KERN HEALTH SYSTEMS

August 8, 2019

Dear Public Policy/Community Advisory Committee Member,

The next Public Policy/Community Advisory Committee (PP/CAC) meeting will take place on Tuesday, August 13, 2019 at 12:00pm. The meeting will be held at Kern Family Health Care located at **5701 Truxtun Avenue, Suite 201, Bakersfield, CA 93309** in the Board Room.

Included in this packet are:

1. Meeting agenda
2. Minutes from the last meeting
3. Membership Enrollment Report - Medi-Cal

Action Items:

- 2019 2nd Quarter Grievance Summary Report (Attachment)
- 2019 2nd Quarter Grievance Report (Attachment)
- 2019 2nd Quarter Health Education Activities Report (Handout)
- School Wellness Awards (Presentation)
- 2019 2nd Quarter Disease Management Report (Attachment)

Please review these items before the meeting. A hardcopy will be provided for you at the meeting. Lastly, salad from Victor's Grill will be provided for lunch.

If you are not able to attend the meeting or if you have any questions, please call me at (661) 664-5536 or send me an e-mail maritzaj@khs-net.com. Thank you for your support. I look forward to seeing you at the meeting!

Sincerely,

Maritza Jimenez

Maritza Jimenez
Marketing & Public Affairs Representative
Kern Health Systems

AGENDA

PUBLIC POLICY/COMMUNITY ADVISORY COMMITTEE

KERN HEALTH SYSTEMS
5701 Truxtun Avenue
Suite 201 - Board Room
Bakersfield, California 93309

Regular Meeting
Tuesday, August 13, 2019

12:00 P.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 9700 Stockdale Highway, Bakersfield, 93311 during regular business hours, 8:00 a.m. – 5:00 p.m., Monday through Friday, following the posting of the agenda. Any supporting documentation that relates to an agenda item for an open session of any regular meeting that is distributed after the agenda is posted and prior to the meeting will also be available for review at the same location.

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

COMMITTEE TO RECONVENE

Members: Janet Hefner, Jennifer Wood, Jasmine Ochoa, Valerie Rangel, Cecilia Hernandez-Colin, Beatriz Basulto, Jenny Albert.

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" ARE CONSIDERED TO BE ROUTINE AND NON-CONTROVERSIAL BY KERN HEALTH SYSTEMS STAFF. THE "CA" REPRESENTS THE CONSENT AGENDA. CONSENT ITEMS WILL BE CONSIDERED FIRST AND MAY BE APPROVED BY ONE MOTION IF NO MEMBER OF THE BOARD 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 BOARD CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

CA-3) Minutes for Public Policy/Community Advisory Committee meeting on May 14, 2019 (Attachment) – APPROVE

CA-4) Membership Enrollment Report - Medi-Cal – (Attachment) – APPROVE

5) Member Services Report – (Nate Scott – Director of Member Services)
a. 2019 2nd Quarter Grievance Summary Report
b. 2019 2nd Quarter Grievance Report
(Attachments) – APPROVE

6) Health Education Report – (Isabel Silva, MPH – Director of Health Education/ Cultural & Linguistics Services)
a. 2019 2nd Quarter Health Education Activities Report – (Handout)
b. School Wellness Awards – (Presentation)
APPROVE

7) Disease Management Reports – (Michael Pitts, RN – Deputy Director of Health Services)
a. 2019 2nd Quarter Disease Management Report – (Attachment) – APPROVE

ADJOURN TO TUESDAY, NOVEMBER 12, 2019 (TBD) IF COMMITTEE APPROVES DATE. PLEASE NOTE NEW LOCATION FOR NOVEMBER MEETING: 2900 BUCK OWENS BOULEVARD. NEW OFFICE SCHEDULED TO OPEN ON SEPTEMBER 16, 2019. KHS WILL NO LONGER HAVE OFFICES ON STOCKDALE HIGHWAY OR TRUXTUN AVENUE.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the Board of Directors may request assistance at the Kern Health Systems office, 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.

SUMMARY OF PROCEEDINGS

PUBLIC POLICY/COMMUNITY ADVISORY COMMITTEE

KERN HEALTH SYSTEMS
5701 Truxtun Avenue
Suite 201 - Board Room
Bakersfield, California 93309

Regular Meeting
Tuesday, May 14, 2019
12:00 P.M.

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COMMITTEE RECONVENED

Members Present: Janet Hefner, Juan Vega, Pam Townsend, Beatriz Basulto

Members Absent: Jennifer Wood, Cecilia Hernandez-Colin, Jenny Albert

Meeting called to order at 12:06 P.M. by Louie Iturriria, Director of Marketing and Member Services

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CA-3) Minutes for Public Policy/Community Advisory Committee meeting on February 12, 2019 (Attachment) – APPROVED

CA-4) Membership Enrollment Report - Medi-Cal – (Attachment) – APPROVED

CA-5) Spanish Member Handbook – (Attachment) – APPROVED

All Consent Agenda Items Approved (CA-3 through CA-5)
Vega-Hefner: All Ayes

6) Health Homes Program – (Julie Worthing – Administrative Director, Health Homes Program)
a. Kern Family Health Care – Health Homes Program
(Presentation Only)

