KERN HEALTH SYSTEMS

2025 Quality Improvement Health Equity Program Description

Executive Quality Improvement Health Equity Committee (EQIHEC)
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I. Introduction

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

KHS is a special county health authority governed by a 16-member Board of Directors. This diverse board includes representatives such as the Chief Executive Officer of the local safety net hospital, a safety net care provider, ten community representatives nominated by the County Supervisors, two Medi-Cal primary care physicians, one representative from a rural acute care general hospital, and one pharmacist. Board members must work or reside in Kern County and meet the minimum age requirement of 21. The Board oversees the establishment and operation of a comprehensive managed care system, ensuring access to high-quality medical care, promoting cost efficiency, and adhering to the principles of Chapter 7, Part 3 of Division 9, Section 14000 of the California Welfare, and Institutions Code.

As of 2024, KHS serves approximately 403,000 members, with 49% receiving care through the County Hospital system and two large Federally Qualified Health Centers (FQHCs). While 66% of the population resides in Bakersfield, the remainder is spread across rural areas of Kern County. The largest racial group is Hispanic, accounting for 63% of membership. Language diversity is a key factor, with 70% of members speaking English as their primary language, 29% speaking Spanish, and 1% speaking other languages.

Kern County faces significant health challenges compared to statewide statistics, including higher rates of adult smoking, obesity, physical inactivity, alcohol-impaired driving deaths, sexually transmitted infections, and teen births. However, the county ranks favorably in food environment indices due to fewer low-income residents with limited access to grocery stores and lower rates of excessive drinking.

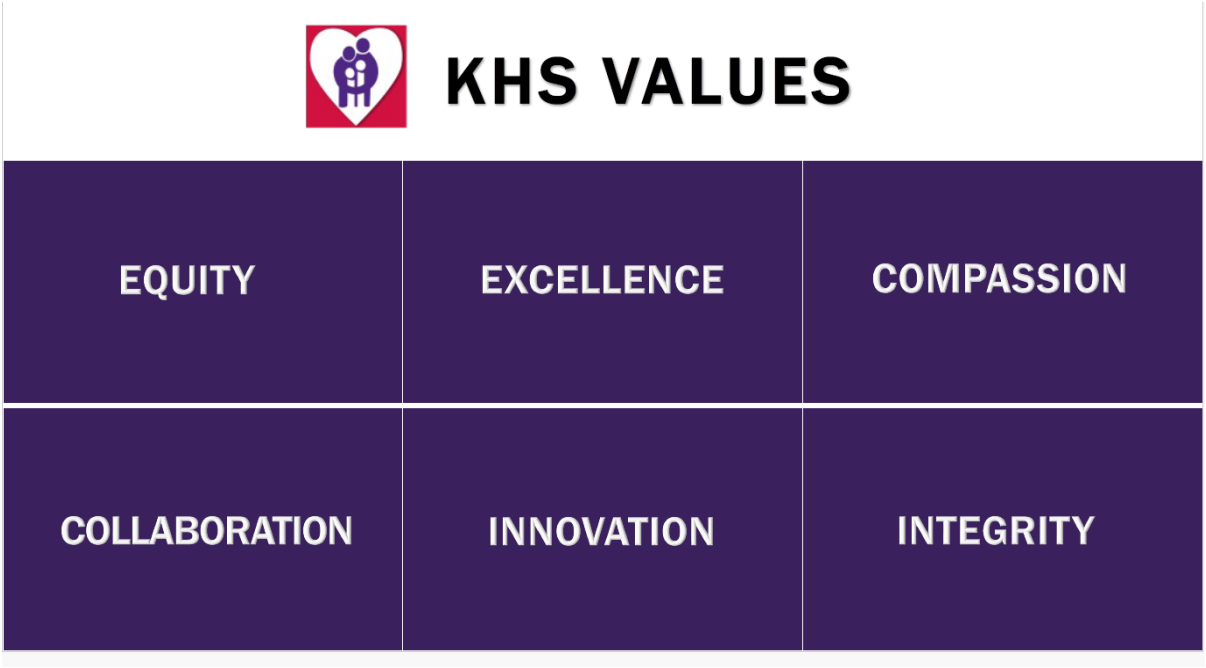
A. Mission & Values

Mission

KHS is committed to improving the health and well-being of our members and the community of Kern County through an integrated, equitable, and member-centered healthcare delivery system. The Quality Improvement Health Equity Program (QIHEP) is designed to objectively monitor, systematically evaluate, and effectively improve the quality, safety, and outcomes of care delivered to our members. By prioritizing health equity and addressing social determinants of health, KHS strives to meet members where they are, empowering them to achieve their optimal health outcomes.

The KHS Quality Improvement Department, in collaboration with the Quality Performance and Health Equity Departments, oversees the program's initiatives and activities, working closely with contracting providers to deliver high-quality care to the populations we serve.

Values



- **Equity**

We foster a culture of fairness and inclusion, ensuring all members and employees are supported, regardless of their zip code, race, ethnicity, preferred language, cultural preferences, or personal history. Equity is at the core of what we do because every person matters. We celebrate diversity and strive to create opportunities for everyone to thrive and contribute their unique gifts.

- **Excellence**

We uphold the highest standards in all that we do, aiming for outstanding results that resonate with the community we serve. Through continuous improvement and dedication, we achieve quality outcomes that lead to a stronger and healthier community. Excellence is reflected in our pride, commitment, and measurable impact.

- **Compassion**

We seek to understand and empathize with others' experiences, extending care and kindness to everyone we serve. Compassion drives our actions and shapes our solutions, ensuring we respond meaningfully to the needs of our members and colleagues.

- **Collaboration**

We harness the collective expertise of our team, providers, and community partners to solve problems and achieve shared goals. Collaboration brings diverse perspectives and strengths together, driving creativity and producing impactful, sustainable results.

- **Innovation**

We embrace new ideas, methods, and solutions to expand possibilities and improve outcomes. Through experimentation and forward-thinking, we adapt to the changing needs of our members and create innovative strategies that maximize efficiency and value.

- **Integrity**

We act with honesty and accountability, staying true to our commitments and values. Integrity builds trust and provides a strong foundation for performance and meaningful impact, ensuring we consistently do the right thing, even when it is not the easy thing.

KHS is committed to delivering on its values by:

- Ensuring all members obtain equal access to socioeconomic and environmental resources,
- Applying a health equity lens at all levels of and in all services provided by KHS,
- Embracing new knowledge and new ways of providing services,
- Practicing tolerance (accepting differences), embracing diversity (celebrating differences where possible), and pursuing inclusivity (finding commonalities and soliciting voice),
- Identifying and challenging historic assumptions and biases,
- Collaborating across programs, divisions, and community agencies/organizations to address community needs and barriers and obtain recommendations to improve services,
- Managing fiscal resources and the use of resources for greatest impact,
- Keeping consumers informed of Health Equity activities and outcome summaries by making them publicly available on the KHS website. Updates and ongoing information are posted at a minimum, on a quarterly basis,
- Leveraging our financial resources to help historically under-supported businesses and communities of color to build stronger capacity and economic health,
- Holding itself accountable through measurement and quality improvement/assurance,
- Building strong internal leaders in the health equity field that demonstrate a sustained, resolute commitment to DEI and collaboration with all stakeholders,
- Committing to eliminating health inequities in Kern County.

B. Background

Kern County is very diverse, with many residents identifying as Hispanic. As the racial and ethnic composition of Kern County continues to change, it is important to create culturally sensitive systems, policies, and environments while protecting the health of the public.

Spanish-language education, documents, and services will continue to be needed as the Hispanic population continues to grow. Additionally, while the total number of Non-Hispanic Asians in Kern County remains small, the proportion of residents identifying as Non-Hispanic Asian has increased 21 percent since 2009. In comparison, during the same time frame, the Hispanic population in Kern County grew by 11 percent.

In Kern County, children 17 and under are at higher risk of living below the poverty level than adults 18 and older. Overall, 31.3% of children live below the poverty level while 22.6% of all Kern County residents live below the poverty level. Studies have shown that children in poverty are more likely to have physical and mental health problems than their peers. This includes lower achievement in test scores, which could limit an individual's ability to make a living wage.

Moreover, Kern County continues to have a smaller proportion of residents with a high school diploma or equivalency than California's average. However, Kern County is expected to have the largest increase in high school graduates in the State by 2028.

Due to the diverse geography of Kern County, from arid high desert to the mountains to the valley, climate also varies. In the summer, heat exhaustion, heat stroke, and heat-related deaths are of concerns in Kern County (i.e., dehydration can exacerbate underlying conditions). Another example, high winds and dust storms in certain parts of the county can aggravate respiratory disorders and contribute to infectious diseases like Valley Fever (coccidioidomycosis).

Kern County's service area has been challenged with provider shortages. Large portions of the county are designated as Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P). These issues are more severe and prevalent in Kern County than other counties within California. The following 4 rural areas are in this classification:

- Taft
- Lost Hills/Wasco
- Fort Tejon
- Lake Isabella

C. KHS Population

The population served by Kern Health Systems (KHS), operating as Kern Family Health Care (KFHC), reflects the diverse demographic, geographic, and socioeconomic characteristics of Kern County. As of 2024, KHS serves approximately 403,000 Medi-Cal members, encompassing a wide range of health and social needs.

Demographics

- Geographic Distribution:
    - Over 66% of KHS members reside in Bakersfield, the county's largest metropolitan area.
    - The remaining members are distributed across rural areas, highlighting a need for geographically equitable healthcare access.

Area	Rural Portions per HRSA	KHS Population	Percentage
Bakersfield	N	223,973	66.9%
Delano & North Kern	Y	30,610	9.1%
Arvin/Lamont	Y	21,978	6.6%
Shafter/Wasco	Y	21,596	6.4%
California City & Southeast Kern	Y	9,434	2.8%
Taft & Southwest Kern	Y	8,897	2.7%
Tehachapi	Y	5,632	1.7%
Ridgecrest & Northeast Kern	Y	4,883	1.5%
Lake Isabella & Kern River Valley	Y	4,023	1.2%
Lost Hills & Northwest Kern	Y	2,194	0.7%
Frazier Park & South Kern	Y	1,244	0.4%
Outside Service Area	N/A	465	0.1%

- Racial and Ethnic Composition:
    - The Hispanic population represents 63% of the membership, emphasizing the importance of culturally relevant care and services.
    - Other racial/ethnic groups include White, African American, Asian, Native American, and individuals identifying as multiracial, reflecting the community's diversity.

Ethnic or Racial Group	% KHS Enrollment
Hispanic	63%
Caucasian	17%
No valid data, unknown or other	11%
Black/African American	6%
Asian Indian	1%
Filipino	1%
Asian/Pacific	1%

- Language Diversity:
    - 70% of members identify English as their primary language.
    - 29% primarily speak Spanish, underscoring the need for language assistance services.
    - 1% speak other languages, requiring culturally and linguistically appropriate services to ensure equitable access to care.

Socioeconomic Characteristics

- Many KHS members face significant socioeconomic challenges, including:
    - Poverty: A large proportion of the population lives at or below the federal poverty level.
    - Unemployment: Economic instability affects access to housing, transportation, and other basic needs.
    - Educational Barriers: Limited education levels impact health literacy and the ability to navigate the healthcare system.

Health Risk Factors

- Kern County exhibits a higher prevalence of health risks compared to statewide averages:
    - Chronic Conditions: High rates of diabetes, hypertension, and obesity among the population.
    - Lifestyle Factors: Elevated smoking rates, physical inactivity, and alcohol use disorders.
    - Maternal and Child Health: Teen births and limited access to prenatal care contribute to poor outcomes in maternal and child health.

Key health behaviors affecting the Kern population are reflected in the following table obtained from County Health Rankings & Roadmaps. :

Health Factors			
Health Behaviors	Kern (KE) County	California	United States
Adult Smoking	15%	10%	16%
Adult Obesity	36%	26%	32%
Food Environment Index	7.4	8.9	7.8
Physical Inactivity	33%	22%	26%
Access to Exercise Opportunities	82%	93%	80%
Excessive Drinking	16%	19%	20%
Alcohol-Impaired Driving Deaths	32%	28%	27%
Sexually Transmitted Infections	763.8	599.1	551.0
Teen Births	32	16	19

Social Determinants of Health (SDOH)

- KHS actively identifies and addresses social determinants that impact the health of its members, including:
    - Housing Insecurity: A significant portion of the population experiences unstable or unsafe housing conditions.
    - Food Insecurity: Access to affordable and nutritious food remains a concern for many families.
    - Transportation Barriers: Limited public transportation options impede access to healthcare facilities, particularly in rural areas.
    - Access to Technology: Digital inequities hinder member engagement in telehealth services and health education initiatives.

Behavioral Health Needs

The mental health and substance use disorder needs of KHS members are significant, with many individuals requiring coordinated care for mild-to-moderate behavioral health conditions. KHS partners with the Kern County Behavioral Health and Recovery Services (KBHRS) to address the needs of members requiring specialty mental health services.

Vulnerable Subpopulations

KHS tailors its programs and services to address the unique needs of vulnerable groups, including:

- Seniors and Persons with Disabilities (SPDs): Older adults and individuals with disabilities require specialized care and enhanced care management services.
- Homeless Individuals: Outreach efforts target unsheltered populations, including street medicine initiatives to deliver care in nontraditional settings.
- Children and Adolescents: Programs focus on preventive care, developmental screenings, and health education for younger members.

Kern County ranks lower compared to other California counties for a variety of public health indicators. Kern County ranks in the bottom 10 California counties for age-adjusted death rates due to diabetes, Alzheimer's disease, coronary heart disease, chronic lower respiratory disease, homicide, and drug-induced deaths1. It is also among the bottom 10 California counties for the incidence of chlamydia, gonorrhea among people 15-44 years old, congenital syphilis, primary and secondary syphilis, infant mortality, and persons under 18 in poverty.

In Kern County's most recent Community Health Assessment, asthma and other respiratory diseases were identified as the top community health problems. According to the California Health Interview Survey, 15.7% of the Kern County population has been diagnosed with asthma. In 2019, the emergency department (ED) rate due to asthma was 46.1 per 100,000 compared to the state average of 42.6 per 100,000. Black/African American people in Kern County experience asthma disparities as demonstrated by their asthma ED visit rate of 181.5 per 100,000 people. This rate is more than four times the rate of the next highest racial/ethnic group in Kern County and more than double the rate of any age group in the county.

Other health disparities identified within Kern County include the teen birth rate (25.9 per 1,000 live births) which was more than double the state average (12.5 per 1,000 live births); the percentage of all pregnancies accessing early prenatal care which was below the state average (KC-79.6%; CA-85.1%); and the obesity rate which was 35.5% compared to 30.3 for California.

Regarding mental health, Kern County's age-adjusted mortality rate due to suicide is 13.5 per 100,000 which is higher than the state averages (CA-10.7 per 100,000).

In accordance with the World Health Organization definition of social determinants of health, (SDOH) are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems.

The improvement of long-term health outcomes, particularly for populations experiencing the greatest inequities in health over time, requires a shift in focus to the upstream factors that are the underlying causes of ill health (Harris County Public Health: Health Equity Policy, 2015). Such health inequities include disparate rates of disease, disability, and premature death. A shift to upstream (Appendix A) factors provides all individuals, regardless of socioeconomic or environmental conditions, the opportunity to attain their full health potential.

Addressing health disparities among identified populations is a priority of KHS. To ensure robust insights regarding disparities, KHS leverages the External Quality Review (EQR) Technical Report, and the KHS Population Needs Assessment. An annual analysis of the EQR is used to identify specific disparities and/or targeted areas of focus to incorporate into strategies to improve member satisfaction, close gaps in care, and highlight other specific needs

for the KHS population. KHS utilizes the EQR recommendations to develop strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services. The KHS PNA uses internal and external data to identify and assess vulnerable member groups by race or ethnicity, age, sex, language, and other member characteristics, including cultural and linguistic needs. The KHS PNA builds upon previous needs assessments and uses various data collection methods and sources. The goal of the PNA is to improve health outcomes for KHS members and ensure that KHS is meeting the needs of its members through:

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

Population Health Management (PHM) services (i.e., basic population health management, enhanced care management, etc.) are offered to all KHS members, and provided in a manner to address member needs and preferences and address health disparities.

Opportunities for Improvement

KHS leverages insights from its annual Population Needs Assessment to identify gaps in care and develop targeted interventions. Key opportunities include:

- Expanding provider networks to improve access in underserved areas.
- Reducing health disparities by addressing inequities in chronic disease management and preventive care.
- Enhancing member engagement through culturally competent health education and communication strategies.
- Strengthening partnerships with community organizations to address SDOH and improve overall member well-being.

II. QIHEP Overview

A. QIHEP Purpose

The KHS Quality Improvement Health Equity Program (QIHEP) is a written description of the overall scope and responsibilities of the program. The QIHEP actively monitors, evaluates, and takes effective action to address any needed improvements in the quality, appropriateness, safety, and outcomes of covered health care services delivered by all contracting providers rendering services to members.

KHS recognizes that a strong program must be the foundation for a successful Managed Care Plan (MCP). In the basic program design and structure, KHS QI systems and processes have been developed and implemented to improve, monitor, and evaluate the quality and safety of care and service provided by contracting providers for all aspects of health care delivery consistent with standards and laws.

The mission of the KHS Health Equity Program is to improve the health and well-being of the community through the delivery of trusted, high quality, cost-effective, and accessible health to all members regardless of race/ethnicity, language spoken, or their cultural/personal preferences. In partnership with the county KHS serves, the goal is to offer whole person-centered care that reflects the best practices available today. KHS's program is built on a foundation of dedication to trusted messaging, high-quality care, culturally sensitive engagement with members, regular collaboration with community partners, continuous improvement, and service by working together with providers. KHS acknowledges an ongoing shared responsibility with its providers, facilities, community stakeholders and other provider organizations to deliver trusted, effective, and timely care and services for its members.

