COMMITTEE: ***EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (EQIHEC)***
DATE OF MEETING: ***September 23, 2025***
CALL TO ORDER: ***7:15 AM BY TRACO MATTHEWS, CHAIR***

Members Present On-Site:	Cassandra Mulder - KC Public Health Satya Arya, MD - ENT. Danielle Colayco, PharmD – Komoto Martha Tasinga, KHS Chief Medical Officer	Allen Kennedy – Quality Team DME Chan Park, MD – Vanguard Family Medicine Todd Jeffries – Bakersfield Community Healthcare	Rukiyah Polk - CAC Chair Jasmine Ochoa – Asst. Director of Health Services Traco Matthews – KHS Chief Health Equity Officer (Non-Voting)
Members Virtual Remote:			
Members Excused=E Absent=A	Debra Cox – Omni Family Health (A) Philipp Melendez, MD – OB/GYN (A)		
Staff Present:	Adriana Salinas – Director of Community & Social Services Alma Garcia, NCQA Accreditation Specialist Anastasia Lester - Sr. Health Equity Analyst Ann StoryGarza - Assistant General Counsel Amy Sanders - Member Services Manger	Maninder Khalsa - Medical Director John Miller - Quality Improvement Medical Doctor Vanessa Nevarez – Health Equity Coordinator Russel Hasting – Manager of Case Management, Pop Health Management Kailey Collier – Director of Quality Performance Steve Pocasangre – NCQA Accreditation Specialist	Marilu Rodriguez – Sr. Health Equity Analyst Melinda Santiago - Director of Behavioral Health Magdee Hugais - Director of Quality Improvement Christine Pence – Senior Director of Health Services Greg Panero – Provider Network Program Manager Pawan Gill - Health Equity Manager

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Quorum	9 of 11 committee members present, Philipp Melendez and Debra Cox were absent.	Committee quorum requirements met.	N/A
Call to Order	Traco Matthews, Chair, called meeting to order at 7:15 am.	N/A	N/A
Public Presentation	There were no public presentations.	N/A	N/A

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Committee Announcements	Traco Matthews gave the opportunity for member updates. • Danielle C. shared that her Community Health Worker (CHW) team has doubled in size, going from two to	• N/A	• N/A

	four. • Cassandra M. shared that Kern County Public Health (KCPH) will be having car seat events on October 4th and November 21st. • Jasmine O. announced that she will be stepping down as a member of the EQIHEC and Maggie V. will be her replacement.	• N/A • N/A	• N/A • N/A
Committee Minutes	**Approval of Minutes** • CA-3) The Committee's Chairperson, Traco Matthews, presented the EQIHEC Minutes from June 17, 2025, for approval.	**Action:** • Satya A., Todd J. second. All aye's. Motion carried.	9/23/25
Old Business	There was no old business to present.	N/A	N/A
New Business	**Consent Agenda Items** • CA-4) Health Equity Transformation Steering Committee (HETSC) Minutes from May 13, 2025. • CA-5) Behavioral Health Advisory Committee (BHAC) Minutes from April 9, 2025. • CA-6) Pharmacy Drug Utilization Review (DUR) Minutes from May 19, 2025. • CA-7) Physician Advisory Committee (PAC) Redacted Minutes from April 2, 2025. • CA-8) Physician Advisory Committee (PAC) Redacted Minutes from May 7, 2025. • CA-9) Population Health Management Committee (PHMC) Minutes from June 4, 2025. • CA-10) Utilization Management Committee (UMC) Minutes from May 14, 2025. • CA-11) Quality Improvement Workgroup (QIW) Minutes from May 22, 2025. • CA-12) Network Adequacy Committee (NAC) Minutes from May 9, 2025. • CA-13a) Wellness & Prevention (W&P) Q2 2025 Activities Report. • CA-13b) Cultural & Linguistics (C&L) Q2 2025	**Action:**	

	Activities Report. • A motion to approve Consent Agenda Items was requested.	• Satya A. first, Todd J. second. All aye's. Motion carried.	9/23/25
	14) Health Equity Transformation Steering Committee (HETSC) • Pawan G. shared the updated Health Equity Workplan which is organized by domains, with three new programs added under the Member Domain and an additional initiative under the Provider Domain. The Intimate Partner Violence (IPV) Community of Practice is conducted in collaboration with the Population Health Learning Center. The goal is to identify and address barriers faced by members experiencing IPV, understand related adverse health effects, and develop mitigation strategies. The second program, Cervical Cancer Screening – Asian Pacific Islander population, is in collaboration with Bakersfield Sikh Women's Association, Adventist Health, and other local organizations aimed to increase cervical cancer screening rates within the target population. The Chlamydia Screening Intervention – Hispanic Population focuses on rural and farming communities, aimed at developing and implementing culturally tailored interventions to improve screening compliance. Lastly, the Equity Practice Transformation (EPT) Program, which was previously discussed but now formally added to the workplan supports 12 participating clinics in meeting their November 2025 deliverables. A motion to approve was requested. • Pawan G. provided Q2 2025 Regional Advisory Committee (RAC) updates. The Q2 RAC meetings were held across all 5 regions of Kern County (Central – Oildale, North – Lost Hills, East – Ridgecrest, West – Buttonwillow, South – Lamont) and the focus was Telehealth. Awareness and understanding of telehealth varied widely across regions: some areas were highly informed due to proactive provider engagement where others had limited knowledge. Many members were unaware that bilingual telehealth options existed. Traco	**Action:** • Danielle C. first, Allen K. second. All aye's. Motion carried. • Danielle C. first, Chan P. second. All aye's. Motion carried.	9/23/25 9/23/25

	M. added that the Department of Healthcare Services (DHCS) encouraged all managed care plans to promote Telehealth awareness due to rising ICE-related concerns impacting members' comfort with in-person care. Traco M. expressed appreciation to the Health Equity department for their continued community engagement efforts. A motion to approve was requested. **15) Quality Improvement Workgroup (QIW)** • Magdee H. presented the QIW Q2 2025 Report which includes the QI Work Plan, quality of care, potential quality issues (PQIs), appeals, NCQA accreditation progress, Cultural & Linguistics, Member Wellness & Prevention, and ECM program updates. PQIs have decreased across the KHS network, indicating improved member safety and provider performance. The NCQA Accreditation results as a Health Plan are 99% and as Health Equity are 100%. These results reflect thousands of hours of cross-departmental collaboration and strong executive support. Traco M. extended appreciation to Magdee, the QI team and all KHS staff for exemplary performance in achieving dual NCQA accreditations. The next accreditation cycle is scheduled for 2028 where QIW will continue to conduct annual gap analyses to stay current with evolving NCQA standards. The 2025 ECM Program Description was reviewed and approved; minor updates were made to reflect the new year's initiatives. A motion to approve was requested. **16) Quality Performance (QP)** • Kailey C. acknowledged that the QP Q2 Report was presented at the previous EQIHEC and is included in the packet for reference to avoid repetition and maintain alignment with the EQIHEC cadence. She presented a year-to-date and year-over-year performance overview for 2025, comparing progress to 2024, sharing that 13 of 18 MCAS measures show	• Satya A. first, Allen K. second. All aye's. Motion carried. • Todd J. first, Chan P. second. All aye's. Motion carried.	9/23/25 9/23/25

	improvement compared to the same period last year. Several measures are hybrid, meaning they require medical record review during the annual audit, so the final rates may change. The 5 measures meeting Minimum Performance Levels (MPLs) are Asthma Medication Ratio (AMR), Cervical Cancer Screening (CCS), Immunization Status for Adolescents (IMA), Lead Screening in Children (LSC), and Topical Fluoride in Children. Kailey C. added that the strong performance gains are attributed to enhanced data integration with providers, ongoing outreach and health equity initiatives, and strong cross departmental collaboration. Traco M. asked if there are early projections for end-of-year performance since the measurement year is nearing completion. Kailey C. responded that it is too early for definitive results. The goal remains to exceed last year's outcomes of 12 measures meeting the MPL. A motion to approve was requested. **<u>17) Behavioral Health Advisory Committee (BHAC)</u>** • Melinda S. presented the Behavioral Health Q2 2025 Report which highlights the department's strategic goals and quarterly progress. The update focused on internal development, quality improvement initiatives, network growth, and coordination efforts with Kern Behavioral Health and Recovery Services (KBHRS). Melinda S. added that there is an upward trend in psychiatry access, driven largely by telehealth expansion. The continued challenge is member awareness of telehealth benefits and technology access barriers like limited Wi-Fi in rural areas. Recruitment and retention grants through PNM are being explored, particularly to boost psychology services for autism assessments and diagnostic evaluations. The BHAC continues to show strong progress in quality improvement, data infrastructure and collaborative partnerships. Next quarter will focus on expanding the local provider base and continuing to improve access and care coordination, particularly for SUD and youth	• Satya A. first, Rukiyah P. second. All aye's. Motion carried.	9/23/25

	behavioral health initiatives. Jasmine O. asked how a successful home visit is defined regarding the Community Health Worker (CHW) metrics for 2024 and 2025. Melinda S. responded that a successful visit is currently defined as making contact with the individual. She added that engagement success does not always translate into improved outcomes and some individuals may require multiple attempts before trust is established and services are completed. Cassandra M. asked if KHS would join a Cohort for school linked programs. Melinda S. replied that KHS began collaborating last year with five LEAs in Cohort 2. She added that an interim MOU is under development and will be presented at the Board of Directors on October 23rd which if approved will allow monitoring of which schools and providers are actively participating. Despite slow progress, the state emphasized that the program will not be discontinued and MCPs are expected to "make it work". A motion to approve was requested. • A motion to approve agenda item 17.b BHAC Department Updates – Receive and File was requested. **<u>18) Population Health Management (PHM)</u>** • Russel H. provided a Q2 2025 PHM update which highlighted the Complex Case Management (CCM) Program. CCM addresses complex medical, behavioral, and social needs of high-risk members. Each member receives a dedicated RN, comprehensive assessment, individualized care plan, and ongoing support to reduce avoidable doctor visits and hospitalizations by empowering members through education, advocacy, and culturally responsive care. Russel H. also shared that CCM underwent an intensive file review as part of the NCQA process and a compliance score of 100% was achieved. A motion to approve was requested. • A motion to approve agenda items 18.b PHM Department Updates – Receive and File was requested. • Allen K. left the meeting at 8:20am.	• Chan P. first, Danielle C. second. All aye's. Motion carried. • Todd J. first, Danielle C. second. All aye's. Motion carried. • Todd J. first, Danielle C. second. All aye's. Motion carried.	9/23/25 9/23/25 9/23/25

	• Traco M. announced that there will be one agenda item per department going forward. **19) Utilization Management (UM)** • Dr. Khalsa presented the 2025 UM report which covered Q2 analytics, including timeliness of decisions, referral notifications, inpatient trends, and hospital utilization. Urgent requests continue to be processed quickly and within compliance timelines while routine requests experience occasional delays due to missing or delayed medical records from providers. Dr. Khalsa added that UM must notify both providers and members of decisions within regulatory timeframes and include clinical criteria for denials. Ongoing staff coaching and training are in place to maintain compliance with DHCS and NCQA requirements. Inpatient numbers remained consistent with Q1 trends, averaging 400-450 hospitalized members at any time. June data appears slightly lower, likely due to pending claims and hospitalizations include a mix of acute, trauma, surgical, and obstetric cases. Members requiring highly specialized services are referred to contracted centers of excellence including Keck/UCS Hospital, USC Norris Cancer Center, and UCLA Medical Center. Dr. Khalsa praised his team for maintaining high standards and responsiveness amid fluctuating referral volumes. Christine P. provided an overview of quality monitoring and compliance in the UM department which includes delays, modifications, and denials. She shared that a recent issue identified some member notification letters were sent to print but not physically mailed due to process gaps and new oversight measures are being implemented to detect and correct these issues promptly, before audits occur. Each finding in the quarterly report includes a Corrective Action Plan (CAP) to address root causes and prevent occurrence. A motion to approve was requested.	• Satya A. first, Chan P. second. All aye's. Motion carried. .	9/23/25

	20) Network Adequacy Committee (NAC) • Greg P. presented the Q2 2025 NAC Report which reviewed network standards, compliance, access monitoring, grievances, and provider growth. The committee's goal remains to ensure timely, equitable access to care and to maintain compliance with DHCS and DMHC requirements. Greg P. added that out of 148 Primary Care Provider (PCP) offices surveyed, 147 met emergency voicemail standards and 145 met urgent access standards. Noncompliant offices were notified by letter and contacted by Provider Relations for corrective follow-up. The NAC found that the top access-related grievances categories are timely access and technology/telephone issues. Most grievances originated from Central Kern, reflecting its higher provider and member density and Eastern Kern continues to face access challenges due to geographic dispersion and provider shortages. Because of these challenges, ongoing provider recruitment and retention grants are focused on Eastern Kern. Full Time Equivalency (FTE) Ratios were shown with a PCP ratio of 1 per 2,000 which is consistently improving and a Physician ratio of 1 per 1,200 members which remains well below the threshold aided by tertiary partnerships such as UCLA, USC, and Valley Children's. Traco M. thanked Greg P. for the clarity and simplicity in his reporting and emphasized that the positive trend in PCP growth was a critical success for improving equitable access and quality care. A motion to approve was requested. **21) Member Services** • Amy S. presented the Operational Board Report that focuses on Q2 member grievances, trends, and areas of concern. The overall volume of grievances and appeals increased by 7% from Q1 to Q1 which is largely attributed to transportation-related grievances due to a change in the transportation scheduling process. The change requires members to schedule rides at least 48	• Danielle C. first, Jasmine O. second. All aye's. Motion carried. • Danielle C. first, Todd J. second. All aye's. Motion carried.	9/23/25 9/23/25

	business hours in advance for non-urgent appointments. Exceptions are made for urgent appointments. Amy S. shared that the top grievance categories are access to care, quality of care, and quality of service. Although access metrics remain stable, member perception of access continues to generate grievances. A motion to approve was requested. • Amy S. presented the Grievance Summary Report which gives a more in-depth look at data than the Operational Board Report. Amy S. shared that 3,475 were received during Q2 with Access to Care Grievances at 36.6%, Quality of Service Grievances at 34.9%, and Quality of Care Grievances at 14.2%. Standard Grievances were at 71.7% (resolved within 30 days) and Exempt Grievances were at 28.3% (resolved within one business day). Resolution Outcomes closed in favor of the enrollee were at 45.9%, closed in favor of the plan or provider at 51.4%, and remained open at time of reporting at 2.7%. Dr. Martha T. clarified that many access to specialist grievances stem from the member perception rather than true provider shortages. An example is a member may request to see a specialist for minor conditions such as a sore throat when a primary care physician can appropriately manage the issue. Dr. Martha T. assured the committee that the network has sufficient specialists, but members' expectations and understanding of when specialty care is needed influence grievance volume. A motion to approve was requested.	• Danielle C. first, Chan P. second. All aye's. Motion carried.	9/23/25

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Next Meeting	The next meeting will be held on Tuesday, December 16, 2025, at 7:15am.	Informational only.	N/A
Adjournment	The Committee adjourned at 9:06am. ***Respectfully Submitted:*** ***Vanessa Nevarez, Health Equity Project Coordinator***	• Danielle C. first, Jasmine O. second. All aye's. Motion carried.	N/A

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

COMMITTEE: ***HEALTH EQUITY TRANSFORMATION STEERING COMMITTEE (HETSC)***
DATE OF MEETING: ***August 12, 2025***
CALL TO ORDER: ***2:05pm - Pawan Gill, Health Equity Manager – CHAIR***

Staff Present:			
Staff Virtual:	• Adriana Salinas, Director of Community and Social Services • Amy Sanders, Member Services Manager • Anastasia Lester, Senior Health Equity Analyst • Bianca Zenteno, Health & Wellness Lifestyle Coach • Cesar Chavez, HRIS and Analytics Manager • Daisy Torrez, Member Engagement Supervisor • Dan Diaz, ECM Clinical Manager • Dina Aldaco, Deputy Director of Grants and Special Programs • Flor Del Hoyo Galvan, Manger of Wellness and Prevention	• Isabel Silva, Senior Director of Wellness and Prevention • Jackie Byrd, Senior Marketing and Communications Specialist • Kailey Collier, Director of Quality Performance • Lela Criswell, Member Engagement Manager • Loni Hill-Pirtle, Director of Enhanced Care Management • Louie Iturriria, Senior Director of Marketing and Member Engagement	• Magdee Hugais, Director of Quality Improvement • Marilu Rodriguez, Senior Health Equity Analyst • Melinda Santiago, Director of Behavioral Health • Nate Scott, Senior Director of Member Services • Pawan Gill, Health Equity Manager • Steve Pocasangre, NCQA Accreditation Specialist • Vanessa Nevarez, Health Equity Coordinator • Traco Matthews, Chief Health Equity Officer

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
QUORUM	Attendance / Roll Call	N/A – Workshop-style Committee	N/A
CALL TO ORDER	Pawan Gill, Health Equity Manager and Chair called the meeting to order at 2:05pm.	N/A	N/A
COMMITTEE MINUTES	There were no previous minutes to approve.	N/A	N/A

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
OLD BUSINESS	There was no old business to present.	N/A	N/A
NEW BUSINESS	**1) Health Equity Updates** • Pawan G. announced that KFHC received their Health Equity accreditation with a pass of 100%. Pawan G. thanked Marilu R., Steve P., Amy S., and other departments for their contribution and commitment towards this achievement. • Pawan G. announced that KFHC has completed their Sexual Orientation Gender Identity (SOGI) training. The training was given to employees as well as contractors and subcontractors. She added that other plans struggled to meet the mandate given by DHCS. • Pawan G. shared that due to changes in funding, this year's Health Equity and Quality Awards have been cancelled. She added that the winners will still be awarded and recognized for their work and videos are still being made. She thanks everyone for their input and nominations which helped the process of choosing the honorees. Isabel S. asked how the awards will be done this year. Pawan G. replied that there will be no ceremony, but there will still be social media recognition, and the videos will celebrate their work. **2) EPT Updates** • Marilu R. provided an overview and update of the Equity and Practice Transformation (EPT) program. She shared that EPT is a three-year, milestone driven program for providers and their practices and they are currently working on milestones for November 1st, 2025, deliverables. In addition, the practices have 3 KPI's to complete. The total amount awarded to practices was $714,754 which all goes towards meeting milestones based on health equity. Pawan	• Informational only. • Informational only. • Informational only. • Informational only.	N/A N/A N/A N/A

	G. pointed out that the practices in this program and the practices being recognized for improvement by QP are the same, which shows they are not just participating in the program for the money, they are also having an impact on the members. **3) HEAL Updates** • Marilu R. provided an overview and update of the Health Equity and Learning (HEAL) committee, which is strictly dedicated to providers and advancing health equity. The committee helps KFHC identify system gaps and develop improvement plans along with sharing funding and grant opportunities. Marilu R. provided some highlights of the last HEAL committee meeting with HETSC sharing that Adventist Health is rolling out their residency program and within the participants of the program, cumulatively, they spoke 9 different languages other than English. The second highlight Marilu R. provided to HETSC was the Komoto Foundation coloring book which is offered in a variety of different languages other than English and Spanish. Nate S. shared that KHS has those coloring books in the walk-in rooms readily available with crayons that are enjoyed by the members. Now that KHS has run out of coloring books he would like to order more. Marilu R. will reach out to Komoto to get more. Pawan G. added that all KHS departments can leverage HEAL if they need provider perspectives/feedback or to introduce new opportunities. Amy S. asked if HEAL needs representation from a grievance perspective or discrimination. Pawan G. replied no and that resources and toolkits are made available to HEAL and feedback is taken to the grievance/discrimination group. Pawan G. added that Amy S. is welcome to join the HEAL committee meetings anytime. **4) RAC Updates** • Anastasia L. presented an overview, sharing highlights and takeaways, of the Q2 RACs where the theme was telehealth. She learned that while some attendees knew or had heard of telehealth, some had no idea or didn't	• Informational only.	N/A

	understand the concept and did not know how to access this service. The 5 regions visited in Q2 were Oildale, Lost Hills, Ridgecrest, Buttonwillow, and Lamont. • Pawan G. provide ways other departments can leverage the RAC's if they need member feedback or want to share new programs/services.		