- **Julie Worthing gave overview of the Health Homes Program to the committee:**
  HHP is a no-cost program that serves members with complex chronic health conditions, like diabetes, hypertension or substance abuse disorder. Members who qualify for the program have a care team to provide supportive services to address their needs, including:
  - **Physical health**
  - **Behavioral health**
  - **Social and Community Needs**

7) Member Services Report – (Nate Scott – Director of Member Services)

a. 2019 1st Quarter Grievance Summary Report
b. 2019 1st Quarter Grievance Report
(Attachments) – APPROVED
Townsend-Vega: All Ayes

8) Health Education Report – (Isabel Silva, MPH – Director of Health Education/ Cultural & Linguistics Services)
   a. 2019 Summer Member Newsletter – (Discussion)
   b. 2019 Winter Member Newsletter – (Discussion)
      Jan Hefner, from the Center for Sexuality and Gender Diversity, suggested to add the subject of endometrial cancers to the winter newsletter.
   c. 2019 1st Quarter Health Education Activities Report
   (Attachment) – APPROVED
   Hefner-Townsend: All Ayes

9) Disease Management Reports – (Michael Pitts, RN – Deputy Director of Health Services)
   a. 2019 1st Quarter Disease Management Report – (Attachment) – APPROVED
   Vega-Townsend: All Ayes

MEETING ADJOURNED BY LOUIE ITURRIRIA,
DIRECTOR OF MARKETING AND PUBLIC RELATIONS @1:02 P.M.
TO TUESDAY, AUGUST 13, 2019 AT 12:00 P.M.

AMERICANS WITH DISABILITIES ACT
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KHS AUGUST 2019 ENROLLMENT:

Medi-Cal Enrollment

As of August 1, 2019, Medi-Cal enrollment is 173,555 which represents a decrease of 0.4% from July enrollment.

Seniors and Persons with Disabilities (SPDs)

As of August 1, 2019, SPD enrollment is 13,674, which is unchanged when compared to July enrollment.

Expanded Eligible Enrollment

As of August 1, 2019, Expansion enrollment is 60,967, which represents an increase of 0.1% from July enrollment.

Kaiser Permanente (KP)

As of August 1, 2019, Kaiser enrollment is 8,705, which represents an increase of 0.4% from July enrollment.

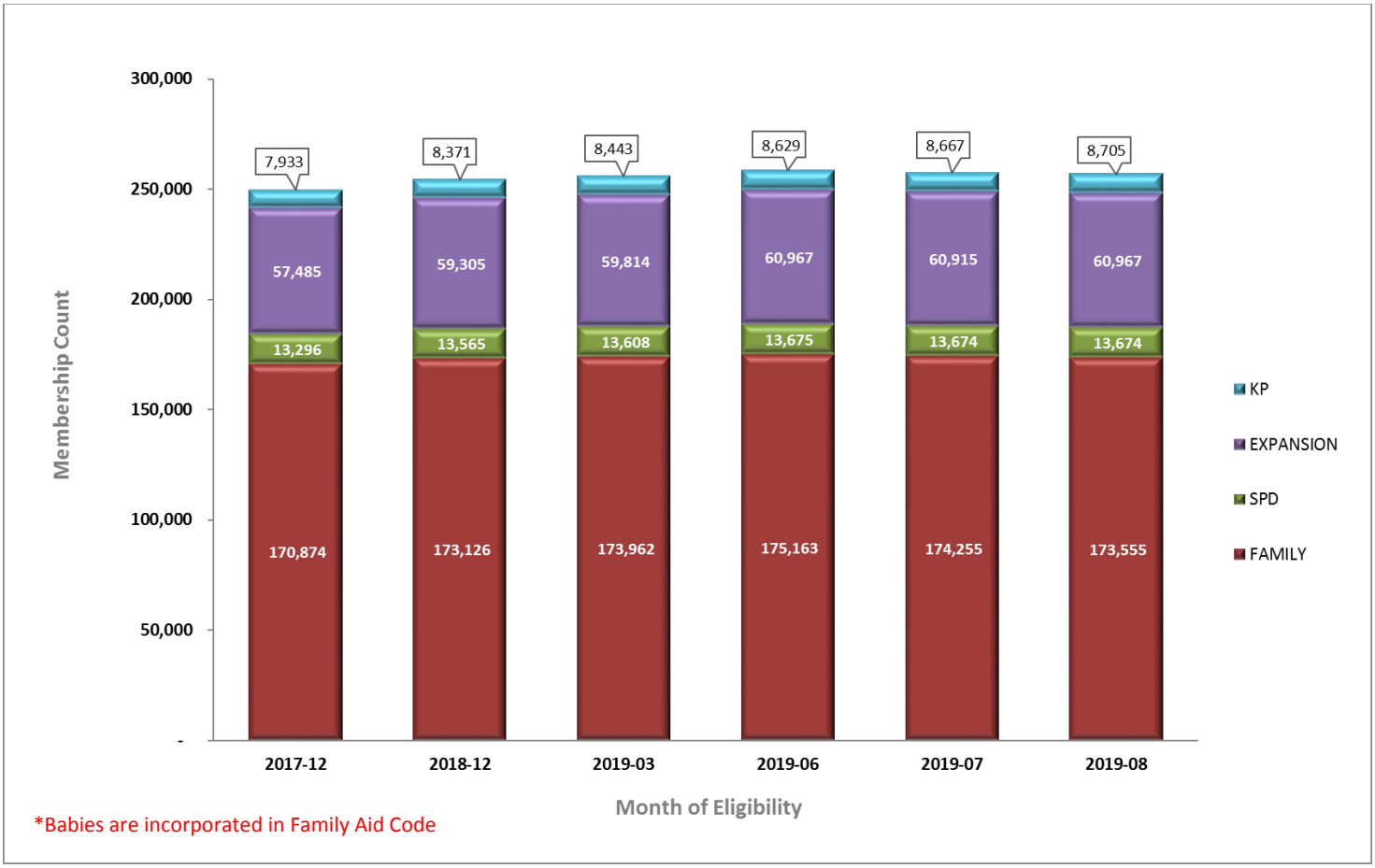
Total KHS Medi-Cal Managed Care Enrollment

