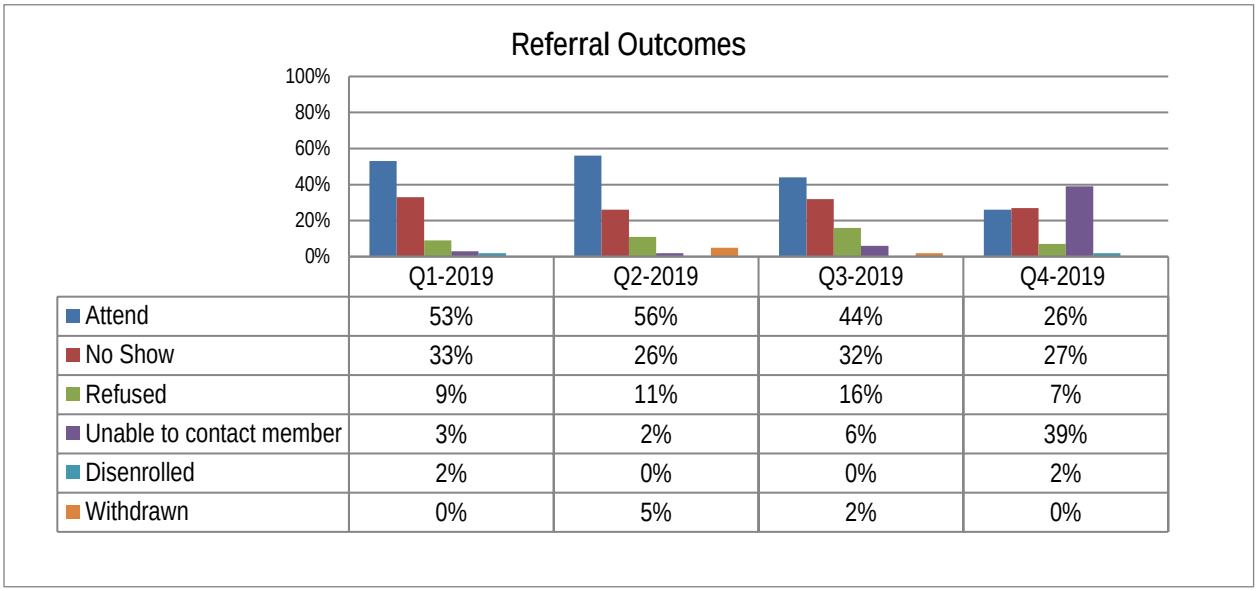
Clinica Sierra Vista (CSV) WIC:

- Diabetes Management Classes
- Heart Healthy Classes

California Smokers' Helpline (CSH):

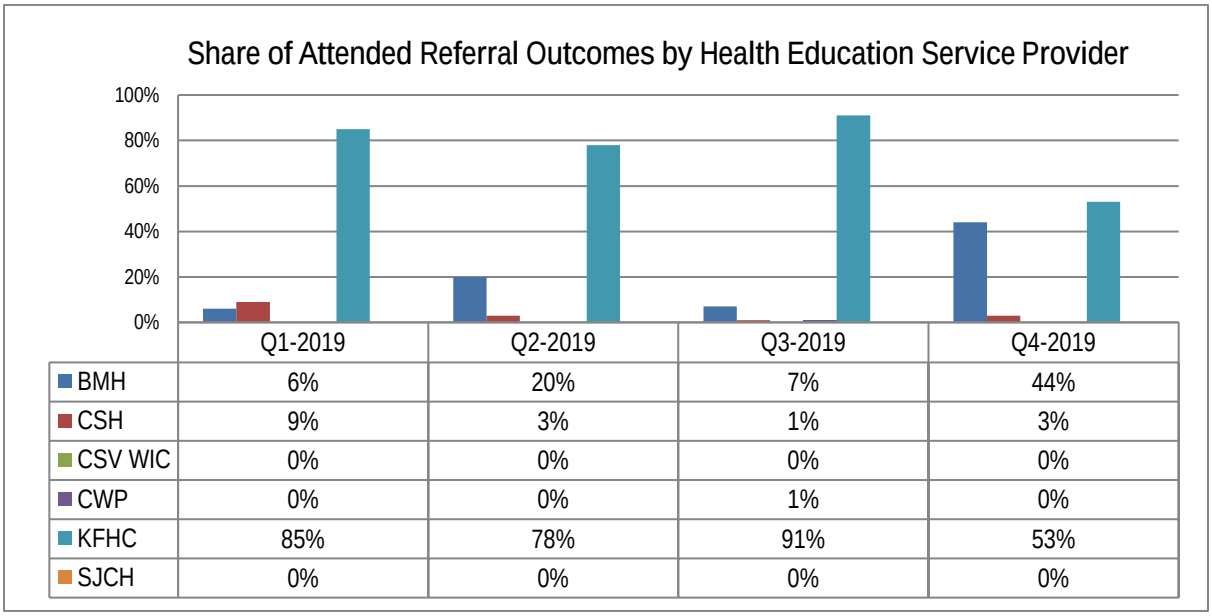
- Telephone Smoking Cessation Counseling

REFERRAL OUTCOMES



	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Attend	53%	56%	44%	26%
No Show	33%	26%	32%	27%
Refused	9%	11%	16%	7%
Unable to contact member	3%	2%	6%	39%
Disenrolled	2%	0%	0%	2%
Withdrawn	0%	5%	2%	0%

During this quarter, the rate of members who received health education services out of all members who accepted services decreased from 44% to 26%.

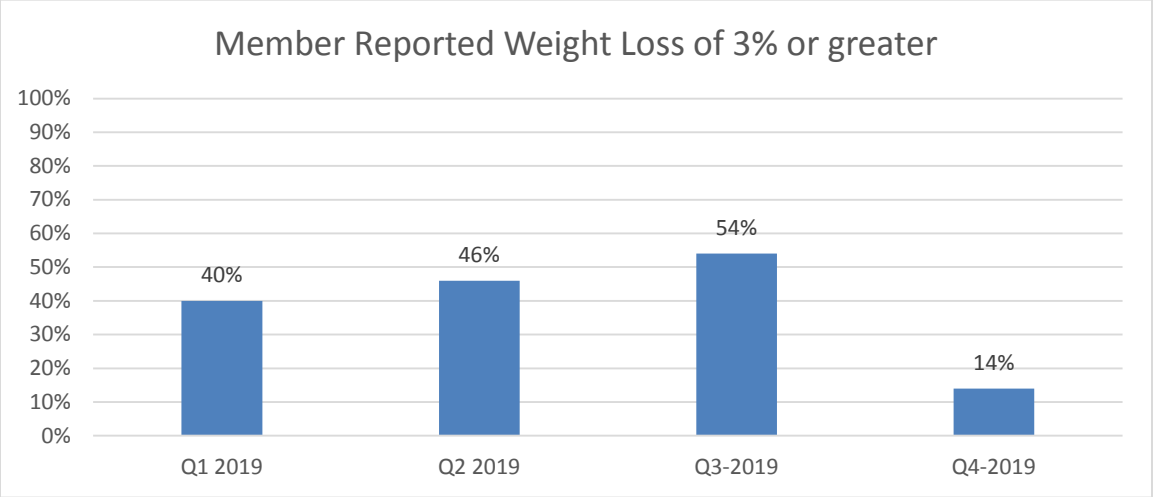


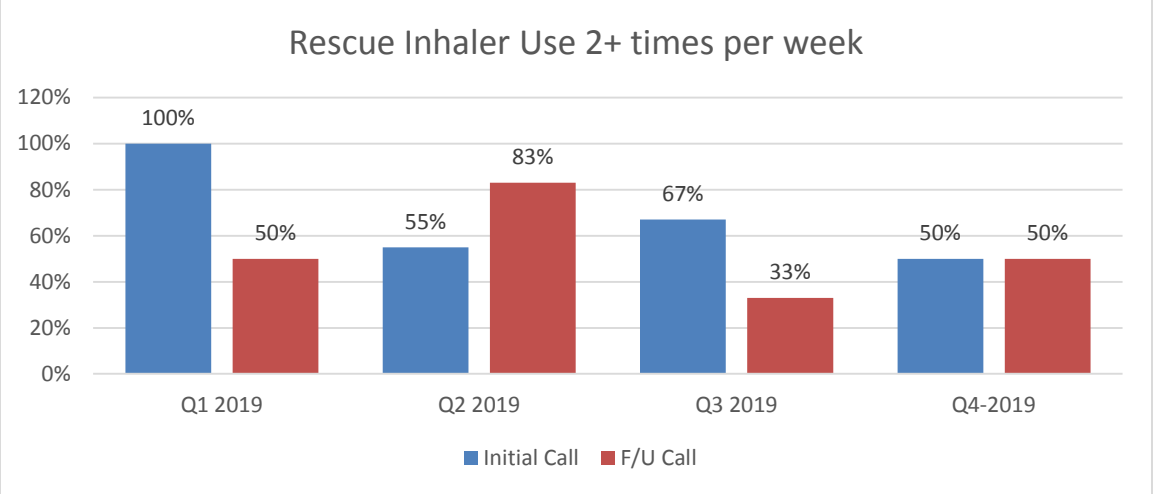
	Q1-2019	Q2-2019	Q3-2019	Q4-2019
BMH	6%	20%	7%	44%
CSH	9%	3%	1%	3%
CSV WIC	0%	0%	0%	0%
CWP	0%	0%	1%	0%
KFHC	85%	78%	91%	53%
SJCH	0%	0%	0%	0%

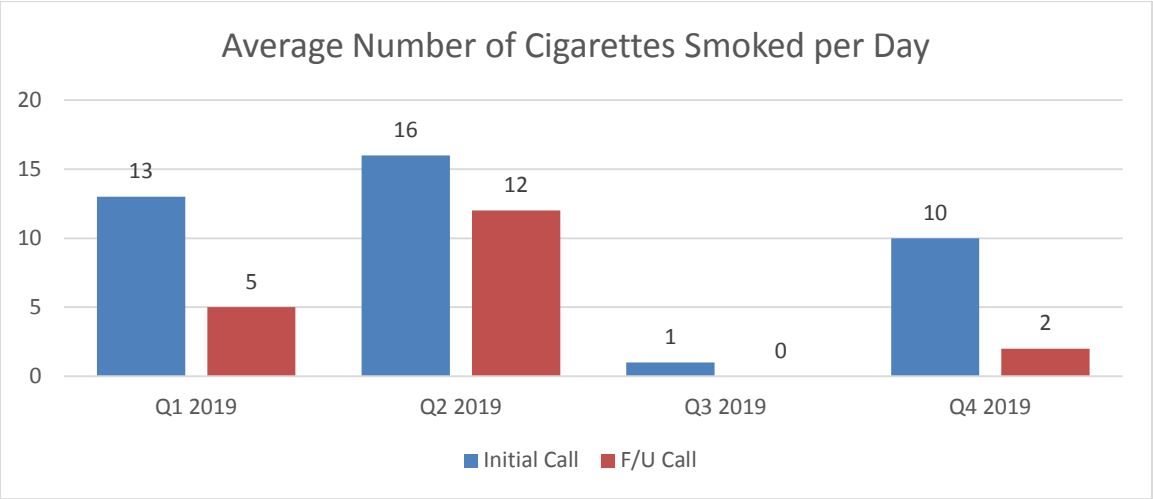
Services through KFHC demonstrates to be the largest share of referral outcomes. This quarter KFHC showed a decrease from 91% in the 3rd quarter to 53% in the 4th quarter of 2019.

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. Of the 19 members who participated in the 3 month follow up call, 13 received weight management education, 1 received tobacco cessation education and 5 received asthma management education. All findings are based on self-reported data from the member.

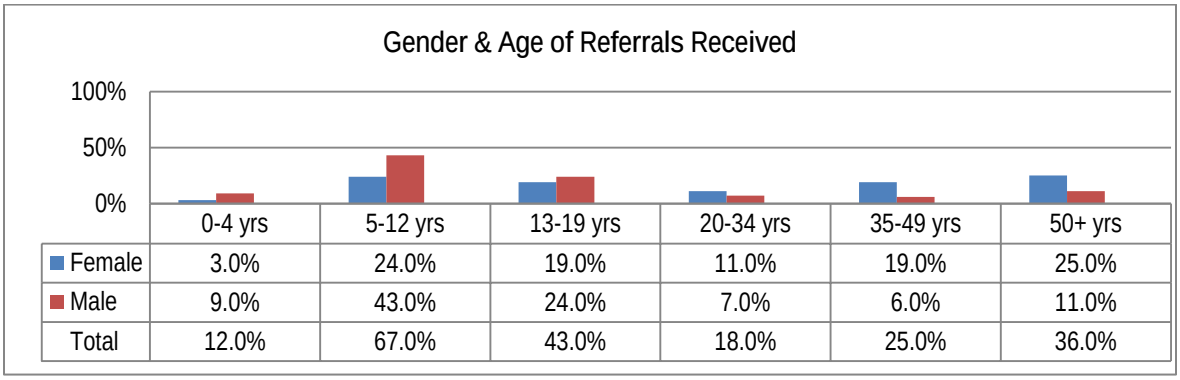






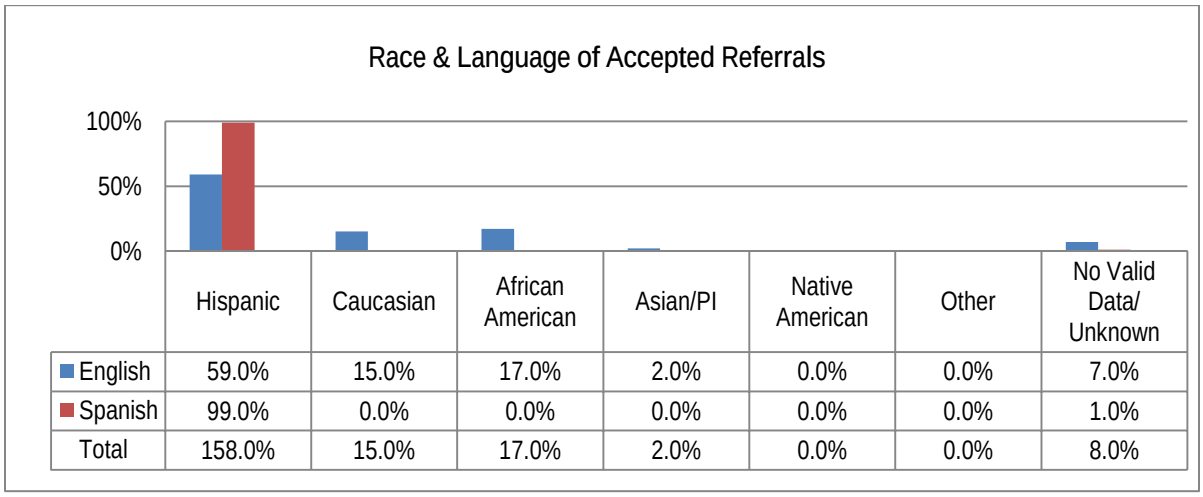
Demographics of Members

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%	24.0%	19.0%	11.0%	19.0%	25.0%
Male	9.0%	43.0%	24.0%	7.0%	6.0%	11.0%
Total	12.0%	67.0%	43.0%	18.0%	25.0%	36.0%

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 50+ years.



	Hispanic	Caucasian	African American	Asian/PI	Native American	Other	No Valid Data/ Unknown
English	59.0%	15.0%	17.0%	2.0%	0.0%	0.0%	7.0%
Spanish	99.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%
Total	158.0%	15.0%	17.0%	2.0%	0.0%	0.0%	8.0%

A breakdown of member classifications by race and language preferences revealed that 99% of members who accepted services are Hispanic and the majority preferred to speak Spanish.

