KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Basic Population Health Management	**Policy #**	19.32-P
Policy Owner	Population Health Management	**Original Effective Date**	09/02/2022
Revision Effective Date	05/2025	**Approval Date**	10/01/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

Basic Population Health Management (BPHM) is the range of programs and services for all Kern Health Systems (KHS) Members, including care coordination and comprehensive wellness and prevention programs, all of which require a strong connection to primary care. BPHM is offered to all Members and provided in a manner to address Member needs and preferences and address health disparities.

All Plan Letter (APL) 22-024 "Population Health Management Policy Guide" and the Managed Care Plan (MCP) Contract provide baseline Department of Healthcare Services (DHCS) requirements for MCPs to implement the Population Health Management (PHM) Program. This includes BPHM, which is an approach to care that ensures that the needed programs and services are made available to each Member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 Code of Federal Regulations (C.F.R.) § 438.208).

II. POLICY

BPHM applies an approach to care that ensures that needed programs and services, including primary care, are made available to each Member, regardless of the Member's risk tier, at the right time and in the right setting.

The key components of BPHM are:

1. Access, Utilization, and Engagement with Primary Care
2. Care Coordination, Navigation, and Referrals across All Health and Social Services, Including Community Supports
3. Information Sharing and Referral Support Infrastructure
4. Integration of Community Health Workers (CHWs) in PHM

5. Wellness and Prevention Programs
6. Programs Addressing Chronic Disease
7. Programs to Address Maternal Health Outcomes
8. BPHM for Children

III. DEFINITIONS

TERMS	DEFINITIONS
N/A	

IV. PROCEDURES

A. KHS Primary Care Provider (PCP) Role and Responsibility in PHM

1. KHS contracts with PCPs to be responsible for select care coordination and health education functions, whenever feasible.
2. PCPs are specifically trained in comprehensive, first contact, and continuing care for individuals with any undiagnosed sign, symptom, or health concern, not limited by origin (biological, behavioral, or social), organ system, or diagnosis.
    a. PCPs promote health, prevent disease, maintain wellness, educate patients, diagnose, and treat acute and chronic illness in various settings (e.g., office, inpatient, critical care, long-term care, home, schools, telehealth).
    b. PCPs collaborate with other healthcare professionals and provide referrals as appropriate. They are the patient's advocate and coordinate cost-effective, timely, and equitable care.
    c. PCPs foster communication with patients and families to encourage engagement in healthcare.
    d. BPHM is a strategic enhancement of what PCPs already do.
    e. PCPs serve as the "quarterback" of the healthcare team, with PHM offering structured oversight and tools to improve patient outcomes.

3. KHS supports PCPs by:
    a. Supplying relevant data to assess patient health
    b. Risk-stratifying patients
    c. Organizing patients by risk level to allocate resources effectively
    d. Outlining care elements such as preventive care and specialist coordination
    e. Identifying care gaps and strategies for patient engagement
    f. Supporting outreach through evidence-based communication plans
    g. Utilizing Electronic Health Records (EHRs) to track patient care
    h. Measuring outcomes via clinical results, satisfaction, and financial metrics
    i. Providing regular reports for internal staff and payors

4. KHS offers PCPs services to support BPHM, including:
    a. Population Identification: Using administrative data to update the "population list" of assigned Members
    b. Risk Stratification: Identifying at-risk Members and tailoring interventions

c. Engagement: Monthly lists of Members not seen in twelve (12) months; incentivizing PCP outreach; alerting PCPs of missing Initial Health Appointments (IHAs)
d. Patient-Centered Interventions: Targeting high-risk Members with timely care and support
e. Impact Evaluation: Providing performance scorecards to PCPs to assess outcomes and drive quality

B. BPHM Elements and Processes

1. KHS ensures each Member:
   a. Has appropriate, ongoing care access
   b. Has an assigned and engaged PCP
   c. Receives needed preventive services
   d. Has access to person-centered care coordination and referrals based on medical and social needs
2. Members are encouraged to select a PCP when joining KHS; one is assigned if they do not choose.
3. PCPs conduct outreach. For Members in Enhanced Care Management (ECM), the assigned ECM Lead Care Manager (LCM) ensures BPHM is incorporated.
4. KHS implements BPHM services promoting health equity and aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).
5. KHS educates PCPs on data availability, reporting, and referral pathways. Enhanced referral infrastructure supports identifying care gaps and patient engagement. Information exchange complies with privacy laws.
6. All Plan Letter (APL) 24-006 guides Managed Care Plans (MCPs) on implementing the CHW Services Benefit. KHS integrates CHWs into the PHM strategy and monitors performance via:
   a. CHW Services Benefit Provider Capacity Template
   b. Short-Term Key Performance Indicators (KPIs):
      i. CHWs completing qualifications
      ii. CHW Violence Prevention Professionals (VPPs) completing qualifications
      iii. Qualified Asthma Preventive Services (APS) Providers
      iv. Members receiving CHW services
   c. Long-Term KPIs:
      i. CHW-to-provider ratio
      ii. Preventive service compliance for CHW-served Members
   d. CHW Utilization Report (includes Current Procedural Terminology (CPT) codes):
      i. Preventive Services – 98960, 98961, 98962 with U2/U3
      ii. Violence Prevention Services – same CPTs with U2
      iii. APS – CPTs with U3, including T1028 with proper Place of Service (POS)
   e. California Advancing and Innovating Medi-Cal (CalAIM) Incentive Payment Program (IPP) Impacts:
      i. A. Members who received CHW services
      ii. B. CHW utilization rate

7. KHS implements as many of the pre-approved Community Supports as possible over six to twelve (6–12) months, integrating them with wellness programs and the PHM Strategy.
8. KHS offers National Committee for Quality Assurance (NCQA)-aligned wellness programs for:
   a. Healthy body mass index BMI maintenance
   b. Smoking/tobacco cessation

c. Physical activity
d. Nutrition
e. Stress management
f. Avoiding risky drinking
g. Depression screening

9. KHS offers evidence-based chronic disease management programs (aligned with NCQA) for:
   a. Diabetes
   b. Cardiovascular disease
   c. Asthma
   d. Depression

10. For children, KHS complies with the Amended 2023 MCP Contract:
    a. IHAs within one hundred and twenty (120) days
    b. Preventive visits
    c. Medically necessary services
    d. Coordination of services across care settings and MCPs

11. KHS reviews preventive health visit and developmental screening utilization:
    a. Develops strategies to improve access and follow-up care coordination
    b. Strengthens Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) delivery via Memorandums of Understanding (MOUs) with First five (5), Women, Infants, and Children (WIC), and every Local Education Agency (LEA) in Kern County.

V. ATTACHMENTS

N/A	

VI. REFERENCES

Reference Type	Specific Reference
All Plan Letter(s) (APL)	APL 22-024 Population Health Management Program Guide (Supersedes APLs 17-012 and 17-013)
All Plan Letter(s) (APL)	APL 24-006 Community Health Worker Services Benefit
Other	42 Code of Federal Regulations (C.F.R.) § 438.208

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	05/05/2025	Revised to format in new KHS Policy template and annual review	S.D. Population Health

			Management
Effective	06/13/2023	Created for APL 22-024 & APL 22-016	Population Health Management

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Department of Health Care Services (DHCS)	06/16/2023 APL 22-024	07/06/2023