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
OPEN FORUM	Pawan opened the floor for announcements.	N/A	N/A
NEXT MEETING	Next meeting will be held Tuesday, November 11th, 2025, at 2:00pm.	N/A	N/A
ADJOURNMENT	The Committee adjourned at 3:00 pm. ***Respectfully submitted:*** ***Vanessa Nevarez, Health Equity Coordinator***	N/A	N/A

For Signature Only – HETSC Minutes 08/12/25

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: **BEHAVIORAL HEALTH ADVISORY COMMITTEE**
DATE OF MEETING: **JULY 16, 2025**
CALL TO ORDER: **12:03 PM BY MELINDA SANTIAGO, DIRECTOR OF BEHAVIORAL HEALTH - CHAIR**

Members Present On-Site:	Marisa Garcia-Trebizo, LMFT - Director at CSV Mesha Muwanga, LMFT – Rhema Therapy Inc.	Melinda Santiago, KHS Director of Behavioral Health	Martha Tasinga MD, KHS Chief Medical Officer
Members Virtual Remote:	Matthew Beare, MD – Clinica Sierra Vista Alison Burrowes, LCSW – Deputy Dir. KBHRS	Tara Gray – MCP Tribal Liaison	
Members Excused=E Absent=A	Anuradha Rao, MD – Omni (A) Cherilyn Haworth, CSUB (A) Franco Song, MD – Psychiatric Wellness Center (A)		
Staff Present:	Vanessa Hernandez, KHS Senior Support Clerk Yolanda Herrera, KHS Credentialing Manager Amy Daniel, Executive Health Services Coordinator	Courtney Morris, KHS Behavioral Health Supervisor	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga, CMO and Melinda Santiago, KHS Director of Behavioral Health called the meeting to order at 12:06 PM.		N/A
Committee Minutes	**Approval of Minutes** Approval of Minutes from April 9, 2025 meeting.	☑ **APPROVED**: A motion was made by M.Garcia-Trebizo LMFT and seconded by M.Muwanga LMFT, to approve the minutes of April 9, 2025. Motion carried.	7/16/25
OLD BUSINESS	**None**		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	**Behavioral Health Quarter 2, 2025 Updates** Melinda Santiago, Director of BH Services provided an update on the 2nd Quarter 2025. The following BH Department developments included: • Launching the BH Audit process focusing on medical necessity, chart reviews, and billing accuracy. Members were asked to review the auditing tool and provide feedback. • Continued efforts on the DSNP Oversight for BH partnership with Delegation Oversight and COSA. • Continued automation of the Substance Use Disorder (SUD) consent form to better streamline workflows. • Continued development of the ABA clinical guidelines to support consistent and appropriate levels of service. • Some staffing changes have been made in the department. • Advancements to the provider portal to support improved coordination between BH Department and PCP Providers. Melinda provided additional Behavioral Health updates include Key Accomplishments and Strategic Goals initiatives for 2025. There was interest in the intent for CHW Home visits and how is that linked back into the Behavioral Health Program. Melinda provided additional insight that the KHS CHW Services are not redundant to the provider's efforts but adds additional outreach to the member to assist with other guidance or support the member may need. Utilization for Non-Specialty Mental Health Services continues in an upward trend and it is projected to hit 18,000 members by end of year 2025. Courtney Morris, BH Supervisor, presented the top 10 providers by member count/higher frequency of care. During member outreach some members expressed concern with these types of calls; therefore staff were educated on how best to communicate to the member.	☑ **CLOSED**: BH Report for 2nd Quarter 2025 was accepted as presented - Informational discussion only.	7/16/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	QI Audit Tool Melinda provided an overview of the QI Audit Tool that will be used to conduct the BH Audits for medical necessity, chart reviews, and billing accuracy. The Audit will consist of a sampling of records to be reviewed to identify training and educational opportunities and not for punitive purposes. The BH Audit will help KHS develop a baseline that will enable KHS to see where our providers are at and where there are areas of opportunities to adjust our program, educate our providers as well as identify the improvements and accomplishments. Question was asked if PCP identification is mandatory to document on the Medical Record as this is not always known by the member or identified at intake. Melinda informed the committee that this information will be readily available on the portal.	☑ **CLOSED**: Informational discussion only	7/16/25
	MAT Presentation Dr. Beare presented the Medication Assisted Treatment (MAT). Traditionally, Methadone treatment was the only available treatment for opioid use disorder as it was easier for members to access. Dr. Beare reported that there are newer treatment options that are much better for use. Additionally, there are new alcohol medication treatment options that curb cravings and are better than the older medication Antabuse that if taken while drinking alcohol would make patients severely sick. The new medication options such as Chantix, Naltrexone and Acamprosate help maintain abstinence from alcohol by decreasing the craving. All treatments are very well demonstrated and successful, and the stigma associated with this disease is fading away; the medical community is open to using these medication assisted treatments and many insurances have now included covering these types of medications. More education to the providers is needed on the availability of Medication Assisted Treatments and listing of Addiction Medicine Providers in the network. Kern Medical has some providers as well as Clinica Sierra Vista; however, more education to our primary	☑ **CLOSED**: Informational discussion only. ☑ **FOLLOW-UP**: Credentialing to provide Melinda with a list of Addiction Medicine Providers in our network.	7/16/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	care providers can benefit our members by starting medication early and allowing members to gauge when therapy is needed. PCP simple treatment, switching patients over, connecting them to an addiction medicine specialist. Obtain low barrier, no mandate on therapy requirements.		
	Regional Access Committee – Quarter 1 2025 Update	☐ **TABLED**: Tabled to **October Meeting**: Informational discussion only.	
	Proposed Provider Portal	☐ **TABLED**: Tabled to **October Meeting**: Informational discussion only.	
	Reporting: EPSDT, FUM/FUA Reports & Inpatient Reports	☐ **TABLED**: Tabled to **October Meeting**: Informational discussion only.	
OPEN FORUM	**Open Forum**	☑ **CLOSED**: Informational discussion only.	7/16/25
NEXT MEETING	Next meeting will be held October 15, 2025.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 1:30 pm. ***Respectfully submitted: Amy Daniel, Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Behavioral Health Advisory Committee Minutes 7/16/2025

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

COMMITTEE: **DRUG UTILIZATION REVIEW (DUR) COMMITTEE**
DATE OF MEETING: **AUGUST 25, 2025**
CALL TO ORDER: **6:41 P.M. BY BRUCE WEARDA – ALTERNATE CHAIR**

Members Present On-Site:	Alison Bell, PharmD – Network Provider, Geriatrics Dilbaugh Gehlawat, MD – Network Provider, Pediatrician Todd Farrer, MD – Network Provider, Geriatrics	Kimberly Hoffmann, Pharm D.,Pharmacist, Psych Bruce Wearda, RPh – KHS Director of Pharmacy	
Members Virtual Remote:	James "Patrick" Person, RPh – Network Provider Sarabjeet Singh, MD - Network Provider, Cardiology		
Members Excused=E Absent=A	Vasanthi Srinivas, MD – Network Provider, OB/GYN - E Joseph Tran, MD – Network Provider – A	Abdolreza Saadabadi, MD – Psych	
Staff Present:	Amy Daniel, KHS Executive Health Services Coordinator	John Miller, MD, KHS Medical Director Sukhpreet Sidhu, MD, KHS Medical Director	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirement met. Introduced Dr. Todd Farrer to the committee. Kim Hoffmann arrived late to the meeting.	*08/25/25*
APPROVAL OF MINUTES	The Committee's Alternate Chairperson, Bruce Wearda, presented the meeting minutes for approval.	☑ **ACTION**: Dr. Gehlawat moved to approve minutes of May 19, 2025, seconded by Alison Bell. 6 approved, 0 nays.	*08/25/25*
OLD BUSINESS	None		*N/A*
NEW BUSINESS	• Report on Plan Utilization Metrics Bruce Wearda shared the metrics with the committee. Dr. Gehlawat asked if Gardasil costs for pediatrics are included. Bruce		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	stated that it is carved out for pediatric children. This only pertains to the adult population. • Educational Articles Bruce Wearda the articles with the committee. 1. Pharmacists Furnishing Nicotine Replacement Therapy Products 2. Menopausal Hormone Therapy for Bothersome Vasomotor Symptoms • DUR General Topics 1. Bruce shared an article regarding "Prescribing Cascades" can put Older Adults at Risk. The committee agreed that it was a very appropriate article. • D-SNP Update 2. Bruce shared that there are many rules that govern D-SNP plans. CMS has guidelines about what can be discussed due to open enrollment. He further explained that there will be co-pays and tiers with D-SNP as opposed to Medi-Cal. He also stated there are 6 protected classes of drugs that all or almost all drugs and their formulations must be covered. He also conveyed that the formulary and MTM programs have been approved by CMS. Bruce then explained that Health Plans must follow CMS guidelines regarding Medicare Part B coverage criteria. Plans must adhere to National Coverage Determination (NCD) and Local Coverage Determination (LCD). If no NCD or LCD exists, plans then may make their own criteria. • NCQA 3. KHS has been approved for both Health Plan and Equity.	Recommended action – Bruce called for a vote to adopt KHS' policy will be to utilize NCD and LCD before applying their own criteria. Alison Bell moved to approve, and Dr. Gehlawat seconded. 6 approved, 0 nays.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• DHCS/Executive Order N 01-19 1. The May Revise Update: Bruce presented the final budget elements. They included things like drugs for weight loss no longer being covered, elimination of covering OTC drugs, and introduction of premiums for individuals between 19-59 with unsatisfactory immigration status. There was a discussion about weight-loss drugs within the committee. Alison Bell stated that Zepbound and Wegovy are listed on the Medi-Cal formulary. Phentermine is not listed. Dr. Farrer questioned how GLP-1's are covered. Bruce said going forward those for diabetic conditions are covered, and weight-loss will not be. Dr. Farrer asked if there was any step-therapy. Bruce said not necessarily step-therapy but there are conditions outlined in the Medi-Cal formulary.		
OPEN FORUM	There were no topics presented during open forum.	☑ **ACTION**: N/A	*08/25/25*
NEXT MEETING	Next meeting will be held Monday, November 24, 2025 at 6:30 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned 7:20 pm.	☑ **ACTION**: Kim Hoffmann moved to adjourn the meeting. Alison Bell seconded it. 7 Ayes, 0 Nays.	*08/25/25*

Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator

For Signature Only – Drug Utilization Review Committee Minutes 08/25/25

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***AUGUST 6, 2025***
CALL TO ORDER: ***7:04 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Hasmukh Amin, MD – Network Provider, Pediatrics	Gohar Gevorgyan, MD – Network Provider, FP Miguel Lascano – Network Provider, OB/GYN	Ashok Parmar, MD– Network Provider, Pain Medicine
Members Virtual Remote:	Atul Aggarwal, MD – Network Provider, Cardiology David Hair, MD - Network Provider, Ophthalmology Abdolreza Saadabadi, MD, PhyD		
Members Excused=E Absent=A	Raju Patel, MD - Network Provider, Internal Medicine (A)		
Staff Present:	Amy Daniel, Executive Health Services Coordinator Michelle Curioso, Director of PHM Yolanda Herrera, Credentialing Manager	Magdee Hugais, Director of Quality Improvement John Miller MD, QI Medical Director Yesenia Sanchez, Credentialing Coordinator	Sukhpreet Sidhu MD, PHM Medical Director Bruce Wearda, Director of Pharmacy

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:04 AM.		N/A
Public Presentation	There were no requests for public presentation		
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of June 4, 2025 for review and approval.	☑ **ACTION**: Dr. Amin moved to approve minutes of June 4, 2025, seconded by Dr. Parmar. Motion carried.	8/6/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Past Public Presentation Follow-up	As requested, Dr. Tasinga provided follow-up regarding Dr. Kumar's request to open or expand the UM Criteria for vascular procedures for venous ablations to include additional provider types. Dr. Tasinga provided the committee with the past issues and history leading to implement vascular guidelines. After thorough analysis, and in light of current budget analysis being focused in other key areas, Dr. Tasinga provided the following information: 1. Review of current data does not reveal any access issues or delays in patients receiving treatment under the current guidelines. 2. Also, there are no member grievances that validate a need to expand the venous ablation network. 3. There is sufficient vascular surgeons who are able to provide treatment to our members.	☑ **CLOSED**: Dr. Tasinga will notify Dr. Kumar that at this time KHS will continue with the current vascular guidelines limiting and redirecting referrals to vascular surgery trained providers.	8/6/25
Committee Announcements	There were no committee announcements	☑ **CLOSED** – Informational Only	N/A
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from Reports dated 06/25/2025 and 8/1/25:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on 06/25/2025 and 08/01/2025 Credentialing Reports, all files met clean file criteria, in compliance with the 60-day turnaround requirements. [redacted] **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **08/06/2025.** The clean files were accepted as presented with no additional discussion. The following	☑ **ACTION**: Dr. Lascano moved to approve the Behavioral/Mental Health Credentialing Report dated 06/25/2025 & 08/01/2025, seconded by Dr. Parmar. Motion carried. ☑ **ACTION**: Dr. Lascano moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 8/6/2025, seconded by Dr. Parmar. Motion carried.	***8/6/25*** ***8/6/25***

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	initial applications were presented for comprehensive review: • [redacted] • [redacted] **RECREDENTIALING REPORT** **Recredentialing Providers Lists Dated 8/6/2025.** Recredentialing files meeting clean file review, report dated 8/6/2025, were accepted as presented with no additional questions or alternative actions. **Member Grievances**: There was one provider presented with Member & Quality Grievances of .99 or higher; however, it was	☑ **ACTION**: Dr. Lascano moved to approve Comprehensive Reviews as listed with approval recommendations for [redacted] (1-year modified appointment), and [redacted] (3-yr appointment), seconded by Dr. Parmar. Motion carried.	*8/6/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	reported there were 579 interactions in 3-years with no QOC concerns identified (Recred #3). The following recredentialing applications were presented for comprehensive review: • [redacted] • [redacted] • [redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated **August 6, 2025**, were accepted as presented with no additional questions or comments by the committee members.	☑ **ACTION**: Dr. Lascano moved to approve recredentialing Comprehensive Reviews as listed with approval recommendations for [redacted] (3-yr appointment), seconded by Dr. Parmar. Motion carried.	*8/6/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS: Yolanda Herrera, KHS Credentialing Manager reported on the June and July 2025 Monthly Monitoring of Disciplinary Actions and/or Adverse Events. Monthly monitoring includes state and federal websites including OIG, SAM, NPDB Continuous Query, DHCS Restricted Providers, DHCS Suspended & Ineligible resulted in two new/updated findings: [redacted]	☑ **ACTION**: Dr. Amin moved to approve acceptance of the Monthly Monitoring report, seconded by Dr. Aggarwal. Motion carried. ☑ **ACTION**: Dr. Lascano [redacted] seconded by Dr. Amin. Motion carried.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OLD BUSINESS			
NEW BUSINESS	**Level 2 Potential Quality Issues (PQIs)** Magdee Hugais, Director of Quality Improvement, presented the August Level 2 PQI Report. [redacted]	[redacted]	[redacted]

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		
	QI Track and Trend July & August Report 2025 Magdee Hugais, Director of Quality Improvement, presented the Potential Quality Issues (PQI) Track and Trend Report data for 6/1/2025-6/30/2025 and 7/1/2025-7/31/2025. The report was accepted as presented with no further action requested or taken by the committee.	☑ **ACTION**: Dr. Amin moved to approve the QI Track and Trend July and August 2025 Report as presented and reviewed, seconded by Dr. Gevorgyan. Motion carried	*8/6/25*
	Medicare Part B Criteria (Pharmacy) Bruce Wearda, Director of Pharmacy presented information regarding Medicare requirement of each health plan to have criteria outlining the coverage of the drugs that fall under the Part B benefit. CMS also requires each plan's governing body to establish or adopt those criteria. Medicare has some National Coverage Determination (NCD) already established that all plans must use. Medicare has Local Coverage Determination (LCD) that must be used for that particular region. Any drug not listed on those lists can have criteria created by the plan.	☑ **ACTION**: Dr. Gevorgyan moved to adopt the NCD and LCD Criteria as outlined in the KHS Part B Drug List dated 06/30/2025, seconded by Dr. Parmar. Motion carried	*8/6/25*
OPEN FORUM	There was no open discussion.	☑ **CLOSED** – Informational Only	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, September 10, 2025 (2nd Wednesday of month due to Labor Day Holiday)	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 7:59 AM. **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator**	**N/A**	*N/A*

For Signature Only – Physician Advisory Committee Minutes 08/06/2025:

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***SEPTEMBER 10, 2025***
CALL TO ORDER: ***7:02 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Hasmukh Amin, MD – Network Provider, Pediatrics	Gohar Gevorgyan, MD – Network Provider, FP	Raju Patel, MD - Network Provider, Internal Medicine
Members Virtual Remote:	David Hair, MD - Network Provider, Ophthalmology Ashok Parmar, MD– Network Provider, Pain Medicine		
Members Excused=E Absent=A	Atul Aggarwal, MD – Network Provider, Cardiology (E) Miguel Lascano – Network Provider, OB/GYN (E)	Abdolreza Saadabadi, MD – Behavioral Health (E)	
Staff Present:	Amy Daniel, Executive Administrative Jake Hall, Deputy Director of Contracting	Yolanda Herrera, Credentialing Manager Magdee Hugais, Director of Quality Improvement John Miller MD, QI Medical Director	Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:02 AM.		N/A
Public Presentation	There were no requests for public presentation		
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of August 6, 2025 for review and approval.	☑ **ACTION**: Dr. Amin moved to approve minutes of August 6, 2025, seconded by Dr. Hair. Motion carried.	9/10/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Committee Announcements	There were no committee announcements	☑ **CLOSED** – Informational Only	**9/10/25**
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from Reports dated 09/02/2025:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on 09/02/2025 Credentialing Reports, all files met clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers pre-approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. Comprehensive Reviews regarding mental health & behavioral health providers were reviewed under the Initial Credentialing Report below. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **09/10/2025** were presented**:** • The clean files were accepted as presented with no additional discussion. • There were no initial applications presented for comprehensive review. **RECREDENTIALING REPORT** Recredentialing Providers Lists Dated **8/6/2025** were presented**:** • Recredentialing files meeting clean file review, report dated 9/10/2025, were accepted as presented with no additional questions or alternative actions. **Member Grievances**: There was one provider presented with Member & Quality Grievances of .99 or higher; however, it was reported there were 579 interactions in 3-years with no QOC concerns identified (Recred #3). The following recredentialing application was presented for comprehensive review:	☑ **ACTION**: Dr. Amin moved to approve the Behavioral/Mental Health Credentialing Report dated 09/02/2025, seconded by Dr. Patel. Motion carried. ☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 9/10/2025, seconded by Dr. Patel. Motion carried.	*9/10/25* *9/10/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• [redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated **September 10, 2025**, were accepted as presented with no additional questions or comments by the committee members. **MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:** Yolanda Herrera, KHS Credentialing Manager reported on the August 2025 Monthly Monitoring of Disciplinary Actions and/or Adverse Events. Monthly monitoring includes state and federal websites including OIG, SAM, NPDB Continuous Query, DHCS Restricted Providers, DHCS Suspended & Ineligible resulted in no new findings or updates.	☑ **ACTION**: Dr. Lascano moved to approve Comprehensive Reviews as listed with approval recommendations for [redacted] (3-yr appointment), seconded by Dr. Parmar. Motion carried. ☑ **ACTION**: Dr. Amin moved to approve monthly monitoring report as presented with no new findings or updates, seconded by Dr. Patel. Motion carried.	*9/10/25* *9/10/25*
OLD BUSINESS	**Level 2 Potential Quality Issues (PQIs)** Magdee Hugais, Director of Quality Improvement, presented the August Level 2 PQI Report. **Case #1** [redacted]	☐ **Pending** – Table request for additional information [redacted]	*Pending*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]	• [redacted]	
NEW BUSINESS	**Level 2 Potential Quality Issues (PQIs)** There were no new cases to present.	☑ **CLOSED** – Informational Only	*N/A*
	QI Track and Trend September Report 2025 Magdee Hugais, Director of Quality Improvement, presented the Potential Quality Issues (PQI) Track and Trend Report data for 8/1/2025-8/31/2025. The report was accepted as presented with no further action requested or taken by the committee.	☑ **ACTION**: Dr. Amin moved to approve the QI Track and Trend July and August 2025 Report as presented and reviewed, seconded by Dr. Gevorygan. Motion carried.	*9/10/25*
	Credentialing Revised Policy and Procedures Yolanda Herrera, Credentialing Manager presented the following P&P revisions: • 23.06-P Non-physician Medical Practitioners *Revised to be compliant with Nurse Practitioner 103 License designation that no longer requires supervision.* • 23.10-P Delegated Credentialing *Revised to become compliant with the new NCQA Standard related to reporting requirements, credentialing information integrity and ongoing monitoring* • 23.19-I Credentialing Information Integrity *Revised due to new standards replacing Credentialing System Controls and policy number will be changed to 23.23.*	☑ **ACTION**: Dr. Amin moved to approve the revisions to QP-Credentialing P&Ps #23.06-P, 23.10-P and 23.23-I as presented, seconded by Dr. Patel. Motion carried	*9/10/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	There was no open discussion.	☑ **CLOSED** – Informational Only	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, October 1, 2025	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 7:40 AM. **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator**	**N/A**	*N/A*

For Signature Only – Physician Advisory Committee Minutes 09/10/2025:

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***POPULATION HEALTH MANAGEMENT COMMITTEE***
DATE OF MEETING: ***SEPTEMBER 3, 2025***
CALL TO ORDER: ***11:03 AM BY SUKHPREET SIDHU, MD - CHAIR***

Members Present On-Site:	Maria Bermudez, Asst. Director at Dept. of Human Services Lordes Bucher, Administrator at KCSOS	Paula De La Riva-Barrera, Manager at First 5 Kern Sukhpreet Sidhu, MD PHM Medical Director	
Members Virtual Remote:	Dr. Babita Datta, MD OB/GYN Wasco Medical Plaza Alissa Lopez, Administrator at KCBHRS	Colleen Philley, Program Director at KC Aging & Adult Martin Reynoso, Supervisor at KC Aging & Adult	
Members Excused=E Absent=A	Christopher Boyd, Licensed Clinical Psychologist (E) Brynn Carrigan, Director at KC Public Health (E) Cristina Castro, Recovery Specialist at KCBHRS (E) Valerie Civelli, MD at LTC Premier Valley Med. Group (E) Dixie Denmark-Speer, Social Services Director Height Street (E)	Minty Dillon, Administrator at Premier Valley Medical Grp (E) Desiree Escobedo, Admissions at Height Street SNF Laura Hasting, NP at Priority Urgent Care (E) Kristine Khuu, Assistant Director at Kern Regional Ctr. (E) Gina Lascon, DON at Delano SNF (E) Lito Morillo, Executive Director at KC Human Services (E)	Jasmine Ochoa, Manager at KC Public Health (E) Ashok Parmar MD, Pain Mgmt. (E) Dr. Vivek Radhakrishan, Primary Care ECM Provider Cody Rasmussen, Administrator at Height Street SNF (E) Jennie Sill, Administrator at KCBHRS (E) Alejandra Vargas, BOM at Height Street SNF (E)
Staff Present:	Michelle Curioso, Director of PHM Shellby Dumlao, Special Programs Nurse Consultant Pawan Gill, Health Equity Manager Russell Hasting, PHM Manager of CM Loni Hill-Pirtle, Director of ECM	Maninder Khalsa, MD UM Medical Director Runa Lemminn, PHM Senior Support Clerk John Miller, MD QI Medical Director Noehmi Morfin, RN PHM Clinical Auditor & Trainer	Paula Nunez-Gonzalez, PHM Case Manager RN Nate Scott, Senior Director of Member Services Lucia Vega, PHM Case Management Assistant