Referrals Accepted by Top Bakersfield Zip Codes			
Q1-2019	**Q2-2019**	**Q3-2019**	**Q4-2019**
93307	93307	93307	93307
93306	93306	93304	93306
93304	93305	93306	93304
93308	93304	93305	93305
93305	93308	93309	93308

KHS serves members in the Kern County area. During this quarter, 88% 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			
Q1-2019	**Q2-2019**	**Q3-2019**	**Q4-2019**
Delano	Delano	Arvin	Arvin
Arvin	Wasco	Delano	Delano
Lamont	Lamont	Shafter	Shafter
Wasco	McFarland	Wasco	Lamont
Shafter	Shafter	Lamont	Wasco
	Arvin		

Additionally, 12% of the members who accepted services reside in the outlying areas of Kern County and the highest concentration of members reside 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 1,064 educational packets to members on the following health topics:

Educational Mailings

	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Anemia	1	1	2	0
Asthma	453	427	648	459
High Cholesterol	23	11	11	4
Diabetes	56	53	45	30
Gestational Diabetes	0	5	1	1
High Blood Pressure	29	4	4	4
COPD	0	0	0	1
Postpartum Care	46	4716	602	263
Prenatal Care	56	145	283	23
Smoking Cessation	252	13	12	15
Weight Management	713	173	370	223
WIC	821	64	157	41
Total	**2,450**	**1,367**	**2,137**	**1,064**

INTERPRETER REQUESTS

Face-to-Face Interpreter Requests

During this quarter, there were 281 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

Q1-2019	Q2-2019	Q3-2019	Q4-2019
Spanish	Spanish	Spanish	Spanish
Vietnamese	Cantonese	Punjabi	Punjabi
Arabic	Punjabi	Arabic	Mandarin
Cantonese	English	Cantonese	Arabic
Punjabi	Arabic	Mandarin	Cantonese
Mandarin			Vietnamese

Telephonic Interpreter Requests

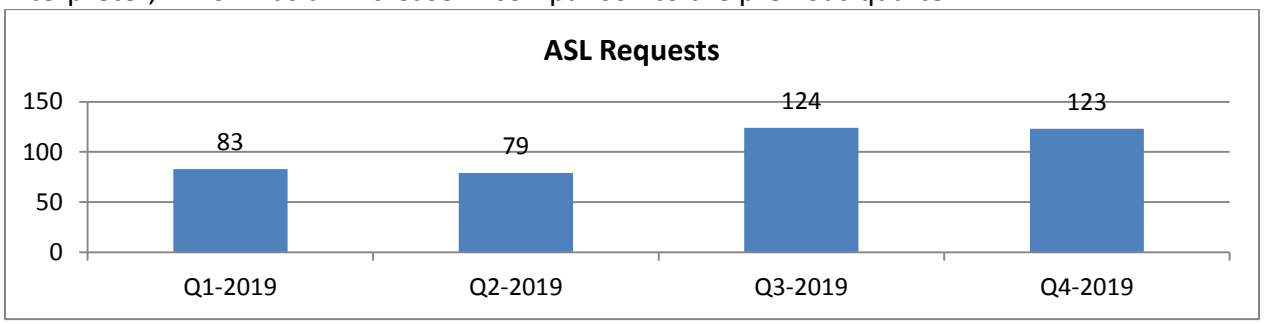
During this quarter, there were 780 requests for telephonic interpreting services through KHS' interpreting vendor, Language Line Solutions. The majority of these requests were for a Spanish interpreter.

Top Languages Requested

Q1-2019	Q2-2019	Q3-2019	Q4-2019
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Arabic	Arabic	Arabic	Arabic
Tagalog	Tagalog	Mandarin	Tagalog
Vietnamese	Mandarin	Tagalog	Vietnamese

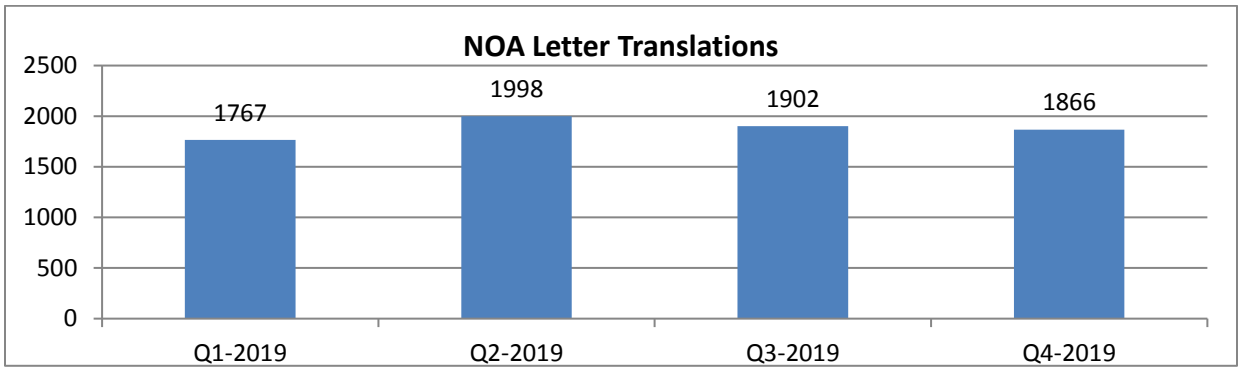
American Sign Language (ASL) Requests

During this quarter, there were a total of 123 requests received for an American Sign Language interpreter, which was an increase in comparison to the previous quarter.



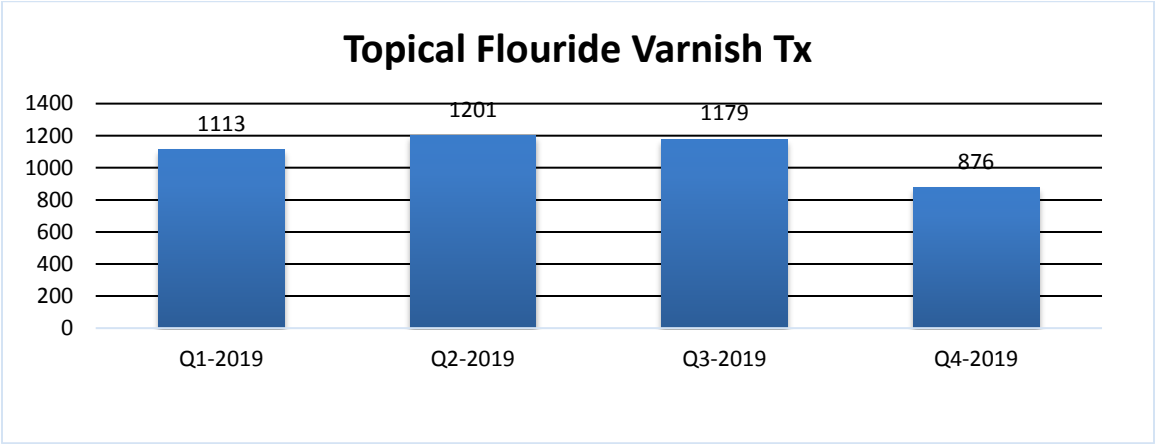
DOCUMENT TRANSLATIONS

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, 1,866 Notice of Action letters were translated into Spanish for the UM and Pharmacy departments.



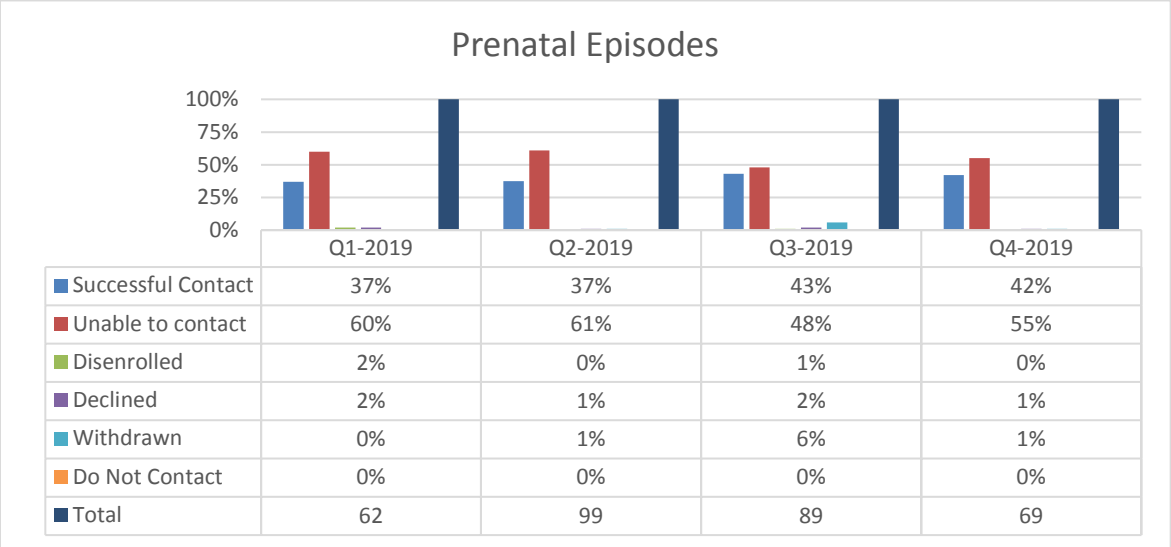
TOPICAL FLUORIDE VARNISH TREATMENTS

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.



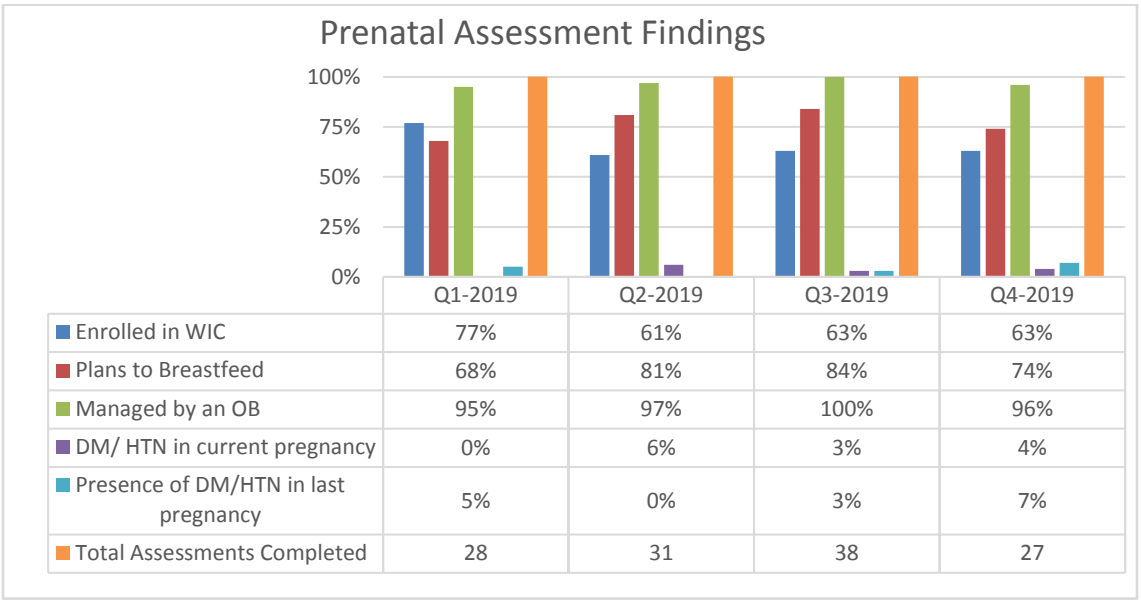
PERINATAL OUTREACH AND EDUCATION

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.



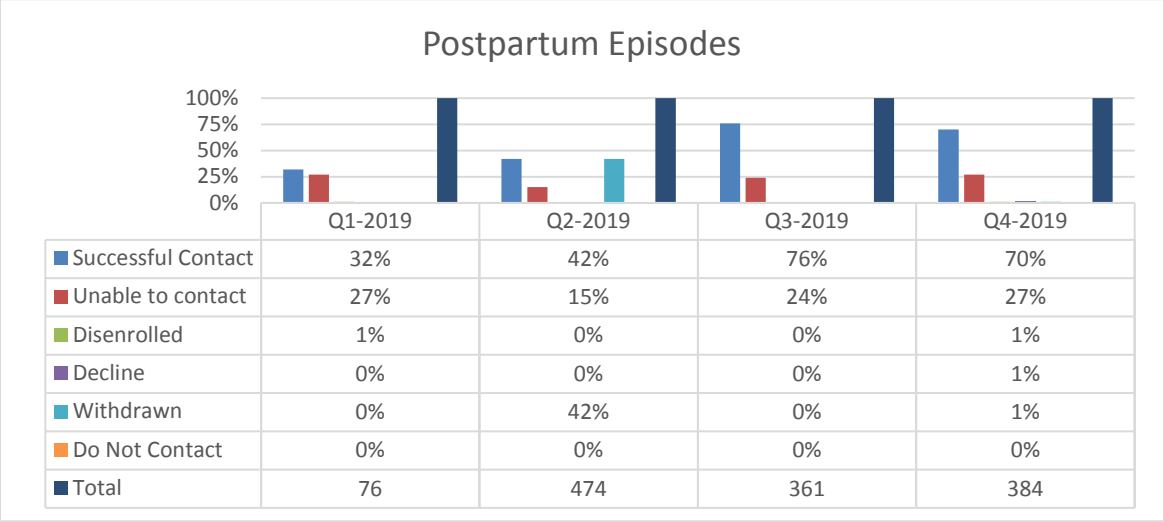
	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Successful Contact	37%	37%	43%	42%
Unable to contact	60%	61%	48%	55%
Disenrolled	2%	0%	1%	0%
Declined	2%	1%	2%	1%
Withdrawn	0%	1%	6%	1%
Do Not Contact	0%	0%	0%	0%
Total	62	99	89	69

During the 4th quarter, 68 episodes for pregnant members were created and 42% were successfully contacted.



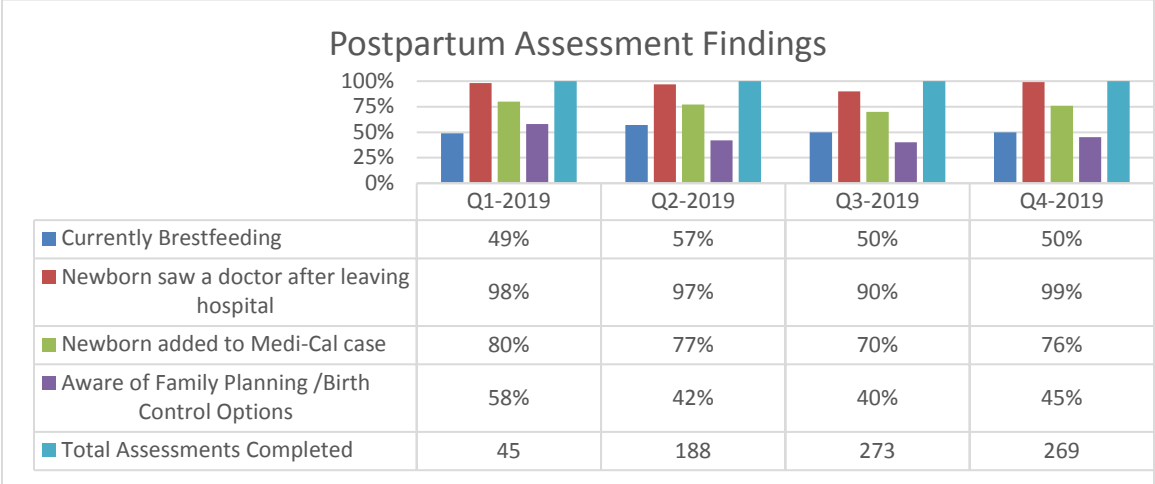
	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Enrolled in WIC	77%	61%	63%	63%
Plans to Breastfeed	68%	81%	84%	74%
Managed by an OB	95%	97%	100%	96%
DM/ HTN in current pregnancy	0%	6%	3%	4%
Presence of DM/HTN in last pregnancy	5%	0%	3%	7%
Total Assessments Completed	28	31	38	27

The total prenatal assessments completed decreased from 38% in the 3rd quarter of 2019 to 27% in the 4th quarter of 2019.