At a high level, the program seeks to emulate the guidance found in the Department of Health Care Services' 2022 Comprehensive Quality Strategy, which summarizes the state's goal of helping Medi-Cal members achieve longer, healthier, and happier lives through both clinical health care services and non-clinical services. This program integrates clinical and non-clinical services to create a holistic healthcare environment, improving member health outcomes. Disparate impacts from the COVID-19 pandemic have underscored the need for urgency and the necessity of building partnerships with trusted community stakeholders to increase trust with members. These two areas of providing additional non-clinical supports and increasing trust are key changes designed to catalyze different outcomes.

KHS staff are constantly evaluating member differences and preferences regarding race, ethnicity, culture, gender identity, sexual orientation, and language. Through its Quality Improvement Health Equity Program (QIHEP), KHS intends to implement standards on culturally and linguistically appropriate services to achieve the following key objectives:

- Respond to current and projected demographic changes in the populations served.
- Understand the impact of race, ethnicity, culture, gender identity, sexual orientation, and language in whole person health.
- Improve the quality of services and outcomes for members.

B. QIHEP Scope

KHS QIHEP is composed of several systematic processes that monitor and evaluate the quality of clinical care and health care service delivery to KHS members. The QIHEP scope includes regular needs assessments based on race/ethnicity, language, cultural preferences, health disparities, and stakeholder engagement. Again, it should be

noted that this expanded scope covers both clinically focused and non-clinically focused areas. Each of these defined areas of program scope include, but are not limited to, the following:

- Monitor and identify opportunities to monitor, evaluate, and take action to address needed improvements in the quality of care delivered by all KHS network providers rendering services to KHS members.
- Maintain a process and structure for quality improvement with contracting providers that includes identification of quality-of-care problems and a corrective action process for resolution for all provider entities.
- Promote efficient use of health plan financial resources.
- Identify health disparities and take action to support health equity.
- Oversee and direct processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
- Monitor and improve the quality and safety of clinical care for covered services for KHS members.
- Ensure members have access to covered health care in accordance with federal and state regulations, and our contractual obligations with the California Department of Health Care Services (DHCS).

This is accomplished through the development and maintenance of an interactive health care system that includes the following elements:

1. Development and implementation of a structure for monitoring, evaluating, and taking effective action to address any needed improvements in the quality of care delivered by all KHS network providers rendering services to KHS members.
2. A process and structure for quality improvement with contracting providers. This includes identification of quality-of-care problems and a corrective action process for resolution for all provider entities.
3. Oversight and direction of processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
4. Assurance that members have access to covered health care in accordance with federal and state regulations, and our contractual obligations with the California Department of Health Care Services (DHCS).
5. Monitoring and improvement of the quality and safety of clinical care for covered services for members.

The KHS QIHE Program applies to all programs, services, facilities, and individuals that have direct or indirect influence over the delivery of health care to KHS members. This may range from choice of contracted provider to the provision and a commitment to activities that improve clinical quality of care (including behavioral health), promotion of safe clinical practices and enhancement of services to members throughout the organization.

The scope of the QIHE Program includes the following elements:

1. The QIHE Program is designed to monitor, oversee, and implement improvements that influence the delivery, outcome, and safety of the health care of members, whether direct or indirect.
    a. KHS does not unlawfully discriminate against members based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability.
    b. KHS will arrange covered services in a culturally and linguistically appropriate manner. The QIHE Program reflects the population served and applies equally to covered medical and behavioral health services.
2. The QIHE Program monitors the quality and safety of covered health care administered to members through contracting providers. This includes all contracting physicians, hospitals, vision care providers, behavioral health care practitioners, pharmacists and other applicable personnel providing health care to members in inpatient, ambulatory, and home care settings. New this year is the addition of street medicine providers. Street medicine provider refers to a licensed medical provider who conducts patient visits outside of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be living.
3. The QIHE Program assessment activities encompass all diagnostic and therapeutic activities, and outcomes affecting members, including primary care and specialty practitioners, vision providers, behavioral health care providers, pharmaceutical services, preventive services, prenatal care, and family planning services in all applicable care settings, including emergency, inpatient, outpatient, and home health.
4. The QIHE Program evaluates quality of service, including the availability of practitioners, accessibility of services, coordination, and continuity of care. Member input is obtained through member participation on the Community Advisory Committee (CAC), grievances, and member satisfaction surveys.
5. The QIHE Program activities are integrated internally across appropriate KHS departments. This occurs through multi-departmental representation on the QI/UM Committee.
6. KHS and Kern County Department of Health jointly cover mental health care. It is arranged and covered, in part, by Kern County Behavioral Health and Recovery Services (KBHRS) pursuant to a contract between the County and the State.

Application of the Quality Improvement Health Equity Program occurs with all procedures, care, services, facilities, and individuals with direct or indirect influence over the delivery of health care to members.

Quality Improvement Integration: the QIHE Program includes quality improvement, utilization management, risk management, credentialing, member's rights and responsibilities, and preventive health & health education.

As part of KHS' commitment to ensure the rights of our members to quality health care, the following six rights to Quality Health Care have been adopted:

1. Right to Needed Care
    - Accurately diagnosed and treated
    - Care is coordinated across all the doctors and specialists
2. Right to Equitable Care
    - All people, regardless of their gender, race, ethnicity, geographical location, or socioeconomic status receive the good quality health care they need
    - Developing culturally competent care; for example, by expanding medical translation services, after-hours appointment, mobile health clinics or telehealth, etc.
3. Right to Place of Care
    - Did the patient go to the right place for care?
    - Is the patient going to the ER or Urgent Care for primary care?
    - Is the patient transitioned to the right place for care?
4. Right to Timely Care
    - Timely access to care
    - How long did the patient have to wait to get health care appointments and telephone advise?
    - Is the patient up to date with their preventative care?
5. Right to Be Part of Your Care
    - Patients and their families are part of the care team and play a role in decisions.
    - Information is shared fully and in a timely manner so that patients and their family members can make informed decisions.
6. Right to Safe Care
    - Conduct continuous quality assurance and improvement
    - Customer and provider satisfaction surveys or interviews
    - Chart audits
    - Site reviews
    - Administration of medications

The QIHEP scope includes regular needs assessments based on race/ethnicity, language, cultural preferences, health disparities, and stakeholder engagement. Again, it should be noted that this expanded scope covers both clinically focused and non-clinically focused areas. Each of these defined areas of program scope include, but are not limited to, the following:

- Quality Improvement – Understanding health disparities is critical to identify the differences in treatment provided to members of different racial/ethnic or cultural groups that are not justified by the underlying health conditions or treatment preferences of patients. KHS will implement multiple programs to monitor, assess, and improve healthcare services to reduce health disparities within its membership.
- Quality Performance – Identification of gaps in care, opportunities to support providers and members, and overall responsibility for high quality and equitable care for the members we serve. Quality Performance is comprised of site reviews, MCAS/HEDIS, performance improvement projects, and organizational initiatives related to quality.
- Health Education & Cultural Linguistics – Ensuring members have access to appropriate language services including bilingual services, oral interpretation, and written/sight translations as appropriate. The network providers have access to these services to ensure the members receive information in their preferred method.
- Population Health Management – Promoting meaningful engagement and partnerships with network providers, communities, public health agencies, and schools and community-based organizations (CBOs), to support the improvement of data sharing among delivery systems to identify and mitigate SDOH to reduce disparities and ensure that all members are connected to primary care, appropriate wellness, prevention, and disease management activities and to identify and connect those members who are at risk for developing complex health issues to more specialized services.
- Member Engagement – Engaging all key stakeholders is a very critical process to collect and evaluate feedback from members, practitioners, and other community groups. The information is collected through multiple avenues including Member Advisory Committees, ongoing surveys from members and practitioners, discussions with large provider groups, etc.
- Provider Network Management – Evaluating the network's cultural responsiveness is one of the key components of the health equity program. This includes the ability of practitioners and providers to understand the individual values, beliefs, and behaviors shaped by cultural factors of diverse groups. KHS educates providers and practitioners annually on how to consider and integrate these members preferences into the delivery of healthcare services.
- Utilization Management – Facilitating, communicating, and collaborating among members, practitioners, providers, and the organization, to support cooperation and appropriate utilization of health care benefits.

Monitoring and reporting under and over utilization trends to eliminate care variations within vulnerable populations and proactively closing gaps in the care continuum.

- Policies & Procedures – The following components are integrated into KHS' policies and procedures across multiple areas:
    - Community input and advisement on relevant cultural, linguistic and Seniors and Persons with Disabilities (SPD) awareness issues via the established Community Advisory Committee
    - A Population Needs Assessment is conducted periodically to assess the need for special initiatives regarding cultural competency, linguistic sensitivity, and SPD awareness issues among practitioners and members.
    - Best efforts will be made to recruit and retain staffing that is reflective of the membership.
    - Creative efforts will be made to increase partnership with vendors and community-based organizations (CBOs) that are reflective of the membership.
    - KHS staff and provider network will be provided with opportunities for training and tools to promote cultural competency, linguistic sensitivity, and SPD awareness.
    - KHS will participate with government, community and educational institutions in symposiums related to cultural competency, linguistic sensitivity, and SPD awareness.
    - KHS will maintain systems that readily identify language and ethnic specific member data.
    - Through grant programs, KHS gives preference to funding agencies that can provide culturally and linguistically appropriate services that are accessible to the membership and the community.

C. QIHEP Goals

KHS has developed and implemented a plan of activities to encompass a progressive health care delivery system working in cooperation with contracting providers, members, community partners and regulatory agencies. The QI Department annually evaluates program objectives and progress, making modifications based on guidance from the KHS Board of Directors. The results of the evaluation are considered in the subsequent year's program description. Specific objectives of the QIHE Program include:

1. Improving the health status of members by identifying potential areas for improvement in the health care delivery system.
2. Developing, distributing, and promoting guidelines for care including preventive health care and disease management through education of members and contracting providers.
3. Developing and promoting health care practice guidelines through maintenance of standards of practice, credentialing, and recredentialing. This applies to services rendered by medical, behavioral health and pharmacy providers.

4. Establishing and promoting open communication between KHS and contracting providers in matters of quality improvement. This includes maintaining communication avenues between KHS, members, and contracting providers to seek solutions to problems that will lead to improved health care delivery systems.
5. Monitoring and oversight of delegated activities.
6. Performing tracking and trending on a wide variety of information, including:
    a. Over and underutilization data,
    b. Grievances,
    c. Potential and actual quality of care issues,
    d. Accessibility of health care services,
    e. Compliance with Managed Care Accountability Set (MCAS) preventive health and chronic condition management services,
    f. Pharmacy services, and
    g. Primary Care Provider facility site and medical record reviews to identify patterns that may indicate the need for quality improvement and that ensure compliance with State and Federal requirements.
7. Promoting awareness and commitment in the health care community toward quality improvement in health care, safety, and service.
8. Continuously identifying opportunities for improvement in care processes, organizations or structures that can improve safety and delivery of health care to members.
9. Providing appropriate evaluation of professional services and medical decision making and to identify opportunities for professional performance improvement.
10. Reviewing concerns regarding quality-of-care issues for members that are identified from grievances, the Community Advisory Committee (CAC), or any other internal, provider, or other community resource.
11. Identifying and meeting external federal and state regulatory requirements for licensure.
12. Continuously monitoring internal processes to improve and enhance services to members and contracting providers.
13. Performing an annual assessment and evaluation of the effectiveness of the QIHE Program and its activities to determine:
    a. How well resources have been deployed in the previous year to improve the quality and safety of clinical care,
    b. The quality of service provided to members, and
    c. Modifications needed to the QIHE Program.

Results of the annual evaluation are presented to the Executive Quality Improvement Health Equity Committee (EQIHEC) and Board of Directors.

KHS acknowledges that culture change is necessary to achieve its health equity vision. As such, the vision and goals include a combination of qualitative and quantitative metrics. Some efforts will be initiated simply because they align with KHS's values and are perceived as being the "right thing to do" for the organization. Other objectives will have discrete measurements that are directly connected to DHCS contract requirements or KHS's annual goals or strategic plan. Some may be a blend of values-based goals and contractual obligations. Populations of focus particularly include:

A. Members affected by Health Disparities,

B. Limited English Proficiency (LEP) Members,

C. Children with Special Health Care Needs,

D. Seniors and Persons with Disabilities,

E. Persons with chronic conditions.

Culture (values-based) goals:

• Provide leadership to staff and provider network to support the long-term culture change needed to address any identified health disparities.

• Invite all stakeholder groups (i.e., members, providers, staff, community stakeholders, contractors, subcontractors, etc.) to better understand and engage in health equity work because it belongs to all of us.

• Provide educational opportunities to all stakeholders (above). Trainings will be provided through multiple modalities including not limited to:

o Online self-education classes

o In-person coaching/training

o Live Webinars

o Dissemination of educational materials

• Support development, workforce diversity, and training that increase cultural sensitivity, cultural awareness, and cultural humility in KHS's staffing and provider network.

• Establish partnerships and collaborations with community-based organizations that elevate social and racial justice in the communities served.

• Continue to solicit and incorporate diverse stakeholder perspectives through surveys and stakeholder meetings.

Goals to Meet Member's Cultural and Linguistic Needs:

• Target 90% of members who utilized interpreting and translation services are "satisfied" as indicated in satisfaction survey results.

• Deliver 90% of translation and interpretation service requests before or on the requested due date.

• Resolve 100% of cultural and language related grievances within 30 business days.

Goals to Directly Address Health Disparities:

• Identify disparities in care for selected MCAS/HEDIS measures. These may include, but will not be limited to, the following:

o Well Child Care (i.e., Well child visits, childhood immunizations, etc.)

o Maternity Care (i.e., disparities for Black and Native American persons)

o Mental Health (i.e., maternal, and adolescent depression screenings, follow up for mental health and substance use disorder)

o Cancer Screenings (i.e., Breast, Cervical, and Colorectal)

o Management of Chronic Conditions (i.e., Diabetes, hypertension, asthma, etc.)

• Address at least one disparity in care in each of the groups mentioned in the bullet above. Reduce the disparity between the highest and lowest performing populations (with reasonable membership) by 5% by 2025. For example:

o Increase well child visits for Black children by 15% by 2025.

o Increase maternal depression screenings for Black mothers by 15% by 2025.

o Increase the rate of annual diabetes screening for members who speak an Asian language in comparison to English speaking patients.

o Increase equity of member involvement in treatment planning for Black Non-Hispanic (77%), Hispanic (66%), and other race/ethnic populations (64%) to 85% or higher on the member satisfaction survey.

• MCAS measures - KHS is held accountable to meet the 50th percentile or better for measurement year (MY) 2025. Results for the 2024 measures will be calculated and submitted in report year (RY) 2025. The measures are in the following table:

#	MEASURE	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
Behavioral Health Domain				
1	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	Administrative	Yes
2	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	Administrative	Yes
Children's Health Domain				
3	Child and Adolescent Well-Care Visits*	WCV	Administrative	Yes
4	Childhood Immunization Status: Combination 10*	CIS-10-E	ECDS	Yes
5	Developmental Screening in the First Three Years of Life	DEV	Administrative	Yesiii
6	Immunizations for Adolescents: Combination 2*	IMA-2-E	ECDS	Yes
7	Lead Screening in Children	LSC	Hybrid/Admin**	Yes
8	Topical Fluoride for Children	TFL-CH	Administrative	Yesiii
9	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	W30-6+	Administrative	Yes
10	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits*	W30-2+	Administrative	Yes
Chronic Disease Management Domain				

11	Asthma Medication Ratio*	AMR	Administrative	Yes
12	Controlling High Blood Pressure*	CBP	Hybrid/Admin**	Yes
13	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	GSD	Hybrid/Admin**	Yes
Reproductive Domain				
14	Chlamydia Screening in Women	CHL	Administrative	Yes
15	Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	Hybrid/Admin**	Yes
16	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	Hybrid/Admin**	Yes
Cancer Prevention Domain				
17	Breast Cancer Screening*	BCS-E	ECDS	Yes
18	Cervical Cancer Screening	CCS-E	ECDS	Yes
Report only Measures to DHCS				
19	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED ii	Administrative	No
20	Adults' Access to Preventive/Ambulatory Health Services	AAP	Administrative	No
21	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	No

22	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	Administrative	No
23	Colorectal Cancer Screening*	COL-E	ECDS	No^^
24	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	No
25	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	Administrative	No
26	Depression Remission or Response for Adolescents and Adults	DRR-E	ECDS	No^^
27	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	ECDS	No^^
28	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Administrative	No
29	Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	Administrative	No
30	Follow-Up After ED Visit for Substance Use – 7	FUA	Administrative	No

	days*			
31	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	No
32	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase	ADD-Init	Administrative	No
33	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	No
34	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	Administrative	No
35	Pharmacotherapy for Opioid Use Disorder*	POD	Administrative	No^^
36	Plan All-Cause Readmissions*	PCR ii	Administrative	No
37	Postpartum Depression Screening and Follow Up*	PDS-E	ECDS	No^^

38	Prenatal Depression Screening and Follow Up*	PND-E	ECDS	No^^
39	Prenatal Immunization Status	PRS-E	ECDS	No^^
Long Term Care Report Only Measures to DHCS				
40	Number of Out-patient ED Visits per 1,000 Long Stay Resident Days*	HFS	Administrative^	No
41	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization*	SNF-HAI	Administrative^	No
42	Potentially Preventable 30- day Post-Discharge Readmission*	PPR	Administrative^	No

III. Authority and Responsibility

The organizational structure includes the following personnel and committees:

A. KHS Board of Directors (BOD)

The Kern Health System (KHS) Board of Directors (BOD) has final authority and accountability for the KHS Quality Improvement Health Equity Program (QIHEP). The Board has delegated the responsibility for development and implementation of the QIHEP to the Executive Quality Improvement Health Equity Committee (EQIHEC). The EQIHEC is chaired by the KHS's Chief Medical Officer (CMO) and Co-Chaired by the KHS Health Equity Officer.

