KERN HEALTH SYSTEMS

REGULAR MEETING OF THE QI/UM COMMITTEE

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

At
2900 Buck Owens Boulevard
4th Floor Kern River Room
Bakersfield, CA 93308
(Virtual Meeting)

The public is invited

For more information, call (661) 664-5000

Agenda

Quality Improvement (QI) / Utilization Management (UM) Committee
(VIRTUAL) MEETING

Kern Health Systems
4th Floor Kern River Room
2900 Buck Owens Boulevard
Bakersfield, California 93308

Virtual Meeting
Thursday, August 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 May 21st, 2020 – APPROVE

7) Physician's Advisory Committee (PAC) Summary of Proceedings 2nd Quarter – RECEIVE AND FILE
   - May 2020
   - June 2020

Pharmacy Reports

CA-8) Pharmacy TAR Log Statistics 2nd Quarter 2020 – RECEIVE AND FILE

Quality Improvement Department Summary Reports

9) Quality Improvement Department Summary Reports 2nd Quarter 2020- 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-2nd Quarter 2020 –RECEIVE AND FILE
   - KFHC Volumes Report 2nd Quarter 2020 – RECEIVE AND FILE
   - Kaiser Reports will be available upon Request

VSP Reports

11) VSP Reports
- Medical Data Collection Summary Report 2020– APPROVE
- VSP DER Effectiveness Report – APPROVE
- VSP Monthly Call Response Summary- APPROVE

Member Services

12) Grievance Operational Board Update - RECEIVE AND FILE
- 2nd Quarter 2020

13) Grievance Summary Reports – RECEIVE AND FILE
- 2nd Quarter 2020

Provider Relations

14) Re-credentialing Report 2nd Quarter 2020 – RECEIVE AND FILE
CA-15) Board Approved New Contracts – RECEIVE AND FILE
CA-16) Board Approved Providers Reports – RECEIVE AND FILE
CA-17) Provider Relations Network Review Report 2nd Quarter 2020– RECEIVE AND FILE

Disease Management

18) Disease Management 2nd Quarter 2020 Report – APPROVE

DHCS COVID-19 Documents

19) DHCS Hypertension Recommendations for Covid-19 Postcard- RECEIVE AND FILE

Policies and Procedures

CA-20 QI/UM Policies and Procedures- APPROVE
- 2.26-I Hospital Readmissions- Identification of Potential Inappropriate Care Issues
- 3.31-P Emergency Services Clean
- 3.40-I Continuity of Care for New Members
- 3.61-I Comprehensive Case Management and Coordination of Care

Health Education Report

CA-21) Health Education Activity Report 2nd Quarter 2020 – APPROVE
CA-22) Population Needs Assessment 2nd Quarter 2020 -APPROVE

UM Department Reports

23) Combined UM Reporting 2nd Quarter 2020 – APPROVE

ADJOURN TO THURSDAY, NOVEMBER 12TH, 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
(VIRTUAL) MEETING

Kern Health Systems
2900 Buck Owens Boulevard
Bakersfield, California 93308

Virtual Meeting
Thursday, May 21, 2020
7:00 A.M.

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Members Present: Danielle C Colayco, PharmD; Allen Kennedy; Chan Park, MD; Martha Tasinga; MD, CMO

Members Absent: Jennifer Ansolabehere, Satya Arya, MD; PHN; Philipp Melendez, MD; Maridette Schloe; MS, LSSBB

Meeting was called to order at 7:06 A.M. by Jane Daughenbaugh, Director of Quality Improvement

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STAFF RECOMMENDATION SHOWN IN CAPS

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NO ONE HEARD.

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee Members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Gov. Code Sec. 54954.2[a]) **NO ONE HEARD.**

3) Announcements – **None**

4) Closed Session – **N/A**

5) CMO Report –

- **COVID impact to KHS**
  - **Telehealth expansion**
  - **Authorization extensions for many services from January through December 2020**
- **Provider Relief Program**
  - **Funding advances related to reduction in services during COVID**
  - **Application available on KHS website**

CA-6) QI/UM Committee Summary of Proceedings February 20th, 2020 – APPROVED
Kennedy-Park: All Ayes

7) Physician's Advisory Committee (PAC) Summary of Proceedings 1st Quarter – RECEIVED AND FILED - **Park-Kennedy: All Ayes**
   - February 2020
   - March 2020

CA-8) Pharmacy TAR Log Statistics 1st Quarter 2020 – RECEIVED AND FILED
Park-Kennedy: All Ayes

9) Quality Improvement Department Summary Reports 1st Quarter 2020- APPROVED
Park-Kennedy: All Ayes

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

- KFHC APL Grievance Report-1st Quarter 2020 –RECEIVED AND FILED
- KFHC Volumes Report 1st Quarter 2020 – RECEIVED AND FILED
- Kaiser Reports will be available upon Request

VSP Reports - Park-Kennedy: All Ayes
11) VSP Reports

- Medical Data Collection Summary Report 2020– APPROVED
- VSP DER Effectiveness Report – APPROVED

Member Services - Park-Colayco: All Ayes
12) Grievance Operational Board Update - RECEIVED AND FILED

- 1st Quarter 2020

13) Grievance Summary Reports – RECEIVED AND FILED

- 1st Quarter 2020

Provider Relations – Park-Kennedy: All Ayes
14) Re-credentialing Report 1st Quarter 2020 – RECEIVED AND FILED
CA-15) Board Approved New Contracts – RECEIVED AND FILED

- Effective March 1st, 2020
- Effective April 1st, 2020
- Effective May 1st, 2020

CA-16) Board Approved Providers Reports – RECEIVED AND FILED

- Effective March 1st, 2020
- Effective April 1st, 2020
- Effective May 1st, 2020

CA-17) Provider Relations Network Review Report 1st Quarter 2020– RECEIVED AND FILED

Disease Management - Park-Kennedy: All Ayes

18) Disease Management 1st Quarter 2020 Report – APPROVED

QI-UM Program Document Reports - Park-Kennedy: All Ayes

19) KHS 2019 QI Program Evaluation – RECEIVED AND FILED
20) KHS 2020 QI Program Description – RECEIVED AND FILED
21) KHS 2020 QI Work Plan – RECEIVED AND FILED
22) KHS 2019 UM Program Evaluation - RECEIVED AND FILED
23) KHS 2020 UM Program Description - RECEIVED AND FILED

Health Education Reports - Park-Kennedy: All Ayes

24) Health Education Activity Report 1st Quarter 2020 – APPROVED

- **Population Needs Assessment is currently being prepared to submit to DHCS by 6/30/20. Findings and action plan will be presented to the committee at the next quarterly meeting.**

- **Virtual health education classes via GoToMeeting are now offered in lieu of in-person meetings due to COVID-19 pandemic. 1:1 telephonic appointments are also being made available to members. Services are available in English and Spanish. Greater participation is being found with the English speaking members through the virtual health education classes. Class dates and times can be found on the KFHC website.**

- **Video Remote Interpreting Services are available in lieu of in-person interpreting services. Telephonic interpreting services are still being encouraged. Providers can contact the C&L Supervisor or their PR Rep for more information. Detailed information on interpreter requests can be found in the quarterly health education activities report.**

- **Fall 2020 Member Newsletter is currently being planned. Articles will include information on telehealth appointments and COVID-19. Newsletter is estimated to arrive at member homes the end of September.**

UM Department Reports – Kennedy-Park: All Ayes

25) Combined UM Reporting 1st Quarter 2020 – APPROVED
26) Provider Information and Resources during COVID-19 Emergency
    - CDPH National Infant Immunization Flyer - RECEIVED AND FILED
    - Asthma and COVID-19 Postcard - RECEIVED AND FILED

- Immunization Week Takeaway - RECEIVED AND FILED
- Prenatal and Postpartum Care QI Postcard - RECEIVED AND FILED
- Well-Child visits and COVID-19 Postcard - RECEIVED AND FILED
- QI Diabetes Post Card - RECEIVED AND FILED

- **Deb Murr, CHSO, provided information to the committee regarding the new post card information regarding prenatal and post-partum care, diabetes, asthma care, and well child visits that provide education and guidance regarding care during COVID-19 pandemic.**

- **Shannon provided overview to the committee on UM reporting. Discussed actions taken including staff refresher training regarding criteria selection and attachment to address the quarter where compliance was found to be 75%. Improvements were seen in subsequent quarters. Also briefly discussed slight inpatient length of stay we are seeing in late first quarter to current day. Discussed planned revision to inpatient reporting to further separate inpatient acute admissions, observation stays, and post-acute stays.**

Meeting adjourned by Dr. Martha Tasinga, M.D., C.M.O. @ 8:52 A.M.
to Thursday, August 20, 2020 at 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

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

Wednesday, May 6, 2020
7:00 A.M.

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COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Ph.D; David Hair, M.D., Miguel Lascano, M.D., Ashok Parmar, M.D., Raju Patel, M.D.; Martha Tasinga, M.D., C.M.O.

Members Absent: None

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

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   - **NO ONE HEARD**

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

CLOSED SESSION

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

   - **New App (LSC-ASC) Action tabled pending clarification of procedures approved under the accreditation with the Joint Commission.**
   - **New App (SK) Provider's past adverse actions at Cedars Sinai were discussed in detail and there were no reservations by the members that would preclude adding this provider to the network. Patel motioned/Lascano 2nd**
   - **New App (LL) Action tabled pending additional information related to settled case. Provider will be asked for further details surrounding the missed Rh negative status and what quality of care concerns were in question in Hanford.**
   - **New App (BS) Provider's past adverse actions and satisfactory completion of probation were discussed in detail and there were no reservations by the members that would preclude adding this provider to the network.**
   - **PRV004006 -Recedentialing application and current MBC probationary requirements were discussed. Motion to proceed with recredentialing as long as all probationary requirements are being met including**

supervision by M. Berry, MD and no solo practice. If probationary requirements are not being met, PAC will review at next meeting.

- **PRV001719 - Recedentialing application and settled case reviewed in detail. Members discussed the punctured lung being a known complication of Trigger Point Injection in the lumbar spine. There were no reservations by the members that would preclude adding this provider to the network. Amin motion / Hair 2nd**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:50 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on March 4, 2020 – APPROVED
Amin-Patel: All Ayes

5) 2019 Utilization Management (UM) Evaluation - APPROVED

6) 2020 Utilization Management (UM) Program Description – APPROVED
Lascano-Patel: All Ayes (for Items 5 & 6)

7) 2019 Quality Improvement (QI) Program Evaluation- APPROVED

8) 2020 Quality Improvement (QI) Program Description – APPROVED

9) 2020 Quality Improvement (QI) Program Work plan - APPROVED
Amin-Parmar: All Ayes (for Items 7, 8, & 9)

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 8:07 A.M. TO WEDNESDAY, JUNE 3, 2020 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

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

Wednesday, June 3, 2020
7:00 A.M.

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COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Ph.D; David Hair, M.D., Ashok Parmar, M.D., Raju Patel, M.D., Martha Tasinga, M.D., C.M.O.

Members Absent: Miguel Lascano, M.D.

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

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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   - **NO ONE HEARD**

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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ADJOURNED TO CLOSED SESSION @ 7:09 A.M.

CLOSED SESSION

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

   - **Dr. Tasinga informed the committee that prior to the State's stay-in-place orders, the PAC planned to conduct a 6-month follow-up on Provider PRV000383's review of procedures conducted last year. Provider PRV000383's is requesting to continue to do some of the reviewed procedures. An extensive discussion was completed regarding the provider not having hospital privileges at any local in the event a complication arises requiring an emergent transfer to the hospital. PAC members also discussed the procedures being requested could potentially be outside a family practitioners scope of practice in some situations.**
   - **The committee members agreed further review was needed regarding the practitioner's request and scope of practice for a family practitioner and will be reviewed at the next meeting in order for further committee guidance and recommendations for this request.**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:47 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on May 6, 2020 – APPROVED
Parmar-Patel: All Ayes

5) Review Policy 3.40-I Continuity of Care for New Members - APPROVED
Parmar-Patel: All Ayes

6) Review Policy 3.61-I Comprehensive Case Management – APPROVED
Parmar-Patel: All Ayes

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 7:56 A.M. TO WEDNESDAY, AUGUST 5, 2020 @ 7:00 A.M.

NO JULY MEETING

AMERICANS WITH DISABILITIES ACT
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Quarter/Year of Audit	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020
Month Audited	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Total TAR's for the month	3652	3300	3311	3367	3099	3409						
TAT Compliant	100%	100%	100%	100%	99%	100%						
NOA Compliant	98%	96%	98%	100%	100%	100%						
APPROVED TAR'S												
Timeliness - Reviewed & Returned in 1 busines day	77/77	76/76	79/79	87/87	73/74	68/68						
Date Stamped	77/77	76/76	79/79	87/87	74/74	68/68						
Fax copy attached	77/77	76/76	79/79	87/87	74/74	68/68						
Decision marked	77/77	76/76	79/79	87/87	74/74	68/68						
DENIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	64/64	47/47	61/61	58/58	56/56	59/59						
Initally Denied - Signed by Medical Dir and/or Pharm	64/64	47/47	61/61	58/58	56/56	59/59						
Letter sent within time frame	64/64	47/47	61/61	58/58	56/56	59/59						
Date Stamped	64/64	47/47	61/61	58/58	56/56	59/59						
Fax copy attached	64/64	47/47	61/61	58/58	56/56	59/59						
Decision marked	64/64	47/47	61/61	58/58	56/56	59/59						
Correct form letter, per current policies used	64/64	47/47	61/61	58/58	56/56	59/59						
NOA Commentary Met	63/64	45/47	60/61	58/58	56/56	59/59						
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	0	0	0	0	0	0	0	0	0	0
DUPLICATE TAR'S												
Timeliness - Reviewd & Returned in 1 business day	17/17	21/21	9/9	7/7	15/15	16/16						
Date Stamped	17/17	21/21	9/9	7/7	15/15	16/16						
Fax copy attached	17/17	21/21	9/9	7/7	15/15	16/16						

KERN HEALTH SYSTEMS
Quality Improvement Department Quarterly QI-UM Committee Report
Q2 2020

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 Inappropriate Care (PIC) Notifications

II. Site Reviews

   a. Initial Full Site Reviews

   b. Periodic Full Site Reviews

   c. Focus/Interim Reviews

III. Quality Improvement Projects

   a. Performance Improvement Projects (PIPs)

   b. MCAS Member Incentive and Engagement Project

IV. MCAS Accountability Set (MCAS) Updates

V. Policy and Procedures and other program documents

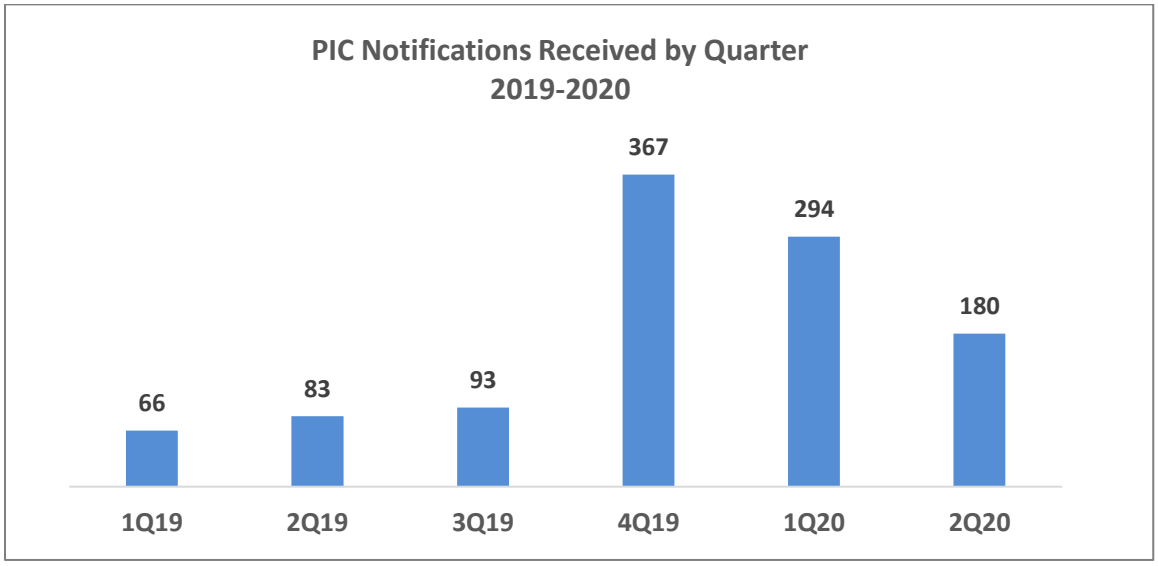
I. Potential Inappropriate Care (PIC) Notifications:

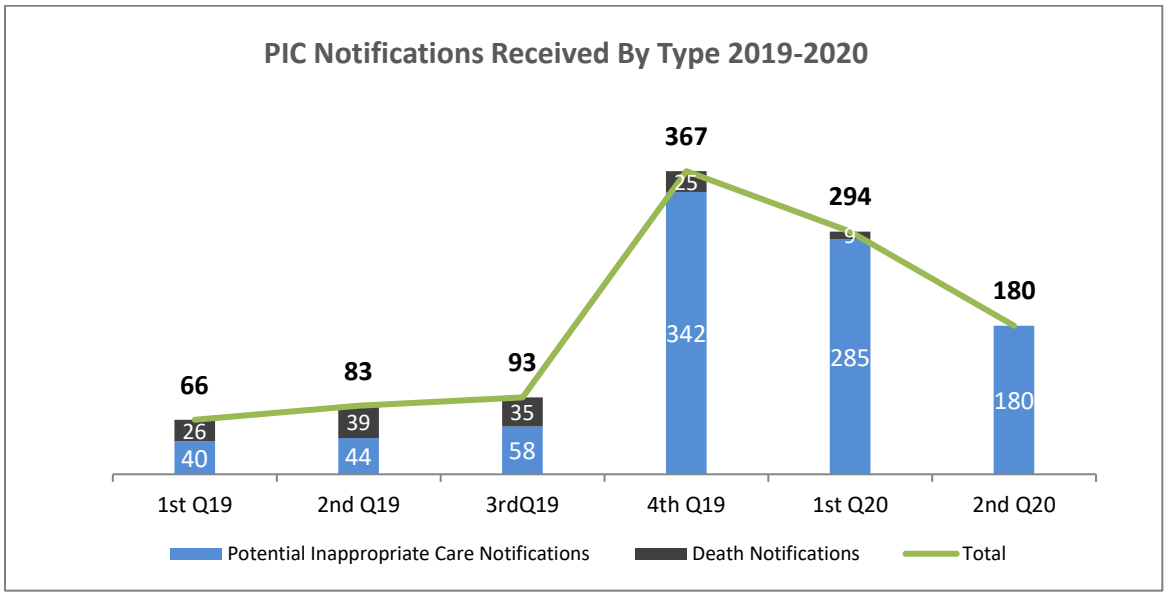
QI receives Notifications from various sources to review for potential inappropriate care issues.

On receipt of a potential inappropriate care issue, a high-level review is completed by a QI RN to determine what level of Potential Quality Issue exists.

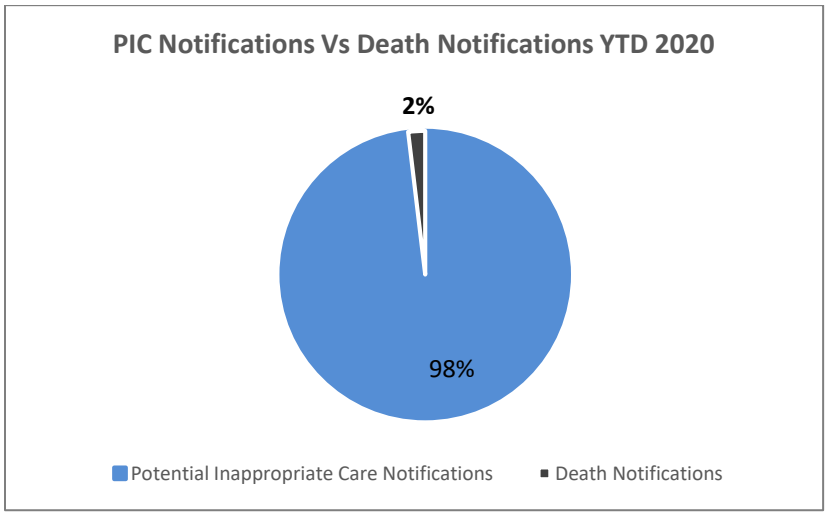
PICs are assigned a level based on the outcome of the review. The levels assigned are as follows:

- 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





From the above charts, we received a total of 180 notifications for the 2nd Quarter of 2020. This is almost a 39% decrease in the notifications compared to previous quarter. Some of the decline in the PIC notifications may be due to the COVID-19 pandemic that started to gain attention during the month of March. There might also be decline due to change in the referral process that occurred in the 4th quarter 2019. We will continue to monitor for any trending.



Compared to last quarter total YTD PIC vs death notifications, PICs increased by 1% and Death notifications decreased by 1%. QI only receives death notifications if there is a quality of care concern. Since March 2020, no death notifications with a quality of care concern have been received which is the reason for the decline.

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:

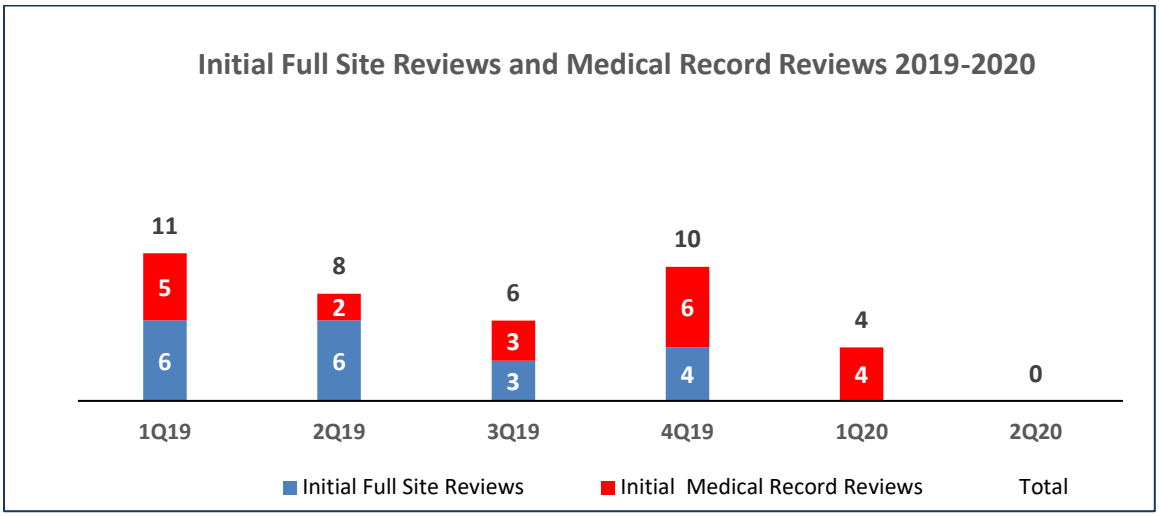
Exempted Pass: 90% or above
Conditional Pass: 80-89%
Not Pass: below 80%

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.

THE DEPARTMENT OF HEALTH CARE SERVICES (DHCS) HAS DELAYED MANAGED CARE PLANS FROM CONDUCTING SITE REVIEWS UNTIL 6 MONTHS AFTER THE COVID-19 EMERGENCY RESPONSE SITUATION HAS ENDED. KHS IS ATTEMPTING TO DO ABBREVIATED REVIEWS DURING THE PANDEMIC AS PROVIDERS ARE ABLE TO DO SO.

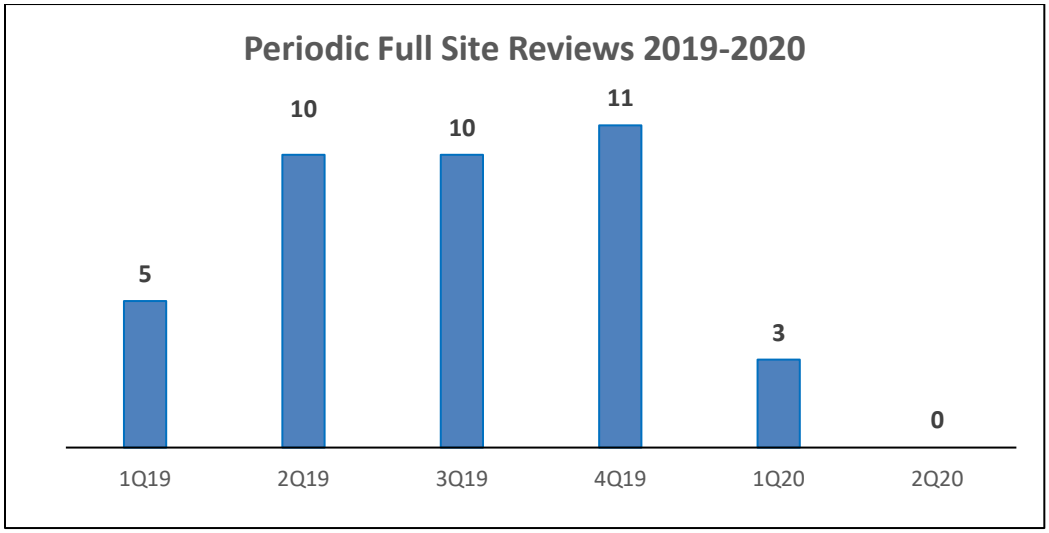
Initial Facility Site Review and Medical Record Review Results:



No trends are identified, and this chart simply reflects the volume of new providers in KHS's Network. Due to COVID-19 pandemic and for the safety of staff, providers and members, KHS staff are not physically going to provider offices. FSRs and MRRs are being done using an abbreviated model as an interim measure until we are able to return to doing full on-site reviews after the COVID-19 emergency response situation ends. Our ability to do this reduced form of review is dependent on the providers' ability to provide the necessary documentation. We are going to explore the possibility of using an audio-visual app to conduct portions of these reviews.

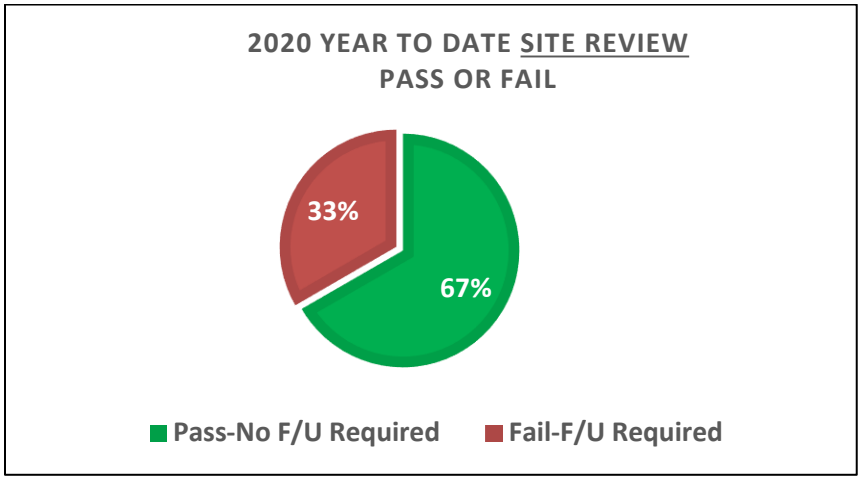
Periodic Full Site Reviews

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.

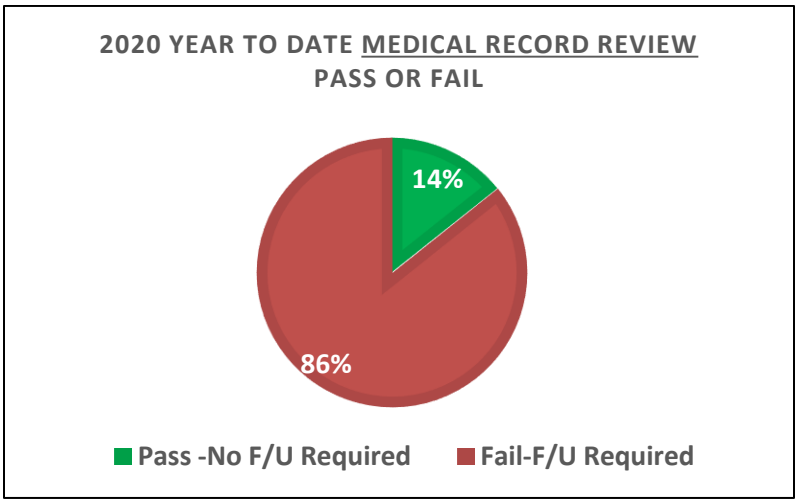


This above chart reflects the number of Periodic Full Site Reviews that were due and completed for each quarter. Due to COVID-19 pandemic and for the safety of staff, providers and members, KHS staff are not physically going to provider offices. FSRs and MRRs are being done using an abbreviated model as an interim measure until we are able to return to doing full on-site reviews after the COVID-19 emergency response situation ends. Our ability to do this reduced form of review is dependent on the providers' ability to provide the necessary documentation. We are going to explore the possibility of using an audio-visual app to conduct portions of these reviews.

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



In 2020 YTD 67% of the Initial and Periodic site reviews performed passed on the first visit and 33% required follow-up. Since last quarter, there is no change in this percentage, as there are no full site reviews or follow ups conducted since March due to Covid-19 situation.

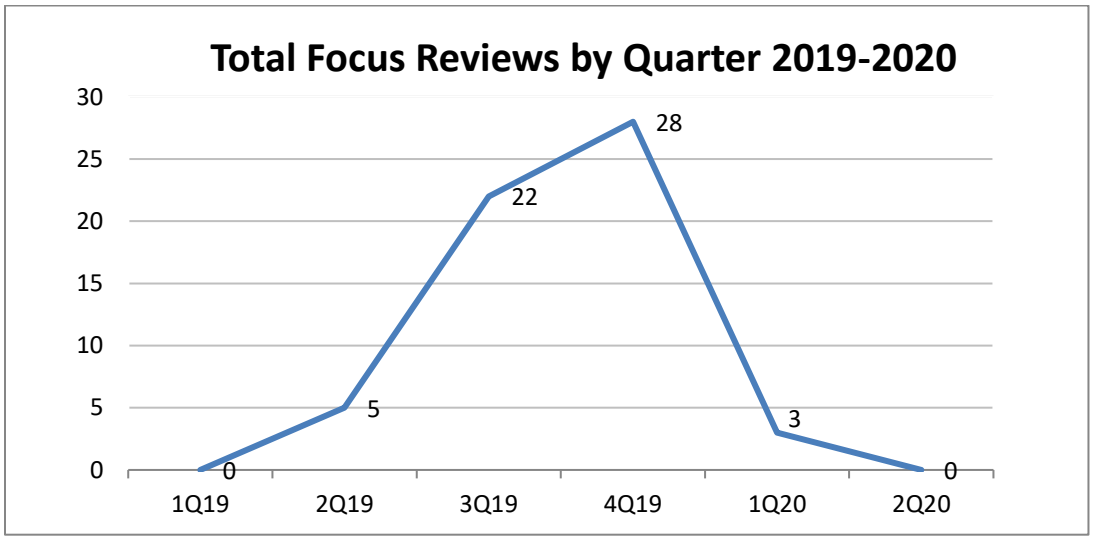


For 2020 YTD, there were 7 medical reviews conducted. All the sites except one failed in the first visit and all the other had an additional follow-up scheduled. Typically, there are more follow-ups required for Medical Record Reviews.

Quality Improvement explores opportunities to improve areas on a broader basis for areas with consistent non-compliance. For the Q2 of 2020 there were no site reviews conducted except one Medical record review. We have insufficient data to pick the top 3 deficiencies identified in facility site reviews and Medical record reviews.

Focus Reviews:

Focus Reviews are conducted between Initial and first Periodic Full Site Reviews or between two Periodic Full Site Reviews. Typically, they occur about every 18 months. These reviews are intended to be a check-in to ensure the provider is compliant with the 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.

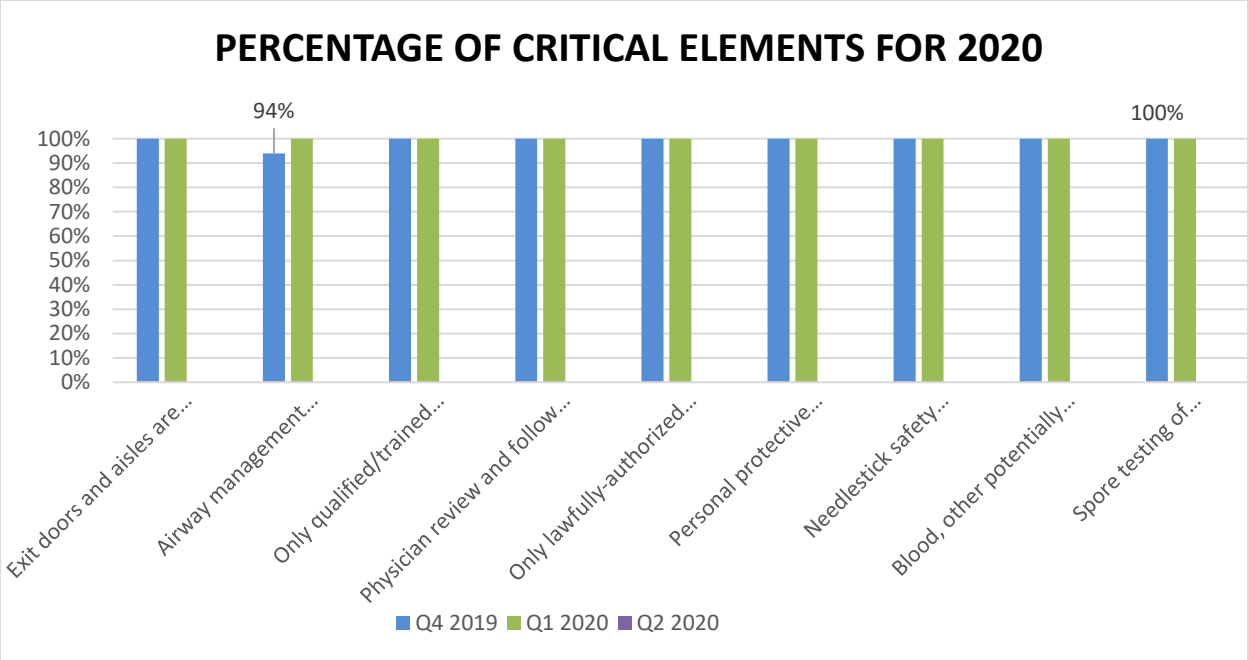


Note There is no data for the 1st Quarter of 2019 due to HEDIS Review Activity.

For the Q2 of 2020 there are no focus reviews due to COVID-19 pandemic and for the safety of staff, providers and members, KHS staff are not physically going to provider offices. Focus Review are being done using an abbreviated model as an interim measure until we are able to return to doing full on-site reviews after the COVID-19 emergency response situation ends. Our ability to do this reduced form of review is dependent on the providers' ability to provide the necessary documentation. We are going to explore the possibility of using an audio-visual app to conduct portions of these reviews.

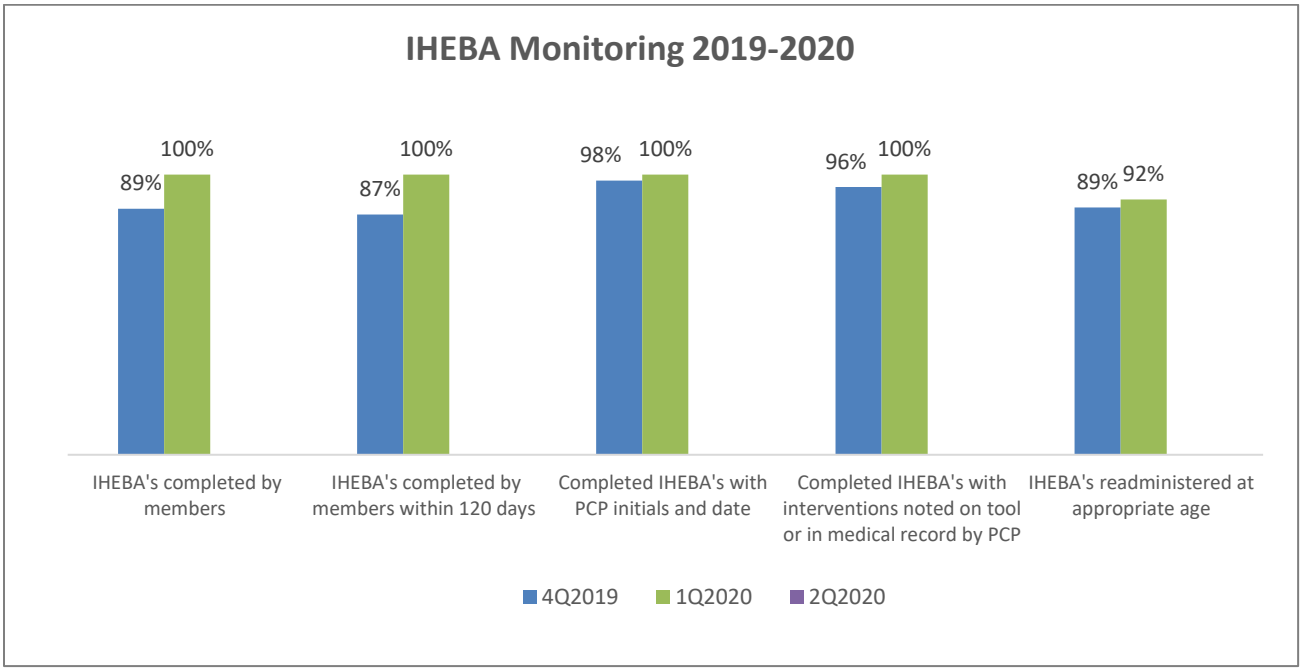
KHS is responsible for systematic monitoring of all PCP and OB/GYN sites between each regularly scheduled, full scope site review surveys. This monitoring includes the nine (9) critical elements. These nine critical survey elements are related to the potential for adverse effect on patient health or 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.



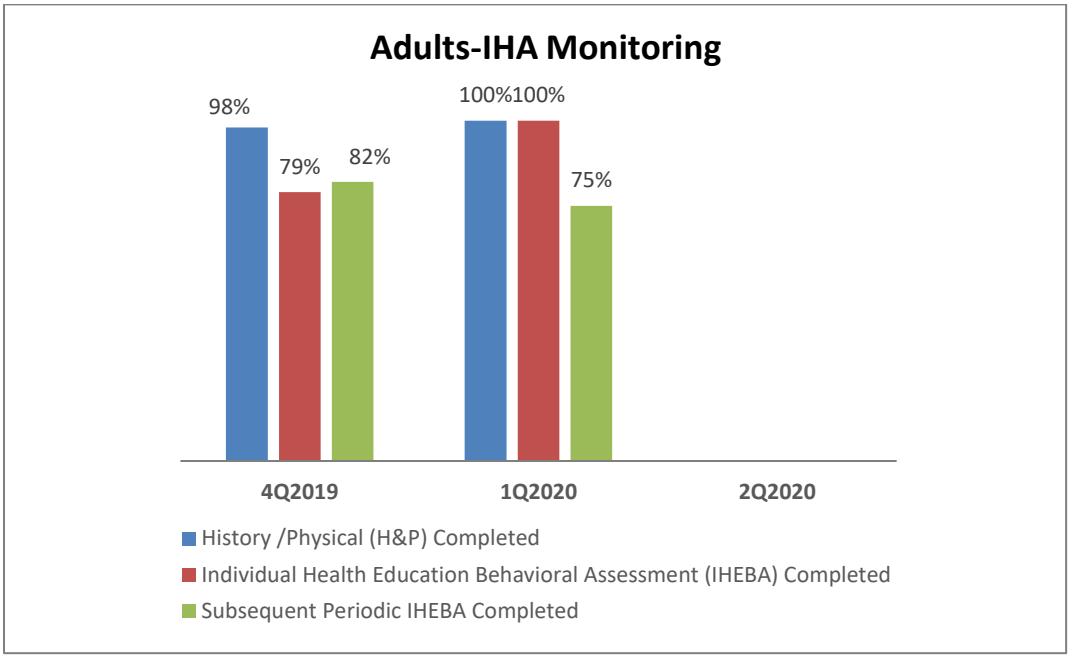
Analysis for Critical Elements:
The above Critical elements are reported only for Focus reviews. Since there were no focus reviews performed in 2nd Quarter of 2020 (due to COVID-19) there is no data for this quarter.

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%.

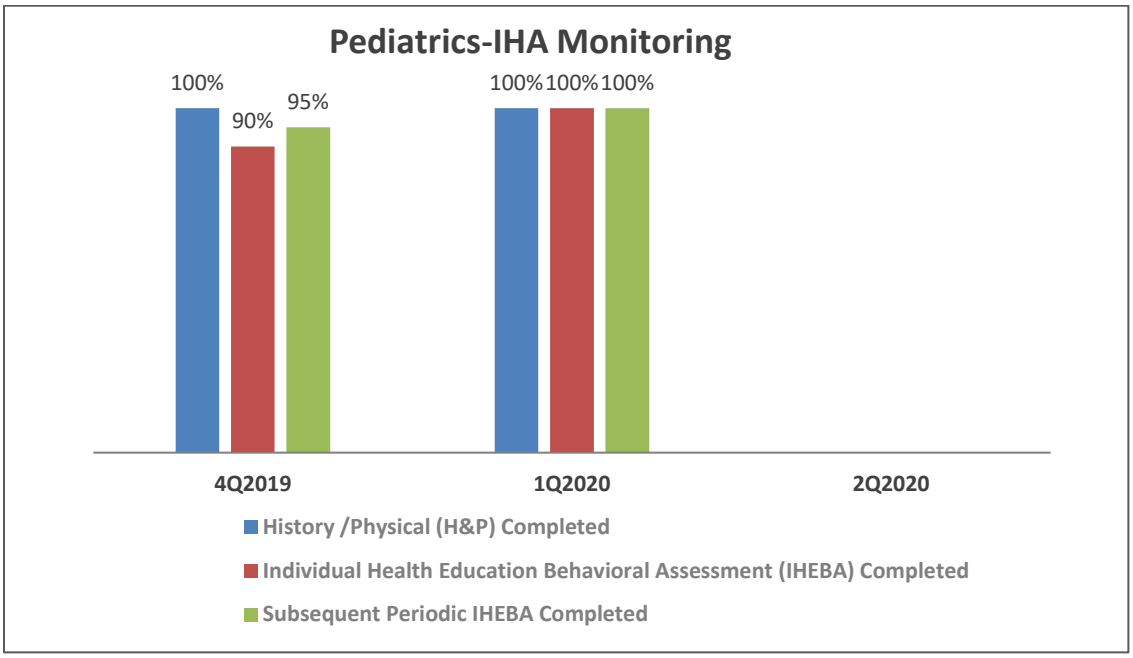


IHEBA Results: There were no focus reviews performed in 2nd Quarter of 2020 due to COVID-19 pandemic.

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.

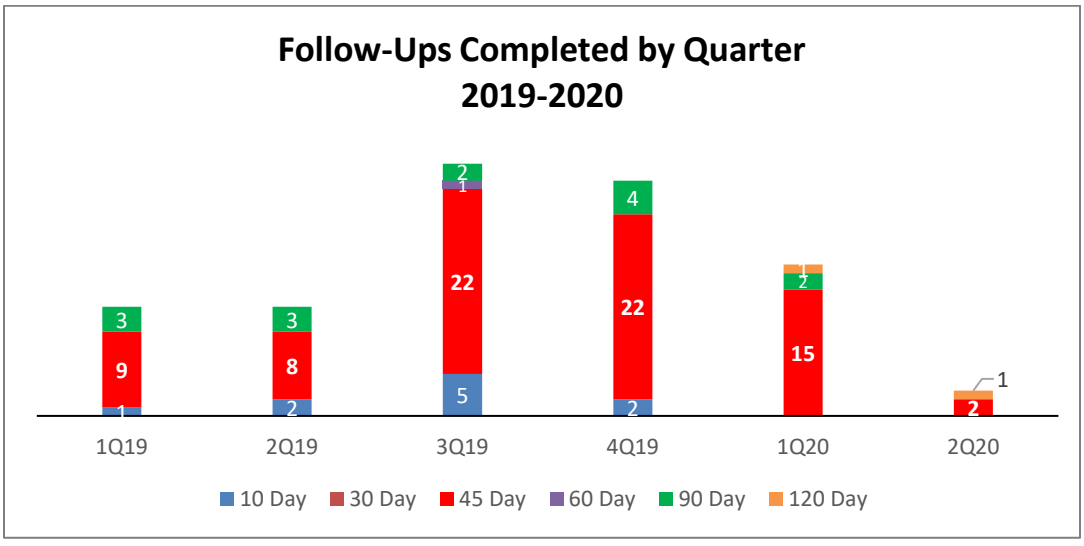


ADULT IHA Results: There were no focus reviews performed in 2nd Quarter of 2020 due to COVID-19 pandemic.



PEDIATRIC IHA Results: There were no focus reviews performed in 2nd Quarter of 2020 due to COVID-19 pandemic.

Site Review Corrective Action Plans (CAPs):



There were two 45 Day and one 120 Day abbreviated follow up completed in Q2 of 2020. Due to COVID-19 pandemic and for the safety of staff, providers and members, KHS staff are not physically going to provider offices. FSRs and MRRs are being done using an abbreviated model as an interim measure until we are able to return to doing full on-site reviews after the COVID-19 emergency response situation ends. Our ability to do this reduced

form of review is dependent on the providers' ability to provide the necessary documentation. We are going to explore the possibility of using an audio-visual app to conduct portions of these reviews.

III. Quality Improvement Projects

a. Performance Improvement Projects (PIPs)

NOTE THAT DUE TO THE CURRENT COVID-19 PANDEMIC, DHCS STOPPED ALL PIPs. THEY INTEND TO BEGIN A NEW CYCLE OF PIPs LATER THIS YEAR. PLANS MAY OPT TO SELECT THE SAME TOPIC OR MAY CHOSE NEW ONES.

b. MCAS Member Incentive Project:

This is a project to establish a program using Member Rewards and Member Outreach to support members that are compliant with MCAS measures. Member Outreach includes the use of Interactive Voice Recognition (IVR) and Text Messaging. DHCS notified all MCP's of a new requirement for EPSDT services in response to the current COVID pandemic. The requirement is 2 phased and focuses on children between 0 and 6 years of age. It involves conducting Member Outreach to Childhood Immunization and Blood Lead level screening. This requirement has been folded into this project and will be the first set of measures that IVR calls will be implemented. After these 2 Phases are completed (around Sep 30th, 2020), we will initiate Incentives and Outreach for select MCAS Measures.

IV. Managed Care Accountability Set (MCAS) Updates (also referred to as HEDIS):

All the IDSS, non-HEDIS and SPD/non-SPD rates were submitted to NCQA and HSAG on 05/30/2020. By 06/08/2020 responses were received from the auditor requesting input on all measures that had a 5% or greater change from the previous year or significantly varied from State benchmarks. All the review items were addressed with no further issues identified. KHS completed submitting the final attestations to both NCQA and HSAG, thus successfully completing the MCAS RY2020 audit submissions.

Current MY2020 MCAS measures have been significantly impacted by COVID-19 pandemic. Most of MCAS Measures are of preventive care services. Many members are avoiding going to Provider Offices due to the pandemic. We are awaiting further directions from DHCS in terms of how MCP's will be required to report rates for these measures. This includes information of any sanctions or any corrective actions they would typically impose.

Rates below (MY2020) are not considered typical to our plan because of the reduced services provided during the pandemic.

MY2020 MCAS Rate Tracking Report
As of 06-30-2020 (HEDIS Dashboard)

Hybrid Measures Held to MPL

Measure		Current MY2020 Rate (as of June2020)	MY2019 MPL	MY2019 KHS Rate	Current Vs. MY2019 MPL	Current Vs. MY2019 KHS Rate
AWC	Adolescent Well-Care Visits	13.57	54.26	36.01	-40.69	N/A
ABA	Adult Body Mass Index Assessment	20.27	90.27	78.10	-70.00	N/A
CCS	Cervical Cancer Screening	44.77	60.65	56.20	-15.88	-11.43
CIS-10	Childhood Immunization Status – Combo 10	15.12	34.79	29.93	-19.67	-14.81
CDC-H9*	HbA1c Poor Control (>9.0%)	78.25	38.52	57.91	-39.73	-20.34
CBP	Controlling High Blood Pressure <140/90 mm Hg	3.21	61.04	38.93	-57.83	-35.72
IMA-2	(meningococcal, Tdap, HPV)	31.09	34.43	41.36	-3.34	-10.27
PPC-Pre	Prenatal & Postpartum Care – Timeliness of Prenatal Care	11.27	83.76	84.18	-72.49	-72.91
PPC-Post	Prenatal & Postpartum Care – Postpartum Care	55.22	65.69	81.02	-10.47	-25.80
WCC-BMI	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents	16.01	79.09	66.42	-63.08	-50.41
WCC-N	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition	7.12	70.92	N/A	-63.80	N/A
WCC-PA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity	6.64	64.96	N/A	-58.32	N/A
W15	Well-Child Visits in the First 15 months of Life – Six or More Well Child Visits	2.77	65.83	32.60	-63.06	32.60
W34	Well-Child Visits in the 3rd 4th 5th & 6th Years of Life	23.59	72.87	65.21	-49.28	-41.62

* A lower rate indicates better performance

Administrative Measures Held to MPL

Measure		Current MY2020 Rate (as of July 2020)	MY2019 MPL	MY2019 KHS Rate	Current Vs. MY2019 MPL	Current Vs. MY2019 KHS Rate
AMM - Acute	Antidepressant Medication Management – Acute Phase Treatment	52.67	52.33	50.24	0.34	2.43
AMM - Cont.	Antidepressant Medication Management – Continuation Phase Treatment	31.15	36.51	32.64	-5.36	-1.49
AMR	AsthmaMedication Ratio	55.13	63.58	48.78	-8.45	6.35
BCS	Breast Cancer screening	46.57	58.67	57.29	-12.10	-10.72
CHL	Chlamydia Screening in Women Ages 16 – 24	48.9	58.34	55.29	-9.44	-6.39
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	41.11	81.04	N/A	-39.93	N/A
APM	Metabolic Monitoring for Children and Adolescents	7.69	33.33	N/A	-25.64	N/A

Indicates we met or exceeded MPL/RY2020 rate

Indicates we met the HPL.

MY2019 MPL Currently we are in the process of identifying the new 50th percentiles for MY2020.

N/A' is for measures that were not reported for RY2020

All current rates displayed above are admin(Claims) rates as of July 2020. Medical record abstarctions begin after December 2020.

V. **Policy Updates:** A new policy for Potential Inappropriate Care (PIC) referrals has been developed and is in the final stages of approval.