As of August 1, 2019, total Medi-Cal enrollment is 256,901, which represents a decrease of 0.2% from July enrollment.

Membership as of Month of Eligibility	FAMILY	SPD	EXPANSION	KP	BABIES	Monthly/ Member Months Total
2017-12	170,428	13,296	57,485	7,933	446	249,588
2018-12	172,650	13,565	59,305	8,371	476	254,367
2019-03	173,572	13,608	59,814	8,443	390	255,827
2019-06	174,762	13,675	60,967	8,629	401	258,434
2019-07	173,860	13,674	60,915	8,667	395	257,511
2019-08	173,076	13,674	60,967	8,705	479	256,901 *

**Annually during 3rd and 4th quarters, the Kern County Department of Human Services (DHS) processes higher amounts of Medi-Cal renewals resulting in decreased enrollment. Historically, this enrollment reappears as new member growth during the 1st quarter of the following year as these Medi-Cal eligibles become re-enrolled.*

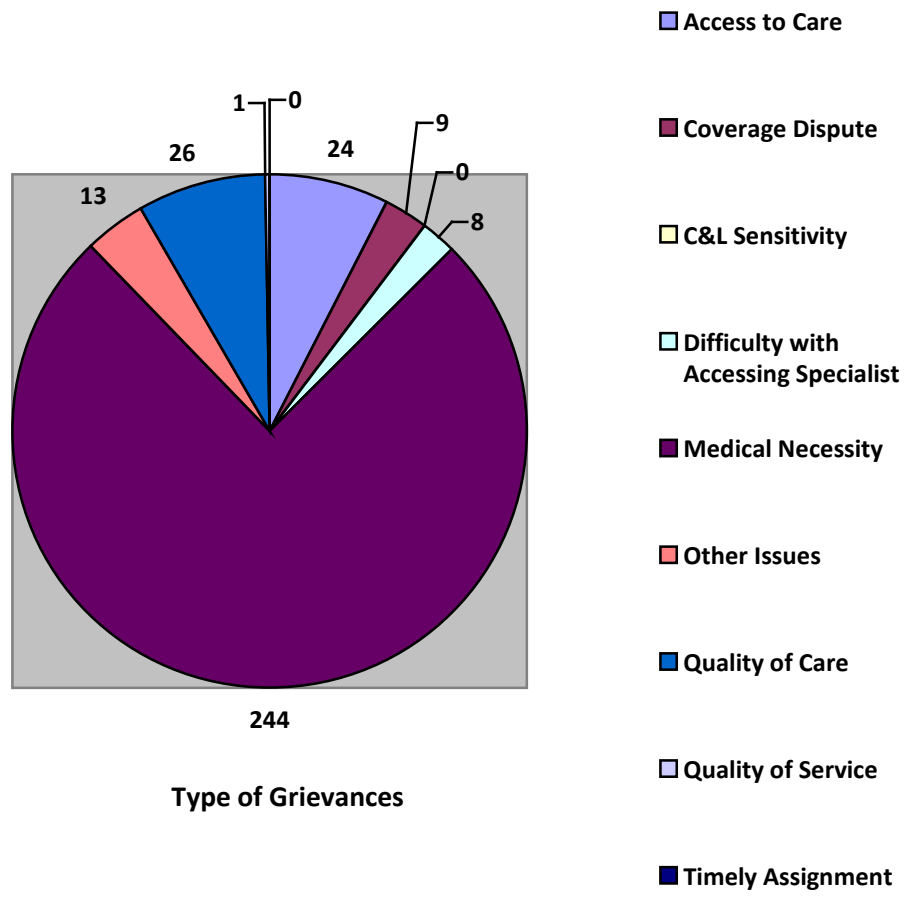
***In June 2019, we identified that membership numbers were not being refreshed. All reported membership volumes have since been reconciled, thus the difference in the membership counts previously reported.*