	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Successful Contact	32%	42%	76%	70%
Unable to contact	27%	15%	24%	27%
Disenrolled	1%	0%	0%	1%
Decline	0%	0%	0%	1%
Withdrawn	0%	42%	0%	1%
Do Not Contact	0%	0%	0%	0%
Total	76	474	361	384

During the 4th quarter, 365 postpartum members were created and 70% were successfully contacted.



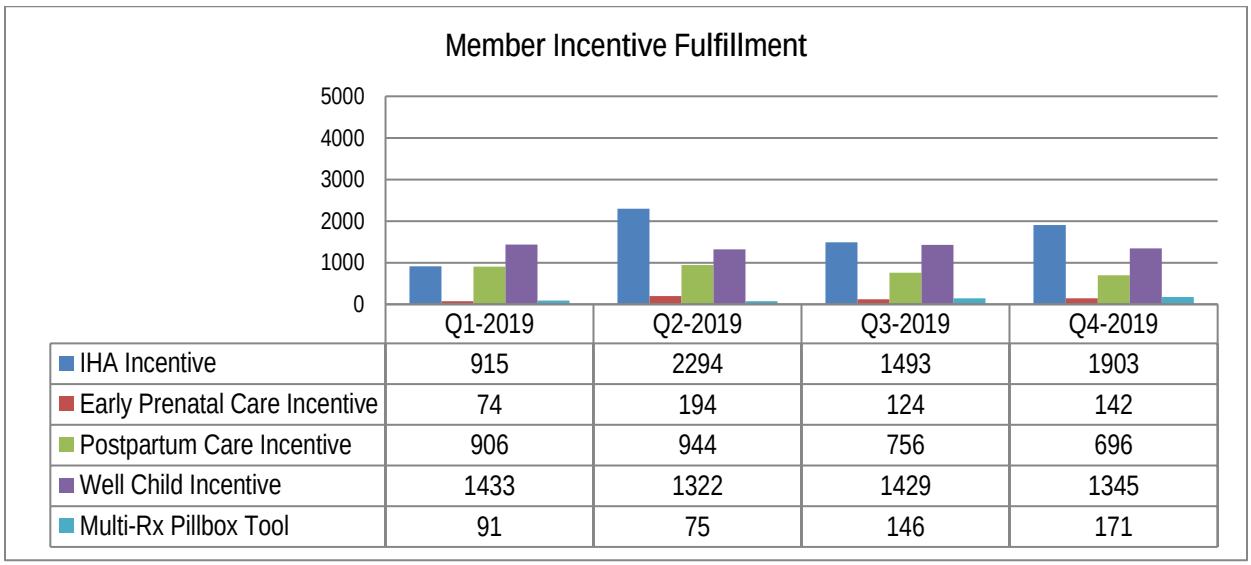
	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Currently Brestfeeding	49%	57%	50%	50%
Newborn saw a doctor after leaving hospital	98%	97%	90%	99%
Newborn added to Medi-Cal case	80%	77%	70%	76%
Aware of Family Planning /Birth Control Options	58%	42%	40%	45%
Total Assessments Completed	45	188	273	269

Postpartum assessments completed decreased from 273 assessments in the 3rd quarter of 2019 to 269 assessment completed in the 4th quarter of 2019.

MEMBER WELLNESS BASED INCENTIVES AND CHRONIC CONDITION TOOLS

During the 4th quarter of 2019, KHS continued to offer wellness based incentives and one chronic condition tools for members. In January 2019, the IHA incentive was changed to a gift card instead of a first aid kit based on member feedback regarding the incentive. This incentive program was also expanded to provide one incentive per eligible member instead of per household.

- **Initial Health Assessment (IHA)** – newly enrolled members who complete the IHA visit within 120 days of enrollment are mailed a $10 gift card.
- **Early Prenatal Care** – pregnant members who complete prenatal care during the 1st trimester will receive a $30 gift card.
- **Postpartum Care** – members who complete the postpartum visit within 21-56 days following delivery will receive an additional $30 gift card.
- **Well Child** – members ages 12 -23 months who complete a well child visit are mailed a $25 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 tool to members.



	Q1-2019	Q2-2019	Q3-2019	Q4-2019
IHA Incentive	915	2294	1493	1903
Early Prenatal Care Incentive	74	194	124	142
Postpartum Care Incentive	906	944	756	696
Well Child Incentive	1433	1322	1429	1345
Multi-Rx Pillbox Tool	91	75	146	171

Health Services Quarterly Committee Reporting- Reporting Period October1, 2019 to December 31, 2019

Health Services Overview

The 2019 membership enrollment remained stable at 255,000 in Q4 2019. Additional benefit coverage and broadening interdisciplinary collaboration to support the membership growth will continue through 2020.

- MCAL Healthier California for All (aka CalAIM)
  - Long Term Care
  - Transplants
  - Population Health
  - Pharmacy Carve Out to State MCAL Fee for Service
- Homebound program
- MCAS 2020
- P4P

The following pages reflect statistical measurements for Utilization Management, Case Management and Disease Management detailing the ongoing compliance activity for the 4th Quarter 2019.

Respectfully submitted,

Deborah Murr RN, BS-HCM
Chief Health Services Officer
Kern Health System

Utilization Management Reporting

Timeliness of Decision Trending

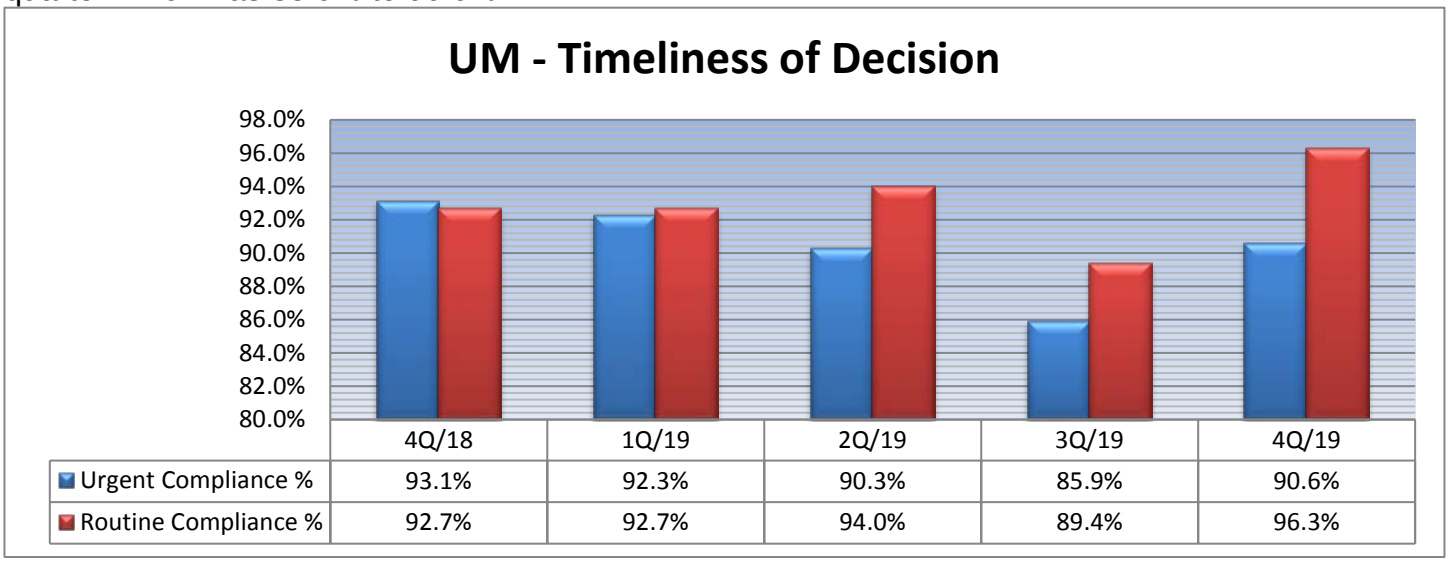
Summary:
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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

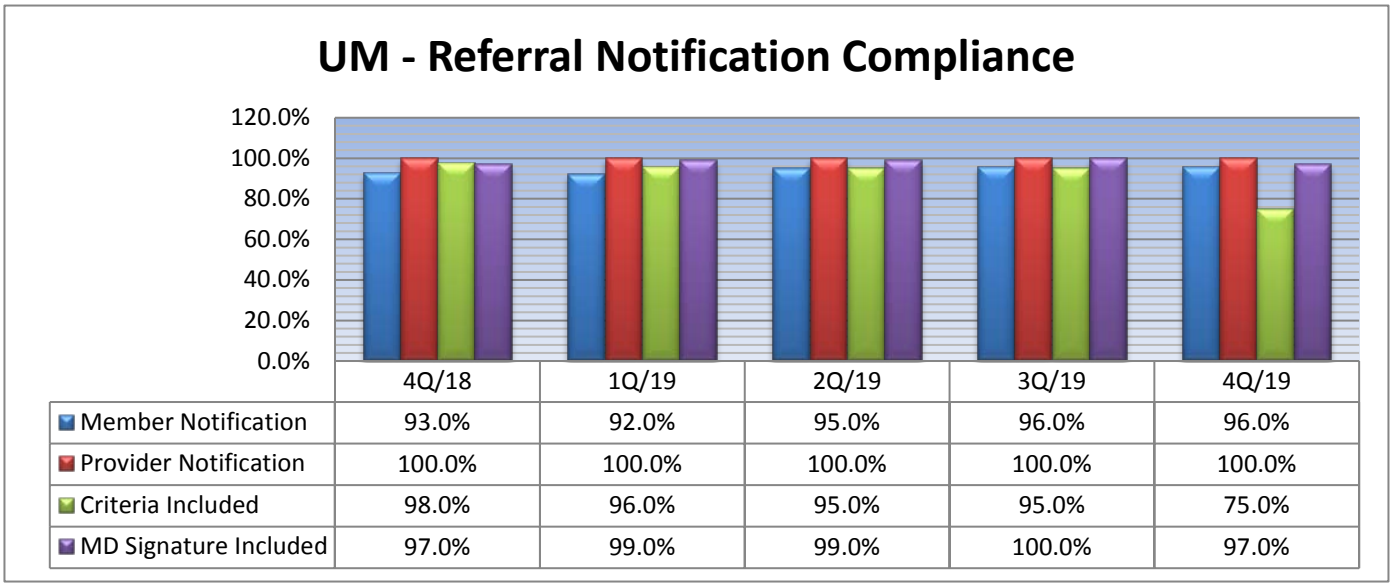
There were 47,563 referrals processed in the 4th quarter 2019 of which 4,383 referrals were reviewed for timeliness of decision. In comparison to the 3rd quarter's processing time, routine referrals increased from the 3rd quarter which was 89.4% to 96.3% and urgent referrals increased from the 3rd quarter which was 85.9% to 90.6%.



	4Q/18	1Q/19	2Q/19	3Q/19	4Q/19
Urgent Compliance %	93.1%	92.3%	90.3%	85.9%	90.6%
Routine Compliance %	92.7%	92.7%	94.0%	89.4%	96.3%

Audit Criteria:

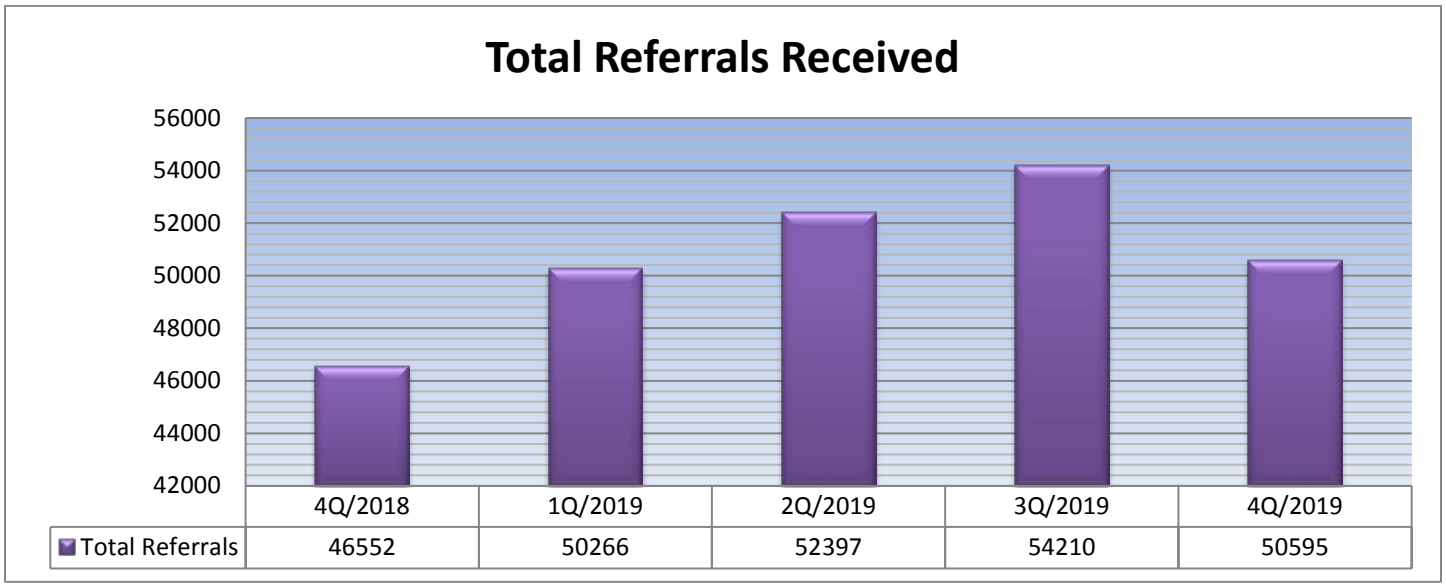
- Member Nofication: Letter of referral decision sent to member within 24 hours
- Provider Notification: Referral is faxed back to the provider with 24 hours of decision
- Criteria Included: Criteria provided to provider on denial reason
- MD Signature: MD Signature included all referrals/NOA letters upon denial