KAISER REPORTS

(PROPRIETARY AND CONFIDENTIAL)

Available upon Request

Medical Data Collection Summary Report

Period Covered: August, 2019 through July, 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:	22,684	
Diabetes?:	1,222	5.4%
Diabetic Retinopathy:	194	.9%
Glaucoma:	313	1.4%
Hypertension:	930	4.1%
High Cholesterol	378	1.7%
Macular Degeneration:	43	.2%

Estimated Number of Cases

Total Members:	260,618	
Diabetes?:	6,182	2.4%
Diabetic Retinopathy:	546	.2%
Glaucoma:	1,034	.4%
Hypertension:	26,826	10.3%
High Cholesterol	39,541	15.2%
Macular Degeneration:	343	.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: KERN HEALTH SYSTEMS - 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	August	541	43	25	68
	September	4,151	241	177	418
	October	525	50	29	79
	November	0	0	0	0
	December	1,916	139	20	159
2020	January	878	52	9	61
	February	503	18	12	30
	March	0	0	0	0
	April	6,190	51	7	58
	May	1,677	22	0	22
	June	1,367	5	0	5
	July	436	0	0	0
Totals		**18,184**	**621**	**279**	**900**

LTM Effectiveness* : 5 %

12-Month Effectiveness (Feb 2019 - Jan 2020) : 10 %

* 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.

Call Response Summary Report

JUNE 2020

Kern Health Systems 12049397
On average, for 1,000 members, VSP receives 18 calls per month

Total Client Calls

579

Category	Reasons For Calling	Client Counts	Client Percent	VSP Percent Book-of-Business
Eligibility	IVR Available Services	116	29.15%	20.77%
	Check Eligibility	66	16.58%	.01%
	Correcting	7	1.76%	.00%
	Coverage/Relation	7	1.76%	.00%
	10 or more Dependents	5	1.26%	.00%
	Refer to Client	5	1.26%	.00%
	ID Number/ID Card Inquiry	4	1.01%	.00%
	Other	2	.50%	.00%
	Not Active	1	.25%	.00%
	Not Found	1	.25%	.00%
	Wrong ID / Provided ID	1	.25%	.02%
Category Subtotal - Eligibility		215	54.03%	20.80%
Doctor Referral	Email	36	9.05%	.00%
	IVR Doctor Referral	36	9.05%	1.38%
	Verbal or Mail	11	2.76%	.00%
	Doctor Access	6	1.51%	.00%
	Emailed List	1	.25%	.03%
	Provided Verbal List	1	.25%	.00%
Category Subtotal - Doctor Referral		91	22.87%	1.41%
Member Benefits	Available Services	26	6.53%	.00%
	Benefits Description	13	3.27%	.00%
	Glasses Related	3	.75%	.00%
	Medically Related	1	.25%	.00%
Category Subtotal - Member Benefits		43	10.80%	.00%
Claims	Claim Status	24	6.03%	2.22%
	Status	3	.75%	.00%
	Letter	1	.25%	.00%
	Payment	1	.25%	.00%
Category Subtotal - Claims		29	7.28%	2.22%
Authorizations	Authorizations	6	1.51%	1.56%
Category Subtotal - Authorizations		6	1.51%	1.56%

Call Response Summary Report

JUNE 2020

Kern Health Systems 12049397
On average, for 1,000 members, VSP receives 18 calls per month

Total Client Calls

579

Category	Reasons For Calling	Client Counts	Client Percent	VSP Percent Book-of-Business
Language Lines / Miscellaneous	Spanish	6	1.51%	.00%
Category Subtotal - Language Lines / Miscellaneous		6	1.51%	.00%
TPA/Individual Plan	Enrollment	2	.50%	.00%
	Premiums/Billing	1	.25%	.00%
Category Subtotal - TPA/Individual Plan		3	.75%	.00%
Complaint	Clients	1	.25%	.00%
	Doctor	1	.25%	.00%
Category Subtotal - Complaint		2	.50%	.00%
Member Authorization	Self-Certified	1	.25%	.00%
Category Subtotal - Member Authorization		1	.25%	.00%
Member Website Assistance	Register	1	.25%	.00%
Category Subtotal - Member Website Assistance		1	.25%	.00%
Open Access	IVR OON Info	1	.25%	1.20%
Category Subtotal - Open Access		1	.25%	1.20%
Complaints	None	0	.00%	.00%
Category Subtotal - Complaints		0	.00%	.00%

GRAND TOTAL **398**

2020 2nd Quarter Operational Report

KERN HEALTH SYSTEMS
kernhealthsystems.com

2nd Quarter 2020 Grievance Report

Category	Q2 2020	Status	Issue	Q1 2020	Q4 2019	Q3 2019	Q2 2019
Access to Care	33		Appointment Availability	53	56	34	32
Coverage Dispute	0		Authorizations and Pharmacy	0	0	1	9
Medical Necessity	246		Questioning denial of service	222	187	220	244
Other Issues	11		Miscellaneous	34	14	16	13
Potential Inappropriate Care	210		Questioning services provided. All cases forwarded to Quality Dept.	273	323	66	26
Quality of Service	8		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	2	0	0	1
Total Formal Grievances	508			584	580	337	325
Exempt**	986		Exempt Grievances-	1620	1140	1545	1321
Total Grievances (Formal & Exempt)	1494			2204	1720	1882	1646

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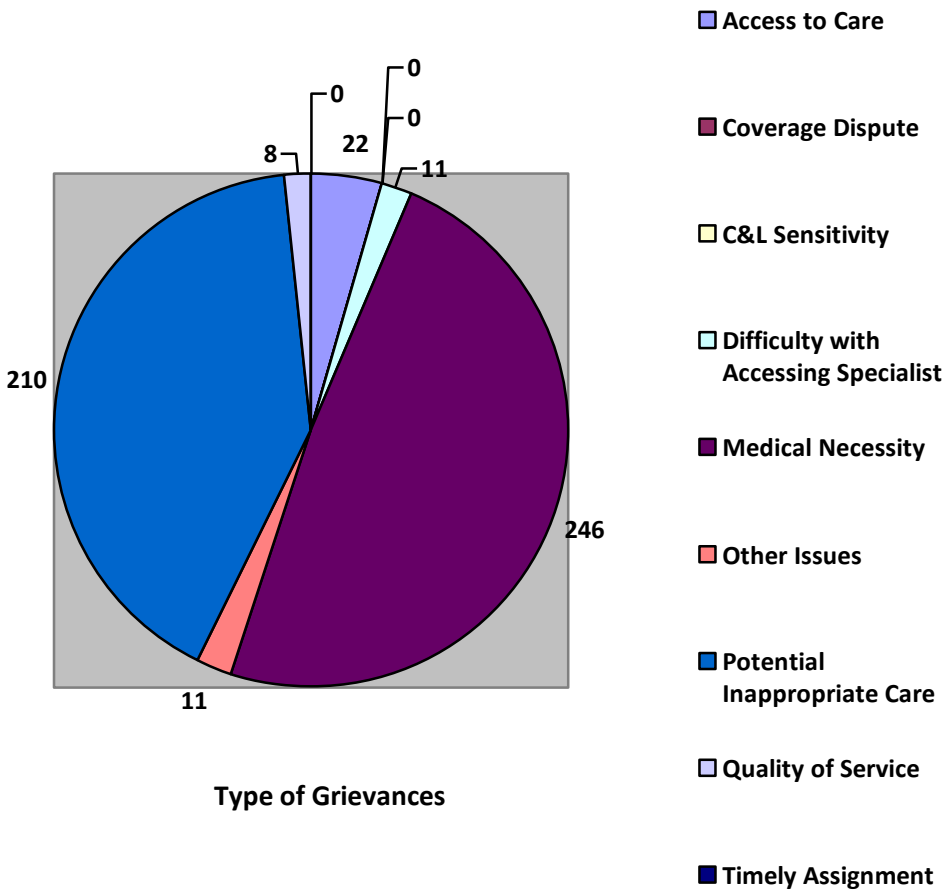
Additional Insights-Formal Grievance Detail

Issue	2nd Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	29	20	0	9	0
Coverage Dispute	0	0	0	0	0
Specialist Access	4	3	0	1	0
Medical Necessity	246	150	0	80	16
Other Issues	11	8	0	3	0
Potential Inappropriate Care	210	31	179	0	0
Quality of Service	8	7	0	1	0
Total	508	219	179	94	16

2nd Quarter 2020 Grievance Summary

Issue	Number	In Favor of Health Plan	Further Review by Quality	In favor of Enrollee	Still under review
Access to care	22	17	0	5	0
Coverage dispute	0	0	0	0	0
Cultural and Linguistic Sensitivity	0	0	0	0	0
Difficulty with accessing specialists	11	6	0	5	0
Medical necessity	246	161	0	85	0
Other issues	11	8	0	3	0
Potential Inappropriate care	210	31	179	0	0
Quality of service	8	6	0	2	0
Timely assignment to provider	0	0	0	0	0



Grievances per 1,000 Members = 1.89

During the second quarter of 2020, there were five hundred and eight formal grievances and appeals received. Two hundred and eighty three cases were closed in favor of the Enrollee; two hundred and twenty five cases were closed in favor of the Plan. Five hundred and eight cases closed within thirty days.

Access to Care

2nd Quarter 2020 Grievance Summary

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

Ten members complained about the lack of available appointments with their Primary Care Provider (PCP). Eight of the cases closed in favor of the Plan after the responses indicated the offices provided appropriate access to care based on the Access to Care Standards for PCP appointments. Two of the cases closed in favor of the Enrollee after the responses indicated the offices 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. Five cases closed in favor of the Plan after the responses indicated the members were seen within the appropriate wait time for an appointment or the members were there as a walk-in, which are not held to Access to Care standards. Three cases closed in favor of the Enrollee after the responses indicated the members were not seen within the appropriate wait time for an appointment.

Three members complained about the telephone access with their Primary Care Provider (PCP). All three cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate telephone access.

One member complained about a provider not submitting a referral authorization request in a timely manner. This case closed in favor of the Plan after it was determined the referral authorization request was submitted timely.

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

There were no grievances pertaining to Cultural and Linguistic Sensitivity.

Difficulty with Accessing a Specialist

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

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

appropriate wait time for an appointment based on Access to Care Standards. One case closed in favor of the Enrollee after the responses indicated the members may not have been seen within the appropriate wait time for an appointment based on the Access to Care Standards.

One member complained about the physical access with their specialist. The case closed in favor of the Enrollee as a response from the specialty office was not received.

One member complained about the telephone access with a specialist office. The case closed in favor of the Plan after the responses indicated the member was provided with the appropriate telephone access.

Medical Necessity

There were two hundred and forty six appeals pertaining to Medical Necessity. One hundred and sixty one cases were closed in favor of the Plan. Eighty five of the cases closed in favor of the Enrollee. The following is a summary of these issues:

One hundred and ninety four members complained about the denial or modification of a referral authorization request. One hundred and sixteen 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; therefore, the denials were upheld. One case was closed in favor of the Plan and modified. Seventy eight cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned.

Fifty two 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; therefore, the denials were upheld. Seven 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 eleven grievances pertaining to Other Issues. Eight cases were closed in favor of the Plan after the responses indicated appropriate service was provided. Three cases closed in favor of the Enrollee after the responses indicated appropriate service may not have received appropriate service may not have been provided.

Potential Inappropriate Care

There were two hundred and ten grievances involving Potential Inappropriate Care issues. These cases were forwarded to Quality Improvement (QI) for their due process. Thirty one cases were closed in favor of the Plan, as it was determined a quality of care issue was not identified. One hundred and seventy nine cases were closed in favor of the Enrollee as a potential quality of care issue was identified and are still under further review with QI.

The following is a summary of these issues:

One hundred and thirty four members complained about the potential inappropriate care received from a Primary Care Provider (PCP). All records and/or responses were sent to QI for further review and investigation. Nineteen cases closed in favor of the Plan as no inappropriate care issue was identified. One hundred and fifteen cases closed in favor of the enrollee as a potential inappropriate care concern was identified and is still under further review with QI.

Fifty six members complained about the potential inappropriate care received from a specialty provider. All records and/or responses were sent to QI for further review and investigation. Eight cases closed in favor of the Plan as no potential inappropriate care issue was identified. Forty eight cases closed in favor of the Enrollee as a potential inappropriate care concern was identified and is still under further review with QI.

Nineteen members complained about the potential inappropriate care received from providers staffed by an urgent care, hospital, or a non-hospital affiliated clinic. All records and/or responses were sent to QI for further review and investigation. Four cases closed in favor of the Plan as no potential inappropriate care issue was identified. Fifteen cases closed in favor of the Enrollee as a potential inappropriate care issue was identified and is still under further review with QI.

One member complained about the potential inappropriate care received from a pharmacy. All records and/or responses were sent to QI for further review and investigation. The case closed in favor of the Enrollee as a potential inappropriate care concern was identified and is still under further review with QI.

Quality of Service

There were eight grievances involving Quality of Service issues. Six of the cases were closed in favor of the Plan. Two of the cases closed in favor of the Enrollee. The following is a summary of these issues:

Eight members complained about the service they received from their providers or non-clinical staff. Six cases closed in favor of the Plan after the response determined the member received appropriate service. Two cases closed in favor of the Enrollee as the response indicated the member may not have received appropriate service.

Timely Assignment to Provider

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

Kaiser Permanente Grievances

During the second quarter of 2020, there were forty grievances and appeals received by KFHC members assigned to Kaiser Permanente. Five cases closed in favor of the Plan. Twenty nine cases were closed in favor of the Enrollee. Six cases are still open and pending closure.

Access to Care

2nd Quarter 2020 Grievance Summary

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

Five members complained about the excessive wait time to be seen for an appointment. Four cases closed in favor of the Enrollee. One case is open pending closure.

One member complained about the lack of available appointments with their Primary Care Provider (PCP). The case closed in favor of the Enrollee.

Coverage Dispute

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

Ten members complained about a service they requested; however, the requests were not covered. Four cases closed in favor of the Plan and the services were not covered. Five of the cases closed in favor of the Enrollee and the services were provided. One case is still open pending closure.

Medical Necessity

There were no cases pertaining to Medical Necessity. The following is a summary of these issues:

Quality of Care

There were twenty four grievances pertaining to quality of care. The following is a summary of these issues:

Nine members complained about the inadequate facilities that are non-access related. Five cases closed in favor of the Enrollee. One case closed in favor of the Plan. Three cases are open pending review of closure.

One member complained about the quality of care they received from a hospital. The case closed in favor of the Enrollee.

Ten members complained about the quality of care they received from a provider. All ten cases are open pending review for closure.

Four members complained about a provider denying treatment. Three cases closed in favor of the Enrollee. One case is open pending review for closure.

Quality of Service

There were no grievances pertaining to a Quality of Service.

KERN HEALTH SYSTEMS
2nd Quarter 2020
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: July 2, 2020

Department: Provider Relations

Monitoring Period: April 1, 2020 through June 30, 2020

Population:

Providers	Credentialed	Recredentialed
MD's	37	96
DO's	5	5
AU's	0	1
DC's	0	1
AC's	0	3
PA's	10	6
NP's	21	18
CRNA's	0	2
DPM's	0	4
OD's	0	3
ND's	0	0
RD's	1	0
BCBA's	5	1
LM's	0	0
Mental Health	6	1
Ocularist	0	0
Ancillary	7	38
OT	0	0
TOTAL	**92**	**179**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	0	3	3	0
Allergy & Immunology	0	1	1	0
Anesthesiology / CRNA	0	4	4	0
Audiology	0	1	1	0
Autism / Behavioral Analyst	5	1	6	0
Cardiology	1	4	5	0
Chiropractor	0	1	1	0
Colon & Rectal Surgery	1	0	1	0
Critical Care	0	4	4	0
Dermatology	5	3	8	0
Emergency Medicine	3	2	5	0
Endocrinology	1	1	2	0
Family Practice	13	21	34	0
Gastroenterology	1	2	3	0
General Practice	8	5	13	0
General Surgery	5	2	7	0
Genetics	0	0	0	0

KERN HEALTH SYSTEMS
2nd Quarter 2020
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Gynecology	0	0	0	0
Gynecology/Oncology	0	0	0	0
Hematology/Oncology	2	3	5	0
Hospitalist	0	5	5	0
Infectious Disease	1	0	1	0
Internal Medicine	4	10	14	0
Mental Health	6	1	7	0
MidWife (Certified)	0	0	0	0
MidWife (Licensed)	1	0	1	0
Naturopathic Medicine	0	0	0	0
Neonatology	0	1	1	0
Nephrology	0	4	4	0
Neurological Surgery	1	2	3	0
Neurology	1	0	1	0
Obstetrics & Gynecology	6	7	13	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	0	6	6	0
Optometry	0	3	3	0
Orthopedic Surgery / Hand Surg	2	3	5	0
Otolaryngology	0	0	0	0
Pain Management	0	1	1	0
Pathology	0	1	1	0
Pediatrics	2	15	17	0
Physical Medicine & Rehab	1	0	1	0
Plastic Sugery	0	0	0	0
Podiatry	0	4	4	0
Psychiatry	3	10	13	0
Pulmonary	0	5	5	0
Radiation Oncology	0	0	0	0
Radiology	7	18	25	0
Registered Dieticians	1	0	1	0
Rheumatology	1	1	2	0
Sleep Medicine	0	2	2	0
Thoracic Surgery	0	1	1	0
Urology	6	0	6	0
Vascular Medicine	0	0	0	0
Vascular Surgery	0	0	0	0
KHS Medical Directors	0	0	0	0
TOTAL	**88**	**158**	**246**	**0**

KERN HEALTH SYSTEMS
2nd Quarter 2020
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	3	3	0
DME	0	2	2	0
Hearing Aid Dispenser	0	0	0	0
Home Health	1	3	4	0
Home Infusion/Compounding	0	1	1	0
Hospice	0	3	3	0
Hospital	0	2	2	0
Laboratory	1	6	7	0
Lactation Consultant	0	1	1	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	2	6	8	0
Pharmacy/DME	1	0	1	0
Physical / Speech Therapy	0	2	2	0
Prosthetics & Orthotics	0	2	2	0
Radiology	0	0	0	0
Skilled Nursing	0	0	0	0
Sleep Lab	0	0	0	0
Surgery Center	2	5	7	0
Transportation	0	3	3	0
Urgent Care	0	0	0	0
TOTAL	**7**	**39**	**46**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS
2nd Quarter 2020
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

KERN HEALTH SYSTEMS
2nd Quarter 2020
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Kern Health Systems
Board Approved Effective 06/01/20

Legal NameDBA	Specialty	Vendor #	Address	ContractEffective Date
Kimberly Dixon, MD Corporation dba: The Childrens Clinic of Bakersfield	PCP / Pediatrics	PRV061111	1700 A Street Bakesfield CA 93301	6/1/2020
Michelle L. Remmes, MD	PCP / Internal Medicine	PRV006573	2021 22nd Street Bakesfield CA 93301	6/1/2020
Kern Surgery Center, LLC	Ambulatory Surgery Center	PRV052863	2323 16th Street Ste 507 Bakersfield CA 93301	6/1/2020
PharMedQuest Pharmacy Services	Pharmacy	PRV060385 PRV060386	PharMedQuest Pharmacy Services dba #1: CSV PMQ Wible Pharmacy 2400 Wible Rd Rm 1 dba #2CSV PMQ Bakersfield Pharmacy 2000 Phys Blvd Rm B Bakersfield CA	**Retro-Eff** **4/13/2020**
NextGen Laboratories, Inc	Laboratory	PRV037473	2020 20th Street Bakersfield CA 93301	6/1/2020
Hemant Dhingra, MD CEO The Nephrology Group, Inc	Nephrology	PRV013885	3933 Coffee Road Ste. B Bakersfield CA 93308 *Multiple Locations	**Retro-Eff** **4/1/2020**
BASS Medical Group Canyon Oaks Foot and Ankle	Podiatry	PRV030020	Omni Clinic (Location) 210 N Chester Ave Bakersfield CA 93308	6/1/2020
CHA Medical Group PC	Ophthalmology	PRV054267	8150 Brimhall Rd Ste 401 Bakersfield CA 93312	6/1/2020

Kern Health Systems
Board Approved Effective 06/01/20

	NAME	LEGAL NAME/ADDRESS	Provider #	Group #	SPECIALTY	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
	Kern Surgery Center LLC	Kern Surgery Center LLC 2323 16th Street Ste 507 Bakersfield CA 93301	PRV052863	PRV052863	Ambulatory Surgery Center	New Contract	Yes Eff 6/1/20
	NextGen Laboratories, Inc.	NextGen Laboratories, Inc. 2020 20th Street Bakersfield CA 93301	PRV037473	PRV037473	Laboratory	New Contract	Yes Eff 6/1/20
	PharMedQuest Pharmacy Services	PharMedQuest Pharmacy Services dba #1: CSV PMQ Wible Pharmacy 2400 Wible Road Room 1 PRV060385 NPI: 1407480148 TIN: 830342603 dba #2: CSV PMQ Bakersfield Pharmacy 2000 Physicians Blvd Room B Bakersfield CA PRV060386 NPI: 1649810235 TIN: 830342603	PRV060385 PRV060386	PRV060385 PRV060386	Pharmacy	New Contract	Yes Retro-Eff 4/13/20
	Remmes, Michelle MD	Michelle L. Remmes MD 2021 22nd Street Bakesfield CA 93301	PRV006573	PRV006573	Internal Medicine	New Contract	Yes Eff 6/1/20
	Kar, Saibal MD	Centric Health Central Cardiology Medical Clinic 2901 Sillect Avenue Ste. 100 Bakersfield CA 93308	PRV002405	PRV000503	Cardiovascular Disease & Interventional Cardiology	Existing	Yes Eff 6/1/20
	Steinberg, Brenda DO	Universal Healthcare Services, Inc. *All Locations TIN: 711031193 Ages: ALL Type: PCP - ASSIGNABLE Universal Urgent Care and Occupational Medicine, Inc. *All Locations TIN: 465474617 Ages: ALL Type: SPECIALIST - NON-ASSIGNABLE Limitations: UC	PRV059828	ALL SITES	General Practice (PCP) & Emergency Med (UC)	Existing	Yes Eff 6/1/20
	Amjadi, Firooz MD	Adventist Health Physicians Network 2701 Chester Ave Ste. 202 Bakersfield CA 93306	PRV003860	PRV029329	Orthopedic Surgery	Existing	Yes Eff 6/1/20
	Bledsoe, Aaron PA-C	LA Laser Center PC 1200 N China Lake Blvd Ste. A Ridgecrest CA 93555	PRV054546	PRV013922	Dermatology	Existing	Yes Eff 6/1/20
	Borlina, Amy LCSW	Clinica Sierra Vista (CSV) 7800 Niles Street Bakersfield CA 93306	PRV060321	PRV000002	Clinical Social Worker	Existing	Yes Eff 6/1/20
	Brown, Howard MD	Adventist Health Physicians Network 2701 Chester Ave Ste. 202 Bakersfield CA 93306	PRV059329	PRV029329	Orthopedic Surgery	Existing	Yes Eff 6/1/20

	Chavez, Guadalupe NP-C	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	PRV059241	ALL SITES	Family Practice	Existing	**Yes** **Eff 6/1/20**
	Fatehchehr, Soorena MD	Kern County Hospital Authority 9300 Stockdale Highway Ste. 100 & 300 1700 Mt Vernon Ave Bakersfield CA	PRV060199	ALL SITES	OB/GYN & Female Pelvic Surgery	Existing	**Yes** **Eff 6/1/20**
	Gould-Simon, Aron MD	Kern Radiology Medical Group 2301 Bahamas Drive Bakersfield CA 93309	PRV010185	ALL SITES	Diagnostic Radiology / Nuclear Medicine	Existing	**Yes** **Eff 6/1/20**
	Krauchuk, Daniel DO	Pain Institute of California, Inc dba: Pain Institute of Central California, Inc 9802 Stockdale Highway Ste. 105 Bakersfield CA 93311	PRV060686	PRV000510	Physical Medicine & Rehabilitation	Existing	**Yes** **Eff 6/1/20**
	Lee, Jae MD	Clinica La Victoria A Medical Corp 2303 S Union Avenue Ste. C2 Bakersfield CA 93307	PRV059716	PRV000408	General Practice	Existing	**Yes** **Eff 6/1/20**
	Marquez, Damaris LCSW	Clinica Sierra Vista (CSV) 2000 Physicians Blvd Bakersfield CA 93301	PRV060320	PRV000002	Clinical Social Worker	Existing	**Yes** **Eff 6/1/20**
	McLarty, Marcella MD	Adventist Health Medical Center Tehachapi 105 West E Street Tehachapi CA 93561	PRV061106	ALL SITES	General Surgery / Colon & Rectal Surgery	Existing	**Yes** **Eff 6/1/20**
	Medina, Amber NP-C	Adventist Health Medical Center Tehachapi 9350 North Loop Blvd Cal City CA 93505	PRV061107	ALL SITES	Family Practice	Existing	**Yes** **Eff 6/1/20**
	Mendoza, Alexandra NP	Alan F. Dakak, MD, Inc 3941 San Dimas Street Ste. 101 Bakersfield Omni Family Health 4151 Mexicali Drive Bakersfield CA 1701 Stine Road Bakersfield CA	PRV060759	PRV000342 PRV000019	Pediatrics & Internal Medicine	Existing	**Yes** **Eff 6/1/20**
	Nguyen, Victoria DO	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV061108	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 6/1/20**
	Pugalenthi, Amudhan MD	Dignity Health Medical Foundation 3838 San Dimas St. Ste. B-231 Bakersfield CA 93301	PRV059240	PRV012886	General Surgery / Surgery Oncology	Existing	**Yes** **Eff 6/1/20**
	Robertson, Arleada, PA	Vernon Sorenson Urgent Care Vernon Sorenson Urgent Care 3838 San Dimas Street Ste. B-121 Bakersfield CA 93301	PRV032628	PRV000216	Emergency Medicine	Existing	**Yes** **Eff 6/1/20**
	Salvador, Jose NP-C	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA 93306	PRV060511	ALL SITES	General Surgery	Existing	**Yes** **Eff 6/1/20**

	Skoblar, Eric MD	Emergency Physicians Urgent Care, Inc. Accelerated Urgent Care - *All Locations 212 Coffee Road Bakersfield CA 93309	PRV057972	ALL SITES	Family Practice	Existing	**Yes** **Eff 6/1/20**
	Singh, Bani MD	Dignity Health Medical Foundation 9500 Stockdale Highway Ste. 203 Bakersfield CA 93311	PRV059631	PRV012886	Family Practice	Existing	**Yes** **Eff 6/1/20**
	Sobh, Nader DO	Emergency Physicians Urgent Care, Inc. Accelerated Urgent Care - Coffee Road 212 Coffee Road Bakersfield CA 93309	PRV061100	ALL SITES	Family Practice	Existing	**Yes** **Eff 6/1/20**
	Vasudeva, Arun MD	Centric Health 3008 Sillect Avenue Ste. 100 Bakersfield CA 93308	PRV061110	PRV000503	Internal Medicine	Existing	**Yes** **Eff 6/1/20**
	Velosa, Luis MD	Telehealthdocs Medical Corporation *All Locations 2215 Truxtun Avenue Ste. 100 Bakersfield CA 93301	PRV061101	ALL SITES	Psychiatry	Existing	**Yes** **Eff 6/1/20**
	Wedeen, Glenn MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Drive Bakersfield CA 93309	PRV001092	ALL SITES	Diagnostic Radiology / Nuclear Medicine	Existing	**Yes** **Eff 6/1/20**
	Willson, Kasey PA-C	LA Laser Center PC 5600 California Avenue Ste. 101 & 103 Bakersfield CA 93309	PRV045222	PRV013922	Dermatology	Existing	**Yes** **Eff 6/1/20**
	Zahlan, Bassam MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV005085	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 6/1/20**

KERN HEALTH SYSTEMS

Provider Network Management
Network Review
Quarter 2, 2020

- **After-hours Calls**
- **Appointment Availability Survey**
- **Access Grievance Review (Q1, 2020)**
- **Geographic Accessibility & Annual DHCS Network Certification**
- **Network Adequacy & Provider Counts**

KERN HEALTH SYSTEMS

After-hours Calls

Quarter 2, 2020

AFTER-HOURS CALLS

Q2, 2020

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:

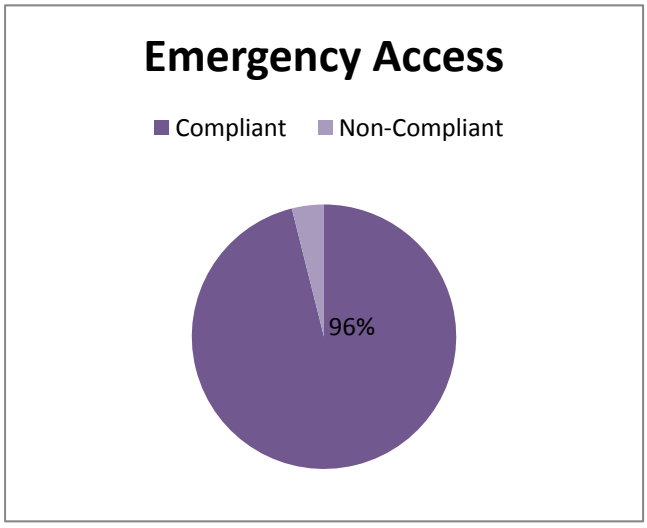
1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

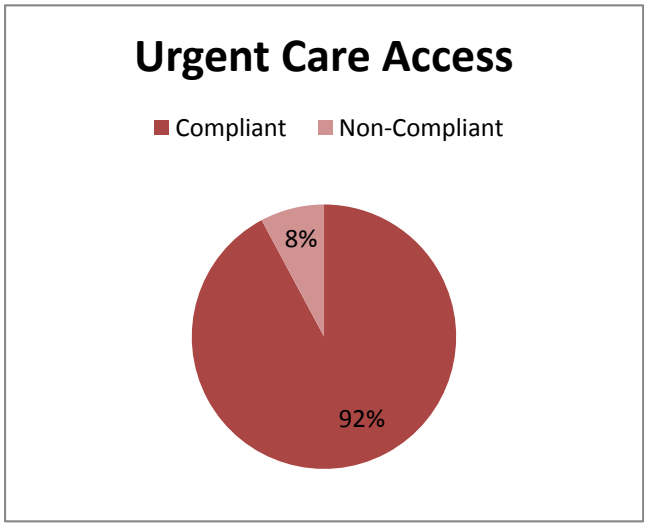
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

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

128 provider offices were contacted during Q2 2020. Of those offices, 123 were compliant with the Emergency Access Standards and 118 were compliant with the Urgent Care Access Standards.





AFTER-HOURS CALLS

Q2, 2020

Trending / Follow –Up / Outreach

Due to the COVID-19 pandemic, at this time, the Plan is utilizing the after-hours survey calls to monitor compliance at a network-wide level. The Plan found minimal change in compliance with the emergency and urgent care after-hours access standard when compared to prior quarters, with all percentages remaining over 90%.

Compliance with after-hours standard	Q3 2019	Q4 2019	Q1 2020	Q2 2020
Emergency Access	98%	98%	96%	96%
Urgent Care Access	93%	95%	93%	92%

The Plan will continue to review results of provider groups against prior quarters. The Plan is sending letters (template attached) to providers who were identified to be non-compliant during the Q2 after-hours survey; to ease administrative burdens on contracted providers during this time, the Plan is not taking any other action against providers based on the results of Q2 after-hours survey.

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 2, 2020

Provider Network Management

Appointment Availability Survey

Q2, 2020

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 Q2 2020.

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 Q2 2020, the Plan's average wait time for a primary care appointment was **9.8 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 Q2 2020, the Plan's average wait time for a specialist appointment was **5.4 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 Q2 2020 the Plan's average wait time for a first prenatal visit with an OB/GYN was **8.8 days**, and was found to be in-compliance with the 10 day/2 week standard.

The Plan utilizes the quarterly appointment availability survey to monitor compliance at a network-wide level. Upon review of the results of the Q2 2020 appointment availability survey, the Plan recognized an increase in the average wait-time for a primary care appointment, while still remaining in compliance with the standard; the Plan believes this increase is due to temporary office closures that occurred during Q2 2020 as a result of the COVID-19 pandemic.

Appointment Availability Survey

Q2, 2020

Average wait time for appointment (in days)	Q3 2019	Q4 2019	Q1 2020	Q2 2020
Primary Care	3.7	3.1	4.4	9.8
Specialist	5.7	5.3	3.1	5.4
OB/GYN	N/A	5.4	7	8.8

The Plan will continue to review results of individual providers/provider groups against prior quarters. The Plan is sending letters (template attached) to providers who were identified to be non-compliant during the Q2 appointment availability survey; to ease administrative burdens on contracted providers during this time, the Plan is not taking any other action against providers based on the results of Q2 appointment availability survey.

Phone Answering Timeliness Results

Utilizing the methodology outlined above, KHS conducts a phone answering timeliness survey in conjunction with the appointment availability survey. During Q2 2020 calls were answered within an average of **3.8 rings**.

	Q3 2019	Q4 2019	Q1 2020	Q2 2020
Average rings before call was answered	2	1.4	1.8	3.8

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. With this letter, I have included a copy of KHS policy that outlines required appointment availability standards.

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

Additionally, KHS shall ensure its network of providers meets compliance with time and distance standards as required by the Department Health Care Services' (DHCS) annual network certification.

For geographic service areas (zip codes) found to not meet the above standards, KHS shall maintain alternative access standards, to be filed and approved with the DHCS and DMHC.

3.6 **Appointment Waiting Time and Scheduling:**
The "appointment waiting time" means the time from the initial request for health care services by a Member or the Member's treating provider to the earliest date offered for the appointment for services inclusive of the time for obtaining authorization from the plan, and completing any other condition or requirement of the plan or its contracting providers. KHS shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition. Members must be offered appointments within the following timeframes:

Type of Appointment	Time Standard
Urgent care appointment for services that do not require prior authorization[1]	Within 48 hours of a request
Urgent appointment for services that require prior authorization	Within 96 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Non-urgent appointment with a specialist	Within 15 business days of a request
Non-urgent appointments with a physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent appointments with a non-physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of a request
Pediatric CHDP Physicals	Within 2 weeks upon request
First pre-natal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

Exceptions to Appointment Waiting Time and Scheduling:

KERN HEALTH SYSTEMS

Access Grievance Review

Quarter 1, 2020

Provider Network Management

Access Grievance Review

Q1, 2020

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".

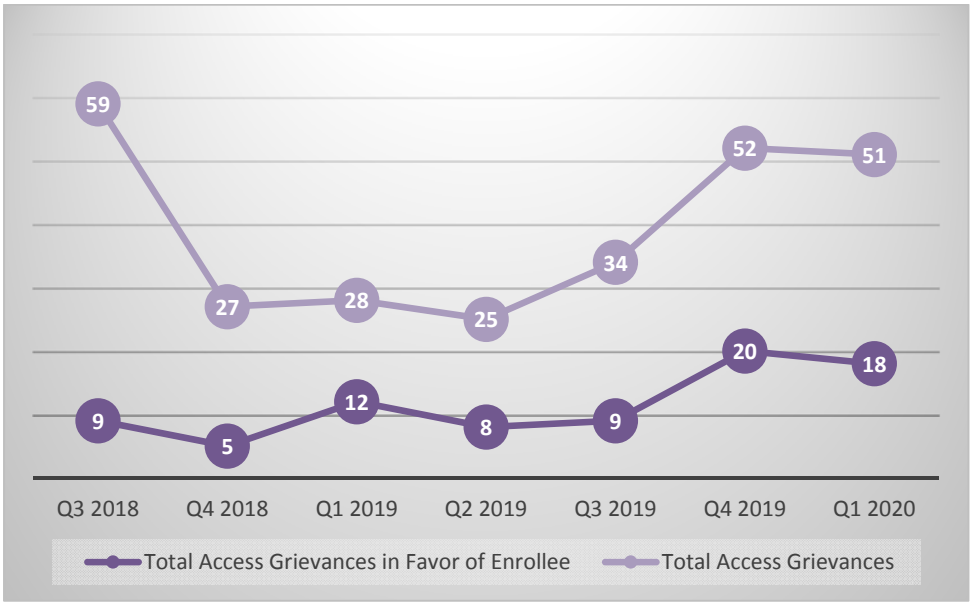
The time standards for access to a primary care appointment, specialist appointment, and in-office wait time are outlined in KHS policy 4.30-P *Accessibility Standards.*

During Q1 2020, fifty-one (51) access-related grievances were received and reviewed by the KHS grievance committee. In thirty-thirty (33) of the cases, no issues were identified and were closed in favor of the plan. The remaining **eighteen (18) 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

The eighteen (18) grievances that were closed in favor of the enrollee were forwarded to the Plan's Provider Network Management Department and were reviewed by the Provider Network Analyst Team against all access grievances received in the previous year. The received access grievances were categorized as follows:

Access to Care	**7**
Access - Appointment Availability	5
Access - Wait Time	2
Difficulty Accessing a Specialist	**11**
Access - Appointment Availability	6
Access – Wait Time	5



Access Grievance Review

Q1, 2020

Due to the COVID-19 pandemic, at this time, the Plan is utilizing the quarterly access grievance review to monitor Plan access at a network-wide level. To ease administrative burdens on contracted providers during this time, the Plan is not taking any action against providers based on the results of Q1 access grievance review.

Upon review of Q1 2020 access grievances, the Plan found that the grievance totals were in line with the totals from the prior quarter (Q4 2019), while also noting that the prior quarter had experienced a slight increase when compared to quarterly totals from the year prior (Q3 2018 – Q3 2019). The Plan will continue to monitor total access grievances against the Plan, as well as potential trends amongst individual providers/provider groups via the quarterly access grievance review.

KERN HEALTH SYSTEMS

Geographic Accessibility & Annual DHCS Network Certification

Quarter 2, 2020

Provider Network Management

Geographic Accessibility

Q2, 2020

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 – 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 20-003, 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 completed required reporting during Q1/Q2 2020. During Q2 2020 a portion of the originally submitted alternative access standard requests were sent back to the Plan to resubmit with additional justification. Review of the Plan's compliance with DHCS Network Certification reporting requirements and requested alternative access standards is still ongoing with the DHCS. As part of it's on going monitoring the Plan reviews additions/deletions in the provider network against the recently completed geographic accessibility analysis and as of the end of Q2 2020 has not identify any significant changes.

KERN HEALTH SYSTEMS

Network Adequacy & Provider Counts

Quarter 2, 2020

Provider Network Management

Network Adequacy & Provider Counts

Q2, 2020

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.**

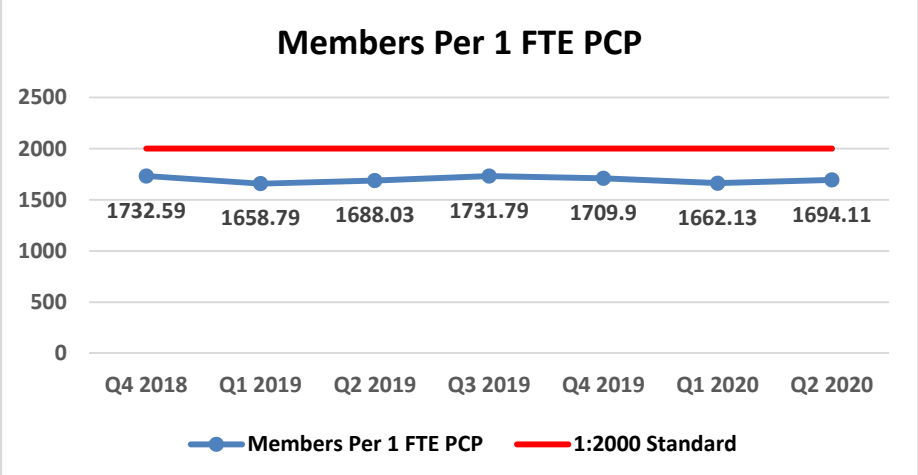
Network Adequacy & Provider Counts

Q2, 2020

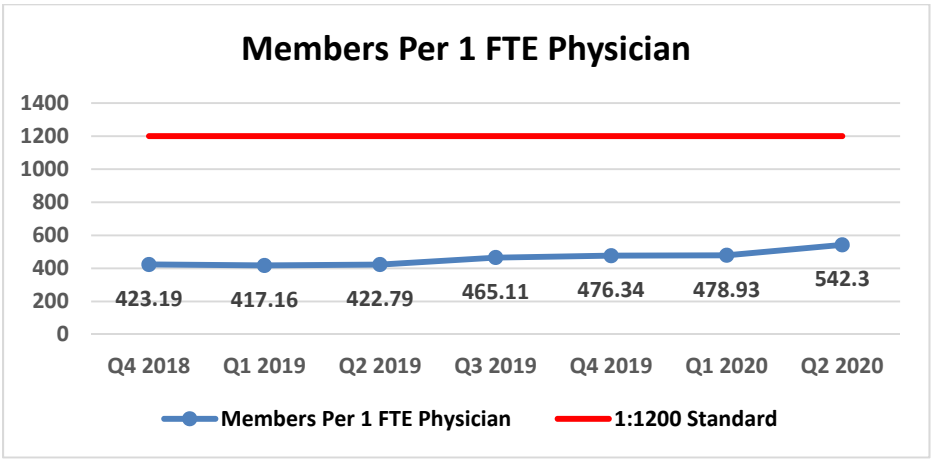
Full Time Equivalency Compliance Calculations

Of KHS' 270,392 membership at the close of Q1 2020, 9,828 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 Q2 2020, the plan was contracted with 404 Primary Care Providers, a combination of 223 physicians and 181 mid-levels. Based on the FTE calculation process outlined above, with a 49.06% PCP FTE percentage, KHS maintains a total of **153.81 FTE PCPs**. With a membership enrollment of 260,564 utilizing KHS contracted PCPs, KHS currently maintains a ratio of **1 FTE PCP to every 1694.11 members**; KHS is compliant with state regulations and Plan policy.



As of the end of Q2 2020, the plan was contracted with 1113 Physicians. Based on the FTE calculation process outlined above, with a 43.19% Physician FTE percentage, KHS maintains a total of **480.66 FTE Physicians**. With a total membership enrollment of 260,564 utilizing KHS contracted Physicians, KHS currently maintains a ratio of **1 FTE Physician to every 542.30 members**; KHS is compliant with state regulations and Plan policy.

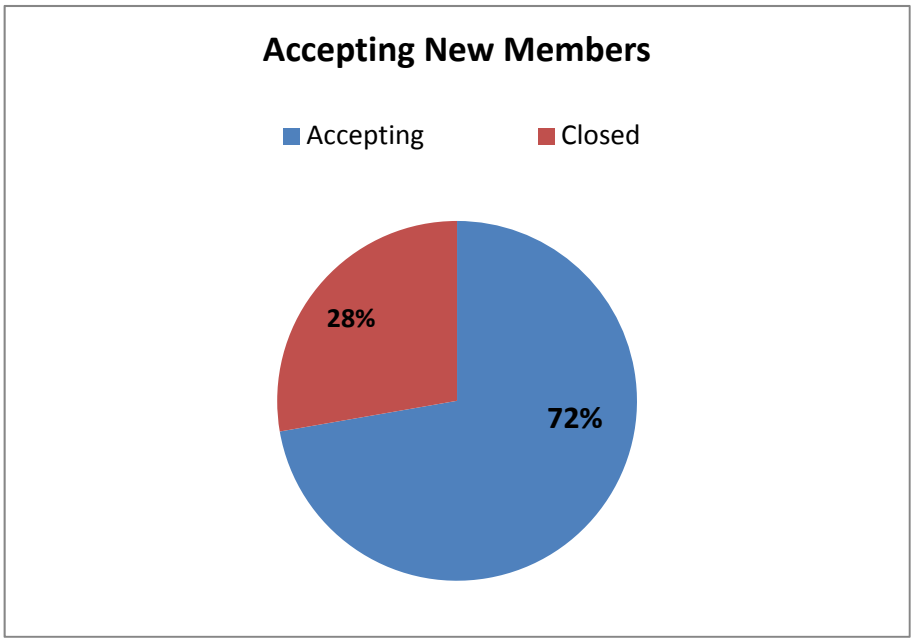


Network Adequacy & Provider Counts

Q2, 2020

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. **The Plan calculated that 72% 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.