*Babies are incorporated in Family Aid Code

2nd Quarter 2019 Grievance Summary

Issue	Number	In Favor of Health Plan	In favor of Enrollee	Still under review
Access to care	24	19	5	0
Coverage dispute	9	9	0	0
Cultural and Linguistic Sensitivity	0	0	0	0
Difficulty with accessing specialists	8	5	3	0
Medical necessity	244	184	60	0
Other issues	13	13	0	0
Quality of care	26	14	12	0
Quality of service	1	1	0	0
Timely assignment to provider	0	0	0	0



Type of Grievances

Grievances per 1,000 Members = 1.25

During the second quarter of 2019, there were three hundred and twenty five grievances received. Eighty cases were closed in favor of the Enrollee; two hundred and forty five cases were closed in favor of the Plan. Three hundred and twenty four cases closed within thirty days, and one case was pended as additional information was required. Ninety eight cases were received from SPD (Seniors and Persons with Disabilities) members. One hundred and forty one cases were received from Medi-Cal Expansion members.

2nd Quarter 2019 Grievance Summary

Access to Care

There were twenty four grievances pertaining to access to care. Nineteen cases closed in favor of the Plan. Five cases closed in favor of the Enrollee. The following is a summary of these issues:

Fifteen members complained about the lack of available appointments with their Primary Care Provider (PCP). Eleven 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.

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

One member complained about the telephone access with their Primary Care Provider (PCP) appointment. This case closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access.

Coverage Dispute

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

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

Three members complained about the denial of a referral authorization request. All of the cases closed in favor of the Plan and the decisions were upheld after it was determined that the requests were appropriately denied as the requested services were not a covered benefit or the requested providers were not contracted under KFHC.

Cultural and Linguistic Sensitivity

There were no grievances pertaining to Cultural and Linguistic Sensitivity.

Difficulty with Accessing a Specialist

There were eight grievances pertaining to Difficulty Accessing a Specialist. Five cases closed in favor of the Plan. Three cases closed in favor of the Enrollee. The following is a summary of these issues:

Two members complained about the lack of available appointments with a specialist. One case closed in favor of the Plan after the responses indicated the offices provided

appropriate access to care based on the Access to Care Standards for specialty appointments. One case closed in favor of the Enrollee after the response indicated the office many not have provided appropriate access to care based on the Access to Care Standards for specialty appointments.

Two members complained about the wait time to be seen for a specialist appointment. One case closed in favor of the Plan after the responses indicated the member was seen within the appropriate wait time for an appointment. One case closed in favor of the Enrollee after the response indicated the member may not have been seen within the appropriate wait time for an appointment.

Four members complained about telephone access with a specialist's office. Three cases closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access. One case closed in favor of the Enrollee after the response indicated the office may not have provided appropriate telephone access.

Medical Necessity

There were two hundred and forty four grievances pertaining to Medical Necessity. One hundred and eighty four of the cases were closed in favor of the Plan. Sixty of the cases closed in favor of the Enrollee. The following is a summary of these issues.

One hundred and ninety seven members complained about the denial or modification of a referral authorization request. One hundred and thirty 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. Five out of the one hundred and thirty nine upheld cases were modified. Fifty eight cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned.

Forty seven members complained about the denial or modification of a TAR. Forty five 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. Two cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned.

Other Issues

There were thirteen grievances pertaining to Other Issues. All of the cases closed in favor of the Plan. The following is a summary of these issues:

One member complained they felt discriminated against by the staff in a provider's office due to them placing her on hold and how far out they scheduled her appointment. This case closed in favor of the Plan after the response from the provider indicated the member received the appropriate services and was not discriminated against.
One member complained that they felt discriminated against by a provider for refusing to see or treat her when not feeling well. This case closed in favor of the Plan after the

response from the provider indicated the reason member was not seen was because she did not have an appointment scheduled.

One member's mother complained that they felt discriminated against by a provider for not accepting member as a patient due to medical conditions. This case closed in favor of the Plan after the response from the provider indicated the provider was not taking new patients at this time.

One member complained that that they felt a specialist was racist towards them because of the language they spoke and because the provider did not provide the treatment they felt they needed. This case closed in favor of the Plan after the response from the provider indicated the provider used a translator during the appointment and recommended member be referred to a different specialist who could assist her better with her medical condition.

One member complained they paid out of pocket for durable medical equipment (DME) at a provider's office after staff told them the Plan would cover it. This case closed in favor of the Plan after the response from the provider acknowledged they never told member it would be covered and the member chose to pay. Member was provided emergency claim forms to submit receipts for review of reimbursement.

One member's mother complained that they felt member was discriminated against by the staff and providers with a hospital for suggesting she take member to an out of area hospital if services are needed in the future. This case closed in favor of the Plan after the response from the hospital indicated member's care was transferred to a children's hospital after no progress was made locally.

One member complained that they felt discriminated against by the staff and providers with a hospital because she felt they discharged her without treating her. This case closed in favor of the Plan after the response from the hospital indicated member was treated but did not agree with the treatment plan and left the hospital after verbal discharge was given.

One member complained that they felt discriminated against by the staff of a provider's office due to the color of her skin. This case closed in favor of the Plan after the response from the provider indicated the member received the appropriate services and they were not discriminated against.