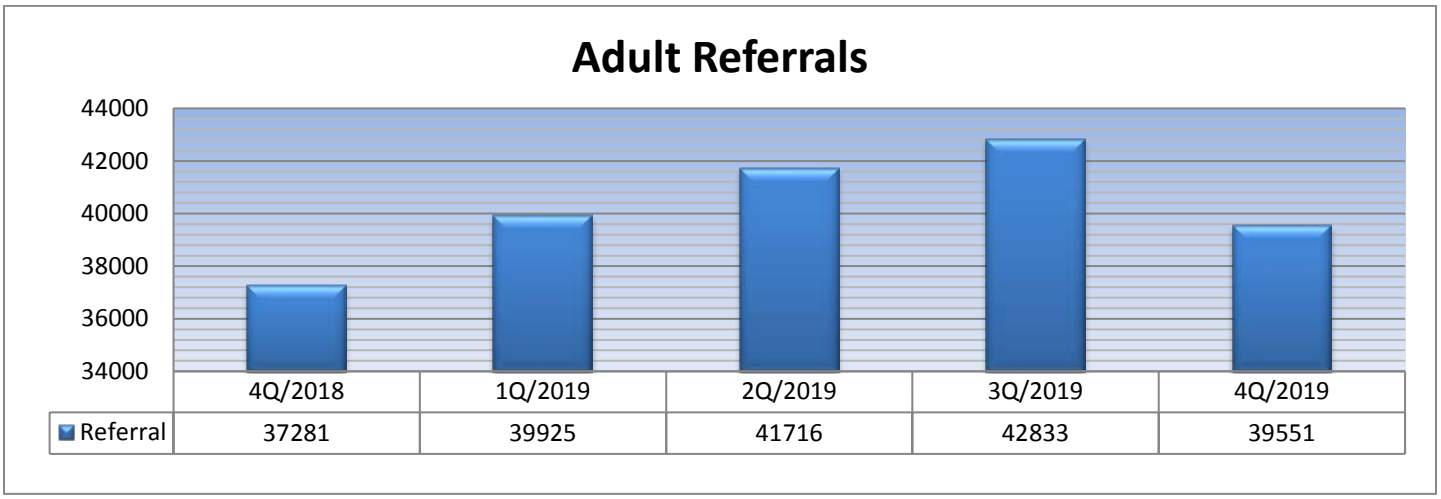


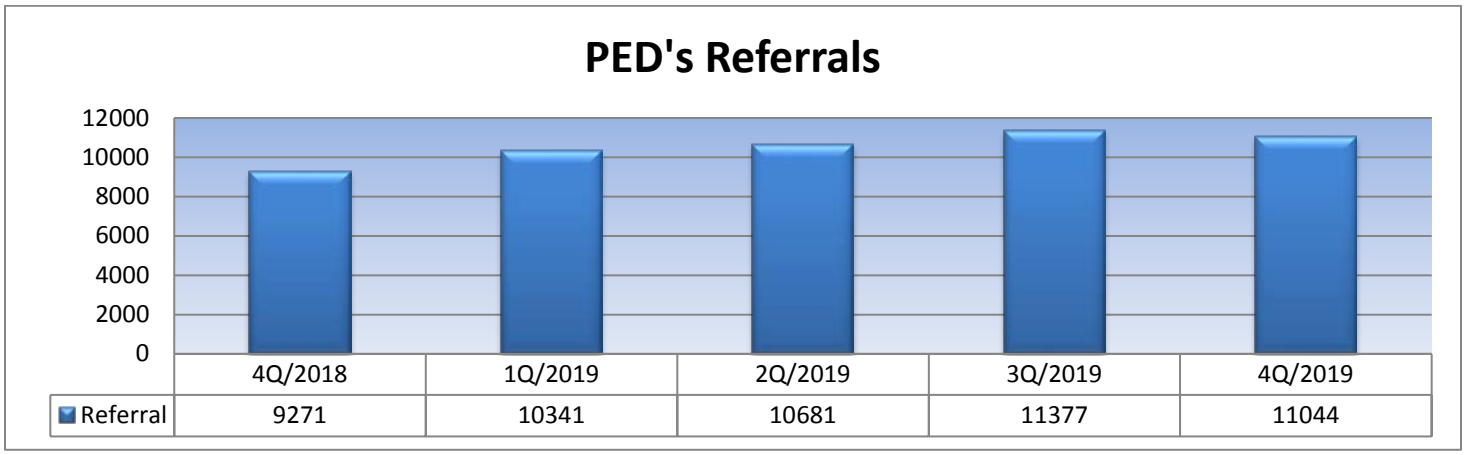
	4Q/18	1Q/19	2Q/19	3Q/19	4Q/19
Member Notification	93.0%	92.0%	95.0%	96.0%	96.0%
Provider Notification	100.0%	100.0%	100.0%	100.0%	100.0%
Criteria Included	98.0%	96.0%	95.0%	95.0%	75.0%
MD Signature Included	97.0%	99.0%	99.0%	100.0%	97.0%

Summary: Overall compliance rate from the 4th Qtr of 2019 is 92% which decreased from the 3rd Qtr which was 98%. Staff re-education and Care Web QI software use will be conducted.

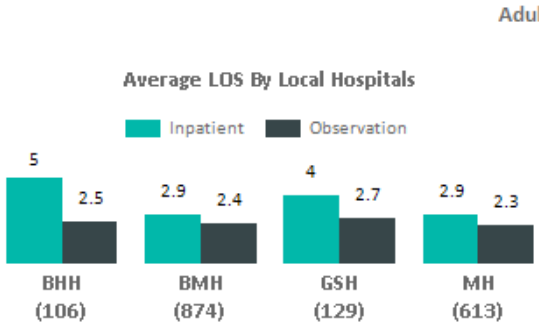
Outpatient Referral Statistics

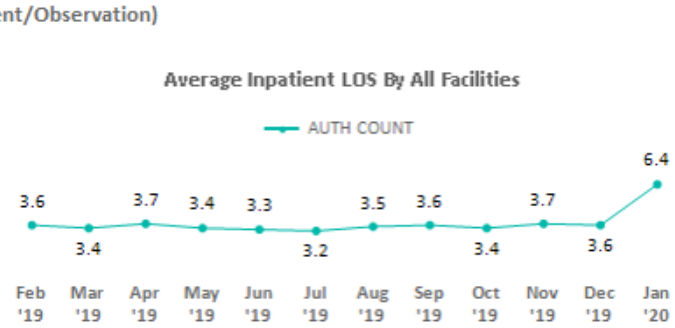






KHS 4th Quarter Inpatient and LOS Report





Adult Admission(Inpatient/Observation)

Participating Providers			
Provider Name	**Admit Count**	**LOS**	**Avg LOS**
ADVENTIST HEALTH BAKERSFIELD S	636	2180	3.43
ADVENTIST HEALTH COMMUNITY CAR	13	29	2.23
ADVENTIST HEALTH MEDICAL CENTE	25	57	2.28
ANTELOPE VALLEY HOSPITAL	6	18	3.00
BAKERSFIELD HEART HOSPITAL	106	491	4.63
BAKERSFIELD MEMORIAL HOSPITAL	874	2373	2.72
BELLAGIO IN THE DESERT	2	102	51.00
CHILDRENS HOSPITAL OF LOS ANGE	1	1	1.00
DELANO REGIONAL MEDICAL CENTER	66	176	2.67
DIGNITY HEALTH	1	12	12.00
ENCOMPASS HEALTH REHABILITATIO	6	59	9.83
GGNSC SHAFTER LP	1	6	6.00
GOOD SAMARITAN HOSPITAL	129	456	3.53
HOFFMANN HOSPICE OF THE VALLEY	2	7	3.50
KECK HOSPITAL OF USC	85	315	3.71

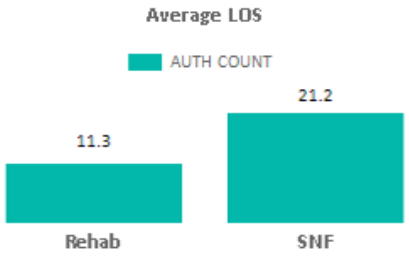
KERN COUNTY MEDICAL AUTHORITY	568	1702	3.00
KERN MEDICAL CENTER	9	45	5.00
KERN VALLEY HEALTHCARE DISTRIC	9	31	3.44
LIFEHOUSE BAKERSFIELD OPERATIO	1	14	14.00
MERCY HOSPITAL	613	1643	2.68
PARKVIEW JULIAN	2	52	26.00
PETERSEN	1	3	3.00
RIDGECREST REGIONAL HOSPITAL	7	27	3.86
SANTA MONICA UCLA MC AND ORTHO	2	6	3.00
SORRENTO IN THE DESERT	3	27	9.00
UCLA MEDICAL CENTER	12	32	2.67
UNITED CARE FACILITIES	9	137	15.22
USC NORRIS CANCERHOSPITAL	8	45	5.63
USC VERDUGO HILLS HOSPITAL	4	17	4.25
VALLEY CHILDRENS HOSPITAL	1	2	2.00
VFP HOMES	2	59	29.50
Total	**3206**	**10129**	**3.16**

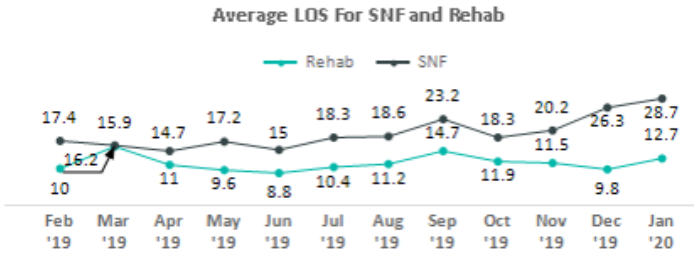
Non Participating Providers			
Provider Name	**Admit Count**	**LOS**	**Avg LOS**
ADVENTIST HEALTH REEDLEY	1	2	2.00
ALVARADO HOSP. LLC	1	1	1.00
ANTELOPE VALLEY HOSPITAL	21	115	5.48
ANTELOPE VALLEY ORTHOTICS & PR	1	1	1.00
ARROWHEAD REG MED CTR	1	3	3.00
ARROWHEAD REGIONAL MED	1	7	7.00
BARSTOW COMM HOSPITAL	2	7	3.50
BEVERLY HOSPITAL	1	5	5.00
BRONSON BATTLE CREEK HOSPITAL	1	1	1.00
CARONDELET ST MARYS	1	17	17.00
CEDARS SINAI MEDICAL CENTER	2	28	14.00
CITRUS VALLEY MEDICAL CENTER I	1	28	28.00
DESERT REGIONAL MEDICAL CENTER	1	3	3.00
DOCTORS MEDICAL CENTER	1	6	6.00
FOOTHILL PRESB HOSP	1	4	4.00
FRENCH HOSPITAL MEDICAL CNTR	1	1	1.00
FRESNO COMMUNITY HOSPITAL AND	4	17	4.25
GLENDALE MEMORIAL HO	1	2	2.00

GROSSMONT HOSPITAL CORPORATION	1	1	1.00
HARBOR - UCLA MED FOUNDATION	2	9	4.50
HENRY MAYO NEWHALL	2	34	17.00
HI DESERT MEDICAL CE	1	2	2.00
HOAG MEMORIAL HOSPITAL	1	1	1.00
HUNTINGTON BEACH HOSPITAL	1	1	1.00
KAISER FOUNDATION	1	3	3.00
KAWEAH DELTA MEDICAL CENTER	3	4	1.33
KINDRED HOSPITAL	1	46	46.00
KINDRED HOSPITAL SAN GABRIEL	3	69	23.00
KND DEVELOPEMENT	1	3	3.00
LAC USC MEDICAL CENTER	6	32	5.33
LAC-HARBOR UCLA MED	1	3	3.00
LAKEWOOD REGIONAL	1	3	3.00
LANCASTER HOSPITAL CORPORATION	6	35	5.83
LEE MEMORIAL HEALTH SYSTEM	1	1	1.00
LOMA LINDA UNIVERSITY MEDICAL	1	19	19.00
LOS ROBLES HOSPITAL & MC	4	23	5.75
MAMMOTH HOSPITAL	1	2	2.00
MARIAN REGIONAL MEDICAL CENTER	3	8	2.67
MARTIN LUTHER KING JR COMMUNIT	2	9	4.50
METHODIST HOSPITAL OF SACRAMEN	1	13	13.00
MISSION COMMUNITY HOSPITAL	1	2	2.00
ONE AND ONLY CONGREGATE LIVING	1	23	23.00
PACIFICA HOSPITAL OF THE VALLE	1	45	45.00
PARKSIDE CONGREGATE LIVING, IN	1	13	13.00
PRESBYTERIAN INTERCOMMUNITY HO	1	5	5.00
PRIME HEALTHCARE SERVICES RENO	1	3	3.00
PROVIDENCE HOLY CROSS MEDICAL	1	4	4.00
PROVIDENCE SAINT JOSEPH	1	16	16.00
RIVERSIDE COMMUNITY HOSPITAL	3	10	3.33
RIVERSIDE COUNTY REGIONAL	2	12	6.00
ROCHELLE COMMUNITY HOSPITAL AS	1	2	2.00
SALINAS VALLEY HOSPITAL	1	1	1.00
SAN ANTONIO REGIONAL	1	2	2.00
SANTA BARBARA COTTAGE HOSPITAL	1	6	6.00
SCRIPPS MERCY	2	13	6.50
SIERRA VIEW MEDICAL CENTER	2	5	2.50
SOUTHERN CALIFORNIA HOSPITAL	1	1	1.00

SOUTHERN HILLS MED CENTER	1	2	2.00
ST JOSEPHS MEDICAL	1	2	2.00
ST LUKES NAMPA MEDICAL CENTER	1	2	2.00
ST MARY MEDICAL CENTER	3	8	2.67
ST VINCENT MED CTR	1	10	10.00
ST. MARY'S HOSPITAL AND MED CE	1	3	3.00
SUNRISE HOSPITAL AND MEDICAL	1	15	15.00
TORRANCE MEMORIAL MEDICAL CENT	2	3	1.50
TRI-CITY MEDICAL CTR	2	3	1.50
TULARE REGIONAL MEDICAL CENTER	1	2	2.00
UCI MEDICAL CENTER	1	3	3.00
UCSD MEDICAL CENTER	1	6	6.00
UCSF MEDICAL CENTER	2	9	4.50
VALLEY PRESBYTERIAN HOSPITAL	1	30	30.00
VALLEYWISE HEALTH	2	9	4.50
WASHINGTON REGIONAL MEDICAL CE	1	2	2.00
YUMA REGIONAL MEDICAL CENTER	1	1	1.00
Total	**133**	**846**	**6.36**

Adult Admissions (SNF/Rehab)