KHS's Board of Directors (BOD) is the governing body of the organization and has ultimate responsibility for the quality of care and service delivered by Kern Health Systems. The BOD:

- Approves the annual QIHEP description.
- Approves the annual quality management work plan which contains measures specific to the QIHEP.
- Reviews the annual QIHEP Evaluation.
- Reviews reports about QIHEP activities and measures as provided by the Quality Improvement Health Equity Committee (described below).
- Reviews and confirms the appropriate resources needed to implement the QIHEP recommended by the Quality Improvement Health Equity Committee.

B. Chief Executive Officer (CEO)

Appointed by the Board of Directors, the CEO has the overall responsibility for KHS management and viability. Responsibilities include: KHS direction, organization, and operation; developing strategies for each department including the QIHE Program; Human Resources direction and position appointments; fiscal efficiency; public relations; governmental and community liaison, and contract approval. The CEO directly supervises the Chief Financial Officer (CFO), CMO, Compliance Department, and the Director of Marketing and Member Services. The PAC reports to the CEO and contributes information regarding provider issues. The CEO interacts with the CMO regarding ongoing QIHE Program activities, progress towards goals, and identified health care problems or quality issues requiring corrective action.

C. Chief Medical Officer (CMO)

KHS' Chief Medical Officer (CMO) is a physician, Board Certified in his or her primary care specialty, holding a current valid, unrestricted California Physician and Surgeon License. The CMO is an ex-officio member of the BOD and reports to the Chief Executive Officer (CEO). The CMO is the senior healthcare clinician and has the ultimate responsibility for the QIHE Program and assigns authority for aspects of the program to the Chief Equity Officer and Quality Medical Director.

The KHS CMO must have a valid license to practice medicine in the State of California, the ability to effectively function as a member of a team, and excellent written and verbal communication skills. The CMO is responsible to the Board of Directors to provide medical direction for KHS, including professional input and oversight of all medical activities of the QIHE Program.

The CMO reports to the CEO and communicates directly with the Board of Directors. The CMO devotes the majority of the time to quality improvement activities.

The responsibilities of the CMO include:

- supervising the following Medical Services departments and related staff: Quality Improvement, Utilization Management, Pharmacy, Wellness & Prevention.
- supervising all QI activities performed by the Quality Improvement Department.
- providing direction for all medical aspects of KHS, preparation, implementation, and oversight of the QIHE Program, medical services management, resolution of medical disputes and grievances; and medical oversight on provider selection, provider coordination, and peer review.
- developing and implementing medical policy for utilization and QI functions, reviewing current medical practices so that that medical protocols and medical personnel of KHS follow rules of conduct, assigned members are provided healthcare services and medical attention at all locations, and medical care rendered by providers meets applicable professional standards for acceptable medical care and quality. These standards should equal or exceed the standards for medical practice developed by KHS and approved by the California Department of Health Care Services (DHCS) or the California Department of Managed Health Care (DMHC).
- providing direction to the EQIHEC and associated committees including PAC and Drug Utilization Review (DUR) Committee.
- providing assistance with study development and coordination of the QIHE Program in all areas to provide continued delivery of quality health care for members.
- assisting the Director of Provider Network Management with provider network development
- communicating with the CFO to ensure that financial considerations do not influence the quality of health care administered to members.
- providing oversight for the development and ongoing revision of the Provider Policy and Procedure Manual related to health care services.
- executing, maintaining, and updating a yearly QIHE Program for KHS and an annual summary of the QIHE Program activities to be presented to the Board of Directors.
- assuring timely resolution of medical disputes and grievances.
- working with the appropriate departments to develop culturally and linguistically appropriate member and provider materials that identify benefits, services, and quality expectations of KHS.
- providing continuous assessment of monitoring activities, direction for member, provider education, and coordination of information across all levels of the QIHE Program and among KHS functional areas and staff.
- providing direction for internal and external QIHE Program functions, and supervision of KHS staff including:
    - Application of the QIHE Program by KHS staff and contracting providers
    - Participation in provider quality activities, as necessary

- Monitoring and oversight of provider QIHE Programs, activities, and processes
- Oversight of KHS delegated and non-delegated credentialing and recredentialing activities
- Retrospective review of KHS credentialed providers for potential or suspected deficiencies related to quality of care
- Monitoring and oversight of any delegated UM activities
- Supervision of Health Services staff involved in the QIHE Program, including: Director of Quality Improvement, Director of Wellness & Prevention and Cultural & Linguistics Services, Population Health Management (PHM) Director, Utilization Management (UM) Director, Pharmacy Director, and other related staff
- Supervision of all Quality Improvement Activities performed by the QI Department
- Monitoring covered medical and behavioral health care provided to ensure they meet industry and community standards for acceptable medical care
- Active participation in the functioning of the plan grievance procedures

D. Chief Health Equity Officer (CHEO)

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

E. Chief Operating Officer (COO)

Under direction of the CEO, plans, directs, monitors, coordinates, interprets, and administers all functional activities and policies related to Claims, Member Services, and AIS/Compliance departments. The COO is responsible for directing all activities of the Claims, Provider Relations, Member Services, and AIS/Compliance departments for a Knox-Keene Act-licensed health maintenance organization. COO maintains authority for setting policies and procedures for the departments, which are consistent with the policies and procedures set by the KHS Board of Directors and the CEO and fall in compliance with regulatory requirements. Executive is responsible for and has decision making authority regarding the organization in the absence of the CEO.

F. Quality Improvement Medical Director

The Medical Director of Quality must have a valid license to practice medicine in the State of California, the ability to effectively function as a member of a team, and excellent written and verbal communication skills. The Medical Director will provide clinical leadership and guidance in the development and measurement of the strategic approach to quality, performance improvement, and patient satisfaction, and safety. As determined by the plan CMO, the Medical Director assists in short- and long-range program planning, total quality management including quality improvement, and external relationships, as well as develops and implements systems and procedures for all medical components of health plan operations.

In collaboration with the CMO and others, the Medical Director creates and implements health plan medical policies and protocols. The Medical Director monitors provider network performance and reports all issues of clinical quality management to the CMO and EQIHEC. Additionally, he or she represents the health plan on various committees and routinely reports to the Board of Directors on credentialing and re-credentialing of network providers. The Medical Director provides medical oversight into the medical appropriateness and necessity of healthcare services provided to Plan members and is responsible for meeting medical cost and utilization performance targets.

Under direction of the Chief Medical Officer:

- Serve as a member of the following committees of the KHS Board of Directors: EQIHEC, PAC, P&T/DUR, Quality Improvement Committee, and Grievance Committee.
- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS.
- Is responsible for reviewing and managing utilization of health care services at all levels of care to achieve high quality outcomes in the most cost-effective manner.
- Provides clinical leadership to the clinical departments staff and works collaboratively with the directors of the other Departments of KHS to ensure compliance with the contractual and regulatory requirements.
- Provide clinical support and education to the provider network in support of standards of care and evidence-based medicine and use of clinical criteria in decision management.
- Represents KHS in the medical community and in general community public relations.
- Participates in the implementation of the KHS Credentialing Program.
- Responsible for Review and identification of area for improvement and provide clinical leadership in the implementation of KHS Quality Improvement Plan and the Utilization Management Plan.
- Lead and/or attend and actively participate in meetings and committees as assigned by the CMO.

- Actively Participates as a member of the Health Services management team.
- Performs duties and responsibilities identified for the Medical Director under the Quality Improvement Plan, the Utilization Management Plan.

G. Behavioral Health Provider

The Behavioral Health Provider is a participating BH provider with an MD or PhD in Psychology and is licensed to practice in California. The Behavioral Provider is involved in all behavioral health aspects of the QI and UM Programs and advises the BHAC Committee aimed at improving behavioral healthcare services. Responsibilities include acting as the chairperson in the KHS Behavioral Health Advisory Committee (BHAC), reports to EQIHEC and provides reports on the key BHAC monitoring activities including but not limited to:

- Exchange of information between PCPs and behavioral health specialists.
- Coordination between KHS and Kern County Managed Behavioral Health Organization (MBHO) and certified SUD providers for substance use disorder services to promote continuity of care.
- Supervision of diagnosis, treatment, and referral for members with co-existing medical and behavioral conditions.
- Collaboration with pharmacy for the use of psycho-pharmaceutical medications.
- Identification of social determinants of health, and other potential barriers to receiving BH care, including access.
- Actively participating in the BHAC Committee and related subcommittees in collaboration with the CMO.
- Establishing QI and UM policies and procedures relating to behavioral healthcare.
- Participating in quality activities related to continuity and coordination of care between medical and BH practitioners.

H. Executive Quality Improvement Health Equity Committee (EQIHEC)

The EQIHEC provides overall direction for the continuous improvement process and monitors that activities are consistent with KHS's strategic goals and priorities. The EQIHEC addresses equity, quality, and safety, of clinical care and service, program scope, yearly objectives, planned activities, timeframe for each activity, responsible staff, monitoring previously identified issues from prior years, and conducts an annual evaluation of the overall effectiveness of the Quality Improvement Health Equity Program (QIHEP) and its progress toward influencing network-wide safe clinical practices. The QIHEP utilizes a population management approach to members, providers, and the community, and collaborates with Local, State, and Federal Public Health Agencies and Programs.

The EQIHEC consists of actively participating clinical and non-clinical providers. The physicians are voting members for clinical decision making. The QIHEC is comprised of internal and community participants. This process promotes an interdisciplinary and interdepartmental and community approach and drives actions when opportunities for improvement are identified.

The EQIHEC members consist of:

- Community Attendees:
    - 2 Participating Primary Care Physicians 2 Participating Specialty Physicians
    - 1 Federally Qualified Health Center (FQHC) Provider
    - 2 CAC members 1-Member of Board of Directors consumer & 1-community consumer 1 Pharmacy Provider
    - 1 Kern County Public Health Officer or Representative 1 Home Health/Hospice Provider
    - 1 DME Provider
- Internal KHS Attendees:
    - CMO
    - Health Equity Officer
    - Quality Improvement Medical Director
    - Quality Improvement Director
    - Quality Performance Director
    - Utilization Management Director
    - Population Health Management Director
    - BH Committee Behavioral Health Provider
    - KHS Chief Operating Officer (Grievances & Appeals)
    - P&T Committee Pharmacist
    - Public Policy Physician Advisory Committee Physician
    - Wellness & Prevention Director
    - Health Equity Manager
    - Provider Relations Director

The EQIHEC is required to meet at least four times annually and more frequently as determined. The activities of the EQIHEC and QI subcommittees providing information to the EQIHEC are formally documented in transcribed minutes, which summarize each agenda item, including deliberations, decisions, actions taken, recommendations and required follow-up. Key activities of the EQIHEC are the review and approval of the QIHE Program and Work-Plan, and QIHE quarterly and annual evaluations. The EQIHEC's findings and recommendations are reported quarterly by the CMO to the BOD.

The EQIHEC monitors and evaluates equity, quality, safety, appropriateness and outcomes of care and services to KHS members.

Activities:

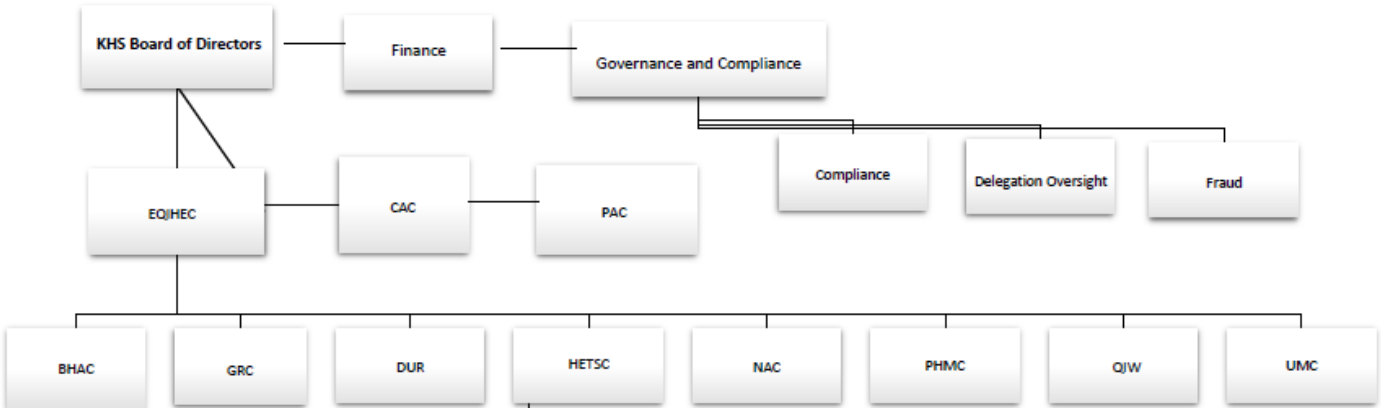
1. Formulates organization-wide improvement activities with QIHE subcommittee support.
2. Identifies appropriate performance measures, standards, and opportunities for performance improvement,
3. Assures QIHE Program activities are compliant with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, and NCQA,
4. Evaluates contract-specific interventions and outcomes.
5. Identifies actions to improve quality and prioritize based on analysis and significance; and indicate how the Committee determines these actions to ensure satisfactory outcomes,
6. Works closely with the IT Department for collection of data strategy and analytics to effectively analyze data related to the goals and objectives and establish performance goals to monitor improvement,
7. Ensures all departments can align project goals and map out responsibilities and deadlines prior to project implementation,
8. Ensures outcomes undergo quantitative and qualitative analyses that incorporate aggregated results over time and compare results against goals and benchmarks,
9. Reviews the analysis and evaluation of QIHE activities of subcommittees and identifies needed actions and ensures follow up as appropriate,
10. Ensures that root cause analyses and barrier analyses are conducted for identified underperformance with appropriate targeted interventions,
11. Reviews and modify the QIHE program description, annual QIHE Work Plan, quarterly work plan reports and annual evaluation of the QIHE program as necessary to maintain goals and priorities,
12. Communicates the quality health equity improvement process to practitioners/providers and members through appropriate persons and venues,
13. Ensures that the information available to the Plan regarding accessibility, availability and continuity of care is reviewed and evaluated, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services,
14. Ensures the annual HEDIS, CAHPS and Health Outcomes Survey (HOS) submissions are delivered according to technical specifications and deadlines,
15. Support and assist practitioners and providers to improve safety within their practices,
16. Design and implement strategies to improve compliance,
17. Develop objective criteria and processes to evaluate and continually monitor performance and adherence to the clinical and preventive health guidelines,

18. Meets healthcare industry standards of practice,
19. Improves quality, safety, and equity of care and service to members,
20. Conducts facility site and medical record reviews to ensure and support safe and effective provision of equitable clinical service,
21. Reviews, evaluates, and makes recommendations regarding oversight of delegated activities, such as audit findings, trending, and reports.

I. Quality Subcommittees

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

Committee Structure



1. Behavioral Health Advisory Committee (BHAC)

KHS' responsibility for administering and managing behavioral health and substance use care is dependent on the Medi-Cal member's severity of impairment. For behavioral health, KHS services are typically for treatment of mild to moderate impairment also referred to as non-specialty mental Health. Kern County Medi-Cal Behavioral Organization manages severe mental health impairment referred to as Specialty Mental Health Services. In for substance use disorders KHS provides screening, brief intervention, and counseling (SBIRT) services and refers members for treatment for misuse of alcohol. Active treatment for Medi-Cal members with substance use disorder (SUD) services must be rendered by a SUD Drug Medi-Cal certified program.

KHS covers Behavioral Health Treatment (BHT), including Applied Behavior Analysis (ABA) therapy, for Medi- Cal beneficiaries under the age of 21.

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

The BHAC is chaired by a KHS credentialed and participating behavioral health provider with an M.D. or Psychologist. Committee attendees include community providers and stakeholders, and internal KHS departmental staff in the Population Health Management, Utilization Management, Health Equity, Pharmacy, and Quality Improvement Departments.

The committee meets at a minimum four (4) times a year. The key activities of the committee include:

a. Methods to exchange information and data between KHS the MBHO, Certified SUD Providers, PCP, and Specialists.
b. Appropriate diagnosis, treatment, and referral for members with coexisting medical, behavioral and SUDs for all levels of care.
c. Management of treatment, access, and follow-up care for members with coexisting medical, behavioral and SUDs for all levels of care.
d. Appropriate use of psycho-pharmaceuticals meds.
e. Addressing access to care barriers, health inequities, social determinants of health, and cultural and linguistic needs differences for the BH and SUD populations.

All BHAC review reports, discussions, and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

2. Drug Utilization Review Committee (DUR)

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

Activities:

a. Pharmacy guidelines, and policies and procedures based on clinical evidence for those drugs under the medical benefit, often referred to as Physician Administered Drugs (PADs).
b. Pharmacy utilization safety measures.
c. Drug Utilization Review.
d. Review of reports to identify members and providers with potentially inappropriate/excessive utilization of medication therapy.

The DUR Committee meets at a minimum (four) times a year. All reports, discussions, and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

3. Grievance Review Committee (GRC)

Kern Health System Grievance and Appeals Process pursuant to which a member, or a provider or Authorized Representative acting on behalf of a member and with the Member's written consent, may submit a Grievance or Appeal for review and resolution. The Grievances and Appeals process addresses the receipt, handling, and disposition of Member Grievances and Appeals, in accordance with the Department of Health Care Services (DHCS) Contract and applicable state and federal statutes, regulations and DHCS All Plan Letters. KHS maintains written records of each Grievance and Appeal as detailed in Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations.