One member complained that they felt discriminated against by a provider and their staff due to their sexuality. This case closed in favor of the Plan after the response from the provider indicated the member received the appropriate services and they were not discriminated against.

One member complained that a provider gave them the test results of another patient; therefore, a HIPAA violation was present. This case closed in favor of the Plan after the response from the provider indicated the member was not provided with the PHI of another patient. This case was sent to Compliance for further review.

One member appealed the denial of hospice care services with a non-participating provider. This case closed in favor of the Plan after the member was retro-disenrolled

from the plan during the processing of the appeal. Thus making the member no longer eligible with the Plan during the requested dates the authorization was asking services to be covered for.

One member's mother complained that a specialist would not allow her to attend her adult child's medical appointments. This case closed in favor of the Plan after the response from the provider indicated the member agreed that mother did not need to be in the exam room with her during the appointments, after mother had been disruptive.

One member complained that she felt the provider was not treating and diagnosing her in an acceptable time frame. This case closed in favor of the Plan as after the response from the provider indicated member was seen in an appropriate time frame and had future appointments and testing scheduled.

Quality of Care

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

Fifteen members complained about the quality of care received from a Primary Care Provider (PCP). Seven cases were closed in favor of the Plan after it was determined that the provider or their staff provided the member with the appropriate care. Eight cases closed in favor of the Enrollee after review of all medical documents and written responses received indicated that the care received may have been below standard.

Nine members complained about the quality of care received from a specialty provider. Five cases were closed in favor of the Plan after it was determined that the specialist provided the member with the appropriate care. Four cases closed in favor of the Enrollee after review of all medical documents and written responses received indicated that the care received may have been below standard.

Two members complained about the quality of care received from providers staffed by an urgent care. Both of these cases closed in favor of the Plan after it was determined that the hospital provided the members with the appropriate care

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

Quality of Service

There was one grievance pertaining to Quality of Service. This case closed in favor of the Plan. The following is a summary of this issue:

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

Timely Assignment to Provider

2nd Quarter 2019 Grievance Summary

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

Kaiser Permanente Grievances

During the second quarter of 2019, there were forty one grievances and appeals received by KFHC members assigned to Kaiser Permanente. Thirty nine cases were closed in favor of the Enrollee. Two cases are still pending closure at the time of this report.

Access to Care

There were four 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. These cases closed in favor of the Enrollee.

One member complained about the lack of Primary Care Provider (PCP) availability. This case closed in favor of the Enrollee.

Coverage Dispute

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

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

Medical Necessity

There were no grievances pertaining to Medical Necessity received this quarter.

Quality of Care

There were no grievances pertaining to quality of care received this quarter.

Quality of Service

There were thirty grievances pertaining to Quality of Service. Twenty eight cases closed in favor of the Enrollee. Two cases are still open pending review. The following is a summary of these issues:

Thirty members complained about the services being inadequate at a facility. Twenty eight cases were closed in favor of the Enrollee. Two cases are still open and pending review.

Grievance Report

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

Category	Q2 2019	Trend	Issue	Q1 2019	Q4 2018	Q3 2018
Access to Care	32		Appointment Availability	41	32	59
Coverage Dispute	9		Authorizations and Pharmacy	14	12	21
Medical Necessity	244		Questioning denial of service	228	240	267
Other Issues	13		Miscellaneous	9	10	7
Quality of Care	26		Questioning services provided. All cases forwarded to Quality Dept.	29	22	30
Quality of Service	1		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	6	3	2
Total Grievances	325			327	319	386

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Additional Insights-Grievance Detail

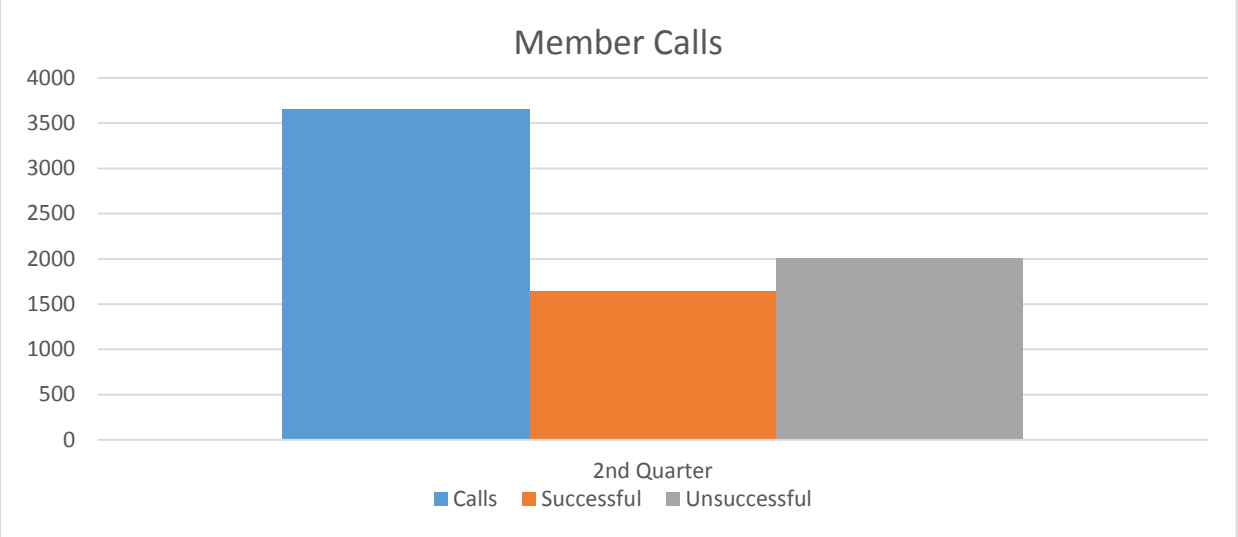
Issue	2nd Quarter Grievances	Upheld Plan Decision	Overturned Ruled for Member	Still Under Review
Access to Care (PCP)	24	19	5	0
Coverage Dispute	9	8	0	1
Specialist Access	8	5	3	0
Medical Necessity	244	184	60	0
Other Issues	13	13	0	0
Quality of Care	26	14	12	0
Quality of Service	1	1	0	0
Total	325	244	80	1