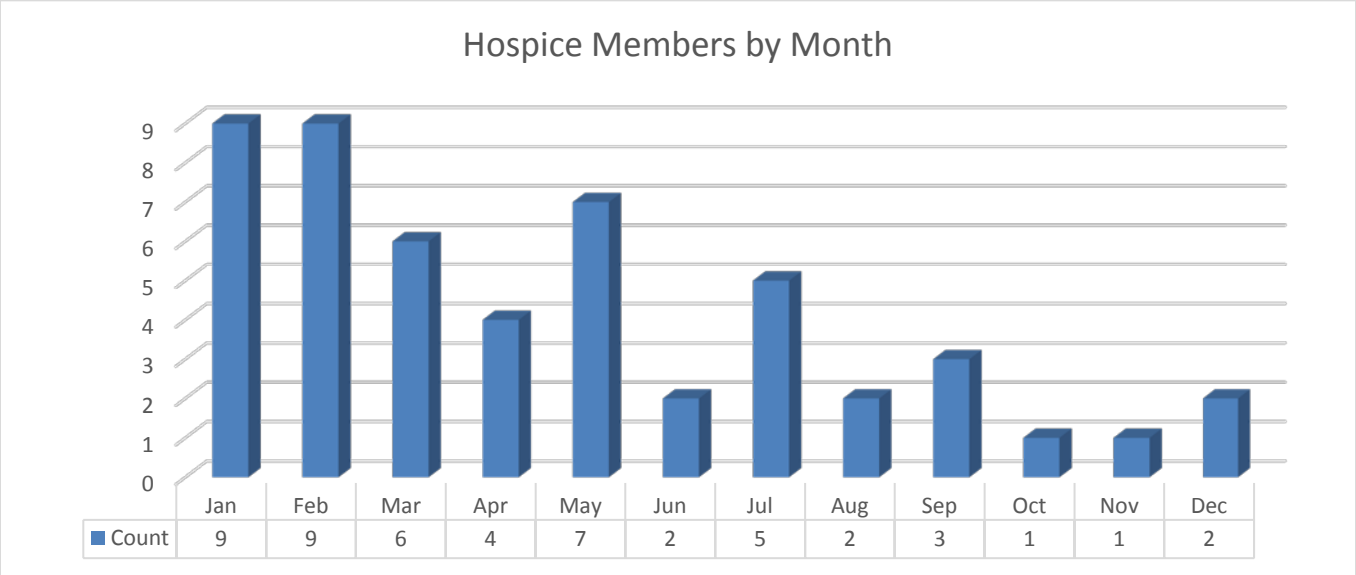


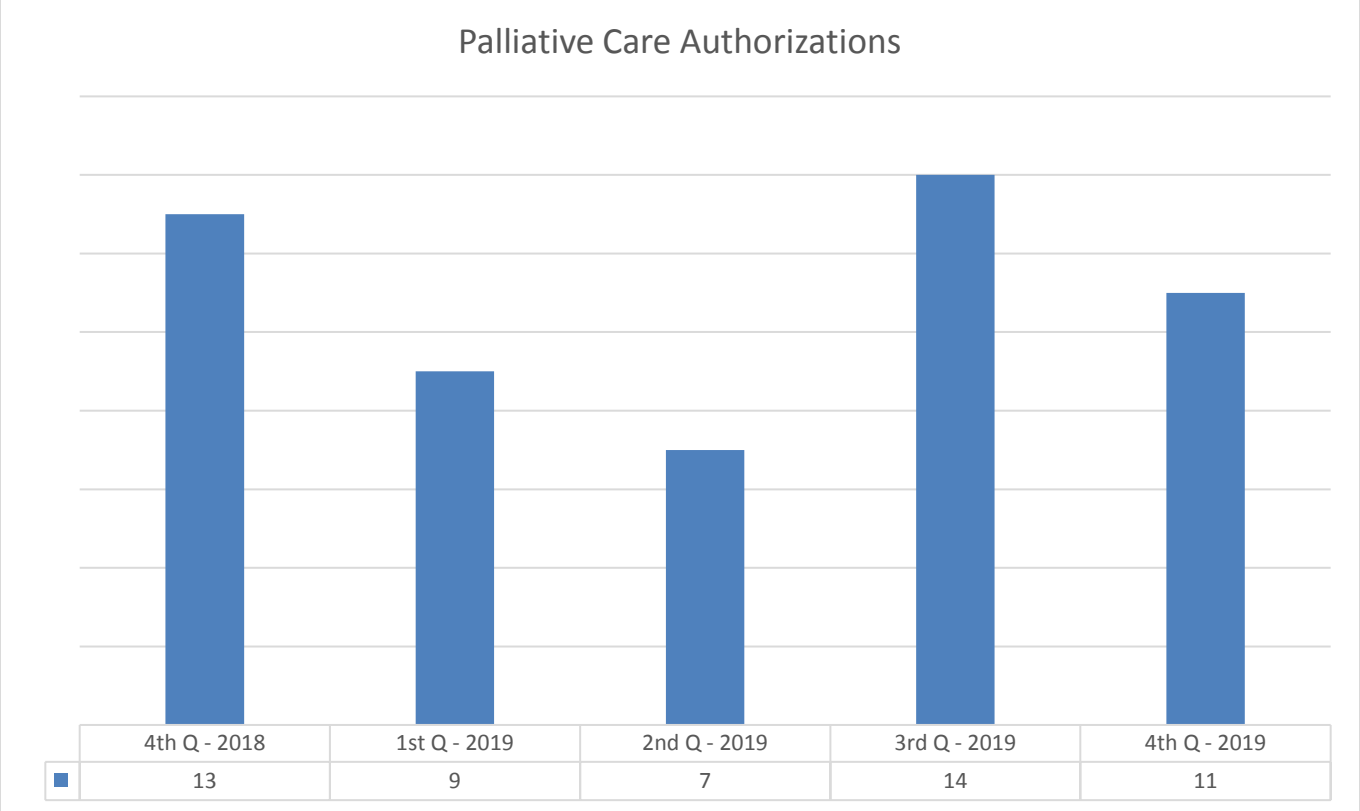
Participating Providers			
Provider Name	**Admit Count**	**LOS**	**Avg LOS**
BELLAGIO IN THE DESERT	7	83	11.86
CAPRI IN THE DESERT	4	28	7.00
DELANO POSTACUTE CARE	3	36	12.00
ENCOMPASS HEALTH REHABILITATIO	24	270	11.25
GGNSC SHAFTER LP	18	385	21.39
HOFFMANN HOSPICE OF THE VALLEY	8	368	46.00
KERN VALLEY HEALTHCARE DISTRIC	1	39	39.00

MERIDIAN HOSPICE CARE INC	1	9	9.00
NAPOLI IN THE DESERT	1	17	17.00
PARKVIEW JULIAN	11	156	14.18
PROCARE HOSPICE	1	180	180.00
SORRENTO IN THE DESERT	3	75	25.00
UNITED CARE FACILITIES	69	1084	15.71
VFP HOMES	10	140	14.00
Total	**161**	**2870**	**17.83**

Non Participating Providers			
Provider Name	**Admit Count**	**LOS**	**Avg LOS**
DELANO REGIONAL MEDICAL CENTER	1	49	49.00
EVERGREEN AT ARVIN HEALTHCARE	2	95	47.50
EVERGREEN AT BAKERSFIELD, LLC	1	61	61.00
HEIGHT STREET SKILLED CARE	1	32	32.00
KINGSTON HEALTHCARE CENTER	8	181	22.63
ONE AND ONLY CONGREGATE LIVING	1	58	58.00
PACIFICA HOSPITAL OF THE VALLE	1	82	82.00
PARKSIDE CONGREGATE LIVING, IN	2	70	35.00
SENIOR CONGREGATE LIVING, INC.	1	59	59.00
Total	**18**	**687**	**38.17**

Data analytics being conducted to ensure accurate capture of PAR vs. NPAR and Acute vs. SNF/LTC facilities and appropriate LOS.

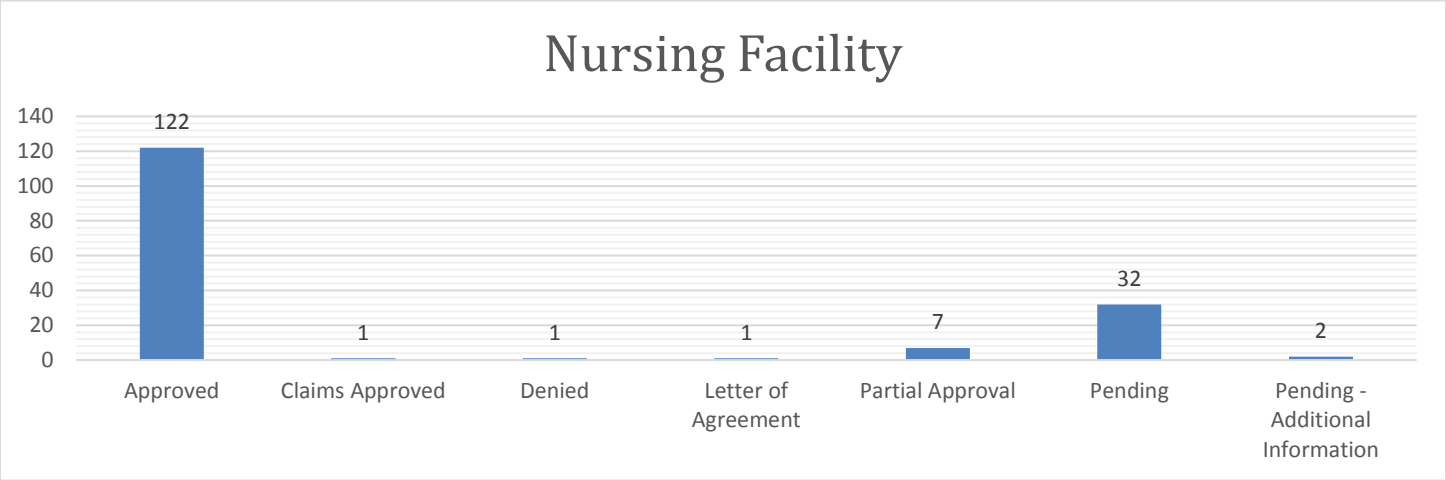

Hospice Members by Month
9
8
7
6
5
4
3
2
1
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
Count 9 9 6 4 7 2 5 2 3 1 1 2

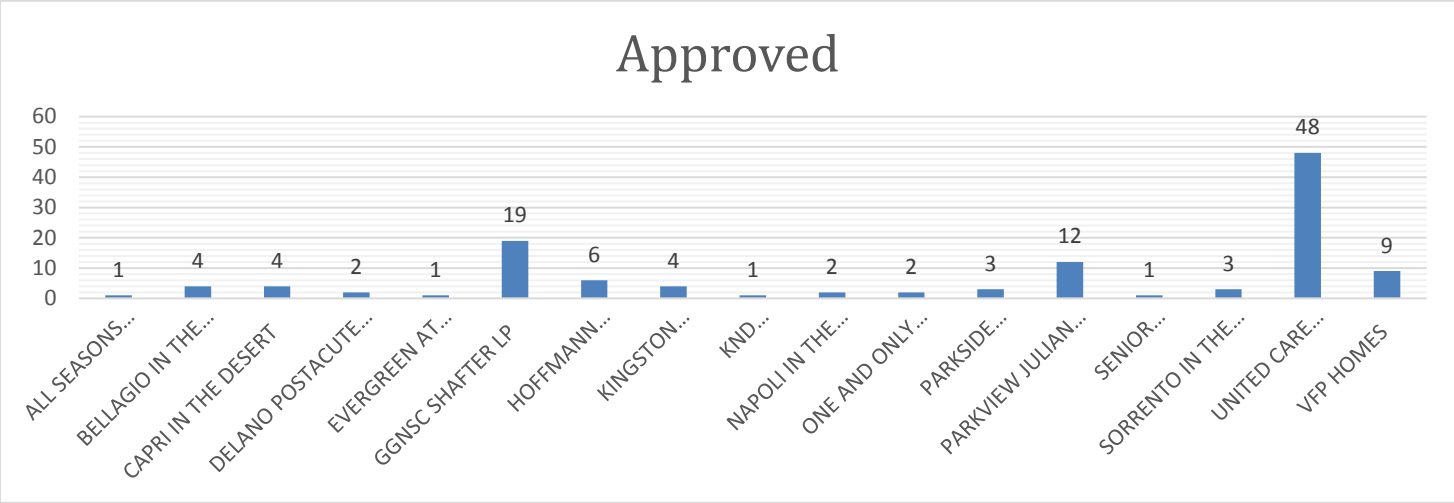

Palliative Care Authorizations
4th Q - 2018 1st Q - 2019 2nd Q - 2019 3rd Q - 2019 4th Q - 2019
13 9 7 14 11

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 4th quarter 2019, there were 167 referrals for Nursing Facility Services. The average length of stay was 31.2 days for these members. During the 3rd quarter there was only 1 denials of the 175 referrals.





Health Dialog Report

October:

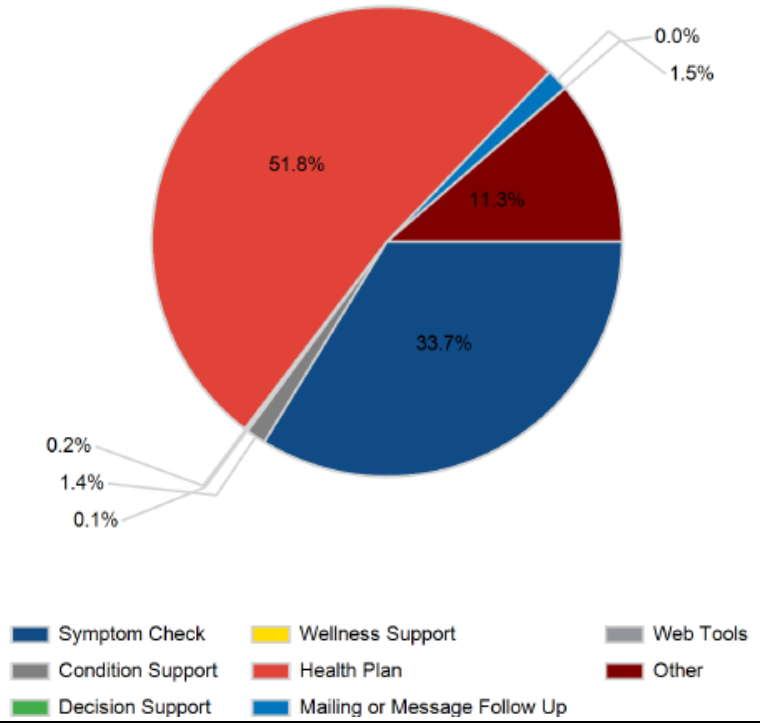
Name: Total Population

Reporting Period: Nov 2018 - Oct 2019

Individuals Eligible in Reporting Period: 294,915

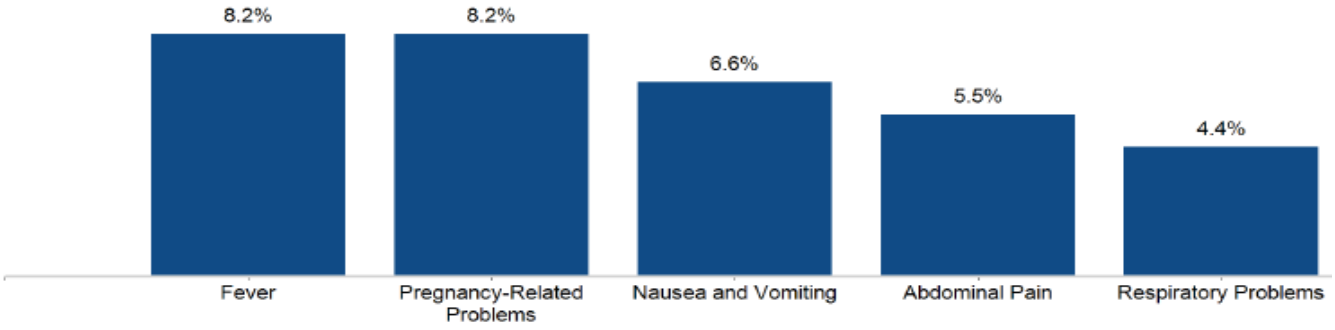
Individuals Eligible in October 2019: 250,278

Member Inbound Call Reasons (Rolling Twelve Months)

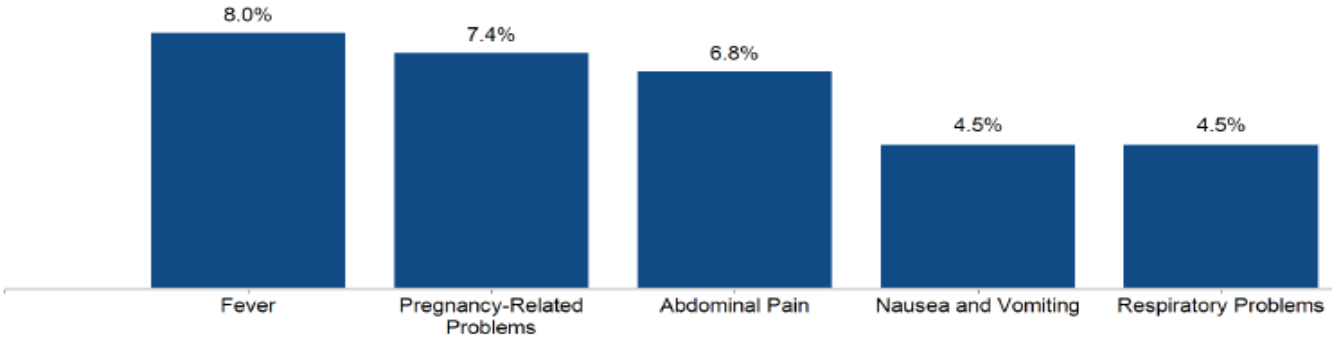


REASON	NUMBER
Symptom Check	2,617
Condition Support	105
Decision Support	7
Wellness Support	12
Health Plan	4,019
Mailing or Message Follow Up	116
Web Tools	2
Other	878

Most Frequent Symptoms - Inbound Symptom Check Calls (Oct-2019)



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



November:

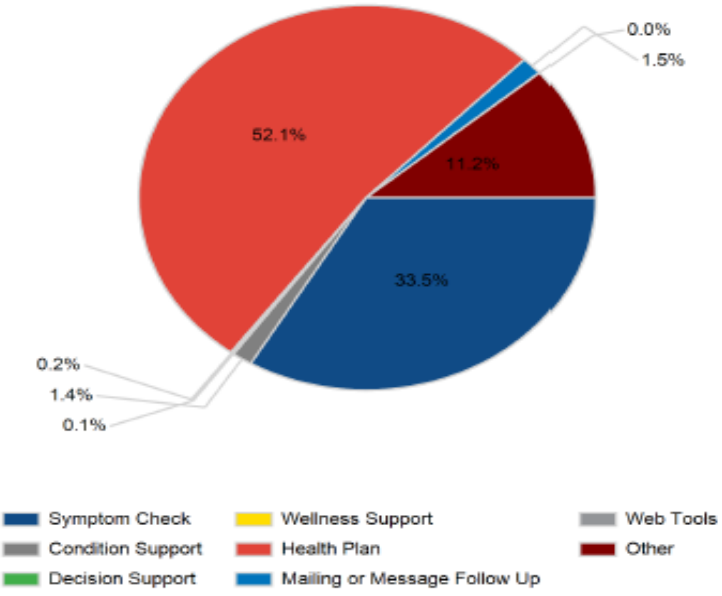
Name: Total Population

Reporting Period: Dec 2018 - Nov 2019

Individuals Eligible in Reporting Period: 295,757

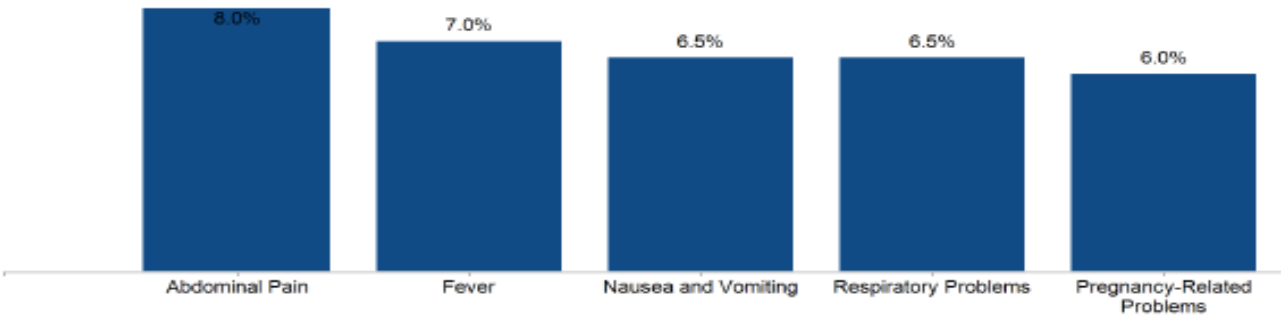
Individuals Eligible in November 2019: 250,660

Member Inbound Call Reasons (Rolling Twelve Months)

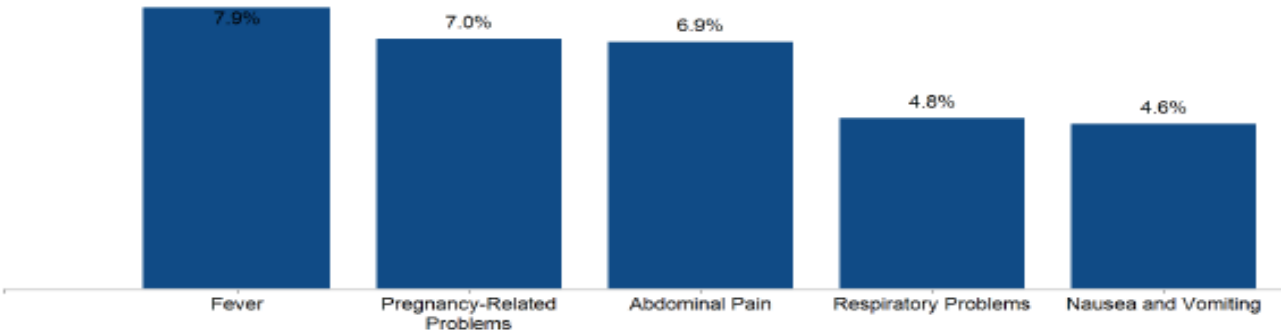


REASON	NUMBER
Symptom Check	2,633
Condition Support	112
Decision Support	7
Wellness Support	13
Health Plan	4,098
Mailing or Message Follow Up	119
Web Tools	2
Other	883

Most Frequent Symptoms - Inbound Symptom Check Calls (Nov-2019)



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



December:

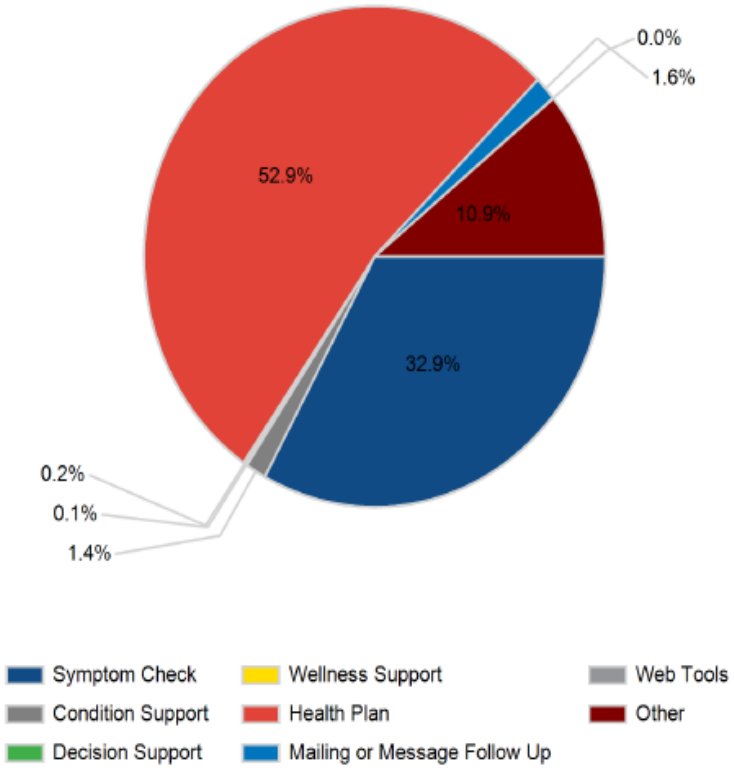
Name: Total Population

Reporting Period: Jan 2019 - Dec 2019

Individuals Eligible in Reporting Period: 296,250

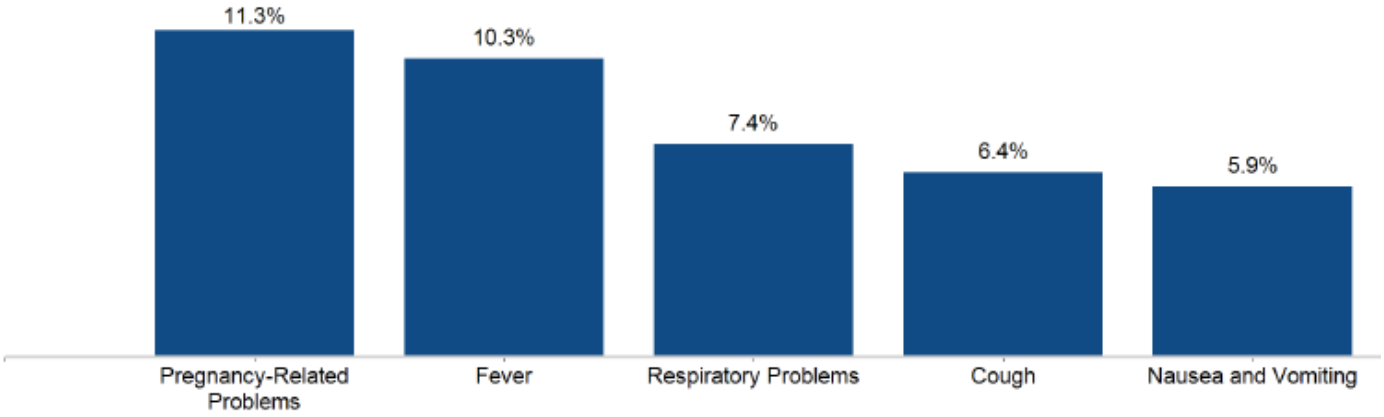
Individuals Eligible in December 2019: 249,700

Member Inbound Call Reasons (Rolling Twelve Months)

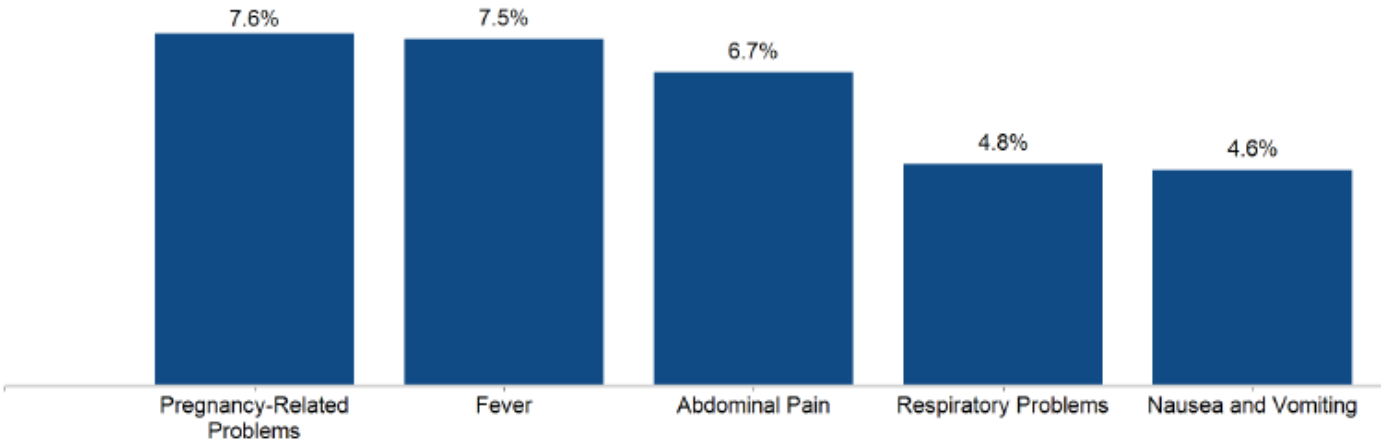


REASON	NUMBER
Symptom Check	2,608
Condition Support	114
Decision Support	8
Wellness Support	15
Health Plan	4,191
Mailing or Message Follow Up	125
Web Tools	2
Other	863

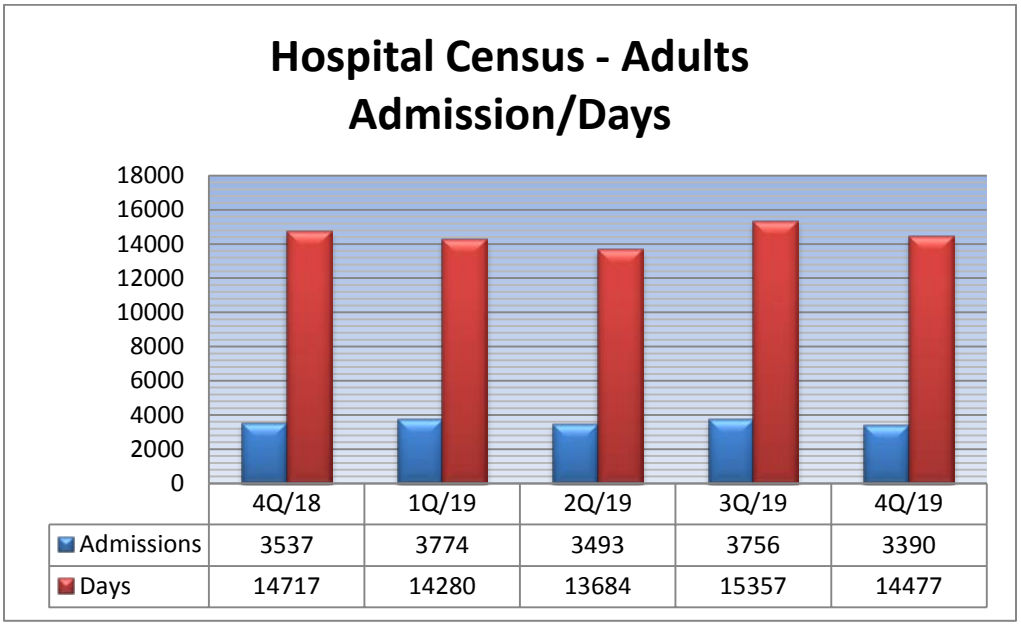
Most Frequent Symptoms - Inbound Symptom Check Calls (Dec-2019)



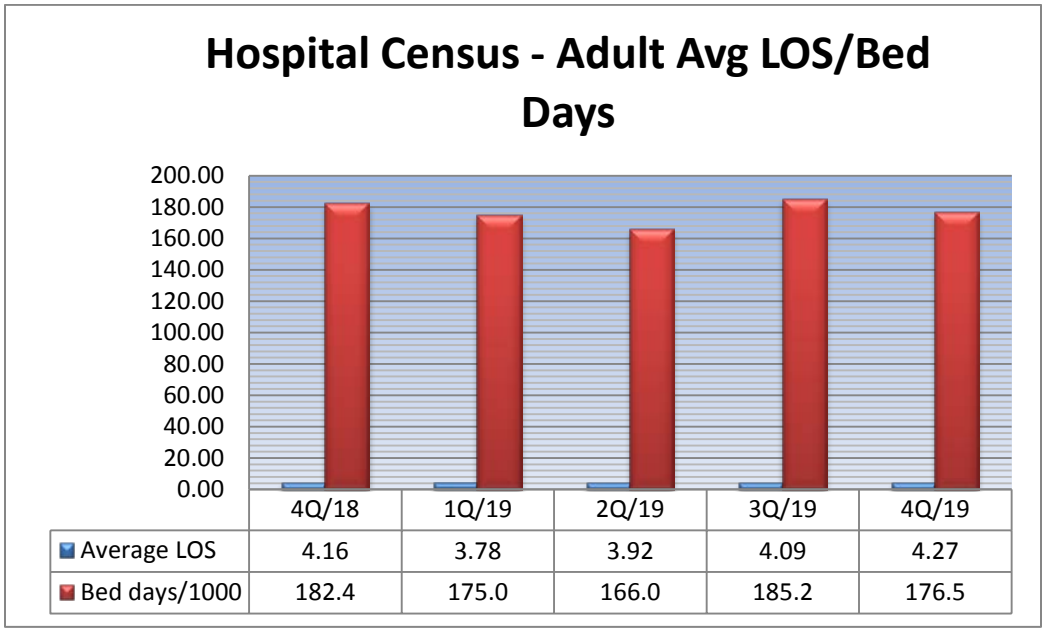
Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



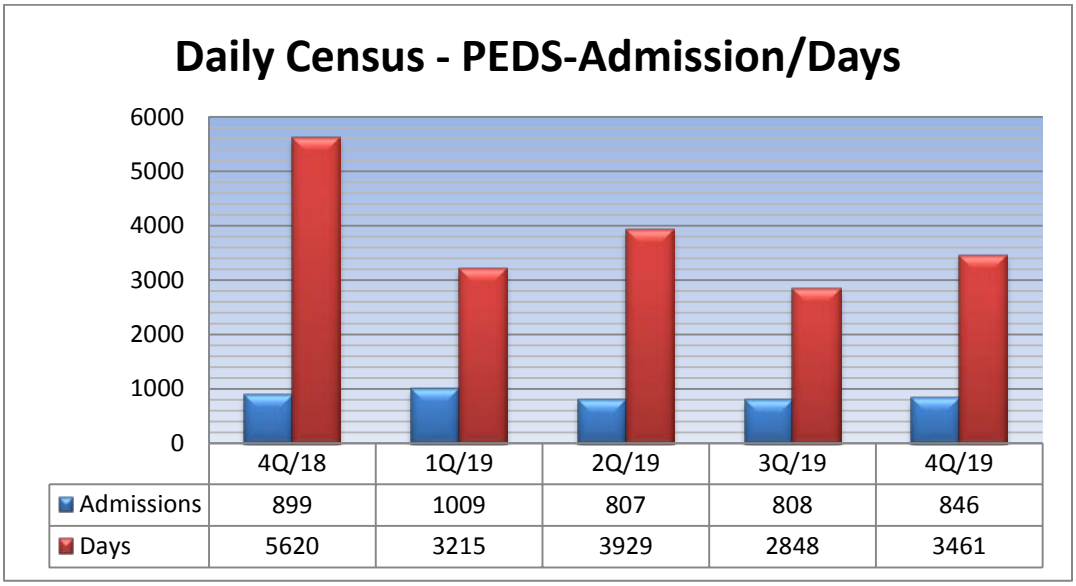
Inpatient 4th Quarter Trending



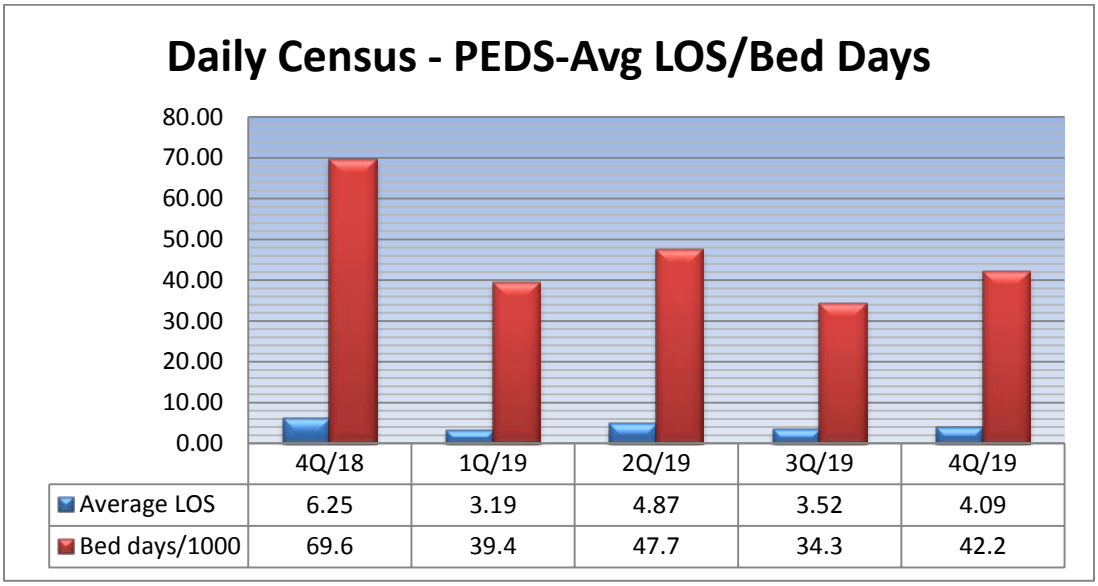
	4Q/18	1Q/19	2Q/19	3Q/19	4Q/19
Admissions	3537	3774	3493	3756	3390
Days	14717	14280	13684	15357	14477