All complaints, grievances, investigations, follow-up, tracking, and trending reports are prepared by the KHS Quality Improvement Department and submitted to the Grievance and Appeals (G&A) Review Committee. This committee is a subcommittee of the EQIHEC. The G&A Review Committee meets at a minimum four (4) times a year.

Under the direction and oversight of the Chief Medical Officer (CMO) or physician designee, individual and aggregate data on member grievances and appeals is reviewed by the G&A Review Committee. The committee is charged with evaluating and analyzing G&A data to identify systemic patters of improper services denials and other trends impacting health care delivery to Members By implementing necessary changes and process improvements for any adverse trends identified.

Grievances may address, but are not limited to, the following issues:

a. Difficulty obtaining an appointment,
b. Customer service at the provider or practitioner office,
c. Billing issues,
d. Difficulty accessing specialists,

e. Facility Conditions,
f. Confidentiality issues,
g. Refusals of PCP to refer the member for care,
h. Cultural Issues.

Appeals may address, but are not limited to, the following issues:

a. Appeals of denied Treatment Authorization Requests (TAR),
b. Appeals of level-of-care determinations,
c. Appeals of KHS claims payment denials,
d. Appeals of primary care physician request for disenrollment.

All G&A review reports and discussions and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

4. Health Equity Transformation Steering Committee (HETSC)

The Health Equity Transformation Steering Committee (HETSC)is an internal committee established to ensure KHS remains an organization that understands and addresses social and racial justice and health equity to meet member needs. The committee is responsible for identification and management of equity efforts throughout the organization including the planning, organization, and the direction, of the Health Equity Program. The HETSC is charged with systematic analysis to identify root causes of health disparities impacting KHS members and collaborating across the organization, with providers, and with other community agencies to eradicate inequities for KHS members served. The HETSC reviews and updates relevant health equity policies and procedures and may review the annual Population Needs Assessment (PNA) to identify opportunities for advancing health equity, incorporating applicable findings into the QIHE program. The HETSC, shall monitor, evaluate, and take timely action to address necessary improvements in the quality and equity of care delivered by Network Providers in any setting, and take appropriate action to improve upon quality improvement and health equity goals.

This workgroup includes the areas of focus described below. Due to significant overlap and alignment, the KHS DEI/JEDI workgroup may serve as the steering workgroup for health equity.

1. Development of Internal Resources:
   - The focus is to provide learning opportunities and activities for staff that promote personal and professional growth and understanding around issues of social and racial justice, equity, diversity, inclusion, and cultural humility.
2. Provider Network Development:

- Focus is to assess specific regional needs and existing skills of the provider network around health equity and provide training, resources, and support to providers to help build on their professional skills and help ensure they provide culturally sensitive and equitable treatment to all members.

3. Member Advocacy & Community Engagement:
    - Primary focus is to identify and promote ways that members can be educated about and provide feedback regarding their experiences with providers, KHS, and other systems in which their health is affected. Member feedback will be utilized to inform strategies developed to advocate for members' needs. The secondary focus is to sponsor and or participate in community events that are geared toward social and racial justice, develop initiatives that engage the community, impact health disparities, and help erase the stigmas surrounding mental health and substance use.
4. Human Resources Enhancement:
    - The focus is to work on recruitment, retention, and promotion of a more diverse workforce, as well as to ensure KHS has a welcoming and inclusive environment for all employees. The HR department is responsible for creating, implementing, and overseeing DEI policies and practices that have a direct impact on the workforce and its stakeholders. Also, the HR department is committed to upholding the highest standards for prioritizing equitable and inclusive practices and ensuring that the organization is representative of the communities it serves. By working closely with all departments and stakeholders, this workgroup will partner with the HR department to help ensure that the organization is inclusive, equitable, and responsive to the needs of the employees and communities it serves.
5. Monitoring and Evaluation for Continuous Improvement:
    - Focus is to identify how effectively staff apply internal QIHEP policies and procedures. The policy workgroup will determine areas of staff development and training to ensure discrimination is not present through the application of policies and procedures.

The Health Equity Department Manager reports to the Health Equity Officer and is charged with overseeing the day-to-day operations of the Health Department and is responsible for organizing and preparing the HETSC agenda, minutes, reporting and committee activities for reporting to the Executive Quality Improvement Health Equity Committee (EQIHEC).

The HETSC has established objectives to address health disparities to include:

a. Increase the awareness of health equity and quality and implement strengthened, expanded and/or new health equity quality activities to support providers and members ultimately reducing health inequities within KHS' membership.
b. Ensure services provided to members promote equity and are free of implicit bias or discrimination.

c. Implement programs that address the causes of inequity that members and their communities experience, food insecurity, housing problems, tobacco use, and other concerns.
d. Analyze the existence of significant health care disparities in clinical areas.
e. Reduce health disparities among members by implementing targeted quality improvement programs.
f. Promote physician involvement in health equity/ disparities and activities.
g. Conduct focused groups or key informant interview with cultural or linguistic minority members to determine how to meet their needs.
h. Address social determinants of health.

5. Network Adequacy Committee (NAC)

The Network Adequacy Committee (NAC) shall advance the mission of Kern Health Systems (KHS) of improving the health status of our members through an integrated managed health care delivery system. The NAC will report to the KHS Executive Quality Improvement Health Equity Committee (EQIHEC) on KHS' monitoring activities, corrective actions, and regulatory requirements related to network access, availability, and adequacy.

Function – The functions of the NAC are as follows:

1. **Establish Network Standards**: Ensuring network accessibility standards (capacity/adequacy, appointment availability, geographic accessibility, etc.) align with Department Health Care Services (DHCS), Department of Managed Health Care (DMHC), and National Committee for Quality Assurance (NCQA) standards.
2. **Monitor Network Compliance:** Review monitoring activities conducted by the Plan to measure network compliance with established standards.
3. **Promote Health Equity**: Implement review processes that monitor network adequacy amongst diverse populations, focusing on equitable access to care across different demographic and geographic groups.
4. **Steer Continuous Improvement:** Provide feedback on proposed corrective actions and ensure they are appropriate to address identified issues. Track progress of active corrective action plans.

Composition – The NAC is delegated by the EQIHEC to monitor and report on network adequacy. The committee will make recommendations and report findings to the EQIHEC.

Cadance - The NAC will meet quarterly with additional meetings, as necessary.

6. Population Health Management Committee (PHMC)

KHS follows the NCQA definition for Population Health Management: "Population Health Management is a model of care that addresses individuals' health needs at all points along the continuum of care with a "Whole Person"

approach supported through participation, engagement, and targeted interventions for a defined population." The Population Health Management Committee oversees the Population Health Management (PHM) Model of Care (MOC) that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of the PHM MOC is to maintain or improve the physical and psychosocial well- being of individuals and address health disparities through cost effective and tailored health solutions.

The PHMC is a collaborative group that engages business units from multiple KHS departments across the organization that are involved in the development, execution and monitoring and evaluation of programs for members across the continuum of health. Each year a Population Needs Assessment is conducted by KHS. The annual PNA describes the overall health and social needs of KHS's membership by analyzing service utilization patterns, disease burden, and gaps in care of members, considering their risk level, geographic location, and age groups. PHMC members focus on strategies related to gaps identified in the PNA, addressing adverse patterns and outcomes to improve members' physical and psychosocial well-being through cost-effective and tailored solutions.

The following departments support the PHMC:

- Quality Improvement
- Quality Performance
- Utilization Management
- Member Services
- Behavioral Health
- Enhanced Care Management
- Health Equity
- Wellness and Prevention

These departments provide the analysis of service utilization patterns, disease burden, health and functioning of eligible members with chronic medical conditions that may also be exacerbated by significant psychosocial needs, and other gaps in care for KHS members.

The following programs are incorporated into PHM and fall under the administration of the afore mentioned Departments:

- LTC & LTSS
- Major Organ Transplants
- Transitions of Care (TOC)

PHM works collaboratively with the following programs and Departments:

- California Children's Services (CCS)
- Enhanced Care Management (ECM)
- Community Support Services (CSS)
- Behavioral Health

The PHM strategy focuses on the "whole person" throughout the care continuum to:

- Provide wellness services and intervene on the highest-risk members,
- Improve clinical health outcomes,
- Promote efficient and coordinated health care utilization,
- Maintain cost effectiveness, and quality care,
- Improve access to essential medical, mental health, and social services,
- Improve access to affordable care,
- Ensure appropriate utilization of services,
- Improve coordination of care through an identified point of contact,
- Improve continuity of services for members across transitions in healthcare setting, providers, and health services.
- Improve access to preventive health services.
- Improve beneficiary health outcomes

Activities:

a. Responsibilities of the committee include leading strategic analytics, evaluation design, clinical and economic evaluation, and optimizing programing, ensuring that PHM addresses health at all points on the continuum of care,
b. Ensures that the medical care provided meets the community standards for acceptable medical care,
c. Collaborates with behavioral health practitioners and entities to ensure appropriate utilization of behavioral health services and continuity and coordination of medical and behavioral healthcare.
d. Improve communications (exchange of information- data sharing) between primary care practitioners, specialists, behavioral health practitioners, and health delivery organizations and ancillary care provider,
e. Monitors appropriate use and monitoring of medications,
f. Incorporates Population Health Management Model into policies, procedures, and workflows,
g. Improving member access to primary and specialty care, ensuring members with complex health conditions receive appropriate service,

h. Identifies and reduces barriers to needed healthcare and social services for members with complex health conditions,
i. Improve member health status through the delivery of wellness and disease prevention services, programs, and resources by educating and empowering members to effectively use primary and preventive health care services, modify personal health behaviors, achieve, and maintain healthier lifestyles, and follow self-care regimens and treatment therapies for existing medical conditions,
j. Ensures continuity in treatment access and follow-up for members with co-occurring medical, behavioral health, and SUD conditions.
k. Promotes routine depression, anxiety, trauma-based care, and substance use disorder screenings are completed, and appropriate follow-up referrals are made for adolescent and adult members with chronic health conditions and for women during pregnancy and the postpartum period.
l. Link members to ECM, CSS, SUD Providers and other community-based programs with comprehensive and holistic approaches.

7. Community Advisory Committee (CAC)

The Community Advisory Committee (CAC) provides a mechanism for structured input from KHS members regarding how KHS operations impact the delivery of their care. The Board of Directors delegates the CAC to provide input in the development of public policy activities for KHS. The committee makes recommendations and reports findings to the Board of Directors. The role of the CAC is to implement and maintain community linkages.

Function – The functions of the CAC are as follows:

1. Review changes in policy or procedures that affect KHS Members.
2. Provide updates on state policies or issues that affect Members.
3. Allow committee members to have input on issues that have an impact on KHS Members (i.e. marketing materials, KHS website including the web Provider Directory or Doctor Search, the Evidence of Coverage, brochures, flyers, Health Education materials, Radio/TV/Billboard advertisements, incentive ideas/items, etc.).
4. Allow committee members to share experiences that will help KHS improve how care is delivered.
5. Advise on educational and operational issues affecting members who speak a primary language other than English;
6. Advise on cultural and linguistic issues.

8. Quality Improvement Workgroup (QIW)

The focus of the QIW is on clinical quality, patient safety, and patient and provider experience in four functional areas: HEDIS/Medi-Cal Managed Care Accountability Sets (MCAS), NCQA Accreditation, Quality Improvement, and Network Clinical Oversight. The QIW will ensure KHS members receive quality health care by identifying and addressing outcomes that deviate from standards in the afore-mentioned committee responsibilities.

Activities:

1. Review and approve the QIHE Program Description, the annual Work Plan, and annual Evaluation of the work plan.
2. Ensure compliance with DHCS facility site review requirements.
3. Review aggregate data of potential quality of care issues (PQIs), identify areas of improvement, and oversee implementation of improvements.
4. Oversee KHS safety program.
5. Oversee the identification of quality-of-care trends and recommend corrective action as needed.
6. Monitor evidence-based care through the HEDIS and Managed Care Accountability Set (MCAS) audit and make recommendations for areas of improvement.
7. Review and discuss YTD quality improvement initiatives.
8. Monitor member satisfaction by reviewing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Outcomes and address measures of dissatisfaction.

9. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a subcommittee of the EQIHEC and focuses on the UM activities. The UM Committee supports the QIHEC around appropriate provision of medical services and provides recommendations for UM activities. The responsibilities of the UMC are to develop, recommend, and refine the UM program policies and procedures, including medical necessity criteria, establishment of thresholds for acceptable utilization levels, and reliability of clinical information with the involvement of appropriate, actively practicing practitioners; and develop and implement a monitoring system to track, compile and evaluate UM measures against pre-established standards and the identification of over and under and utilization patterns.

Activities:

a. Establish and implement written utilization management protocols and criteria applicable to the review of medical necessity for inpatient, outpatient, and ancillary services.
b. Ensure that UM decisions:

1) Are made independent of financial incentives or obligations.
2) Medical decisions, including those by delegated providers and rendering providers, are not unduly influenced by fiscal and administrative management
3) Physician compensation plans do not include incentives for denial decisions.
4) Physician and UM decision designees are not rewarded for utilization review decisions.

c. Educate staff, contracted practitioners, and vendors on KHS utilization management policies and procedures to ensure compliance with the goals and objectives of the Utilization Management Program.
d. Review established nationally acceptable utilization benchmarks, medical literature, and outcome data, as applicable.
e. Develop and implement a monitoring system to track, compile and evaluate patterns and variations in care.
f. Continually monitor and evaluate utilization practice patterns of staff and contracted practitioners and vendors and identify variations in care.
g. Review state regulatory oversight of LTC and CBAS facilities and develop and maintain a process to identify and work with Quality and Credentialing teams to address quality issues.
h. Develop and maintain effective relationships with linked and carved-out service providers available to members through County, State, Federal and other community-based programs to ensure optimal care coordination and service delivery.
i. Facilitate and ensure continuity of care for members within and outside of KHS network.
j. Develop and implement performance measures to assure regulatory turn-around-time frames are met.

J. QI Support Committees

1. Delegation Oversight Committee

The purpose of the Kern Health Systems (KHS) Delegation Oversight Committee (DOC) is to ensure adequate oversight of performance and adherence to regulatory contracts, requirements, and KHS standards related to subcontractors to which KHS delegates any plan-required function(s). This includes oversight of the entire spectrum, from pre-delegation auditing, monthly Joint Operating Meetings, routine oversight of delegate reporting and/or audits, and annual audits conducted by KHS Department leads and staff. The Compliance Department is the leader, facilitator, and coordinator of formal audits of Delegated Entities as outlined in the annual compliance and monitoring/auditing work plans.

KHS may choose to delegate Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Credentialing, Compliance, Claims, and other departments activities and responsibilities to qualified entities, where regulatorily allowed. The DOC is responsible to oversee the ongoing assessment of performance results to ensure contract and regulatory requirement adherence, as well as achieving business goals and outcomes to deliver quality outcomes for our members.

Duties and Responsibilities

1. Evaluate prospective delegated vendor's ability to perform the proposed delegated activities prior to delegation through a pre-delegation audit conducted by the relevant business areas.
2. Ensure KHS departments which delegate functions establish performance and reporting deliverables for departmental business needs designed to assess the effectiveness of health care delivery to members and compliance with regulatory requirements.
3. Review business owners' updates on monitoring and oversight activities and subcontractor performance, recommending action and providing feedback where necessary.
4. Assist Departments with establishing effective departmental auditing tools designed to measure and report delegated entity performance to ensure compliance with regulatory requirements.
5. Review results of all annual audits of delegated entities, as coordinated by the Compliance Department in accordance with the annual compliance, monitoring and auditing work plans.
6. In conjunction with the Delegation Oversight department, ensure KHS business owners perform all necessary oversight of the functions delegated as set forth in the written delegation agreement on behalf of KHS.
7. Review and evaluate delegated entity's performance, including business owner updates on monitoring and oversight activities presented to the DOC.
8. Assist with identifying opportunities for performance improvement and /or recommending corrective action plans as needed when a deficiency has been identified.
9. Review findings, recommended changes to contracts and policies, and requested initiatives or project updates by the delegate entity.
10. Make recommendations to the Chief Compliance and Fraud Prevention Officer, Compliance Committee, Contract Business Owners, Governance and Compliance Committee and/or Board of Directors regarding the compliance status of the delegated entity as it relates to compliance with regulatory requirements, performance, and/or other documented requirements.
11. Escalate outstanding issues from the DOC to the Compliance Committee and/or Kern Health Systems Board of Directors, as needed.
12. Recommend and provide oversight of corrective action plans (CAPs) to address deficiencies from initiation through CAP closure.

13. Propose sanctions up to and including the revocation and/or termination of delegation if the delegated entity's performance is inadequate and corrective action plans are not successful.

2. Physician Advisory Committee (PAC)

The functions of the Physician Advisory Committee (PAC) encompass multiple activities to include, serving as the KHS Credentialing and Peer Review Committee, overseeing and determining the review and approval of medical technologies and clinical criteria sets, addressing and managing the review of sentinel conditions or adverse events identified for quality concerns, and evaluates the credentials of all current and prospective practitioners and providers to be added to the KHS network, based upon requirements by DHCS, DMHC, CMS, or applicable law. The PAC is actively involved in the establishment of policies related to KHS Code of Conduct, Protected Health Information (PHI) and Fraud Waste and Abuse (FWA). The PAC is comprised of a broad spectrum of KHS participating physician representatives from primary and specialty care.