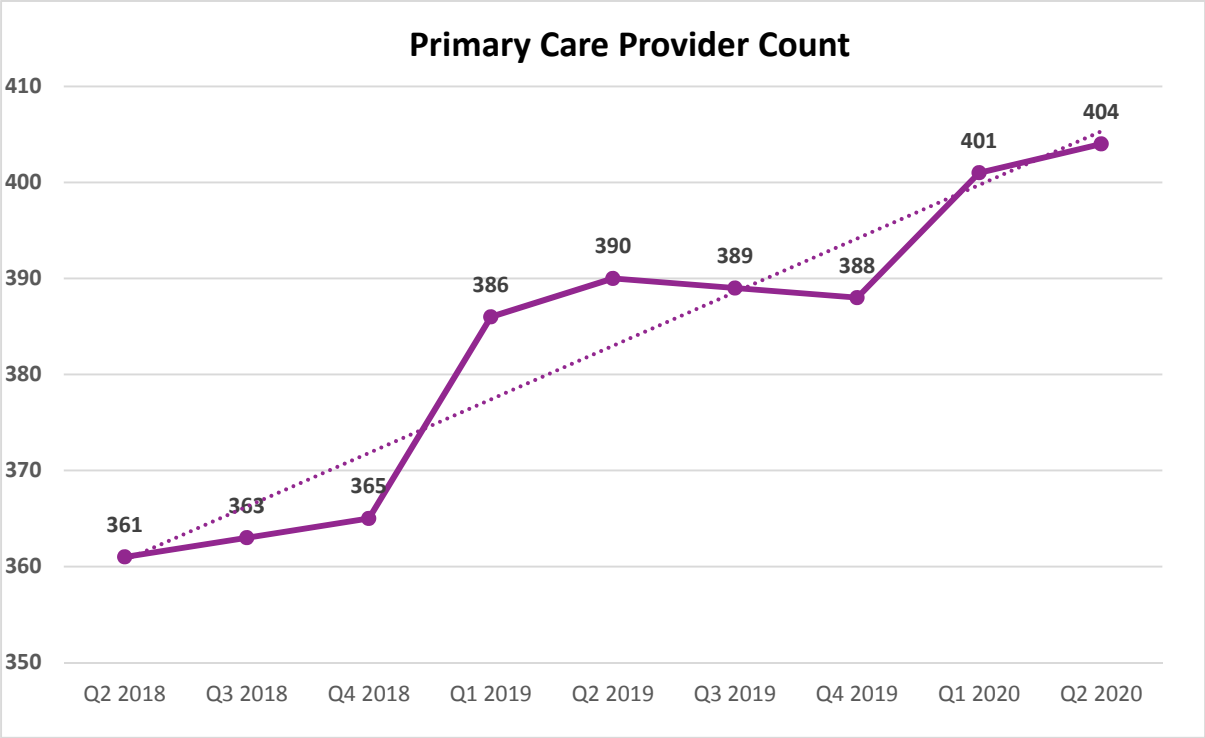


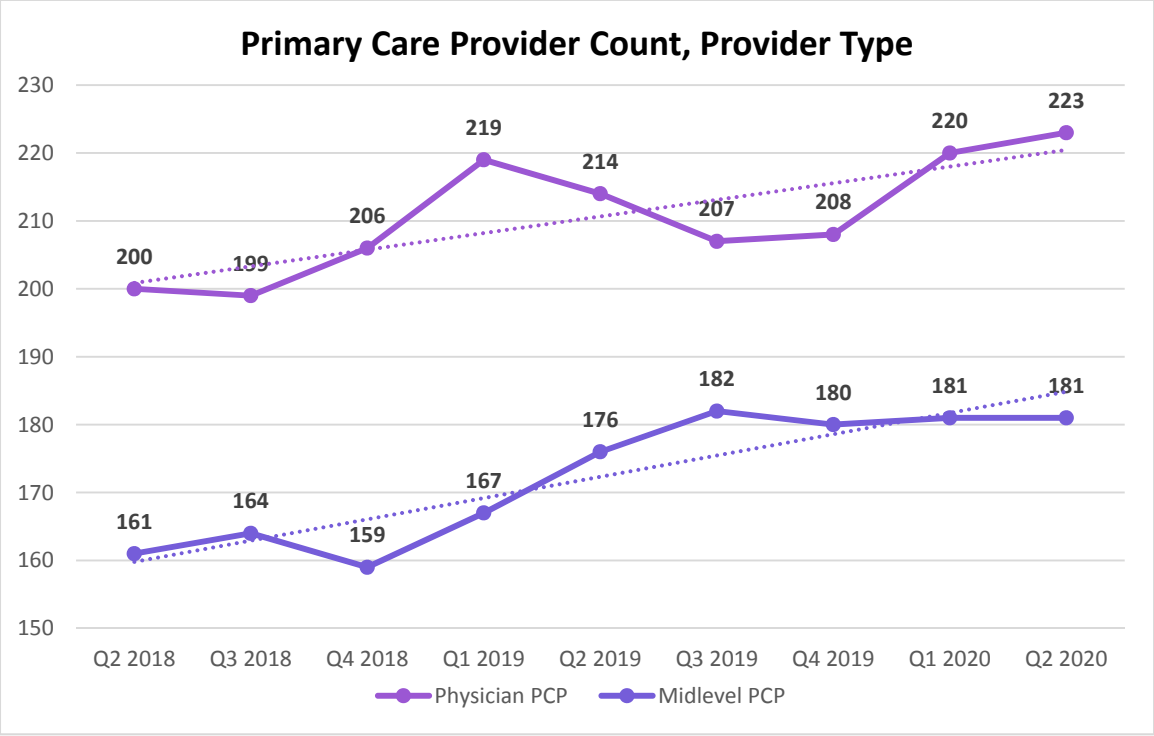
Network Adequacy & Provider Counts

Q2, 2020

KERN HEALTH SYSTEMS

Provider Counts – Primary Care Providers



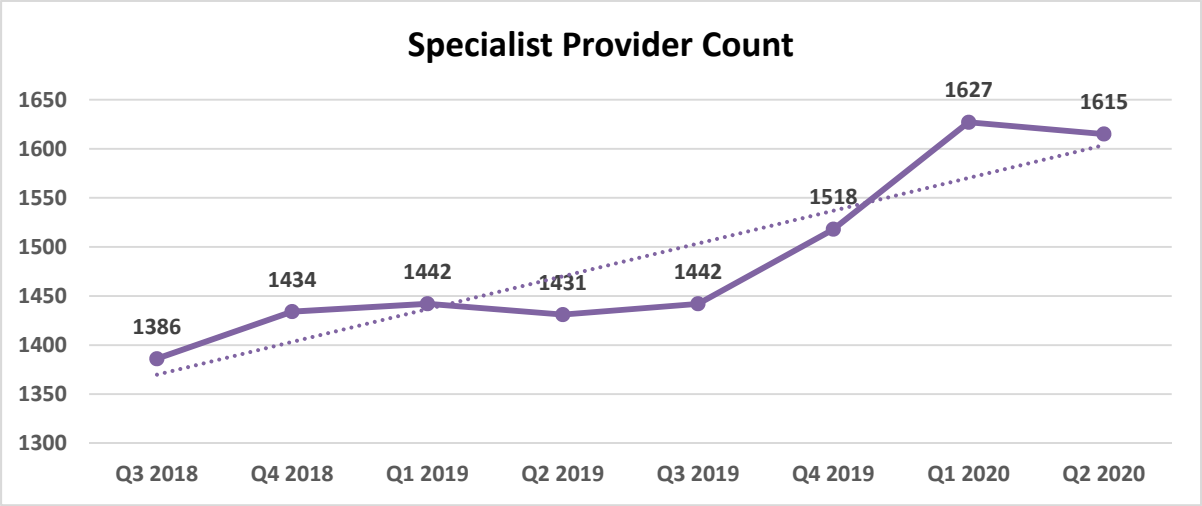


Network Adequacy & Provider Counts

Q2, 2020

KERN HEALTH SYSTEMS

Provider Counts – Specialist Providers



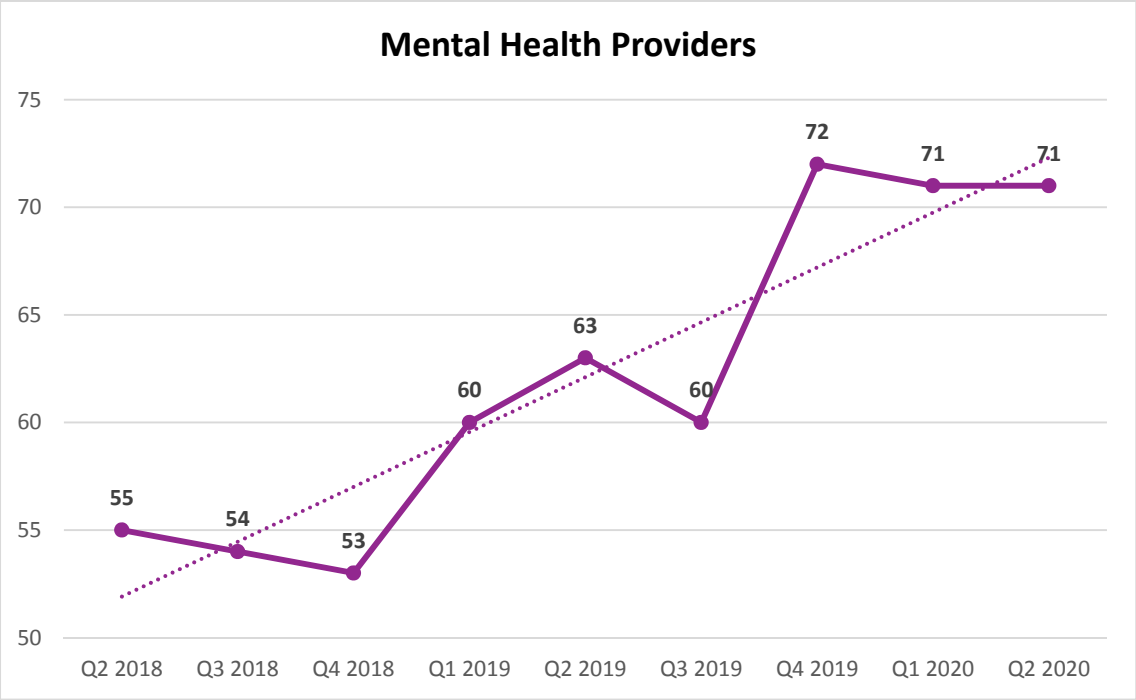
Selected Specialties, Provider Count									
	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020
Cardiology	40	41	39	39	39	39	40	40	38
Dermatology	29	31	31	31	31	31	35	33	36
Endocrinology	18	17	17	16	17	19	20	20	19
Gastroenterology	14	15	16	16	16	18	20	20	22
Hematology	17	17	18	18	18	18	18	17	18
Infectious Disease	11	12	11	10	10	12	10	9	10
Nephrology	20	22	23	23	24	22	22	22	21
Neurology	19	23	24	23	22	23	25	25	26
Oncology	20	20	20	21	22	23	23	22	24
Ophthalmology	25	25	28	29	29	30	32	33	32
Orthopedic Surgery	17	17	17	18	20	19	20	21	20
Pain Medicine	27	28	26	25	30	36	38	37	36
Physical Medicine & Rehab	20	21	21	21	23	23	27	27	24
Plastic Surgery	15	15	15	15	14	14	14	15	15
Podiatry	23	24	24	20	20	21	22	22	22
Psychiatry	40	46	45	46	46	48	54	54	53
Pulmonary Disease	23	22	22	22	21	21	21	20	20
Rheumatology	10	12	14	13	16	16	17	10	11
Urology	8	8	9	8	10	12	13	13	15

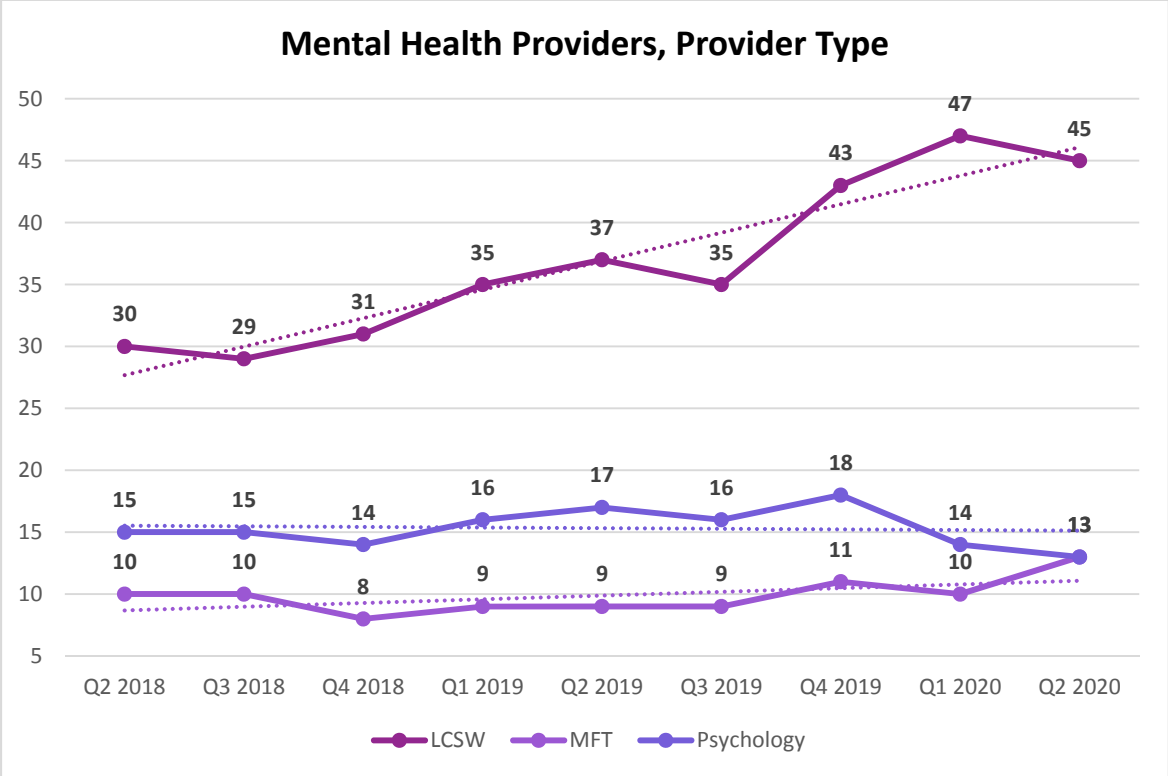
	> 5% Increase		> 5% Decrease
	≤ 5% Increase		≤ 5% Decrease

Network Adequacy & Provider Counts

Q2, 2020

Provider Counts – Mental Health (Psychology, LMFT, LCSW)





Network Adequacy & Provider Counts

Q2, 2020

KERN HEALTH SYSTEMS

Provider Counts – Facilities

	2017	2018	2019	Current
Hospital	18	18	18	18
Surgery Center	19	16	17	19
Urgent Care	13	17	17	17

Provider Counts – Other Provider Types

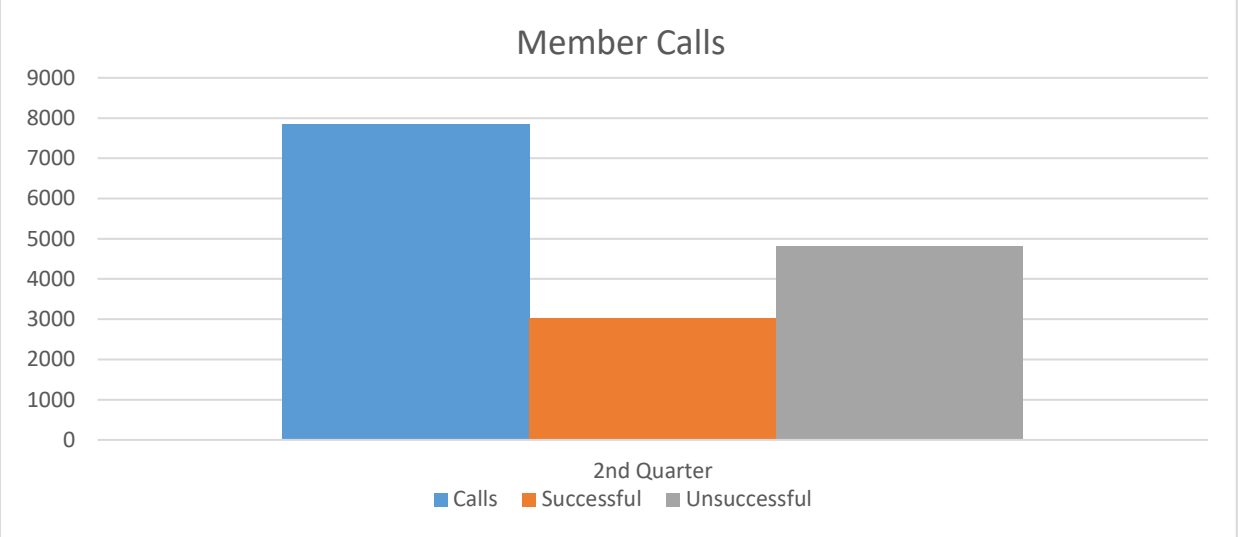
	2017	2018	2019	Current
Ambulance/Transport	15	15	13	14
Dialysis	13	14	16	16
Home Health	13	12	13	14
Hospice	6	7	11	11
Pharmacy	133	136	139	143
Physical Therapy	29	29	29	29

Disease Management Quarterly Report

2nd Quarter, 2020

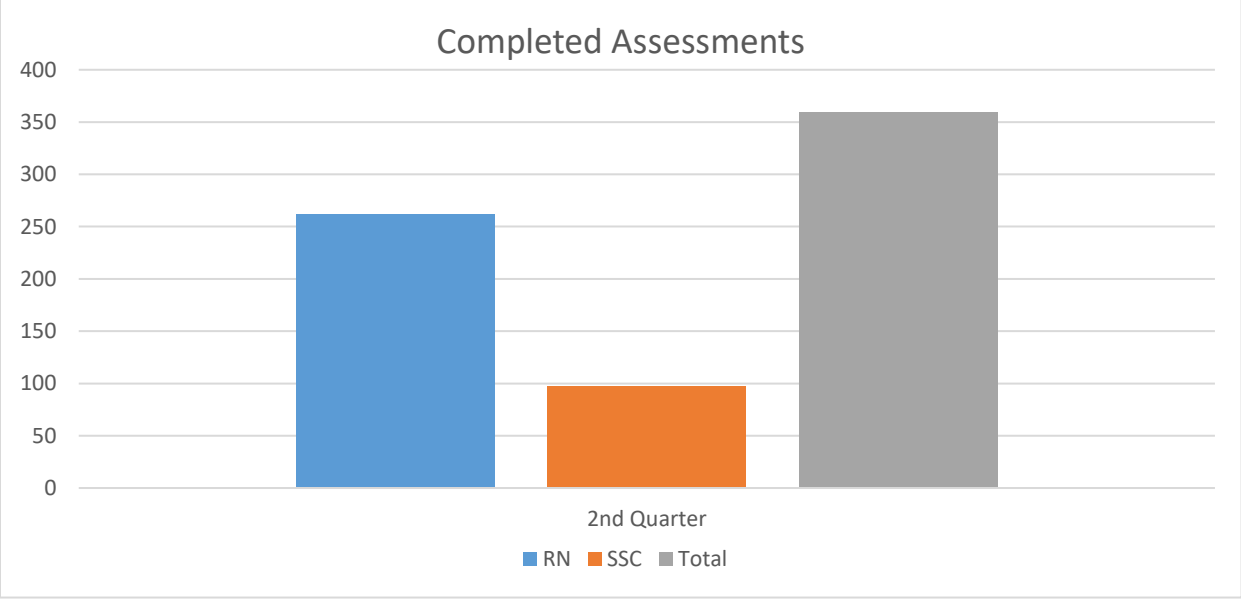
Telephone Calls: A total of 7,836 calls were made by the DM staff during the 2nd Quarter, 2020.

Member Calls Attempted	Successful Calls	Unsuccessful Calls	Total Member Calls	% Contacted
RN	1,664	3,180	4,844	34%
SSC	1,365	1,627	2,992	46%
Total	**3,029**	**4,807**	**7,836**	**39%**



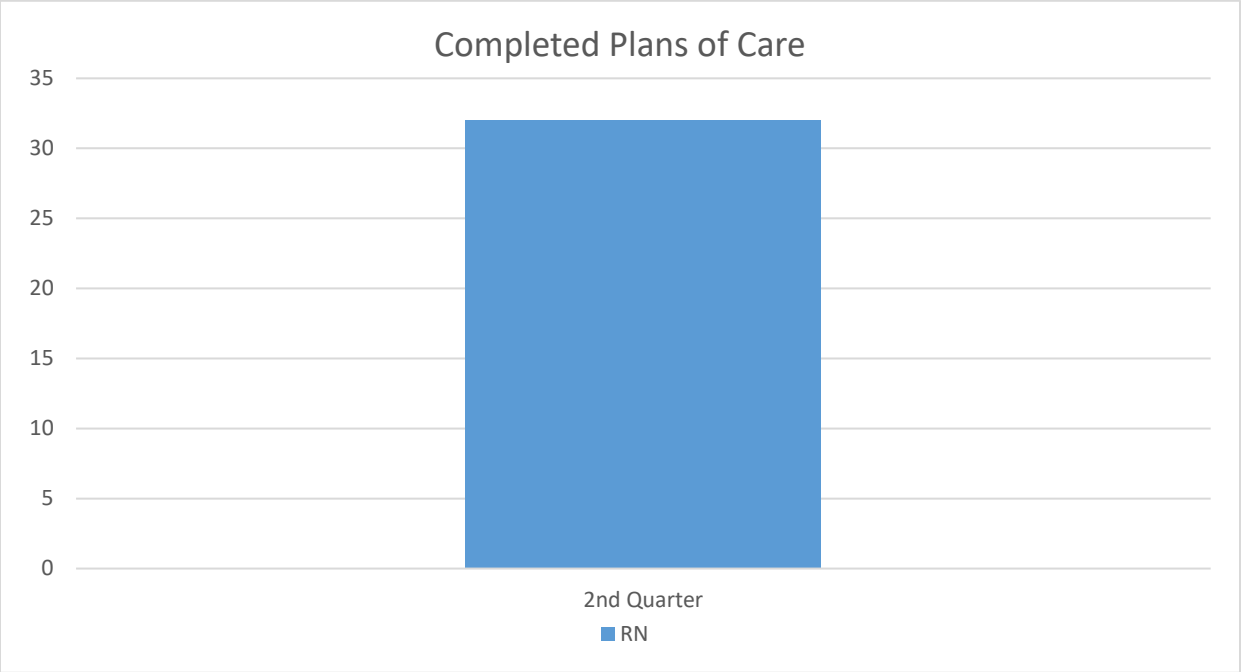
New Assessments Completed.

RN	SSC	Total
262	97	359



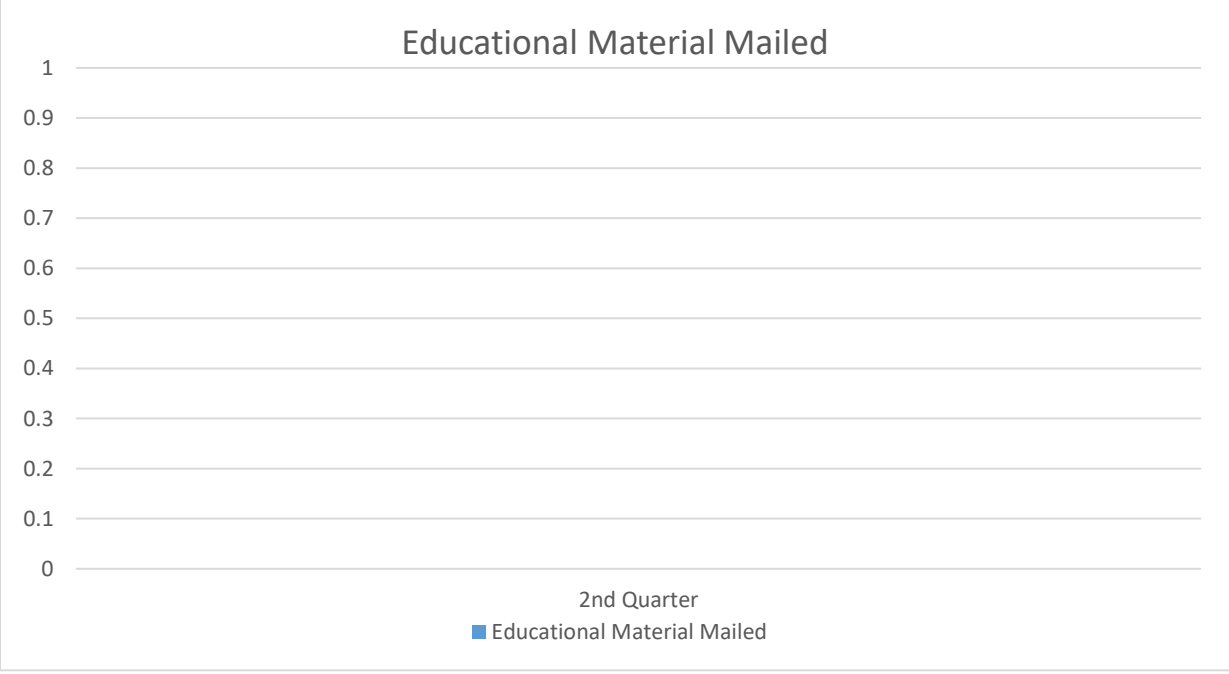
Plans of Care Completed & Closed.

RN
32



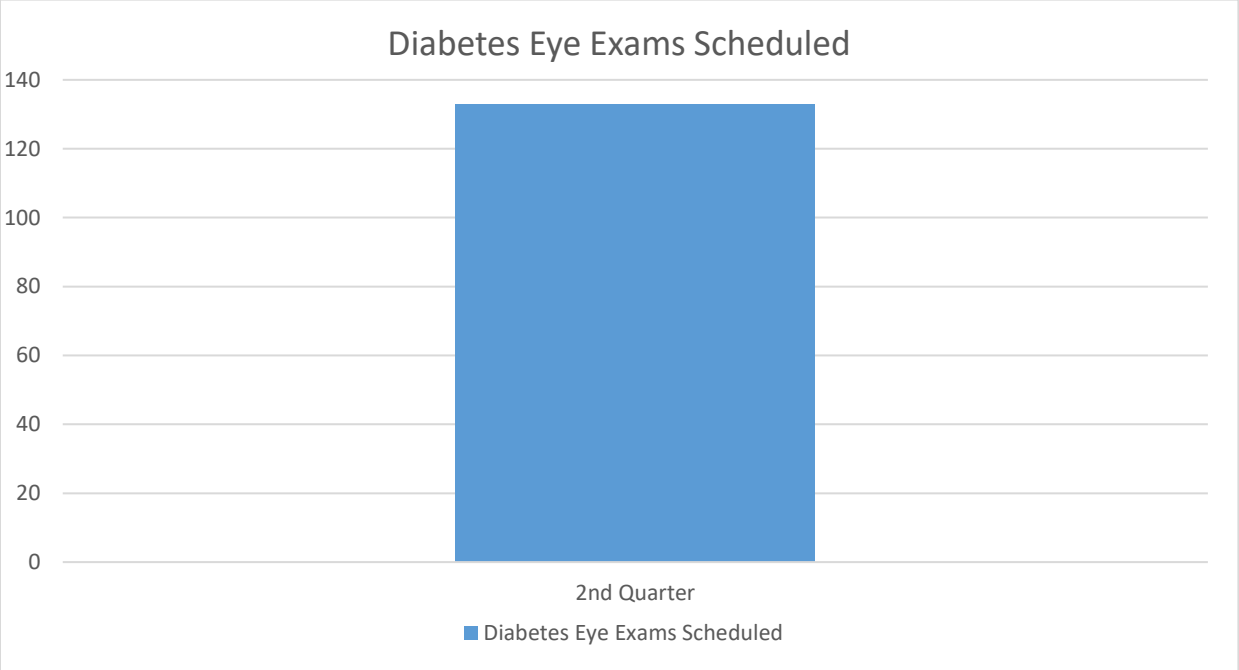
Educational Material Mailed. No educational material being mailed at this time

0



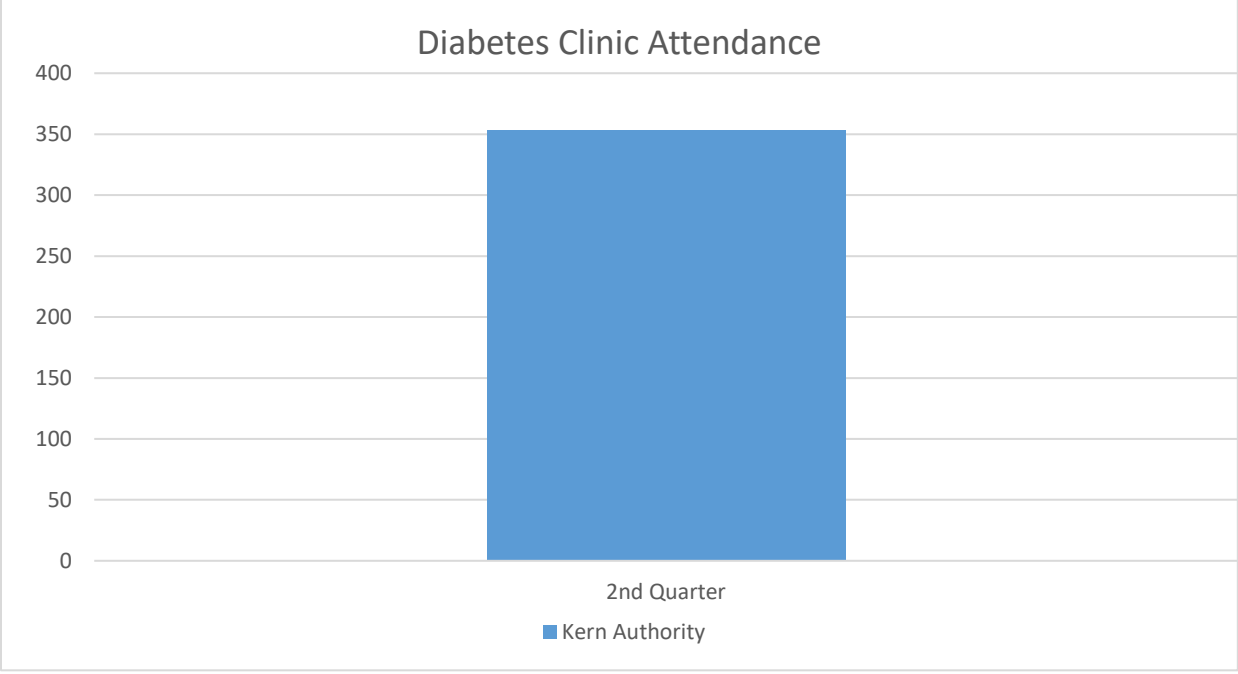
Diabetes Eye Exams Scheduled.

133



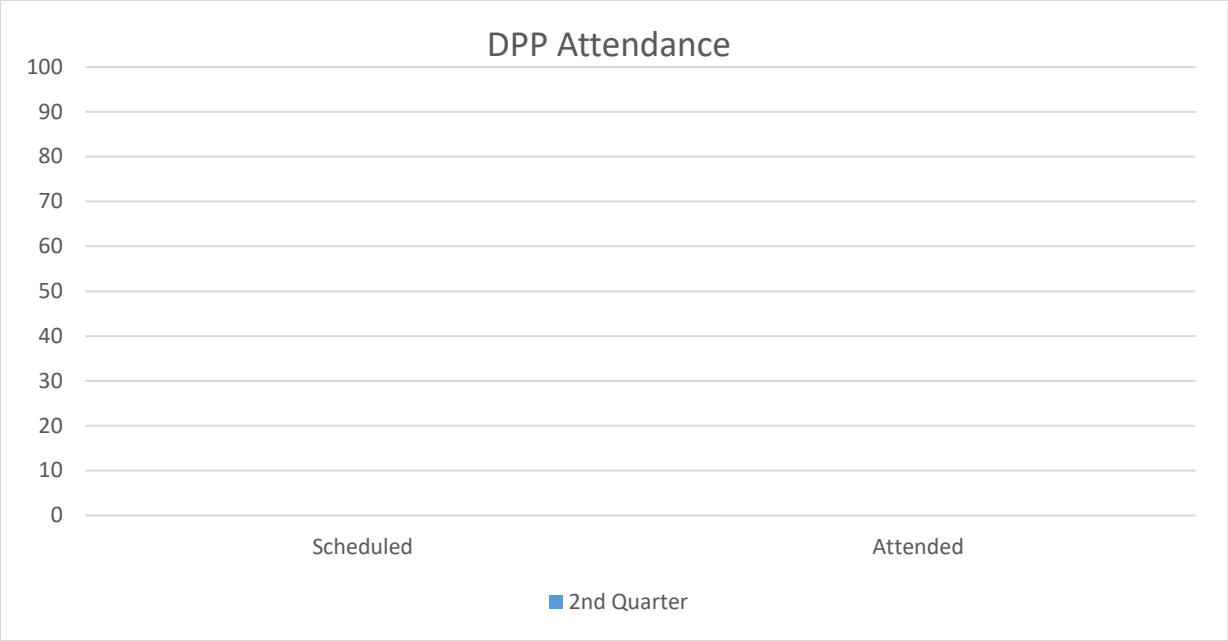
Diabetes Clinic Attendance.

Kern Authority
353

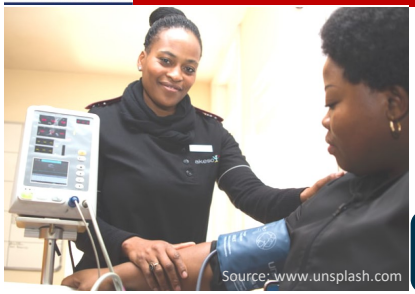


Diabetes Prevention Program: The first DPP program was completed at the end of February, 2020. Of the 48 members who attended the first session on March, 4th, 2019, 22 members completed the 26 sessions. The 2nd cohort has been delayed as a result of COVID19.

Sessions Scheduled to Attend (Jan & Feb)	Actual Sessions Attended (Jan & Feb)
0	0



Recommendations During COVID-19



Managing Hypertension (Part 1)

Older adults and people with severe underlying medical conditions that may include hypertension, seem to be at higher risk for developing more serious complications from COVID-19 illness.

Center for Disease Control

A Reminder of Resources for MCPs

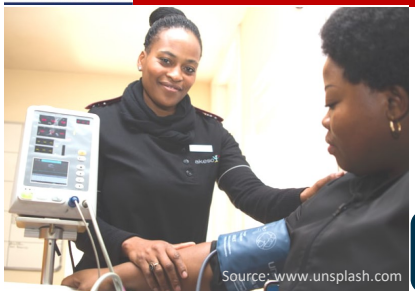
Provider Virtual Approaches

- **Remote Biometric Monitoring:** Sensor kits that wirelessly transmit biometric data to a phone from medical devices, such as blood pressure (BP) cuffs. Based on results, the patient is contacted and triaged by a nurse or pharmacist.
- **Tele Tuck-in Program:** A call center care team calls patients at home who need ongoing assessment, medication access and management, including education and reminders to receive vital immunizations. Refer to ACC guidance.
- **Telehealth:** An audiovisual conference platform app for member screening exams, lab follow-up and case management by the care team.
- **Mobile Health Platforms:** Automated text messaging applications of personalized care support and instructions to members (e.g., VA Annie).

Support for Members

- **Targeted Messaging:** Data-driven high risk member outreach to avoid contributors to high BP and use of My Cardiac Coach, a progress tracker for monitoring BP and weight.
- **Self-Care under Safe Conditions:** Self-care information amid COVID-19 and stress management tips for members.
- **Free Online Support Network:** The American Heart Association has a free online support network that connects people with similar health concerns (e.g., find high BP under chronic conditions).
- **BP Monitoring Log:** Use of a downloadable printable BP log to alert members of BP changes over time. Choose and provide BP device, if available option, with validated clinical accuracy of readings.

Recommendations During COVID-19



Managing Hypertension (Part 2)

Older adults and people with severe underlying medical conditions that may include hypertension, seem to be at higher risk for developing more serious complications from COVID-19 illness.

Center for Disease Control

A Reminder of Resources for MCPs

Important Take-Aways

Pharmacy Support

Increased Pharmacy Access and Medication Availability

- Drive-thru or curbside pick-up
- 90-day or greater supply of medications
- Medication mailing and waiving of fees
- Use team-based care approach, including pharmacist.

Pharmacy Follow-up

- Pharmacist-led medication management, review, reconciliation, and counseling.
- Coordination with providers on care for high risk members.

Resources and Messaging During COVID-19

Member Support

For Vulnerable and High Risk Members

- Emotional support calls for vulnerable groups (e.g., Friendship Line California for the elderly).
- Medi-Nurse advice line for Medi-Cal fee-for-service beneficiaries who don't have a regular doctor, as well as the uninsured.
- Updated DHCS COVID-19 information for members and beneficiaries.
- Remind members to take cardiac medications (i.e., RAAS antagonists) as prescribed.
- Assure members, using community health workers for messaging, that they can continue to safely receive vital health services and needed immunizations to keep members healthy.
- Assure members that it is safe to go to the ED with symptoms of a heart attack or stroke.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Hospital Re-admissions – Identification of Potential ~~Quality of~~Inappropriate Care Issues				POLICY #: 2.26-I	
DEPARTMENT: Quality Improvement					
Effective Date: 10/1999	Review/Revised Date: ~~08/05/2019~~06/01/2020	DMHC		PAC	X
		DHCS		QI/UM COMMITTEE	X
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
~~Senior Director of~~Chief Health Services Officer

_____ Date _____
Director of Quality Improvement

POLICY:

Kern Health Systems (KHS) will evaluate hospital re-admissions that occur within 30 days of the first hospital discharge to identify any trends in quality of care issues.

Not all re-admissions within thirty (30) days are due to Quality of Care Issues. The following mechanisms will be used to ensure appropriate evaluation occurs to identify quality of care concerns and opportunities for improvement in care provided:

1. A sampling of 50 re-admissions per quarter will be selected for review and case selection will represent a comprehensive view of the entire pool of 30 day re-admissions (e.g. male versus female, hospital, geographic area, age, diagnosis, etc.).
2. The Business Intelligence team produces a monthly report of all 30-day Re-admissions that is used for case review selection. Case selection may be focused depending on identified trending patterns. .
3. If at any time there are 100 or more 30 day readmission reviews awaiting review for potential ~~quality of~~inappropriate care identification, the QI team will narrow the pool to 50 re-admissions for each quarter based on the method described in section 1 above.

4. Cases selected for review are evaluated for a potential quality of care concern by a QI RN.
5. After the RN completes their review, any review outcome greater than a level 0 ~~it~~ is sent to a medical director ~~or their designee~~ for final determination of whether a potential ~~quality of~~inappropriate care (PIC) concern exists and identification of follow up actions needed.
6. An aggregate report of 30 day re-admissions to evaluate trending will be presented to the QI-UM Committee for review and recommended actions.
7. Re-admissions excluded from review for a potential quality of care concern include:
    a. Re-admissions that are only an observation stay and do not involve actual hospital admission.
    b. Scheduled re-admission as part of a planned course of treatment.
    c. Transfers to another hospital with no break between discharge and admission between hospitals.
    ~~d. Patients scheduled or anticipated for readmission (e.g. patient being scheduled for and returning to the hospital for further treatment of a disease, illness or injury).~~

PROCEDURES:

1.0 INITIAL EVALUATION OF RE-ADMISSIONS

Hospital re-admissions occurring within 30 days from the date of discharge for a previous hospital stay are evaluated to identify any ~~potential quality of care~~PIC issue ~~(PQI)~~. Cases selected for review are entered into the Health Services ~~care~~ medical management system's ~~30 Day Re-admission Review~~QR module and a QI RN initiates the process for evaluating if a potential quality of care concern is present. If additional medical records are needed, the RN advises the QI Senior Support Clerk who submits the request to the facility. The RN completes the process for potential quality of care concerns. (See Policy and Procedure 5.01-I, KHS Member Grievance and Appeal System, and APL 17-006, Grievance and Appeal Requirements).

If a ~~potential quality of care~~PIC issue is identified, ~~a notification form~~the episode is ~~completed, sent to the designated QI RN and QI~~referred to the Medical Director ~~and process for PQIs is initiated~~for final determination if a quality of care (QOC) is present and the level of QOC.

A report of all 30 day re-admissions is run from KHS' Business Intelligence team. On a quarterly basis, the QI-UM Committee reviews re-admissions in aggregate to identify any trending patterns. Categories reviewed include but are not limited to the following categories:

- Male
- Female
- Ages 0 – 12
- Ages 13 – 17
- Ages 18 – 64
- Ages 65 and over
- Hospital
- Diagnosis
- Geographic area
- Provider

~~The QI Director or their designee~~A QI RN screens all cases ~~initiated~~ referred ~~by UM~~as a 30 day re-admission to ensure that each is appropriate for review within the readmission

process and with consideration of exclusions listed in the Policy section above, item 7.

Cases that do not pass the screening process may be reviewed for other quality of care related concerns (example: death).

2.0 REVIEW OF MEDICAL RECORDS

After the initial screening is completed, the QI RN will notify the SCC if additional medical records are needed. The SCC faxes ~~a~~ the request for ~~the inpatient and outpatient~~ records to the provider designated by the reviewing QI nurse. Once the records ~~have arrived~~are received, the SSC uploads the documents into the ~~care~~ medical management system and ~~puts the episode to the 30 day re-admissions queue~~notifies the reviewing QI RN.

A QI Nurse reviews the documents and summarizes the member's care and any potential quality of care concerns that occurred related to the re-admission. ~~–~~The summary uses the SBAR format of situation, background, assessment and recommendation~~should include a~~ for a synopsis of the clinical facts supporting their quality of care concern. ~~Once t~~The summary is ~~complete, the QI Nurse~~ documented~~s the information~~ in the episode within the ~~care~~ medical management system. ~~–~~The nurse ~~immediately~~ assigns the episode to ~~the~~ a ~~QI~~ Medical Director ~~or their physician designee~~ to make a final determination~~e~~ whether a ~~Quality of Care Issue~~QOC issue ~~actually~~ exists ~~and to take action~~and any follow up action needed. The ~~QI~~ Medical Director ~~or their physician designee~~ reviews the records for internal or external quality of care issues and opportunities for improvement. The QI nurse works with the ~~QI~~ Medical Director ~~or their physician designee~~ for any follow up actions requested. Follow up action may include both internal and external opportunities for improvement. Internal issues will be discussed with the relevant department(s) and a mitigation plan developed as appropriate. The QI nurse and ~~QI~~ Medical Director ~~or their physician designee~~ will coordinate for external quality of care issues to identify who will communicate with the external provider and the necessary follow up actions.

Where indicated a referral to KHS's other medical management programs such as UM, CM and DM will be made to manage complex or challenging member issues. .

The ~~QI~~ Medical Director ~~or their physician designee~~ may draft a letter requesting further information and/or clarification regarding the issue in question.~~—~~ If a ~~quality of care~~QOC issue is identified, the Medical Director or designee will inform the involved facility's QI Department or the responsible provider of the findings. Not all identified ~~quality of care~~QOC issues will require a corrective action plan but all will be tracked for re-credentialing purposes.

3.0 CLOSING CASE

Based on the outcome of the review, the case may be closed with a Severity Level of

- 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

Copies of all written correspondence and pertinent documents are ~~filed in the appropriate, secured Quality Improvement files~~retained within the Health Services medical management system.

4.0 TRACKING AND TRENDING

Tracking and trending is performed to identify opportunities for improvement that may not be initially evident by chart review. This is done to identify any persistent patterns of concerns and opportunities for improvement.

The Medical Director requesting tracking and trending identifies and documents the specific areas for focus and the period of time to conduct tracking and trending. All cases selected for tracking and trending are logged ~~by the QI SSC into Jiva~~and maintained by the QI SCC. All notifications that are identified as a ~~PQI~~ QOC for tracking and trending are monitored, at a minimum, on a monthly basis. A report is run ~~within the first week~~during the month following the report month for all active track and trend cases. New PQI activity is summarized by the QI RN and presented to the Medical Director for review and direction. . After reviewing the active track and trending cases, the Medical Director makes a decision to:

- Stop tracking and trending and close the case due to no quality of care issue identified or the identified QOC has been resolved
- ~~Stop tracking and trending and close the case due to the identified quality of care issue has been corrected~~
- Continue tracking and trending ~~with the same focus and for the original period of time identified~~
- ~~Continue tracking and trending with modification of the focus and for the original period of time identified~~
- ~~Continue tracking and trending with the same focus, but for a different time period~~
- ~~Continue tracking and trending with a modification of the focus and a different time period.~~

Any trends identified will be discussed with the Medical Director ~~or designee~~ to evaluate if the ~~PQI~~ QOC leveling and follow up action need to be adjusted. Physician--specific trends will be reported to Provider ~~Relations~~ Network Management for inclusion in the recredentialing process.

ATTACHMENTS:

- Attachment A – Readmission Review Worksheet
- Attachment B – Chart Review Process Flowchart

REFERENCE:

Policy 5.01 KHS Member Grievance and Appeal System
APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
Title 22, CCR, Section 53858(e)(2)

Revision 2020-06: Minor adjustments and clarifications to update job titles, department name, system name reference, etc. Added use of SBAR summary note format. Updated medical director outcomes for tracking and trending review. Review and revisions made by Director of QI.

Revision 2019-08: Policy updated to define PQI levels, follow up actions, and process for tracking and trending by Director of QI.

Revision 2015-05: PAC approved 6/3/2015. Policy updated to include new processes such as the Transition of Care Program and Outpatient Care Management. Attachment A revised. Attachment B added.

Revision 2013-08: Policy reviewed by Director of Quality Improvement, Health Education and Disease Management. No revision need, titles updated. **Revision 2009-04:** Routine review provided by QI Department. **Revision 2005-03:** Revised to comply with DHS 2005 Contract. Effective Date 01/01/01: Changes requested by QI.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Emergency Services				POLICY #: 3.31-P	
DEPARTMENT: Utilization Management					
Effective Date: 04/2005	Review/Revised Date: 06/16/2020	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Claims

_____ Date _____
Director of Utilization Management

POLICY[1]:
Emergency services may be provided by any qualified emergency provider.

Emergency services will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

- California Health and Safety Code §1317; 1317.1; and 1371.4
- California Code of Regulations Title 28 §1300.67(g)
- California Code of Regulations Title 22 §§53216; and 53855
- 2004 DHCS Contract Exhibit A-Attachment 5(2) and (3); Exhibit A – Attachment 6 (5) and (9);

Exhibit A – Attachment 9 (6); and Exhibit E - Attachment 1, (31);

- ❖ DHCS Letter: Payment for Emergency Services to Non-Contracted Providers (October 1, 2001)

DEFINITIONS:

Emergency Medical Condition[2]	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: A. Placing the member's health (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, B. Serious impairment to bodily functions C. Serious dysfunction of any bodily organ or part; or D. With respect to a pregnant woman who is having contractions, inadequate time to affect a safe transfer to another hospital before delivery, or that transfer may impose a threat to the health and safety of the woman or the unborn child.
Emergency Services and Care[3] [4]	Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition within the capability of the facility. This includes an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.
Stabilized[5]	A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, a transfer of the patient.

PROCEDURES:

1.0 ACCESS

Emergency services and care are available and accessible to members on a 24-hour a day, seven days a week basis within the KHS service area.[6] KHS members have access to all emergency service facilities in Kern County. All emergency services facilities in Kern County provide care on a 24-hour-a-day, 7-day-a-week basis with one or more Physicians and one Nurse on duty in the facility at all times.[7]

KHS does not require prior authorization for emergency services and care.[8] Members may receive emergency services and care from any qualified provider.

Members needing advice or triage to an emergent care center may contact the KHS 24-Hour Telephone Triage Service at 1-800-391-2000.

The KHS Chief Medical Officer or a designee who is licensed as a "physician or surgeon"[9], is available 24 hours per day, seven days per week to coordinate the transfer of care of a member whose emergency condition is stabilized, to authorize medically necessary post-stabilization services, and for general communication with emergency room personnel.[10]

1.1 Out-of-Area Services[11]

For the Medi-Cal Product, emergency services are covered if they are provided within the United States. In addition, emergency care services requiring hospitalization are covered if they are provided in Canada or Mexico. Emergency services provided in any other country are not covered.

2.0 COVERED SERVICES

Members presenting to an emergency department for treatment should be provided with a medical screening examination (MSE) to determine whether or not an emergency condition exists. An MSE may include ancillary services routinely available to the emergency department that are necessary to determine whether an emergency condition actually exists.

If, after completion of the MSE, an emergency medical condition is found to exist, the emergency department shall treat and stabilize the member up to and including admission to the hospital.

If, after the MSE, an emergency medical condition has been determined not to exist or the emergency condition has been stabilized, prior authorization for further services is not required for post-stabilization hospital care.[12] KHS does not require transfer to a contracted acute care hospital. The facility shall submit notification of admission either through the KHS provider portal or by faxing the facesheet and clinical documentation to (661) 664-5190 for tracking purposes and automatic authorization. If there is a disagreement between KHS and the Provider regarding the need for necessary medical care following stabilization of the member, KHS shall assume responsibility for the care of the patient either by having medical personnel contracting with KHS personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with KHS agree to accept the transfer of the patient[13].

2.1 Emergency Psychiatric Conditions

Emergency services and care for psychiatric conditions are covered by KHS, including initial history and physical within 24 hours after admission to a psychiatric facility. All other psychiatric services with the exception of initial consults occurring while admitted for other medical condition or other outpatient mild to moderate mental health services are carved out of the Medi-Cal Product.

KHS covers all professional services, except the professional services of a mental health specialist, when required for the emergency services and care of a member whose condition meets specialty mental health medical necessity criteria.

KHS covers the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria when such services and care do not result in the admission of the member for psychiatric inpatient hospital services or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility.

Members in need of urgent and emergency psychiatric care that are identified by KHS, including person-to-person telephone transfers, will to be referred to the county crisis program during their call center hours. A toll free telephone crisis hotline will be maintained for telephonic support as well as guidance for receiving additional treatment. Members needing immediate crisis intervention may self-refer to the Crisis Stabilization Unit where on-site Mental Health staff is available 24 hours a day.

2.2 Emergency Transportation

Coverage includes appropriate ambulance services as described in *KHS Policy and Procedure 3.50-P Ambulance Transportation Services.*[14]

2.3 Emergency Pharmaceuticals

Under emergent circumstances, Provider shall administer and/or dispense a sufficient quantity of medication to the member to last until the member can reasonably be expected to have a prescription filled.

3.0 DOCUMENTATION

Although emergency services do not require prior authorization, practitioners/providers must submit a *Referral/Prior Authorization Form* or the hospital facesheet with any additional clinical documentation to KHS as soon as reasonably possible after care has been provided for tracking purposes. (Form included as an attachment to *KHS Policy and Procedure #3.22-P Referral Process*.) This requirement does not apply to Emergency Room Physicians but only to other types of Providers who perform emergency services.

4.0 COORDINATION OF CARE, MONITORING, AND REPORTING

KHS monitors primary care practitioners for adequate follow-up care for those members who have been screened in the Emergency Room and require non-emergency care through the QI site review process and reporting.[15]

KHS uses *Referral/Prior Authorization Forms* and other documentation received from practitioners/providers to conduct coordination of care, tracking, and case management activities.

5.0 REIMBURSEMENT

Claims must be submitted and are processed in accordance with *KHS Policy and Procedure #6.01-P Claims Submission/Reimbursement*. Provider disputes regarding claims payment must be submitted and are processed in accordance with *KHS Policy and Procedure # 6.04-P Practitioner/Provider Disputes Regarding Claims Payment*.

KHS reimburses all medically necessary emergency claims according to the eligibility of the member at the time of service and the level of care received by the member. At a minimum, reimbursement for a MSE is made to all emergency room practitioners/providers, (professional and facility component and hospital based urgent care facilities).

Contracted providers are reimbursed based on negotiated rate. Non-Contracted providers are reimbursed at Billed charges or Medi-Cal FFS rates, whichever is less. All services are subject to Medi-Cal Correct Coding Editing and Guidelines.

For emergency inpatient services, in the absence of a negotiated rate, claims are reimbursed in accordance with the following guidelines: Applicable Diagnostic Related Group (APR-DRG) reimbursement rates for out-of-network emergency, and post-stabilization acute inpatient services provided to MCP beneficiaries by general acute care hospitals.

6.0 PROVIDER REQUIREMENTS

All non-contract and out-of-area Emergency Departments must follow applicable laws and regulations when KHS members present for care.

7.0 DELEGATED OVERSIGHT

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 applicable APLs, Policy Letters, and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

REFERENCE:

[1] **Revision 2020-04:** Revised by Director of UM per DMHC comments dated 1/14/2020. Added Section 7.0 for language regarding delegated oversight. **Revision 2014-08:** Revised by Director of Health Services to comply with All Plan Letter 13-004. Revised per DMHC comments dated 9/7/06. Added contract language for dispensing medication in emergency cases. Revised per DMHC Comments dated 09/06/06. **2005-10:** Revised per DHS Workplan Comments 6d (9/1/05) and 6h (9/1/05). Revised to reflect the deletion of external policy 3.15 – Urgent Care/Emergent Care 24 Hour Telephone Triage. **Revision 2005-08:** Revised per DHS Comments (7/12/05). **Revision 2005-04:** Policy reviewed against DHS Contract 03-76165. No revision needed per Lacey Campbell. **Revision 2004-05:** Created as part of routine revision of emergency services policies. Contains elements of the following policies that will be deleted upon the release of 3.23*:#3.12 – Prior Authorization for Urgent Care and Non-Emergent ER Services (2000-05); #6.24 – Emergency/Urgent Care Reimbursement Guidelines (2002-02*). **Formerly #3.23.**

[2] HSC §1317.1(b) and (c) and 2004 DHS Contract Exhibit E – Attachment 1(31). Combines the least restrictive elements of both definitions. Title 22 §51056 also has a similar definition.

[3] HSC §1317.1(a). Definition from DHS Contract Exhibit E-Attachment 1(32) is not included because it is less restrictive.

[4] " For the purposes of Section 1371.4 emergency services and care as defined in this paragraph shall not apply to services provided under managed care contracts with the Medi-Cal program to the extent that those services are excluded from coverage under the contract." HSC §1317.1(a)(2)

[5] HSC §1317.1(j)

[6] CCR Title 28 §1300.67(g)(1); DHS Contract A-6 (5) and A-9 (6)

[7] DHS Contract A-6 (5)

[8] CCR Title 22 §53855(a); DHS Contract Exhibit A-Attachment 5(2)(F) and (3)(A); DHS Contract A-9 (6)(A)

[9] "physician and surgeon" added per DMHC comment 9/6/06.

[10] DHS Contract A-6 (9) and A-9 (6)(C)

[11] CCR Title 22§51006

[12] HSC 1371.4(c); CCR Title 22 §53855(a)
[13] DMHC comment letter dated 9/6/2006
[14] CCR Title 28 §1300.67(g)(1)
[15] DHS Contract A-9 (6)(B)

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Continuity of Care for New Members				POLICY #: 3.40-I	
DEPARTMENT: Health Services - Utilization Management					
Effective Date: 01/1996	Review/Revised Date: 5/20/2020	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Network Administration Officer

_____ Date _____
Chief Health Services Officer

_____Date _____
Director of Utilization Management

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

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

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

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

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

COC does not apply to members who had an option to remain with their previous health plan.[1]

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

DEFINITIONS:

Acute condition[2]	Medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.
Existing Relationship	The member has seen a primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment unless otherwise specified in this policy.
Individual Provider[3]	A person who is licensed as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.
Medical Exemption Request (MER)	A request to the Department of Health Care Services (DHCS) for temporary exemption from Managed Care Plan (MCP) enrollment until the Medi-Cal beneficiary's condition has stabilized to enable a transfer to an MCP provider of the same specialty without deleterious medical effects.
New Member	A new member is an enrollee who has transitioned from FFS Medi-Cal or another qualifying government program and is assigned a mandatory aid code.
Provider[4]	Any professional person, organization, health facility (including a hospital), or other person or institution licensed by the state to deliver or furnish health care services.
Provider group[5]	Includes a medical group, independent practice association, or any other similar organization.
Quality of Care	A quality of care issue means KHS can document its concerns with the

Issue	provider's quality of care to the extent that the provider would not be eligible to provide services to any other KHS beneficiaries.
Maternal mental health condition[9]	A mental health condition that can impact a woman during their pregnancy or during the postpartum period, or that arises during pregnancy or in the postpartum period, up to one year after delivery.
Serious chronic condition[6]	Medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following: A. Persists without full cure or worsens over an extended period of time B. Requires ongoing treatment to maintain remission or prevent deterioration
Terminal Illness[7]	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Terminated Provider[8]	A practitioner, provider group, or hospital whose contract to provide services for KHS is terminated or not renewed by any of the contracting parties.

PROCEDURES:

1.0 QUALIFYING FOR CONTINUITY OF CARE[9]

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

1. KHS is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider);

   a. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment with KHS for a non-emergency visit, unless otherwise specified in the All Plan Letter (APL18-008).