Disease Management Quarterly Report

2ND Quarter, 2019

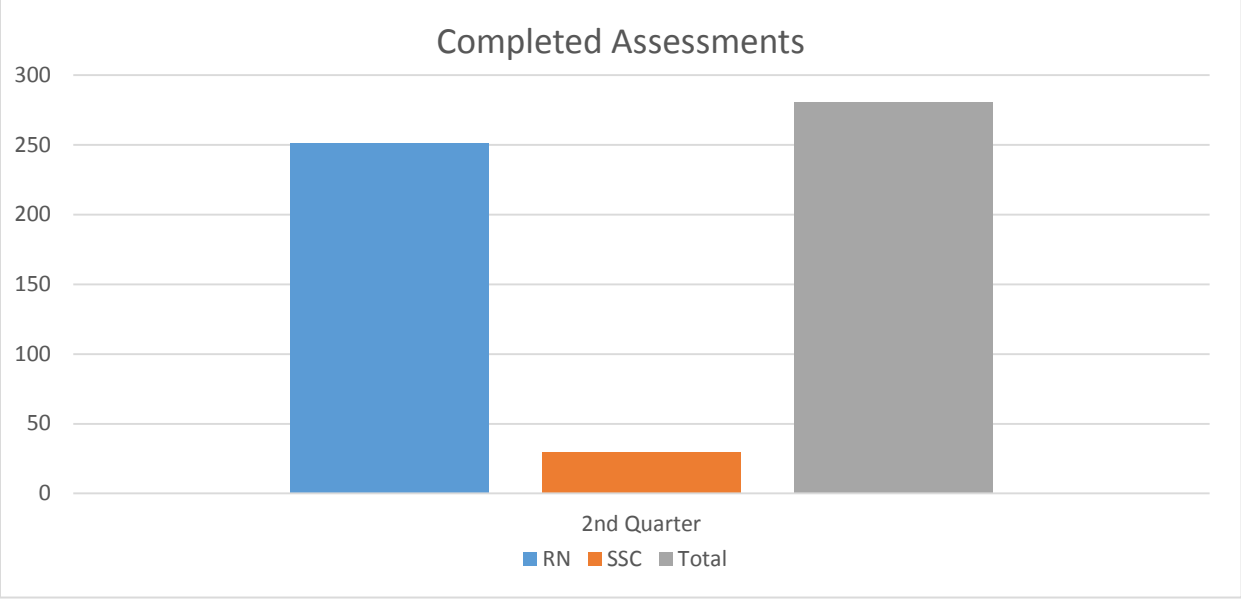
Telephone Calls: A total of 3,654 calls were made by the DM staff during the 2nd Quarter, 2019.

Member Calls Attempted	Successful Calls	Unsuccessful Calls	Total Member Calls	% Contacted
RN	856	1,582	2,438	35%
SSC	789	427	1,216	65%
Total	**1,645**	**2.009**	**3,654**	**45%**