PAC- Credentialing and Peer Review

The minutes are confidential, and information is protected under California Business and Professions Evidence Code 1157. In accordance with state law, minutes containing confidential peer review information will be redacted. The responsibilities of the Credentialing/Peer Review Committee are to develop, monitor, and maintain credentialing standards, oversight of the credentialing program, delegated credentialing oversight, conducting performance monitoring from quality improvement activities and member complaints in the recredentialing decision making process for the KHS network of Participating Practitioners and Health Delivery Organizations. The PAC Committee establishes and maintains credentialing/re-credentialing policies and procedures that are consistent with National Committee for Quality Assurance (NCQA) standards, as well as applicable State and Federal laws and regulations. The Credentialing Committee may not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation, patient type or patient's insurance coverage in which the practitioner specializes.

Activities:

a. Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards.
b. Promote continuous improvement in the quality of the care and service provided by the KHS Network Providers.
c. Investigate patient, member or practitioner complaints or concerns about the quality of clinical care or service provided and to make recommendations for corrective actions, if appropriate.
d. Provide guidance on the overall direction of the credentialing program.

e. Review at least annually the Credentialing Committee Program Description to assure that the program is comprehensive, effective in meeting the goals and standards of KHS credentialing/ recredentialing procedures and supports the Continuous Quality Improvement process.
f. Evaluate quality concerns related to medical care and make determinations as to whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards.
g. Monitoring the reporting of Provider Preventable Conditions

PAC-Medical Technologies and Clinical Criteria Sets

a. The PAC uses principles of evidence-based medicine in its evaluation of clinical guidelines oversight and monitoring of the quality and cost-effectiveness of medical care provided to KHS members.
b. Performs reviews of technologies for use by medical and behavioral staff in the utilization review process.
c. Outlines the medical necessity criteria for coverage for a specific technology, service, or device and as applicable incorporates Federal and State regulations.
d. Ensures KHS does not exert economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted, nor to pressure providers or institutions to render care beyond the scope of their training or experience.
e. Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers;

PAC-Code of Conduct, Confidentiality, and Fraud Waste and Abuse

The PAC is instrumental in participating in the establishment and maintenance of:

1. Confidentiality policies and procedures for protection of confidential member, practitioner, and provider information in accordance with applicable state and federal regulations.
2. Protection of member identifiable health information by ensuring members' protected health
   information (PHI) is only released in accordance with federal, state, and all other regulatory agencies.
3. Providing oversight in strategies to reduce FWA in provider networks.

3. Compliance Committee

Kern Health Systems (KHS) is committed to the preservation and integrity of its mission through the enforcement of contractual, legal, ethical, and regulatory standards and guidelines. All KHS employees are expected to adhere to these governing laws, regulations, and ethical standards. Management is responsible for ensuring such compliance; therefore, compliance is an integral part of good organizational governance.

The establishment of the KHS Compliance Committee (Committee) through this Charter evidence KHS' commitment to the highest integrity and ethical standards, thereby supporting compliance with contractual obligations, all applicable laws, and regulations. The Compliance Committee is an oversight committee.

1. The Compliance Committee's responsibilities include, but are not limited to:

a. Determine the appropriate strategy and/or approach to promote compliance; to prevent, detect, and correct potential violations; and to advise the Compliance Officer accordingly.

b. Review and approve training related to Compliance and Fraud, Waste, or Abuse issues and ensure that training and education are effective and appropriately completed;

c. Review Fraud, Waste or Abuse Reports, including member and provider reported cases;

d. Review reported HIP AA Incidents, including prevention education;

e. Review Timely Access Reporting;

f. Review DHCS Attestation Reporting deliverables;

g. Review delegated entities to ensure their performance on delegated functions meet KHS standards;

h. Review internal and external audits reports and auditing tools, including reporting outcomes and remediation efforts. Address when there is risk of program non-compliance and/or potential FWA, and ensure CAPs are implemented and monitored for effectiveness;

i. Review overall effectiveness of the internal controls designed to ensure compliance with applicable regulations in daily operations;

j. Review reports from the Compliance Officer, on at least a quarterly basis, concerning the Compliance Program;

k. Monitor the Quality Improvement and Grievance Processes, including opportunities to improve quality and service through trend management;

l. Validate that KHS has appropriate and current compliance policies and procedures;

m. Review the Office of Compliance's process for soliciting, evaluating, and responding to reports and disclosures within the Compliance Program.

n. Oversee the implementation of applicable federal and state programs, including contractual, legal, and regulatory requirements, as they relate to compliance risk, and coordinate with the Compliance Officer to ensure the adequacy of the Compliance Program to manage the compliance oversite of programs; and

o. Respond and manage Ad Hoc issues.

2. In accordance with KHS Policy 4-40-P Corrective Action Plans, the Compliance Committee will monitor the issuance of Corrective Action Plans (CAPs) by the KHS Physician Advisory Committee (PAC). The Compliance Committee will also review tracking and trending concerns and make recommendations when deemed necessary.

3. In collaboration with the PAC, the Compliance Committee, shall evaluate the effectiveness of each CAP and make recommendations regarding ongoing monitoring activates to ensure continued compliance.

4. Health Equity Advisory Board

The Health Equity Advisory Board recruits racially, ethnically, and culturally diverse (including those from LGBTQI+ communities) people from various stakeholder groups across the County. These include, but are not limited to, general consumers from racial groups that make up KHS's members, Kern County health officer or a designated representative, County Human Services representatives, community advocates, and traditional and safety net providers. Advisory Board members focus on issues of diversity, equity, and inclusion in KHS procedures and metrics to improve health equity. They may:

- Participate in establishing public policy which is defined as acts performed by KHS or its employees and staff to assure comfort, dignity and convenience of patients who rely on KHS' facilities to provide health care services to them, their families, and the public.
- Review and make recommendations on marketing and member materials.
- Review and make recommendations on the complaints and grievance process.
- Review and make recommendations on member and provider satisfaction surveys.
- Review and make recommendations on activities related to Quality Improvement, educational, operational, and cultural competency issues affecting Limited English Proficiency (LEP) members.
- Review and make recommendations on staff & provider health equity related training
- Review and make recommendations on contracted vendors and CBOs.

5. Health Equity and Learning (HEAL)

The mission of the Provider HEAL Committee is to foster a collaborative environment among healthcare providers in Kern Health Systems, dedicated to advancing health equity. The purpose of the committee is to:

1. Solicit Feedback: Act as a platform for providers to share challenges faced in the field and gather feedback to address issues related to health equity to help inform the development of KHS's training offerings, programs and support for Provider Network
2. Resource Sharing: Facilitate the exchange of resources, funding opportunities, best practices, and innovative approaches to improve healthcare service delivery with a focus on health equity
3. Training and Development: Identify, develop, and promote opportunities for training and professional development to enhance providers' knowledge and skills in delivering equitable healthcare
4. Practice Expansion: Explore and discuss opportunities for expanding access and/or services that align with and support health equity initiatives

Composition

The HEAL reports to the Health Equity Steering and Transformation Committee.

Membership

1. Membership in the Provider HEAL Committee is open to all healthcare practices within Kern Health Systems network that express an interest in promoting health equity.
2. Membership is voluntary and may include healthcare professionals, administrators, and other relevant stakeholders.
3. Members are expected to actively contribute to the mission and objectives of the committee.

Meetings

1. The committee shall meet regularly, at least quarterly, either in person or virtually
2. Additional ad-hoc meetings may be called as necessary to address specific issues or opportunities.

6. Regional Advisory Committee (RAC)

The Regional Advisory Committee (RAC) is a quarterly meeting held in one city in each of the five regions of Kern County. Every quarter a topic is selected to discuss with Members and community stakeholders to learn strategies for improvement and challenges being faced. The meetings are open to everyone in the region and information gained from each region is synthesized to help inform gaps and best practices occurring throughout the county.

These finding are presented to the Health Equity Transformation Steering Committee (HETSC) for review and determination of action steps to address the needs of the county and services to Kern Family Health Care members.

IV. Organizational Structure and Resources

A. Clinical Oversight of QIHEP

Under the direction of the CMO, the Medical Directors are responsible for clinical oversight and management of the QI, UM, BH, Wellness and Prevention and PHM activities, participating in QIHEP for KHS and its Practitioners, and overseeing credentialing functions. Medical Directors must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one (1) of the American Specialty Boards. Principal accountabilities include:

1. Developing and implementing medical policy for Health Services department activities and QI functions;
2. Reviewing current medical practices ensuring that protocols are implemented and medical personnel of KHS follow rules of conduct;
3. Ensuring that assigned Members are provided health care services and medical attention at all locations;
4. Ensuring that medical care rendered by Practitioners meets applicable professional standards for acceptable medical care.

B. Quality Improvement Department (QI)

Quality Improvement Director

Under the direction of the Chief Medical Officer (CMO) and Quality Improvement (QI) Medical Director, the Director of Quality Improvement leads the development, implementation, and oversight of QI initiatives to enhance health outcomes and address health disparities within the Kern Health Systems (KHS) membership. The Director ensures alignment with the KHS Quality Management Plan, Medi-Cal contractual requirements, and NCQA accreditation standards while fostering a culture of continuous improvement.

Key responsibilities include:

- QI Program Development: Designs and implements programs that align with KHS's Health Equity and Quality Improvement goals, regulatory standards, and contractual obligations.
- Performance Monitoring & Reporting: Oversees data collection, medical record reviews, and analysis of key performance indicators to inform decision-making.

- Provider & Community Collaboration: Engages with contracted providers and external partners to drive QI initiatives, address disparities, and improve member health outcomes.
- Regulatory Compliance & Accreditation: Ensures compliance with Medi-Cal QI requirements, oversees credentialing, and leads efforts for accreditation preparedness.
- Interdepartmental Coordination: Facilitates collaboration across KHS departments and external agencies to integrate QI activities into organizational workflows.
- Leadership & Workforce Development: Provides mentorship to QI staff, ensuring professional growth and alignment with KHS's health equity objectives.

The Director of QI plays a pivotal role in advancing health equity by identifying disparities, implementing targeted interventions, and continuously improving healthcare quality across the KHS network.

NCQA Manager

The NCQA Manager, under the direction of the Director of Quality Improvement, ensures KHS maintains NCQA accreditation and compliance with State regulations related to the Quality Improvement Program. This role provides oversight for the successful completion of initial and renewal accreditation efforts and ensures ongoing alignment of KHS departments with NCQA standards, State certification, and contractual quality requirements.

Key responsibilities include:

- Accreditation & Regulatory Compliance: Leads the development, implementation, and coordination of policies, procedures, and workflows to meet NCQA, Medi-Cal, and Medicare D-SNP model of care requirements.
- Quality Program Support: Integrates NCQA standards and State regulations into QI processes, ensuring compliance across all KHS business areas.
- Policy & Process Development: Oversees the development and revision of accreditation and compliance policies, incorporating feedback from regulatory agencies.
- Cross-Departmental Collaboration: Works with KHS leadership and staff to embed quality improvement initiatives into organizational operations, supporting a culture of continuous improvement and health equity.

The NCQA Manager plays a critical role in maintaining KHS's commitment to quality, accreditation, and regulatory compliance, ensuring that all initiatives support health equity and member-centered care.

NCQA Accreditation Specialist

Under the direction of the NCQA Manager, the NCQA Accreditation Specialist supports the planning, execution, and maintenance of NCQA Health Plan and Health Equity Accreditation at Kern Health Systems (KHS). This role ensures

accreditation readiness by coordinating efforts across departments, following established guidelines, and maintaining a comprehensive NCQA accreditation work plan.

Key responsibilities include:

- Accreditation Readiness & Compliance: Assists in managing the NCQA accreditation process, ensuring adherence to standards, quality studies, and interventions that support regulatory compliance and health equity goals.
- Process Coordination & Monitoring: Leads interdepartmental coordination to support accreditation requirements, track progress, and facilitate corrective action plans.
- Quality & Performance Enhancement: Works to ensure outstanding clinical performance and a positive member experience, contributing to KHS's commitment to continuous quality improvement and equitable care.

The NCQA Accreditation Specialist plays an essential role in sustaining NCQA compliance, ensuring high-quality care delivery, and reinforcing KHS's mission to advance health equity and member well-being.

Quality Improvement Manager, RN

Under the direction of the Director of Quality Improvement, the Quality Manager ensures state, regulatory, and contractual compliance for the Quality Improvement (QI) Program.

Key responsibilities include:

- Regulatory & Audit Oversight: Manages delegation audits, and external quality reviews, ensuring compliance with Medi-Cal and contractual requirements.
- Quality Improvement Initiatives: Leads Improvement Plans, PIPs, and other targeted quality initiatives aimed at enhancing care delivery and patient outcomes.
- Operational Leadership: Applies clinical expertise and analytical skills to oversee the day-to-day operations of the QI team, driving data-informed strategies to improve performance and member health equity.

The Quality Manager plays a critical role in advancing quality improvement efforts, ensuring compliance, and supporting KHS's mission to enhance equitable and high-quality care.

Quality Improvement Supervisor, RN

The Quality Improvement (QI) Supervisor RN oversees the daily operations and activities of clinical and non-clinical staff within the QI Department, ensuring the effective management of clinical grievances, Potential Quality Issues (PQIs), Performance Improvement Projects (PIPs), and other key quality initiatives. This role involves providing leadership, guidance, and oversight to maintain compliance with regulatory requirements and drive continuous

improvement. The QI Supervisor collaborates closely with the QI Manager to optimize workflows, enhance efficiency, and support the successful execution of quality improvement initiatives.

Quality Improvement Nurse, RN

The QI Nurse assists in clinical activities related to monitoring, assessing, and improving performance in ambulatory and inpatient health care delivery or health care related services to Kern Health Systems (KHS) membership. The QI Nurse assists in the implementation of the KHS QI Program Plan by doing the following activities:

- Communicates with contracted providers regarding studies and audit findings,
- Delivers provider or member education in support of quality health care,
- Conducts medical record reviews and audits, and HEDIS or HEDIS-like chart reviews,
- Performs clinical investigation of potential quality of care issues and grievances and writes an effective clinical summary of the investigation for referral to a medical director,
- Develop and ensure completion of provider corrective action plans related to quality-of-care issues or regulatory or accreditation non-compliance,
- Develop and complete performance improvement projects aimed at improving member compliance with specific preventive health measures.

Quality Improvement Coordinator

Reporting to the Quality Manager, the Quality Improvement (QI) Coordinator plays a key role in data collection, record maintenance, and regulatory compliance support for the QI Program. This position is integral to Managed Care Accountability Set (MCAS) initiatives, intervention development, and provider site review activities.

Key responsibilities include:

- Data Collection & Reporting: Supports MCAS methodology, assists in data entry, report preparation, and ensures accurate documentation for QI activities.
- Regulatory & Compliance Support: Assists in medical record requests, record preparation, and QI interventions, ensuring readiness for audits and compliance with State and contractual requirements.
- Provider Site Review Assistance: Provides administrative support for facility site reviews and collaborates with internal departments and external agencies to facilitate QI initiatives.

The QI Coordinator plays a vital role in supporting quality improvement efforts, ensuring regulatory compliance, and assisting in the execution of data-driven health equity interventions within the QI Program.

C. Quality Performance Department (QP)

Senior Director of Contracting and Quality Performance

Under the direction of the Chief Operating Officer (COO) and Chief Medical Officer (CMO), the Senior Director of Contracting and Quality Performance (QP) is responsible for provider contracting, quality performance, and practice transformation initiatives at Kern Health Systems (KHS). This role ensures the integrity of provider agreements, value-based care initiatives, and quality improvement (QI) programs, aligning with regulatory, legal, and strategic business objectives.

Key responsibilities include:

- Contracting & Compliance: Develops and negotiates provider contracts, ensuring compliance with regulatory requirements, risk mitigation, and alignment with KHS's business needs.
- Quality & Performance Management: Oversees Pay-for-Performance (P4P) programs, Managed Care Accountability Set (MCAS) reporting, and provider QI initiatives to enhance provider engagement and healthcare quality.
- Practice Transformation & Value-Based Care: Supports providers in transitioning to value-based care models, leveraging health IT and data analytics to improve care delivery and health equity.
- Provider Network Efficiency & Financial Performance: Leads process improvements, rate development for provider contracts, and oversight of special provider funding distributions.
- Credentialing & Compliance Oversight: Ensures facility site review processes, credentialing standards, and provider compliance with contractual and legal requirements.

The Senior Director of Contracting and QP plays a critical role in driving provider network integrity, optimizing quality performance, and advancing health equity, ensuring that contracted providers deliver high-quality, culturally competent, and accessible care for KHS members.

Director of Quality Performance

Under the direction of the Senior Director of Contract and Quality Performance, the Director of Quality Performance is responsible for oversight, implementation, and management of new quality improvement initiatives specific to the Provider Network and membership. This includes being responsible for HEDIS and MCAS functions and collaborating and supporting providers to improve health outcomes related to those measures. The Director is also responsible for quality improvement initiatives related to Performance Improvement Projects (PIPs) and Facility Site Reviews (FSRs). The Director will communicate and coordinate with contract providers regarding required studies, participation, and improvement projects. Related duties include ongoing data collection, medical record reviews, report writing, and collaboration with other KHS departments, as well as outside agencies.

The Director of Quality Performance is responsible for HEDIS/MCAS and performance and site review components of the Quality Improvement Program. This position will be responsible for oversight of maintaining compliance with Medi-Cal contractual stipulations for the performance of KHS and KHS contracted providers. In addition, this person will be an effective contributor to the KHS business planning and fiscal processes.