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Sukhpreet Sidhu, MD, KHS PHM Medical Director called the meeting to order at 11:03 AM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of June 4, 2025 were presented for review and approval.	☑ **ACTION**: Paula De La Riva-Barrera moved to approve minutes of June 4, 2025, seconded by Babita Datta. Motion carried.	*9/3/2025*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Welcome & Introduction PHM Announcements: Michelle Curioso presented the following: • PHM Committee Roster: Members were asked to let her know if you want to remove your name. • PHM Program Updates- o Baby Steps & Baby Steps Plus: KHS has coordinated with Dr Parmar to take over the program. The program will include psycho-social screening and will allow 3 CMAs to shift activities to other areas of need. Care coordination for high risk still applies. o Long Term Care Member Visits- Monthly visits to LTC members have been reduced to quarterly visits. • Dr Sidhu informed the members that we have also met with our SNFist team regarding the long-term member visits and further our LTC nurse has moved into Care Management.	☑ **CLOSED**: Informational discussion only.	*9/3/2025*
REVIEW AND APPROVAL	**Review and Approval of Policy** Review and Approval of the following Policy revisions: (*Approval by Committee Members)* • Basic Population Health Management • Handling of Care Management & Non-Duplication of Services Content remains the same and only the template has been updated. • Transitional Care Services- Changes were made to ensure the safe transition and appropriate follow up with care coordination. Content remains the same and the template was changed for formatting.	☑ **ACTION**: Maria Bermudez moved to approve the listed Policy and Procedures, seconded by Dr. Babita Datta. Motion carried.	*9/3/2025*
OLD BUSINESS	**LTC Summit 2025 Updates** - Michelle Curioso, Director of PHM, presented the updates for the 3rd Annual Summit to be held October 15, 2025, at Hodel's in Bakersfield. However, the ***Summit has since been discontinued until further notice*** due to budget constraints.	☑ **CLOSED**: Informational discussion only.	*9/3/2025*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	**Enhanced Case Management**-Loni Hill-Pirtle, Director of ECM, presented the following updates: • ECM began in 2022 as part of Cal-Aim, is part of PHM. Approaches clinical and non-clinical needs for the whole person. • ECM is top tier, most complex (not necessarily sickest) members. • Stratified every week to find new members that meet criteria • In-house care management focusing on the highest need/most vulnerable • Children are anyone up to age 20 for ECM • The list of providers is updated monthly on website under ECM • Prisoner pre-release case management is billed to Medi-Cal. • County is working to go live with pre-release services on Oct 1, 2025. • Dr. Sidhu asked if the released population is staying in Kern County? Loni said usually yes, due to family being here, etc. • Kern County Probation will make referrals for juveniles, sheriffs for adults. • KC was found by DHCS to have performed in 4th place for ECM penetration rates. No additional questions were raised.	☑ **ACTION**: Paula De La Riva-Barrera moved to approve the ER Frequent User/Utilizer Report, seconded by Colleen Philley. Motion carried.	*9/3/2025*
	Complex Care Management – presented by Russell Hasting, PHM Manager of CM: • Overview covers 2024 outcomes and what is trending for 2025. • Supports members with multiple chronic conditions & complex needs. • Members are identified using an ACG predictive modeler by John Hopkins, internal referrals, external from community agencies. • CCM is recently NCQA Accredited • CCM is successfully reducing high-cost utilization and supporting vulnerable populations	☑ **CLOSED**: Informational only.	*9/3/2025*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Question: Could social workers refer people to CCM? Russ answered "yes."		
OPEN FORUM	**Open Forum** Michelle Curioso, Director of PHM invited the members to stay and network while enjoying lunch.	**N/A**	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, December 3, 2025 at 11:00 am	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 11:59 AM. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Quality Improvement Committee Minutes 09/03/2025

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***UTILIZATION MANAGEMENT COMMITTEE***
DATE OF MEETING: ***AUGUST 13, 2025***
CALL TO ORDER: ***12:03 PM BY MANINDER KHALSA, MD, UM MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Ashok Parmar, MD –Specialist Pain Medicine	Parikshat Sharma, MD – Outpatient Specialist	Karan Srivastava, MD – Orthopedic Surgeon
Members Virtual Remote:	Maninder Khalsa, MD – KHS UM Medical Director		
Members Excused=E Absent=A	Philipp Melendez, MD – OB/GYN (A)		
Staff Present:	Linda Corbin, Health Services Consultant (Remote) Amy Daniel, Executive Health Services Coordinator Dan Diaz, CCM Manager, RN Erin Endes, Health Services Manager (Remote)	Alma Garcia, NCQA Accreditation Specialist Jiwan Gill-Sharma, UM Inpatient Clinical Supervisor Loni Hill-Pirtle, Director of Enhanced Case Mgmt. Kulwant Kaur, UM Outpatient Clinical Supervisor RN	Christine Pence, Senior Director of Health Services Melinda Santiago, Director of Behavioral Health Nate Scott, Director of Member Services Isabel Silva, Director of Health & Wellness

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were met as the composition as described in the committee charter.	N/A
Call to Order	Dr. Maninder Khalsa, KHS UM Medical Director called the meeting to order at 12:03 PM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of May 14, 2025 were presented for review and approval.	☑ **ACTION**: Dr. Parmar moved to approve minutes of May 14, 2025, seconded by Dr. Srivastava. Motion carried.	8/13/25
OLD BUSINESS	There was no old business to present.	N/A	N/A
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Dr. Khalsa welcomed the members of UM Committee.	☑ **CLOSED**: Informational only.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	UM Report 2nd Quarter 2025 Dr. Khalsa presented the 2nd Quarter 2025 UM Report. The following highlights were noted: • UM Timeliness of Decisions – KHS remains consistent with Urgent compliance at 99.8% and Routine compliance timelines at 100%. • UM Referral Notification is compliance increased to 100% for member notification and 100% provider notification and MD Signature. • Outpatient Referrals – continues to increase in numbers to 103228 from last quarter which was 100842. • Adult & Pediatric Referrals – remain consistent in comparison to past quarters. • Denial Percentage – 1st Quarter denied referrals are 3.5% April, 2.9% May and 3.2% June. • DSNP Policies have been completed and submitted for internal review.	☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members.	*8/13/25*
	UM/Internal Auditing Activities Christine Pence reported on the UM Auditing Activities that included the following items: • HICE Q2 Summary for Inpatient Metrics reflects an appropriate % of change in comparison to 2024 with a downward trend. • Internal Auditing for 2nd Quarter Non-Clinical Staff audits passed 100% and All Licensed Staff reviewers also passed the required IRR Testing with a passing score of 95% or higher. • UM Systems Control Audits were reviewed, indicating 118,923 total files, 11 with non-compliant modifications. Action and interventions included additional training along with 1:1 process training with link to training guides. UM Director will continue to monitor each quarter until improvement of at least one finder over 3 consecutive quarters is demonstrated.	☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members.	*8/13/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	**Open Forum**	☑ **CLOSED**: Informational discussion only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, November 7, 2025 at 12:00 PM	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 1:00 PM ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Utilization Management Committee Minutes 8/13/2025

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***QUALITY IMPROVEMENT WORKGROUP***
DATE OF MEETING: ***SEPTEMBER 11, 2025***
CALL TO ORDER: ***12:05 PM BY JOHN P. MILLER, MD, QI MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Dr. John Paul Miller, KHS QI Medical Director, Chair		
Members Virtual Remote:	Danielle Colayco, PharmD, Executive Director Komoto	Carmelita Magno, Kern Medical Process Improvement Dir.	
Members Excused=E Absent=A	Dr. Mansukh Ghadiya, Family Practice (E) Dr. Joseph Hayes, MD – CMO Omni (E)	Dr. Irving Ayala-Rodriguez, CSV (E)	
Staff Present:	Monique Barrios, QP Clinical Supervisor Kailey Collier, RN, Director of Quality Performance Lela Criswell, Member Engagement Supervisor Michelle Curioso, Director of PHM Amy Daniel, Executive Health Services Coordinator Aurora De La Torre, QP Manager	Flor Del Hoyo Galvan, Manager of Member Wellness Dan Diaz, RN, ECM Clinical Manager Alma Garcia, NCQA Accreditation Specialist Yolanda Herrera, Credentialing Manager Kulwant Kaur, UM Outpatient Clinical Manager Maninder Khalsa, MD, UM Medical Director	Kalpna Patel, QI Supervisor Loni Hill-Pirtle, Director of Enhanced Case Management Magdee Hugais, Director of QI Steven Kinnison, NCQA Manager Melinda Santiago, Director of Behavioral Health

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were met.	9/11/25
Call to Order	Dr. John Paul Miller, KHS QI Medical Director called the meeting to order at 12:03 PM.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. John Miller, presented the May 22, 2025 meeting minutes for approval.	☑ **ACTION**: Danielle Colayco made a motion to approve minutes of May 22, 2025, seconded by Carmi Magno. Motion carried.	9/11/25
OLD BUSINESS	**No Old Business presented.**		N/A
NEW BUSINESS	**ECM Report & Program Description** Dan Diaz, ECM Manager, presented the Q2 2025 ECM Report and Program Description. Some key highlights included: • Closed the loop on referrals to ECM and this process has been added to the program description.	☑ **ACTION**: Danielle Colayco moved to approve the ECM 2nd Quarter 2025 Report and Red-lined Program Description, seconded by Carmi Magno. Motion carried.	9/11/25

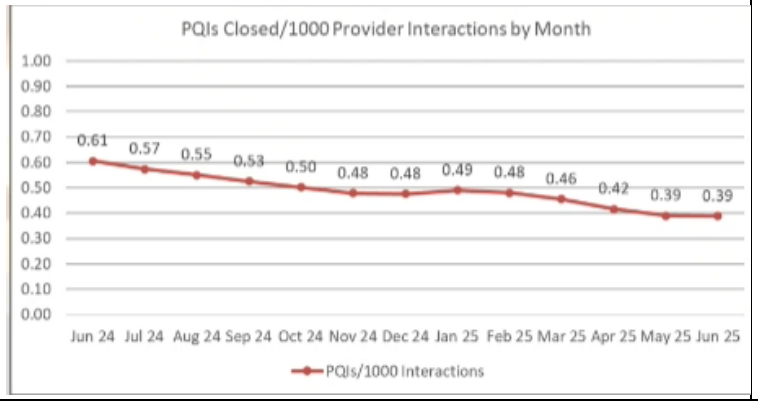
AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Organization chart pending possible development of new job descriptions to describe our current state • Added new Child Welfare Liaison position to support community services • Streamlined authorizations for contracted providers to be able to authorize in 30 days. • ECM has a total of 12,272 members enrolled • ECM interventions have decreased the total number of unique emergency room visits for members enrolled by 5% • Overall ECM satisfaction has increased from 2024 to present. • Red-lined revisions to the ECM Program Description were reviewed with no significant questions from the committee members.		
	Quality & Safety of Clinical Care **MCAS Update**: Kailey Collier, Director of QP, presented the 3rd Quarter Quality Improvement Report including Trending Performance for MY2025 vs MY2024. Some key highlights included: • Purchased multiple lead screening machines for providers in rural regions • 5 mobile unit providers deployed across Kern County • Partnerships with more than 15 school districts • Weekend and evening clinics with two local pediatricians • Streamline member rewards for behavioral health and children's services • Dedicated outreach team focused on children's health, specifically driven by need for annual well-care visits **Site Review Updates**: Kailey also presented the QP Site Review updates. For 2025 YTD, 100% of the Initial and Periodic site reviews passed. Highlights included: • YTD there were 40 site reviews completed by early September 2025 • All Site Reviews completed timely and thoroughly for Q3 2025 • There are no open CAPs pending follow up actions • CMT participates in multiple statewide workgroups focused on updating CDPH trainings to supplement provider education of Children's screenings. • Collaborating with PNM and Learning & Development to share with PCPs.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	9/11/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	OOC Grievances & PQIs Magdee Hugais, QI Director presented the Quality-of-Care Grievances and Potential Quality of Care issues for 2nd Quarter 2025. Magdee reported there were no QOC concern identified to warrant further investigation or additional action.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	9/11/2025

Quarter	Total Grievances Received for PQOC	Grievances Classified as PQOCs	Grievances Classified as Non-PQOCs	Total Grievances Closed
Q3 2024	1007	598	409	2755
Q4 2024	924	505	419	2355
Q1 2025	659	444	215	3006
Q2 2025	968	644	324	1719

Severity Level	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025
Level 0 - No Quality Concern	129	85	18	74	73	67
Level 1 - Potential for Harm	108	75	95	94	71	48
Level 2 - Actual Harm	0	2	0	2	0	0
Level 3 - Actual Morbidity	0	0	0	0	0	0
Total	237	162	113	170	144	115

Appeals and Clinical Network:
Kalpna Patel, QI Supervisor presented the Appeals for 2nd Quarter. PQIs Closed per 1000 Provider Interactions by Month continue to trend downwards and turn-around-time in 30-days is continue to trend downwards.



AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	NCQA Accreditation Steven Kinnison reported that KHS received accreditation in both Health Plan Accreditation and Health Equity. Both accreditations are for 3 years. There was one point missed, and the organization has already closed the gap in complying with the provider manual data elements.	☑ **CLOSED**: Informational Only.	9/11/25
	Cultural and Linguistics Monitoring 1st Quarter 2025 Flor Del Hoyo Galvan W&P Manager presented the C&L Monitoring for 2nd Quarter Report**.** • Bilingual staff call audits 30-Calls Audited with 98% compliance with no difficulty communicating. • 94% of members were satisfied with the linguistic performance • 100% of audited calls for OPI Interpreter Service met expectations. • Overall members were very satisfied with KFHC Services	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	9/11/25
	Member Wellness and Prevention Flor Del Hoyo Galvan, W&P Manager presented the Wellness and Prevention Report 2nd Quarter 2025. Report accepted as presented and available for review due to time constraints.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	9/11/25
	QI Workplan Scorecard Magdee presented the KHS Quality Improvement Annual Work Plan Scorecard. Due to time constraints members were directed to review the report and if any questions to direct those to Magdee.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	9/11/25
OPEN FORUM	**Open Forum** No additional questions or issues were presented for open forums.	☑ **CLOSED**: Informational only.	N/A
NEXT MEETING	Next meeting will be held Wednesday, December 8, 2025 at 12:00 noon.	☑ **CLOSED**: Informational only.	N/A
ADJOURNMENT	The Committee adjourned at 1:00 PM. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	N/A

For Signature Only – Quality Improvement Committee Minutes 09/11/25

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

KERN HEALTH SYSTEMS

COMMITTEE: **Network Adequacy Committee**
DATE OF MEETING: **June 25, 2025**
CALL TO ORDER: **9:03 AM by James Winfrey, KHS - Deputy Director of Provider Network Management, Chair**

Members Present On-Site:	Traco Matthews, KHS - Chief Health Equity Officer Deb Murr, KHS - Chief Compliance and Fraud Prevention Officer Melissa McGuire, KHS - Senior Director of Delegation and Oversight
Members Virtual Remote:	Amisha Pannu, KHS - Senior Director of Provider Network Management (virtual)
Members Excused (E), Absent (A)	Alan Avery, KHS - Chief Executive Officer (E)
Staff Present:	Greg Panero, KHS - Provider Network Analytics Program Manager (virtual) Beatriz Quiroz, KHS - Provider Network Analyst I (virtual) Pawan Gill, KHS - Health Equity Manager (on-site)

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
CALL TO ORDER	- James Winfrey called the meeting to order at 9:03 AM - Quorum/Attendance	- Committee quorum requirements met.	N/A
APPROVAL OF MINUTES	- James Winfrey presented the Q2 2025 Network Adequacy Committee meeting minutes for approval.	☑ **CLOSED**: The committee members in attendance approved Q2 2025 Network Adequacy Minutes.	*7/25/25*
OLD BUSINESS	- No items.	☑ **CLOSED**: Informational only.	*7/25/25*
NEW BUSINESS	Provider Network Management, Q2 2025 Quarterly Network Review - Greg Panero presented the Provider Network Management Q2 2025 Quarterly Network Review. o After Hours Survey Results: Emergency Access at 97% compliant, Urgent Care Access at 96% compliant. Reviewed trending results and discussed Plan follow up action. ▪ During discussion of after-hours survey	☑ **CLOSED**: The committee members in attendance approved Provider Network Management, Q1 2025 Quarterly Network Review .	*7/25/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	that reporting be split up by center based ABA versus in home ABA. Amisha Pannu went into detail about there currently only being 3 providers in network that provide these services at this time and the new requirements coming up that will affect accessibility. ▪ Amisha Pannu asked if it would be possible to increase the sample size in the South Bakersfield region. James explained that in some regions, providers are being surveyed every quarter due to the limited number of providers available. He suggested reviewing the geographic access breakdown only once or twice a year, noting that while PNM currently surveys five providers per region, the majority are concentrated in the Central Region. James also pointed out that some specialists travel to rural areas on a monthly or weekly basis. Although they may appear non-compliant when surveyed, their presence in these areas is a positive. Traco Mathews agreed and suggested that it might be time to start focusing on special populations. James recorded this as an action item and will follow up with Traco for further discussion. ○ Access Grievance Review: The Plan has 342 access grievances found in favor of the member in Q4 2024, for a total of .34 grievances for every 1,000 members. ▪ During discussion of Access grievance review, James explained this could be a sustained downward trend and PNM will continue to monitor and this could possibly be a result of the ongoing retention and recruitment grant. Amisha agreed this is something that could be looked into and suggested reviewing retention and	☑ **CLOSED:** Informational only.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	**Open Forum** - Debb Murr, brought up the upcoming DMHC Audit and inquired whether there were any concerns that needed to be addressed. James responded that, from a Network Adequacy standpoint, there were no issues. - Traco Matthews asked if it would be possible to prepare data to review FTE for the African American population. James confirmed that this could be done upon request and added that a similar report had previously been prepared for NCQA.	☑ **CLOSED**: Informational only.	*7/25/25*
NEXT MEETING	Next meeting will be held Friday, October 24, 2025.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 9:46 AM. ***Respectfully submitted: James Winfrey; Deputy Director of Provider Network Management***	**N/A**	*N/A*

For Signature Only – AADVOC Minutes 7/25/25

The foregoing minutes were APPROVED AS PRESENTED on: 9/11/25 (Date) _____ (Name)

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ (Date) _____ (Name)

KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: Isabel Silva, Senior Director of Wellness and Prevention

Date: December 16, 2025

Re: 3rd Quarter 2025 Wellness & Prevention Department Reports

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Background:

KHS' contract with the DHCS requires that it implements evidence-based wellness and prevention programs inclusive of a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all members. The contract also requires that KHS have a Cultural and Linguistic Services Program and that KHS monitors, evaluates and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services.

Discussion:

Enclosed are the quarterly Wellness and Prevention Department reports summarizing all activities performed during the 3rd quarter of 2025:

- Q3 2025 Wellness & Prevention Activities Report
- Q3 2025 Cultural and Linguistic Services Activities Report

Fiscal Impact:

None.

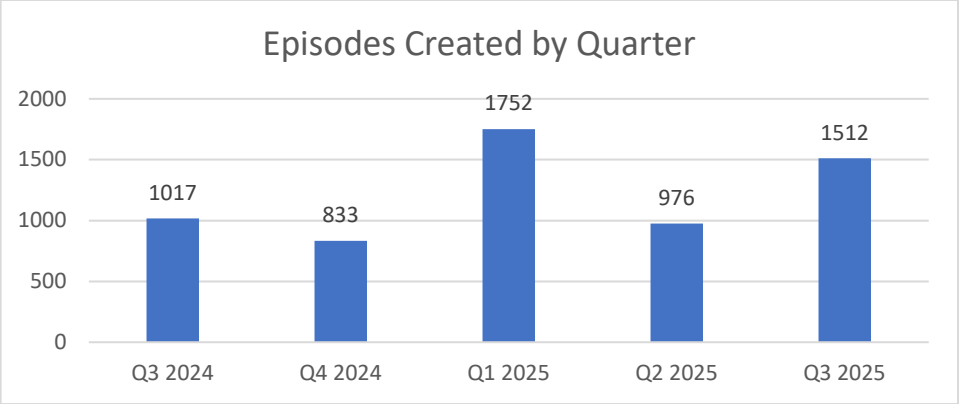
Requested Action:

Review and approval.