2. The provider is willing to accept the higher of KHS's contract rates or Medi-Cal FFS rates;
3. The provider meets KHS's applicable professional standards and has no disqualifying quality of care issues (for the purposes of this APL, a quality of care issue means KHS can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other KHS members);
4. The provider is a California State Plan approved provider;
5. The provider supplies KHS with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

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

1.2 Continuity of Care Process

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

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

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

1.2.1 Retroactive Requests for COC

KHS will retroactively approve a continuity of care request and reimburse providers for services that were already provided if the request meets that meets all continuity of care requirements described above, and t the services that are the subject of the request meet the following requirements:

- Occurred after the member's enrollment into the MCP,
- Have dates of services after December 29, 2014;
- Have dates of services that are within 30 calendar days of the first service for which the provider requests retroactive continuity of care retroactive reimbursement;
- Retroactive continuity of care reimbursement requests must be submitted within 30 calendar days of the first service to which the request applies.

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

A member's self-attestation of a pre-existing relationship is not sufficient proof (instead, actual documentation must be provided), unless KHS makes this option available to the member. Following identification of a pre-existing relationship, KHS determine if the provider is an in-network provider. If the provider is not an in-network provider, KHS will contact the provider and make a good faith effort to enter into a

contract, letter of agreement, single-case agreement, or other form of relationship to establish a continuity of care relationship for the member.

1.3 Request Completion Timeline

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

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

A continuity of care request is considered completed when:

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

1.4 Post Request Process Requirements

If KHS and the out-of-network Medi-Cal FFS provider are unable to reach an agreement because they cannot agree to a rate or KHS has documented quality of care issues with the provider, KHS will offer the member an in-network alternative. If the member does not make a choice, the member will be referred or assigned to an in-network provider. If the member disagrees with the result of the continuity of care process, the member maintains the right to file a grievance.

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

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

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

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

KHS will notify the member 30 calendar days before the end of the continuity of care period about the process that will occur to transition the member's care to an in-network

provider at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

1.5 Extended Continuity of Care

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

1.6 Member and Provider Outreach

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

1.7 Out of Network Provider Referral

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

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

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

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

KHS will allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network MHP provider in

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

3.0 COVERED CALIFORNIA TO MEDI-CAL TRANSITION

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

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

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

KHS will, at the member's or provider's request, offer up to 12 months of continuity of care with out-of-network providers, in accordance with the requirements in this APL.

4.0 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.

5.0 SENIORS AND PERSONS WITH DISABILITIES FFS TREATMENT AUTHORIZATION REQUEST CONTINUITY UPON ENROLLMENT

For a newly enrolled Seniors and Persons with Disabilities (SPDs), KHS will honor any active FFS

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

6.0 BEHAVIORAL HEALTH TREATMENT FOR MEMBERS UNDER THE AGE OF 21 UPON TRANSITION

KHS is responsible for providing Early and Periodic Screening, Diagnostic, and Treatment services for members under the age of 21. Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. In accordance with existing contract requirements and the requirements listed in this APL and APL 19-004, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, KHS will offer members continued access to out-of-network BHT providers (continuity of care) for up to 12 months if all requirements in this APL are met.

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

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

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

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

KHS will provide continuity of care with an out-of-network provider, in accordance with the requirements of this APL, for Medi-Cal FFS beneficiaries who voluntarily transition to an MCP to enroll in the Health Homes Program (HHP). Because HHP services are provided only through the managed care delivery system, continuity of care with out-of-network-providers is not available for HHP services.

8.0 EXISTING CONTINUITY OF CARE PROVISIONS UNDER CALIFORNIA STATE LAW

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

Additional requirements pertaining to continuity of care are set forth in Health and Safety (HSC) Code § 1373.96 and require health plans in California to, at the request of a member, provide for the

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

9.0 PREGNANT AND POST-PARTUM BENEFICIARIES

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

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

10.0 MATERNAL MENTAL HEALTH SERVICES

As noted above, HSC §1373.96 requires health plans in California to, at the request of a member, provide for the completion of covered services by an out-of-network provider relating to treatment of a mental health condition that impacts a woman during pregnancy and immediately after the delivery (the post-partum period), up to one year after delivery.

Pregnant and post-partum Medi-Cal members into KHS have the right to request out-of-network provider continuity of care for up to 12 months in accordance with KHS's contract and the general requirements listed in this APL. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of this APL (continuity of care for members transitioning from FFS to managed care). Please refer to HSC §1373.96 for additional information about any applicable circumstances and requirements.

11.0 MEDICAL EXEMPTION REQUESTS

A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into KHS only until the member's medical condition has stabilized to a level that would enable the member to transfer to a KHS provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from KHS enrollment that only applies to members transitioning from Medi-Cal FFS to KHS. A MER should only be used to preserve continuity of care with a Medi-Cal FFS

provider under the circumstances described above in this paragraph. KHS is required to consider MERs that have been denied as automatic continuity of care requests to allow members to complete courses of treatment with Medi-Cal FFS providers in accordance with APL 17-007.

12.0 REPORTING AND MONITORING

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

KHS will conduct periodic audits, at a minimum of quarterly reviews, to review COC Notice of Action letter applicable use.

13.0 DELEGATION OVERSIGHT

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 Policy Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

Revision 2020-04: Policy revised by Director of Utilization Management to comply with APL 19-014 and changes to HSC §1373.96. **Revision 2019-12:** Language added requiring quarterly audit reviews. **Revision 2019-08:** Additional language to comply with APL18-008. **Revision 2018-08:** Policy to comply with APL 18-008. **Revision 2018-04:** Policy revised to comply with DHCS Deliverable BHT 10E. **Revision: 2018-04:** Policy revised by Administrative Director of Health Services to comply with APL 18-008. **Revision 2017-07:** Policy revised to comply with APL 17-007 new reporting requirements. Reporting changed from quarterly to monthly beginning July 2017. Instructions and templet provided by DHCS. **Revision 2017-01:** Policy revised to included new attachments; Initial Contact letter provided by Member Services Department and the MER Workflow Process

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

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

[1] HSC §1373.96 (e)(1) and (2)

[1] HSC §1376.96 (f)

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

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

[2] HSC §1373.96(c)(1)

[3] HSC §1373.96(k)(1)

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

[5] HSC §1373.65(g)

[6] HSC §1373.96(c)(2)

[7] HSC §1373.96(c)(4)

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

[9] HSC §1373.96(c)

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Comprehensive Case Management and Coordination of Care				POLICY #: 3.61-I	
DEPARTMENT: Health Services - Utilization Management					
Effective Date: 01-2006	Review/Revised Date: 05/20/2020	DMHC	X	PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

POLICY:

Kern Health Systems (KHS) provides basic comprehensive medical case management to Medi-Cal members ("members"). KHS maintains procedures for monitoring the coordination of care provided to members, including medically necessary services delivered within and outside the KHS provider network.

Comprehensive case management and coordination of care will be provided in accordance with the contractual requirements outlined in KHS' Medi-Cal contract with the DHCS.

DEFINITIONS:

Comprehensive Medical Case	Services provided by a Primary Care Physician to promote the coordination of medically necessary health care services, the provision of preventive services in accordance with established standards and

Management Services	periodicity schedules, and the continuity of care for members. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

PROCEDURES:

1.0 GENERAL CASE MANAGEMENT AND COORDINATION OF CARE

KHS members receive comprehensive case management and coordination of care services from their assigned Primary Care Physician (PCP), which includes procedures used to monitor the provision of Basic Case Management**.**

Basic Case Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

An Initial Health Assessment (IHA) consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract.

The PCP is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA.

Members' completed IHA and IHEBA tool are to be contained in the Members' medical record and available during subsequent preventive health visits.

KHS PCP's will make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate the PCP's unsuccessful efforts to contact a Member and schedule an IHA shall be considered compliant with the requirement.

Members will be informed during the New Member entry process to complete the IHA and the Staying Healthy Assessment (SHA) within the designated timeframes with their assigned PCP.

KHS will monitor the IHA/SHA completion through monthly report reconciliation with claims data and if not completed, outreach will be performed to promote gap closure.

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 to identify the need for preventive health visits for all Members under 21 years of age at times specified by the most recent AAP periodicity schedule (Bright Futures guidelines) and anticipatory guidance as outlined in the AAP Bright Futures periodicity schedule. KHS providers will provide, as part of the periodic preventive visit, all age specific assessments and services required by the CHDP program and the age-specific health education behavioral assessment IHEBA as necessary. Where the AAP periodicity exam schedule is more frequent than the CHDP periodicity examination schedule, KHS providers will ensure that the AAP scheduled assessment includes all assessment components required by the CHDP for the lower age nearest to the current age of the child.
- Individual Health Education Behavioral Assessment (IHEBA) performed within 120 calendar days for all members; and that all existing Members who have not completed an IHEBA, must complete it during the next non-acute, preventative care office visit according to the DHCS standardized "Staying Healthy" assessment tools, or alternative approved tools that comply with DHCS approval criteria for the individual health education behavioral assessment IHEBA. The IHEBA tool must be;
    a) administered and reviewed by the primary care Provider during an office visit,
    b) reviewed at least annually by the primary care provider Primary Care Provider with Members who present for a scheduled visit, and
    c) Re-administered by the primary care provider Primary Care Provider at the appropriate age-intervals.
- 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.

IHAs for Adults (Age 21 and older)

- KHS covers and ensures that an IHA for adult Members is performed by the PCP within 120 calendar days of enrollment. The performance of the initial complete history and physical exam for adults includes, but is not limited to:
- blood pressure,
- height and weight,
- total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
- clinical breast examination for women over 40,
- mammogram for women age 50 and over,
- Pap smear (or arrangements made for performance) on all women determined to be sexually active,

- Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
- screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
- IHEBA.

Immunizations

KHS PCP's are responsible for assuring that all adults are fully immunized. KHS will cover and ensure the member's PCP adheres to the timely provision of vaccines in accordance with the most current California Adult Immunization recommendations.

In addition, PCP will provide age and risk appropriate immunizations in accordance with the findings of the IHA, other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment.

KHS PCP's will document attempts to provide immunizations. If the Member refuses the immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the Member or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record. Documented attempts that demonstrate unsuccessful efforts to provide the immunization shall be considered compliant in meeting this requirement.

Member-specific immunization information will be periodically reported to an immunization registry established in the KHS Service Area as part of the Statewide Immunization Information System. Reports shall be made following the Member's initial health assessment IHA and all other health care visits which result in an immunization being provided. Reporting shall be in accordance with all applicable State and Federal laws.

Dental Services

Dental services are not covered under KHS DHCS contract. KHS covers and ensures KHS providers conduct dental screenings/oral health assessments for all Members as a part of the initial health assessment IHA.

For Members under 21 years of age, PCP's responsible for ensuring that a dental screening/oral health assessment is performed as part of every periodic assessment, with annual dental referrals made commencing at age three (3) or earlier if conditions warrant with the eruption of the child's first tooth or at 12 months of age, whichever occurs first.

Members will be referred to appropriate Medi-Cal dental providers for further evaluation and treatment as deemed necessary. KHS PCP's provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish, dental services that may be performed by a medical

professional. Dental services that are exclusively provided by dental providers are not covered benefits under KHS.

Women, Infant, and Children Program

WIC services are not covered under KHS contract with the DHCS. However, KHS has procedures to identify and refer eligible Members for WIC services. As part of the referral process, KHS providers will furnish the WIC program with a current hemoglobin or hematocrit laboratory value and document the laboratory values and the referral in the Member's medical record.

As part of its initial health assessment IHA of Members, or, as part of the initial evaluation of newly pregnant women, the member's PCP will refer and document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program as mandated by 42 CFR 431.635(c). KHS will execute a MOU with the WIC program as stipulated by the DHCS for services provided to Members through the WIC program.

KHS will administer and perform ongoing monitoring of the provision of Complex Case Management to Members to include procedures to identify members who may benefit from complex case management services.

Complex Case Management Services are provided by the primary care provider, in collaboration with KHS, and shall include, at a minimum:

- Basic Case Management Services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team to include the following mental health services performed within the scope of practice for licensed mental health care providers:
  - Individual/group mental health evaluation and treatment (psychotherapy);
  - Psychological testing when clinically indicated to evaluate a mental health condition;
  - Outpatient services for the purpose of monitoring drug therapy;
  - Psychiatric consultation for medication management.
  - Outpatient laboratory, supplies and supplements; and
  - Screening and Brief Intervention (SBI) for substance use conditions.
- Intense coordination of resources to accomplish the goal that the member regains optimal health or improved functionality
- With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually
- Coordination of services for members who have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern e.g. homelessness.
- If a Member becomes eligible for Specialty Mental Health Services during the course of receiving medically necessary Outpatient Mental Health Services, KHS shall continue the provision of non-duplicative, Medically Necessary Outpatient Mental Health Services.
- Any time that a Member requires a 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.

- KHS shall ensure the provision of SBI services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

KHS shall develop an algorithm methodology for risk stratification to identify Members who may benefit from Complex Case Management services, using utilization and claims data, Member Evaluation Tool (MET), clinical data, Health Information Form (HIF), a Predictive Modeling tool and any other available data, as well as member and physician self reported information.

KHS will electronically access member-specific health information, including the member's historical Medi-Cal FFS utilization data provided by DHCS at the time of enrollment. This data may include, but is not limited to:

- Outpatient services,
- Inpatient services,
- Emergency department services,
- Pharmacy, and
- Ancillary services data for the most recent 12 months.

Complex case management services for SPDs must include the concepts of Person-Centered Planning.

Complex Case Management Enrollment Criteria may include but are not limited to:

- Are residing in an acute hospital setting
- Have been hospitalized within the last 90 days, or have had 3 or more hospitalizations within the past year
- Have had 3 or more ER visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases)
- Have ESRD, AIDS, and/or a recent organ transplant
- Have cancer, currently being treated
- Have been prescribed 15 or more prescriptions in the past 90 days
- Major trauma within the previous 3 months
- Four or more chronic conditions
- Readmission within 30 days with the same /similar diagnosis/condition
- Have been on oxygen within the past 90 days,
- Are Pregnant
- Have been prescribed antipsychotic medication with the past 90 days
- Have a self-report of a deteriorating condition
- Chronic conditions including Asthma, COPD, Diabetes, CHF, CAD, and Cirrhosis/Chronic Liver Disease
- SPD members identified as "high risk" through initial risk stratification, HRA, or one of the data or referral sources listed above

- Coordination of services for members who have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnosis or a social circumstance of concern e.g. homelessness.

Criteria for transition out of Complex Case Management may include but are not limited to:

- Loss of eligibility for the program (member no longer enrolled through client).
- Achievement of documented targeted outcomes.
- Chief Medical Officer or designee Decision
- Member opts out of case management program.
- The member is unable to be located.
- Determination by the case manager that he/she is no longer able to provide appropriate case management services (i.e. due to member non-compliance, non-adherence to the plan of care). This last reason for case closure involves discussion and decision making with the Chief Medical Officer or designee.

Person-Centered Planning for SPD Beneficiaries[1]

- Upon the enrollment of a SPD beneficiary, KHS shall provide the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD beneficiary's continuing health care needs.
- Person-Centered Planning shall include identifying each SPD beneficiary's preferences and choices regarding treatments and services, and abilities.
- KHS shall allow the participation of the SPD beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.
- KHS shall monitor that SPD beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.

For the purpose of this policy, Person-centered Planning means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-centered Planning is an integral part of Basic and Complex Case Management and discharge planning. KHS will arrange the following Person-Centered Planning for services to SPD's upon enrollment.

- KHS shall provide, or arrange the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD member's continuing health care needs through careful review of the individualized care plans and Health Risk Assessment (HRA). KHS will foster community resources and facilitate routine and specialty appointments, transportation or other ancillary services necessary to provide health care needs that are identified. Referrals coordination between KHS Care and Case Management will be maintained to allow for prompt and medically necessary services to be received.
- Person-Centered Planning shall include identifying each SPD member's preferences and choices regarding treatments and services, and abilities. Members can request Continuity of Care with either a PCP or specialist. KHS will coordinate the member's requests with the provider to promote ongoing receipt of necessary services without interruption for up to one year. At that time, transition of care will be reviewed to promote continuity of services with contracted providers within KHS network.
- KHS shall allow or arrange the participation of the SPD member, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services. Care management of the entire family unit, not solely the individual,

will be conducted at the request of the member. Members will be encouraged to discuss treatment options with their providers and become an active participant in their healthcare. KHS Member Services Representative may be contacted to inquire as to their membership status as well as any pending services that were previously requested. KHS shall arrange that SPD members receive all necessary information regarding treatment and services so that they may make an informed choice. Information is made available detailing specific services, contracted providers as well as covered benefits in various formats, i.e. newsletters, members mailings or bulletins, provider directory and member handbooks to promote the health care of each individual member. Members are informed of approved services via Approval Letter or Notice of Action (NOA) Letters detailing any modifications or denials for services with alternative treatment options.

Discharge Planning and Care Coordination[2]

KHS shall monitor the provision of discharge planning when a SPD Member is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall review the documentation submitted to determine if the necessary care, services, and supports in the community are available for the SPD Member once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for a discharge planning checklist must include:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.

B. Documentation of pre-discharge factors, including an understanding of the medical condition by SPD Member or a SPD Member representative as applicable, physical and mental function, financial resources, and social supports.

C. Services needed after discharge, type of placement preferred by the SPD Member/ Member representative and hospital/institution, type of placement agreed to by the SPD Member/Member representative, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD Member/Member representative, and pre-discharge counseling recommended.

D. Summary of the nature and outcome of SPD Member/Member representative involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

It is the PCP's responsibility to track referrals and follow-up care. To assist in this effort, KHS provides the PCP with a quarterly list of open authorizations. 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.

2.0 CASE MANAGEMENT AND COORDINATION OF CARE FOR SPECIFIC SERVICES

Case management and coordination of care for specific services are provided as outlined below:

A. Targeted Case Management Services: See *KHS Policy and Procedure #3.13-P: EPSDT Supplemental Services and Targeted Case Management (TCM)*

B. Disease Management Program Services: See *KHS Policy and Procedure #2.35-P: Disease Management*
C. Out-of-Plan Services: See *KHS Policy and Procedure #3.55-I Coordination of Care for Out-of-Network, Seldom Used, and/or Unusual Specialty Services*
D. Specialty Mental Health Services: See *KHS Policy and Procedure #3.14-P Mental Health Services*
E. Alcohol and Substance Abuse Treatment Services: See *KHS Policy and Procedure #3.10-P Alcohol and Drug Treatment Services*
F. Services for Children with Special Health Care Needs: *See KHS Policy and Procedure #3.56-P Services for Children with Special Health Care Needs*
G. California Children's Services: See *KHS Policy and Procedure #3.16-P California Children's Services*.
H. Services for Persons with Developmental Disabilities: See *KHS Policy and Procedure #3.03-P Kern Regional Center Services (Developmental Disabilities and Early Intervention)*
I. Local Education Agency Services: See *KHS Policy and Procedure #3.57-P Local Education Agency Services*
J. School Linked CHDP Services: No local school districts or school sites in Kern County provide CHDP services. For speech services that are not medically necessary and are not covered by Medi-Cal, KHS provides parents of member children with the phone number of *Search and Serve*, a community referral resource for these non-covered services.
K. Foster Care: Foster care and Adoption Assistance Program (AAP) children receive prompt medical care, and KHS promptly authorizes medically necessary services to such children's providers in the county of placement. KHS billing processes are sensitive to the need to make timely payments to providers who treat children placed out-of-county who are KHS members.
L. HIV/AIDS Home and Community Based Services Waiver Program: See *KHS Policy and Procedure #3.11-I Home and Community Based Services (HCBS) Waiver Programs*
M. Dental Services: See *KHS Policy and Procedure #3.06-P Dental Services*
N. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB): See *KHS Policy and Procedure #3.46-P Tuberculosis Treatment*
O. Women, Infants, and Children (WIC) Supplemental Nutrition Program: See *KHS Policy and Procedure #3.08-P WIC*
P. Major Organ Transplants: See *KHS Policy and Procedure #3.02-P Major Organ Transplant*
Q. Waiver Programs: See *KHS Policy and Procedure #3.11-I Home and Community Based Services (HCBS) Waiver Programs*
R. Vision Care: See *KHS Policy and Procedure #3.07-P Vision Care*
S. Nursing Facility and Long Term Care: See *KHS Policy and Procedure #3.42-P Nursing Facility and Long Term Care*
T. Hospice: See *KHS Policy and Procedure #3.43-P Hospice*

REFERENCE:

Revision: 04/2020: Revised to comply with DHCS Audit CAP by Chief Health Services Officer. **Revision 2017-10:** Major revision to policy by Administrative Director of Health Services. **Revision 2016-08:** Minor revisions by Case Management and Health Services**. Revision 2016-05:** Retrospective audit performed on Policy Letter (PL) 14-005. Specified diagnosis codes excluded to comply with (PL) 14-005. **Revision 2014-08:** Policy still pending approval by DMHC as part of the Material Modification. Policy revised by Director of Health Services to comply with Mental Health Carve-In (2013-12). **Revision 2012-04**: Policy revised to comply with SPD Deliverable 11.C. Policy approved by the Department of Health Care Services (DHCS) March 19, 2012.

[1] 2010 DHS Contract Exhibit A, Attachment 11 (1D)

[2] 2010 DHS Contract Exhibit A, Attachment 11(2D)

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Second Quarter 2020

Report Date: July 8, 2020

OVERVIEW

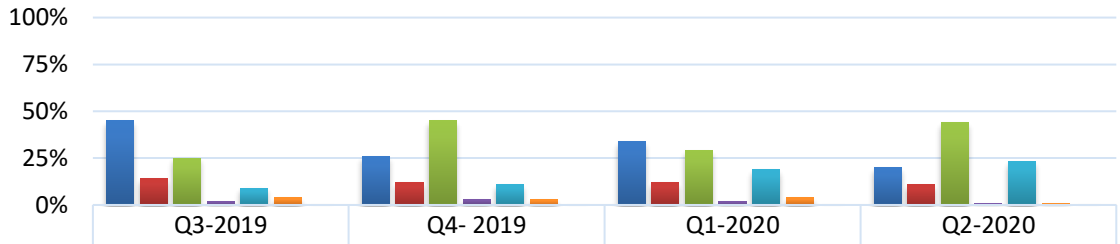
Kern Health Systems' Health Education department provides comprehensive, culturally and linguistically competent services to plan members with the intent of promoting healthy behaviors, improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care.

The following pages reflect statistical measurements for the Health Education department detailing the ongoing activity for the 2nd quarter 2020.

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

REFERRALS FOR HEALTH EDUCATION SERVICES

The Health Education Department (HE) receives referrals from various sources. Internal referrals are received from the Kern Health Systems (KHS) Utilization Management (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.

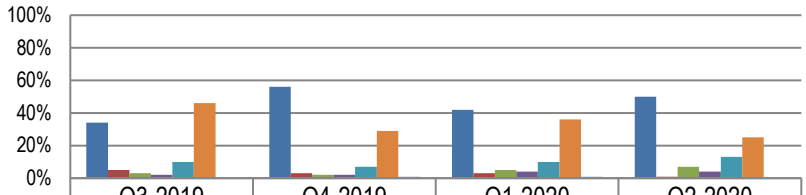


	Q3-2019	Q4- 2019	Q1-2020	Q2-2020
Provider	45%	26%	34%	20%
Member	14%	12%	12%	11%
HE	25%	45%	29%	44%
DM	2%	3%	2%	1%
UM	9%	11%	19%	23%
CM	4%	3%	4%	1%
MS	0%	0%	0%	0%

During this quarter, 697 referrals were received which is a 5% decrease in comparison to the previous quarter.

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Second Quarter 2020

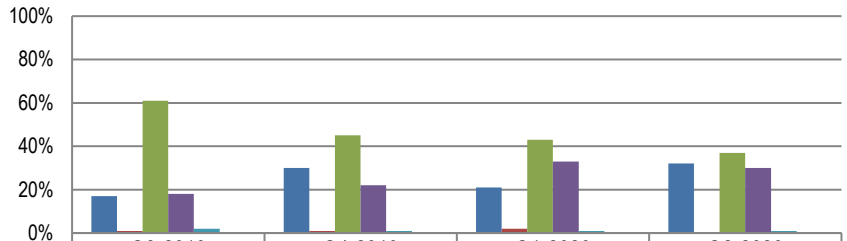
Referrals Received by Topic



	Q3-2019	Q4-2019	Q1-2020	Q2-2020
Asthma	34%	56%	42%	50%
Diabetes	5%	3%	3%	1%
Other Nutritional Counseling	3%	2%	5%	7%
Tobacco Cessation	2%	2%	4%	4%
Weight Mgmt - Adult	10%	7%	10%	13%
Weight Mgmt - Ped/Teen	46%	29%	36%	25%
Educational Material	0%	1%	1%	0%

The HE department receives referrals for various health conditions. This quarter, referrals for Ped/Teen weight management education decreased from 36% to 25% due to a decrease in provider referrals.

Referrals by Status



	Q3-2019	Q4-2019	Q1-2020	Q2-2020
*Accepted Services	17%	30%	21%	32%
Disenrolled	1%	1%	2%	0%
Declined Services	61%	45%	43%	37%
Unable to Contact	18%	22%	33%	30%
Withdrawn	2%	1%	1%	1%
Deceased	0%	0%	0%	0%

The rate of members who accepted to receive health education services increased from 21% in the 1st quarter to 32% in the 2nd quarter of 2020.

HEALTH EDUCATION SERVICE PROVIDERS

The HE department offers various types of services through KHS or through community partnerships. These services are currently being provided in a virtual setting or have been placed on hold due to COVID-19.

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 and Spanish)
- Heart Healthy Classes
- Individual Nutrition Counseling
- Small Steps to a Healthy Weight Classes (English and Spanish)

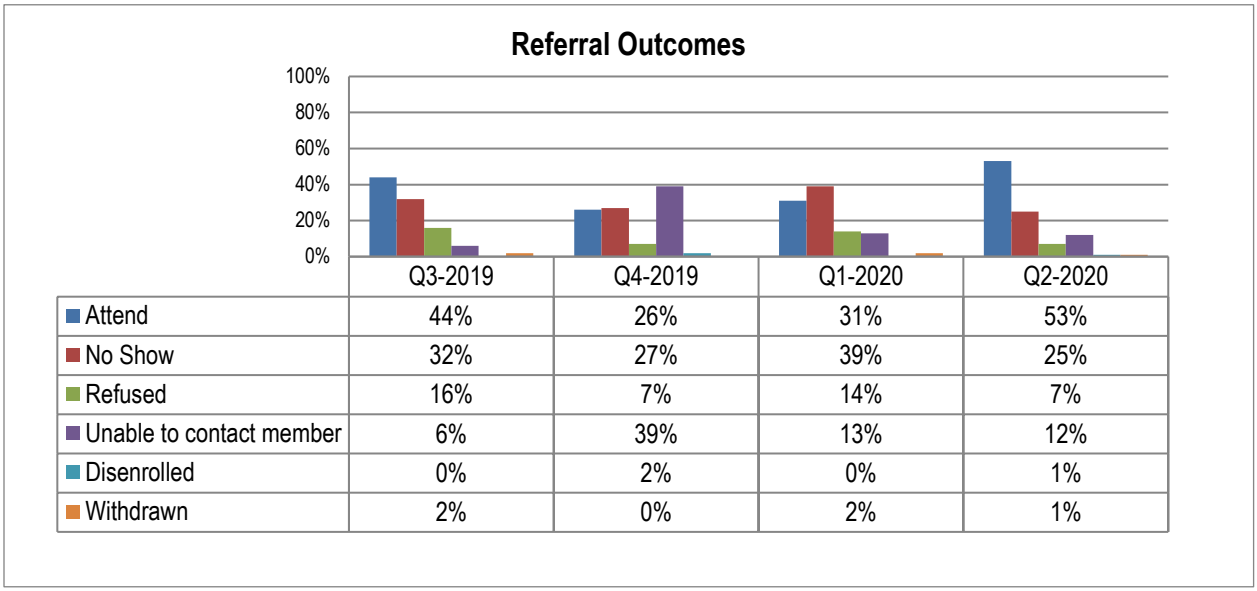
Clinica Sierra Vista (CSV) WIC:

- Diabetes Management Classes
- Heart Healthy Classes

California Smokers' Helpline (CSH):

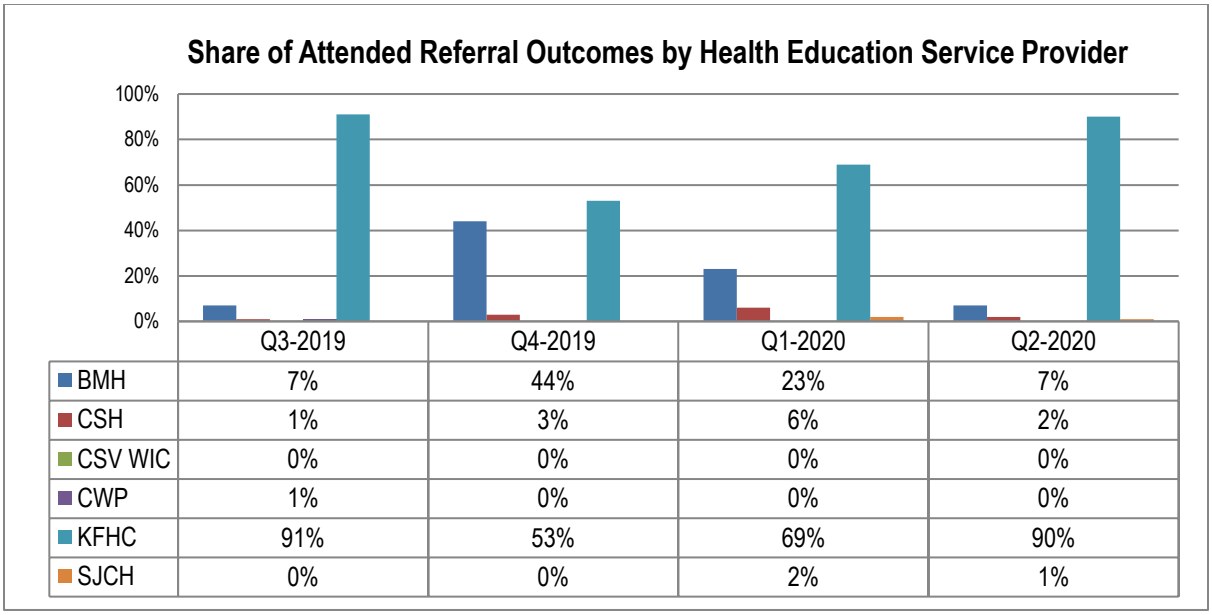
- Telephone Smoking Cessation Counseling

REFERRAL OUTCOMES



	Q3-2019	Q4-2019	Q1-2020	Q2-2020
Attend	44%	26%	31%	53%
No Show	32%	27%	39%	25%
Refused	16%	7%	14%	7%
Unable to contact member	6%	39%	13%	12%
Disenrolled	0%	2%	0%	1%
Withdrawn	2%	0%	2%	1%

During this quarter, the rate of members who received health education services out of all members who accepted services increased from 31% to 53%.

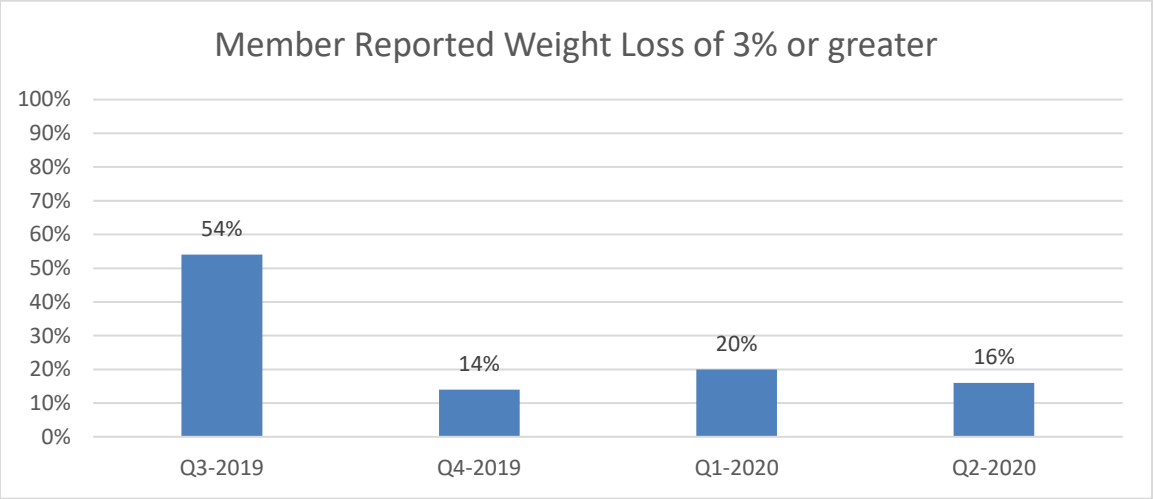


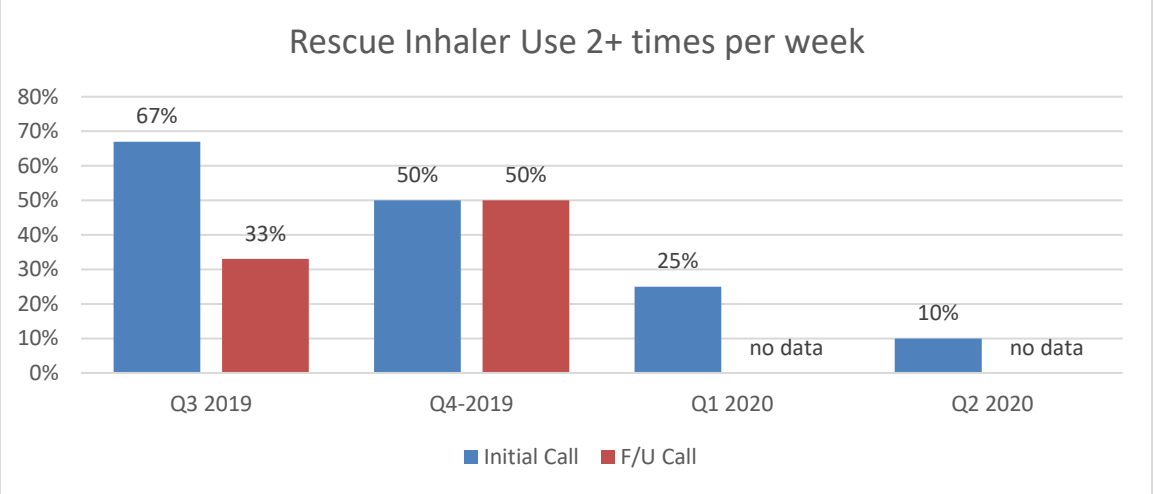
	Q3-2019	Q4-2019	Q1-2020	Q2-2020
BMH	7%	44%	23%	7%
CSH	1%	3%	6%	2%
CSV WIC	0%	0%	0%	0%
CWP	1%	0%	0%	0%
KFHC	91%	53%	69%	90%
SJCH	0%	0%	2%	1%

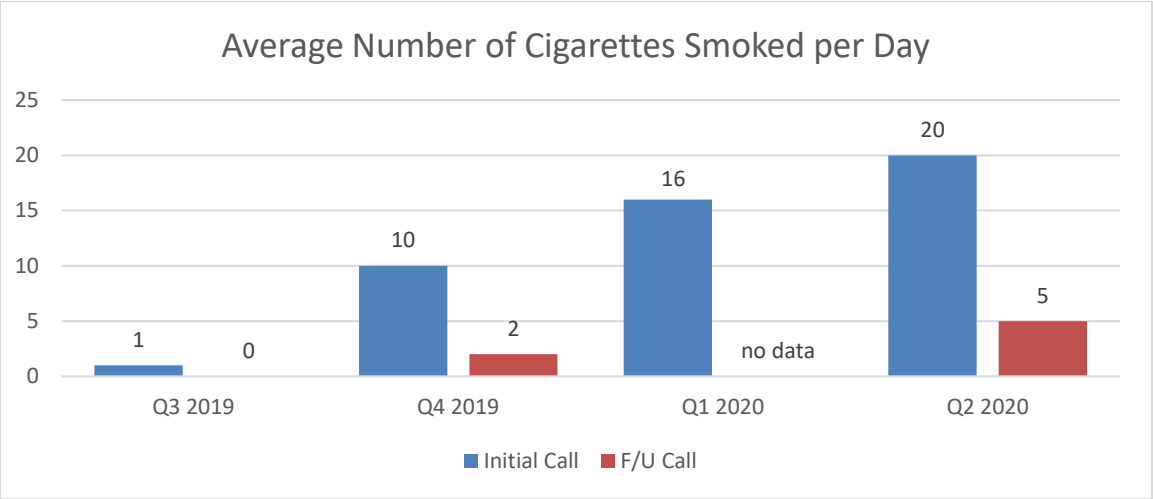
Services through KFHC demonstrates to be the largest share of referral outcomes. This quarter KFHC showed an increase from 69% in the 1st quarter to 90% in the 2nd quarter of 2020.

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 34 members who participated in the 3 month follow up call, 25 received weight management education and 9 received smoking cessation education. There were zero members who received asthma management education who participated in the 3 month follow up call. All findings are based on self-reported data from the member.

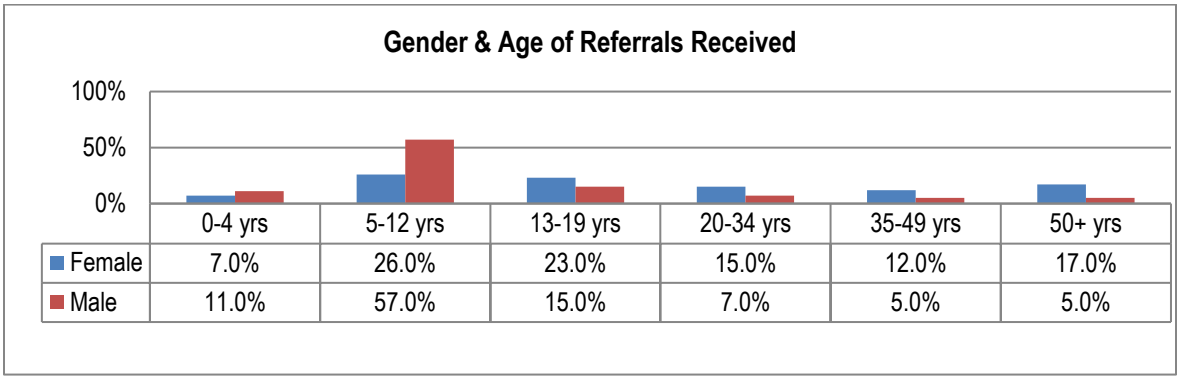






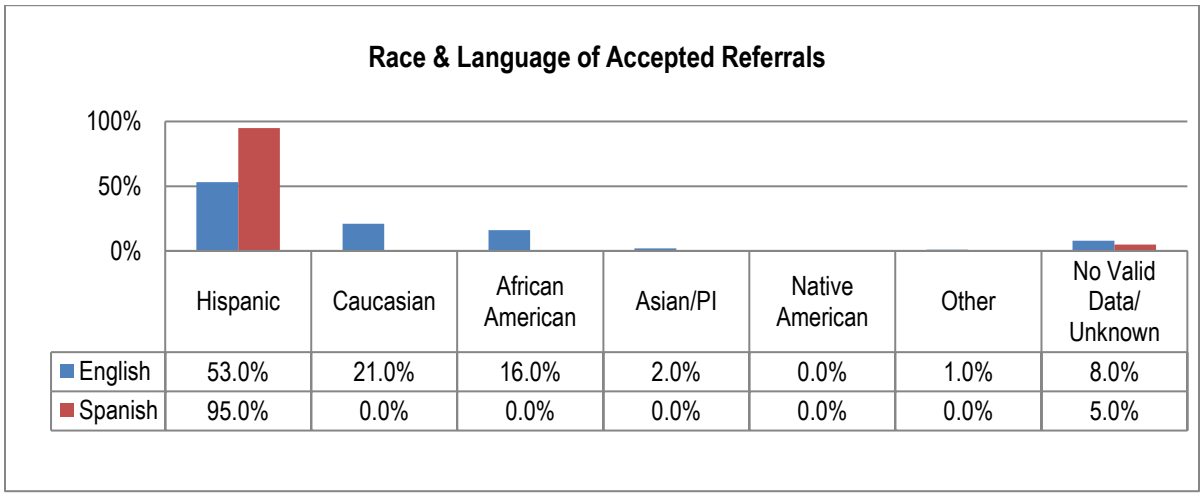
Demographics of Members

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	7.0%	26.0%	23.0%	15.0%	12.0%	17.0%
Male	11.0%	57.0%	15.0%	7.0%	5.0%	5.0%

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



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

Referrals Accepted by Top Bakersfield Zip Codes			
Q3-2019	**Q4-2019**	**Q1-2020**	**Q2-2020**
93307	93307	93307	93307
93304	93306	93306	93306
93306	93304	93304	93304
93305	93305	93309	93308
93309	93308	93305	93309

KHS serves members in the Kern County area. During this quarter, 84% of the members who accepted services reside in Bakersfield and the highest concentration of members were in the 93307 area.

Referrals Accepted by Top Outlying Areas			
Q3-2019	**Q4-2019**	**Q1-2020**	**Q2-2020**
Arvin	Arvin	Delano	Delano
Delano	Delano	McFarland	Lamont
Shafter	Shafter	Tehachapi	Arvin
Wasco	Lamont	Lamont	Shafter
Lamont	Wasco	Arvin	Tehachapi

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

Health Education Mailings

In addition to referrals, the HE department mails out a variety of educational material in an effort to assist members with gaining knowledge on their specific diagnosis or health concern. During this quarter, the HE department was not able to provide material by mail due to COVID-19. Members were directed to access digital information available on the Kern Family Health Care website.

Educational Mailings

	Q3-2019	Q4-2019	Q1-2020	Q2-2020
Anemia	2	0	0	0
Asthma	648	459	305	0
High Cholesterol	11	4	6	0
Diabetes	45	30	20	0
Gestational Diabetes	1	1	2	0
High Blood Pressure	4	4	13	0
COPD	0	1	2	0
Postpartum Care	602	263	564	0
Prenatal Care	283	23	120	0
Smoking Cessation	12	15	12	0
Weight Management	370	223	357	0
WIC	157	41	245	0
Total	**2,137**	**1,064**	**1,646**	**0**

INTERPRETER REQUESTS

Face-to-Face Interpreter Requests

During this quarter, there were 124 requests for face-to-face interpreting services received, which was a decrease in comparison to the previous quarter. KHS employs qualified staff interpreters in Spanish and contracts with the interpreting vendor, CommGap. During this quarter, the majority of these requests were for a Spanish interpreter.

Top Languages Requested			
Q3-2019	**Q4-2019**	**Q1-2020**	**Q2-2020**
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Arabic	Mandarin	Mandarin	Arabic
Cantonese	Arabic	Arabic	Cantonese
Mandarin	Cantonese	Cantonese	Vietnamese
	Vietnamese	Persian	

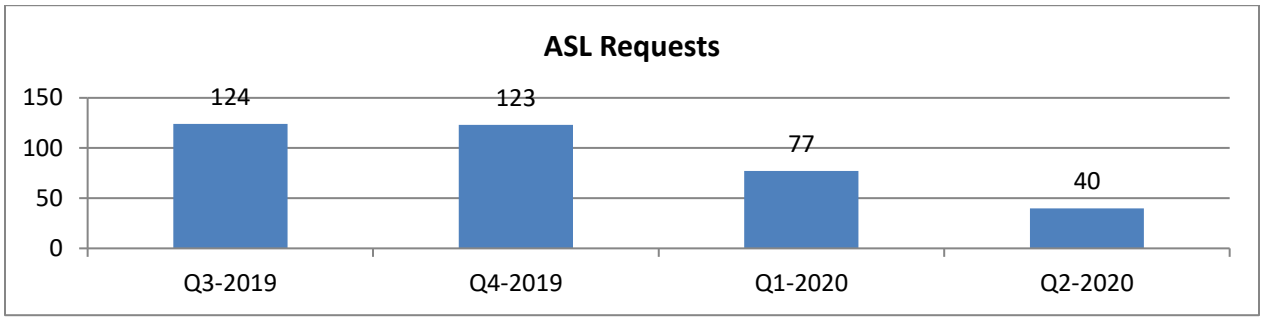
Telephonic Interpreter Requests

During this quarter, there were 919 requests for telephonic interpreting services through KHS' interpreting vendor, Language Line Solutions, which was an increase in comparison to the previous quarter. During this quarter, the majority of these requests were for a Spanish interpreter.

Top Languages Requested			
Q3-2019	**Q4-2019**	**Q1-2020**	**Q2-2020**
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Arabic	Arabic	Arabic	Arabic
Mandarin	Tagalog	Mandarin	Tagalog
Tagalog	Vietnamese	Tagalog	Vietnamese

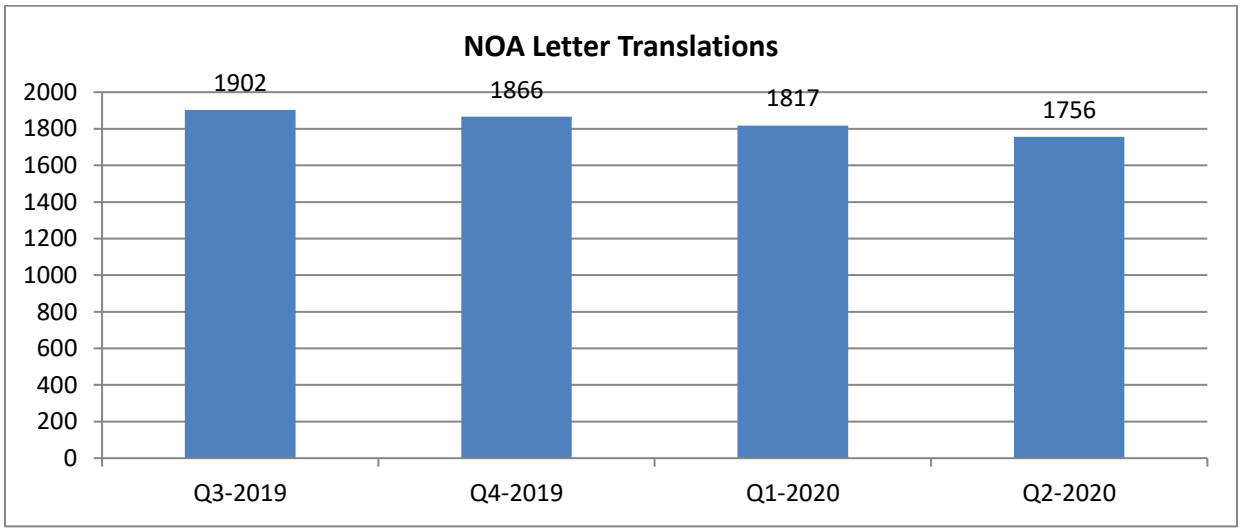
American Sign Language (ASL) Requests

During this quarter, there were a total of 40 requests received for an American Sign Language interpreter, which was a decrease in comparison to the previous quarter.



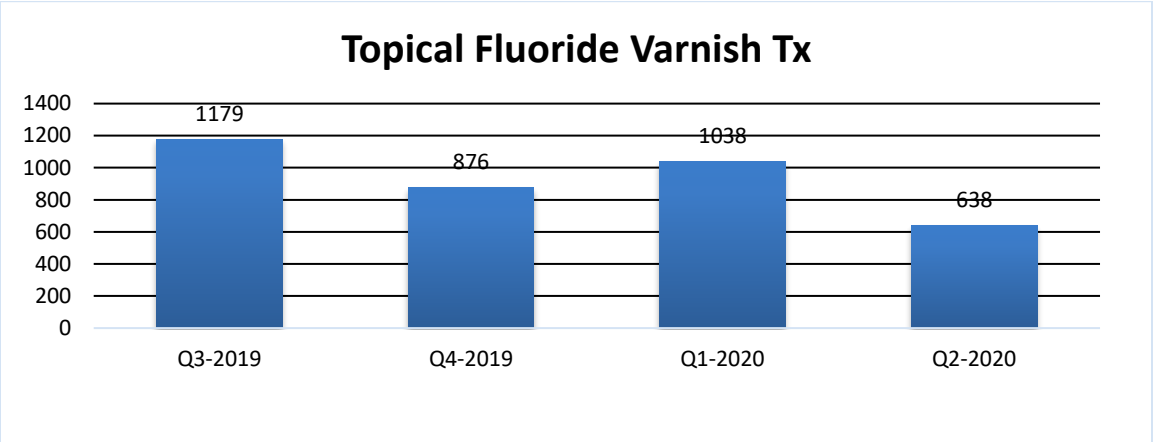
DOCUMENT TRANSLATIONS

The Health Education department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 1,756 Notice of Action letters were translated in-house into Spanish for the UM and Pharmacy departments.



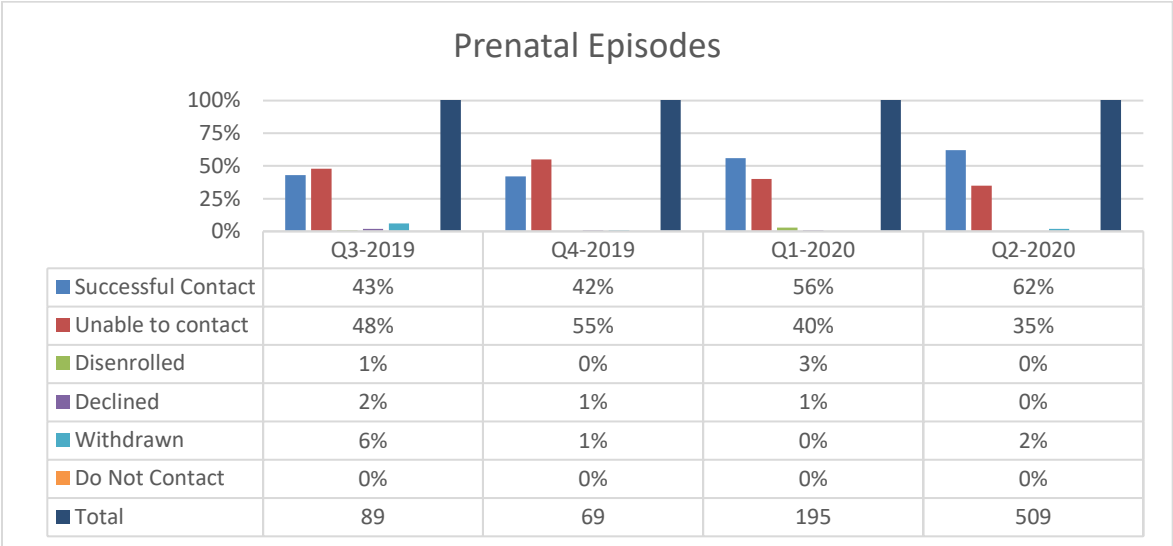
TOPICAL FLUORIDE VARNISH TREATMENTS

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.