Essential Functions include:

- Builds and develops collaborative relationships (internally and externally) vital to the success of programs.
- Assisting network providers and their staff with practice transformation plans to shift into value-based care, improving quality and encounter data submissions.
- Helps practices to identify areas of need and helps with efficiency measures to improve availability, through sharing of scorecards, delivering gaps-in-care information and risk reports, sharing of satisfaction results as applicable, and delivering other critical operational and efficiency reports.
- Monitors and ensures that key quality activities are completed on time and accurately to present results to key departmental management.
- Evaluates project/program activities and results to identify opportunities for improvement.
- Responsible for Quality Performance staff and processes.
- Work collaboratively with Senior Director and Provider Network team to develop physician practice performance profiling on HEDIS/MCAS/STAR metrics, identify opportunities for improvement, and support/manage change implementation.
- Establishes and maintains tracking and monitoring systems for health care quality improvement activities according to regulatory requirements, policies and procedures, and contractual agreements.
- Track and monitor the HEDIS/MCAS improvement operations.
- Identify opportunities and potential barriers in HEDIS/MCAS
- Research and documents current health care standards for use in performance improvement study design and methodologies related to health outcomes.
- Provides guidance, and oversight to staff regarding study design, methodology, data analysis and reporting of Quality performance improvement projects.
- Works with staff to achieve production, timeliness, accuracy, and quality of work.
- Remains current with Department of Health Care Services and Department of Managed Care policy implementation or revisions.
- Participates in the development, review and updating of policies and procedures.

- Manages and evaluates performance of department staff.
- Coordinates guidelines, studies, and performance improvement activities in concert with the utilization management, quality management, pharmacy services, and population health management teams.
- Remains current with HEDIS/MCAS requirements and participates in planning and implementation of methods to improve HEDIS/MCAS performance.
- Education of providers on HEDIS/MCAS and program goals.
- Ensures compliance with applicable regulatory and reporting requirements.
- Coordinates the regular and systematic review of all potential quality of care issues in accordance with state statute.
- Develops and analyzes reports to monitor and evaluate quality performance in meeting established goals.

Quality Performance Nurse, RN

The QP nurses possess a valid California Registered Nursing license and three years registered nurse experience in an acute health care setting preferably in emergency, critical and/or general medical-surgical care. The QP nurses assist in the implementation of the QI Program and Work Plan through the quality monitoring process. Staffing will consist of an adequate number of QI nurses with the required qualifications to complete the full spectrum of responsibilities for the QI Program development and implementation. Additionally, the QI nurses teach contracting providers DHCS MMCD standards and KHS policies and procedures to assist them in maintaining compliance. The primary function of the QP nurse is implementation and support of MCAS performance and KHS' site review program.

MCAS/HEDIS Supervisor

The QP MCAS/HEDIS Supervisor is responsible for oversight and daily operations of KHS' MCAS/HEDIS performance. The Supervisor possesses a bachelor's degree or higher in Healthcare, Business, Data Science, Project Management, or related field. They have at least 2 years' experience in Quality Improvement or in a health care environment with relevant Quality Improvement experience. They also have at least two (2) years' experience in project management work. Under the direction of the Director, the Supervisor manages, plans, coordinates, and monitors Quality Special Programs including but not limited to:

- Annual Managed Care Accountability Set (MCAS) audit and measurement results submission.
- QI Department Strategic Goals and Projects, and Special Programs (such as member incentives

and engagement, DHCS-required project improvement plans, site reviews, etc.).

Quality Performance Operations Analyst

The QP Operations Analyst is responsible for reporting needs related to MCAS and site review reporting needs. The Analyst serves as the Subject Matter Expert (SME) for MCAS and HEDIS aspects of KHS' Quality Program.

Under the direction of the Supervisor and Director, this position provider oversight, management, and validation of data and reports submissions for the annual DHCS MCAS/HEDIS audit. This includes serving as the liaison between the QP department, vendors, and internal KHS departments, such as IT.

Quality Performance Coordinator

The QP Coordinators are responsible for functions related to data collection, data entry, report preparation, maintenance, collaboration, and regulatory compliance support for the department. The coordinator serves as the liaison between the health plan and provider network for record retrieval, scheduling, and various departmental initiatives and interventions. Under the direction of the QP Director and/or Supervisor, the Coordinators perform Quality related duties, including but not limited to MCAS data collection, sorting, chasing, and analyzing medical records.

D. Health Equity Department

Chief Health Equity Officer (CHEO)

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

Health Equity Manager

The Health Equity Manager is responsible for the daily management of the QIHEP including development and management of projects and activities to expand and advance the delivery and quality of health equity measures,

cultural competency services, operational effectiveness through process improvement, contract execution, and monitoring. The Health Equity Manager supervises all staff directly working in the Health Equity Office (HEO).

Senior Health Equity Analyst

The Senior Health Equity Analyst will provide reports, data analytics, project management, process improvement, and data integrity based on the collection, association, compliance review, and interpretation of data and operational processes. The Senior Health Equity Analyst is responsible for developing a complete understanding of the stated and actual needs of Health Equity Office stakeholders (internal and external), not simply their expressed desires, through a methodical analytical process, identify and report gaps, and help develop solutions to address revealed findings. The Senior Health Equity Analyst assists the HEO in defining the technical and reporting needs of KHS's QIHEP and HETSC initiatives and may facilitate or govern analytical discussions between various groups.

Health Equity Project Coordinator

The Health Equity Project Coordinator coordinates and organizes projects for the Health Equity Office. Supports the successful implementation of projects within timelines for associated department assignments and tasks. This position also coordinates the functions of the EQIHEC and all subcommittees.

E. Appeals and Grievances

Member Grievances and Appeals System

KHS Member Grievance and Appeal system complies with the requirements set forth in the 42 Code of Federal Regulations Sections 438.228 and 438.400 – 424, 28 California Code of Regulations Sections 1300.68 and 1300.68.01, and 22 CCR Section 53858. KHS use all notice templates included in the All-Plan letter 21-011 and ensures timely written acknowledgement and a notice of resolution to the member as quickly as possible.

Grievances with a Potential Quality Issue (PQI) identified are referred to the QI department as a PQI referral for further investigation and action. All potential quality of care issues are reviewed by the KHS CMO or their designee to determine the severity level and follow-up actions needed. All cases are tracked and the data provided to the CMO or designee during the provider credentialing/re-credentialing process. Other actions may include tracking and trending a provider for additional PQIs and/or request(s) for a corrective action plan (CAP) for issues or concerns identified during review. The CMO or their designee may present select cases to the PAC for review and direction as needed.

KHS regularly analyzes grievance and appeals data to identify, investigate, report and act upon trends impacting health

care access and delivery to the members.

Grievance Satisfaction Data – KHS reviews Member grievances and satisfaction study results as methods for identifying patient safety issues.

F. Credentialing

The Credentialing Department operates under the direction of the Deputy Director of Contracting and Quality Performance, who reports to the COO and is responsible for Provider Operations, including credentialing and re-credentialing functions, oversight for directly contracted Practitioners, Providers, and delegated IPAs, and resolving credentialing-related Provider issues.

Provider Operations, which includes Provider Contracting, Provider Network Management, Provider Relations, and Provider Training & Development, is committed to having a culturally competent and linguistically accessible network comprised of diverse providers who are knowledgeable and responsive to members' cultural practices and beliefs. This includes a commitment to identifying, assessing, and addressing behavioral health inequities to eliminate disparities and ensure access to healthcare for all members. Provider Operations contributions to organizational QIHE initiatives includes the management of providers' profile and demographic data analyses to that of the KHS members' cultural and linguistical needs.

G. Member Services

KHS implements and maintains written policies and procedures that set forth the Member's rights and responsibilities and shall communicate its policies to its Members, Providers, and, upon request, potential members. Members are also assured of their rights to confidentiality, right to advance directives, and rights to linguistic services.

H. Pharmacy Department

Safety Monitoring: Pharmacy will expand on the current monitoring of opioids/controlled substances as defined by the SUPPORT Act. Though previously managed via prospective Pharmacy Benefit Manager (PBM) rules, KHS will retrospectively review claims for possible action in regard to the Beer's list for geriatric members. KHS will also monitor drug recalls issued by the FDA or manufacturer. Currently for monitoring the potentially inappropriate use of opioids, either, high dose, those without naloxone, and/or in combination with other agents acting on the central nervous system such as benzodiazepines, and muscle relaxants, KHS sends notification letters to the physician on record to evaluate the appropriateness of the regimen for that member.

The Director of Pharmacy or designee participates in interdisciplinary teams weekly to discuss drug regimens of select members. KHS also sends letters to providers regarding drug profiles of members that have been identified as having drug duplications, interactions, and/or missing therapies.

Pharmacy is developing a series of report suites that will identify all HEDIS/MCAS measures we are held accountable for or will be added in the following year (2024). These reports identify members who are non-compliant for that measure, and we will be working with other depts to best close the gap. The approach will incorporate brining in the local pharmacies to help with outreach to the members and providers.

I. Population Health Department (PHM)

The Kern Health System (KHS) Population Health Management (PHM) Service will support whole-person care by integrating and aggregating historical administrative, medical, behavioral, dental, social service and program information from disparate sources. This integrated approach will drive risk-stratification, segmentation, tiering, assessment and screening processes, analytics, and reporting. By transforming raw data into actionable insights, PHM will identify opportunities for continuous quality improvement, reduce bias and error in decision-making. KHS will connect its members to the right services and supports at the right time and place depending on their needs and preferences.

In addition to data integration, PHM will facilitate meaningful engagement with network providers, public health agencies, schools, and community-based organizations (CBOs) to enhance data sharing across delivery systems. These partnerships will promote care coordination and help identify and mitigate social determinants of health (SDOH) that contribute to health disparities. Through these collaborative efforts, KHS aims to connect all members to primary care, preventive and wellness services, and disease management programs while ensuring members at risk for complex health issues are linked to specialized services.

PHM will also gather, share, and assess timely and accurate member data to identify efficient and effective opportunities for intervention. This will be achieved through data-driven risk stratification, predictive analytics, identification of care gaps, and standardized assessment processes. These tools will allow KHS to proactively identify members with rising health risks and provide personalized interventions to improve health outcomes and reduce health disparities.

KHS will support the unique needs of members population, including health and social needs (e.g., behavioral, developmental, physical, and oral health); Long-Term Services and Supports (LTSS) needs as well as health risks, rising risks, and health-related social needs due to social determinants of health (SDOH) in the Population Needs Assessment. KHS is committed to ongoing initiatives to deliver comprehensive, equitable care across its service areas.

J. Human Resources Department

The KHS Human Resources Department is dedicated to promoting diversity and inclusivity within the workforce. Comprised of Talent Acquisition, Employee Relations, Benefits and Wellness Programming, and Learning and Professional Development, the department is committed to implementing equitable and accessible recruiting, hiring, onboarding, professional development, and succession planning practices to ensure and sustain a diverse workforce. To enhance cultural and linguistic competency within the organization, the HR department prioritizes creating a culture of trust, empathy, and humility, guiding employees towards a deeper understanding of cultural and linguistic diversity in their daily work. The department will also work towards developing policies and leadership practices that continuously support diversity, equity, and inclusion in compliance with regulations, supportive of organizational values, and in pursuit of industry best practices. This will help the organization remain trusted and highly responsive to the needs of employees and the communities it serves.

1. Hiring Initiatives

As described in the KHS DEI Program charter, KHS is dedicated to building a workforce that is diverse, qualified, and engaged, and one that reflects the diversity of the communities KHS serves in Kern County. KHS strives to create a workplace environment that is safe, inclusive, and strengths-based, providing abundant opportunities for employees of all backgrounds, cultures, and linguistic abilities to belong and flourish. Human Resources and Hiring Managers are responsible for ensuring that recruiting, hiring, and succession planning practices are inclusive and reflect the demographic needs of the communities.

Commitment to health equity in hiring, recruiting, and succession planning includes posting job opportunities in inclusive language across a network of diversity job sites and job boards to help attract a more diverse workforce, including groups of underrepresented individuals. KHS also incorporates inclusive language into job descriptions, conducts panel interviews with members reflective of the community's diversity, and uses standardized assessment tools. KHS aims to create a diverse and inclusive workforce that can provide better services to all communities.

2. KHS Bilingual Workforce

Departments who employ staff members to provide linguistic services to the membership include Behavioral Health, Wellness & Prevention, Marketing, Member Engagement, Member Services, Utilization Management, Population Health Management, Enhanced Care Management, Community Support Services, Quality Improvement, and Pharmacy. All bilingual staff must pass a verbal bilingual assessment before being hired or during employment. Certificates of linguistic proficiency are monitored and maintained by the Cultural and Linguistic Team. For KHS staff who have received certification of bilingual proficiency, a copy of the certificate is kept in their personnel file with Human Resources.

KHS defines qualified bi-lingual staff as:

- Proficient in speaking and understanding a language other than English.
- Having a fundamental knowledge in a language other than English that includes the use and application of specialized vocabulary, terminology and phraseology, and concepts.
- Having the ability to communicate directly effectively, accurately, and impartially with members who have limited English proficiency.

KHS Member Services Bi-lingual Representative staff will only provide oral interpretation services and are prohibited from providing written translation, including editing, and proofreading translated documents, and sight translation services.

K. Provider Network Management (PNM)

The Provider Network Management (PNM) department is responsible for growing and overseeing the Plan's network of providers and is comprised of: Contracting, Credentialing, Provider Relations, Provider Grants, and Analytics and Regulatory Reporting. The Senior Director of Provider Network heads the PNM department. The Deputy Director of Provider Contracts reports to the Senior Director of Provider Network and oversees Contracting and Credentialing. The Deputy Director of Provider Network reports to the Senior Director of Provider Network and oversees Provider Relations, and Provider Grants, and Analytics and Regulatory Reporting.

The Contracting Team is comprised of a Provider Contracts Supervisor, Contract Specialists, Coordinators. The Contracting Team is responsible for contracting with providers within and adjacent to the network service area to ensure network adequacy for all specialty types. The Contracting department also works with contracted providers to negotiate rates and implement special programs. As needed the Contracting team will negotiate single-case, Letter of Agreements (LOAs) with out-of-network providers.

The Credentialing Team is comprised of a Credentialing Manager and five Credentialing Coordinators. The PNM Credentialing team monitors and tracks provider licenses, certificates, training, Medi-Cal enrollment, and other applicable provider requirements. The Credentialing team also aids in maintaining accurate provider data utilized within Plan's regulatory reporting and provider directory.

The Provider Relations Representative Team is comprised of a Provider Relations Supervisor and seven Provider Relations Representatives. The Provider Relations Representatives are the direct link between the Plan and the Provider. The Provider Representatives are responsible for provider communication and education and conduct

outreach to noncontracted providers for potential recruitment.

The Grants Team is comprised of a Grants Manager and a Grants Specialist. The Grants Team is responsible for developing grant programs and identifying and reaching out to providers who may qualify for certain grants from the Plan. The Grants team is responsible for creation and tracking of appropriate grant's milestones and goals. The KHS grant program works to financially aid and encourage innovative efforts to bring beneficial services to our community.

The PNM Analyst team is comprised of the Provider Network Manager, Provider Network Analytics Program Manager, and three Senior Provider Network Analysts. The PNM Analyst Team is responsible for, monitoring network accessibility, network-related regulatory reporting (DMHC Timely Access and Annual Network Review, DHCS Annual Network Certification), the Provider Satisfaction Survey and maintaining the provider directory (in conjunction with credentialing team).

Provider network accessibility is primarily monitored via the Provider Network Management, Quarterly Network Review. The Quarterly Network Review includes, but is not limited to an Access Grievance Review, Provider Accessibility Monitoring Survey, Geographic Accessibility Review, and Network Adequacy/Provider Counts. These reports track and monitor the Plan's regulatory compliance to standards such as: PCP to member and Physician to Member ratios, Appointment Availability, Provider Response times, Provider After-Hours availability, and In-Office wait times. The PNM Analytics Team monitors and tracks members' geographic access to PCP, Specialist, Non-Physician Mental Health, Specialty OB/GYN, and Hospital providers and confirms the geographic access is within regulatory standards. If any provider type/geographic region is not meeting regulatory standards, it is the responsibility the PNM Analytics Team to request an Alternative Access Standard and identify potential providers for recruitment/contracting activities. The PNM Analytics Team reviews Access Grievance data to determine if any provider, group, or specialty is experiencing the same access issue on a continuous basis. The Provider Relations Department provides routine reports of access study data for review and recommended action by the EQIHEC.

L. Utilization Management Department (UM)

Please refer to the Utilization Management Program (UMP) Description for Utilization Management activities and related UM activities. The UMP is a formal Document supported by clinical, operational, and administrative policies and procedures (P&Ps) delineating how UM functions are performed. The UMP and P&Ps are written to adhere to federal and state regulatory requirements to include CA Health & Safety Code, Title 22, Welfare & Institutions Code, CMS Code of Federal Regulations, the CA Department of Health Care Services 22-20202 KHS Contractual Provisions, and current NCQA Standards and Guidelines. The UM documents are developed through the

involvement of actively involved KHS providers in accordance with H&S Code sections 1363.5 and 1367.01 and 28 CCR sections 1300.70(b)(2)(H) and (c). The UM Director is a standing member of the EQIHE Committee.

M. Behavioral Health Department (BH)

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

For substance use disorders KHS provides screening, brief intervention, and counseling (SBIRT) services and refers members for treatment for misuse of alcohol. Active treatment for Medi-Cal members with substance use disorder (SUD) services must be rendered by a SUD Drug Medi-Cal certified program.

KHS covers Behavioral Health Treatment (BHT), including Applied Behavior Analysis (ABA) therapy, for Medi-Cal beneficiaries under the age of 21.

N. Wellness and Prevention Department- Cultural and linguistics (C&L) and Health Education (HE)

Please refer to the Program Descriptions for Cultural and Linguistics and Health Education for C&L and Health Education activities and related wellness and prevention activities.