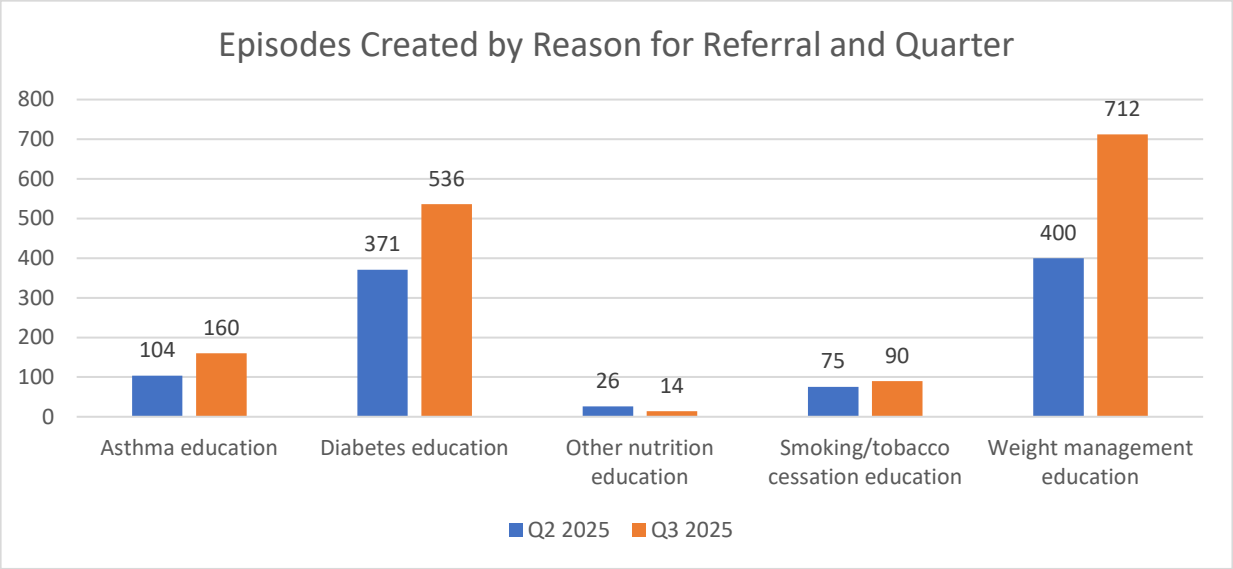
Member Wellness and Prevention

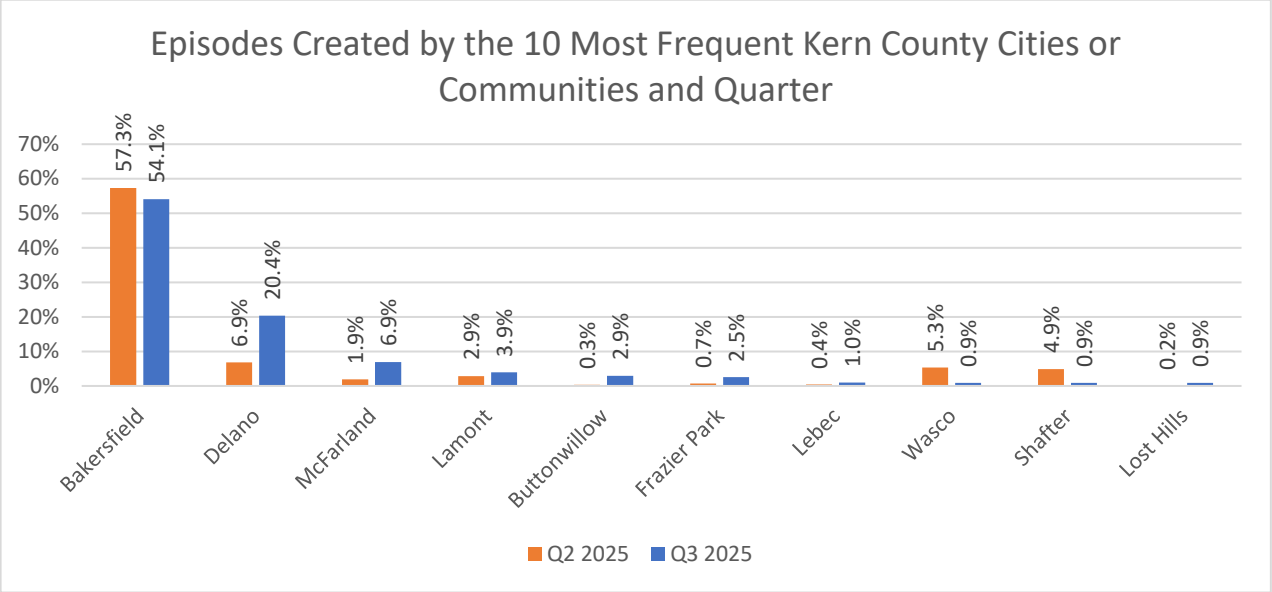
Health Education Referrals

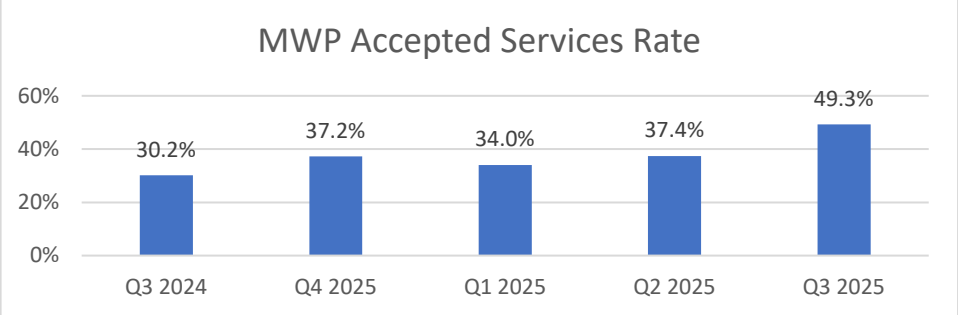
During the third quarter (Q3) of 2025, 1512 referrals for Member Wellness and Prevention (MWP) services were received or created, which was a 48.7% increase in comparison to Q3 2024. Most referrals were for weight management (712), followed by diabetes education (536), and asthma education (160). In Q3 2025, referrals increased for asthma, diabetes, smoking/tobacco cessation, and weight management education compared to the previous quarter. However, referrals declined for other nutrition education. The increase in referrals for weight management education is related to the Comprehensive Obesity Management Pilot Program being led by Universal Healthcare Services. Focused outreach and program availability led to the following referral breakdown by community: most diabetes education referrals were from Delano, most tobacco cessation and weight management referrals were from Bakerfield, and most asthma education referrals were from Bakersfield and Lamont. Most referrals were for members who live in Bakersfield, followed by Delano, McFarland, Lamont and Buttonwillow. The health education service acceptance rate increased from 37.4% in Q2 2025 to 49.3% in Q3 2025. The received services rate increased from 41.6% in Q2 2025 to 44.5% Q3 2025. The received services rate is based on the number of W&P referrals where a member attended a W&P program session or class over the number referrals where a member accepted service.

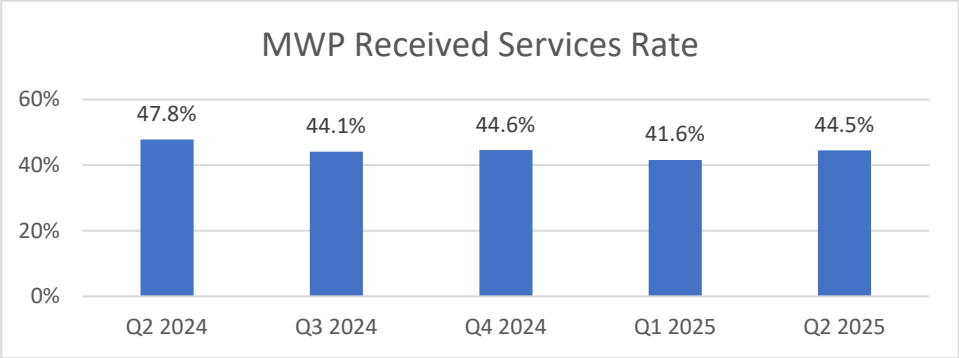


Kern Health Systems
Wellness & Prevention Activity Report
3rd Quarter 2025







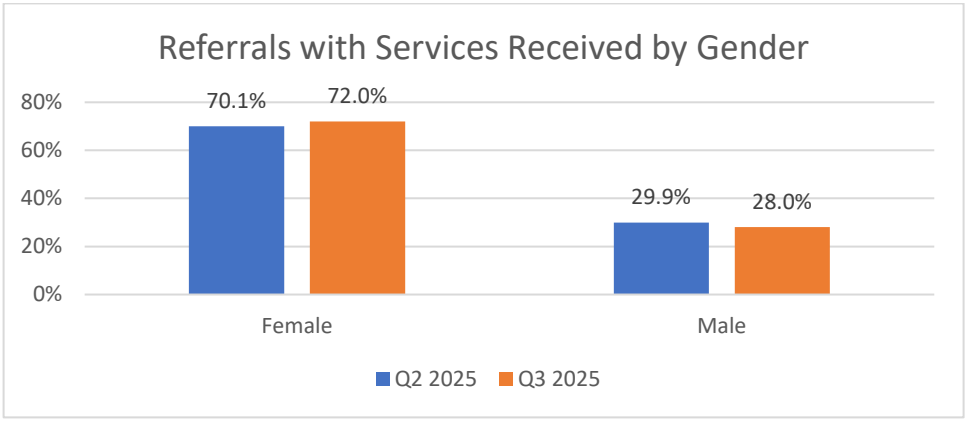


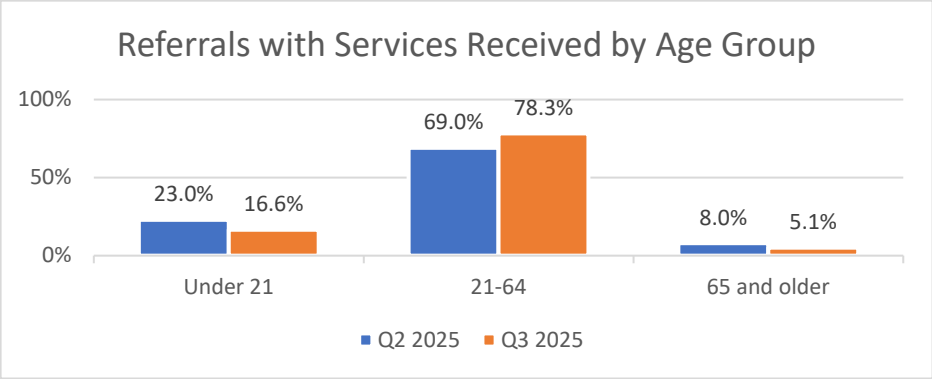
Member Demographics

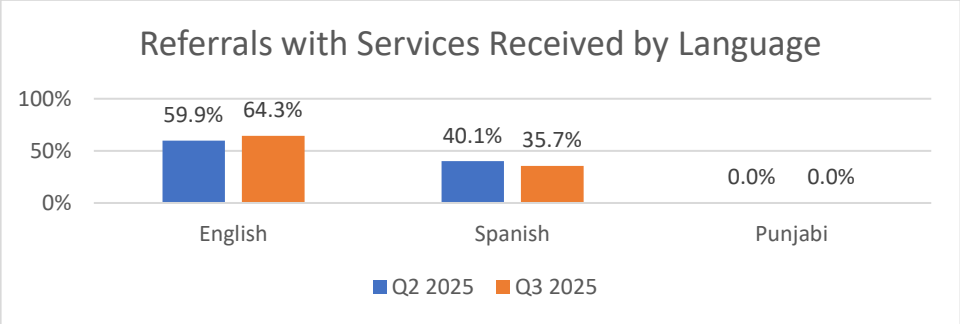
KHS provides MWP services to a culturally and linguistically diverse member population in Kern County. A demographic analysis of MWP referrals involving members who received services during Q3 2025 included the following findings:

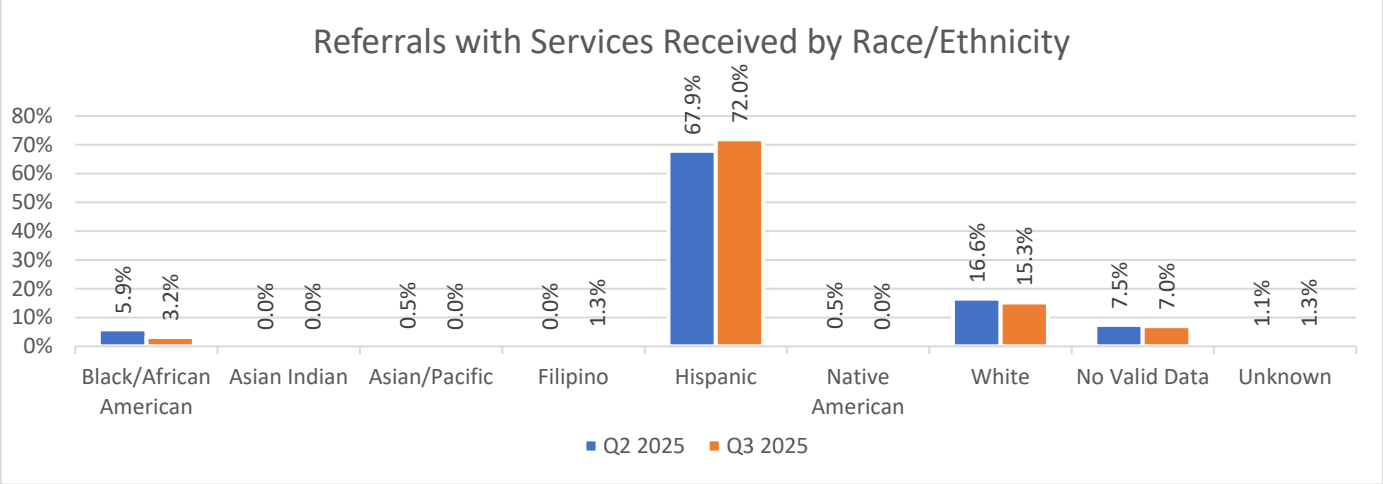
1. The largest age group was 21-64 years, followed by members under 21 years of age and members 65 years and older.
2. Most members who received MWP services were Female (72.0%), Hispanic (72.0%) and spoke English (64.3%).
3. Most members who received services resided in Bakersfield (73.2%), followed by Lamont (5.7%), Delano (5.1%), Shafter (3.2%), and a tie at 1.9% between Arvin, Taft, and Wasco.
4. The Bakersfield zip codes with the highest number of W&P referrals where a member received services were 93306 (13.4%), 93307 (9.6%), 93305 (8.9%), 93301 (8.3%), and 93304 (8.3%).

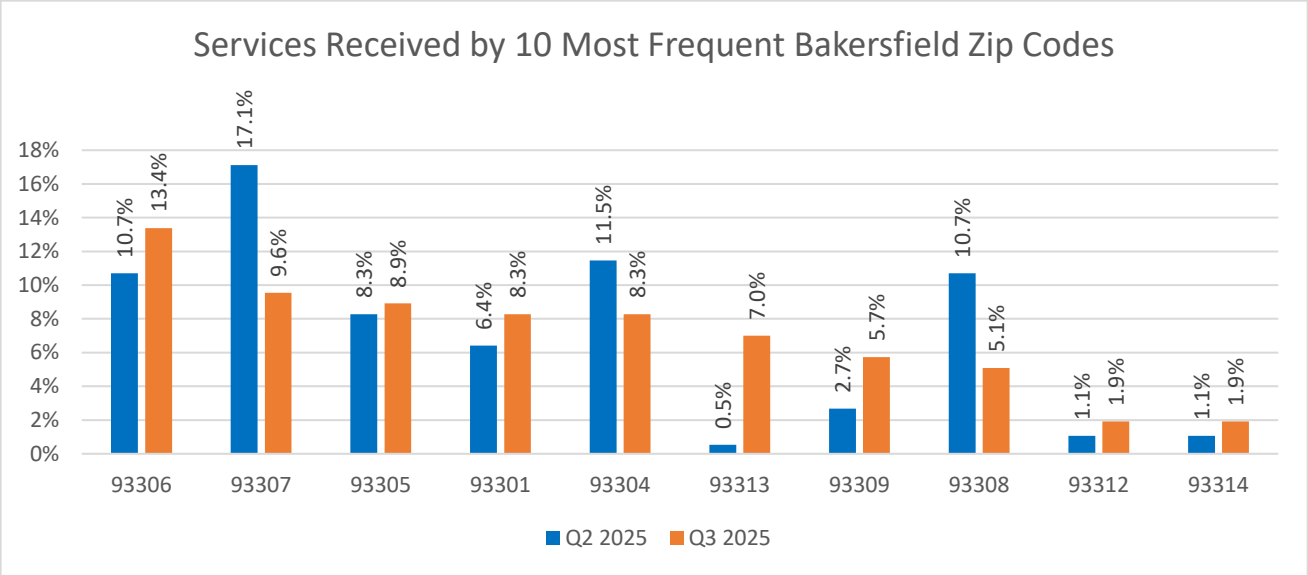
These insights reinforce the importance of targeted outreach by age, language, and geography to ensure equitable access to wellness services across Kern County.

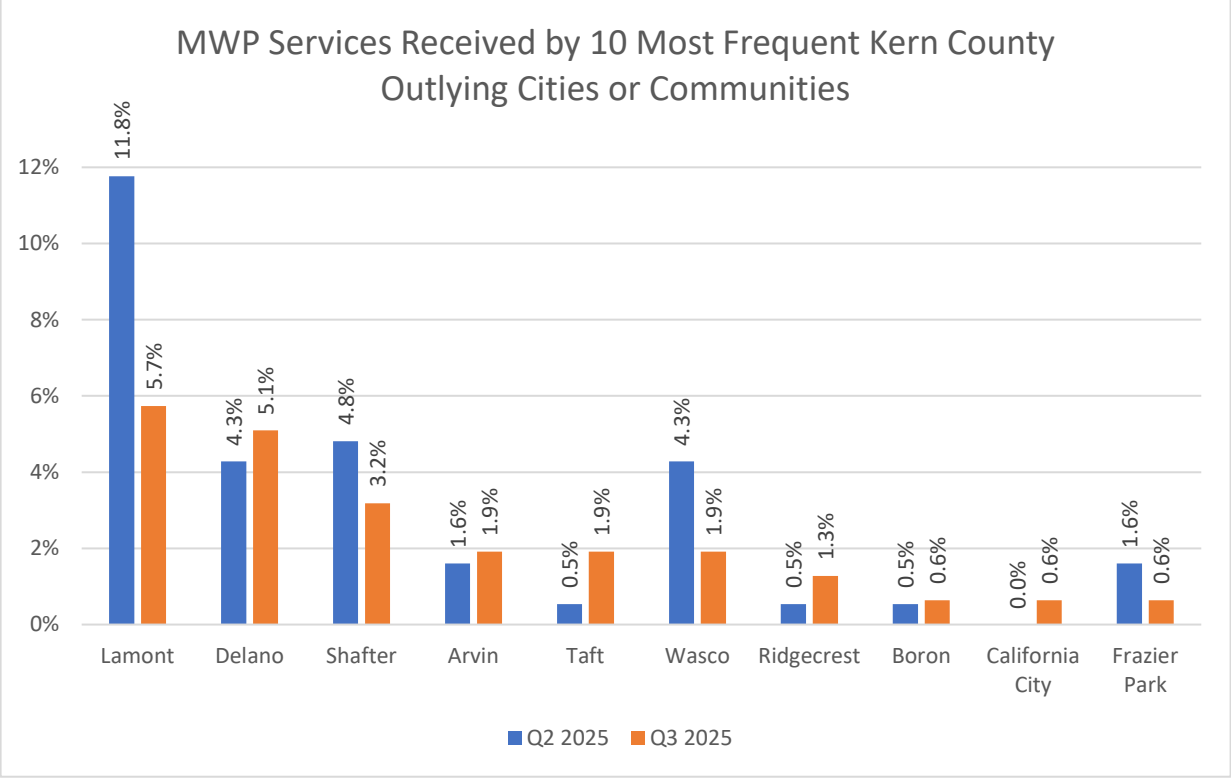



Referrals with Services Received by Age Group
100%
50%
0%
23.0%
16.6%
69.0%
78.3%
8.0%
5.1%
Under 21
21-64
65 and older
Q2 2025
Q3 2025


Referrals with Services Received by Language
100%
50%
0%
59.9%
64.3%
40.1%
35.7%
0.0%
0.0%
English
Spanish
Punjabi
Q2 2025
Q3 2025


Referrals with Services Received by Race/Ethnicity
80%
70%
60%
50%
40%
30%
20%
10%
0%
5.9%
3.2%
0.0%
0.0%
0.5%
0.0%
0.0%
1.3%
67.9%
72.0%
0.5%
0.0%
16.6%
15.3%
7.5%
7.0%
1.1%
1.3%
Black/African American
Asian Indian
Asian/Pacific
Filipino
Hispanic
Native American
White
No Valid Data
Unknown
Q2 2025
Q3 2025

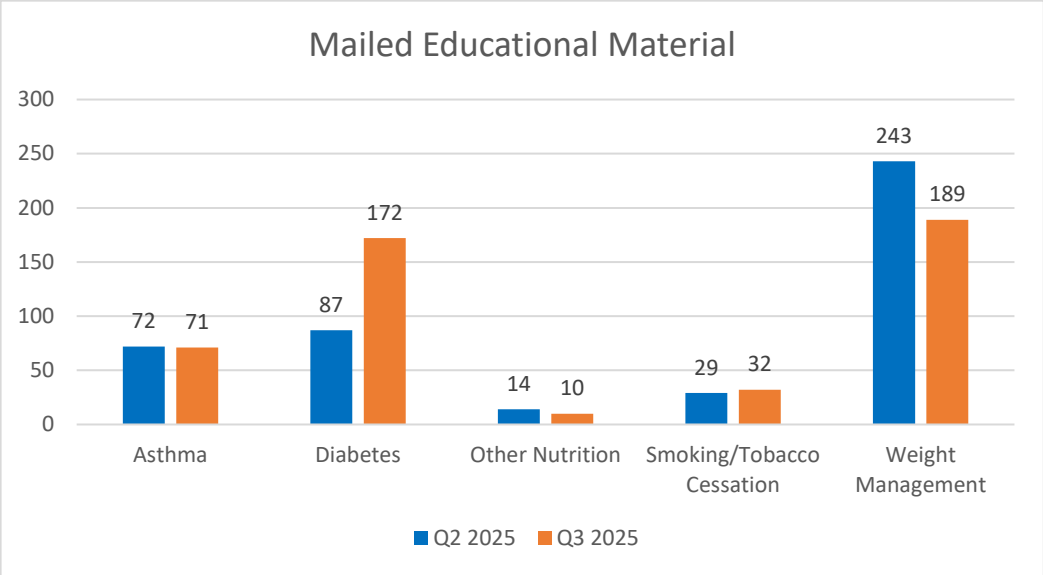




Healthwise Care Collections

Kern Health Systems contracts with WebMD Ignite to provide health education material. WebMD Ignite material is mailed to all members who accept health education services and is offered to members who decline services. In Q3, 474 members were mailed educational material, a 6% increase from Q2 when 445 members were mailed educational material. In Q3, members referred for

diabetes education were more likely to accept mailed educational material compared to other programs.



Health Education Class Service Audit

The Health Education Class Service Audit Tool considers a variety of markers to determine the quality of Health Education Class Services being provided to members. It includes observations on planning and preparation, implementation and delivery, and member engagement during health education classes.