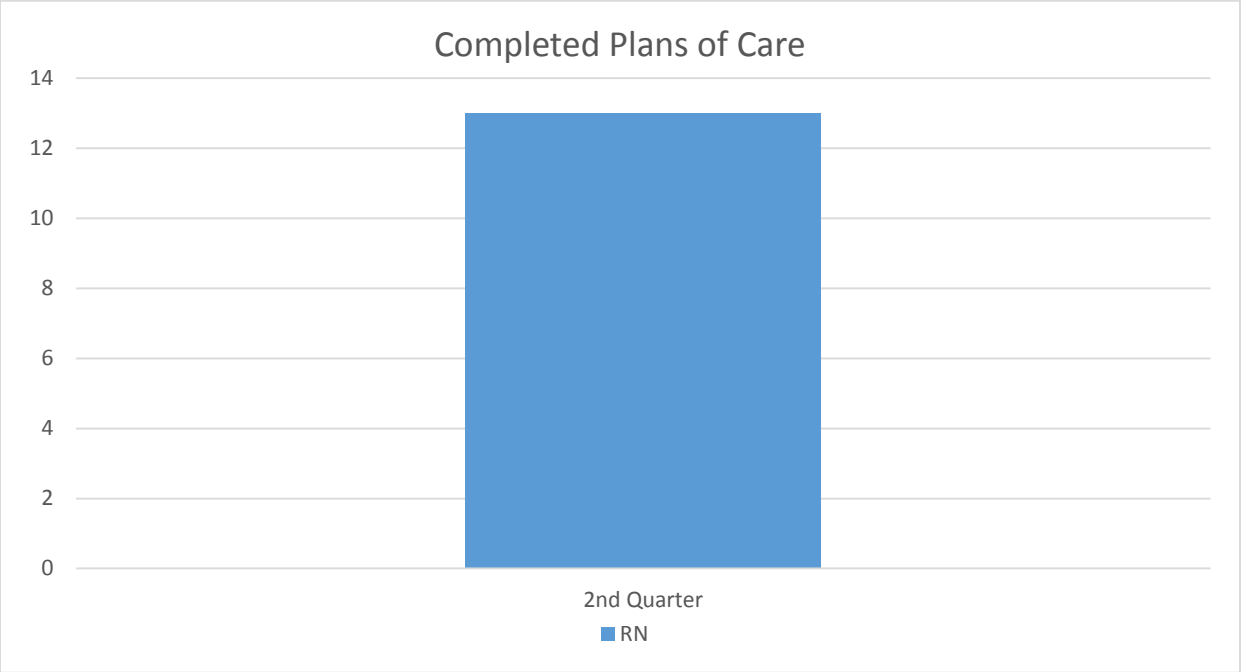
New Assessments Completed.

RN	SSC	Total
251	30	281



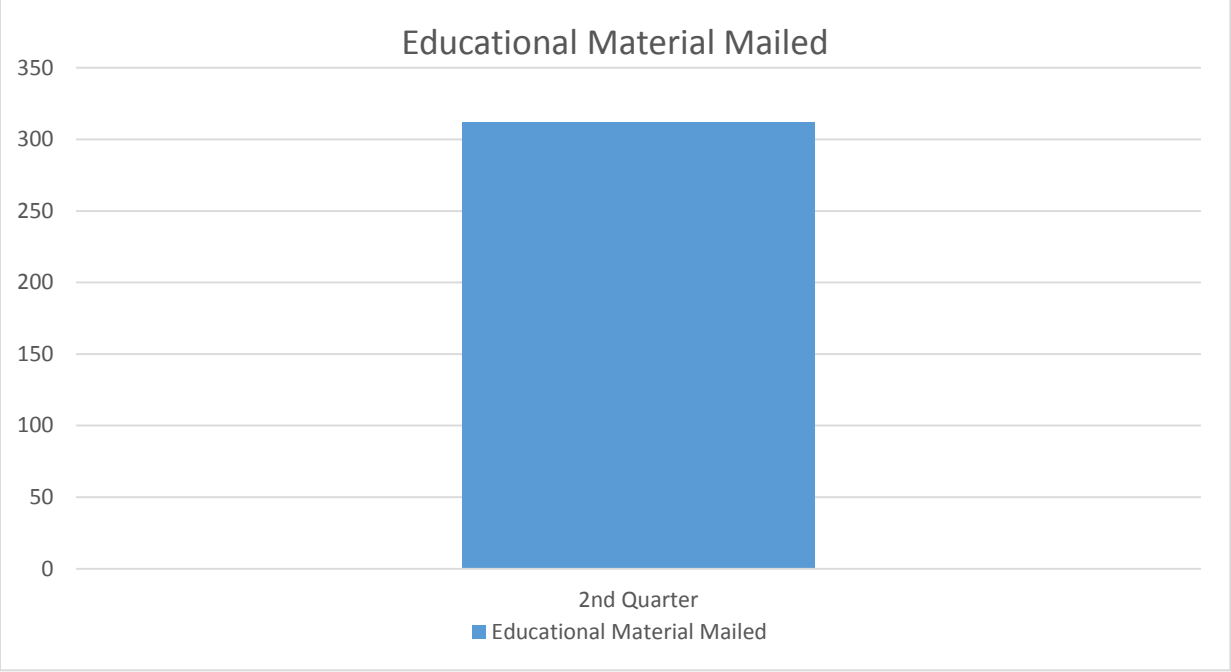
Plans of Care Completed & Closed.

RN
13



Educational Material Mailed.

312



Diabetes Eye Exams Scheduled.