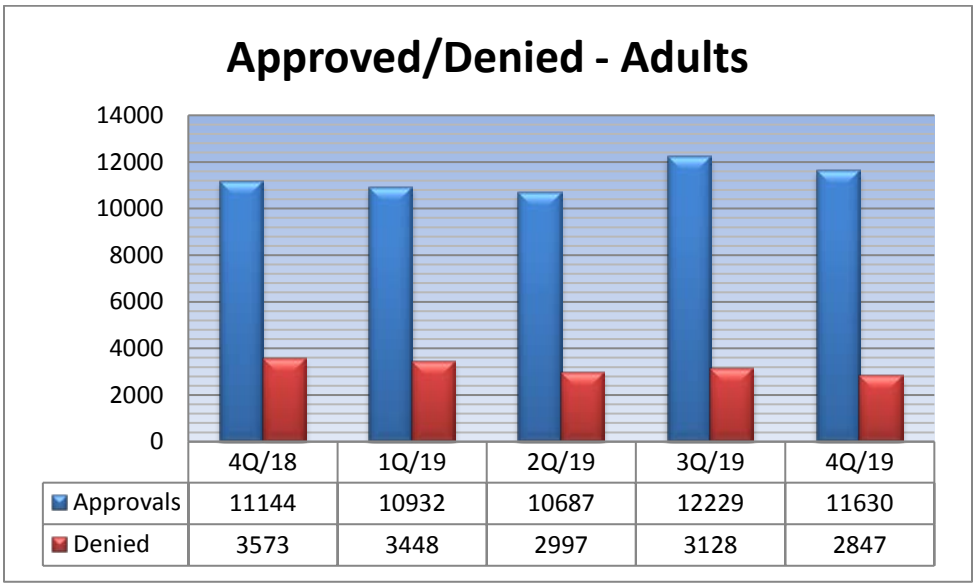
	4Q/18	1Q/19	2Q/19	3Q/19	4Q/19
Average LOS	4.16	3.78	3.92	4.09	4.27
Bed days/1000	182.4	175.0	166.0	185.2	176.5

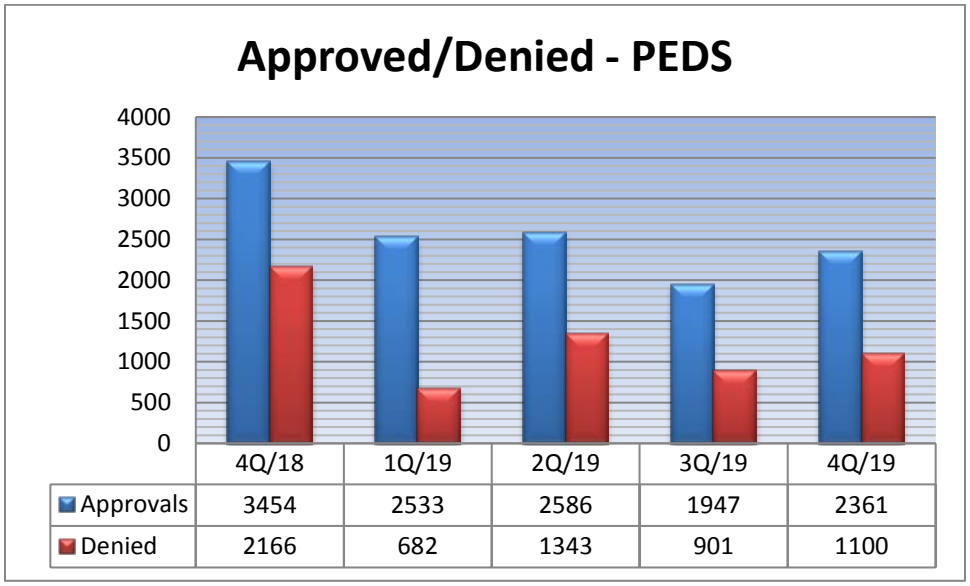


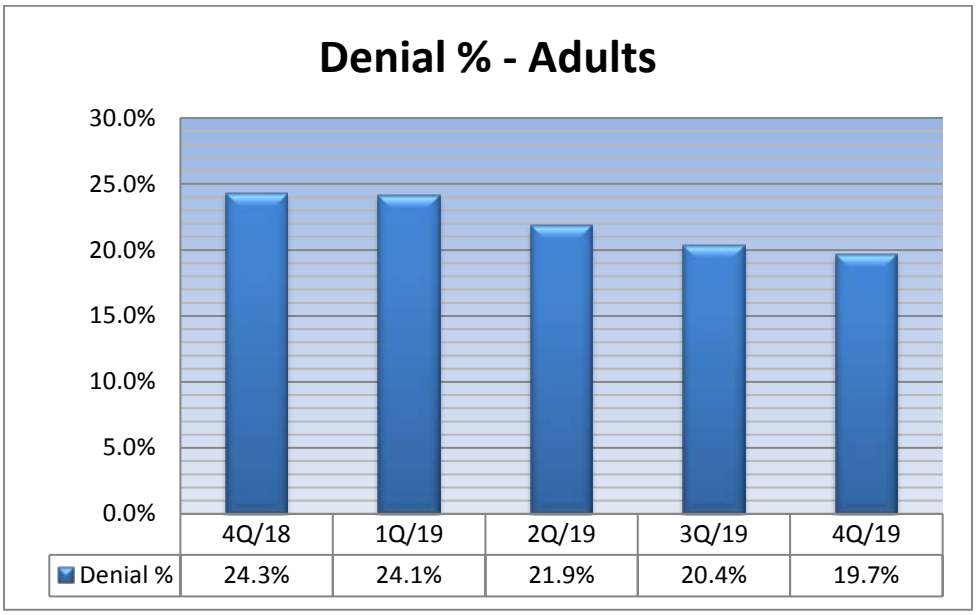
	4Q/18	1Q/19	2Q/19	3Q/19	4Q/19
Admissions	899	1009	807	808	846
Days	5620	3215	3929	2848	3461

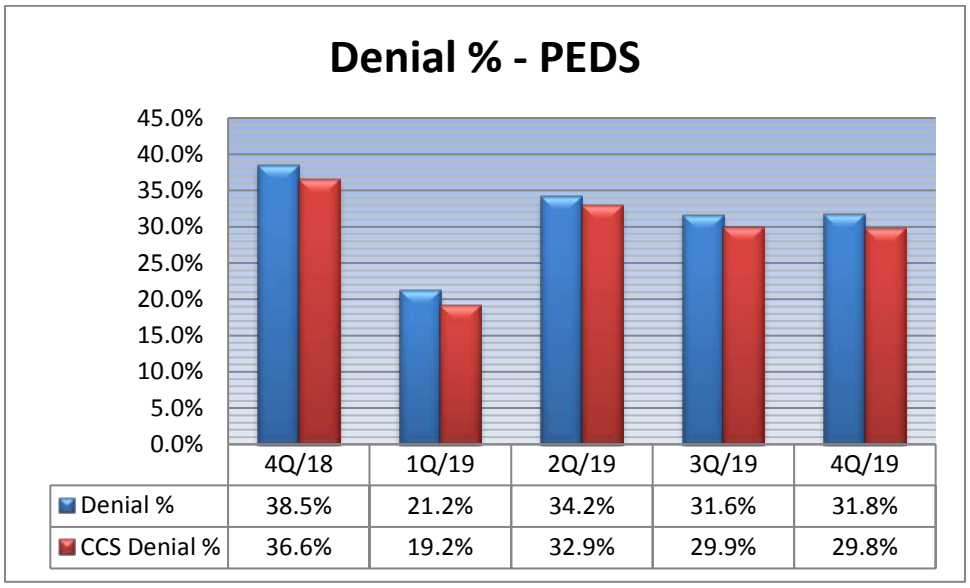


	4Q/18	1Q/19	2Q/19	3Q/19	4Q/19
Average LOS	6.25	3.19	4.87	3.52	4.09
Bed days/1000	69.6	39.4	47.7	34.3	42.2


Approved/Denied - Adults
14000
12000
10000
8000
6000
4000
2000
0
4Q/18
1Q/19
2Q/19
3Q/19
4Q/19
Approvals
11144
10932
10687
12229
11630
Denied
3573
3448
2997
3128
2847


Approved/Denied - PEDS
4000
3500
3000
2500
2000
1500
1000
500
0
4Q/18
1Q/19
2Q/19
3Q/19
4Q/19
Approvals
3454
2533
2586
1947
2361
Denied
2166
682
1343
901
1100





Continuity of Care

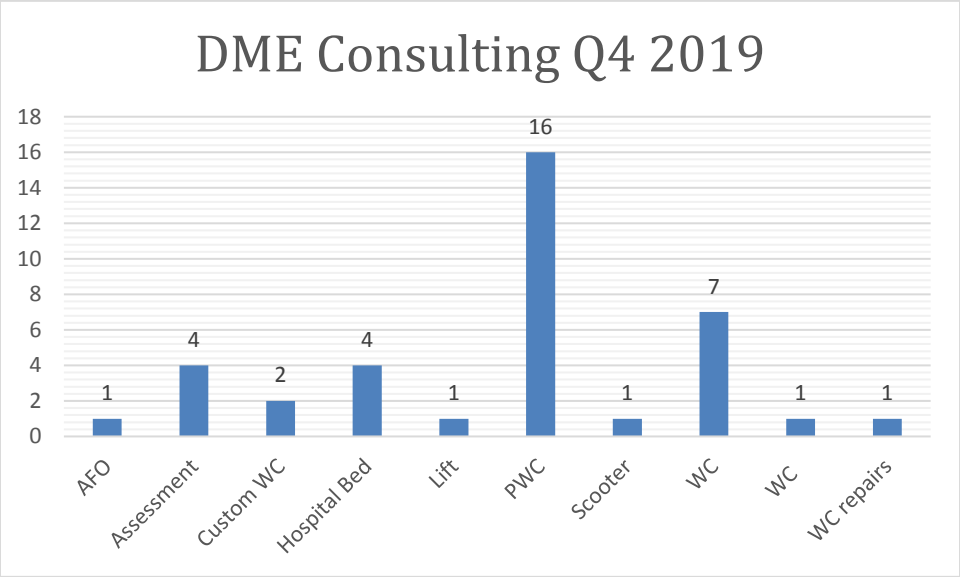
Total Referral – 51

Total Approval – 51

Total Denial - 0

Total SPD COC -12

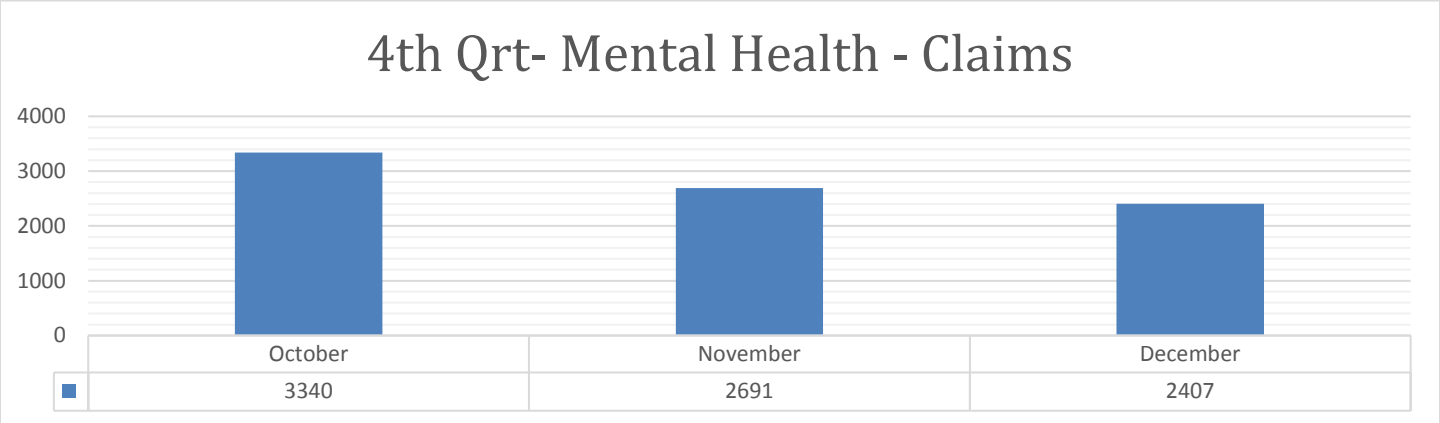
DME Consulting



Autism Reporting

MEMBER COUNT		43	78	7	56	128
Severity %		23.37%	42.39%	3.80%	30%	100%
SEVERITY	Oct	Nov	Dec	Total		
MILD	15	11	19	45		
MODERATE	19	24	34	77		
SEVERE	1	1	5	7		
Approved FBA	32	53	74	159		
Approved Treatment	49	54	88	191		
PENDING DX	25	17	16	58		
	Oct	Nov	Dec	Total		
AGE 7 OR LESS	35	39	46	120		
AGE 8 OR GREATER	25	14	27	66		
TOTAL	60	53	73	186		
% < 7	58.33%	73.58%	63.01%	64.52%		
% > 8	41.67%	26.42%	36.99%	35.48%		

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
2019	January	8,557	327	341	668
	February	8,910	414	315	729
	March	265	24	14	38
	April	1,012	61	50	111
	May	553	40	32	72
	June	729	60	29	89
	July	591	40	28	68
	August	541	39	11	50
	September	4,151	228	13	241
	October	525	42	0	42
	November	0	0	0	0
	December	1,916	12	0	12
Totals		**27,750**	**1,287**	**833**	**2,120**

LTM Effectiveness* : 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.