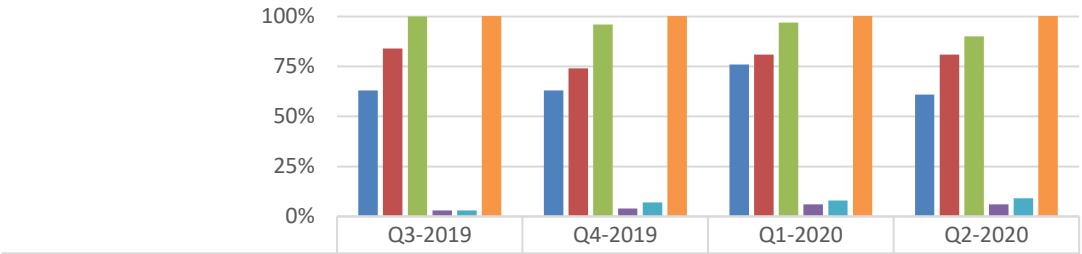
PERINATAL OUTREACH AND EDUCATION

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.



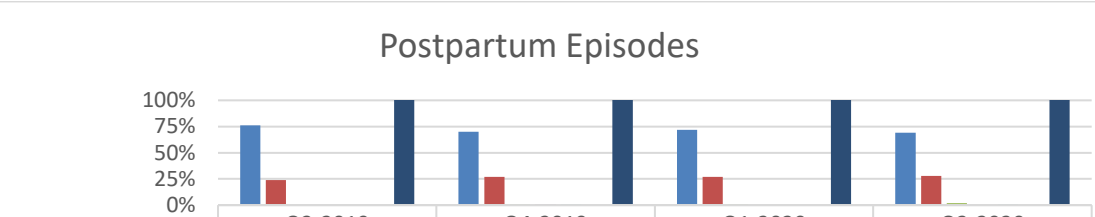
	Q3-2019	Q4-2019	Q1-2020	Q2-2020
Successful Contact	43%	42%	56%	62%
Unable to contact	48%	55%	40%	35%
Disenrolled	1%	0%	3%	0%
Declined	2%	1%	1%	0%
Withdrawn	6%	1%	0%	2%
Do Not Contact	0%	0%	0%	0%
Total	89	69	195	509

During the 2nd quarter of 2020, 455 episodes for pregnant members were created and the rate of successful contacts increased from 56% to 62%.



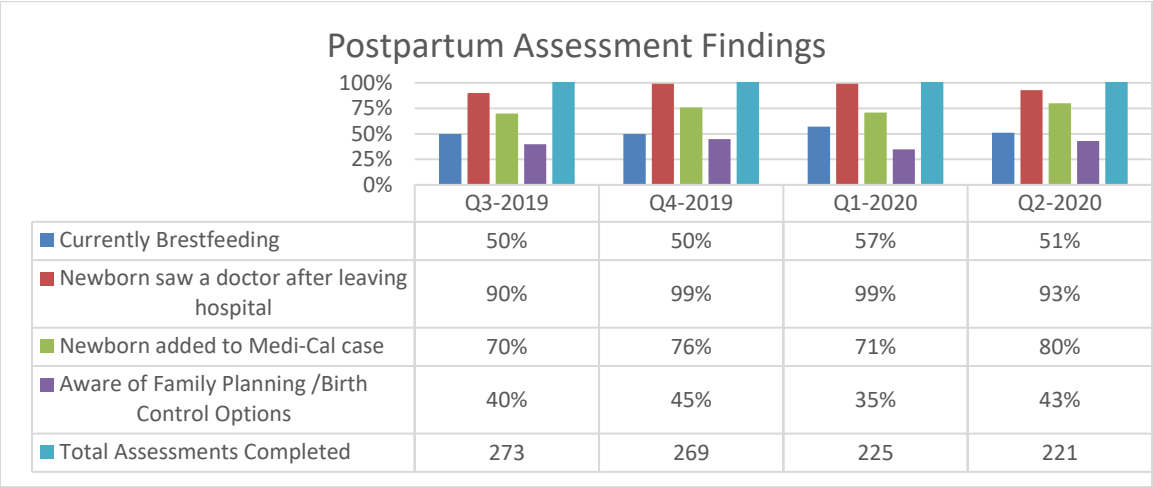
	Q3-2019	Q4-2019	Q1-2020	Q2-2020
Enrolled in WIC	63%	63%	76%	61%
Plans to Breastfeed	84%	74%	81%	81%
Managed by an OB	100%	96%	97%	90%
DM/ HTN in current pregnancy	3%	4%	6%	6%
Presence of DM/HTN in last pregnancy	3%	7%	8%	9%
Total Assessments Completed	38	27	110	316

The total prenatal assessments completed increased from 33% in the 1st quarter of 2020 to 53% in the 2nd quarter of 2020.



	Q3-2019	Q4-2019	Q1-2020	Q2-2020
Successful Contact	76%	70%	72%	69%
Unable to contact	24%	27%	27%	28%
Disenrolled	0%	1%	1%	2%
Decline	0%	1%	0%	0%
Withdrawn	0%	1%	0%	1%
Do Not Contact	0%	0%	0%	0%
Total	361	384	312	318

During the 2nd quarter 2020, 313 postpartum episodes were created and the rate of successfully contacts decreased from 72% to 69%.



	Q3-2019	Q4-2019	Q1-2020	Q2-2020
Currently Brestfeeding	50%	50%	57%	51%
Newborn saw a doctor after leaving hospital	90%	99%	99%	93%
Newborn added to Medi-Cal case	70%	76%	71%	80%
Aware of Family Planning /Birth Control Options	40%	45%	35%	43%
Total Assessments Completed	273	269	225	221

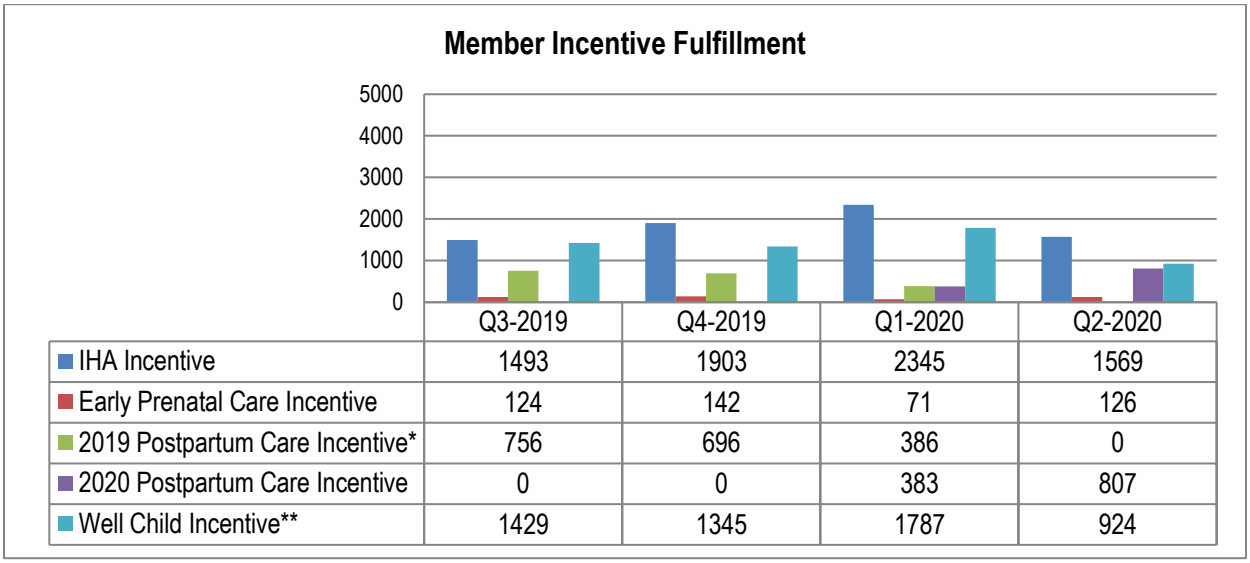
Postpartum assessments completed decreased from 225 assessments in the 1st quarter of 2020 to 221 assessment completed in the 2nd quarter of 2020.

MEMBER WELLNESS BASED INCENTIVES AND CHRONIC CONDITION TOOLS

During the 2nd quarter of 2020, KHS continued to offer wellness based incentives for members. In January 2020, the postpartum care incentive was modified to align with the new MCAS measure where the time frame to complete this visit is now 1-12 weeks following delivery. Additionally, the well child 12-23 months incentive program was discontinued in April and will be replaced with another incentive program that better aligns with the new MCAS measures.

- **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.
- **2019 Postpartum Care** – members who delivered in 2019 and complete the postpartum visit within 21-56 days following delivery will receive a $30 gift card.
- **2020 Postpartum Care** – members who delivered in 2020 and complete the postpartum visit within 1-12 weeks following delivery will receive a $30 gift card.

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Second Quarter 2020



	Q3-2019	Q4-2019	Q1-2020	Q2-2020
IHA Incentive	1493	1903	2345	1569
Early Prenatal Care Incentive	124	142	71	126
2019 Postpartum Care Incentive*	756	696	386	0
2020 Postpartum Care Incentive	0	0	383	807
Well Child Incentive**	1429	1345	1787	924

*Discontinued as of 1/1/2019. Incentives fulfilled due to claims lag.

**Discontinued as of 4/1/2020. Incentives fulfilled due to claims lag.

KERN HEALTH SYSTEMS

Population Needs Assessment Report

2020

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I. Population Needs Assessment Overview

In May 1996, Kern Health Systems (KHS) began to serve Medi-Cal Managed Care beneficiaries by offering Kern Family Health Care (KFHC) as the local initiative health plan. Today, KHS provides services to over 263,000 Medi-Cal Managed Care beneficiaries in Kern County.

The goal of the 2020 KHS Population Needs Assessment (PNA) is to improve health outcomes for KHS members and ensure that KHS is meeting the needs of its members through:

1. Identification of member health needs and health disparities;
2. Evaluation of current health education (HE), cultural and linguistic (C&L), and quality improvement (QI) activities and available resources to address identified concerns; and
3. Implementation of targeted strategies for HE, C&L, and QI programs and services to address member needs.

KHS' 2020 PNA builds upon previous needs assessments and uses various data collection methods and sources. Total membership and demographics have remained similar to KHS' last needs assessment in 2016. Although KHS' membership grew by 15%, half of KHS' membership continues to be children under 18 and the majority of members are still female. Hispanics continue to be the majority of members, and English continues to be the most common primary language. Most members live in Bakersfield and the highest concentration of members continue to reside in the 93307 zip code. Enrollment of Seniors and Persons with Disabilities (SPD) increased by 14% and the Health Home Program (HHP) population amounts to over 25,000 eligible members. KHS has also started collecting the home residence status of members through its Case Management (CM) department which has identified more than 1,500 self-reported homeless members since 2016.

The most frequent diagnoses for Urgent Care (UC) and Emergency Department (ED) visits continue to be upper respiratory infections, fever, urinary tract infections, pharyngitis and headache for KHS members. Obesity, asthma, and diabetes are among the most common chronic conditions affecting Kern County residents which supports KHS' findings of hypertension, dyslipidemia, low back pain, persistent asthma and diabetes as being the top 5 chronic conditions identified through population analysis reports. Review of KHS' pharmaceutical utilization identified Ibuprofen as the top medication prescribed followed by Lisinopril, Amoxicillin, Albuterol Sulfate and Metformin, which further supports KHS' chronic condition population health analysis conclusions. Mental health diagnoses for depression, bipolar disorder and schizophrenia were found to have higher rates among female and English-speaking members, in comparison to male and non-English-speaking members. Depression and bipolar disorder were also found to have the highest rates among Caucasian members whereas African American members had higher rates of schizophrenia. The physical and behavioral chronic conditions associated with tobacco use identified hypertension, anxiety and depression as the top 3 comorbidities.

Referrals requesting HE services have increased by 50.6% since 2018 and the majority of referrals were for weight management, asthma and tobacco cessation. Referrals for asthma education increased by 31 percentage points and tobacco cessation referrals increased by 14 percentage points due to targeted outreach performed by the HE department. Consequently, the

rate of members who accepted to receive health education services decreased by 18 percentage points and the rate of members who received services decreased by 7 percentage points in comparison to the prior year. Requests for qualified interpreters has grown significantly for KHS within the last year. Use of a telephonic interpreter has increased by 59%, in-person interpreter requests for American Sign Language (ASL) have increased by 30% and by 39% for non-English languages. Additionally, KHS has seen the most growth for Spanish- and Punjabi-speaking interpreters.

KHS' access to care surveys identified a small percentage of providers who were found to be non-compliant with urgent and emergent care standards. Further review and analysis of KHS' access to care data revealed KHS members needed better access to:

- Getting needed care;
- Getting care quickly;
- Communicating with their doctor;
- Medical assistance with smoking and tobacco use cessation; and
- Playing a role in shared decision making as it relates to health promotion and education around preventive care.

This data supports the decrease in member adherence to preventive care or treatment where several indicators on DHCS' 2019 Disparities Rate Sheet for KHS demonstrated a decrease in pediatric preventive care, women's health care and chronic condition care.

The following key findings and recommendations were made based on the 2020 PNA.

- Continued member education on the importance of accessing preventive care services with a high emphasis on members with one or more chronic conditions.
- Continued member and provider education on the availability of KHS' health education and interpreting services, the benefits of these services, and how to access these services.
- Explore more non-traditional modes of providing health education services with special emphasis on virtual forms of education and digital communications
- Bridge the communication gap between members and providers to allow for shared decision making around preventive care, effective communication and improvement in health literacy.
- Enhance member communication platforms to allow for more direct communications with members on understanding their gaps in care and how to close these gaps.
- Allow for more member opportunities to provide feedback on incentive programs, services and benefits to better align programs with member needs.
- Offer education and resources to help members and health care providers adapt to the risks of COVID-19.

II. Data Sources

KHS used various methods of internal and external data collection, review and analysis in the development of the 2020 Population Needs Assessment.

National, State, and County Data
National, state, and county data were compared to available membership indicators. Sources utilized for this report include the U.S. Census Bureau, California Health Interview Survey, William's Institute, Kern County Public Health Services Department Community Health Assessment and Improvement Plan, Kern County Health Status Profile, and the California Smokers Helpline.

Consumer Assessment of Healthcare Providers Survey (CAHPS) Data
The 2019 Kern Family Health Care Adult and Child Medicaid CAHPS 5.0 Survey results were reviewed to assess areas of improvement among plan and provider services.

California Department of Health Care Services (DHCS) Data Health Disparities Data
The 2018 and 2019 health disparities data provided by DHCS were reviewed to assess health status and disease prevalence among KHS' membership and within race/ethnic groups.

Healthcare Effectiveness Data and Information Set (HEDIS) Data
Reporting Year 2019 HEDIS rates were used to assess indicators of our members' health care.

2016 Medi-Cal Health Education and Cultural and Linguistic Group Needs Assessment
This report was reviewed and compared with current findings to identify changes in utilization of health services, health education, and cultural and linguistic member needs.

Membership Eligibility Data
KHS membership eligibility data was reviewed and analyzed for 2019 to identify demographic changes by race, language, age, gender, and geographic region since KHS' last needs assessment.

Claims Data
Using ICD-10 codes, claims data from calendar year 2019 were analyzed by race, language, age, gender, and geographic region. Through this analysis, top diagnoses were identified. Emergency department, urgent care, outpatient and inpatient utilization for calendar year 2019 was also reviewed by these variables to identify the top diagnoses and changes in utilization. Additionally, KHS' tobacco registry report was used to identify current smokers and members exposed to tobacco smoke.

Pharmacy Data
Pharmacy claims data from calendar year 2019 was analyzed by top medications dispensed.

2019 Member Satisfaction Survey
KHS administered its annual member satisfaction survey by mail and telephonically to all adult KHS members in 2019. A total of 898 surveys were collected which yielded a 23.1% response rate. Female members accounted for 70.9% of all respondents, 34% were between the ages of 18-34 years and 68.2% were Hispanic.

KHS Chronic Condition Population Analysis Reports
KHS developed population analysis reports to identify chronic condition trends within its membership to aid in program development and targeted intervention. These reports were reviewed to identify chronic condition prevalence rates and health disparities among race/ethnic groups.

2019 KHS Advice Nurse Line Report
Utilization reports from KHS' 24 hours advice nurse line were reviewed to identify call frequency and the top reasons for the calls.

KHS Departmental Reports
The 2019 KHS HE Activities Report was reviewed to identify trends in need for health education services and allows projections for program development. KHS' CM and HHP reports were reviewed for data on KHS' homeless population and critically ill members. KHS' grievance, transportation and provider network management reports were reviewed to identify access to care concerns within the membership.

Public Policy/Community Advisory Committee Survey
The survey investigated the major health concerns of KHS members, barriers to services, access issues, and activities needed to improve KHS' HE and C&L services.

III. Key Data Assessment Findings

Membership/Group Profile

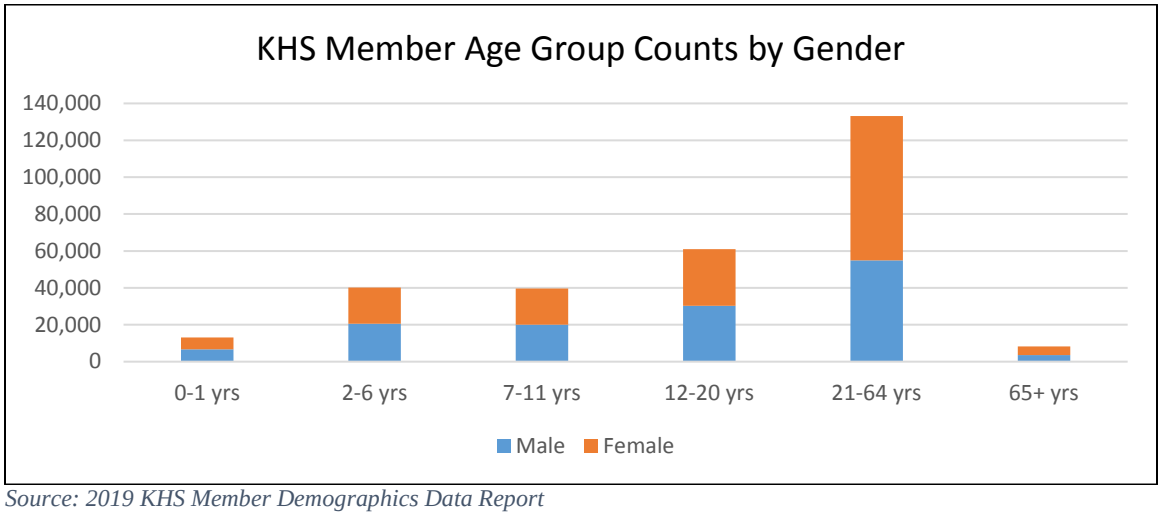
According to KHS' 2019 membership statistics, there were 295,602 Medi-Cal managed care members who had enrolled in the plan that year.[1] This is nearly one third of the population of Kern County[2] and a 15% increase in total annual membership since our last submitted needs assessment in 2016. Although gender makeup at the state and county levels is about evenly split, KHS members are slightly more likely to be female. The table below provides a comparison of KHS' population with the county and state.

	California (CA)	Kern County (KC)	KHS
Population	39,512,223	900,202	295,602
Male (%)	50%	51%	46%
Female (%)	50%	49%	54%

Source: 2019 KHS Member Demographics Data Report; U.S. Census Bureau

KHS' membership is comprised of a mixture of children under 18 (50%), and adults 18 and over (18 to 64 years-48%; 65 and older-2%).[1] In comparison, at the county and state level, nearly one-third of the population is under the age of 18.[1]

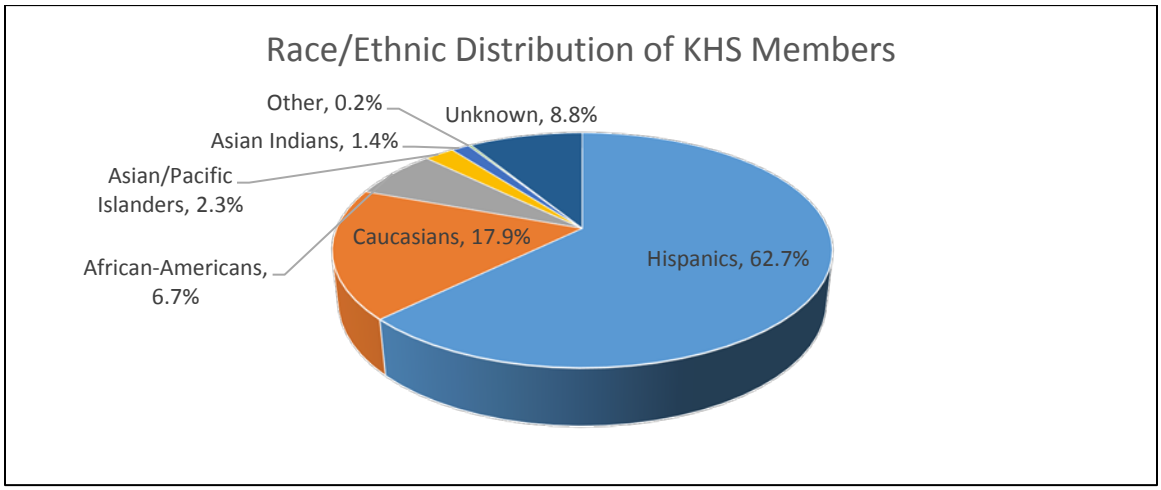
According to The Williams Institute, 5.3% of California's adult population identifies as a Lesbian, Gay, Bisexual, Transgender (LGBT) adult, 24% of this population have children and 23% have an annual income of less than $24,000.[3] The Williams Institute's 2015 publication on the LGBT Divide in California estimated 10% of LGBT adults in California resided in the Southern/Central Farm regions.[4] Although KHS does not currently collect and report on LGBT data of members, we estimate to have a similar percentage of LGBT adults in our county. It is possible that a quarter to a third of this population may be enrolled in our plan.



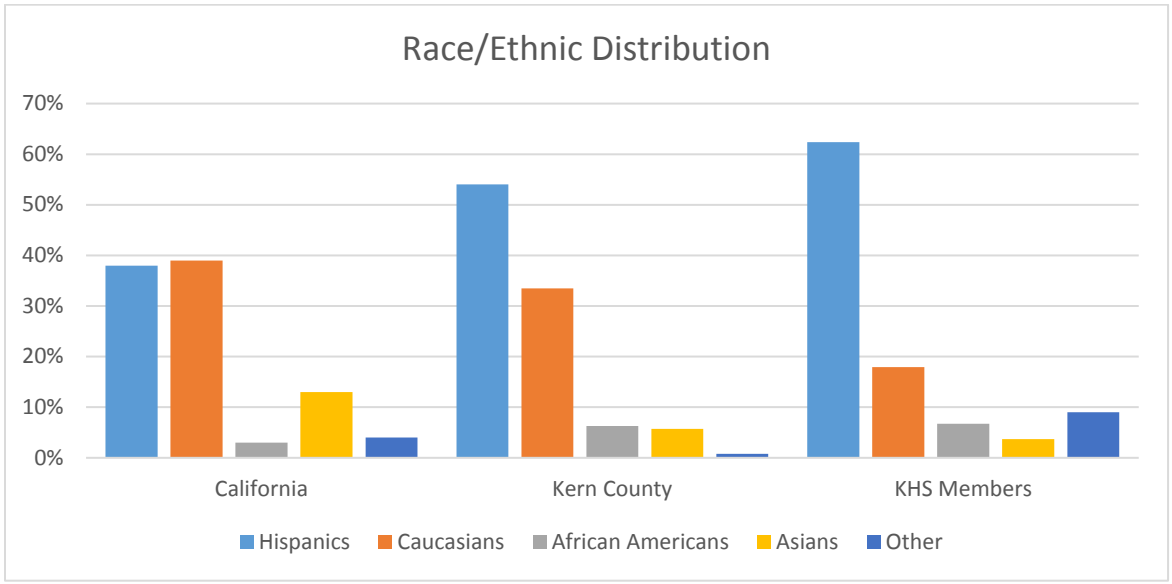
Source: 2019 KHS Member Demographics Data Report

KHS continues to have an ethnically diverse membership. Hispanics continue to comprise the majority of our membership, followed by Caucasians, African Americans, Asians, and other ethnicities. In comparison to data reported in the U.S. Census Bureau, 54% of Kern County and

38% of California residents are Hispanic, followed by Caucasian (KC-33.5%, CA-39%), African American (KC-6.3%, CA-3%), Asian (KC-5.7%, CA-13%), and Other (KC-0.8%, CA-4%).[2]

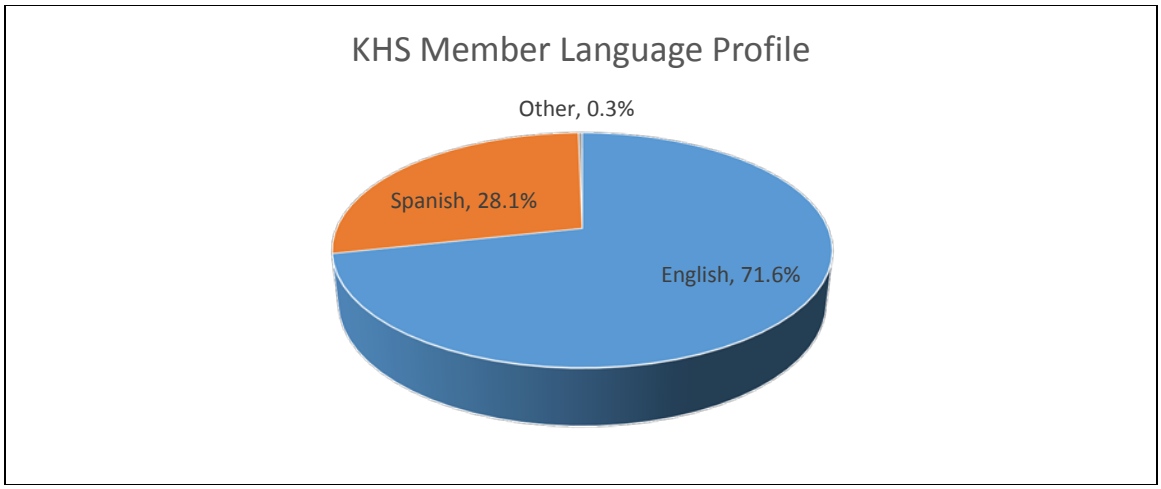


Source: 2019 KHS Member Demographics Data Report



Source: 2019 KHS Member Demographics Data Report

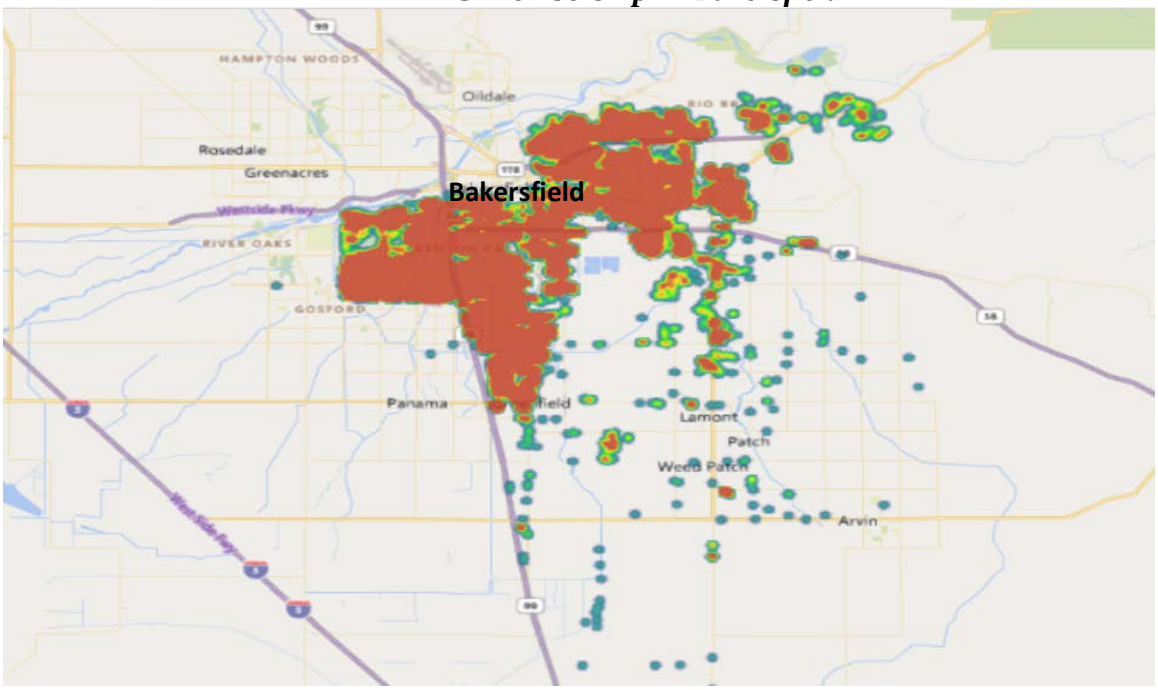
More than two-thirds of KHS' membership is English speaking, close to a third of the membership is Spanish speaking and less than 1% of members speak a language other than English or Spanish.[1] In comparison to data reported in the U.S. Census Bureau, 57% of Kern County and 56% of California residents speak English.[2] This is followed by Spanish (KC-38%, CA-29%), and other languages (KC-5%, CA-15%).



Source: 2019 KHS Member Demographics Data Report

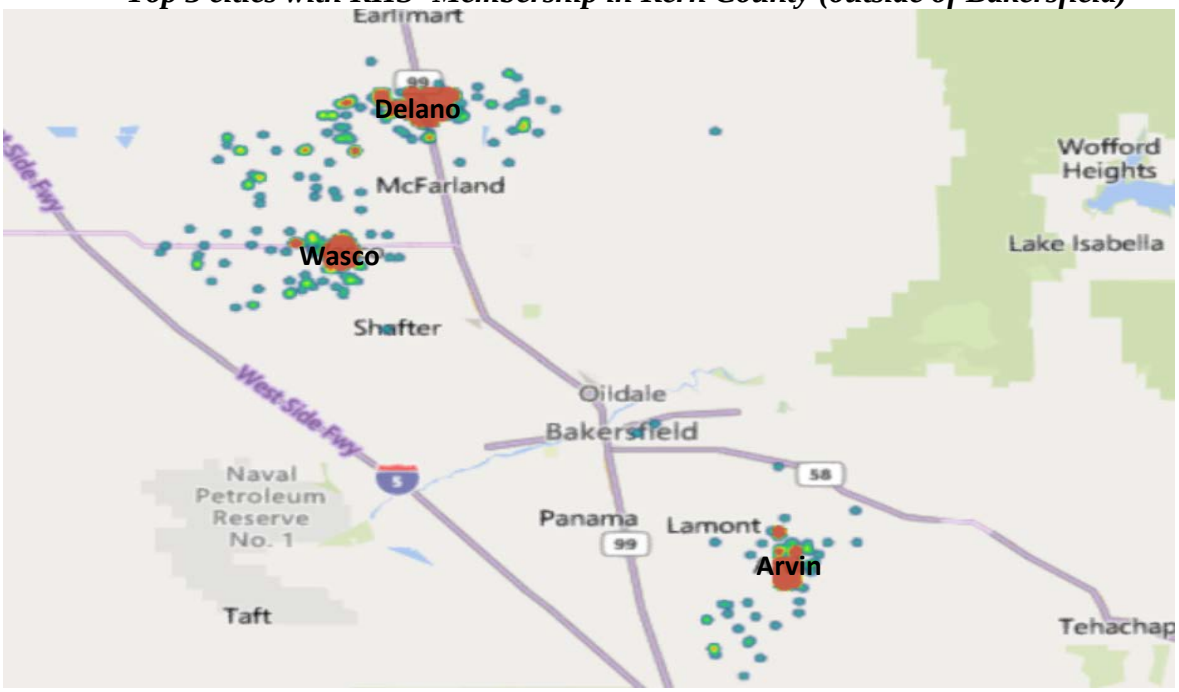
In 2019, the majority of KHS' members lived in Bakersfield (64%), Delano (7.2%), Arvin (3.8%), and Wasco (3.4%).[1] There was a 1% increase in members residing in Bakersfield, and a 1% decrease in members living in Delano compared to the 2016 needs assessment. In Bakersfield, the highest concentration of KHS members is in the 93307 zip code (17.5%), followed by 93306 (8.6%), 93304 (7.9%), 93305 (6.5%), and 93309 (6.2%).

KHS Membership in Bakersfield



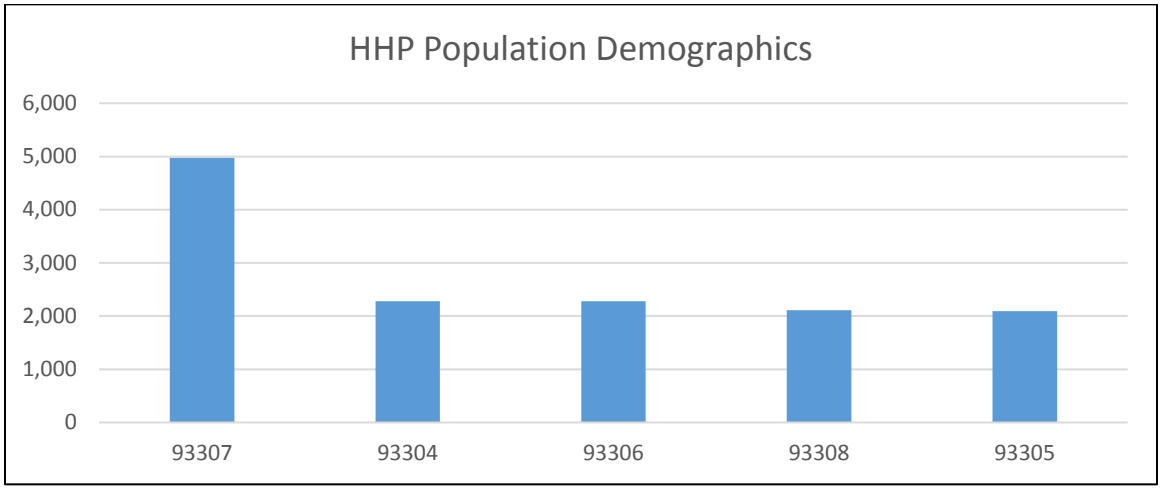
Source: 2019 KHS Member Demographics Data Report

Top 3 cities with KHS' Membership in Kern County (outside of Bakersfield)



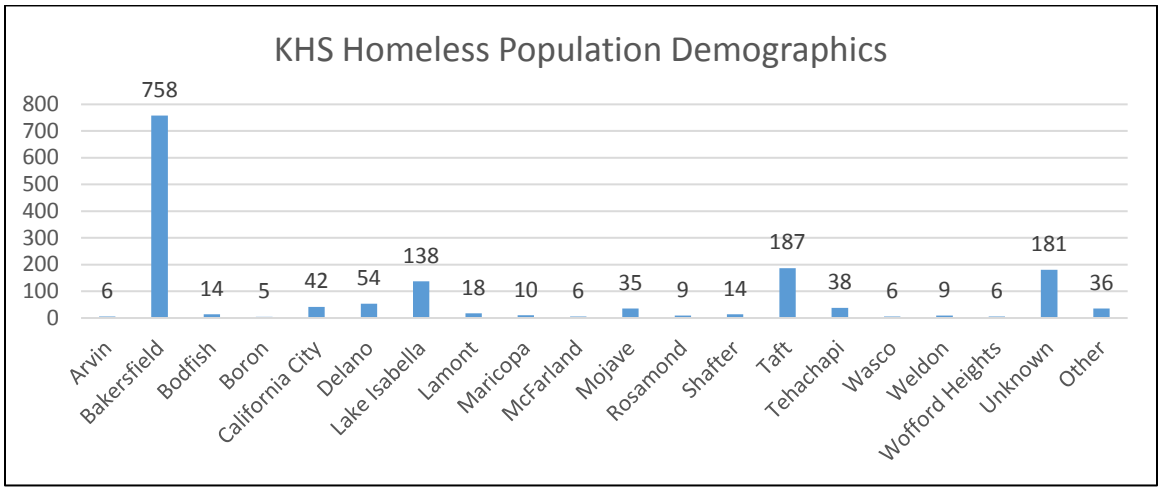
Source: 2019 KHS Member Demographics Data Report

KHS' SPDs account for slightly more than a tenth of the population in Kern County (11%).[1,2] In 2019, KHS had 16,078 SPD members enrolled, which is 5% of our total membership.[1] KHS' HHP population consists of 25,206 members and the majority of these members reside in the 93307 zip code, followed by 93306 and 93304.[5]



Source: 2019 KHS HHP Member Demographics Data Report

KHS collects self-reported data of members who disclose they are homeless through the KHS CM Department. Since 2016, KHS has identified 1,572 homeless members and the majority of these members have reported living in Bakersfield, followed by Taft and Lake Isabella.[6]



Source: 2016-2020 KHS Case Management Homeless Member List

Health Status and Disease Prevalence

Kern County Public Health Profile

Kern County ranks lower for a variety of public health indicators compared to the rest of California. Kern County is in the bottom 5 California counties for age-adjusted death rates due to diabetes, Alzheimer's disease, and coronary heart disease and ranks among the bottom 5 California counties for the incidence of chlamydia, incidence of gonorrhea among males 15-44 years old, and persons under 18 in poverty.[7]

In Kern County's most recent Community Health Assessment, asthma and other respiratory diseases were identified as the top 3 community health problems. Additionally, 13.3% of children and teens have ever been diagnosed with asthma and the age-adjusted emergency room rates due to pediatric asthma was 89.7 per 100,000 compared to the state average of 70.9 per 100,000.

Kern County's teen birth rate (31.7 per 1,000 live births) is considerably higher than the state average (15.7 per 1,000 live births) and the percentage of pregnancies accessing early prenatal care fell below the state average (KC-77.2%; CA-83.5%).[8]

Obesity continues to be on the rise in Kern County. While the state of California met the Healthy People 2020 objective for percentage of obese adults, Kern County ranked 8.5 percentage points higher than the national objective and 13 percentage points higher than the state's rate.

In regards to mental health, Kern County's age-adjusted mortality rate due to suicide is 14.1 per 100,000 which is higher than the state and national averages (CA-10.4 per 100,000; US-13.6 per 100,000).[8]

Health Indicator	Kern County	California
Age-Adjusted Emergency Room Rates for Pediatric Asthma	89.7 per 100,000	70.9 per 100,000
Teen Birth Rate	31.7 per 1,000 live births	15.7 per 1,000 live births
Access Early Prenatal Care	77.2%	83.5%
Percentage of Obese Adults	39%	26%
Age-Adjusted Suicide Mortality Rate	14.1 per 100,000	10.4 per 100,000

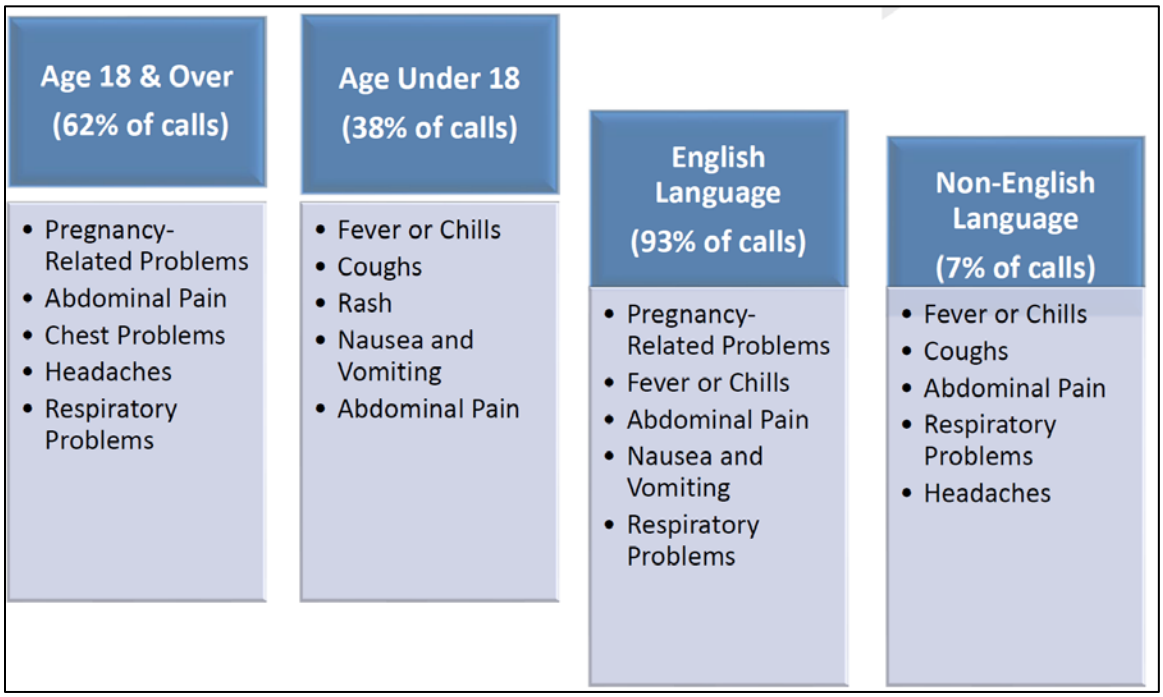
KHS Membership Health Conditions & Diagnoses

KHS medical service claims data revealed that the most commonly diagnosed health problems among KHS members in 2019 included common types of infections, chronic diseases, and pain.[9] The top diagnoses linked to infections included upper respiratory and viral infections, fever, cough, bronchiolitis, bronchitis, pharyngitis, appendicitis, urinary tract infection, sepsis, and pneumonia. The most commonly diagnosed chronic conditions included asthma, heart disease, kidney failure, diabetes, hypertension, chronic obstructive pulmonary disease (COPD), and developmental disorders. The most commonly diagnosed forms of pain were headache, abdominal and pelvic pain, chest pain, chronic pain, low back pain, and throat and chest pain. The table below has a breakdown of the top diagnoses by age group.

Top Diagnoses among KHS Members				
Age Group	**ED**	**INPATIENT**	**OUTPATIENT**	**UC**
0-11 Years	• Upper respiratory and viral infections • Fever • Cough	• Bronchiolitis • Appendicitis • Neonatal jaundice • Asthma	• Upper respiratory and viral infections • Routine child health exam • Fever	• Upper respiratory infections • Pharyngitis • Fever
12-20 Years	• Upper respiratory infections • Urinary tract infection • Headache	• Appendicitis • Sepsis	• Abdominal and pelvic pain • Upper respiratory infection • Headache	• Upper respiratory infections • Pharyngitis • Urinary tract infection
21-64 Years	• Urinary tract infection • Headache • Chest pain	• Sepsis • Hypertensive heart disease • Kidney failure	• Diabetes T2 • Hypertension • Urinary tract infection	• Upper respiratory infection • Pharyngitis • Urinary tract infection
65+ Years	• Urinary tract infection • Chronic pain • Low back pain	• Sepsis • COPD • Hypertension	• Heart disease • Low back pain • Hypertension	• Hypertension • Upper respiratory infection • Bronchitis
SPDs	• Urinary tract infection • Throat and chest pain • Abdominal and pelvic pain	• Sepsis • Pneumonia • Kidney failure	• Chronic kidney disease • Diabetes T2 • Hypertension	• Hypertension • Developmental disorders • Low back pain

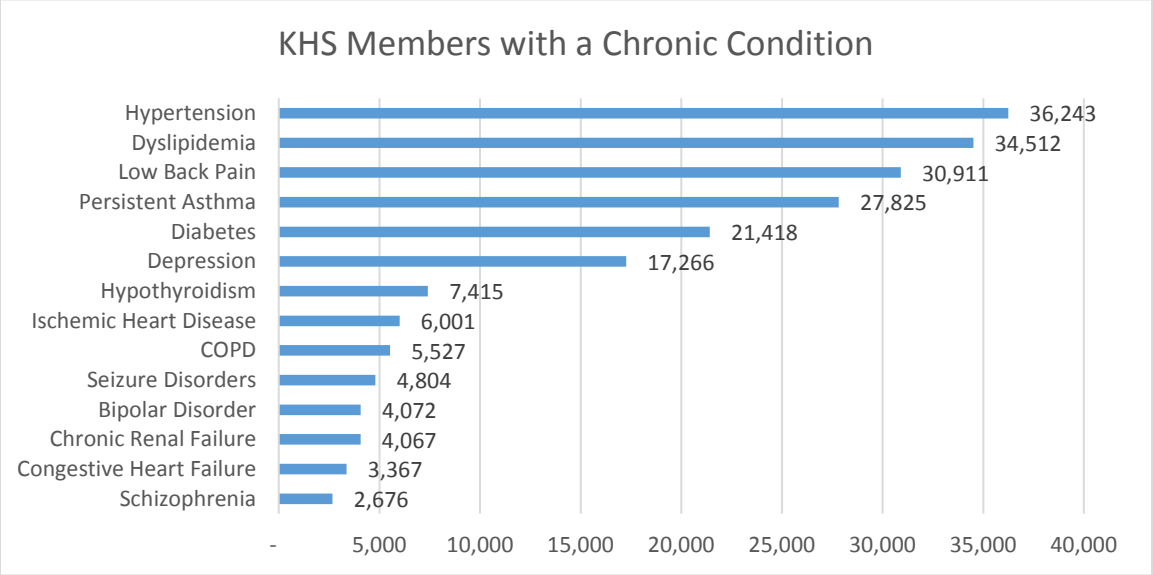
Source: 2019 KHS Top Diagnosis Report

In 2019, KHS's advice nurse line received 7,926 inbound calls from members and more than a third of these calls were for symptom checks by members. More than half of all calls were received between the hours of 9AM-6PM and 25.1% of these calls fell on a Wednesday. [10] Pregnancy-related problems were the top reason for calls received from English-speaking members and members aged 18 years and older. For non-English speaking members and members under 18 years of age, the primary reasons for symptom check calls was for fever or chills and coughs.[11]



Source: 2019 KHS Advice Nurse Line Report

KHS uses the Johns Hopkins ACG Modeler to perform data analysis on member medical service claims for various chronic conditions in a given year. The following data represents the total number of members identified for each targeted chronic condition in 2019.[12]



Source: KHS 2019 Chronic Condition Population Analysis Report

Pharmaceutical Utilization

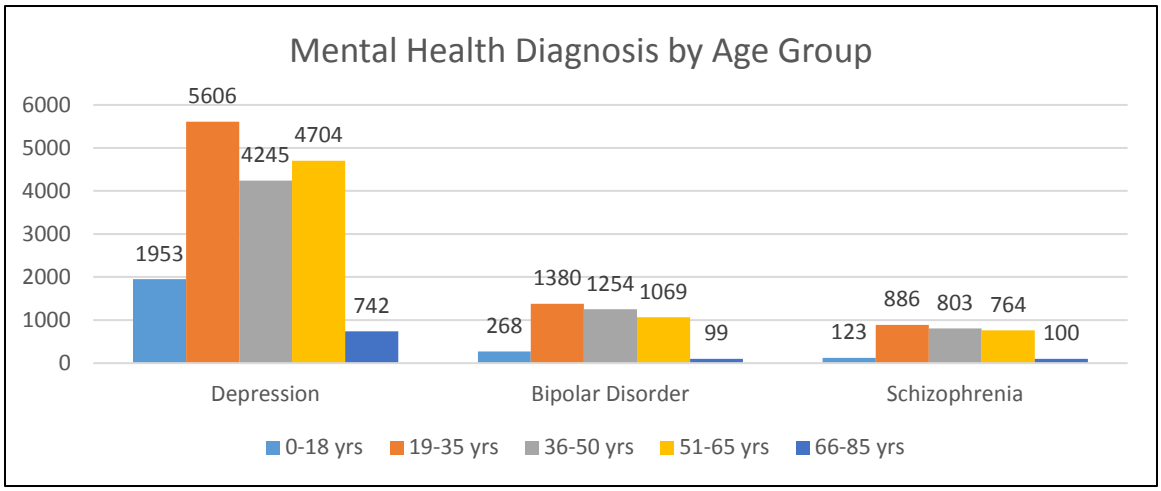
KHS' review of the most frequently dispensed medications in 2019 identified Ibuprofen, Lisinopril, Amoxicillin, Albuterol Sulfate, and Metformin as the top 5 medications prescribed to KHS members.[13] These medications are used to treat health conditions that were identified as top diagnoses among KHS members in 2019, such as abdominal, pelvic, and low back pain, common infections, and chronic conditions, such as type 2 diabetes, asthma, and COPD. Other top medications included those prescribed to treat allergies, hyperlipidemia, fever, inflammation, heart disease, and vitamin D deficiency. Tradjenta was identified to be the most costly medication dispensed, which accounted for $6,564,661 and supports the treatment of type 2 diabetes.[13]

Top 10 Most Prescribed Medications	Relevant Health Conditions
1. Ibuprofen	Fever and pain
2. Lisinopril	High blood pressure and heart failure
3. Amoxicillin	Infections and stomach ulcers
4. Albuterol Sulfate	Breathing problems, such as asthma and COPD
5. Metformin	Type 2 diabetes
6. Loratidine	Allergy symptoms and hives
7. Aspirin	Pain, fever, headache, inflammation, and heart problems
8. Atorvastatin	High cholesterol and triglyceride levels; heart and blood vessel problems
9. Acetaminophen	Pain and fever
10. Ergocalciferol	Vitamin D deficiency

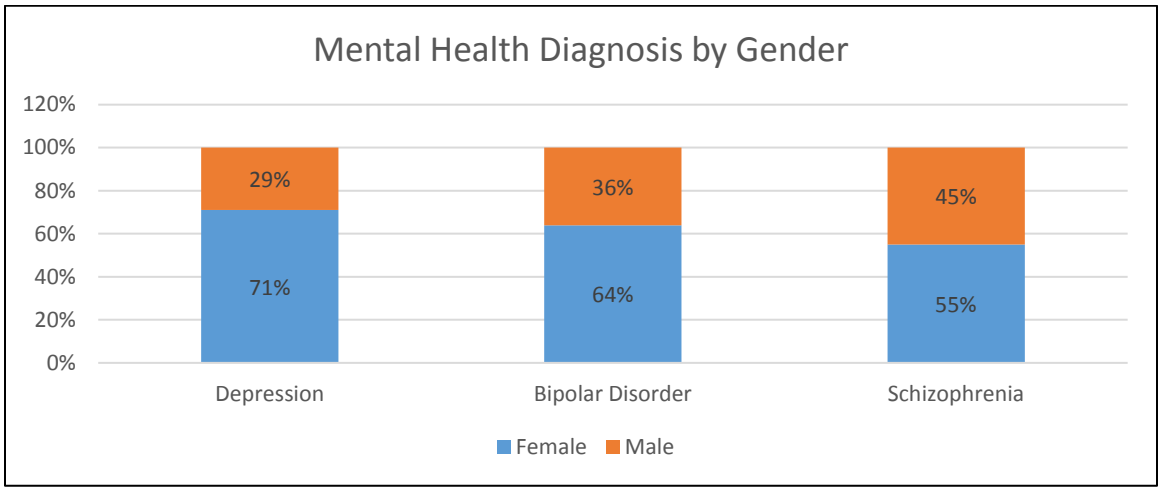
Source: 2019 KHS Top Medications Filled Report

Mental Health Conditions

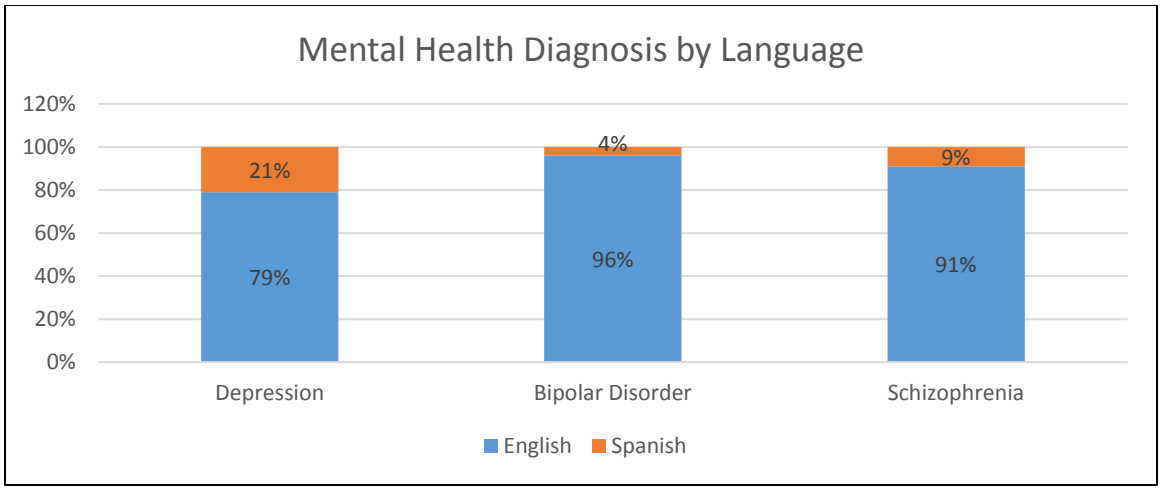
According to KHS' chronic condition population analysis reports, there are 5.9% of KHS members with a diagnosis of depression, 1.39% diagnosed with a bipolar disorder, and 0.91% diagnosed with schizophrenia.[12] Members with a diagnosis of depression, bipolar disorder or schizophrenia were more likely to be English speaking, female, and between the ages of 19-35 years.[14,15,16] Additionally, Caucasian members were more disproportionately affected by depression and bipolar disorder[12, 14] whereas African Americans were more likely to be diagnosed with schizophrenia[16].