The Wellness & Prevention Department is responsible for providing comprehensive, culturally, and linguistically appropriate wellness and prevention services with the intent of promoting health behaviors, improving health outcomes, reducing risk for disease and empowering Members to be active participants in their health care. The W&P department is headed by the Senior Director of Wellness & Prevention and is composed of four teams:

- Cultural & Linguistic Services – comprised of a Manager, Cultural & Linguistic Specialists, and a Cultural & Linguistics Coordinator to provide comprehensive, culturally, and linguistically appropriate competent services to plan members with improved access and health outcomes. These services include, but not limited to linguistic services, translation of written member information materials, training and education for staff, providers, and contracted vendors, and assessing, monitoring, and evaluating the Cultural & linguistics services provided by the Plan, providers, and contracted vendors.
- Community Health & Wellness – comprised of a Manager, Health Education Specialist and Lifestyle Coach to establish community-based health and wellness initiatives that promote health, prevent illness, and improve health literacy to vulnerable communities in Kern County.

- Member Wellness & Prevention (MWP) – comprised of a Manager, Health Educators, Health Education Specialists and Lifestyle Coaches to provide health education, wellness, and prevention programs, services, interventions using evidence-based programs directly to our members or through partnerships with partner organizations. Services are delivered through one on coaching, group classes, written material such as member newsletters, brochures, and other health education material. Partner with providers to enhance provider/patient interaction and increase knowledge of member health education needs. The MWP has oversight of the readability and suitability standards and member incentive programs.
- Wellness & Prevention Partnerships – comprised of a Manager, Program Manager and Program Liaisons to establish and foster relationships and promote preventive service benefits among community partners and providers, such as the local public health department and Women Infants and Children programs, in order to expand access and reach of health and wellness programs and services to members.

KHS is committed to delivering culturally and linguistically appropriate heath care services. Services will comply with Title VI of the Civil Rights Act of 1964, section 1557 of the Affordable Care Act of 2010, 42 CFR section 438.10, Exhibit A, Attachment III, Section 5.2.10 (Access Rights), and APL 21-004. The Senior Director of Wellness and Prevention is a standing member of the EQIHEC.

O. Enhanced Care Management Department (ECM)

Please refer to the Enhanced Care Management Program Description for Enhanced Care Management activities and related ECM activities.

P. Community Support Services (CSS) Department

Please refer to the Community Support Services Program Description for CSS activities and related CSS activities.

Q. Business Intelligence (BI)

Functions include:

- Establish advanced health analytics to ensure that leadership has full purview into the population to improve individual experience of care; improve the health of the population while reducing per capital cost of care for populations.
- Create, manage, and continuously improve Corporate Key Performance Indicators (KPI's)
- Reduce operational silos and proactively manage and improve overall operations.
- Provide and validate standard metrics and information around process improved to ensure that

project goals, objectives, or Return on Investments (ROI) are achieved.

- Establish data governance over various systems to ensure that reliable data can be consumed for analytics and reporting.
- Manage all operational and regulatory reporting inventory for the organization.

R. Information System & Data Management

KHS utilizes information provided through the Information Technology (IT), Operations, and Provider Network Management departments. KHS MIS has the capability to capture, edit, and utilize various data elements for both internal management use and to meet the data quality and timeliness requirements. These include DHCS' encounter data, network provider data, program data, and template data submissions and processes. MIS also has the ability to meet Population Health Management data integration requirements and is able to provide the requested data to DHCS and Centers for Medicare and Medicaid Services upon request.

KHS's Information Technology (IT) Division, comprising of Data Analytics, Information Security, Technical Support Services, and Operational Systems follows the culturally and linguistically appropriate business practices as outlined by KHS Leadership and Human Resources. IT provides new technologies, and enhancing existing systems, to ensure that all KHS staff can perform their work in a culturally competent environment. This includes, but is not limited to, offering technologies and tools compliant with ADA standards, assistive technologies, and website compliance. Data Analytics shall support the organization's QIHE operational initiatives by collecting, storing, analyzing demographic data and profiles of both KHS members and providers, conducting statistical analyses, and aid in the development and facilitation of assessments and surveys.

KHS (MIS) has the capacity to enable interoperability for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks.

KHS MIS supports at a minimum:

- All Medi-Cal eligibility data.
- Information on members enrolled with Kern Health Systems.
- Provider claims status and payment data.
- Health care services delivery encounter data.
- Network provider data.
- Program data.
- Template data.

- Screening and assessment data.
- Referrals including tracking of referred services to follow up with Members to ensure that services were rendered.
- Electronic health records.
- Prior auth requests and specialty referral system.
- Care Management data.
- Care Coordination data.
- Financial information.
- Social drivers of health data.
- Grievance and appeal information.

S. Marketing

The Marketing Department operates under the direction of the Senior Director of Marketing, who reports to the Chief Health Equity Officer. The Marketing Department is responsible for conducting appropriate product and market research to support the development of marketing and Member communication plans for all products including Member materials (e.g., Member Newsletters, Evidence of Coverage, website, etc.). The Quality Improvement and Health Equity Departments work closely with the Marketing and Wellness & Prevention Departments to ensure that Member materials are implemented in a timely manner.

V. Role of Participating Providers

A. Provider Participation

KHS contracts with physicians and other types of health care providers. The Provider Network Management Department conducts a quarterly assessment of the adequacy of contracting providers. All PCPs and specialists must meet KHS credentialing and recredentialing standards. Contracting providers must meet KHS requirements for access and availability. Members may select their PCPs based on cultural needs and preferences. The Provider Directory lists additional languages spoken by PCPs or their office staff.

- **Provider Information** – KHS informs contracting providers through its Provider bulletins, letters and memorandums, distribution of updates to the Provider Policy and Procedure Manual, and training sessions.
- **Provider Cooperation** – KHS requires that contracting providers and hospitals cooperate with QI Program studies, audits, monitoring, and quality related activities. Requirements for cooperation are included in provider and hospital contract language that describe contractual agreements for access to information.

- **Provider Performance** – KHS requires contracted providers to comply with DHCS' Managed Care Accountability Set (MCAS) and participate in quality-based initiatives aimed at improving, access, quality, and health equity for our members. Routine meetings are conducted with a subset of participating providers to ensure monitoring, communication, and supporting of achieving MPLs and maintaining high quality care.

B. Provider and Hospital Contracts

Participating provider and hospital contracts contain language that designates access for KHS to perform monitoring activities and require compliance with KHS QIHE Program activities, standards, and review system.

Provider contracts include provisions for the following:

a. An agreement to participate in the KHS QIHE Program including cooperation with monitoring processes, the grievance resolution system, and evaluations necessary to determine compliance with KHS standards.

b. An agreement to provide access to facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.

c. Cooperation with the KHS QIHE Program including access to applicable records and information.

d. Provisions for open communication between contracting providers and members regarding their medical condition regardless of cost or benefits.

Hospital contracts include provisions for the following:

a. An agreement to participate in the KHS QIHE Program, including cooperation with monitoring processes, the grievance resolution system, utilization review, and evaluations necessary to determine compliance with KHS standards.

b. Development of an ongoing QIHE Program to address the quality of care provided by the hospital including CAPs for identified quality issues.

c. An agreement to provide access of facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.

d. Cooperation with the KHS QIHE Program, including access to applicable records and information.

C. Conflict of Interest

Network practitioners serving on any QI and Health Equity program-related committee, who are or were involved in the care of a member under review by the committee, are not allowed to participate in discussions and determinations regarding the case. Committee members cannot review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issues. All required employees and committee participants sign a Conflict-of-Interest statement on an annual basis. Fiscal and clinical interests are separated. KHS and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care. There are no financial incentives for UM decision-makers that could encourage decisions that result in under-utilization.

Confidentiality Statement

KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process.

VI. Program Documents

A. Work Plan

The annual QIHEP Work Plan is designed to target specific QIHEP activities, projects, tasks to be completed during the upcoming year, and monitoring and investigation of previously identified issues. A focal activity for the Work Plan is the annual evaluation of the QIHE Program, including accomplishments and impact on members. Evaluation and planning the QIHE Program is done in conjunction with other departments and organizational leadership. High volume, high risk or problem prone processes are prioritized.

- The Work Plan is developed by the Quality Improvement and Health Equity Departments on an annual basis and is presented to the EQIHEC and Board of Directors for review and approval. Timelines and responsible parties are designated in the Work Plan.
- The Work Plan includes the objectives and scope of planned projects or activities that address the quality and safety of clinical care, and the quality of service provided to members.

- After review and approval of quality study results including action plans initiated by the EQIHEC, KHS disseminates the study results to applicable providers. This can occur by specific mailings or KHS Provider bulletins to contracting providers.
- The activities in the QIHE Work Plan are annually evaluated for effectiveness.
- QIHE Work Plan responsibilities are assigned to appropriate individuals.

Components of the QIHEP Work Plan:

- Quality and Safety of Clinical Care
- Quality of Service
- Member & Provider Satisfaction

B. Work Plan Evaluation

An annual evaluation of the QIHEP shall be prepared based on the activities presented to the EQIHEC during the calendar year. The EQIHEC reviews and approves the QIHEP evaluation. The QIHEP evaluation shall also be reviewed by the BOD. The Chief Health Equity Officer, with support from the Chief Medical Officer and/or Directors of Quality, will develop an evaluation of the QIHEP based on activities that were presented to the EQIHEC and BOD during the calendar year. The EQIHEC reviews and approves the QIHEP evaluation.

The QIHEP evaluation includes the following:

- A description of completed and ongoing quality improvement activities.
- Trended performance data from indicators to assess quality of care and service.
- An analysis of demonstrated improvements in care and service.
- A thorough evaluation of the program structure and effectiveness of the QIHEP including progress toward influencing safe clinical practices throughout the network.
- Monitoring efforts of medical groups and other subcontractors to ensure that delegated functions meet cultural, linguistic and sensitivity standards.
- Evaluation of patterns/trends for member grievances and discrimination complaints related to cultural/linguistic and sensitivity issues.
- A thorough evaluation of progress on non-clinical goals (i.e., Human Resources, Marketing, Member Engagement, Community Engagement, etc.)

KHS will also utilize the following methods to conduct ongoing monitoring and evaluation of its cultural competency and SPD awareness programs and annual sensitivity, diversity, cultural competency and health equity training for all staff, providers, subcontractors, and downstream subcontractors at key points of contact:

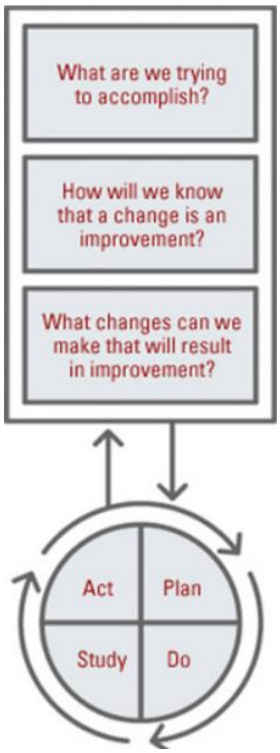
- Disenrollment data,
- MCAS/HEDIS results by race/ethnicity, language, and other demographic factors,
- Complaint and grievance reports,
- Member satisfaction survey results by race/ethnicity, language, and other demographic factors,
- Population Needs Assessments findings results by race/ethnicity, language, and other demographic factors,
- Performance Improvement Projects (PIPS),
- Health Education Activities Reports,
- Training attendance reports, attestations of training completion and/or completion of post-training quizzes.

VII. Quality Improvement Processes

A. KHS Quality Improvement (QI) Initiatives

1. Plan-Do-Study-Act Cycle

The QIHEP quality activities and studies are developed using the Plan-Do-Study-Act (PDSA) Model. The PDSA is an iterative, four-stage problem-solving model used for improving a process or carrying out change.



In accordance with the California Department of Health Care Services (DHCS) 2025 contract KHS will conduct quality studies, quality review activities, results, and assessments and submit the outcomes in reports to the DHCS in the reporting unit level and time frames as directed by DHCS.

2. Data Collection Methodology

KHS employs a structured data collection methodology designed to measure and improve healthcare quality and health equity outcomes. Data collection methods are determined based on the type of measure and available data sources, ensuring accuracy and reliability. Data validation is integral to this process, reinforcing the credibility of findings and supporting data-driven decision-making. Data is continuously collected, aggregated, and analyzed to monitor performance, identify disparities, and uncover opportunities for improvement. When performance gaps are identified, KHS implements targeted interventions with measurable goals. The effectiveness of these interventions is assessed through ongoing data analysis, ensuring that improvements are sustainable over time. If data indicates a need for a different approach, KHS re-evaluates strategies and adjusts action plans accordingly.

3. Measurement Process

KHS systematically monitors and evaluates quality improvement initiatives to assess their effectiveness and compliance with internal policies and external regulatory requirements. Performance is reviewed at least quarterly, with benchmarks and standards derived from:

- Nationally recognized clinical guidelines
- Peer-reviewed research
- Regulatory and contractual requirements
- Internal trend analyses
- State and federal quality measures

KHS uses these metrics to assess accessibility, availability, and equity in healthcare services, ensuring that interventions align with best practices and community needs.

4. Evaluation Process

A comprehensive evaluation framework guides KHS in assessing the effectiveness of Quality Improvement (QI) initiatives. Both quantitative and qualitative methodologies are employed:

- Quantitative Analysis: Benchmark comparisons, trend assessments, and statistical testing are used to evaluate the impact of QI initiatives.
- Qualitative Analysis: Root cause and barrier analyses are conducted collaboratively with key stakeholders to understand systemic challenges and identify sustainable solutions.

Cross-departmental collaboration ensures that evaluation findings inform future quality initiatives, driving continuous improvement in health outcomes.

5. Communication and Feedback

KHS fosters a culture of transparency and engagement through proactive communication with internal teams and external partners, including providers and stakeholders. Key communication channels include:

- Internal Education & Engagement: Staff meetings, committee updates, and training sessions on QI initiatives.
- Provider Communication: Newsletters, targeted mailings, KHS's provider portal, and direct outreach via quality visits.
- Performance Feedback: Providers receive actionable insights, including:
    1. Member-specific service and intervention lists
    2. Clinical guideline recommendations
    3. Performance data from HEDIS, CAHPS, and other quality measures
    4. Recognition for quality improvement achievements
    5. Compliance feedback based on audits, grievances, and utilization trends.

These communications reinforce accountability and foster a collaborative approach to quality improvement.

6. Improvement Processes

Performance indicators are used to identify quality concerns and disparities in care delivery. When deficiencies are detected, KHS initiates corrective actions, which may include:

- Provider-level remediation plans (Corrective Action Plans - CAPs)
- Enhanced provider education and technical assistance
- Temporary restrictions on new member assignments for non-compliant providers
- Delegation oversight adjustments
- Contract terminations for persistent non-compliance.

By integrating rigorous oversight, continuous evaluation, and data-driven decision-making, KHS ensures that quality improvement efforts translate into meaningful and sustainable healthcare enhancements for Medi-Cal members.

VIII. Quality Improvement Work Plan

A. Quality of Clinical Care

1. MCAS Measures

KHS is contractually required to submit data and measurement outcomes for specific health care measures identified by DHCS. The measures are a combination of ones selected by DHCS from the library of Healthcare Effectiveness Data and Information Set (HEDIS) and the Core Measures set from the Centers for Medicare and Medicaid Services (CMS). An audit is performed by DHCS's EQRO to validate that the data collection, data used, and calculations meet the specifications assigned by DHCS.

DHCS has established minimum performance levels (MPL) for several of the MCAS measures. This benchmark is the 50th percentile based on outcomes published in the latest edition of NCQA's Quality Compass report and the National HMO Average. Results submitted to DHCS for the designated MCAS measures are compared to the NCQA benchmarks to determine the Managed Care Plan's (MCP) compliance. When an MCP does not meet the 50th percentile or better for a measure, DHCS may impose financial penalties and require a corrective action plan (CAP). The following table identifies the MCAS measures KHS is held accountable to meet the 50th percentile or better for measurement year (MY) 2025. Results for the 2025 measures will be calculated and submitted in report year (RY) 2026. Please reference table on page 23 for list of MCAS measures.

KHS is contractually required to meet or exceed the DHCS established Minimum Performance Level (MPL) for each required HEDIS measure. For any measure that does not meet the established MPL, or that is reported as a "No Report" (NR) due to an audit failure, an Improvement Plan (IP) is contractually required to be submitted within 60 days of being notified by DHCS of the measures for which IPs are required. Managed Care Plans are required to meet or exceed the performance levels set forth by Department Health Care Services (DHCS) as outlined in their contract.

2. Performance Improvement Projects (PIPs)

KHS is mandated to participate in two (2) PIPs. These PIPs span over an approximate 36-month time frame and are each broken out into four (4) modules. Each module is submitted to HSAG/DHCS for review, input, and approval incrementally throughout the project. The two new PIPS required by DHCS will include annual submissions for 3 years from 2023-2026. The framework for the new PIPs has been updated by DHCS to align with the CMS protocol.

<u>Clinical PIP:</u>

The new cycle of PIPs began in August 2023 and will run through 2026. The clinical PIP is focused on Health Equity,

specific to the W30 0-15 months African American population.

Non-Clinical PIP:

The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health department for support of interventions. QP will be partnering with the Behavioral Health Department, UM, PHM, and any other necessary stakeholders.