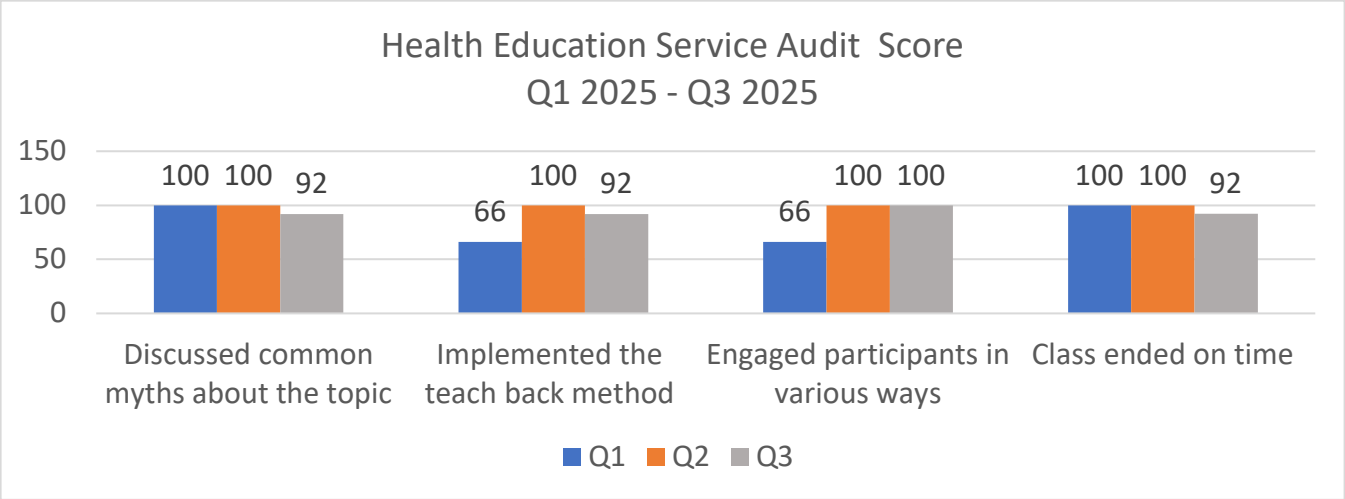
In Q3 2025, class facilitators demonstrated mastery in the following areas:

- Planning and set-up for classes
- Tracking participant attendance and quiz completion
- Covering SMART goals
- Checking for questions
- Covering all topics and materials

No areas fell below the 90% mark.

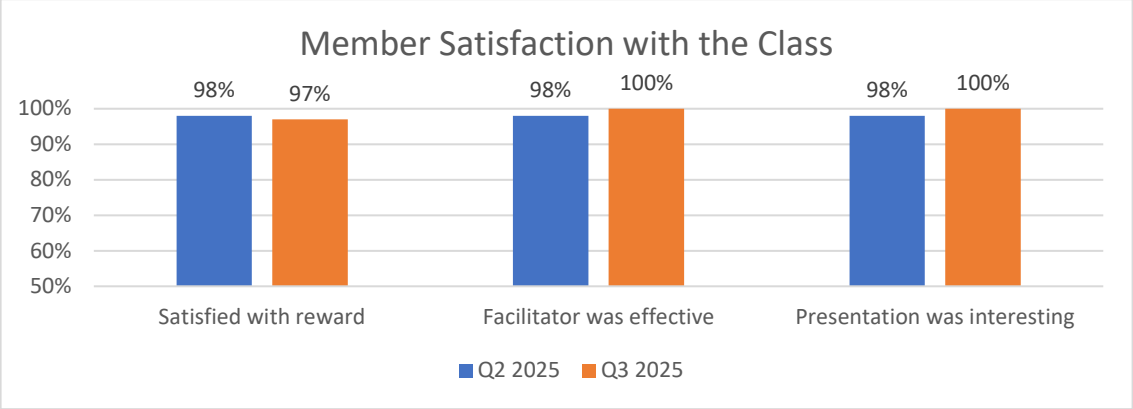
Areas of improvement include:

- Discussing myths around class topics
- Applying the teach-back method
- Ending class on time



Health Education Class Evaluation: Member Questionnaire Findings

Health Education classes include an evaluation questionnaire for participants. The questionnaire is administered at the end of the class session or series. Below is an analysis of the findings from rating type questions about member satisfaction with the class for Q2 2025 and Q3 2025.



Below is an analysis of the findings from open-ended questions for Q3 2025.

What did you like most about the class?
More than 98% percent of participants expressed satisfaction with how the facilitators presented information, the quality of the presentation (was it interesting and easy to follow?), and the rewards.

Member comments indicated that they:

- Value the useful and informative nature of the material, especially regarding nutrition, healthy habits, and wellness.

- Appreciate the instructor's clarity, knowledge, and presentation style.
- Enjoy opportunities for participation, interaction, and discussion.
- Learn applicable knowledge for daily life—diet, physical activity, and grocery habits.
- Found the lessons relevant to their goals, motivating them toward healthier living.

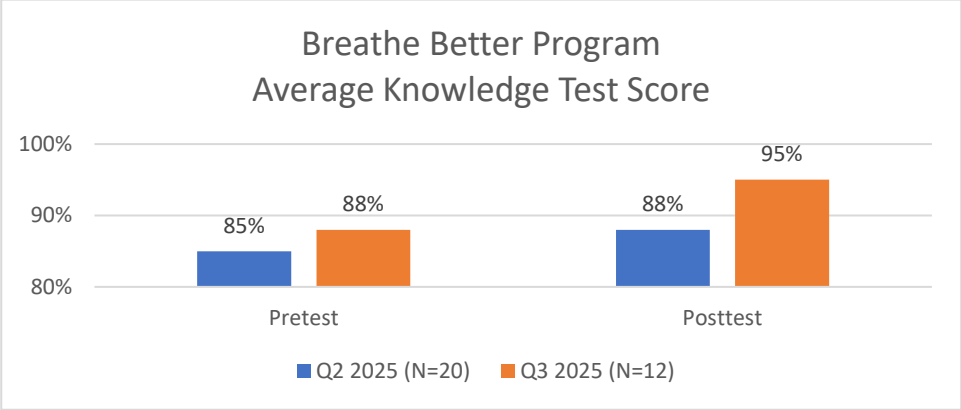
How could we improve the class?
Member comments included:

- Wanting additional health-related tips or reinforcement of concepts.
- Simplifying or ensuring clear communication for all participants.
- The desire to continue with more sessions or follow-ups.

In addition, members referred to the Kick It California (KIC) Quitline are surveyed to gauge satisfaction with this service. No satisfaction survey responses were collected during this quarter. No member accepted services to KIC in Q2.

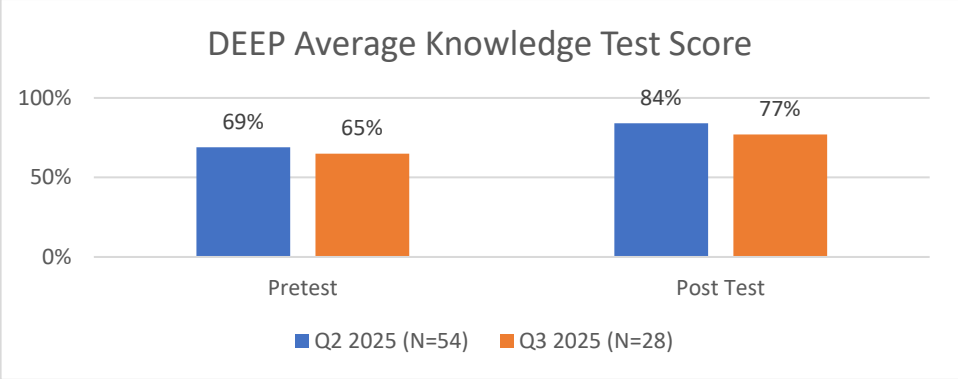
Member Wellness and Prevention Program Evaluation: Knowledge Change

Asthma: Breathe Better Program
The KHS Breathe Better Program is an asthma education program that consists of 2 classes and at least 2 follow-up calls. A pre and posttest questionnaire is administered each series. During Q3 2025, findings revealed there was a 7-percentage point increase in average knowledge test score after completing the series. The largest increase was in understanding when to use controller inhalers as directed by their health care provider.



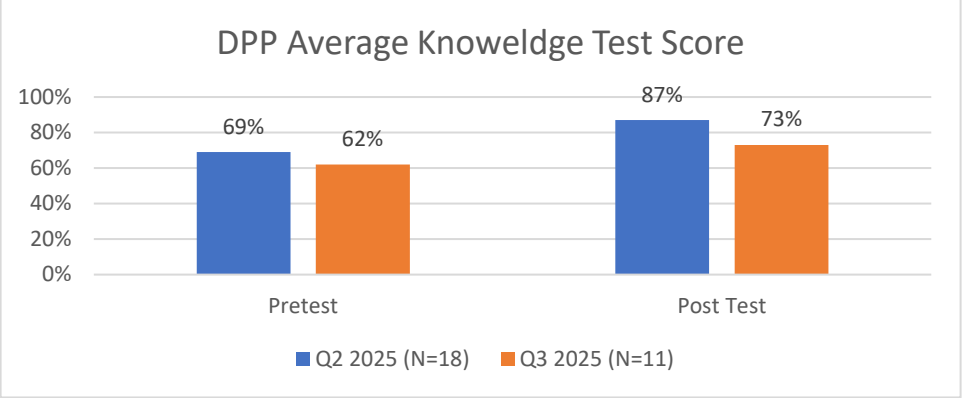
Diabetes Education: Diabetes Empowerment Education Program (DEEP)
DEEP is a diabetes self-management program that has been shown to be successful in helping participants take control of their disease and reduce the risk of complications. The program was developed for low-income and racial and ethnic minority populations. During Q3 2025, findings

revealed a 12-percentage point increase in average knowledge test score when comparing members who completed a pretest (average score 65%) to members who completed a posttest (average score 77%).



Diabetes Prevention: Diabetes Prevention Program (DPP)

The National DPP aims to simplify access to an affordable, high-quality lifestyle change program for individuals with prediabetes or those at risk of type 2 diabetes. The program helps lower their chances of developing type 2 diabetes and enhances their overall health. In Q3, 11 members completed a pretest and posttest for classes 5-12. There was an average 3 percent-point increase in knowledge gain with an average score of 62% at pretest compared to an average score of 73% at posttest.



Nutrition and Weight Management: Eat Healthy, Be Active (EHBA) Program and Activity and Eating Class (A+E)

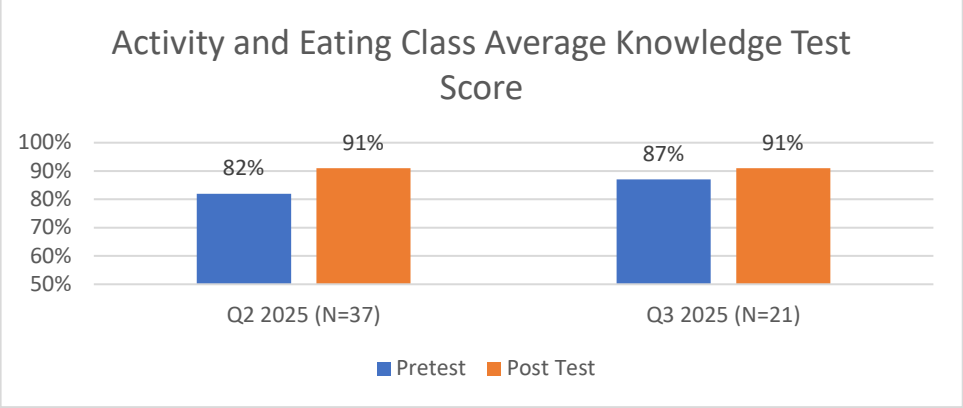
The nutrition and weight management program includes two curriculums that focus on creating healthy habits around eating and physical activity to reduce the risk of chronic illness among the KFHC members and the Kern County population. In September 2023, the Eat Healthy, Be Active curriculum, a 6-class series, along with the Activity and Eating one-time class were launched. Each class lasts

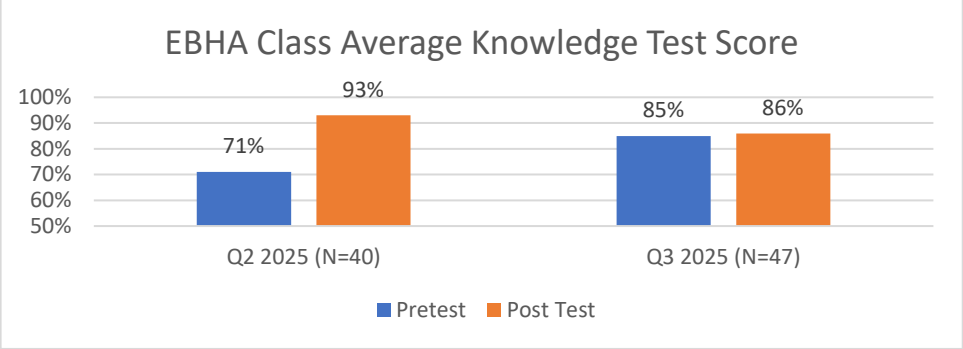
about 90 minutes. Evidence shows that these programs can positively impact behavior around physical activity and nutrition. A pretest and posttest questionnaire is distributed every class.

During Q2 2025, findings revealed that among those members who completed the core pretest and posttest for EBHA or A+E, there was a combined average 3-percentage point increase in knowledge gained after completing classes.

- Members who completed a pretest scored an average of 86% in correct answer compared to an average posttest score of 89%.
- The largest increase in knowledge from pre- to posttest was observed among members who attended the A+E Class – a 4-percentage point increase.

There was also an increase in awareness of the relationship between calorie intake and physical activity, the five recommended food groups, and daily recommended exercise for adults.

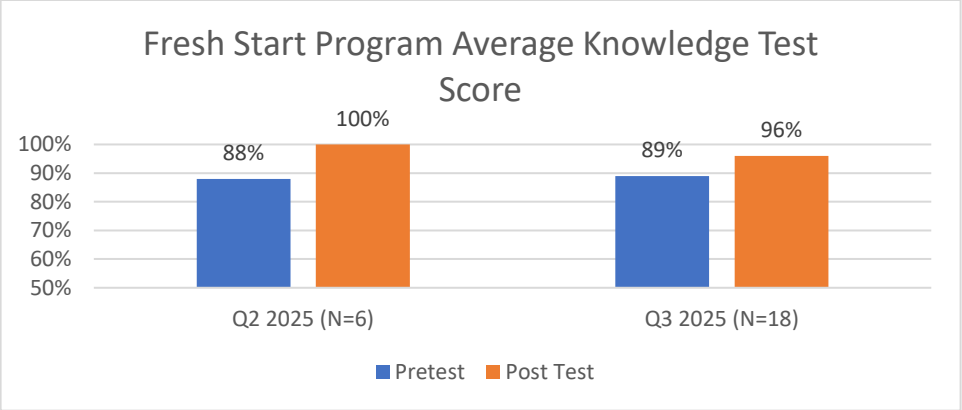




Smoking/Tobacco Cessation: Fresh Start

The Fresh Start program has the goal of reducing harm from tobacco products. Knowledge tests are administered in each series. In Q3 2025, 18 members completed a pretest and/or posttest, with a total of 9 tests completed during this period. There was a 7-percentage point increase in average knowledge score between pretest and posttest responses. Members appear to have gained

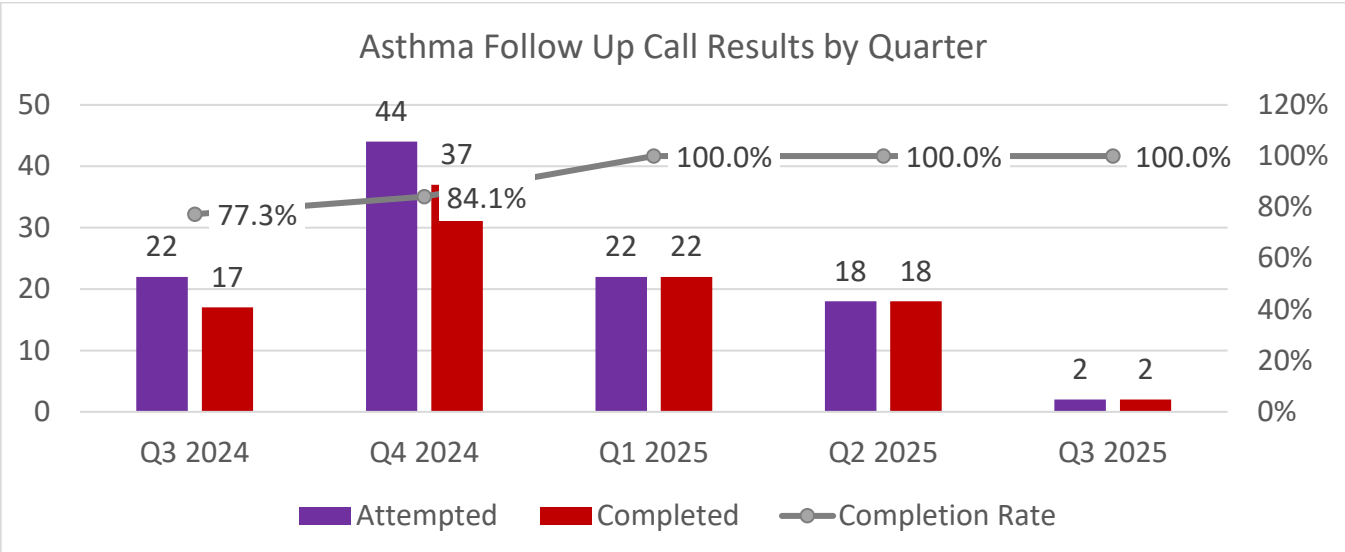
knowledge on the concept of how ambivalence affects their emotions, understanding their triggers, and creating a personal quit plan.



Member Wellness and Prevention Program Evaluation: Outcomes

Asthma: Breathe Better Program

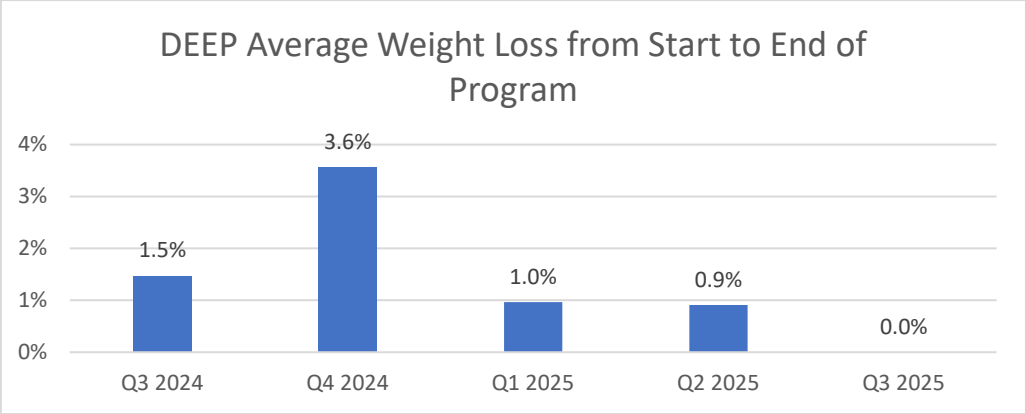
Members who have attended the KFHC Breathe Better Asthma Classes are offered asthma follow-up calls. These calls occur at 1 month, 3 months, and 6 months (optional or only if needed) after attending the classes. During the follow up call, members are screened to determine if asthma symptoms are well controlled using the Asthma Control Test (ACT) screening tool. An ACT score of 20 or higher is an indicator of well controlled asthma. During Q3 2025, 100% of members completed an asthma follow up call compared to 100% for the previous quarter. There was an improvement in average ACT score for both members under 12 years of age and those 12 years and older when comparing the initial assessment to the 3 month follow-up calls.



Q3 2025 Average ACT Scores During Asthma Follow Up Calls		
Call Month	**<12 years of age**	**12+ years of age**
Initial	14	14
3	20	16

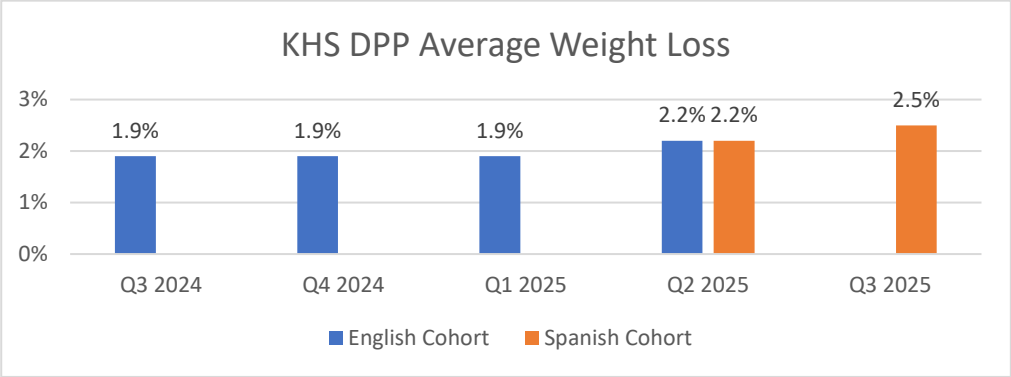
DEEP

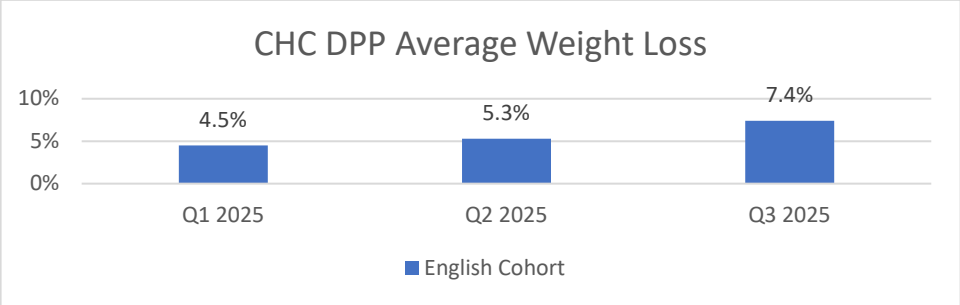
Members who participate in DEEP are weighed at every class as a way to measure program impact. The chart below compares the average weight of participants at the beginning (class 1) and end of the program (class 6). The data shows that participants have experienced an average weight quarterly loss between 0.0%-3.6%. This finding suggests that behavior modifications and recommendations presented during the series may be effective in maintaining or losing weight.