Source: KHS Depression, Bipolar Disorder and Schizophrenia Chronic Condition Population Analysis Reports, 2020



Source: KHS Depression, Bipolar Disorder and Schizophrenia Chronic Condition Population Analysis Reports, 2020



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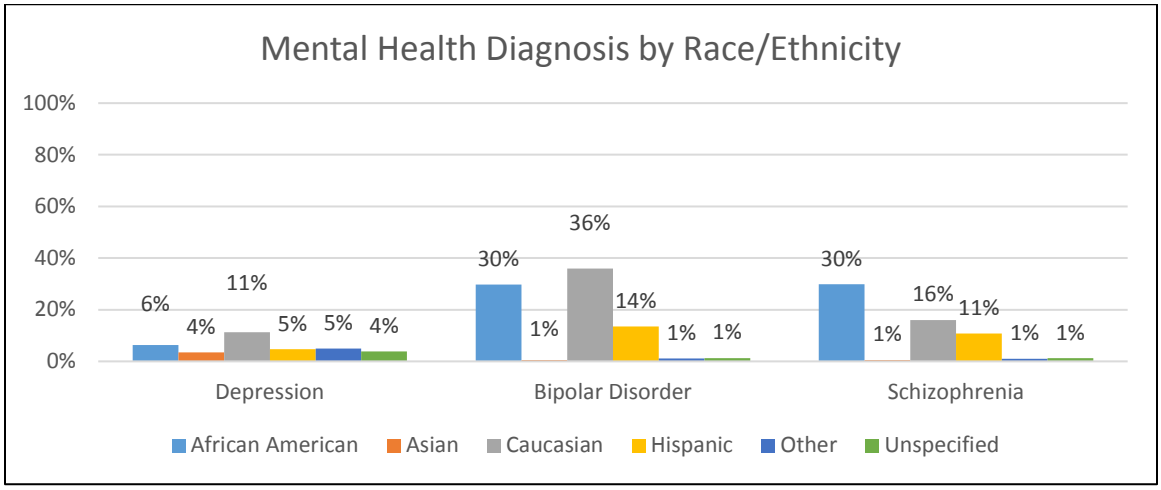
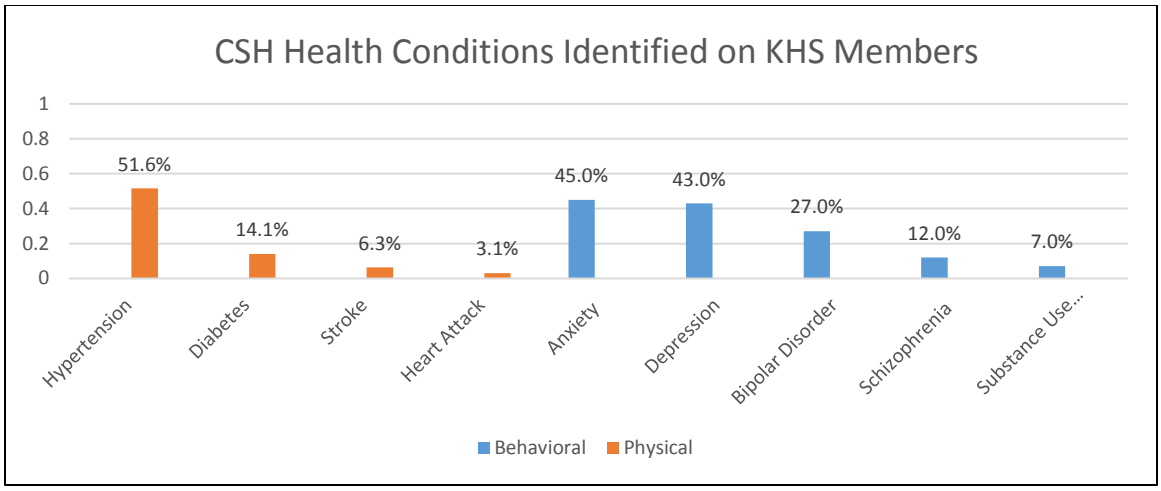


Source: KHS Depression, Bipolar Disorder and Schizophrenia Chronic Condition Population Analysis Reports, 2020

Association of Health Conditions with Smoking and Tobacco Use

The 2019 CAHPS Adult Medicaid Survey performed by the DHCS Health Services Advisory Group (HSAG) identified 19.2% of KHS adult members are current smokers.[20] KHS' tobacco registry report identified about 12% of members are current smokers or have been exposed to tobacco.[17] The California Smokers Helpline (CSH) collects demographic and health data during phone counseling sessions and shares this data with Medi-Cal Managed Care health plans. CSH data revealed most KHS member callers to be English speaking (95.3%), female (69.5%), Caucasian (52.3%), between the ages of 25-44 years (34.4%), and have a high school educational level (34.4%).[18] Review of the behavioral and physical health conditions of KHS member callers identified hypertension and anxiety as the top diagnoses.



Source: 2019 California Smokers Helpline Demographic and health data for Medi-Cal Health Plan

Access to Care

KHS conducts an annual satisfaction survey with adult members using questions developed by CAHPS to capture accurate and complete information about member-reported experiences with health care. The survey specifically measures how well KHS is meeting member's expectations and goals; which areas of service have the greatest effect on overall satisfaction; and, identifies areas of opportunity for improvement. Additionally, HSAG conducts an adult and child CAHPS survey every 2 years with KHS members. Although KHS met or exceeded its 2019 benchmarks on customer service, providing needed information, and ease of filling out forms, the rates shown in red, below, did not meet KHS' 2019 benchmarks.[19,20,21]

Measure	Question	2019 KHS HSAG CAHPS Child Rate	2019 KHS HSAG CAHPS Adult Rate	2019 KHS Adult Rate	2019 KHS Adult Benchmark
Getting Needed Care	Getting care, tests, or treatments necessary	82.7%	82.6%	81.0%	85.2%
	Obtained appointment with specialist as soon as needed	N/A	77.8%	75.7%	80.5%
Getting Care Quickly	Obtaining needed care right away	N/A	82.1%	81.6%	84.6%
	Obtained appointment for care as soon as needed	81.4%	70%	71.1%	79.7%

How Well Doctors Communicate	Doctors explained things in an understandable way	91.3%	90.6%	88.5%	92.0%
	Doctors listened carefully to you	95.1%	88.5%	89.5%	92.2%
	Doctors showed respect for what you had to say	95.7%	90.1%	92.5%	93.7%
	Doctors spent enough time with you	82.5%	87.8%	84.0%	89.5%
Shared Decision Making	Doctor/health care provider talked about reasons you might want to take a medicine	N/A	N/A	90.2%	91.6%
	Doctor/health care provider talked about reasons you might not want to take a medicine	N/A	N/A	65.6%	68.0%
	Doctor/health care provider asked you what you thought was best when talking about starting or stopping a prescription	N/A	N/A	82.1%	79.1%
	Health Promotion and Education	65.0%	69.2%	67.3%	71.3%

Source: 2019 KHS Annual Member Satisfaction Survey, 2019 CAHPS Adult Survey, 2019 CAHPS Child Survey

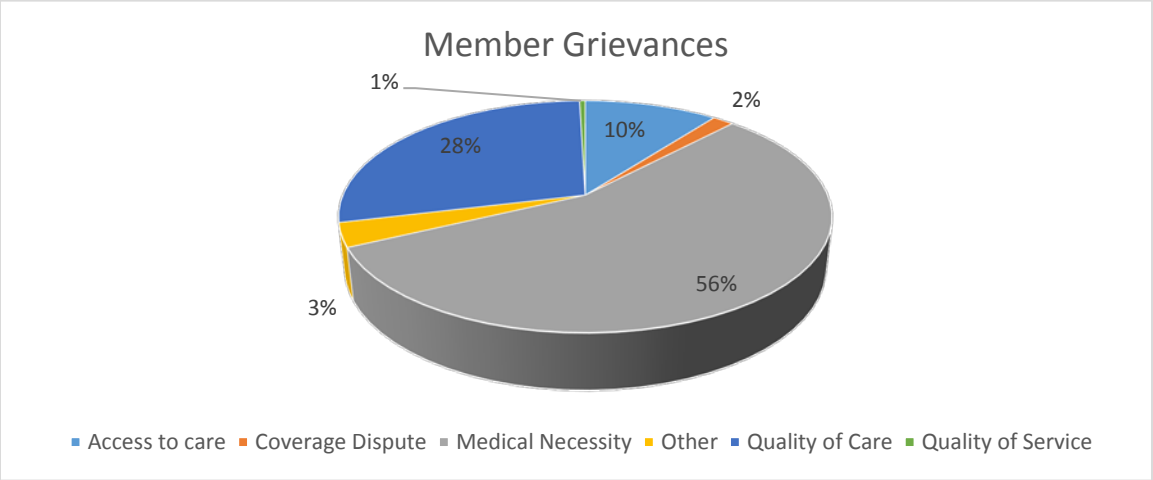
Data on the effectiveness of care measures for flu shots and tobacco use among adults was also collected. Findings revealed the KHS did not meet its 2019 benchmarks on advising current tobacco users to quit and discussing cessation medications and strategies[19] and 39.8% of its adult members did not receive an annual flu shot.[20]

Measure	Question	2019 KHS HSAG CAHPS Child Rate	2019 KHS HSAG CAHPS Adult Rate	2019 KHS Adult Rate	2019 KHS Adult Benchmark
Medical Assistance with Smoking and Tobacco Use Cessation	Advising Smokers and Tobacco Users to Quit	N/A	N/A	73.8%	76.5%
	Discussing Cessation Medications	N/A	N/A	44.0%	52.0%
	Discussing Cessation Strategies	N/A	N/A	37.4%	45.9%
Flu Vaccinations for Adults Ages 18-64	Had a flu shot since July 1 of previous year	N/A	60.2%	N/A	N/A

Source: 2019 KHS Annual Member Satisfaction Survey, 2019 CAHPS Adult Survey

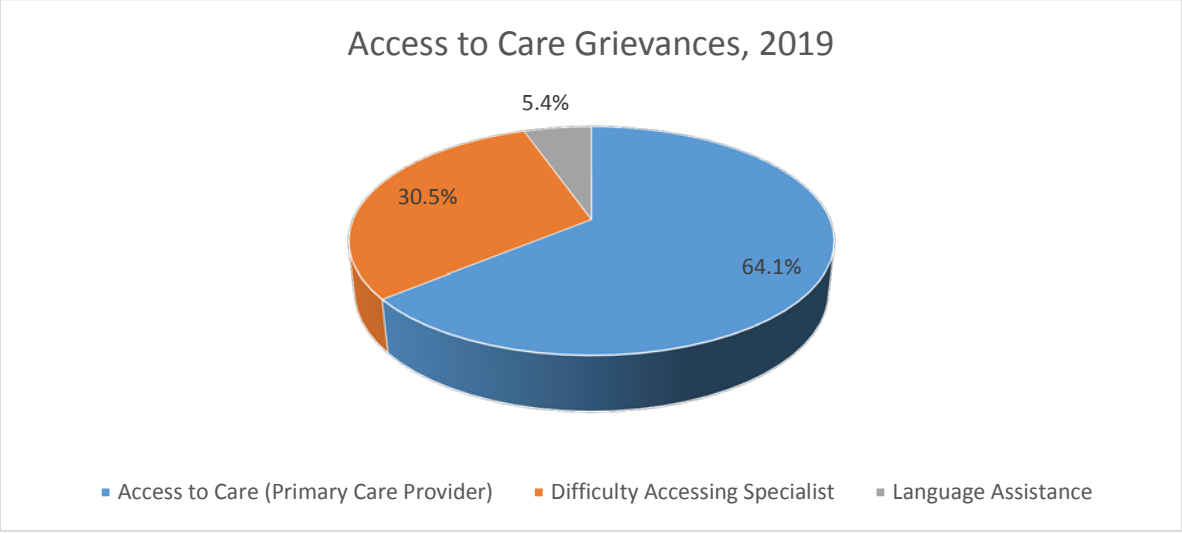
Member Grievances

KHS regularly monitors and reports on its member grievances related to access to care, coverage, medical necessity, quality of care and services, cultural and linguistic sensitivity and other issues. During 2019, there were 1,564 formal member grievances received and the majority of grievances were due to Medical Necessity followed by Quality of Care and Access to Care and 38.7% of these grievances were closed in favor of the member.[22]



Source: 2019 KHS Grievance Operational Board Report

When looking at access to care grievances, Access to Care (Primary Care Provider) accounted for the majority of cases (64.1%) in this grievance category, followed by Difficulty Accessing a Specialist (30.5%) and Language Assistance (5.4%).[23]



Source: 2019 KHS Grievance Operational Board Report

Access to Transportation

KHS' Transportation Program provides transportation for members to get to their medical and other Medi-Cal covered services. Covered modes include Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT). NEMT is provided when medically necessary and requires a Provider Certified Statement from the member's medical provider. NMT is provided to all members who qualify.

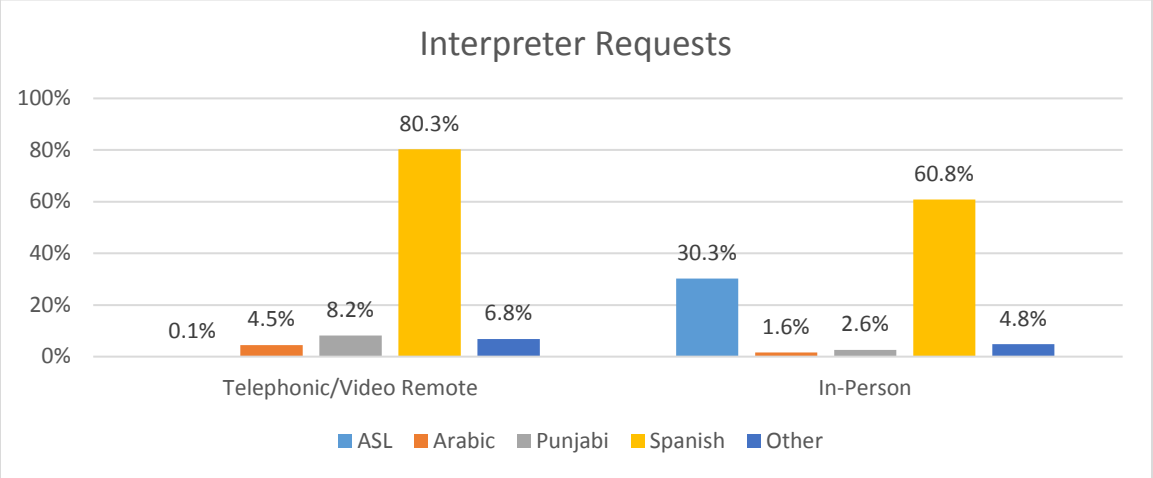
2019 NEMT and NMT Ridership

Mode	Number of Trips Provided	Approx. Number of Members Utilizing Transport Mode
NEMT Wheelchair	65,139	1,200
NEMT Gurney Van	2,130	260
NMT Public Transit	390,427	5,000
NMT Mileage Reimbursement	9,680	4,300

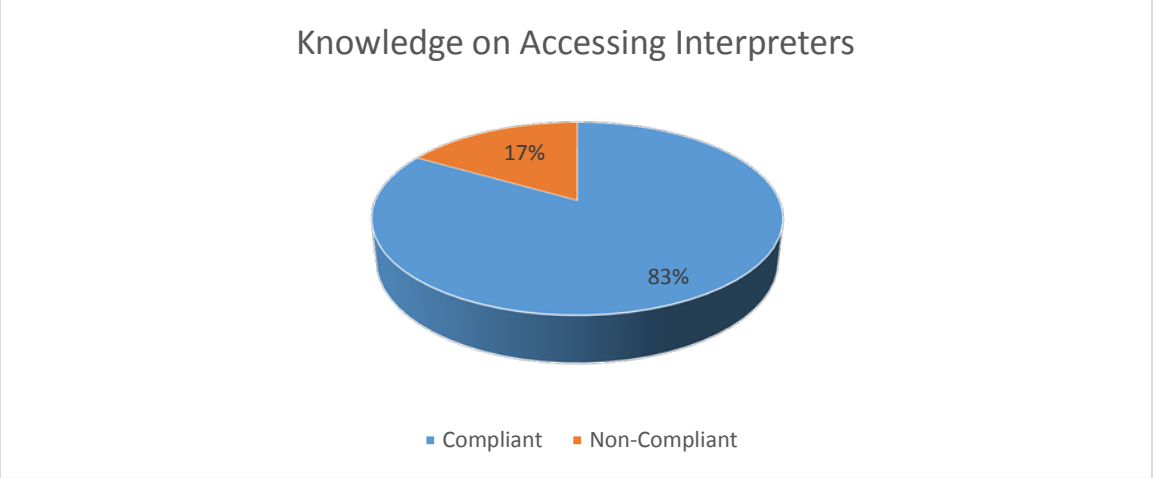
Source: KHS 2019 Transportation Benefit Summary

Access to Interpreter Services

KHS' HE department 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. In 2019, there was a 30% increase is requests for ASL interpreters, a 59% increase in telephonic interpreters, and a 39% increase for in-person interpreters when compared to 2018.[24]



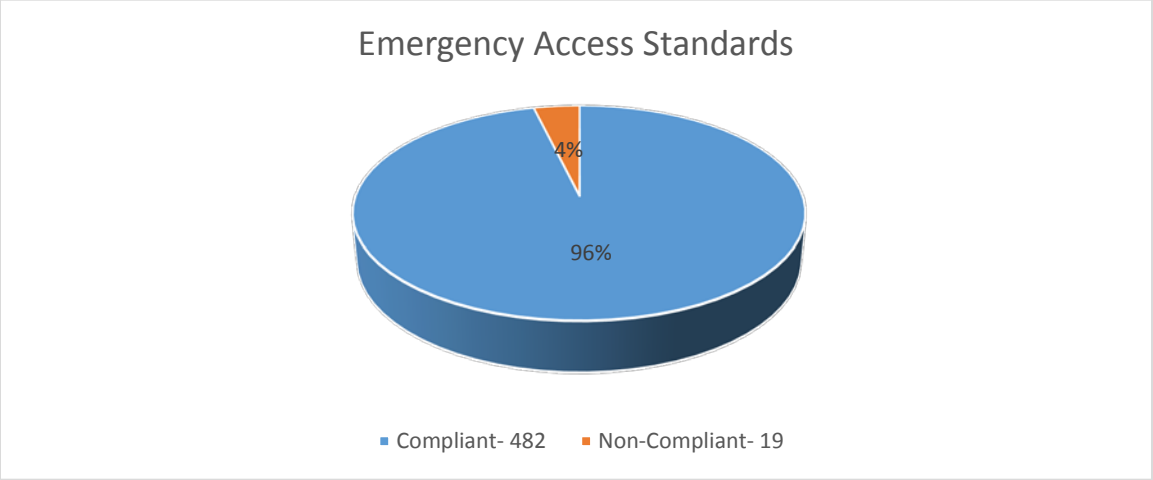
KHS conducts a quarterly interpreting access survey among its provider network. In 2019, a random sample of 60 primary care provider offices and 60 specialist offices were contacted to assess their knowledge on accessing interpreting services for limited English proficient (LEP) members. Findings revealed, 17% of these providers needed additional training on accessing interpreting services for LEP members.[25]



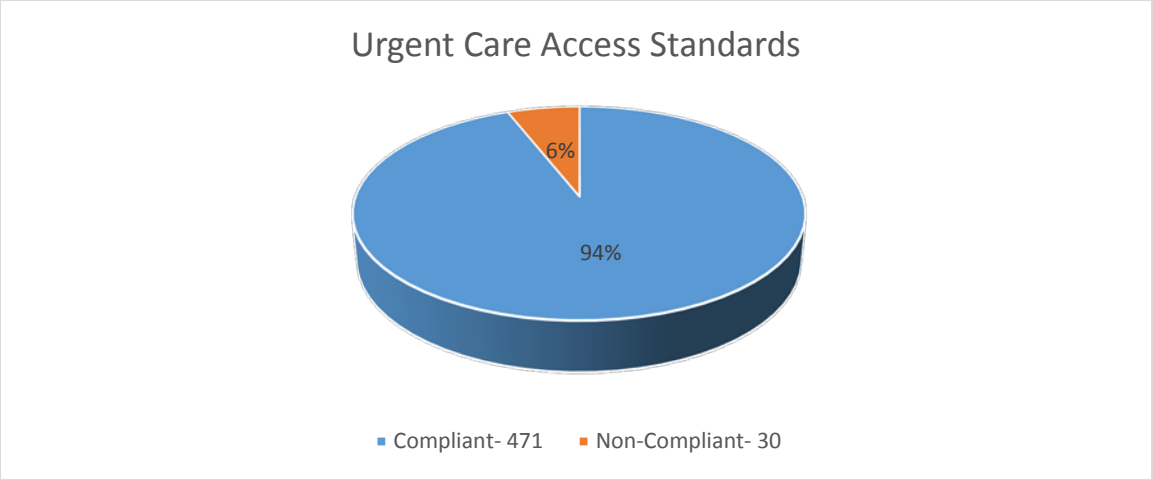
Source: 2019 KHS Interpreter Access Survey Results Report

Emergency & Urgent Care Access Standards

As required by the Department of Managed Health Care (DMHC) Health & Safety Code 1348.8, KHS uses an afterhours caller program to assess compliance with access standards for KHS Members. In 2019, 96% of provider offices were compliant with the Emergency Access Standards and 94% if provider offices were compliant with the Urgent Care Access Standards.[26]



Source: 2019 KHS Provider Network Management Network Review Reports



Source: 2019 KHS Provider Network Management Network Review Reports

Appointment Availability

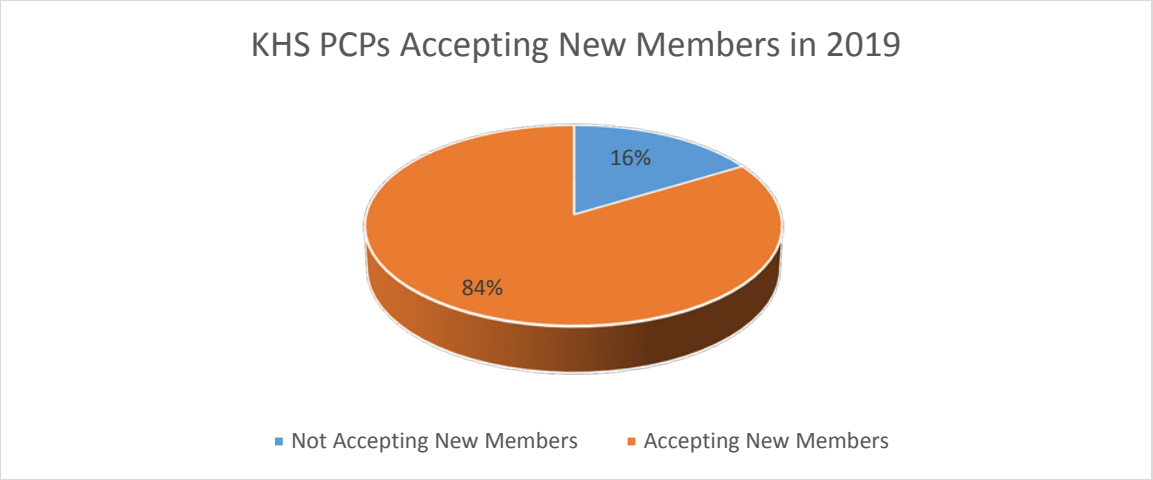
As required by the DHCS and Title 28 CCR Section 1300.67.2.2, KHS uses an appointment availability survey to assess compliance with access standards for KHS Members. A random sample of 60 primary care provider (PCP) offices, 60 specialist offices, and 5 Obstetrics & Gynecology (OBGYN) offices were contacted during 2019 and found to be in-compliance with the standard wait times.[26]

	Providers Contacted	Average Wait Time in Business Days/Provider	Standard Wait Time in Business Days
PCP Offices	60	3.6	10
Specialist Offices	60	7.6	15
OBGYN Offices	5	5.4	10

Source: 2019 KHS Provider Network Management Network Review Reports

New Member PCP Access

KHS monitors the adequacy of its primary care network by reviewing the count/percentage of PCPs who are accepting new members. During 2019, the plan had a combined quarterly average network of 385 PCPs and 84% were accepting new members at a minimum of one location.[26]



Source: 2019 KHS Provider Network Management Network Review Reports

Health Disparities

Health disparities among KHS members vary by race/ethnicity, language, and health outcome. 2019 DHCS Disparities Rate Sheet indicator rates show that African American members are mostly likely to have the worst outcomes for preventive health measures. English speakers generally have worse 2019 DHCS Disparities Rate Sheet indicator rates than Spanish speakers. Racial/ethnic disparities for the top chronic health conditions among KHS members vary by chronic health condition.

A comparison of the 2018 and 2019 DHCS Disparities Rate Sheets revealed improvements in avoidance of antibiotics, cervical cancer screenings, poorly controlled diabetes, immunizations for adolescents, and pediatric counseling for nutrition and physical activity. Consequently, there were also several indicators that decreased, demonstrating a decrease in member adherence to preventive care or treatment.[27] A summary is provided in the table below.

Rate Difference (Percentage Points)	Description of Measurement
-28.3 pp	Decrease in asthma medication management
-4.8 pp	Decrease in outpatient visits based on total population.
-4.3 pp	Decrease in emergency department visits based on total populations.
-4.1 pp	Decrease in hypertensive members with controlled blood pressure readings.
-3.4 pp	Decrease in members who received all childhood immunizations by the age of 2.
-2.7 pp	Decrease in members aged 3-6 years who completed a well child visit.
-1.2 pp	Decrease in members accessing early prenatal care.
-1.2 pp	Decrease in children ages 25 months-6 years accessing primary care services
-1.0 pp	Decrease in children ages 7-11 years accessing primary care services
-0.5 pp	Decrease in children ages 12-19 years accessing primary care services
-0.1 pp	Decrease in children ages 12-24 months accessing primary care services

Source: 2019 DHCS Disparities Rate Sheets

DHCS reviewed the following pediatric preventive care indicators for all Medi-Cal Managed Care Health Plans in the 2019 DHCS Disparities Rate Sheet:

- Children's Access to Primary Care for 12-24 month olds (CAP-1224)
- Children's Access to Primary Care for 25 months to 6 year olds (CAP-256)
- Children's Access to Primary Care for 7-11 year olds (CAP-711)
- Children's Access to Primary Care for 12-19 year olds (CA-1219)
- Childhood immunizations by age 2 (CIS-3)
- Well child visits for 3-6 years (W34)
- Weight Assessment and Counseling for Nutrition (WCC-N)
- Weight Assessment and Counseling for Physical Activity (WCC-PA)

In review of the 2019 DHCS Disparities Rate Sheet indicators by race/ethnicity for pediatric preventive care, there is a trend of unfavorable outcomes for African American KHS members and other members of color. KHS' African Americans most frequently had the worst 2019 DHCS indicators rates in children's access to primary care services and childhood immunizations, whereas KHS' Caucasian members had the worst rates well child visits for 3-6 years olds and weight assessment and counseling for nutrition and physical activity. Conclusions about the preventive health outcomes for Asian, American Indian/Alaskan Native, and Native Hawaiian/Other Pacific Island members cannot not always be drawn because there was there was not enough data for most of the DHCS Disparities Rate Sheet indicators. In review of language preferences, Spanish-speaking members were more likely to be compliant with all pediatric preventive care indicators compared to English-speaking members.

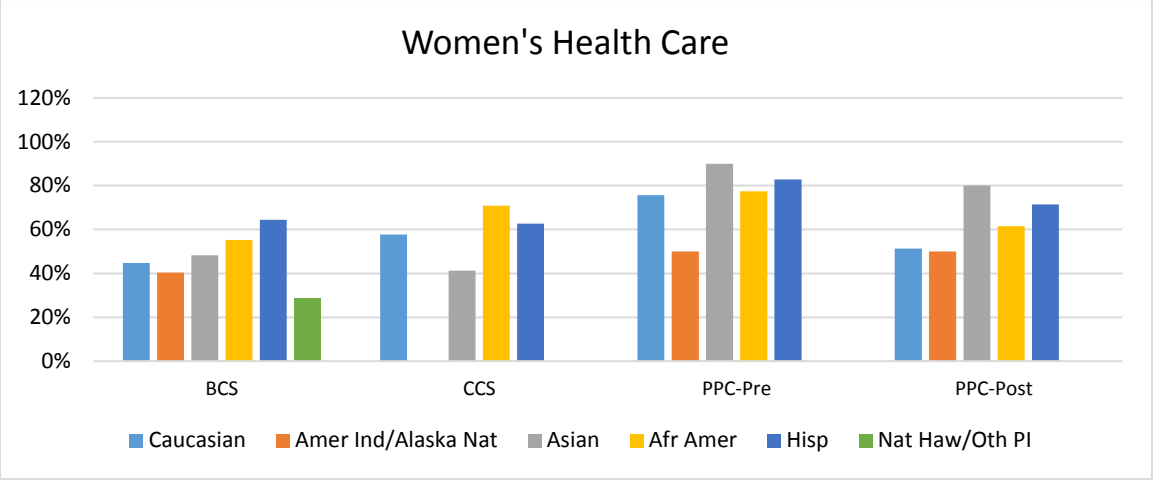
PEDIATRIC PREVENTIVE CARE						
MEASURE	**Caucasian**	**American Indian/ Alaska Native**	**Asian**	**African American**	**Hispanic**	**Native Hawaiian/Other Pacific Islander**
CAP1224	82.9%	100.0%	94.2%	80.9%	91.7%	N/A
CAP256	73.3%	76.0%	84.2%	66.1%	82.7%	100.0%
CAP711	74.3%	63.2%	85.1%	64.8%	82.1%	100.0%
CAP1219	73.3%	66.7%	77.1%	69.9%	80.0%	73.3%
CIS-3	50.00%	N/A	83.33%	40.91%	71.54%	N/A
IMA-2	36.96%	N/A	44.44%	31.25%	41.87%	N/A
W34	60.0%	N/A	57.1%	63.0%	66.0%	N/A
WCC-N	57.1%	0.0%	50.0%	83.3%	71.9%	N/A
WCC-PA	53.1%	0.0%	50.0%	66.7%	68.1%	N/A

Source: 2019 DHCS Health Disparities Rate Sheet

DHCS reviewed the following women's health care indicators for all Medi-Cal Managed Care Health Plans in the 2019 DHCS Disparities Rate Sheet:

- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Early Prenatal Care (PPC-PRE)
- Postpartum Care (PPC-Post)

In review of the 2019 DHCS Disparities Rate Sheet indicators by race/ethnicity for women's health care, KHS' Caucasian members were less likely to obtain breast and cervical cancer screenings, access early prenatal care and complete their postpartum care. KHS' Asian members were also less likely to obtain cervical cancer screenings and KHS' American Indian/Alaskan Native members were less likely to obtain breast cancer screenings. In review of language preferences, Spanish-speaking members were more likely to be compliant with breast and cervical cancer screenings and postpartum care whereas English-speaking members were more likely to be compliant with early prenatal care.



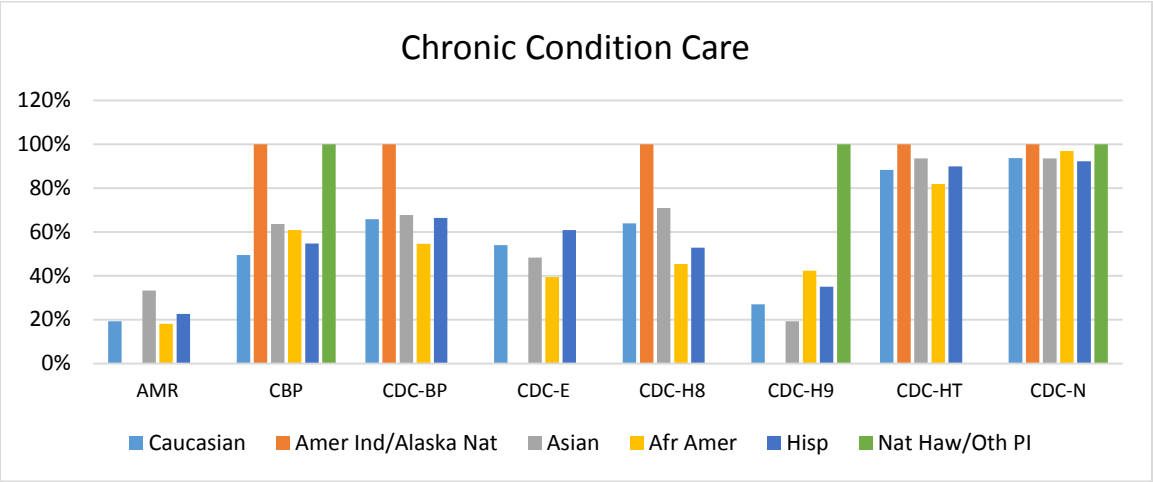
Source: 2019 DHCS Health Disparities Rate Sheet

DHCS reviewed the following chronic condition care indicators for all Medi-Cal Managed Care Health Plans in the 2019 DHCS Disparities Rate Sheet:

- Asthma Medication Management (AMR)
- Control of High Blood Pressure (CBP)
- Comprehensive Diabetes Care – Blood Pressure Control (CBP)
- Comprehensive Diabetes Care – Retinal Eye Exam (CDC-E)
- Comprehensive Diabetes Care – HbA1c Control <8% (CDC-H8)
- Comprehensive Diabetes Care – HbA1c Poor Control >9% (CDC-H9)
- Comprehensive Diabetes Care – HbA1c Testing (CDC-HT)
- Comprehensive Diabetes Care – Nephropathy Monitoring (CDC-N)

In review of the 2019 DHCS Disparities Rate Sheet indicators by race/ethnicity for chronic condition care, there is also a trend of unfavorable outcomes for African American KHS members. KHS' African Americans were more likely to be less compliant with asthma medication adherence, HbA1c testing and control, diabetic retinal exams, and diabetic blood pressure control. Although KHS' Asian, American Indian/Alaskan Native, and Native Hawaiian/Other Pacific Island members may appear to worse preventative care rates, there was not enough data for KHS to draw statistically valid assumptions for these groups in all indicators.

In review of language preferences, Spanish speaking members were more likely to be compliance with all chronic condition care indicators with the exception of the following indicators where English speaking members were more compliant: CBP, CDC-H9, and CDC-N.



Source: 2019 DHCS Health Disparities Rate Sheet

When looking at the most prevalent chronic health conditions among KHS members, racial/ethnic disparities vary by health condition. White members have the highest rate of depression compared to other racial/ethnic groups.[12] Asian members have the highest rates of diabetes, dyslipidemia, and hypertension. African Americans have the highest rates of low back pain and persistent asthma. The racial/ethnic group with the highest rate for each of the top chronic conditions among KHS members is shown in red, below.

	African American	Asian	Caucasian	Hispanic	Other/ Unspecified
Depression	6.3%	3.5%	11.2%	4.7%	3.9%
Diabetes	7.2%	14.5%	7.0%	7.1%	6.1%
Dyslipidemia	9.3%	25.8%	12.6%	11.2%	10.0%
Hypertension	16.4%	23.5%	16.0%	10.5%	10.3%
Low Back Pain	14.0%	13.8%	15.2%	9.0%	7.3%
Persistent Asthma	15.2%	7.2%	12.0%	8.2%	9.1%

Source: KHS All Populations Analysis Report, 2020

IV. Health Education, Cultural & Linguistics, and Quality Improvement Program Gap Analysis

Gaps in Access to Care

As mentioned previously, KHS did not meet its 2019 CAHPS benchmark goals in the areas of:

- Getting Needed Care
  - Getting care, tests or treatments necessary
  - Obtained appointment with specialist as soon as needed
- Getting Care Quickly
  - Obtaining needed care right away
  - Obtained appointment for care as soon as needed
- Health Promotion and Education
- Access to Tobacco Cessation Medication and Strategies to Quit

KHS' access to care grievance data revealed potential challenges that members may face when accessing a specialist where nearly half of the "Difficulty Accessing a Specialist" grievance outcomes were in favor of the enrollee.[23]

Although 83% of KHS' provider network understand how to access interpreting services for KHS members, the remaining 17% is in need of reminders of this member benefit.[25] KHS HE, C&L Department should continue to partner with its Provider Network Management and QI Departments to help coordinate in-services and refresher trainings for providers who are identified as non-compliant through the quarterly interpreter access survey; have had a cultural and linguistic grievance filed against the office site; or, have been identified as an office site that would benefit from additional training.

Transportation challenges for NMT are similar to the challenges for NEMT. Rural areas have limited public transportation availability. Rideshare providers (Uber) typically service the more urban areas without issue and usually have no availability limits. Since rideshare drivers are independent contractors who rely on short route trips to be lucrative and Kern County has an expansive geographic footprint, rural areas are not preferable given that the expense of traveling without a passenger outweighs the benefit of servicing the minimal population in those areas.[28] Single passenger trips for rural areas may be provided by the public transit's curbside bus where available.

Survey responses from KHS' Public Policy/Community Advisory Committee (PP/CAC) identified the following opportunities that KHS should consider to aid members in accessing health care services[29]:

- Improve member awareness and understanding of their medical benefits and how to access these services.
- Reassess length of time to for members to obtain approval for medications and authorizations.

- Improve member health literacy on understanding health plan and medical terminology by creating easy to understand materials and incorporating a glossary of terms.
- Encourage providers to spend more time listening, affirming and being attentive to member needs during visits.
- Expand transportation services, particularly in rural areas.

Gaps in Language Needs and Cultural and Linguistic Competency

KHS' threshold languages as determined by DHCS continues to be English and Spanish; however, the top 4 languages for telephonic interpreting for KHS members in 2019 were Spanish, Punjabi, Arabic and Tagalog. The top 4 languages for in-person interpreting for KHS members in 2019 were Spanish, Punjabi, Cantonese and Mandarin. Although the top 4 non-Spanish languages for interpreters do not meet DHCS' criteria to constitute as a new threshold language for KHS, KHS recognizes that its 4th largest ethnic group are Asian Indian members and requests for Punjabi interpreters continues to grow each year. Survey responses from KHS' PP/CAC members also found recommendations for KHS to start building a staffing model and inventory of both health education and member informing material, educational curriculums and media campaigns that are culturally and linguistically representative of this population. Other considerations to better understand the cultural and linguistic needs of Asian Indian or Punjabi speaking members might include, but not be limited to:

- Effective ways to promote our services to these members
- Engagement of community liaisons, gatekeepers, or organizations that can help KHS connect and communicate
- Identify geographic concentration areas of residence for these members

Requests for ASL interpreters also continues to grow within KHS' membership. KHS has seen a 30% increase in ASL requests since 2018 and a 45% increase since 2016. KHS recognizes that access to in-person ASL interpreters is highly limited in Kern County. With only 12 ASL interpreters residing in Kern County, KHS' interpreting vendor must recruit Los Angeles County interpreters to commute to Kern County to assist ASL members. These interpreters not only face an extensive geographic commute, but also face challenges with severe weather conditions and road closures on the Interstate Highway 5 grapevine route during the Winter and Summer seasons. KHS may need to encourage more use of video remote interpreting services with its provider network and ASL membership to avoid interpreter access delays.

Through the review and analysis of KHS' C&L data, the following areas should also be explored for consideration and inclusion in future program planning in order to expand and enhance KHS' C&L services for its members.

- Continue to research and identify additional vendors to perform in-person interpreting services for members.
- Explore and develop a procedure on how to access and use interpreters during virtual health care visits.
- Identify and recruit additional vendors to provide bilingual certification for KHS staff.

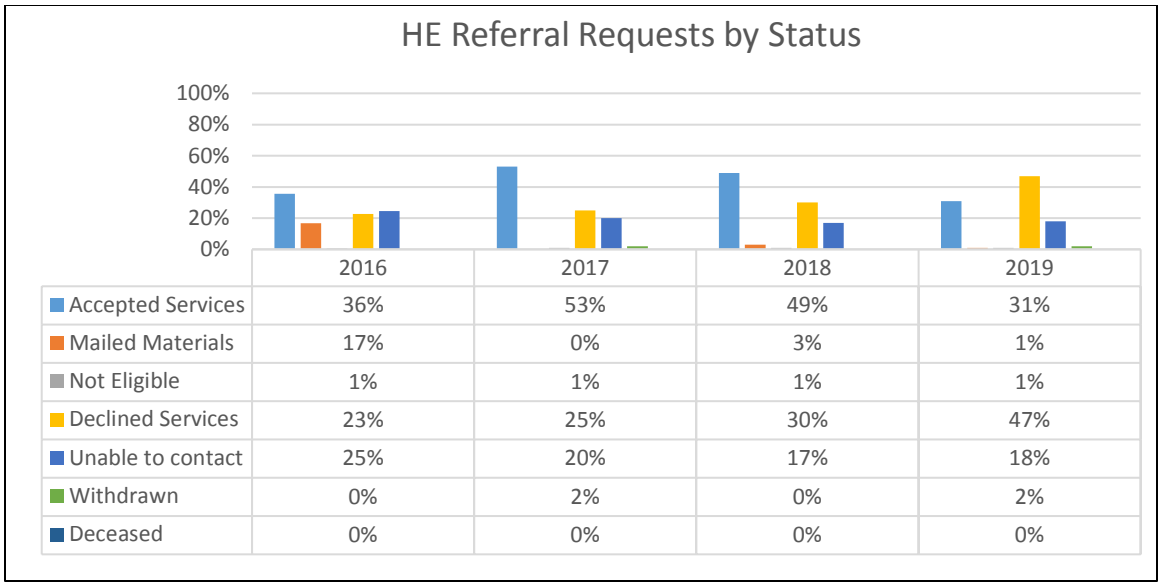
- Increase opportunities for KHS' provider network to participate in trainings on Cultural Competency, Effective Interpreting and Accessing KHS Interpreter Services.
- Increase training opportunities for KHS and its network providers to learn more about the needs the LGBT population.
- Increase promotion of interpreter services among KHS members along with the concerns with using family or friends as interpreters.
- Continue outreach and education efforts with KHS providers on how to access KHS' interpreting services.
- Offer trainings on the principles and ethics for effective interpreting for provider staff used as interpreters during appointments.
- Research and identify additional member and provider tools to communicate interpreter needs for medical appointments.
- Research and connect with growing ethnic groups within KHS' membership to better understand the cultural aspects around accessing health care and use of alternative medicine.

Gaps in Health Education Services

KHS has historically offered health education services and incentives through a variety of modalities, such as in-person group sessions, telephonic counseling, printed mailings, and social media communications. Yet member's awareness and participation in KHS' health education services continues to remain low. KHS' ability to offer regular health education services throughout the county and outside of regular business hours has also been a challenge due to limited venue locations and member's interest and comfort level with travelling to health education service site. KHS' average class attendance was 6.5 members per class for nutrition classes and 3.3 members per class at asthma classes in 2019. Additionally, KHS offered very few individual counseling sessions for nutrition and asthma with a health educator and services were limited due lack of resources and the availability of the KHS health educators.

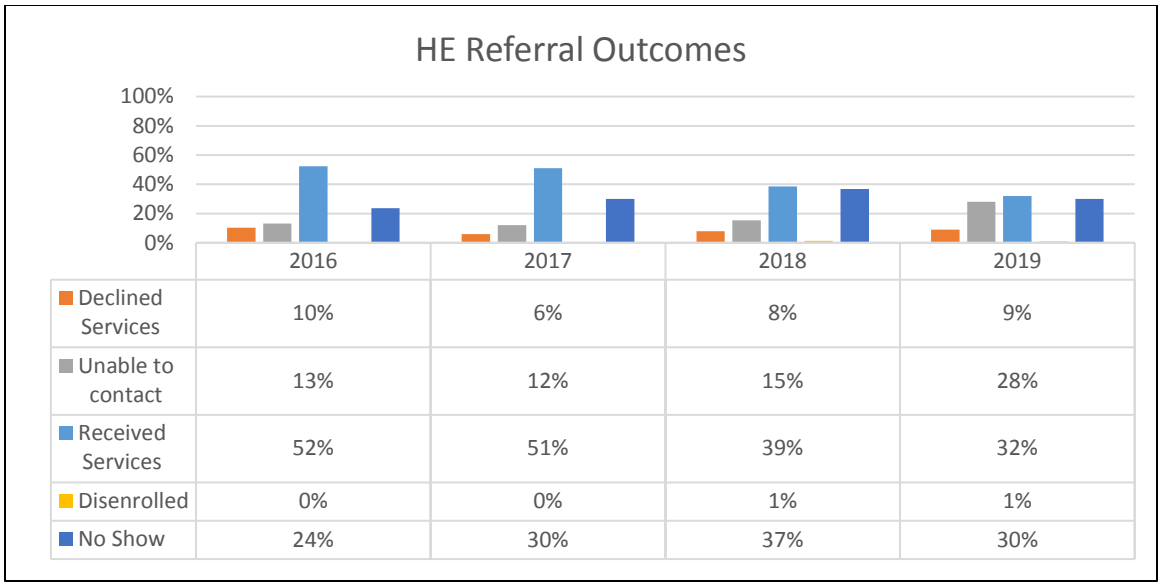
Health Education Utilization

The KHS HE Department processed 4,357 referral requests for health education services in 2019 and weight management, asthma management, and smoking cessation were the top types of referral requests received.[24] Asthma management and smoking cessation referrals increased significantly in 2019 compared to previous years due to targeted outreach performed by KHS HE Department. The rate of members who accepted to receive health education services decreased from 49% in 2018 to 31% in 2019 and the rate of members who declined to receive services increased from 30% in 2018 to 47% in 2019.[24] Referral outcome data revealed a 7 percentage point decrease in the Received Services rate and a 13 percentage point increase in the Unable to Contact rate.[24]



	2016	2017	2018	2019
Accepted Services	36%	53%	49%	31%
Mailed Materials	17%	0%	3%	1%
Not Eligible	1%	1%	1%	1%
Declined Services	23%	25%	30%	47%
Unable to contact	25%	20%	17%	18%
Withdrawn	0%	2%	0%	2%
Deceased	0%	0%	0%	0%

Source: 2019 KHS Health Education Activities Report



	2016	2017	2018	2019
Declined Services	10%	6%	8%	9%
Unable to contact	13%	12%	15%	28%
Received Services	52%	51%	39%	32%
Disenrolled	0%	0%	1%	1%
No Show	24%	30%	37%	30%

Source: 2019 KHS Health Education Activities Report

KHS member health disparities data from DHCS' 2019 Rate Sheet revealed a trend of unfavorable indicator rates among African American KHS members compared to other racial/ethnic groups. African Americans, Asians, and Caucasians were disproportionately overrepresented in claims data for the most prevalent chronic conditions among KHS members. These racial/ethnic disparities may require more in-depth investigations of contributing factors, such as physical characteristics and access to health promoting resources or services in neighborhoods with different social and economic profiles. A better understanding of these contributing factors will lead to evidence-based health promotion and disease prevention program that address top health disparities among KHS members.

Through KHS' health education data collection from class evaluations, member assessments and focus groups, KHS has identified the list of service gaps below. The list below should be explored for consideration and inclusion in future program planning in order to expand and enhance KHS' health education services for its members.

- In-person and virtual educational home visiting programs for chronic condition management.
- Structured programs facilitated by promotores or community health workers that represent targeted racial/ethnic groups.
- Virtual health education classes and individual counseling in lieu of in-person services.
- Expanded member access to digital health education material.
- Group exercise classes, walking groups and gym memberships.
- New incentive programs to encourage participation and adherence with program.
- Educational text message and robocall campaigns.
- Provide childcare and senior care for participants attending in-person classes.
- Social media videos and other digital media content.
- KHS community resource or satellite centers throughout the county.
- Continued enhancement of KHS' corporate website with health education content
- Enhance KHS' Member Portal LiNK to allow members to register for health education services, receive health education communications, and access health education material content.
- Increase promotion and details of KHS health education services and incentive programs and collaborate with community organizations that work directly with KHS members to share information.
- Increase access to health education services through virtual class settings, community partnerships, service contracts, and new venue locations throughout Kern County.
- Explore ways to connect members with internal and external resources to address these complex health problems by working with KHS' Health Homes Program and Case Management Departments, KHS' provider network, and local community-based organizations.
- Work with local policymakers and government officials on ways to plan safer, healthier and more walkable communities.

Quality Improvement Program Gap Analysis

Initial medical record reviews of KHS providers conducted in 2019 by the KHS QI Department found a high fail rate. Twenty-five percent (25%) of the Medical Records Reviews performed passed on the first visit and 75% required additional follow-up.[30] Typically, there are more follow-ups required for Medical Record Reviews.