B. Safety of Clinical Care

1. Patient Safety Program

KHS recognizes that patient safety is a key component of delivering quality health care and focuses on promoting best practices that are aimed at improving patient safety. KHS engages Members and Providers to promote safety practices. KHS also focuses on reducing the risk of adverse events that can occur while providing medical care in different delivery settings. Some of the safety initiatives include:

1. Appropriate Medication Utilization
2. Review of Inpatient Admissions
    a. Readmissions
    b. Length of Stay
    c. Inappropriate Discharges
    d. Unexpected Mortalities
3. Provider Preventable Conditions (PPCs)
4. Potential Quality Issues (PQIs)
5. Initial Health Assessment Monitoring
6. Over-utilization and Under-utilization
7. Performance with healthcare outcomes and clinical processes
8. Adherence to clinical and preventive health guidelines
9. Effectiveness of chronic conditions, population health and care management programs

2. Potential Quality Issues (PQIs)

The QI Department reviews all Potential Quality Issues (PQIs) and adverse events involving practitioners and providers. Areas of review include primary and specialty care, hospitals, long-term care (LTC) facilities, skilled nursing facilities (SNF), and transportation providers. All identified PQIs are referred to the QI Department for investigation and evaluation, ensuring timely and appropriate actions are taken to address potential concerns. The

Medical Director oversees the process, ensuring alignment with recognized standards of care evaluating all cases and referring matters to the EQIHEC and/or Physician Advisory Committee for further assessment, as necessary.

3. Facility Site Review, Medical Record and Physical Accessibility Reviews

Facility site and medical record reviews are performed before a provider is awarded participation privileges and every three years thereafter. As part of the facility review, KHS QP Nurses review for the following potential safety issues:

- Medication storage practices to ensure that oral and injectable medications, and "like labeled" medications, are stored separately to avoid confusion.
- The physical environment is safe for all patients, personnel, and visitors.
- Medical equipment is properly maintained.
- Professional personnel have current licenses and certifications.
- Infection control procedures are properly followed.
- Medical record review includes an assessment for patient safety issues and sentinel events.
- Bloodborne pathogens and regulated wastes are handled according to established laws.

In collaboration with other Kern County Health Plans for Site Reviews KHS coordinates, as described in APL 22-017, Site Reviews: Facility Site Review and Medical Record Review and the applicable MOU.

4. Credentialing and Recredentialing

KHS maintains a comprehensive pre-contractual and post-contractual assessment and monitoring system to ensure that contracting providers have the capacity and capability to perform required functions. The pre-contractual assessment requires providers seeking to contract with KHS to complete a detailed document covering key areas such as health care delivery systems— including clinical safety, access and waiting times, referral tracking, medical records, and health education— as well as credentialing information. Post-contractual monitoring includes ongoing evaluation to ensure continued compliance with contractual requirements, quality standards, and regulatory guidelines. Specific policies outline the standards, tools, and processes used to support these activities, ensuring accountability and quality in provider credentialing and recredentialing.

C. Quality of Service

1. Grievance and Appeals

KHS monitors performance areas affecting Member experience. KHS has established categories and quantifiable standards to evaluate grievances received by Members. All grievances are categorized in several different categories

including but not limited to the following: continuity of care, geographic access, language access, provider availability, timely access, discrimination, care coordination, and quality of care. The organization's goal is to resolve all grievances within thirty (30) days of receipt. KHS grievances and appeals data is presented on a quarterly basis to the EQIHEC and PAC as needed. KHS goal is to maintain the overall complaint rate below thresholds as established by regulatory agencies such as DHCS, DMHC, and CMS.

2. Access to Care

The Plan maintains ongoing monitoring efforts to ensure its network is able to provide appropriate access to health care services, in line with regulatory standards and member needs. The Plan's Provider Network Management department utilizes appointment availability surveys, capacity/adequacy analysis, grievance reviews, provider/member mapping, and other tools to conduct Plan monitoring; these efforts are presented to the Plan's Network Adequacy Committee (NAC) and EQIHEC on a quarterly basis. Areas monitored include, but are not limited to: appointment availability, access to after-hours-care, time, and distance (geographic) accessibility, provider type availability, and network capacity.

D. Member and Provider Satisfaction

Member Satisfaction

KHS conducts a comprehensive CAHPS survey and analysis annually to assess Member satisfaction with the services and care received. CAHPS is a set of standardized surveys that ask health care consumers to report on and evaluate their care experience. The survey focuses on key areas like getting care needed; getting appointments to PCPs and Specialty Care Providers (SCPs); satisfaction with KHS and its Practitioners; and other key areas of the Plan operations. CAHPS surveys serve as a means to provide usable information about quality of care received by the Members. KHS uses this tool as one of its key instruments to identify opportunities for improvement. As part of the annual evaluation, KHS reviews the CAHPS results to identify relative strengths and weaknesses in performance, determines where improvement is needed, and tracks progress with interventions over time.

Provider Satisfaction

KHS monitors performance areas affecting provider satisfaction annually and submits the results to DHCS and CMS. This study assesses the satisfaction experienced by KHS's network of PCPs, SCPs, and Behavioral Health Providers. Information obtained from these surveys allow plans to measure how well they are meeting their Providers' expectations and needs. This study examines the satisfaction of the Provider network in the following areas: overall satisfaction, all other plans, finance issues, utilization and quality management network, coordination of care, pharmacy, Health Plan Call Center Service Staff, and Provider relations. Based on the data collected, KHS reports

the findings to the QIW and EQIHEC. The committees review the findings and make recommendations on potential opportunities for improvements.

E. Addressing Cultural, Ethnic, Racial and Linguistic Needs of Members

Integrated KHS Resources and Documents Utilized to Support the QIHE Program:

Population Needs Assessment

The Wellness & Prevention Department conducts population needs assessment of KHS' members to determine health education and cultural/linguistic needs. The Population Needs Assessment will be updated every year for the duration of the contract with DHCS. The contents of the Population Needs Assessment will define the goals and objectives, data sources and methodology, member demographics, member health status, disease prevalence and gap analysis, health education and cultural and linguistic service needs, and key recommendations, planned actions and conclusions. (APL19-011). KHS uses the PNA to inform its QIHEP priorities and share pertinent information regarding the PNA findings and the identified targeted strategies with its providers.

Population Health Model of Care

The KHS Population Health Management (PHM) Model of Care (MOC) is to provide a strategic road map defining the approach towards the provision of healthcare and preventative services and focuses on collaborative partnerships with providers to assist in delivering high-quality care to all members in a timely and efficient manner while reducing costs. The PHM MOC is designed to better coordinate member's care and utilize various data sources to draw insights on how to address each member's individual needs and make hospitals and clinics more accessible and effective.

PHM is a proactive, data-driven strategy focused on improving the health of a given population by a defined network of financially linked providers, achieved in partnership with the community (Health Catalyst, 2020). The Primary Care Physician (PCP) forms the backbone of PHM. The PCP is the signal caller who identifies problems early through various clinical and socio-behavioral screenings and refers patients to specialists. At the same time, KHS provides support to the PCP to ensure the patient receives high-quality, comprehensive health care in a timely manner. The Director of PHM is a standing Member of the Health Equity Transformation Steering Committee.

Diversity, Equity, and Inclusion and Health Equity Education and Training

KHS does not delegate health equity activities. Providers are required to actively participate and comply with Health Equity activities. To support this expectation, KHS provides annual training to employees, contracted staff, providers, sub-contractors, and downstream subcontractors at key points of contact on sensitivity, diversity, cultural

competency, effective communication, health equity, and inclusion relating to members. Training will promote access and delivery of services in a culturally competent manner to all members and potential members regardless of their sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation or identification with any other persons or groups defined in Penal Code 422.56. Training will consider structural and institutional racism, heath inequities and its impact on members, staff, providers, subcontractors, and downstream subcontractors. Trainings will include, but not be limited to topics such as:

- Beliefs about illness and health for identified cultural groups within KHS' membership and Kern County,
- Need for gender affirming care,
- Methods for interacting with providers and the health care structure,
- Traditional home remedies that may impact provider recommended treatment plans,
- Skills and practices regarding culture-related health care issues of the membership,
- How cultural competency relates to quality of care and access to care,
- Appropriate use and provision of interpreters,
- Translation process of written informing documents,
- Health literacy,
- PNA findings and identified targeted strategies,
- Culturally and linguistically appropriate community resources,
- Required completion of Continuing Medical Education on cultural competency and implicit bias.

IX. External Audits/Regulatory Audits and Delegation Oversight

A. Auditing and Monitoring Activities

Enforcement/Compliance: The Director of Quality Improvement is responsible for monitoring and oversight of the QIHE Program, including enforcement of compliance with KHS standards and required activities. Compliance activities can be found in sections of policies related to the specific monitoring activity. The general process for obtaining compliance when deficiencies are noted, and CAPs are requested, is delineated in policies. Compliance activities not under the oversight of QI are the responsibility of the Compliance Department.

Medical Reviews and Audits by Regulatory Agencies – The KHS Director of Compliance & Regulatory Affairs, in collaboration with the CHSO and the Director of Quality Improvement manages KHS medical reviews and medical audits

by regulatory agencies. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QIHE Program. CAPs for medical matters are approved and monitored by the EQIHEC.

B. Delegation

KHS delegates quality improvement activities as follows:

1. VSP – delegation of QI processes with oversight through the EQIHEC.

X. Conflict of Interest

All members of the Equity, Quality Improvement, and Health Equity Committee (EQIHEC) and its subcommittees are required to review and sign a Conflict of Interest Statement, affirming their commitment to ethical decision-making. Committee members must disclose any potential conflicts of interest and recuse themselves from discussions and voting on matters where they have a direct or indirect interest. Individuals personally involved in the care or service provided to a patient, or in an event or finding undergoing quality evaluation, may not vote or render a decision regarding the appropriateness of such care. By signing the Conflict of Interest Statement, members agree to abide by its terms, ensuring transparency and integrity in the committee's decision-making process.

XI. Confidentiality

All members, participating staff, and guests of the EQIHEC Committee and subcommittees are required to sign the Committee Attendance Record, including a statement regarding confidentiality and conflict of interest. All KHS employees are required to sign a confidentiality agreement upon hire. Confidentiality agreements are maintained in the practitioner or employee files, as appropriate. All peer review records, proceedings, reports and member records are maintained in a confidential manner in accordance with state and federal confidentiality laws.

Member's Right to Confidentiality:

KHS retains oversight for provider confidentiality procedures. KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process. The EQIHEC Committee reviews

practices regarding the collection, use and disclosure of medical information.

XII. Information Security

Fraud, Waste, and Abuse (FWA) – The Quality Improvement Department provides support to the KHS Fraud, Waste, and Abuse program in the following ways:

a. **PQI Referrals** – In the course of screening and investigating PQI referrals, the QI Department consistently evaluates for any possible FWA concerns. All FWA concerns are referred to the KHS Compliance Department for further evaluation and follow up.

b. **FWA Investigations** – The QI Department clinical staff may provide clinical review support to the Compliance Department for FWA referrals being screened or investigated.

c. **FWA Committee** – The Director of QI or their designee is an active member of the KHS FWA Committee to provide relevant input and suggestions for topics and issues presented.

Health Insurance Portability and Accountability Act (HIPAA)

KHS complies with all applicable HIPAA requirements supported by HIPAA compliance policies. All HIPAA related policies are accessible to all KHS contracted providers and KHS staff. HIPAA information is posted on the KHS website. Ongoing mandatory education is required annually for all staff.

XIII. Communication of Quality and Health Equity Activities

Results of performance improvement activities are communicated to the appropriate department, and/or multidisciplinary committee as determined by the nature of the activity. The EQIHEC subcommittees report their summarized information to the EQIHEC quarterly to facilitate communication along the continuum of care. The EQIHEC reports activities to the Governing Board, through the CMO or designee, on a quarterly basis. EQIHEC participants are responsible for communicating pertinent, non-confidential QIHE issues to all members of KHS staff. Communication of QIHE trends to KHS contracted entities, members, practitioners and providers is through the following:

- Practitioner participation in the EQIHEC and its subcommittees
- Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
- Practitioner and member newsletters regarding relevant QIHE program topics
- The QIHEP description, available to providers and members on the KHS website. This includes QIHEP goals, processes and outcomes as they relate to member care and service.

- Annual practitioner education through provider relations and the Provider Manual

XIV. Annual Evaluation

Annual Evaluation of the KHS Quality Improvement Health Equity Program

On an annual basis, KHS evaluates the effectiveness and progress of the QIHE Program and Work Plan, and updates the program as needed. The CMO, with assistance from the Quality Improvement Medical Director, Director of QI, Pharmacy Director, Director of Wellness & Prevention, Director of Marketing, Director of Member Services, Senior Director of Contracting & QP and Director of QP, documents a yearly summary of all completed and ongoing QIHE Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms.

The report includes pertinent results from QIHE Program studies, member access to care surveys, physician credentialing and facility review compliance, member satisfaction surveys, and other significant activities affecting medical and behavioral health care provided to members. The report demonstrates the overall effectiveness of the QIHE Program. Performance measures are trended over time to determine service, safety, and clinical care issues, and then analyzed to verify improvements. The CMO presents the results to the EQIHEC Committee for comment, suggested program adjustments and revision of procedures or guidelines, as necessary. Also included is a Work Plan for the coming year. The Work Plan includes studies, surveys, and audits to be performed, compliance submissions, reports to be generated, and quality activities projected for completion.

The yearly QIHE Program summary and Work Plan are presented to the Board of Directors for assessment of covered health care rendered to members, comments, activities proposed for the upcoming year, and approval of changes in the QIHE Program. The Board of Directors is responsible for the direction of the QIHE Program and actively evaluates the annual plan to determine areas for improvement. Board of Director comments, actions and responsible parties assigned to changes are documented in the minutes. The status of delegated follow-up activities is presented in subsequent Board meetings. A summary of QIHE activities and progress toward meeting QIHE goals is available to members and contracting providers upon request by contacting KHS Member Services.

_____ Date _____

Chief Executive Officer

Emily Duran

_____ Date _____

Chief Medical Officer

_____ Date _____

Chief Health Equity Officer

_____ Date _____

Chief Operations Officer

_____ Date _____

Medical Director of Quality Improvement

_____ Date _____

Director of Quality Improvement

_____ Date _____

Senior Director of Contracting & Quality Performance

_____ Date _____

Director of Quality Performance

_____ Date _____

Senior Director of Wellness and Prevention

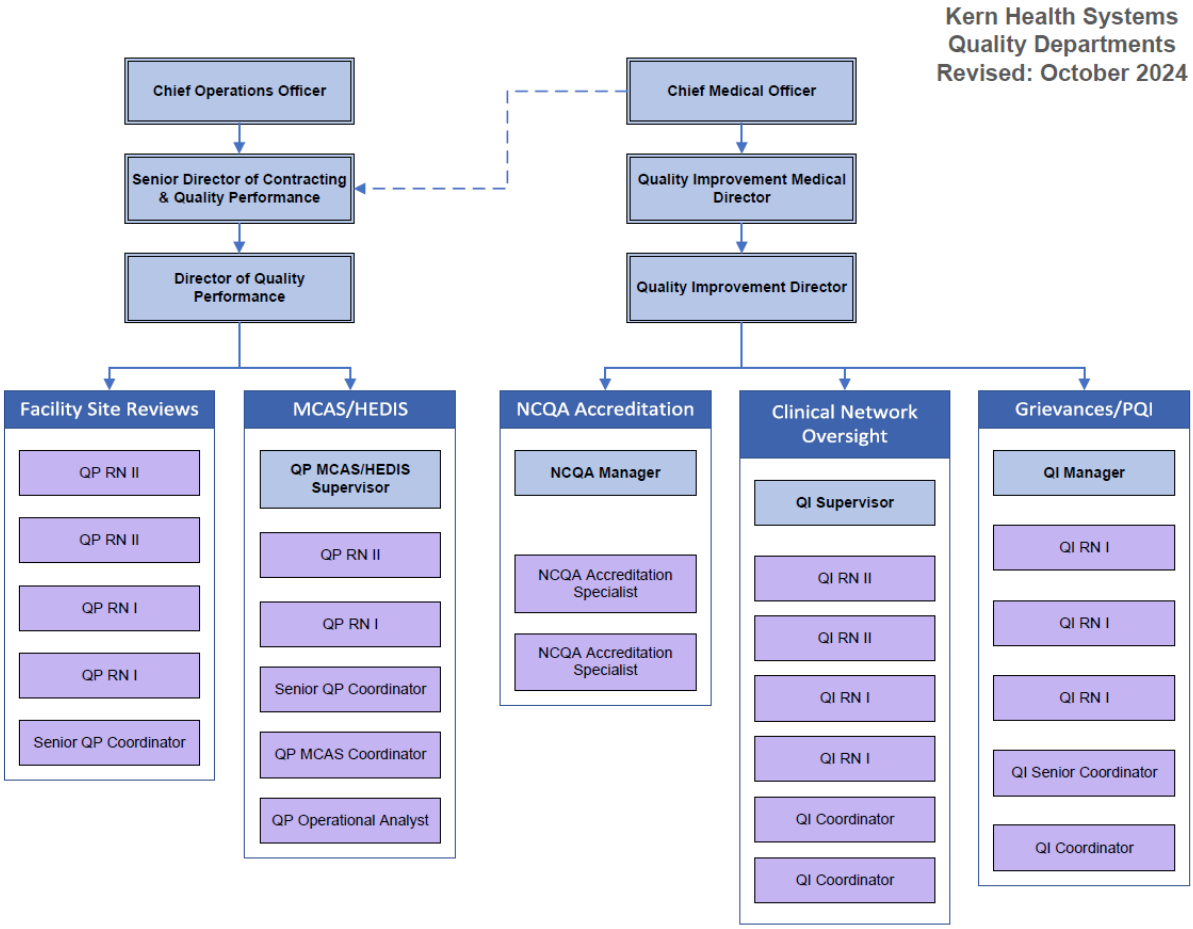
_____ Date _____

Director of Population Health Management

XV. Appendix

Appendix A: Population Needs Assessment October 2024

Appendix B: Quality Departments Organization Structure



Appendix C: Health Equity Office Organization Structure

Kern Health Systems
Health Equity Office
Revised: December 2024