DPP

Members who participate in DPP are weighed at every class as a way to measure program impact. The initial combined cohort weight is compared with the combined weight at the end of each month to calculate average weight loss per member each month and quarter. The average individual weight loss percentage by quarter is shown in the chart below. By the end of Q3 2025, 14 members were enrolled in the KHS Spanish DPP cohort with an average weight loss of 2.5% and 9 members were enrolled in the California Health Collaborative (CHC) English DPP cohort with an average weight loss of 7.4%.





Kick It California (KIC) Tobacco Cessation

KHS has partnered with KIC to increase outreach efforts to members who have reported smoking within the last year. The initiative marks a significant milestone in our efforts to provide proactive cessation support to Kern Family Health Care members. KIC began outreach to KFHC members in July 2025. The Q3 report provides a baseline for future outreach campaigns and will serve as a reference point for continuous improvement in program design, outreach strategies, and reporting standards.

KIC Key Metrics	Total	Percentage
Referrals Received	1000	
Members From Outreach Attempts	20	
Enrolled	14	1.4%
Coach Attempted Enrolled	 499 10	 2.0%
IVR Attempted Enrolled	 499 4	 0.8%
Completed 1st Coaching Call	6	
Nicotine Replacement Therapy Mailed	9	

Preliminary results:

- Enrollment rates were modest (1.4% overall), indicating a need for enhanced member engagement strategies.
- Coach-led outreach showed higher success (2.0%) compared to IVR (0.8%), suggesting prioritization of live coaching calls.

Findings

- Data and reporting from KIC are a work in progress and a complete report for Q3 is expected in November 2025 for a more complete analysis.
- Member feedback would be useful to understand barriers to enrollment and improve enrollment rates.

Member Wellness Campaign

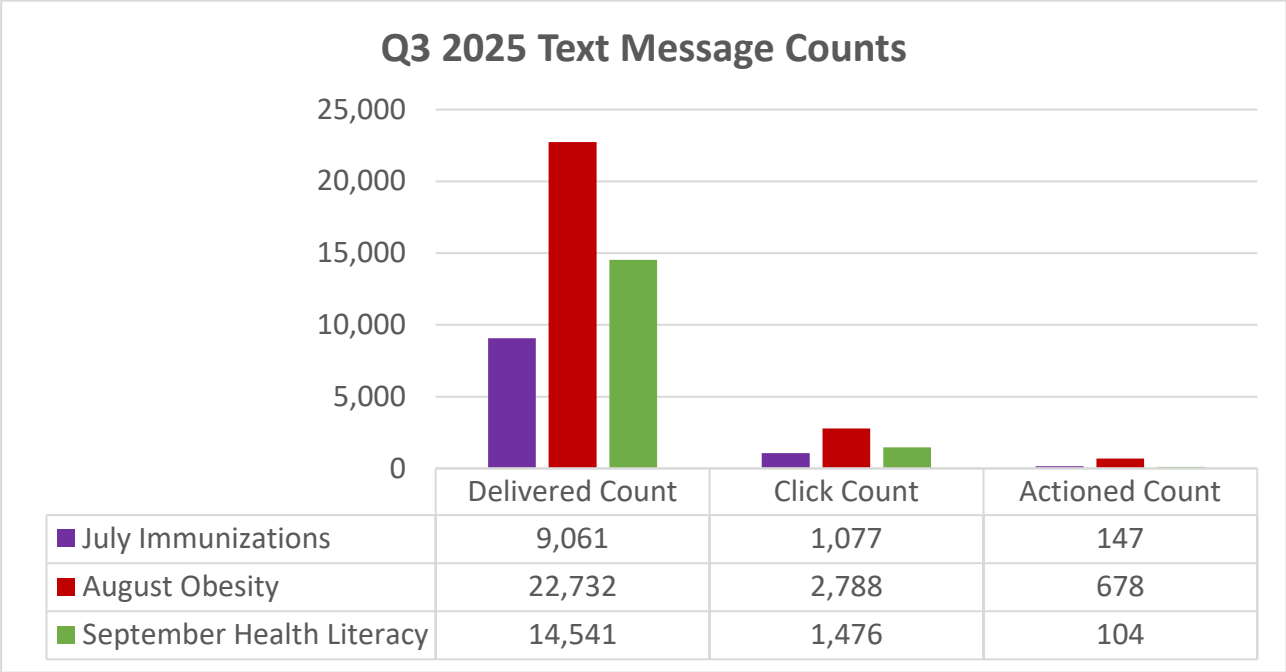
Member Newsletter

The Fall 2025 Newsletter was mailed to homes September 14–18. There was a total of 66,018 newsletters mailed. This edition of the newsletter focuses on children's health. For households who have opted in to text, the newsletter was sent out by text September 16 – 19. The newsletter was texted out to 17,089 members. A total of 11,915 members were English speaking, and 5,274 members were Spanish speaking.

Prevention Messaging - Text

The Member Wellness & Prevention team adopted a text messaging wellness campaign in 2025 as a way to provide health education on specific topics to a larger population. Messages go out to households that have opted in to text at the time the text message goes out.

- In July, the topic was immunizations. The message went out to households with members 17 years or younger. There was a total of 9,061 members who were outreached and 11.9% clicked on the message.
- In August, the topic was obesity. This message went out to all households that were opted in text messaging. There was a total of 22,732 members who were outreached and 12.3% clicked on the message.
- In September, the text message topic was health literacy. This message went out to all households that were opted in text messaging. There was a total of 14,541 members who were outreached and 10.2% clicked on the message.



	Delivered Count	Click Count	Actioned Count
July Immunizations	9,061	1,077	147
August Obesity	22,732	2,788	678
September Health Literacy	14,541	1,476	104

Prevention Messaging – Social Media
MWP staff collaborates with the KHS Marketing team to develop wellness and prevention messaging for Kern Family Health Care members. The messages are posted on the social media platforms Facebook and Instagram. They are posted in English and various in Spanish with the hashtag *#KFHCWellness #BienestarConKFHC* to identify the collaborative campaign messages and increase message visibility with our members.

In **Q3** messages were about Children's Immunizations, Well-Child Visits and Pain Management. These messages were posted in English and various in Spanish with the hashtag *#KFHCWellness #BienestarConKFHC* to identify the collaborative campaign messages and increase message visibility with our members.

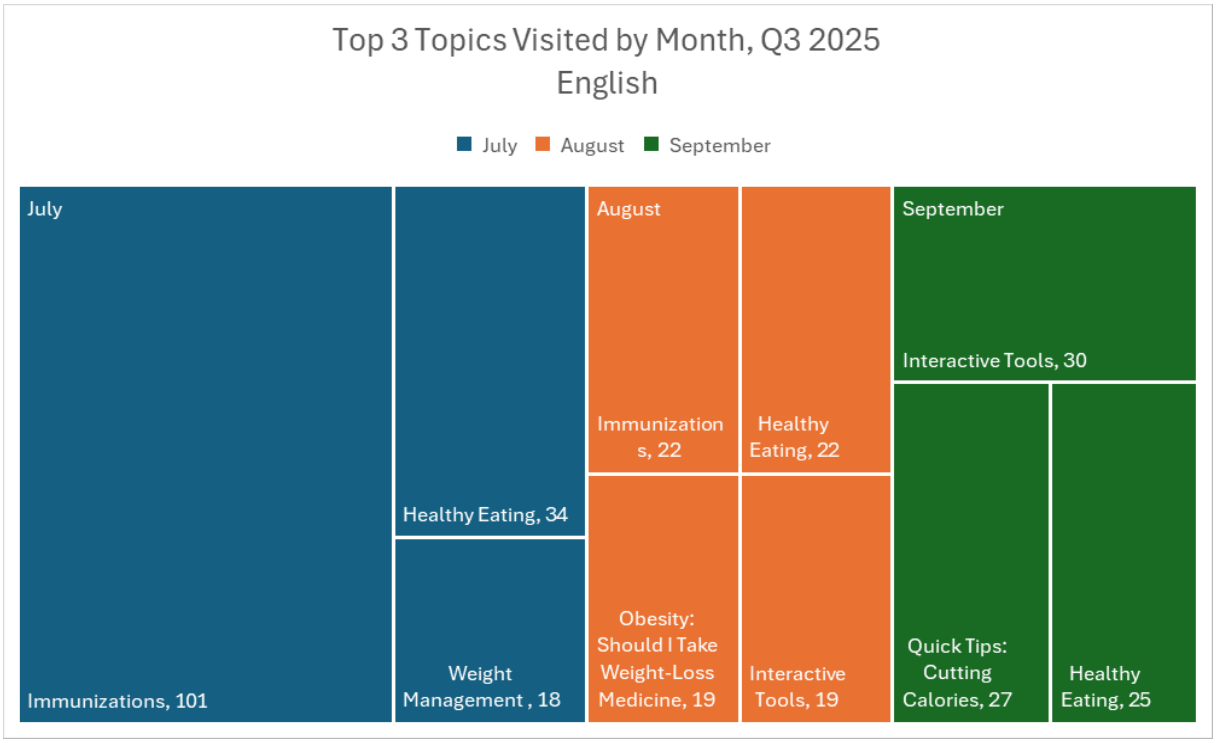
- The following posts have the highest engagement rates for their corresponding month. Children's Immunizations: Via Facebook, with a 5.6% engagement rate, the post is headlined as "Is your child's immunization card lost? California's Digital Vaccine Record portal…"
- Well-Child Visits: Via Facebook with a 5.4% engagement rate, the post is headlined as "Going to the doctor by yourself can be a little scary, but there is nothing to worry…"
- Pain Management: Via Facebook with a 7% engagement rate, the post is headlined as "Fibromyalgia can cause pain in the muscles and soft tissue…"

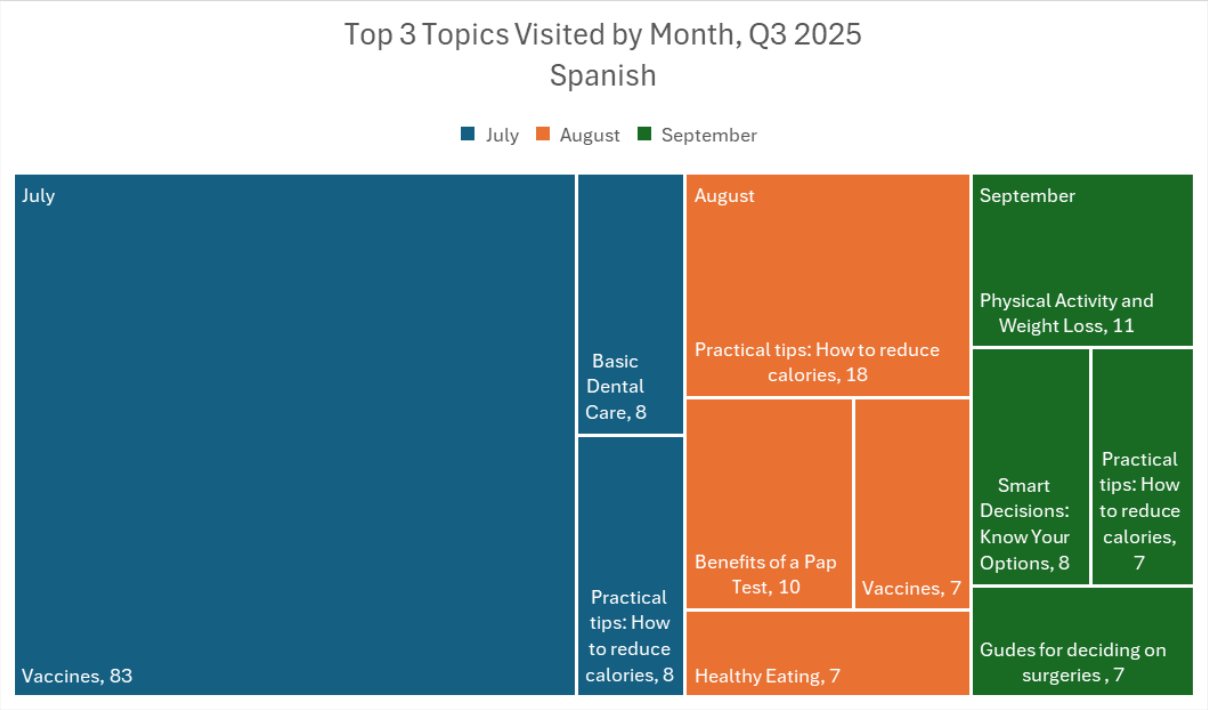
Month Published	Topic	Posts	Impressions	Average Engagement Rate	Average Engagements	Reactions/ Comments/ Shares

July	Children's Immunizations	16	5100	2.5%	8	86/2/13
August	Well-Child Visits	14	5438	1.9%	6	63/0/4
September	Pain Management	18	9137	1.5%	6	58/0/8

Prevention Messaging - Self-Management Care Collections

Kern Health Systems contracts with WebMD Ignite to provide self-management tools on the corporate website. The self-management tools provide health and wellness information at members' fingertips. The charts below show the highest number of topics visited per month. Each is based on language, English and Spanish. The month of August 2025, both languages had more than one topic rank at number 3, with the same number of visits.



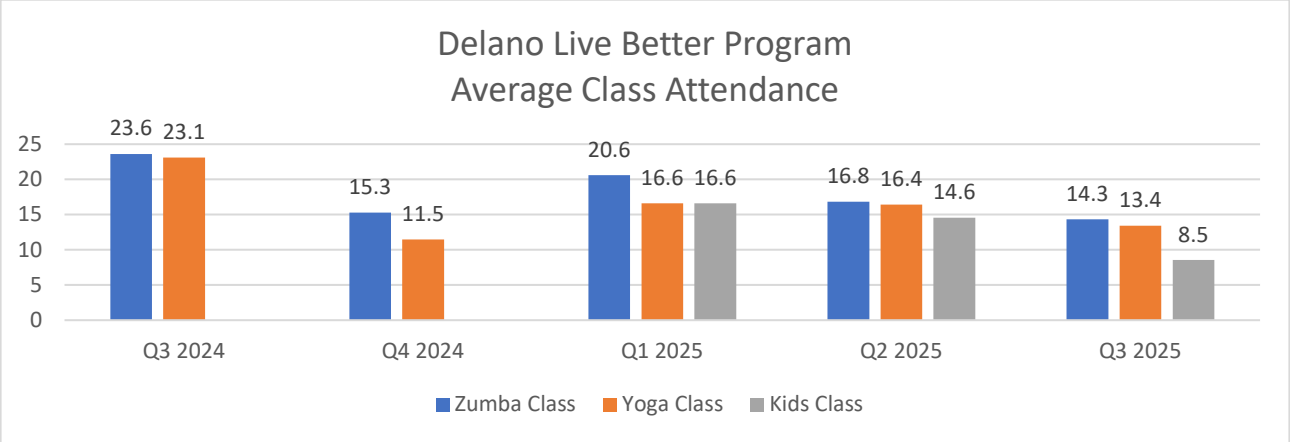

Top 3 Topics Visited by Month, Q3 2025
Spanish
July
August
September
July
Vaccines, 83
Basic Dental Care, 8
Practical tips: How to reduce calories, 8
August
Practical tips: How to reduce calories, 18
Benefits of a Pap Test, 10
Vaccines, 7
Healthy Eating, 7
September
Physical Activity and Weight Loss, 11
Smart Decisions: Know Your Options, 8
Practical tips: How to reduce calories, 7
Gudes for deciding on surgeries , 7

Community Health and Wellness

Live Better Program

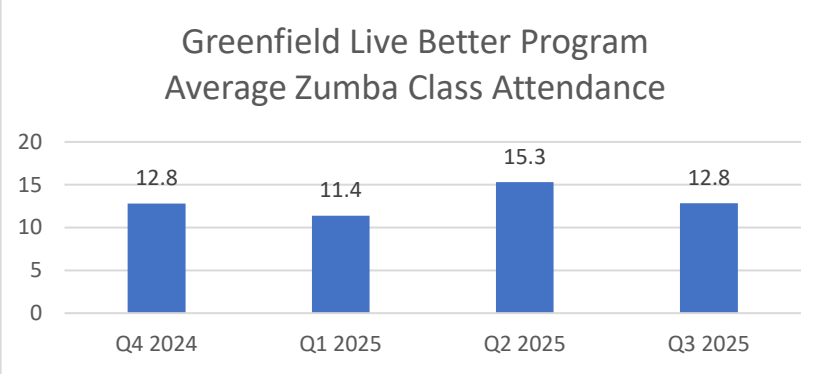
Delano

Attendance for Yoga and Zumba classes remained consistent, and youth classes have shown strong participation. Average attendance in Q3 2025 for the Zumba, yoga, and youth classes was 14.3, 13.4, and 8.5, respectively.



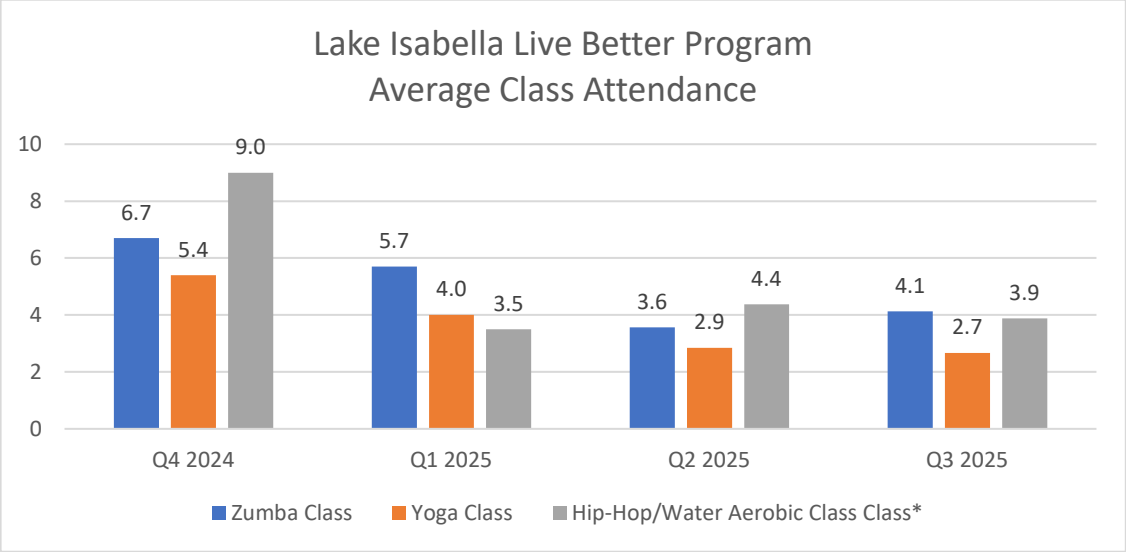
Greenfield

Zumba classes continue to be held by the Greenfield Walking Group where the class attendance averaged 12.8 per session held in Q3 2025.



Lake Isabella

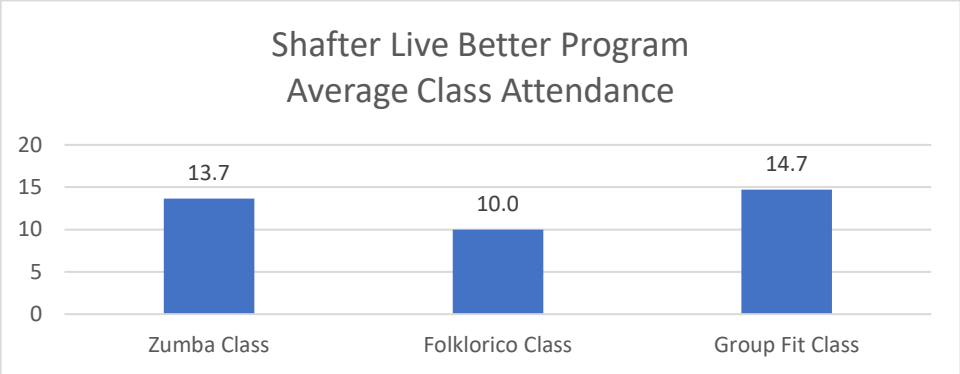
Average attendance in Q3 2025 for the Zumba, yoga, and hip-hop and water aerobics classes was 4.1, 2.7, and 3.9, respectively.



*The water aerobics class began in Q2 2025.

Shafter

The Shafter site was launched in July and continues to have strong engagement. Average attendance in Q3 2025 for the Zumba, folklorico, and group fit classes was 13.7, 10.0, and 14.7, respectively.



Other Wellness and Prevention Activities

Highlights of other initiatives and activities during Q3 2025 included:

1. Read Your Beats Program
    a. KHS' Read Your Beats Program offers free heart health education material and access to blood pressure monitors. Community members can visit one of the sites to check their blood pressure, learn about what the numbers mean and find resources on how to keep their heart healthy.
    b. The first launch was hosted at the Shafter Library and Learning Center in September. After 4

weeks, we have received 44 total readings from the community. The average blood pressure readings for Shafter have been 123/78 and a pulse average of 73.

c. KHS partnered with the Kern County Library on the second site which will be at Beale Library in Bakersfield and launched in Q4.

2. Anvros Gym Membership Pilot
    a. The department partnered with Anvros Gym in McFarland to offer a 3 month gym membership to KHS members. A total of 69 members have enrolled to date.
3. Community Events
    a. The W&P Department hosted an Activity + Eating Class with a cooking demo in partnership with the Cal-Learn program. This program focuses on supporting pregnant and parenting teens at the Department of Human Services.
    b. In late July, the department attended the Lideres Campesinas Crew of the Week celebration in Delano. Lideres Campesinas is a community-based organization that focuses on uplifting the voices of farmworkers all over California. Throughout the event, farmworkers celebrated with a free lunch and a mobile resource fair. The department provided resources on the KHS Live Better sites and health education classes to about 40 crew members.
    c. The department also partnered with The Motherhood Project to host a series of postpartum support group sessions. Educational sessions on infant safety, mental health and postpartum recovery were provided by KHS and a total of 12 members participated.
4. Asthma Preventive Services (APS)
    a. In Q3 2025, KHS had 3 contracted supervising APS providers and a total of 247 members received APS.
5. Community Health Worker (CHW) Services
    a. In Q3 2025, KHS had 14 contracted or subcontracted CHW Services providers and a total of 919 members received CHW Services.