The QI Department explores opportunities to improve areas on a broader basis for areas with consistent non-compliance.

Facility Site Review deficiencies are listed below:

- No documentation of checking of medication expiration dates, yielding expired medications found in site
- Compliance with annual training required for providers and staff
- Compliance with spore testing for infection control purposes
- No evidence of physician and staff education (child/elder abuse, sensitive services)
- Tracking of referral process thru closures

Medical Record Review opportunities for improvement during quality audits for 2019 are listed below.

- Outreach efforts for missed appointments
- Timely immunizations for children
- Pediatric dental assessment
- Adolescent immunizations
- Vision and hearing screening
- Cervical cancer screening
- TB screening
- Adult immunizations
- Staying healthy assessments
- Pap smear
- STI and chlamydia screening

When looking at the Individual Health Education Behavioral Assessment (IHEBA) monitoring results, KHS providers scored lower in the 4th quarter when compared with previous quarters. Skewed results may have been caused by one KHS provider who had 0 Staying Healthy Assessments (SHA) done for all ten patients reviewed; in addition, there were five other providers who scored below Minimum Performance Level (MPL). Corrective Action Plans (CAPS) were issued and follow up reviews were done.

HEDIS 2019

HEDIS 2019 is a tool used by more than 90 percent of America's health plans, to measure performance on important dimensions of health care and services. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA), a private, not-for-profit organization dedicated to improving health care quality, since 1990.

All Medi-Cal managed care health plans must submit annual measurement scores for the required External Accountability Set (EAS) performance measures. DHCS currently requires all contracted health plans to report selected HEDIS measures to comply with the EAS reporting requirement. The previous calendar year is the standard measurement year for HEDIS data. Therefore, the HEDIS 2019 results shown in this report are based on 2018 data. All Plan Letter 17-014 states that for each measure below the established MPL or with an audit result of "Not Reportable" (NR), the health plan must submit a rapid-cycle improvement and implementation of Plan, Do, Study, Act (PDSA) cycles to increase the potential for improved outcomes within 60 days of being notified by DHCS of the measures for which Improvement Plans (IP) are required. KHS did not meet the MPL for two EAS measures. One was the Asthma Medication Ratio (AMR) and the other was for Well-Child Visits (W34 - ages 3-6 years old).

Hybrid Measures

Measure		Current 2019 Rate	2019 MPL	2019 HPL	2018 KHS Rate	Current Vs. 2019 MPL	Current Vs. 2019 HPL	Current Vs. 2018 KHS
CCS	Cervical Cancer Screening	60.34	54.26	70.68	58.39	6.08	-10.34	1.95
CIS-3	CIS – Combo 3	65.45	65.45	79.56	68.86	0.00	-14.11	-3.41
CDC-E	Eye Exam (Retinal) Performed	56.93	50.85	68.61	58.94	6.08	-11.68	-2.01
CDC-HT	HbA1c Testing	89.13	84.93	92.70	89.60	4.20	-3.57	-0.47
CDC-H9 *	HbA1c Poor Control (>9.0%)	33.15	47.20	29.68	30.66	14.05	-3.47	-2.49
CDC-H8	HbA1c Control (<8.0%)	55.43	44.44	59.49	58.21	10.99	-4.06	-2.78
CDC-N	Medical Attn. for Nephropathy	92.93	88.56	93.43	92.88	4.37	-0.50	0.05
CDC-BP	Blood Pressure Control <140/90	65.58	56.20	77.50	69.89	9.38	-11.92	-4.31
CBP	Controlling High Blood Pressure	54.26	49.15	71.04	58.39	5.11	-16.78	-4.13
IMA-2	Immunizations for Adolescents (Combo 2)	40.63	26.28	46.72	36.74	14.35	-6.09	3.89
PPC-Pre	Timeliness of Prenatal Care	81.27	76.89	90.75	82.48	4.38	-9.48	-1.21
PPC-Pst	Postpartum Care	67.64	59.61	73.97	66.67	8.03	-6.33	0.97
WCC-N	Counseling for Nutrition	70.56	59.85	83.45	63.02	10.71	-12.89	7.54
WCC-PA	Counseling for Phys Activity	65.21	52.31	78.35	57.91	12.90	-13.14	7.30
W-34	Well-Child Visits	63.99	67.15	83.70	66.67	-3.16	-19.71	-2.68

* A lower rate indicates better performance therefore the number of required numerators must decrease by the number shown.

Administrative Measures								
Measure		Current 2019 Rate	2019 MPL	2019 HPL	2018 KHS Rate	Current Vs. 2019 MPL	Current Vs. 2019 HPL	Current Vs. 2018 KHS
AAB**	Avoidance of Antibiotic Treatment	31.33	27.63	44.64	27.63	3.70	-13.31	3.70
AMR	Asthma Medication Ratio	21.49	56.85	71.93	49.80	-35.36	-50.44	N/A
BCS	Breast Cancer Screening	56.57	51.78	68.94	55.98	4.79	-12.37	N/A
CAP-1224	12-24 Months	89.62	93.64	97.71	89.69	-4.02	-8.09	-0.07
CAP-256	25 Months – 6 Years	80.28	84.39	92.88	81.44	-4.11	-12.60	-1.16
CAP-711	7-11 Years	79.9	87.73	96.18	80.88	-7.83	-16.28	-0.98
CAP-1219	12-19 Years	78.35	85.81	94.75	78.84	-7.46	-16.40	-0.49
DSF	Depression Screening and Follow-Up for Adolescents and Adults	0.00	N/A	N/A	0.00	N/A	N/A	N/A
LBP**	Use of Imaging for Low Back Pain	73.33	67.19	79.88	71.59	6.14	-6.55	1.74
MPM-ACE	ACE inhibitors or ARBs	89.71	85.97	92.87	90.19	3.74	-3.16	-0.48
MPM-Diu	Diuretics	90.50	86.06	92.90	89.79	4.44	-2.40	0.71

** Rate for these measures derived by an inverse calculation. The number of required numerators must decrease by the number shown.

Note: For measures shaded in gray, DHCS is not holding MCPs accountable to meet the MPLs for HEDIS Report Year 2019 (Measurement Year 2018).

QI Performance Improvement Projects

Based on the final 2019 rates of HEDIS, two new Performance Improvement Projects (PIPs) were initiated in 2019 and DHCS allowed KHS to incorporate the required rapid-cycle improvement PDSA cycles into those two projects. Those two measures are the Asthma Medication Ratio (AMR) and the W34 Well-Child visits (ages 3-6 years old). IPs 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:

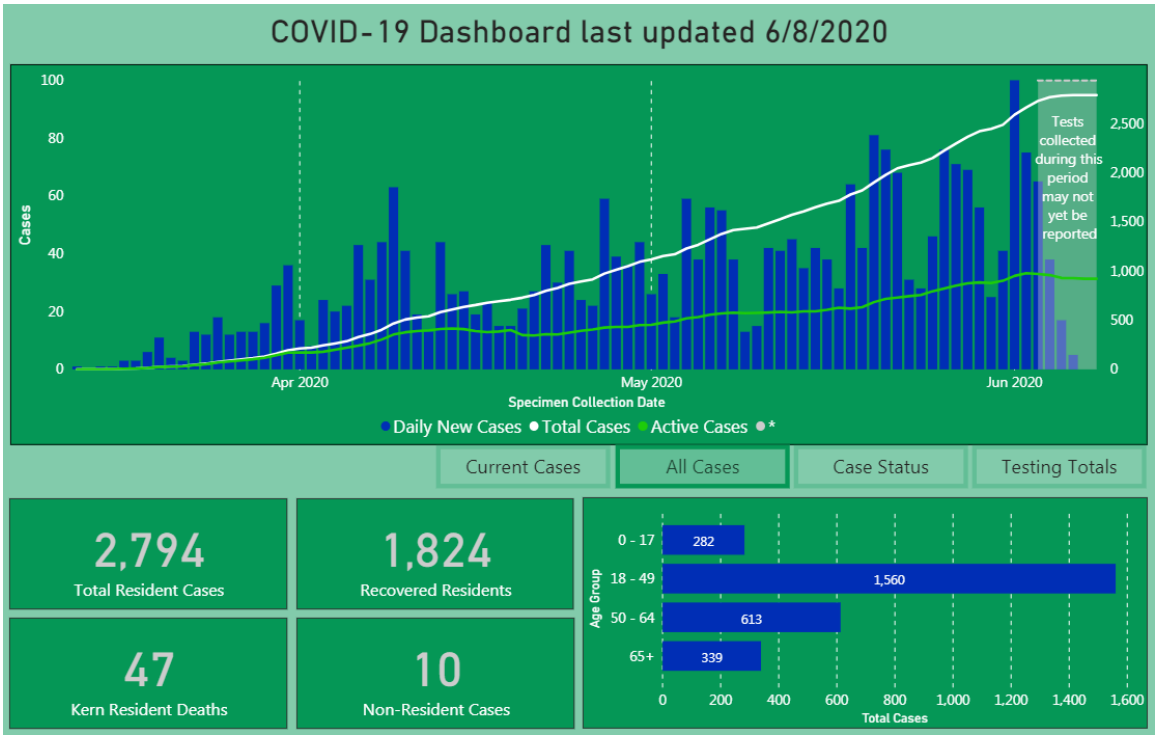
- Disparities in W34 (Well Child Visits on ages 3-6 years old): The proposal for the KHS' Disparities W34 (Well Child Visits on ages 3-6 years old) PIP got accepted by DHCS for 2019-2021 on August 15, 2019. Kern Pediatrics has accepted to partner with us on this PIP to improve member care. Our PIP team is working closely with providers to identify gaps in care and act appropriately to address them.

- 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 have 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.

Other: COVID-19

A total of 2,794 positive COVID-19 cases and 47 deaths due to COVID-19 have been confirmed in Kern County as of June 8, 2020.[31] The image below, from the Kern County Public Health Services Department (KCPHSD) website summarizes COVID-19 cases since testing began in Kern County. The total number of cases continues to steadily increase.

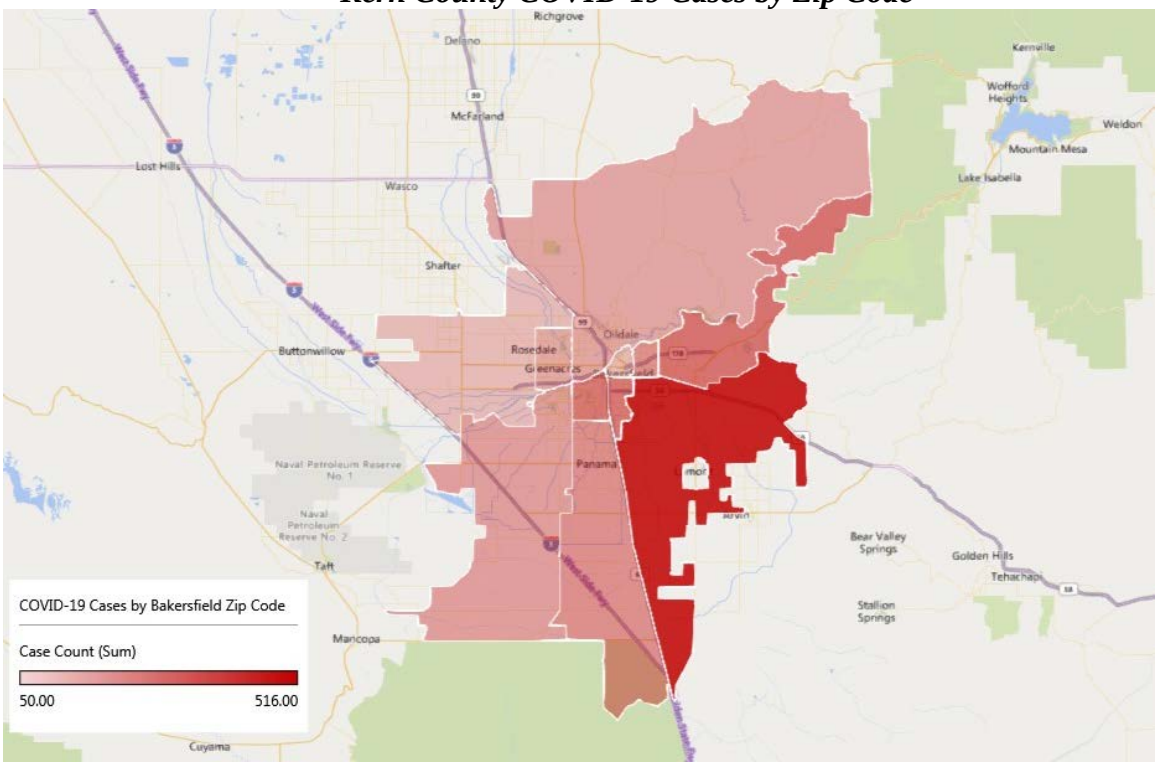
KCPHSD COVID-19 Dashboard



Source: Kern County Public Health COVID-19 Dashboard

In Kern County, 74.8% of COVID-19 cases are in Bakersfield and 65.5% of cases in Bakersfield are in zip codes that are east of California State Route 99. The map below shows that COVID-19 cases in Bakersfield are concentrated in zip codes in the eastern and southern areas of Bakersfield. Zip codes with a darker red color have more cases.

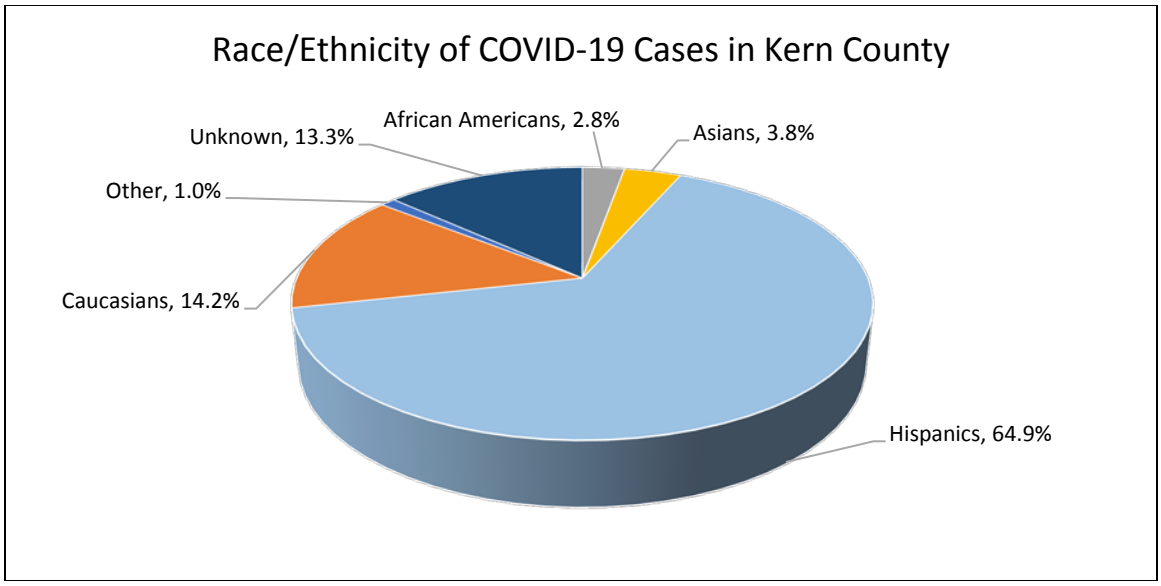
Kern County COVID-19 Cases by Zip Code



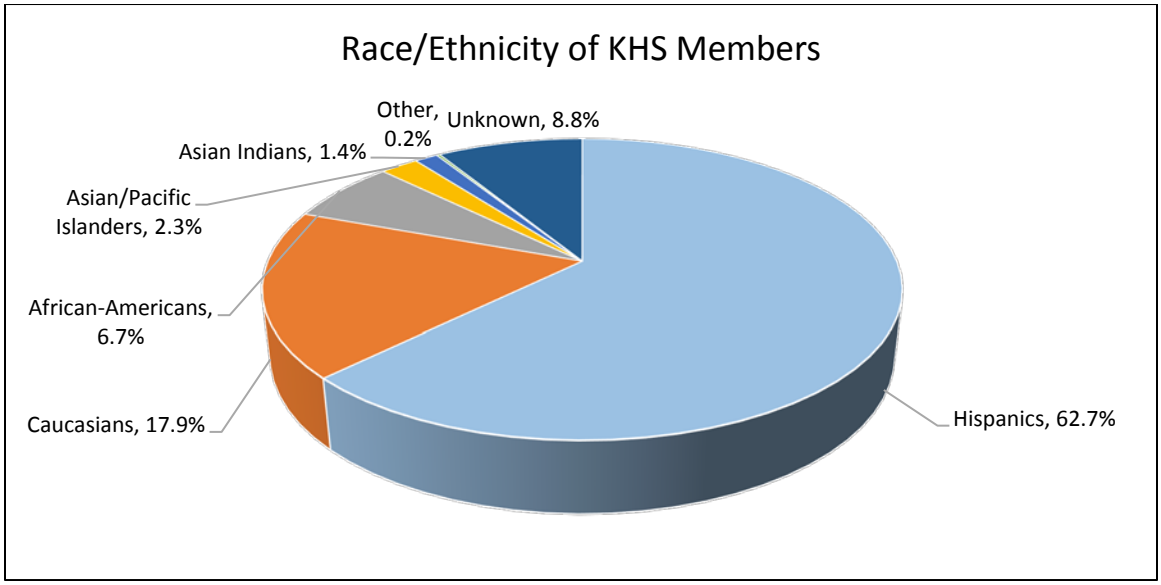
Source: Kern County Public Health COVID-19 Dashboard

The effects of COVID-19 on the health of racial and ethnic minority groups is still emerging. However, current data suggest there is a disproportionate burden of illness and death among racial and ethnic minority groups.[32] COVID-19 cases in Kern County are following this nationwide health disparity and appear to be disproportionately higher among Hispanics than Caucasians. Hispanics account for the largest proportion of cases (64.9%), followed by Caucasians (14.2%), and Unknown (13.3%), and Asians (3.8%), African Americans (2.8%), and Other (1.0%).[31] When looking at the overall Kern County racial/ethnic profile, Hispanics are 54.0% of the population, followed by Caucasians (33.5%), African Americans (6.3%), Asians (5.4%), and American Indians and Alaska Natives (2.6%).[33]

The racial/ethnic breakdown of COVID-19 cases in Kern County is similar to the racial/ethnic profile of KHS members. The exception appears to be African Americans, where their proportion of COVID-19 cases in Kern County is lower than their share of the KHS member population. This may change as more Kern County residents are tested.



Source: Kern County Public Health COVID-19 Dashboard

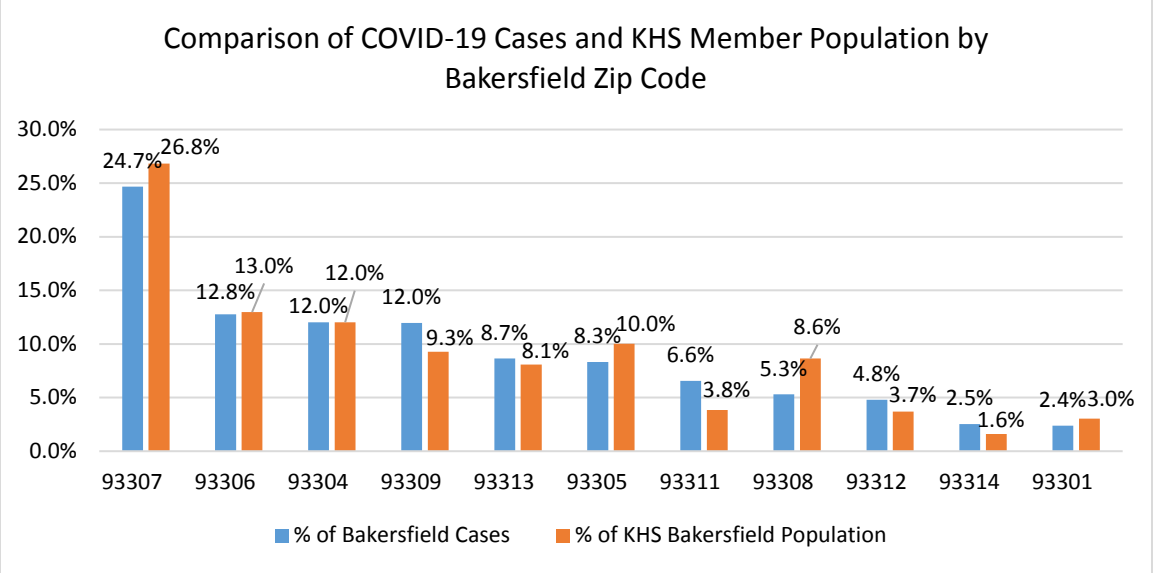


Source: 2019 KHS Member Demographics Data Report

A comparison of Kern County COVID-19 cases by zip code reveals a resemblance to the distribution of KHS members by zip code. The distribution of COVID-19 cases in the top three Bakersfield zip codes is very similar to the distribution of KHS members in the same zip codes.

Bakersfield Zip Code	Population	COVID-19 Case Count	% of Bakersfield Zip Code Cases	KHS Member Population	% of KHS Bakersfield Population
93307	84,948	516	24.7%	45,697	26.8%
93306	70,208	267	12.8%	22,105	13.0%
93304	50,787	251	12.0%	20,490	12.0%
93309	60,893	250	12.0%	15,809	9.3%
93313	51,245	181	8.7%	13,756	8.1%
93305	39,114	174	8.3%	17,069	10.0%
93311	44,862	137	6.6%	6,530	3.8%
93308	54,042	111	5.3%	14,709	8.6%
93312	59,359	100	4.8%	6,295	3.7%
93314	26,992	53	2.5%	2,726	1.6%
93301	12,345	50	2.4%	5,151	3.0%

Sources: Kern County Public Health COVID-19 Dashboard; 2019 KHS Member Demographics Data Report



Sources: Kern County Public Health COVID-19 Dashboard

COVID-19 is likely to disproportionately impact the KHS population compared to the overall county population. KHS members have lower incomes and are more likely to be racial or ethnic minority groups compared to the overall Kern County population. COVID-19 is likely to continue to be a burden for KHS members as they may be less likely to have the option to work from home and limit exposure to the coronavirus. They may be more likely to be or live with essential workers who interact with the general public.

The shelter-in-place mandate due to the COVID-19 pandemic has created significant gaps in KHS' ability to offer health education and cultural and linguistic services to KHS members and its provider network. Although KHS is currently not able to offer any in-person health education services, KHS has used this time as an opportunity to test out virtual health education sessions with members. KHS anticipates that members will be reluctant to attend in-person group classes due to COVID-19 concerns and fears. A survey among KHS' PP/CAC identified virtual health education classes as the primary service that would be most effective with KHS members and in-person classes as being the least effective. KHS will continue to expand its virtual health education services as member demand increases. For members who do not have access to a smart device, limited internet access, or are technologically challenged, KHS will need to continue to look for options that address this health education service gap.

V. Action Plan

Objective 1: *By May 2023, there will be a 5% increase in the percentage of newly enrolled members and members aged 0-15 months, 3-6 years and 12-21 years accessing preventive care services as measured by the W15, W34 and AWC MCAS measures and KHS' IHA Completion rate.* **Data Source:** *(RY 2019 HEDIS Data, KHS Claims Data, 2019 DHCS Health Disparities Rate)*
Strategies
1. Implement member rewards programs that encourage members to see their PCP for a wellness exam at age appropriate intervals.
2. Create a member and provider communication and outreach plan, timeline and calendar to promote the importance of wellness exams and member rewards programs through all KHS communication channels, health education classes, community partners and KHS' provider network.
3. Procure an Interactive Voice Response (IVR) solution to assist with performing member outreach through automated calls on preventive care and gaps in care.
4. Partner with schools, network providers and School Wellness Centers to bridge the gap in member's access to preventive care services.
5. Obtain member feedback on the member rewards program, reward interests and barriers to accessing preventive care services that is inclusive of cultural beliefs on accessing care.
6. Show gaps in care to members through the Member Portal
7. Provide visibility to gaps in care to all member facing staff and KHS' provider network.
8. Create monthly reports for each new rewards program to monitor and track member participation and effectiveness of the rewards program.
9. Develop a program evaluation plan, methodology and timeline for the member rewards program.
10. Develop and distribute a MCAS Provider Booklet that explains each MCAS measure for MY 2020 and offer tips for saying compliant.

Objective 2: *By June 2021, increase the percentage of African American members who receive all recommended childhood immunizations by the age of 2 years from 41% to 46%.* **Data Source:** *(RY 2019 HEDIS Data, 2019 DHCS Health Disparities Rate Sheet)*
Strategies
1. Partner with local community based organizations, such as the Black Infant Health program, to encourage and educate parents on the importance of completing childhood immunizations for members under 2 years of age.
2. Create an outreach script and leverage KHS' IVR solution to send automated childhood immunization reminder calls to African American member households with a member under 2 years of age.
3. Identify and develop outreach material that connects African American members to childhood immunizations.
4. Distribute preventive care guides and well-baby reward postcards and posters to family resource centers and community programs and at community events that focus on the African American population.

5.	Identify geographic areas within the county that have a high concentration of African American members and work with the providers in these areas to distribute outreach and educational material.
6.	Distribute a provider bulletin on the health disparity correlation between African Americans and childhood immunizations.
7.	Include an article in the Spring 2021 member newsletter that provides resources on where to obtain childhood immunizations.
8.	Coordinate social or mass media messaging on childhood immunizations during national observances, such as Black History Month and World Children's Day.

VI. Stakeholder Engagement

KHS' PP/CAC is comprised of members and representatives from the county's Department of Human Services, KCDPHS, Family Resource Centers, and the Center for Gender Identity and Sexual Diversity. The PP/CAC was engaged to provide input on KHS' PNA through an online and telephonic survey on the current issues impacting the community, major challenges KHS members face when accessing services, suggestions on how to encourage participation in preventive care screenings and health education services, and how to improve KHS' understanding of the diverse cultural and linguistic needs of KHS members. Due to the COVID-19 pandemic, KHS was limited in its ability to obtain in-person feedback from the PP/CAC and other community groups.

The PNA findings and action plan will be presented to KHS' Quality Improvement/Utilization Management Committee which is comprised of KHS primary care providers, specialists, pharmacies, home health and durable medical equipment providers. KHS' contracted provider network will be notified of the PNA findings and action plan through the KHS website, provider portal and provider bulletin. Providers will be encouraged to contact KHS' Director of Health Education, Cultural and Linguistic Services for additional information, questions and comments.

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Health Services Quarterly Committee Reporting- Reporting Period April 1, 2020 thru June 30, 2020

Health Services Overview

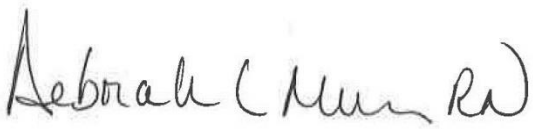
The 2020 membership enrollment remained stable at 261,000 in Q2 2020. Additional benefit coverage and broadening interdisciplinary collaboration to support the membership growth will continue through 2020.

- COVID-19 Impact
  - Referral requests
  - Elective procedures
  - After Hours Support

- Back to Care Initiative
  - Preventative Services

The following pages reflect statistical measurements for Utilization Management, Case Management and Disease Management detailing the ongoing compliance activity for the 2nd Quarter 2020.

Respectfully submitted,



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

Utilization Management Reporting

Timeliness of Decision Trending

Summary:

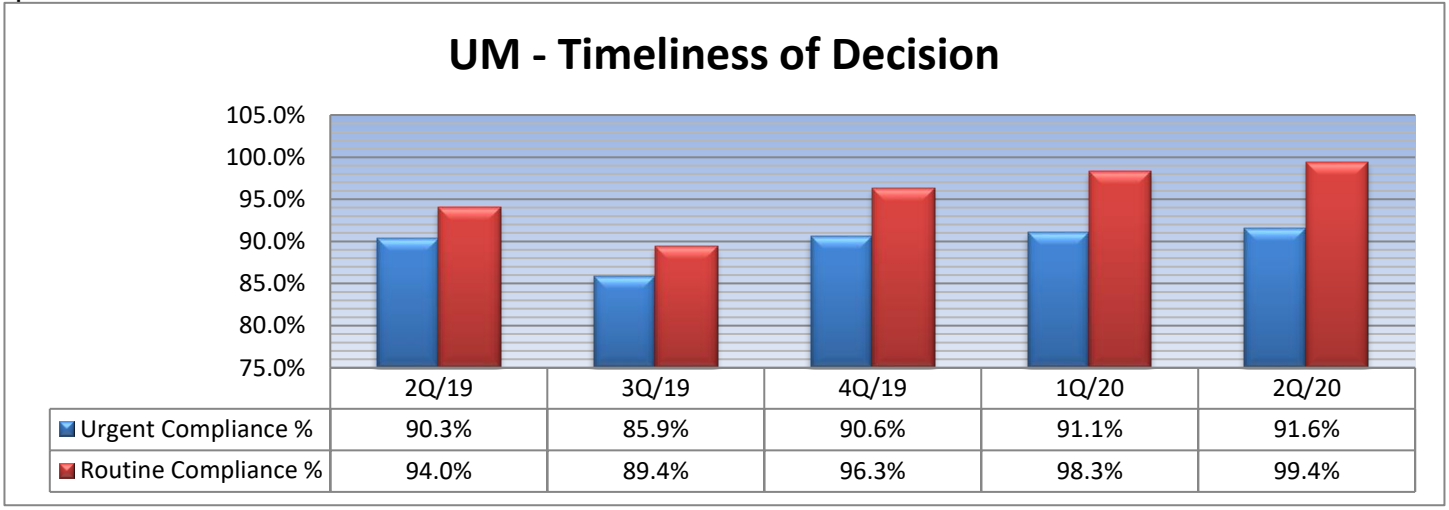
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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

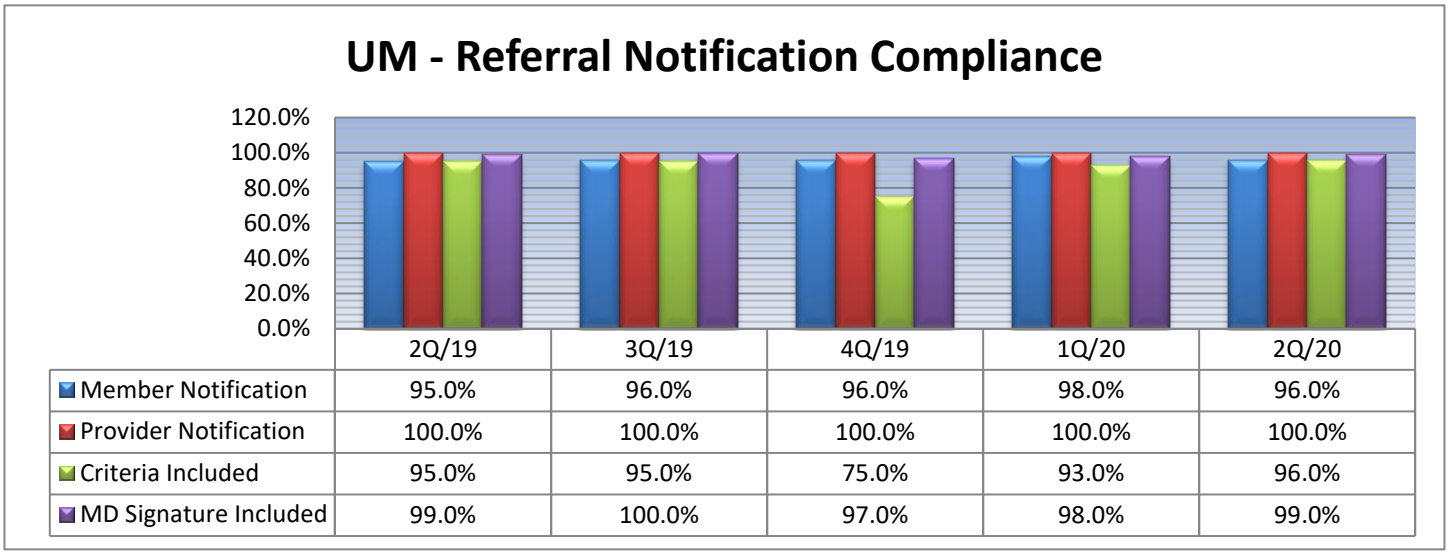
There were 41,130 referrals processed in the 2nd quarter 2020 of which 3,701 referrals were reviewed for timeliness of decision. In comparison to the 1st quarter's processing time, routine referrals increased from the 1st quarter which was 98.3% and urgent referrals increased from the 1st quarter which was 91.1% to 96.1%.



	2Q/19	3Q/19	4Q/19	1Q/20	2Q/20
Urgent Compliance %	90.3%	85.9%	90.6%	91.1%	91.6%
Routine Compliance %	94.0%	89.4%	96.3%	98.3%	99.4%

Audit Criteria:

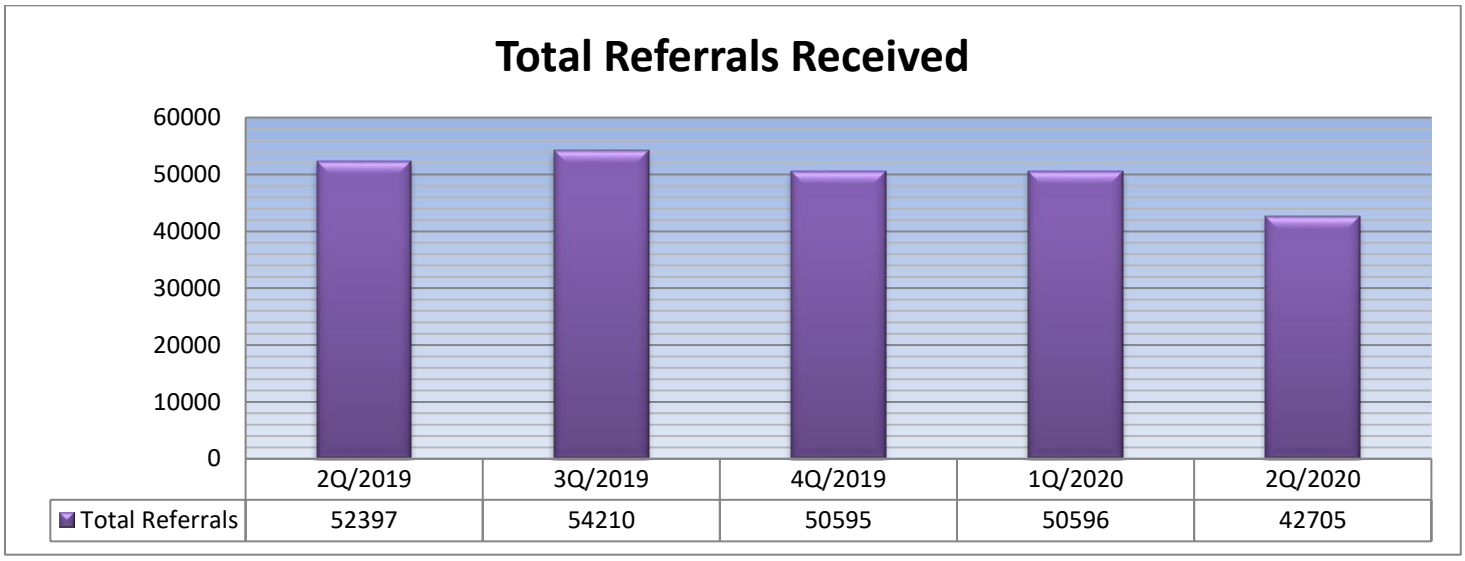
- Member Nofication: Letter of referral decision sent to member within 24 hours
- Provider Notification: Referral is faxed back to the provider with 24 hours of decision
- Criteria Included: Criteria provided to provider on denial reason
- MD Signature: MD Signature included all referrals/NOA letters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

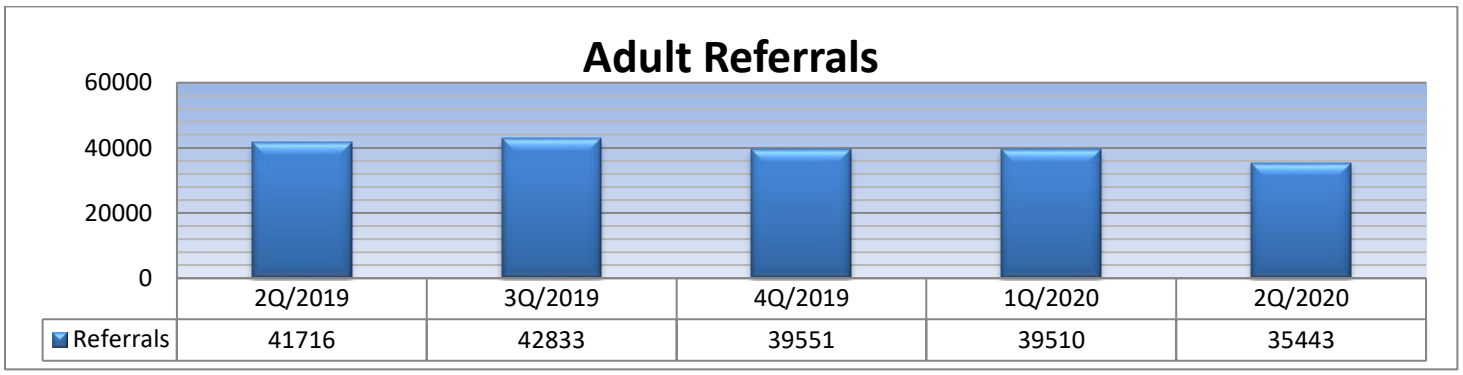


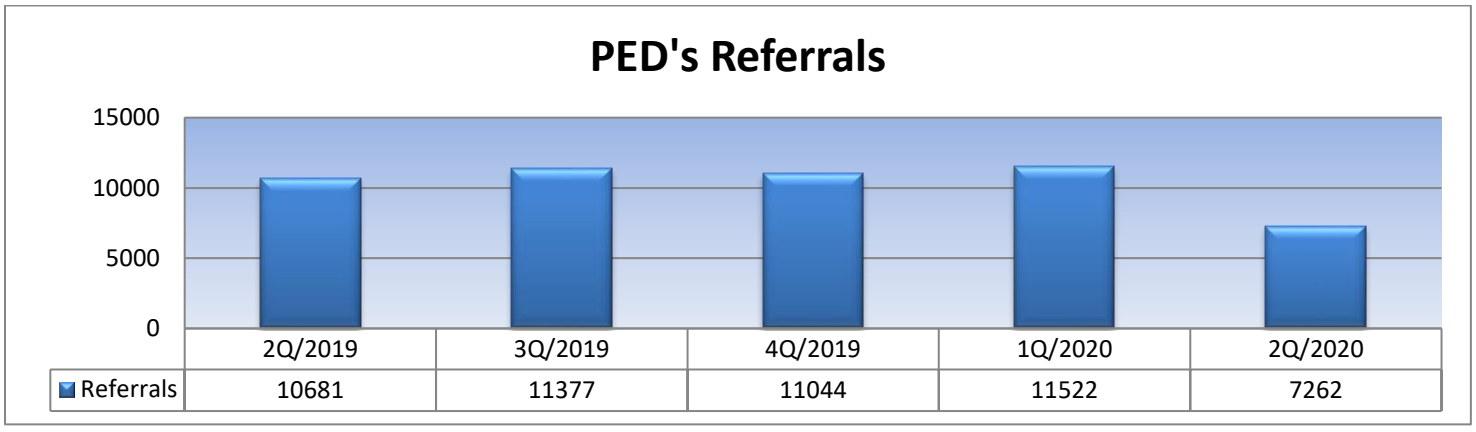
	2Q/19	3Q/19	4Q/19	1Q/20	2Q/20
Member Notification	95.0%	96.0%	96.0%	98.0%	96.0%
Provider Notification	100.0%	100.0%	100.0%	100.0%	100.0%
Criteria Included	95.0%	95.0%	75.0%	93.0%	96.0%
MD Signature Included	99.0%	100.0%	97.0%	98.0%	99.0%

Summary: Overall compliance rate from the 2nd Qtr. of 2020 is 98% which increased from the 1st Qtr. which was 97%.

Outpatient Referral Statistics

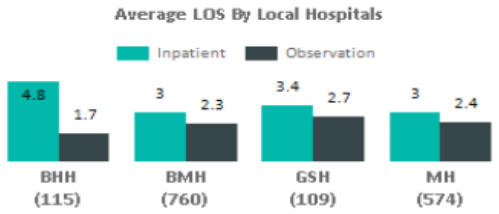


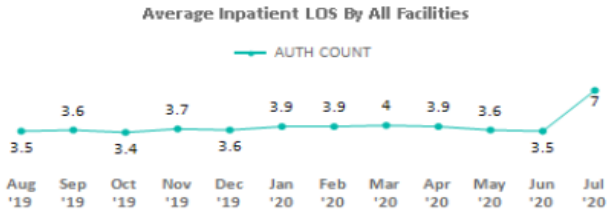




2nd Quarter Inpatient and LOS Report

Adult Admission(Inpatient/Observation)





Participating Providers

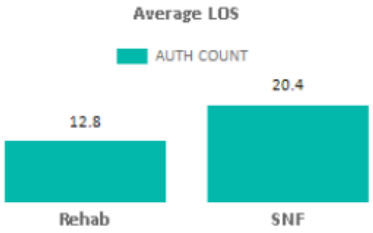
Provider Name	Admit Count	LOS	Avg LOS
ADVENTIST HEALTH BAKERSFIELD S	520	1736	3.34
ADVENTIST HEALTH COMMUNITY CAR	4	11	2.75
ADVENTIST HEALTH MEDICAL CENTE	22	66	3.00
ANTELOPE VALLEY HOSPITAL	1	1	1.00
BAKERSFIELD HEART HOSPITAL	115	508	4.42
BAKERSFIELD MEMORIAL HOSPITAL	760	2186	2.88
BELLAGIO IN THE DESERT	1	14	14.00
DELANO REGIONAL MEDICAL CENTER	72	183	2.54
ENCOMPASS HEALTH REHABILITATIO	3	55	18.33
GOOD SAMARITAN HOSPITAL	109	359	3.29
HOFFMANN HOSPICE OF THE VALLEY	2	5	2.50
KECK HOSPITAL OF USC	78	503	6.45
KERN COUNTY MEDICAL AUTHORITY	569	1714	3.01
KERN VALLEY HEALTHCARE DISTRIC	9	28	3.11
MERCY HOSPITAL	574	1586	2.76
PARKVIEW JULIAN	1	12	12.00
RIDGECREST REGIONAL HOSPITAL	4	10	2.50
SANTA MONICA UCLA MC AND ORTHO	4	15	3.75
SORRENTO IN THE DESERT	3	47	15.67
UCLA MEDICAL CENTER	12	124	10.33
UNITED CARE FACILITIES	6	77	12.83
USC NORRIS CANCER HOSPITAL	2	34	17.00
USC VERDUGO HILLS HOSPITAL	1	7	7.00
VFP HOMES	1	13	13.00
Total	**2873**	**9294**	**3.23**

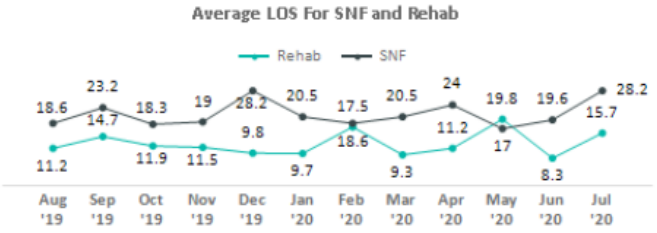
Non Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
ADVENTIST MEDICAL CENTER	1	4	4.00
ADVENTIST SIMI VALLEY HOSPITAL	1	5	5.00
ANTELOPE VALLEY HOSPITAL	48	236	4.92
BAPTIST HEALTH MEDICAL CENTER	1	3	3.00
CALIFORNIA HOSPITAL MEDICAL CE	1	7	7.00
CEDARS SINAI MEDICAL CENTER	3	48	16.00
CENTINELA HOSPITAL MEDICAL GRO	1	21	21.00
CHI ST VINCENT HOSPITAL HOT SP	1	7	7.00
COMMUNITY MEMORIAL HOSPITAL OF	1	4	4.00
DAMERON HOSPITAL ASSOCIATION	2	4	2.00
ERLANGER MEDICAL CENTER	1	3	3.00
FREEMAN HEALTH SYSTEM	1	2	2.00
FRESNO COMMUNITY HOSPITAL AND	7	30	4.29
GL MEE MEMORIAL HOSPTIAL	1	2	2.00
GLENDALE MEMORIAL HO	1	3	3.00
HEMET VALLEY MED	1	10	10.00
HENRY MAYO NEWHALL	11	25	2.27
HUNTINGTON MEMORIAL HOSPITAL	1	2	2.00
JOHN MUIR MED CENTER	2	7	3.50
JOHN MUIR MEDICAL CENTER	1	5	5.00
KAISER FOUNDATION HOSPITAL	1	1	1.00
KAWEAH DELTA MEDICAL CENTER	1	15	15.00
KINDRED HOSPITAL SAN GABRIEL	2	64	32.00
KND DEVELOPEMENT	1	45	45.00
KND REAL ESTATE 40 LLC	5	72	14.40
LAC HARBOR-UCLA MED CTR -HUMC	1	4	4.00
LAC-USC MEDICAL CTR	2	39	19.50
LANCASTER HOSPITAL CORPORATION	6	48	8.00
LOMA LINDA UNIVERSITY	1	4	4.00
LOMA LINDA UNIVERSITY MEDICAL	1	37	37.00
MARIAN REGIONAL MEDICAL CENTER	1	2	2.00
MCALLEN MEDICAL CENTER	1	6	6.00

MEMORIAL HOSPITAL OF GARDENA	2	4	2.00
MERCY MEDICAL CENTER	1	1	1.00
MILLS PENINSULA MEDICAL CENTER	1	1	1.00
MOUNTAIN VIEW HOSPITAL	2	23	11.50
NON PARTICIPATING PROVIDER	1	4	4.00
NORTHBAY MEDICAL CENTER	1	1	1.00
NORTHRIDGE HOSPITAL MEDICAL CE	1	34	34.00
PACIFICA HOSPITAL OF THE VALLE	1	1	1.00
PARKSIDE CONGREGATE LIVING, IN	1	21	21.00
PRESBYTERIAN INTERCOMMUNITY HO	1	3	3.00
PRIME HEALTHCARE SERVICES	1	2	2.00
PROVIDENCE HOLY CROSS MEDICAL	1	2	2.00
QUEEN OF VALLEY CAMPUS	2	4	2.00
REGIONAL MEDICAL CENTER BAYONE	1	20	20.00
RIVERSIDE COMMUNITY HOSPITAL	2	9	4.50
SAINT AGNES MEDICAL CENTER	2	3	1.50
SALEM HOSPITAL	1	3	3.00
SALINAS VALLEY HOSPITAL	1	4	4.00
SAN FRANCISCO GENERAL MED CENT	1	2	2.00
SANTA PAULA HOSPITAL	1	2	2.00
SANTA ROSA MEMORIAL HOSPITAL	1	1	1.00
SCRIPPS MERCY	1	13	13.00
SIERRA VISTA REGIONAL MEDICAL	2	2	1.00
SOUTHERN CALIFORNIA PERMANENTE	1	3	3.00
ST JOSEPH HOSPITAL HUMBOLDT	1	2	2.00
ST JOSEPHS MEDICAL	1	3	3.00
TEMECULA VALLEY HOSPITAL INC	1	8	8.00
UCSD MEDICAL CENTER	1	8	8.00
UCSF MEDICAL CENTER	1	6	6.00
UNIVERSITY MEDICAL CENTER	1	2	2.00
UNIVERSITY OF CALIFORNIA DAVIS	1	3	3.00
VALLEY BAPTIST HEALTH SYSTEM	2	6	3.00
VERITAS HEALTH SERVICES, INC.	1	1	1.00
VICTOR VALLEY GLOBAL MEDICAL C	2	2	1.00
WELLSTAR PAULDING HOSPITAL	1	4	4.00
WHITE MEMORIAL MEDICAL CENTER	1	1	1.00
Total	**164**	**992**	**6.05**

Adult Admissions (SNF/Rehab)





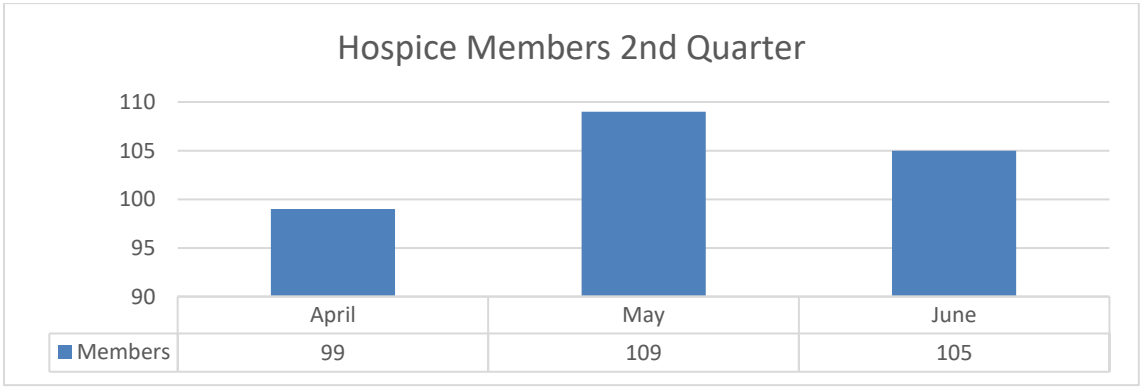
Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
BELLAGIO IN THE DESERT	4	57	14.25
CAPRI IN THE DESERT	3	58	19.33
DELANO POSTACUTE CARE	5	134	26.80
ENCOMPASS HEALTH REHABILITATIO	28	331	11.82
GGNSC SHAFTER LP	5	157	31.40
GOOD SAMARITAN HOSPITAL	8	163	20.38
HOFFMANN HOSPICE OF THE VALLEY	4	354	88.50
MERCY HOSPITAL	1	1	1.00
NAPOLI IN THE DESERT	1	33	33.00
PARKVIEW JULIAN	7	121	17.29
ROSE DESERT CONGREGATE	1	13	13.00
SORRENTO IN THE DESERT	19	295	15.53
UNITED CARE FACILITIES	70	1170	16.71
VFP HOMES	9	195	21.67
Total	**165**	**3082**	**18.68**

Non Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
GLADSTONE CARE AND REHABILITAT	1	27	27.00
KINGSTON HEALTHCARE CENTER	5	104	20.80
LOS ANGELES CARE CENTER	1	1	1.00
ONE AND ONLY CONGREGATE LIVING	1	52	52.00
PACIFICA HOSPITAL OF THE VALLE	5	74	14.80
PARADISE CONGREGATE LIVING	1	8	8.00
PARKSIDE CONGREGATE LIVING, IN	5	188	37.60
WEST VALLEY CONGREGATE HEALTH	2	39	19.50
Total	**21**	**493**	**23.48**

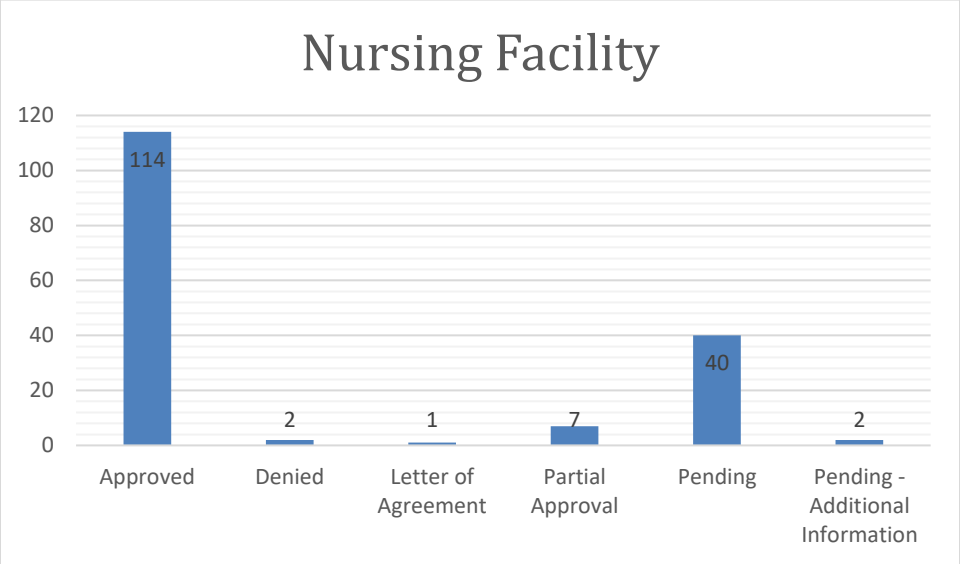
Disclaimer: SNF/LTC should not be calculated in the acute hospital LOS and PAR/NPAR not accurately reflected--report under revision.