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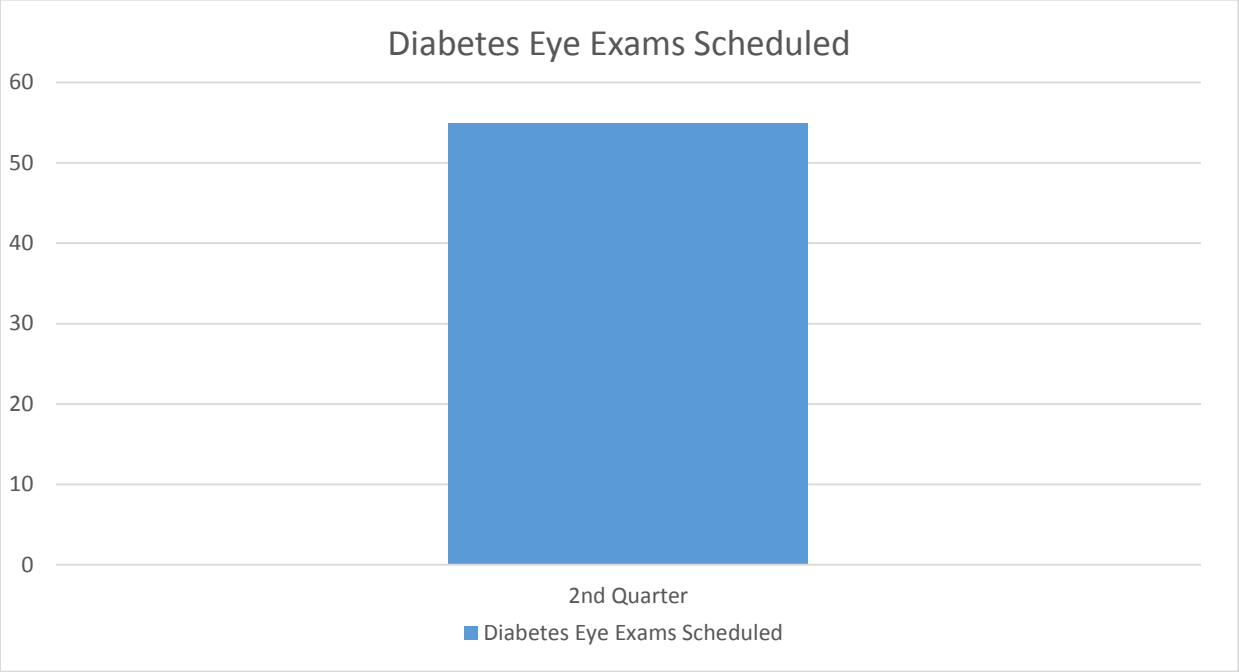
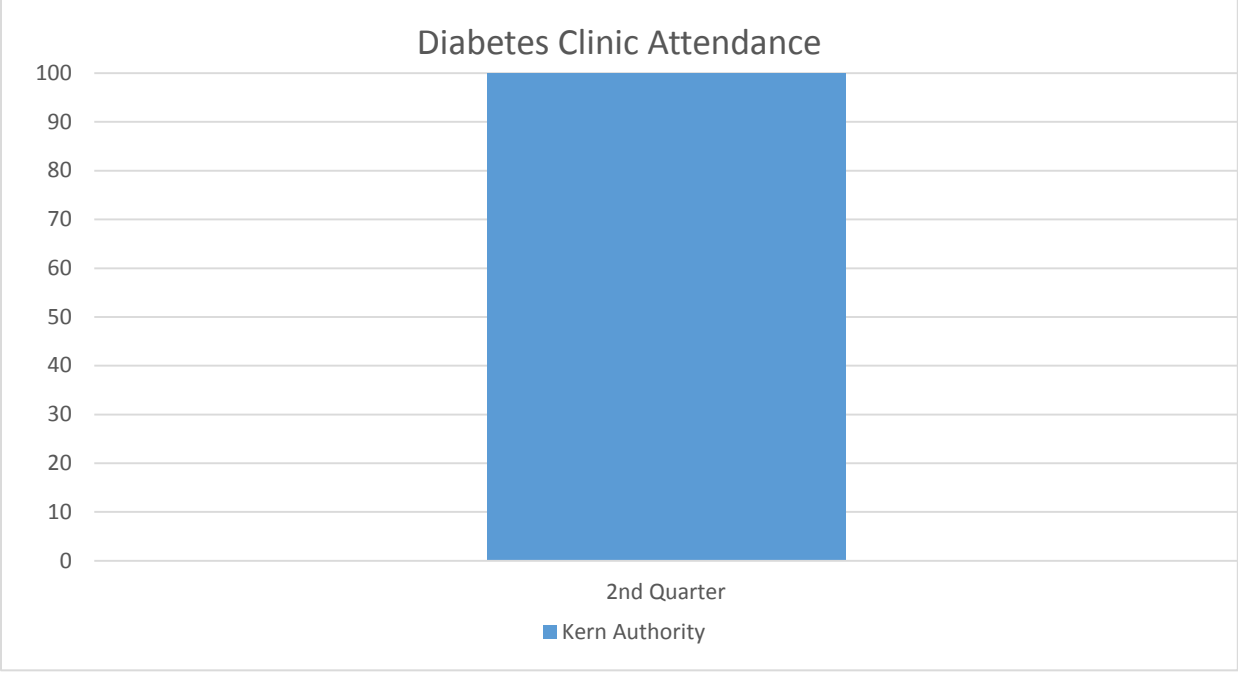


Diabetes Clinic Attendance.

Kern Authority
259



Diabetes Prevention Program: At the end of the 2nd Quarter, 27 members remain enrolled in the program.

Sessions Scheduled to Attend	Actual Sessions Attended
402	391