Kern Health Systems
Cultural & Linguistic Services Activities Report
3rd Quarter 2025

Executive Summary

Report Date: November 13th, 2025
Reporting Period: July 2025 – September 2025

OVERVIEW

Kern Health Systems' Cultural and Linguistic (C&L) Services Program helps ensure that comprehensive, culturally, and linguistically competent services are provided to plan members with the intent of improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care. The Executive Summary below highlights the larger efforts currently being implemented by the C&L Team. Following this summary reflects the statistical measurements for the C&L Services Program detailing the ongoing activity for Q3 of 2025.

Interpreter Requests

- Language Breakdown:
  - Top Over the Phone Interpreting (OPI) languages
  - Top Onsite languages
  - Top Virtual Remote Interpreting (VRI) languages

Service Monitoring

Member and Staff Survey Monitoring	Did it meet KHS's standard this quarter (Y/N)
OPI/VRI Member Satisfaction Survey	Y
Onsite Member Satisfaction Survey	Y
Translation Member Satisfaction Survey	Y
KHS Staff OPI Satisfaction Survey	Y
TTY (711 Relay)	Y
Post Call Survey	Y

Vendor Monitoring & Evaluation	Did it meet KHS's standard this quarter (Y/N)
CommGap Vendor Linguist Performance	Y
LLS Vendor Linguistic Performance	Y
Harte Hanks	Y
VSP	Y
Carnet	Y

C&L Trainings

- Interpreter Access Survey Provider Training
- KHS Bilingual Staff Training
- C&L Grievance Provider Training

Respectfully submitted,
Isabel Silva, MPH, CHES
Senior Director of Wellness and Prevention

Kern Health Systems
Cultural & Linguistic Services Activities Report
3rd Quarter 2025

Cultural and Linguistic Services

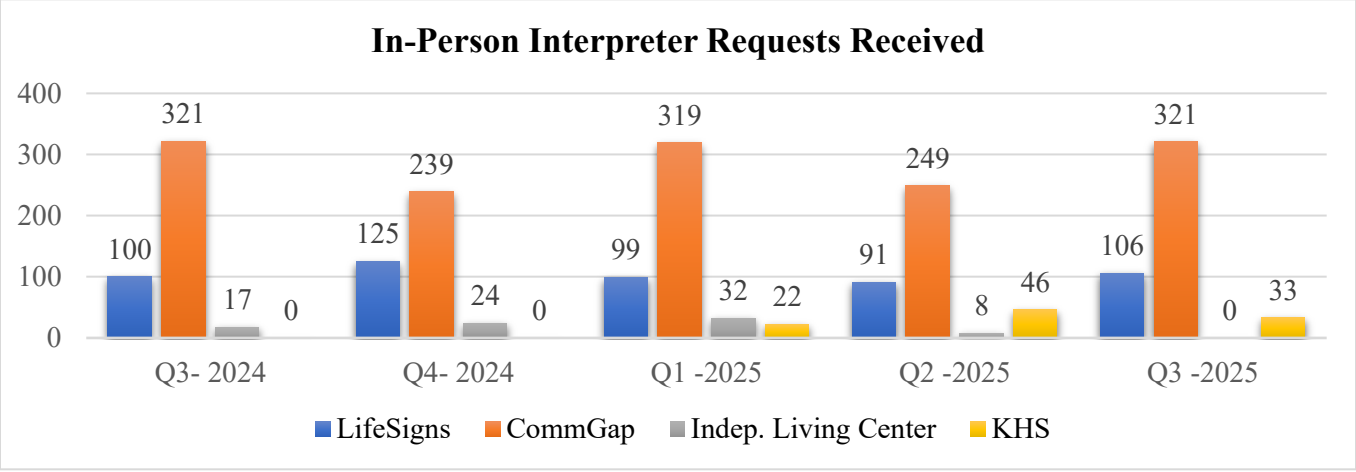
Interpreter Requests

During this quarter, the Cultural and Linguistic Services department received a total of 2538 interpretation service requests, categorized as follows:

- 321 Face-to-Face Interpreting requests
- 1923 Telephonic Interpreting requests
- 188 Video Remote Interpreting (VRI) requests
- 106 American Sign Language (ASL) Interpreting requests

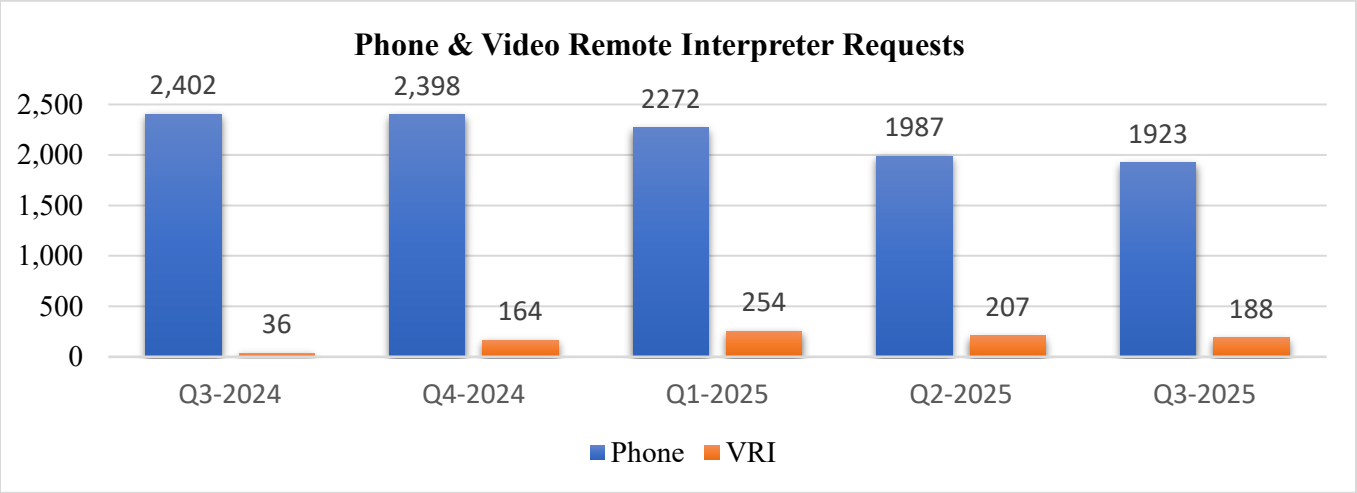
The top three languages requested are shown as follows.

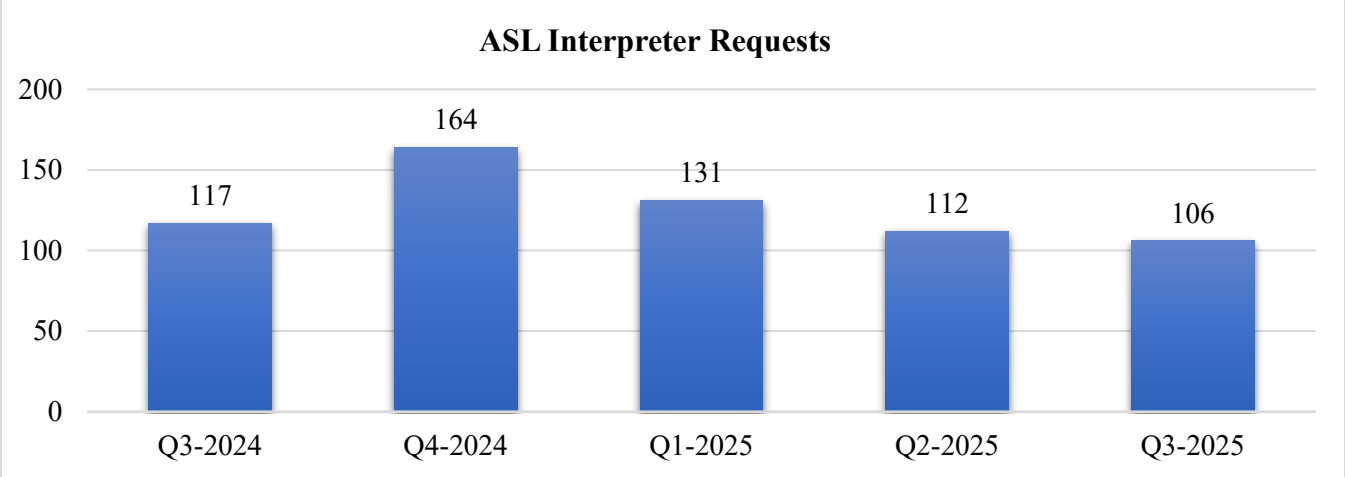
Interpreting Languages Requested	
Phone (OPI) & Video Remote (VRI)	**In-person (Onsite)**
Spanish	Spanish
Punjabi	ASL
Arabic	Farsi



Kern Health Systems
Cultural & Linguistic Services Activities Report
3rd Quarter 2025

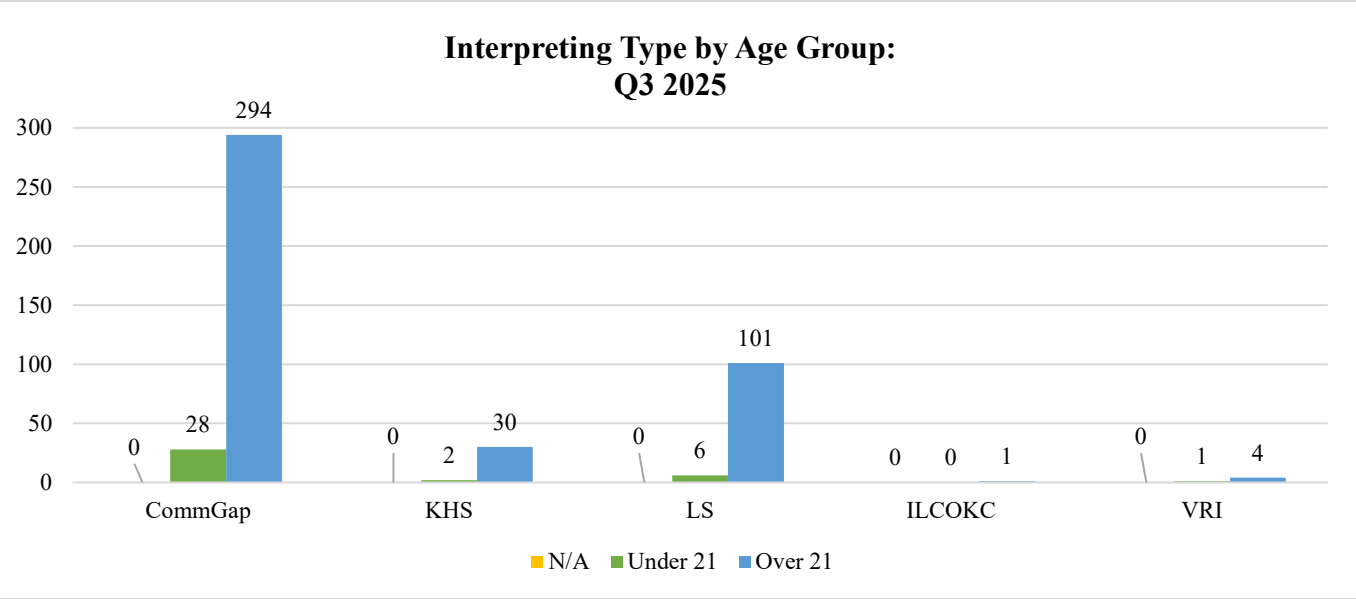
Languages Offered by Agency			
LifeSigns (LS)	**CommGap**	**Independent Living Center of Kern County (ILCOKC)**	**Kern Health Systems (in house)**
American Sign Language	Over 140 languages on-demand	American Sign Language	Spanish





A total of 467 in person, Video Remote Interpreting (VRI), and American Sign Language (ASL) interpreting service sessions were provided during Q3 2025. Of these sessions:

- 430 were provided to members 21 and older
- 31 were provided to members under the age of 21
- 0 were classified as "Not Applicable" due to the nature of the service



Written Translations

The Cultural and Linguistics department is responsible for managing the translation of written materials to ensure accessibility for members with Limited English Proficiency (LEP). Translation requests are completed either in-house by qualified staff translators or through a contracted, certified translation vendor.

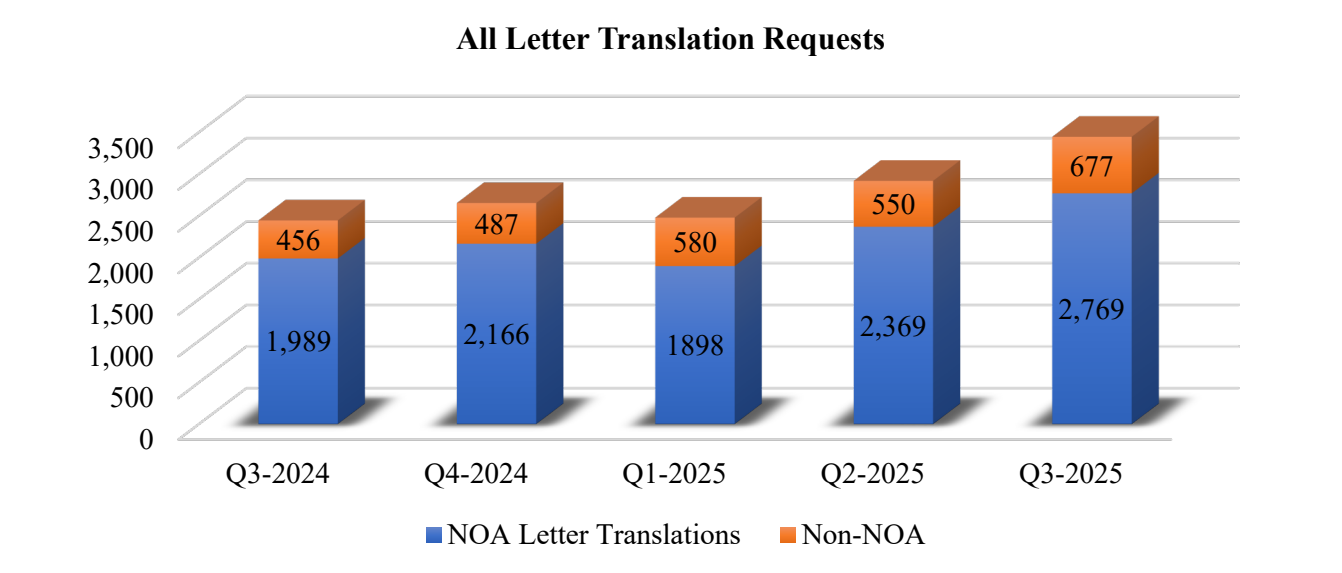
Written translation requests are categorized into five major types:

- Notice of Action (NOA) Letters
- Grievance Letters (GTLs)
- Provider Termination Letters (PTLs)
- Language Line Services (LLS)
- Non- NOA Letters – include all other translation types not classified above, such as fliers, consent letters, educational materials, slide decks, surveys, and more.

In addition to written translations, the department also processes Alternative Format Requests to support members with visual or other disabilities. These formats include:

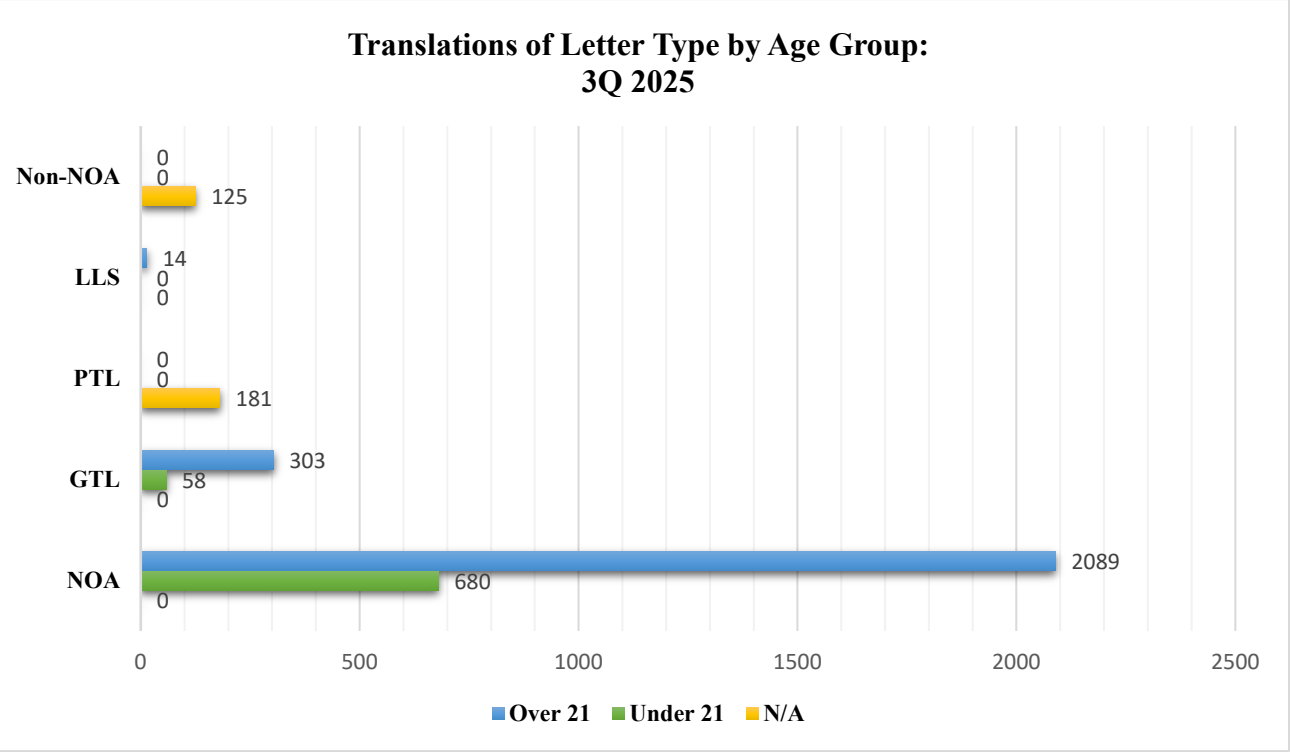
- Braille
- Large Print
- Audio

During this reporting period, the department received and completed 3446 written translation requests, along with all associated alternative format requests.



Translations were further classified by member age group:

- 2406 translations were provided for members 21 and older
- 738 for members under the age of 21
- 306 were classified as “Not Applicable” due to the nature of the content.



Cultural and Linguistic Services Audits

Vendor Over-the-Phone (OPI) Interpreter Call Monitoring

During this quarter, Language Line Solutions conducted an audit on 30 randomly selected Over-the-Phone Interpreter (OPI) service calls. These calls were randomly selected from the vendors monthly invoices. Calls audited were in Korean, Mandarin, Punjabi, Spanish, Vietnamese, Arabic, Thai, Tagalog, and Dari languages.

Calls were evaluated on the following items:

- Interpreter's Customer Service
- Interpretation Accuracy and Skills
- Adherence to the Code of Ethics and Standards of Practice

Audit findings revealed 100% of calls reviewed "Met Expectations" for all 3 of the above items.

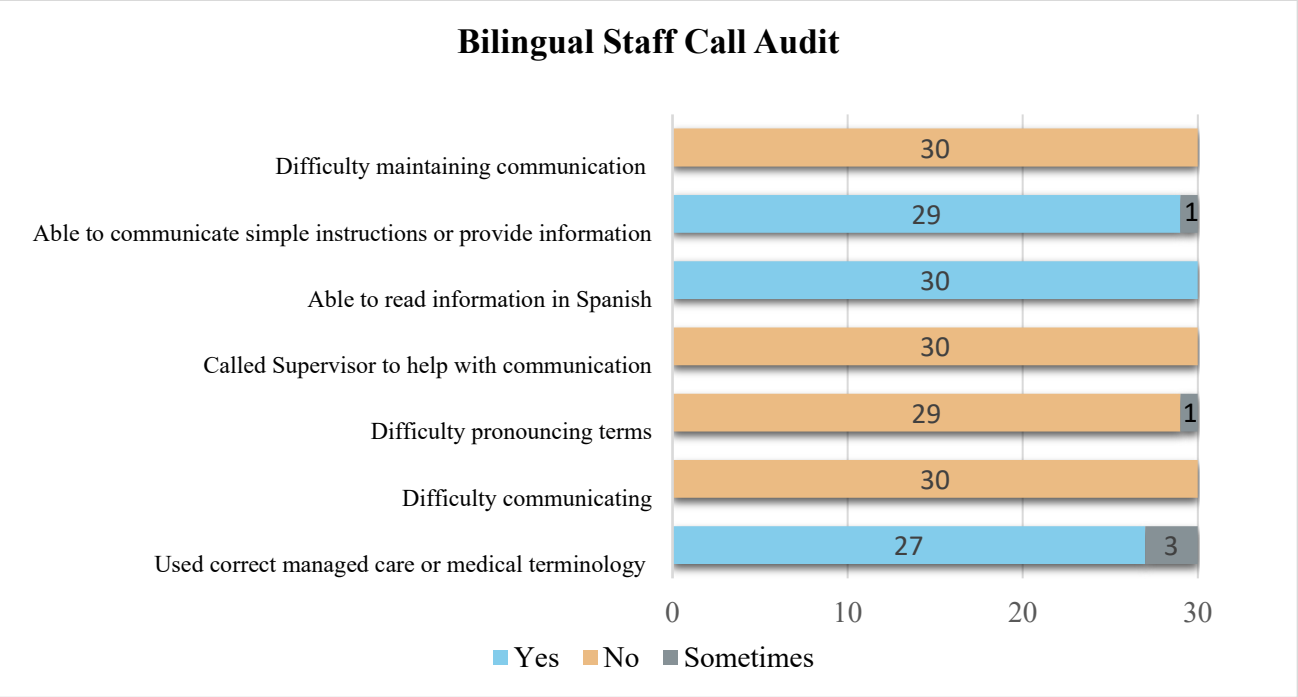
Call Number	Interpreter ID	Language	Medical Interpreter Skills Assessment Date	Medical Interpreter Skills Assessment Result	QA Observation Date	QA Observation Score
CR-0560189876	406999	SPANISH	1/23/2023	Pass	7/24/2025	3/3
CR-0560204587	391351	SPANISH	5/25/2022	Pass	7/3/2025	3/3
CR-0560194737	468350	SPANISH	2/10/2025	Pass	7/23/2025	3/3
CR-0560205626	461981	PUNJABI	12/4/2024	Pass	9/19/2025	3/3
CR-0560204566	442637	MIXTECO	9/20/2024	Pass	8/27/2025	3/3
CR-0560202300	474541	PUNJABI	5/27/2025	Pass	8/12/2025	3/3
CR-0560207513	453697	PUNJABI	9/23/2024	Pass	7/10/2025	3/3
CR-0560211583	401727	ARABIC	12/9/2022	Pass	7/11/2025	3/3
CR-0560209597	466921	SPANISH	1/31/2025	Pass	9/12/2025	3/3
CR-0560214062	413329	SPANISH	10/13/2023	Pass	8/15/2025	3/3
CR-0565594180	401035	FARSI	11/7/2022	Pass	9/17/2025	3/3
CR-0565638531	420159	ARABIC	8/5/2023	Pass	7/7/2025	3/3
CR-0566168408	201355	LAOTIAN	1/6/2014	Pass	9/3/2025	3/3
CR-0566802741	401263	VIETNAMESE	12/7/2022	Pass	8/5/2025	3/3
CR-0568280289	219639	KOREAN	2/1/2011	Pass	9/4/2025	3/3
CR-0568590588	10085	ILOCANO	3/2/2022	Pass	4/28/2022	Pass
CR-0571683827	476416	SPANISH	6/27/2025	Pass	7/8/2025	3/3
CR-0571702547	479677	SPANISH	8/8/2025	Pass	9/2/2025	3/3
CR-0571722249	478790	SPANISH	7/28/2025	Pass	9/12/2025	3/3
CR-0571719716	399654	SPANISH	11/11/2022	Pass	7/16/2025	3/3
CR-0573189776	434951	PUNJABI	4/25/2024	Pass	7/11/2025	3/3
CR-0573195939	371422	ROMANIAN	3/18/2021	Pass	7/22/2025	3/3
CR-0573207707	464233	SPANISH	12/23/2024	Pass	7/21/2025	3/3
CR-0573213614	478272	SPANISH	7/21/2025	Pass	9/26/2025	3/3
CR-0573227404	467545	HINDI	2/3/2025	Pass	8/6/2025	3/3
CR-0573262683	480629	SPANISH	8/25/2025	Pass	9/11/2025	3/3
CR-0573268129	447779	SPANISH	3/18/2025	Pass	8/6/2025	3/3
CR-0573271461	444704	SPANISH	5/31/2024	Pass	9/30/2025	3/3
CR-0573292180	376320	SPANISH	11/2/2021	Pass	8/26/2025	3/3
CR-0573312277	478862	SPANISH	7/29/2025	Pass	9/19/2025	3/2

Bilingual Staff Call Audit

During this quarter, a total of 30 Spanish audio calls from KHS member facing departments were reviewed to assess the linguistic performance of the bilingual staff. The calls were audited using a standardized set of criteria designed to identify any potential communication barriers when interacting with members in a language other than English. The criteria are summarized in the chart below.