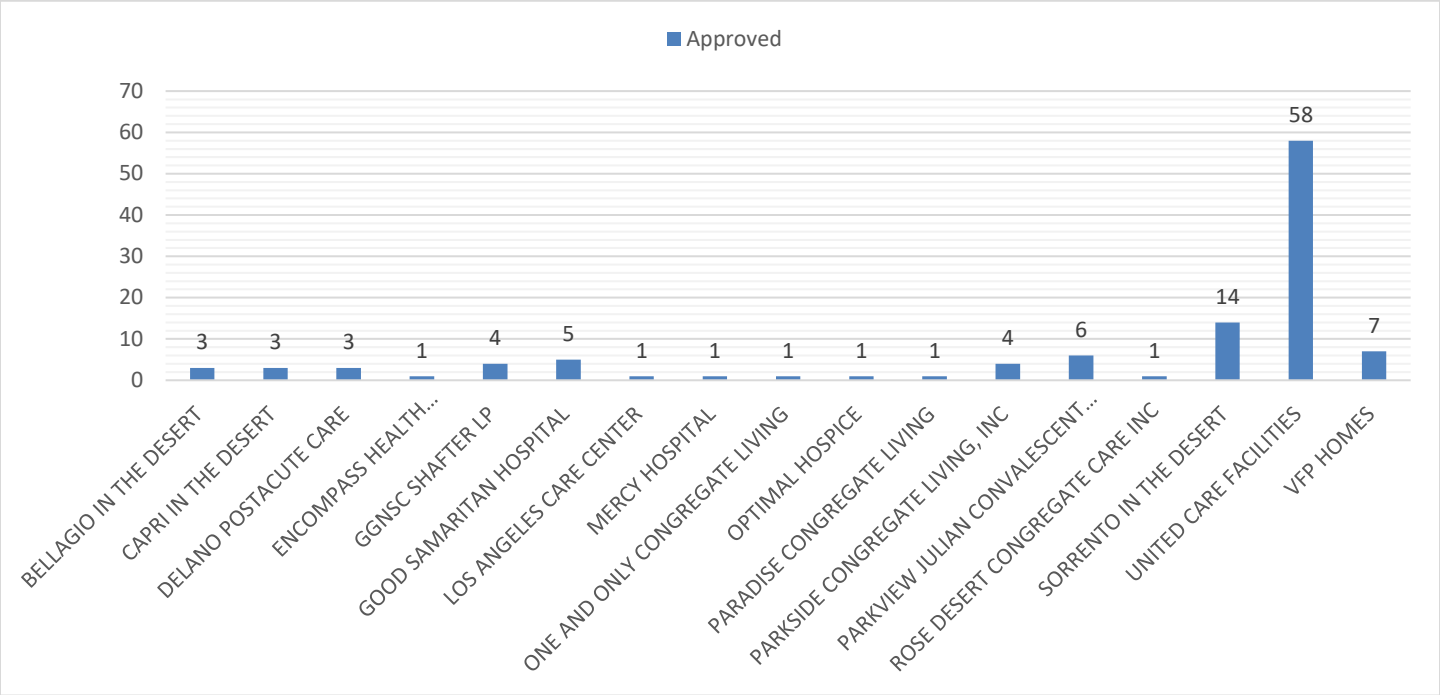


Nursing Facility Services Report

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.

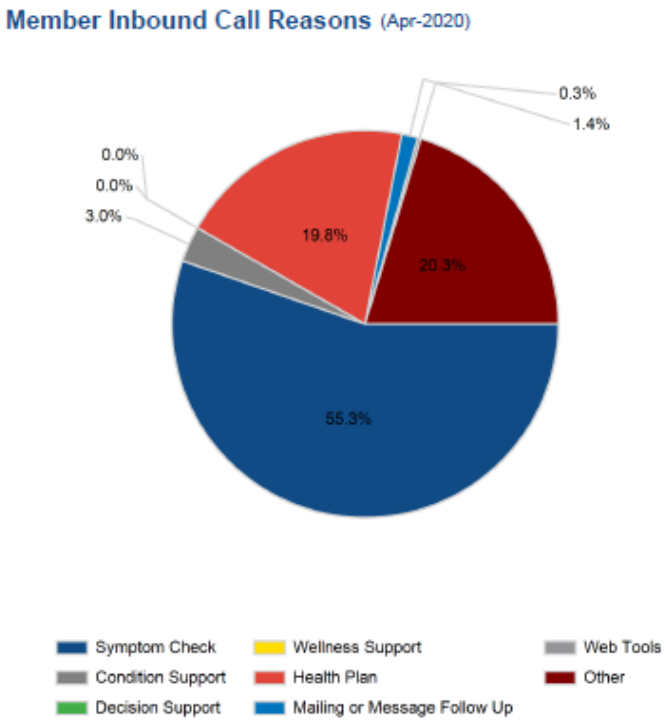
Summary: Summary: During the 2nd quarter 2020, there were 171 referrals for Nursing Facility Services. The average length of stay was 31.2 days for these members. During the 1st quarter there was only 6 denials of the 190 referrals.



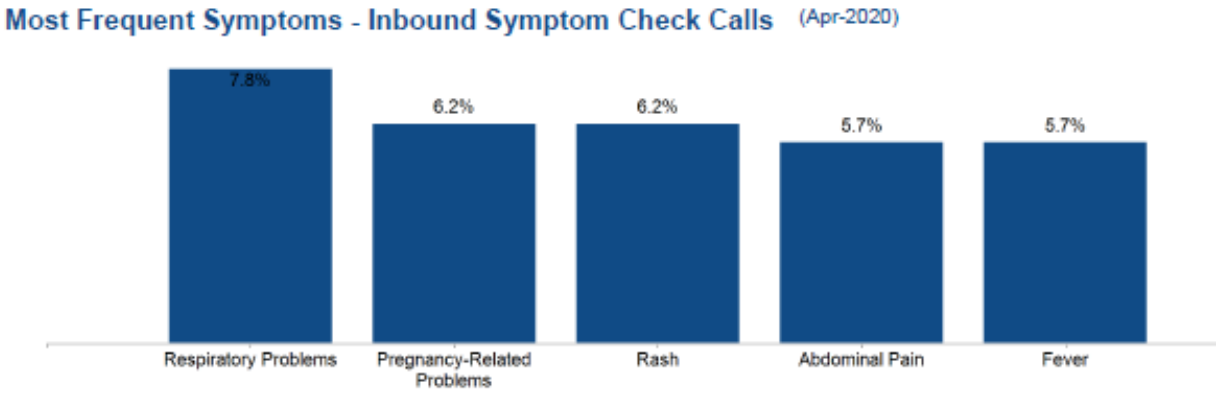

Approved
70
60
50
40
30
20
10
0
3
3
3
1
4
5
1
1
1
1
1
4
6
1
14
58
7
BELLAGIO IN THE DESERT
CAPRI IN THE DESERT
DELANO POSTACUTE CARE
ENCOMPASS HEALTH...
GGNSC SHAFTER LP
GOOD SAMARITAN HOSPITAL
LOS ANGELES CARE CENTER
MERCY HOSPITAL
ONE AND ONLY CONGREGATE LIVING
OPTIMAL HOSPICE
PARADISE CONGREGATE LIVING
PARKSIDE CONGREGATE LIVING, INC
PARKVIEW JULIAN CONVALESCENT...
ROSE DESERT CONGREGATE CARE INC
SORRENTO IN THE DESERT
UNITED CARE FACILITIES
VFP HOMES

Health Dialog Report

April:

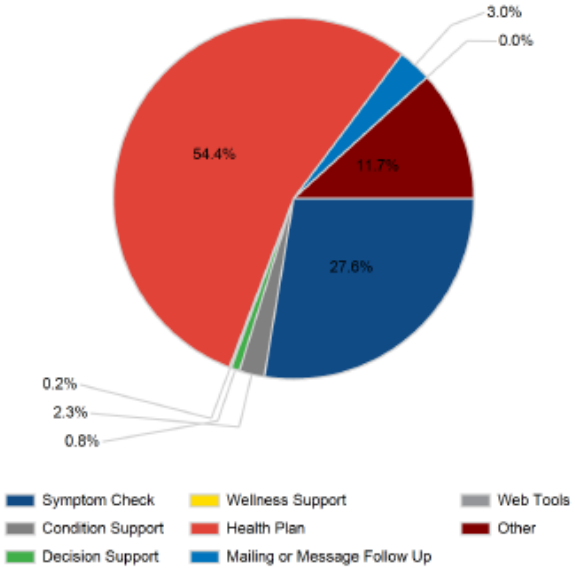


REASON	NUMBER
Symptom Check	204
Condition Support	11
Decision Support	0
Wellness Support	0
Health Plan	73
Mailing or Message Follow Up	5
Web Tools	1
Other	75



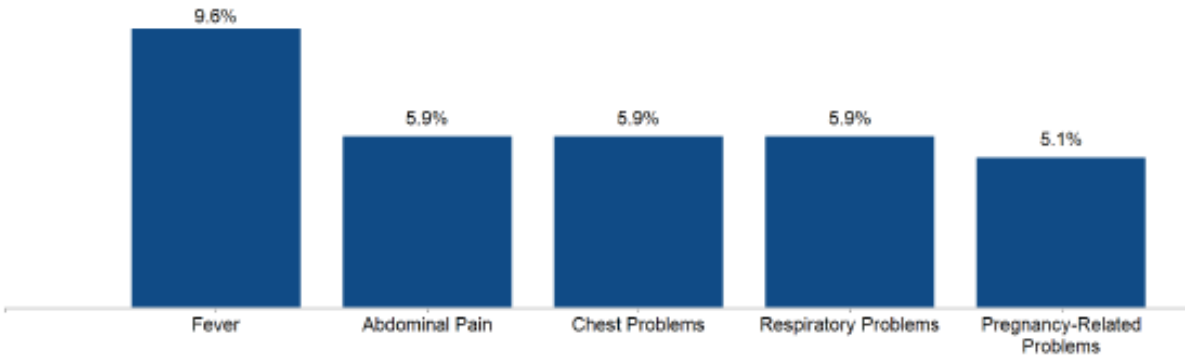
May:

Member Inbound Call Reasons (May-2020)



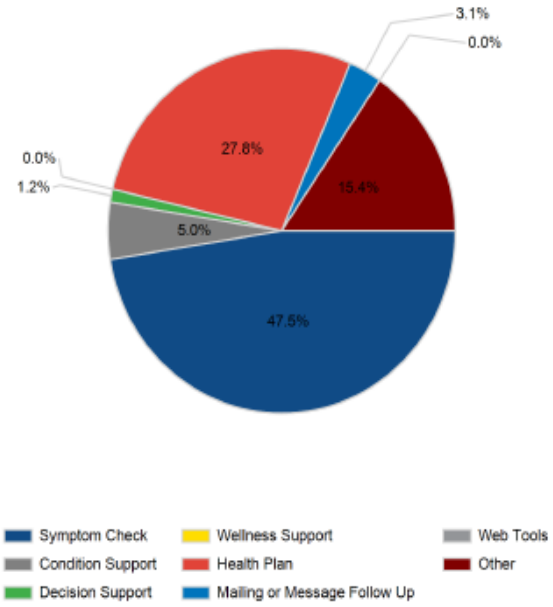
REASON	NUMBER
Symptom Check	146
Condition Support	12
Decision Support	4
Wellness Support	1
Health Plan	288
Mailing or Message Follow Up	16
Web Tools	0
Other	62

Most Frequent Symptoms - Inbound Symptom Check Calls (May-2020)



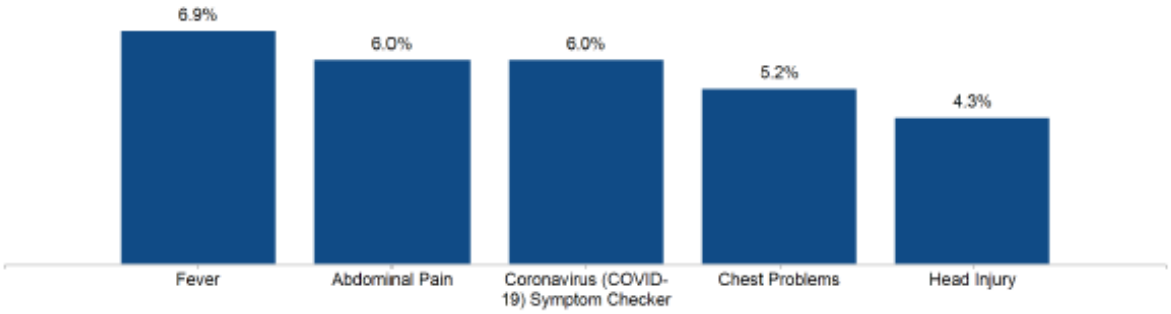
June:

Member Inbound Call Reasons (Jun-2020)

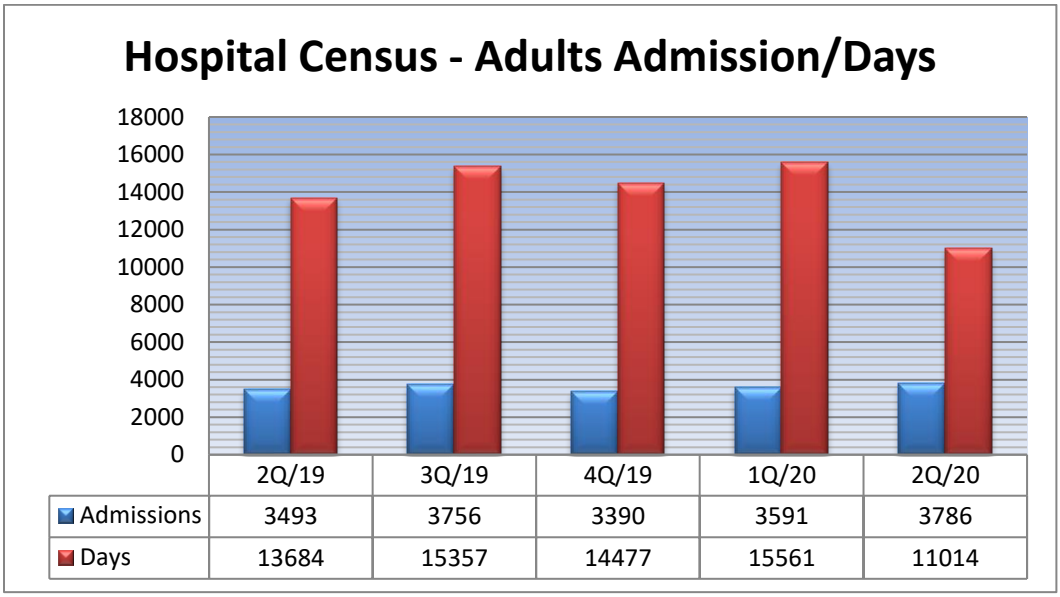


REASON	NUMBER
Symptom Check	123
Condition Support	13
Decision Support	3
Wellness Support	0
Health Plan	72
Mailing or Message Follow Up	8
Web Tools	0
Other	40

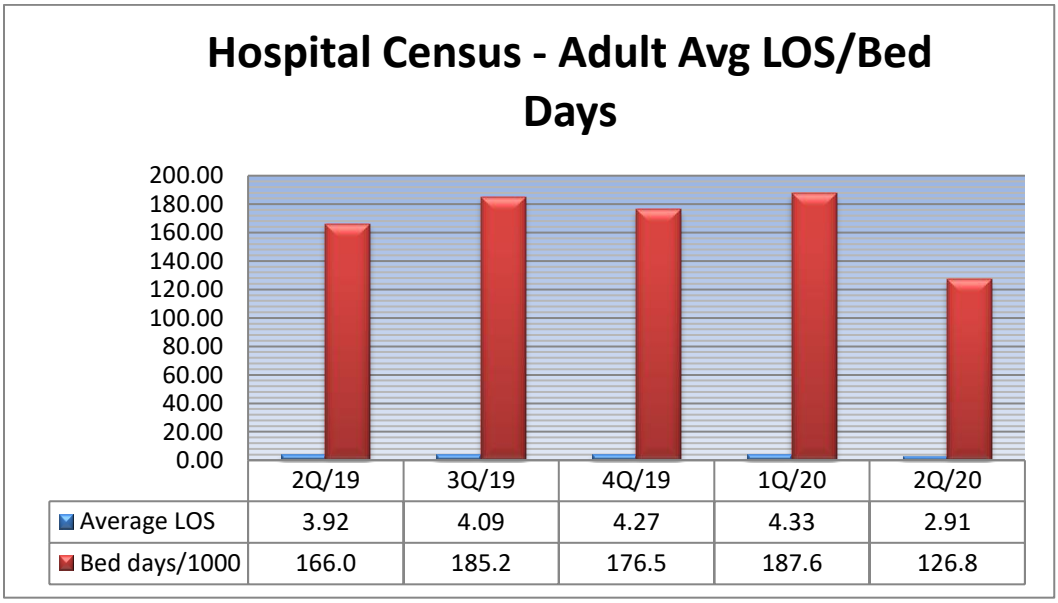
Most Frequent Symptoms - Inbound Symptom Check Calls (Jun-2020)



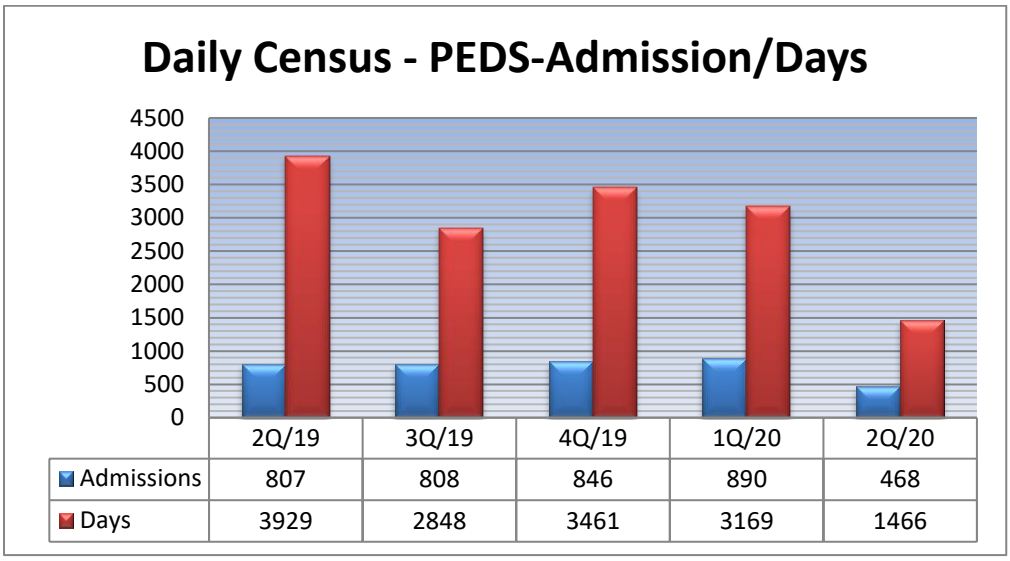
Inpatient 2nd Quarter Trending



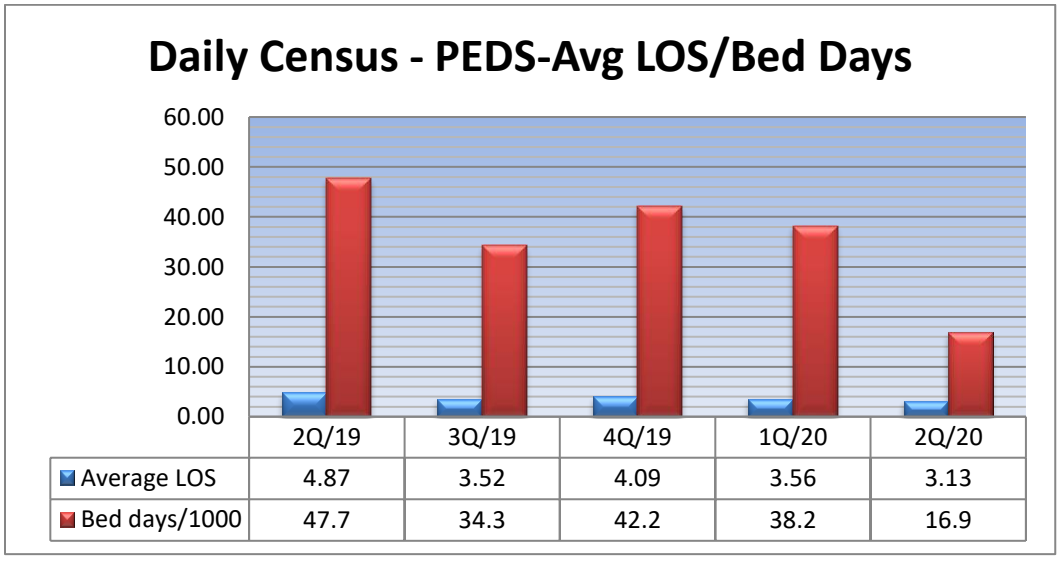
	2Q/19	3Q/19	4Q/19	1Q/20	2Q/20
Admissions	3493	3756	3390	3591	3786
Days	13684	15357	14477	15561	11014



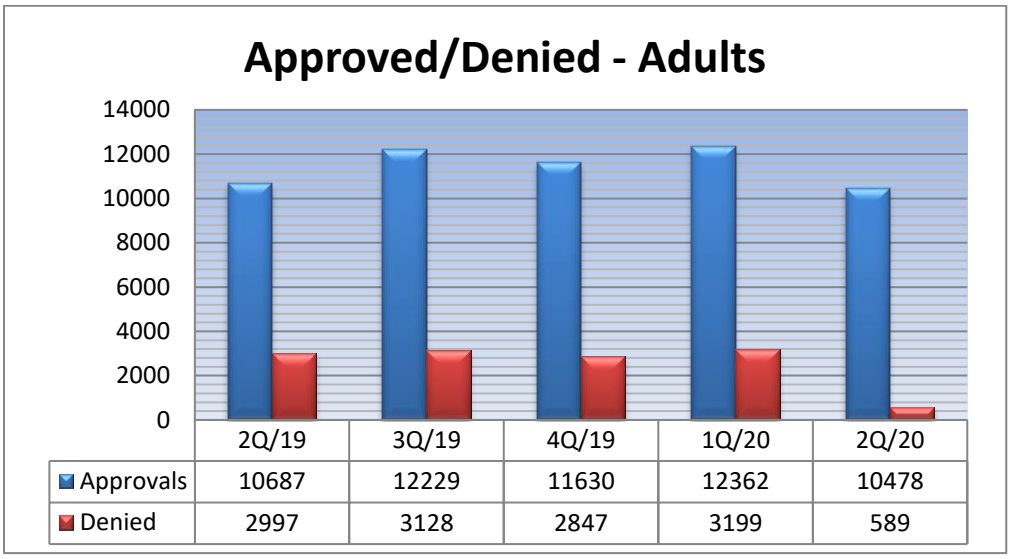
	2Q/19	3Q/19	4Q/19	1Q/20	2Q/20
Average LOS	3.92	4.09	4.27	4.33	2.91
Bed days/1000	166.0	185.2	176.5	187.6	126.8



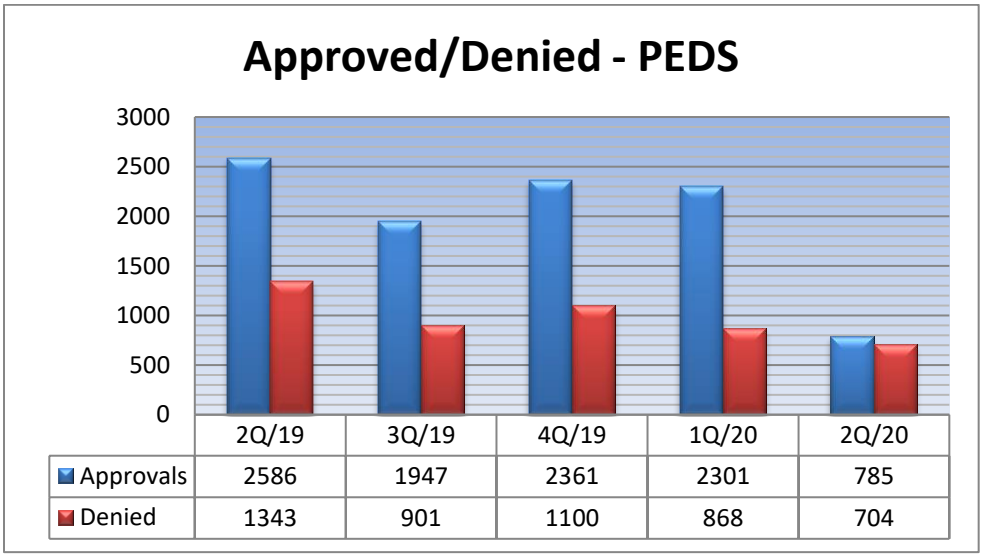
	2Q/19	3Q/19	4Q/19	1Q/20	2Q/20
Admissions	807	808	846	890	468
Days	3929	2848	3461	3169	1466



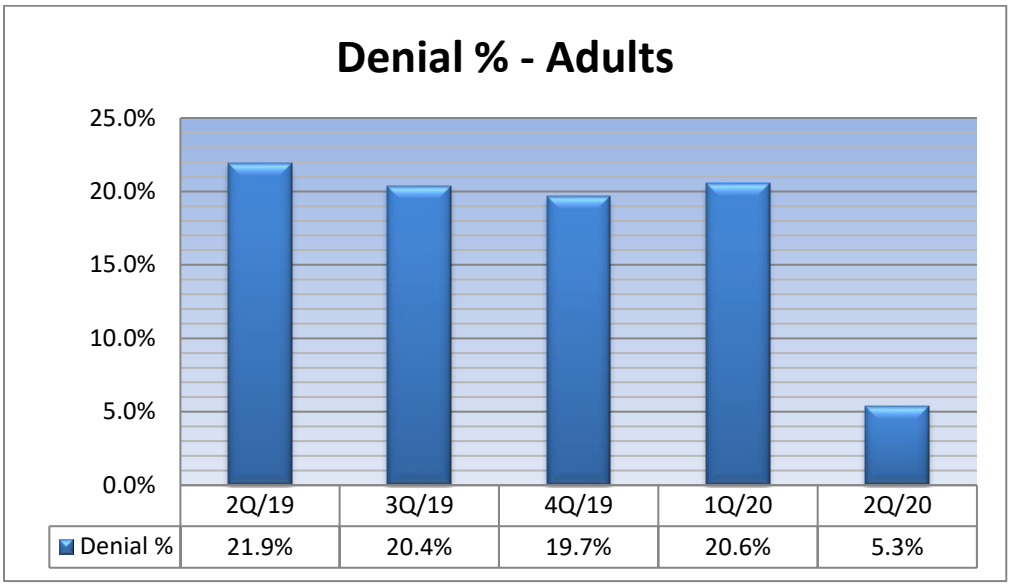
	2Q/19	3Q/19	4Q/19	1Q/20	2Q/20
Average LOS	4.87	3.52	4.09	3.56	3.13
Bed days/1000	47.7	34.3	42.2	38.2	16.9

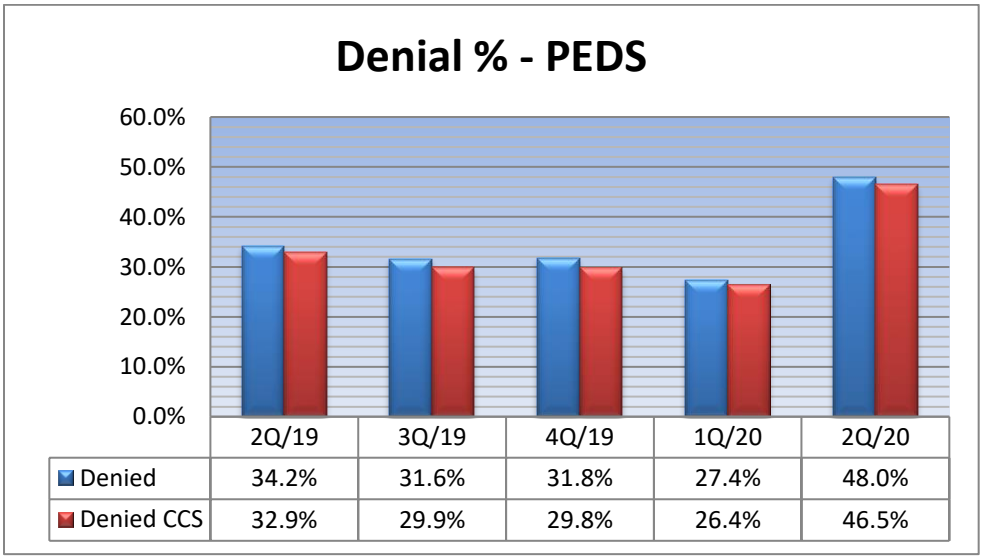


	2Q/19	3Q/19	4Q/19	1Q/20	2Q/20
Approvals	10687	12229	11630	12362	10478
Denied	2997	3128	2847	3199	589



	2Q/19	3Q/19	4Q/19	1Q/20	2Q/20
Approvals	2586	1947	2361	2301	785
Denied	1343	901	1100	868	704





Continuity of Care

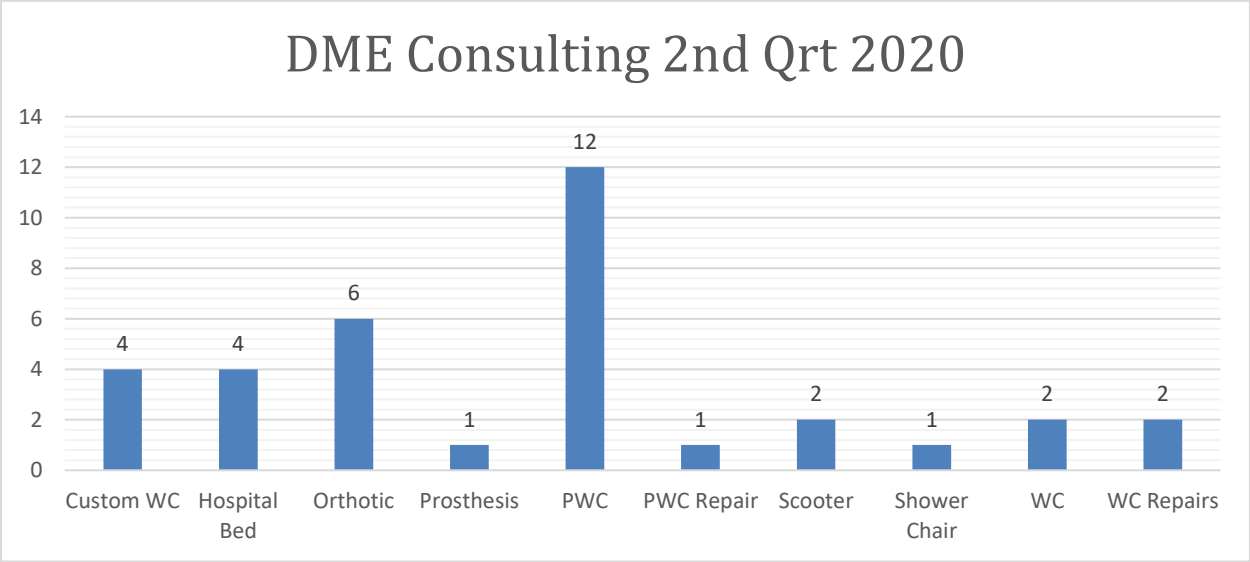
Total Referral – 5

Total Approval – 5

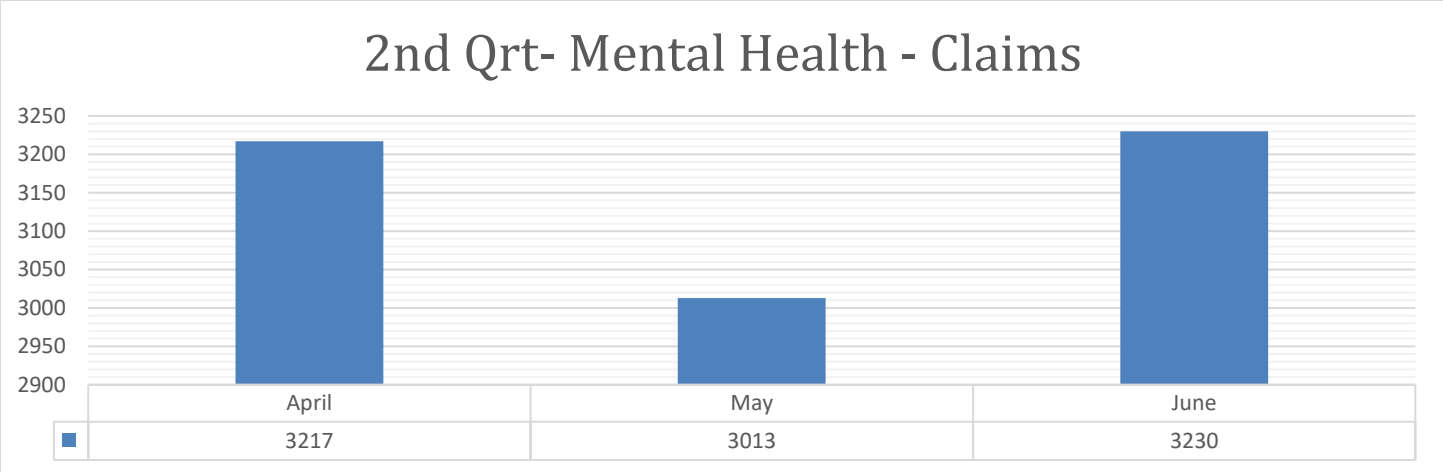
Total Denial - 0

Total SPD COC -4

DME Consulting



Mental Health



ABA Services

UNIQUE CASES		Mild	Moderate	Severe	Pending Dx	Total
MEMBER COUNT		54	92	14	34	194
Severity %		27.84%	47.42%	7.22%	18%	100%
SEVERITY	Apr	May	Jun	Total		
MILD	12	31	13	56		
MODERATE	35	28	33	96		
SEVERE	3	6	5	14		
Approved FBA	62	61	59	182		
Approved Treatment	60	75	70	205		
PENDING DX	10	10	19	39		
	Apr	May	Jun	Total		
AGE 7 OR LESS	35	42	41	118		
AGE 8 OR GREATER	25	33	29	87		
TOTAL	60	75	70	205		
% < 7	58.33%	56.00%	58.57%	57.56%		
% > 8	41.67%	44.00%	41.43%	42.44%		

Diabetic Exam Reminder Effectiveness Report

Client: KERN HEALTH SYSTEMS - 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	July	591	40	35	75
	August	541	42	25	67
	September	4,151	239	177	416
	October	525	50	29	79
	November	0	0	0	0
	December	1,916	139	20	159
2020	January	878	52	7	59
	February	503	18	2	20
	March	0	0	0	0
	April	6,190	26	0	26
	May	1,677	8	0	8
	June	1,367	0	0	0
Totals		**18,339**	**614**	**295**	**909**

LTM Effectiveness* : 5 %

12-Month Effectiveness (Jan 2019 - Dec 2019) : 9 %

* 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: July, 2019 through June, 2020
Prepared for: KERN HEALTH SYSTEMS - (12049397)

Reported Cases

	Members	
Received Eye Exam:	23,928	
Diabetes?:	1,296	5.4%
Diabetic Retinopathy:	212	.9%
Glaucoma:	313	1.3%
Hypertension:	974	4.1%
High Cholesterol	396	1.7%
Macular Degeneration:	44	.2%

Estimated Number of Cases

Total Members:	252,378	
Diabetes?:	6,008	2.4%
Diabetic Retinopathy:	532	.2%
Glaucoma:	1,005	.4%
Hypertension:	26,058	10.3%
High Cholesterol	38,308	15.2%
Macular Degeneration:	335	.1%

KERN HEALTH SYSTEMS
CASE MANAGEMENT DEPARTMENT MONTHLY REPORT

Report Date: July 9th, 2020

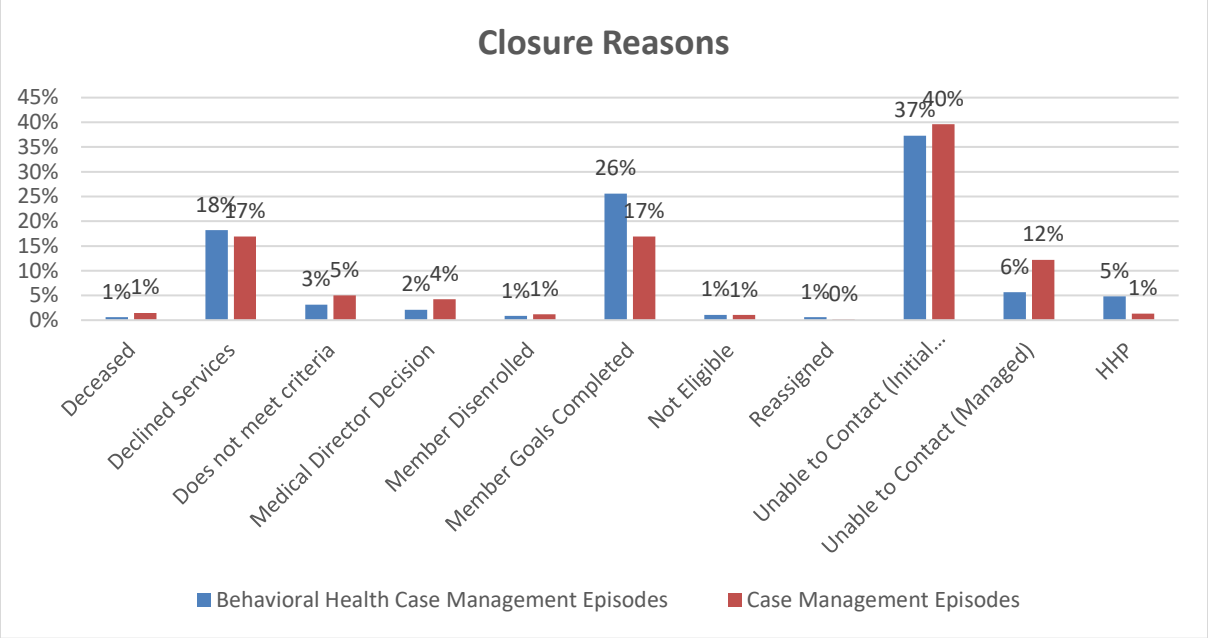
Reporting Period: April 1st, 2019- June 30th, 2019

During the months of April thru June, a total of 1,392 members were managed by the Case Management Department.

Episode Type	Closed Episodes	Open Episodes	Referral Episodes	Total
Case Management	685	139	5	829
Behavioral Health Case Management	480	80	3	563

Episode Source other than ACG Modeler	Behavioral Health Management Episodes	*Percentage*	Case Management Episodes	*Percentage*
All Internally Generated Complex Case Management	11	3%	112	35%
All Internally Generated Disease Management	1	0%	2	1%
All Internally Generated Grievance	3	1%	7	2%
All Internally Generated Hospital Discharge	1	0%	18	6%
All Internally Generated Medical Director	1	0%	21	7%
All Internally Generated Member Request	7	2%	8	2%
All Internally Generated UM Generated	7	2%	8	2%
CEG Modeler	0	0%	1	0%
BH Mental Health	8	2%	0	0%
CM DM HE Facility Based Social Worker	3	1%	0	0%
CM DM HE Health Education	5	1%	1	0%
CM DM HE Member Services	14	4%	11	3%
CM DM HE Provider	4	1%	5	2%
CM DM High ER Utilizer	99	26%	0	0%
Critical High Risk SPD	3	1%	0	0%
DM HE Social Worker Case Management	3	1%	4	1%
HE Postpartum Claim	4	1%	0	0%

HE Prenatal Claim	7	2%	0	0%



Members Closed and Referred to HHP	Behavioral Health Case Management Episodes	Case Management Episodes
HHP	2	9

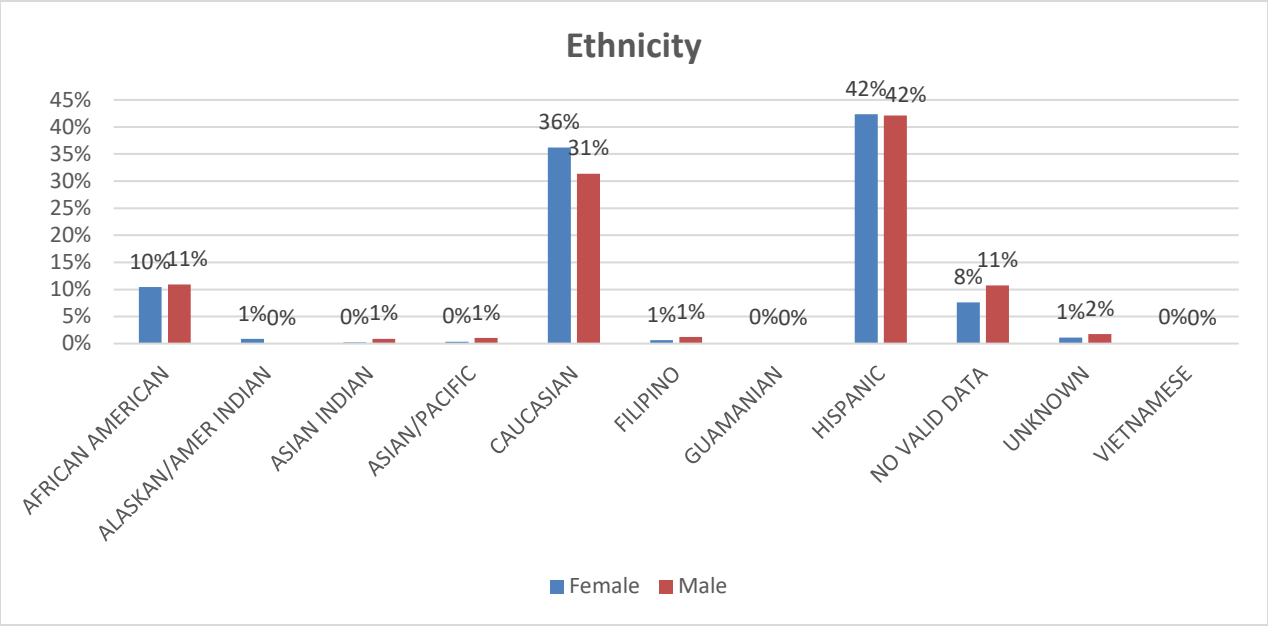
Closed Episodes with Admits within 30 days after Closure	Total
Behavioral Health Case Management	15
Case Management	50
Percentage of closed cases Readmitted	3%

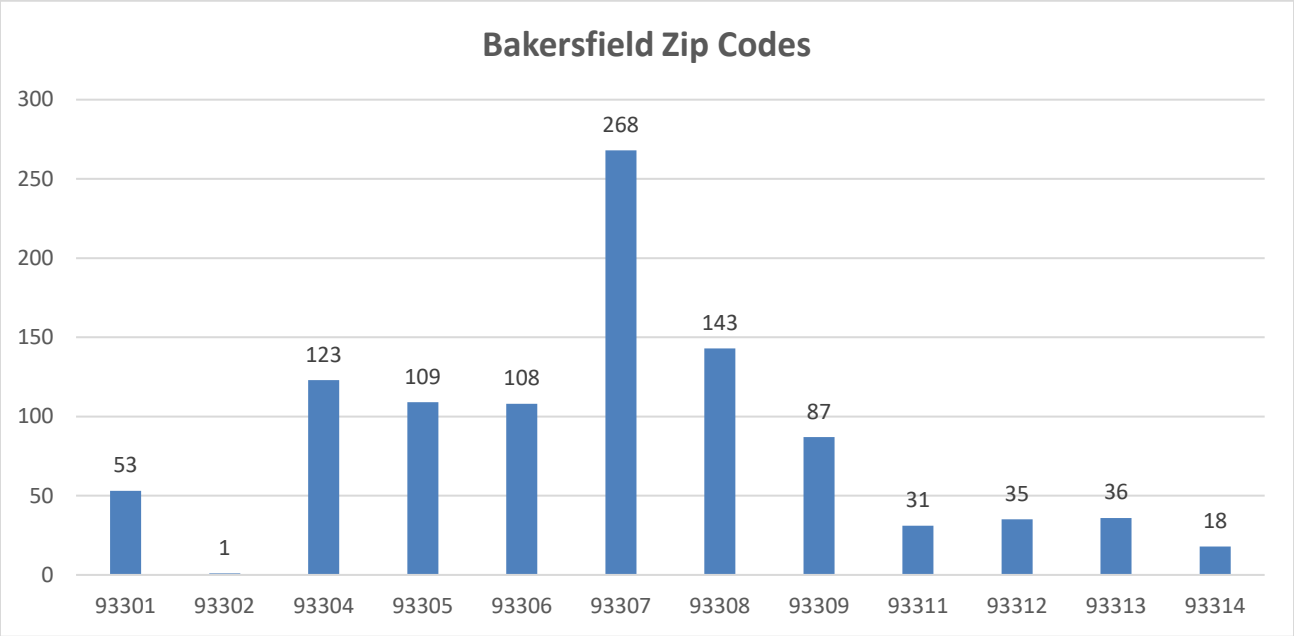
Assessments/Plan of Care	Behavioral Health Case Management Episodes	Case Management Episodes	Total
Assessments	76	129	205
Plan of Care	75	133	208

During the months of April thru June, 95% of the members managed were 65 years of age or younger.

Age	<18	18-40	41-65	>65	Total
Case Management	34	168	577	50	829
Behavioral Case Management	55	190	298	20	563

Of the 1,392 members managed during the months of April thru June, the majority of members were female at 59%. The majority of members' ethnicity was Hispanic at 42%.





Outlying Areas

City	Total
ARVIN	28
BODFISH	7
BORON	2
BUTTONWILLOW	3
CALIF CITY	16
DELANO	68
FRAZIER PARK	5
INYOKERN	2
KINGMAN	1
LAKE ISABELLA	17
LAMONT	30
LANCASTER	3
MARICOPA	1
MARTINEZ	1
MC FARLAND	15

MC KITTRICK	1
MCFARLAND	1
MERCED	1
MOJAVE	14
N/A	14
NORTH EDWARDS	3
ONYX	1
ROSAMOND	5
SAN JOSE	1
SANTA MARIA	1
SANTA ROSA	1
SHAFTER	27
STOCKTON	1
TAFT	42
TEHACHAPI	36
WASCO	20
WELDON	7
WOFFORD HTS	5

Notes Completed

Note Source	Behavioral Case Management Episodes	Case Management Episodes
Activity Note	996	1259
Add Episode Note	42	71
Care Plan Problem Note	168	612
Change Status Note	1439	1639
Edit Episode Note	21	102
Episode Note	94	213
Goals	265	510
Interventions	279	515

Letters

Letter Template	Behavioral Health Case Management Episodes	Case Management Episodes
Appointment Letter English	16	27
Appointment Letter Spanish	4	15
Consent Form English	3	8
Consent Form Spanish	1	5
Discharge English	95	156
Discharge Spanish	15	50
Educational Material	22	29
Mental Health Alert to PCP	1	0
Suicide Hospital Letter to MD	1	0
Unable to Contact	334	475
Welcome Letter Bilingual	75	149

Activities Completed

Activities Completed	Total
CMA's	2,215
Nurses	1,160
Social Workers	714

Activity Type

Activity Type	Behavioral Health Case Management Episodes	Case Management Episodes
Education	161	166
Fax	82	133
Letter Contact	314	558

Member Services	21	27
Phone Call	1,113	1,565

Activity Name

Activity Name	Behavioral Health Case Management Episodes	Case Management Episodes
Appointment Reminder Calls	26	36
Centric Appointment	2	4
Close Episode for UTC	24	21
Community Resources	14	3
Contact Member	204	192
Contact Pharmacy	8	21
Contact Provider	110	256
COVID-19 Education	206	296
Create Work Item	27	28
Educate the member on advanced care documents.	0	1
HHP	5	0
Homeless	0	2
ICT	9	8
Incoming Call	0	6
Inpatient Discharge Follow Up	30	113
Language Line	90	147
Mail Appointment Letter	20	27
Mail Authorization	0	1
Mail Consent Letter	3	14
Mail Discharge Letter	112	194
Mail Educational Material	67	116
Mail Pill Box	1	4
Mail Pocket Calendars	2	5
Mail Provider Directory	1	3
Mail Unable to contact letter	68	143
Mail Urgent Care Pamphlet	5	0
Mail Welcome Letter	3	15
Medication Review	0	2
Mental Health Alert to PCP	1	0
Plan of care	75	116
Provided Information	0	15
Request Medical Records	21	62
Return Mail	6	5
Schedule Physician Appointment	28	44
Transportation	4	11
Verbal consent to be received	519	538

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 50 percent of the Complex Group from April thru June 2020.

The John Hopkins Predictive Modeler identified SPD's represent 43% percent of the Complex Group from April thru June 2020. HRA identified SPD members represent 41% and other sources of SPD members represent 16%.