Medical Data Collection Summary Report

Period Covered: January, 2019 through December, 2019
Prepared for: KERN HEALTH SYSTEMS - (12049397)

Reported Cases

	Members	
Received Eye Exam:	28,209	
Diabetes?:	1,510	5.4%
Diabetic Retinopathy:	196	.7%
Glaucoma:	280	1.0%
Hypertension:	1150	4.1%
High Cholesterol	446	1.6%
Macular Degeneration:	43	.2%

Estimated Number of Cases

Total Members:	247,962	
Diabetes?:	5,736	2.3%
Diabetic Retinopathy:	509	.2%
Glaucoma:	963	.4%
Hypertension:	25,003	10.1%
High Cholesterol	37,454	15.1%
Macular Degeneration:	314	.1%

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

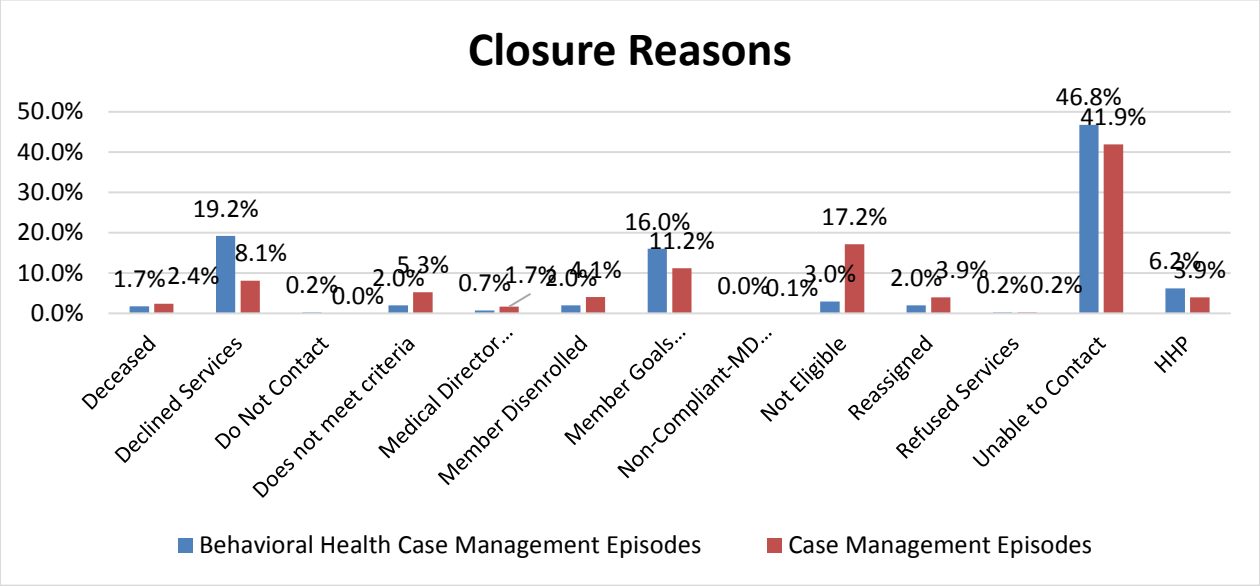
KERN HEALTH SYSTEMS
CASE MANAGEMENT DEPARTMENT MONTHLY REPORT

Reporting Period: October 1st, 2019- December 31st, 2019

During the months of October thru December, a total of 1,469 members were managed by the Case Management Department.

Episode Type	Closed Episodes	Open Episodes	Referral Episodes	Total
Case Management	666	235	27	928
Behavioral Health Case Management	412	118	11	541

Episode Source other than ACG Modeler	Behavioral Health Management Episodes	*Percentage*	Case Management Episodes	*Percentage*
All Internally Generated Complex Case Management	93	21.1%	202	47.2%
All Internally Generated Disease Management	1	0.2%	2	0.5%
x	3	0.7%	7	1.6%
All Internally Generated Hospital Discharge	0	0.0%	13	3.0%
All Internally Generated Medical Director	0	0.0%	8	1.9%
All Internally Generated Member Request	5	1.1%	11	2.6%
All Internally Generated UM Generated	13	3.0%	13	3.0%
BH Mental Health	27	6.1%	0	0.0%
CM DM HE Facility Based Social Worker	2	0.5%	0	0.0%
CM DM HE Health Education	4	0.9%	0	0.0%
CM DM HE Member Services	21	4.8%	4	0.9%
CM DM HE Provider	1	0.2%	2	0.5%
CM DM High ER Utilizer	119	27.0%	0	0.0%
Critical High Risk SPD	21	4.8%	0	0.0%
DM HE Social Worker Case Management	6	1.4%	3	0.7%
High Risk SPD	124	28.2%	163	38.1%



Members Closed and Referred to HHP	Behavioral Health Case Management Episodes	Case Management Episodes
HHP	12	22

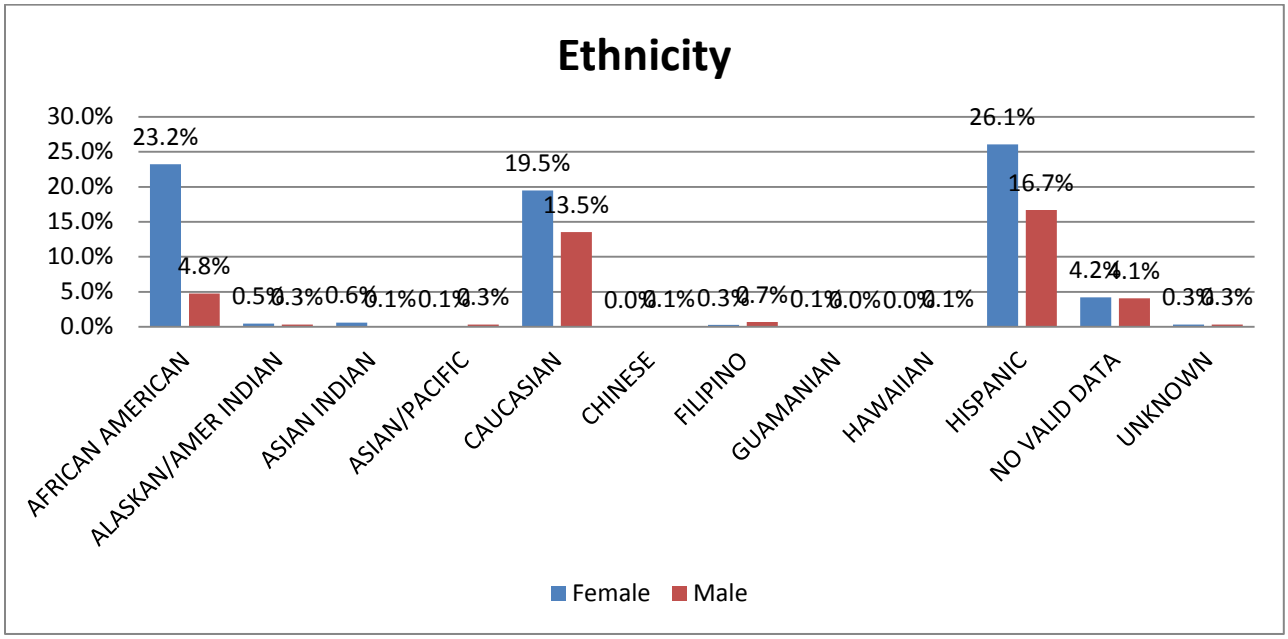
Closed Episodes with Admits within 30 days after Closure	Total
Behavioral Health Case Management	20
Case Management	73
Percentage of closed cases Readmitted	6%

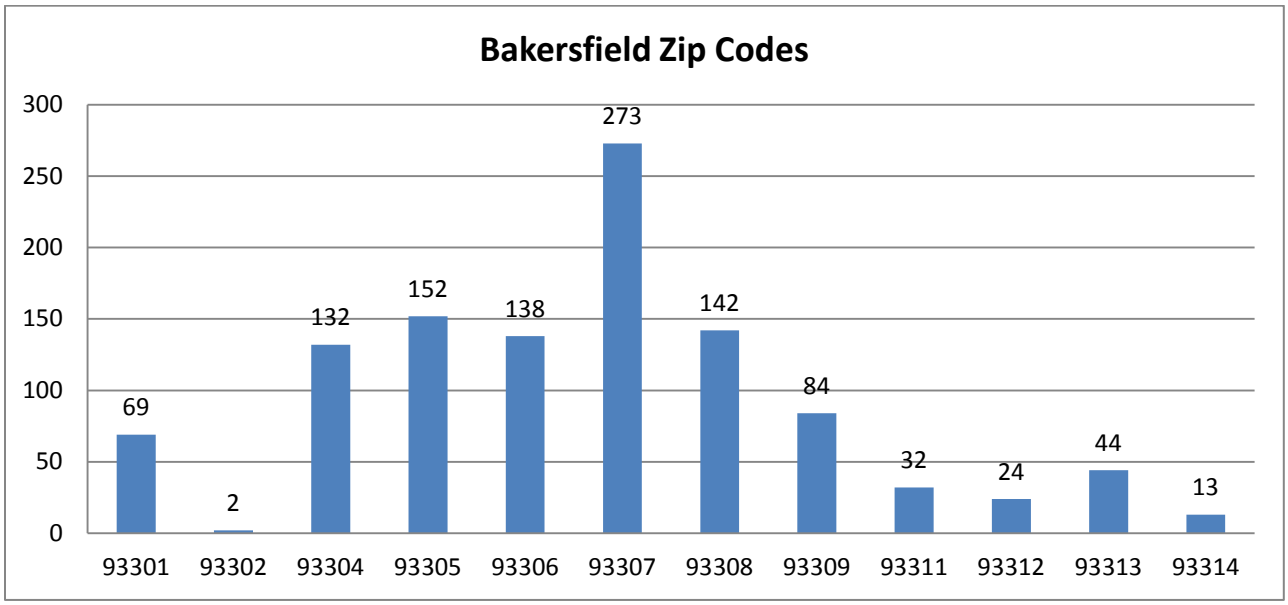
Assessments/Plan of Care	Behavioral Health Case Management Episodes	Case Management Episodes	Total
Assessments	141	258	399
Plan of Care	123	256	379

During the months of October thru December, 94% of the members managed were 65 years of age or younger.

Age	<18	18-40	41-65	>65	Total
Case Management	36	165	661	66	928
Behavioral Case Management	53	197	275	16	541

Of the 1,469 members managed during the months of October thru December, the majority of members were female at 59%. The majority of members' ethnicity was Hispanic at 43%.





Outlying Areas

City	Total
ARVIN	28
BEAR VLY SPGS	1

BODFISH	7
BORON	5
BUTTONWILLOW	2
CALIF CITY	20
DALY CITY	1
DELANO	54
ESPARTO	1
FRAZIER PARK	3
FRESNO	1
INYOKERN	2
KERNVILLE	1
LAKE ISABELLA	14
LAMONT	23
LANCASTER	1
LOS ANGELES	1
LOST HILLS	2
MARICOPA	2
MC FARLAND	17
MOJAVE	10
N/A	15
NORTH EDWARDS	3
ONYX	2
PASO ROBLES	1
PEARBLOSSOM	1
ROSAMOND	8
SANTA ANA	1
SHAFTER	27
SUN VALLEY	1
TAFT	33
TEHACHAPI	41
WASCO	26
WELDON	2
WOFFORD HTS	6

Notes Completed

Note Source	Behavioral Case Management Episodes	Case Management Episodes
Activity Note	1460	1968
Add Episode Note	417	229

Care Plan Problem Note	278	361
Change Status Note	1524	2392
Edit Episode Note	17	356
Episode Note	66	410
Goals	204	386
Interventions	520	679

Letters

Letter Template	Behavioral Health Case Management Episodes	Case Management Episodes
Appointment Letter English	45	52
Appointment Letter Spanish	10	16
Consent Form English	8	33
Consent Form Spanish	3	15
Discharge English	59	99
Discharge Spanish	7	29
Educational Material	219	308
Mental Health Alert to PCP	9	0
Unable to Contact	352	673
Welcome Letter Bilingual	126	296

Activities Completed

Activities Completed	Total
CMA's	3,348
Nurses	1,394
Social Workers	650

Activity Type

Activity Type	Behavioral Health Case Management Episodes	Case Management Episodes
Fax	44	297
Letter Contact	614	1,047
Member Services	33	48
Phone Call	1,165	2,016

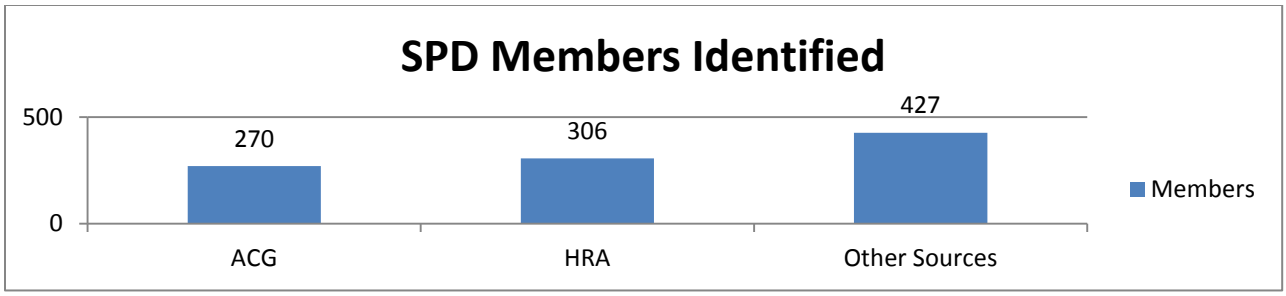
Activity Name

Activity Name	Behavioral Health Case Management Episodes	Case Management Episodes
Appointment Reminder Calls	14	54
Basic Needs	3	1
Centric Appointment	1	8
Community Resources	57	32
Contact Member	261	249
Contact Pharmacy	2	13
Contact Provider	118	252
Create Work Item	40	48
HHP	12	22
Homeless	4	1
ICT	35	52
Incoming Call	2	0
Inpatient Discharge Follow Up	42	204
Language Line	57	119
Mail Appointment Letter	53	21
Mail Authorization	0	3
Mail Consent Letter	10	39
Mail Discharge Letter	66	126
Mail Educational Material	183	304
Mail Pill Box	47	117
Mail Pocket Calendars	54	107
Mail Provider Directory	9	15
Mail Unable to contact letter	84	198
Mail Urgent Care Pamphlet	28	27
Mail Welcome Letter	6	24
Mental Health Alert to PCP	8	1
Plan of care	123	245
Provided Information	0	38
Public Health Nurse	0	3
Request Medical Records	82	135
Return Mail	12	3
Schedule Physician Appointment	62	56
Transportation	22	74
Verbal consent to be received	472	788

Seniors and Persons with Disabilities (SPDs):

SPD Members are identified for Complex Case Management through use of the John Hopkins Predictive Modeler, through Health Risk Assessments and other sources including member requests and outside and internal requests. The SPD population represents a total of 68 percent of the Complex Group from October thru December 2019.

The John Hopkins Predictive Modeler identified SPD's represent 18% percent of the Complex Group from October thru December 2019. HRA identified SPD members represent 21% and other sources of SPD members represent 29%.



SPD Health Risk Assessment Information:

*The following information reflects the prior 2 months of this report due to receiving completed data each month for the prior month.

In the months of October and November, a total of 10,014 members were identified for an outside vendor to contact for completion of a Health Risk Assessment. The total percentage of completion outreach/attempt for the month were at 99.19%.

October HRA Summary	Metric	Count	Percentage	Per Day
99.81%	Completed (or 2 calls attempted)	2657	100%	116
	Partial HRA	174	7%	8
	Full HRA	294	11%	13
	Opted out	55	2%	2
	High Risk members	157	6%	7
	Critical Members	26	1%	1
	Members Contacted	2467	93%	107
	Call Attempts	6528		
	Total Surveys Attempted	468		
	Avg # of Calls Per Member	2		
	Avg # Calls per Day	284		
Completion Rate	Avg # of Questions Answered	24		
Sent: 2662; Received: 2657				

November HRA Summary	Metric	Count	Percentage	Per Day
98.97%	Completed (or 2 calls attempted)	7276	99%	383
	Partial HRA	400	5%	21
	Full HRA	674	9%	35
	Opted out	167	2%	9
	High Risk members	406	6%	21
	Critical Members	52	1%	3
	Members Contacted	6846	93%	360
	Call Attempts	19799		
	Total Surveys Attempted	1074		
	Avg # of Calls Per Member	3		
	Avg # Calls per Day	1042		
Completion Rate	Avg # of Questions Answered	25		
Sent: 7352; Received: 7276				