Findings:

Results showed that 98% of bilingual staff demonstrated effective communication in Spanish, with no significant issues identified in their ability to engage with members in their preferred language.

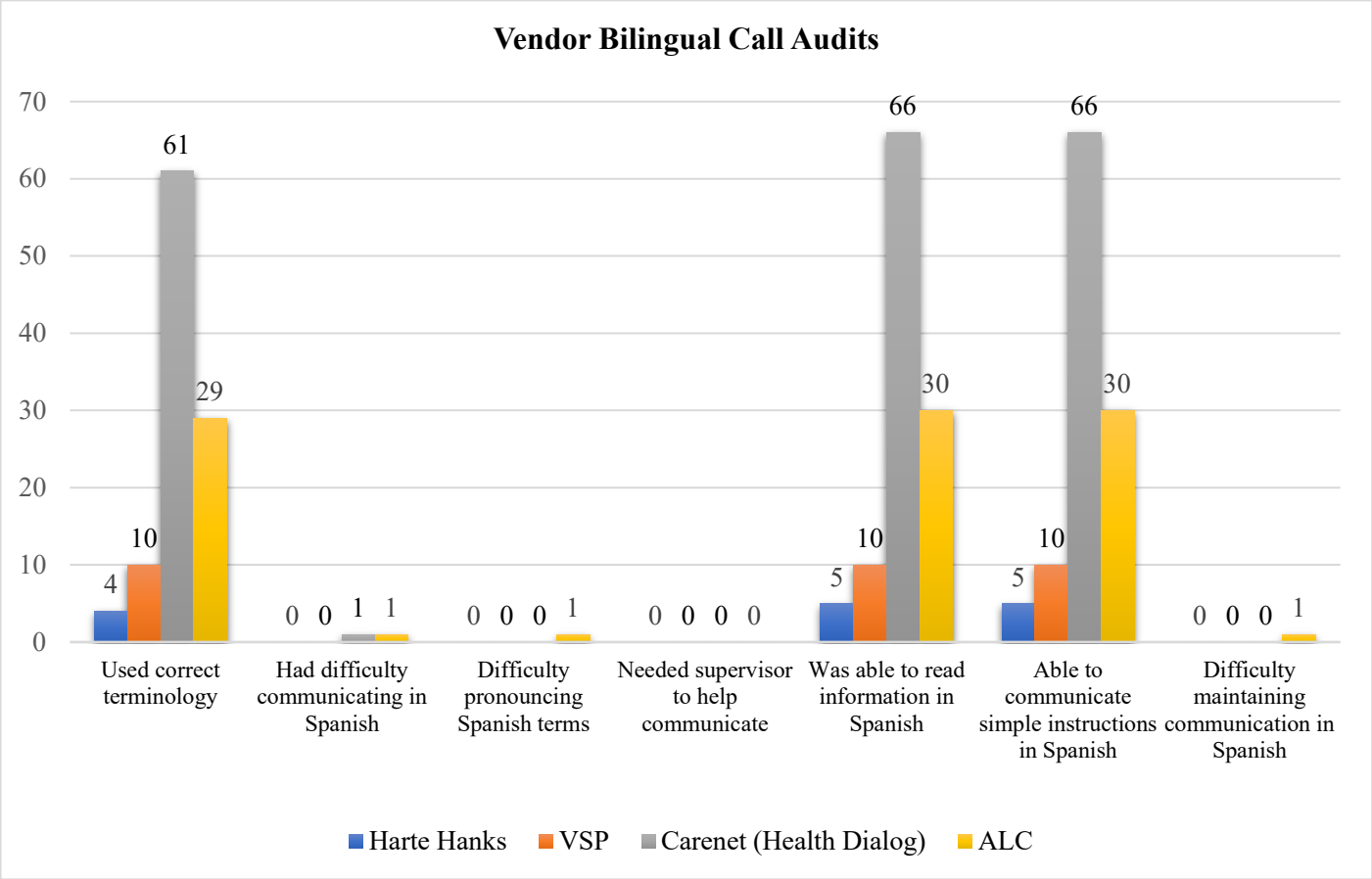


Post Call Survey

During this quarter, a total of 10,680 Spanish Post Call Survey responses were collected from members across all KHS member-facing departments. The survey is designed to assess members' experiences with bilingual staff, specifically evaluating the linguistic performance during calls conducted in Spanish. Findings revealed that 98% of surveyed members reported satisfaction with the bilingual staff's ability to communicate effectively in Spanish.

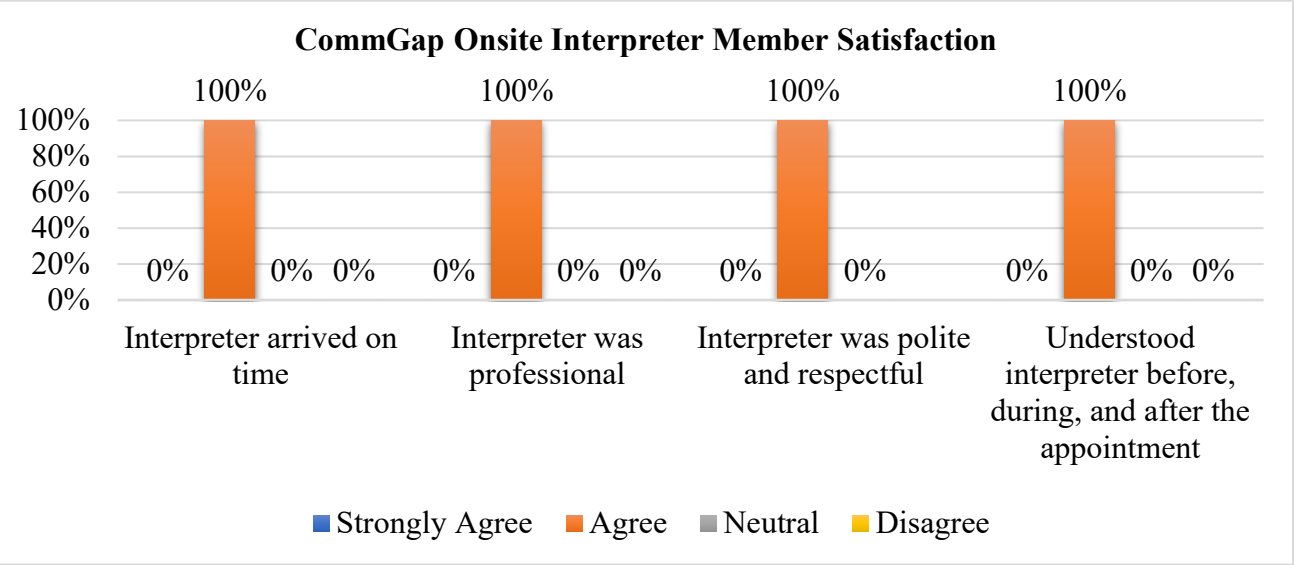
Vendor Bilingual Call Audits

During this quarter, a total of 126 Spanish audio calls were received from contracted vendors with KHS. These vendors include: VSP, Carenet, Harte Hanks, and ALC. These audio calls were reviewed to assess the linguistic performance of the vendor's bilingual staff. Findings revealed that 98% of bilingual staff did not have difficulty communicating with members in a non-English language.



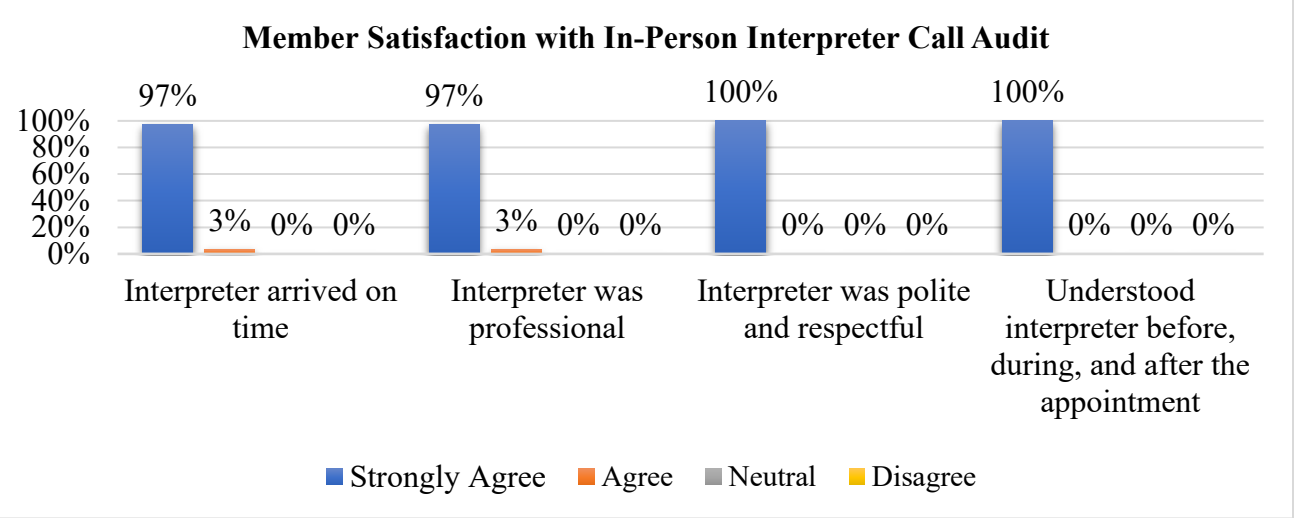
CommGap Onsite Interpreting Member Satisfaction Survey

During this quarter, an interpreter satisfaction survey was conducted by KHS's vendor, CommGap, targeting members who received onsite interpreter services during provider visits. A total of 21 members were surveyed following their in-person encounters. Of the 21 surveys sent out, 100% of respondents "Agreed" that they were satisfied with the interpreter services they received from the CommGap.



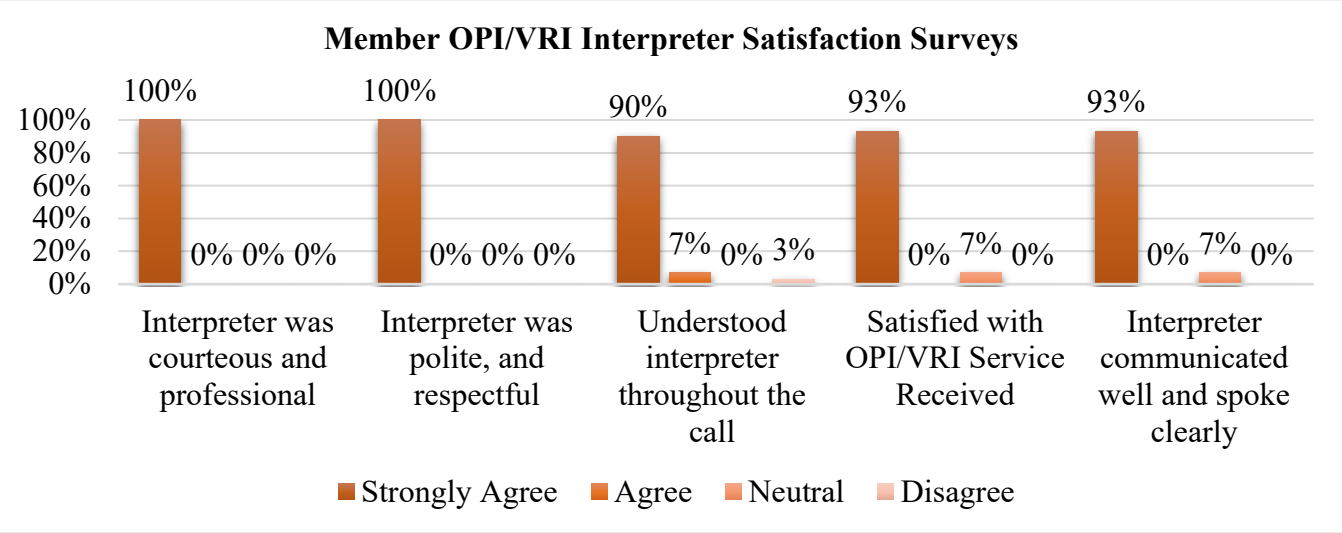
Member In-person Interpreting Satisfaction Call Surveys

During this quarter, a total of 34 satisfaction survey calls were conducted by the C&L specialists with members who received in-person interpreting services, either from KHS interpreters or through our vendor, CommGap. The survey results revealed a 91% satisfaction rate, indicating that members were highly satisfied with both the interpreters and the services they received.



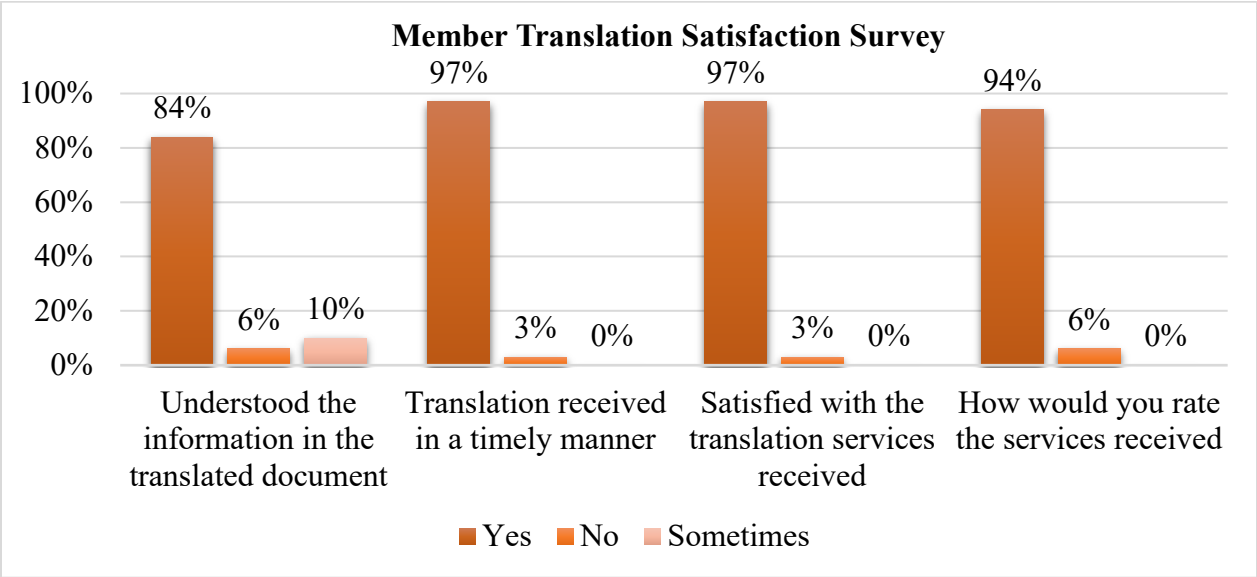
Member OPI & VRI Interpreting Satisfaction Call Survey

During this quarter, a total of 30 satisfaction survey responses were collected from members who received Over-The-Phone (OPI) and Video Remote (VRI) interpreting services. Of the 30 survey responses, 23 responses were for OPI services, and 7 responses were for VRI services. The survey concluded with 99% of members reporting they "Strongly Agreed" with being satisfied with the OPI/VRI interpreter services they received.



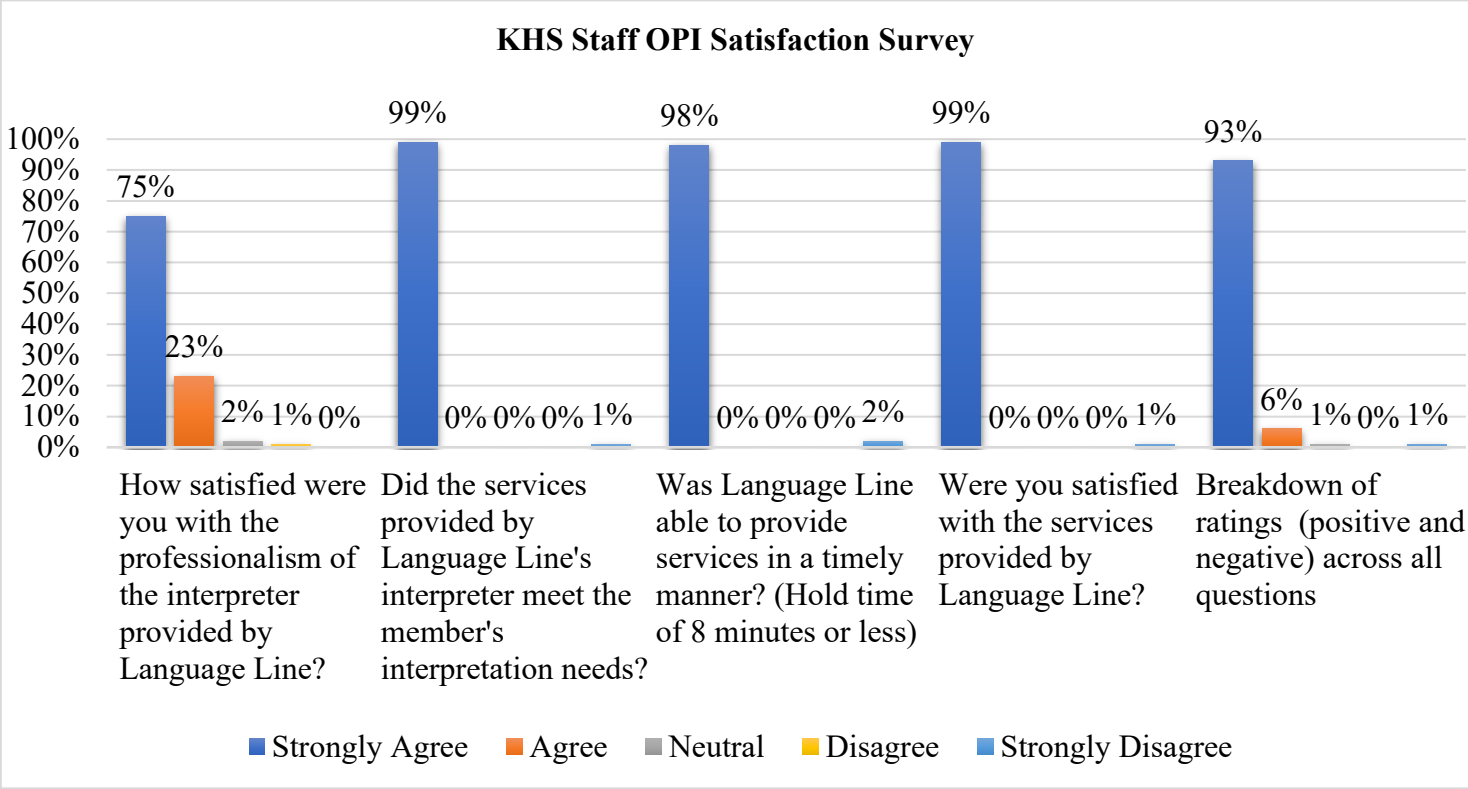
Translation Member Satisfaction Survey

During this quarter, a total of 31 translation satisfaction interviews were conducted for members who received a translation completed by C&L translators and by our vendor Language Line Solutions. The purpose of this survey is to determine the members' satisfaction regarding our translation services. Of the 31 calls completed, 95% of members were satisfied with the services received.



KHS Staff Satisfaction Over-the-Phone (OPI) Survey

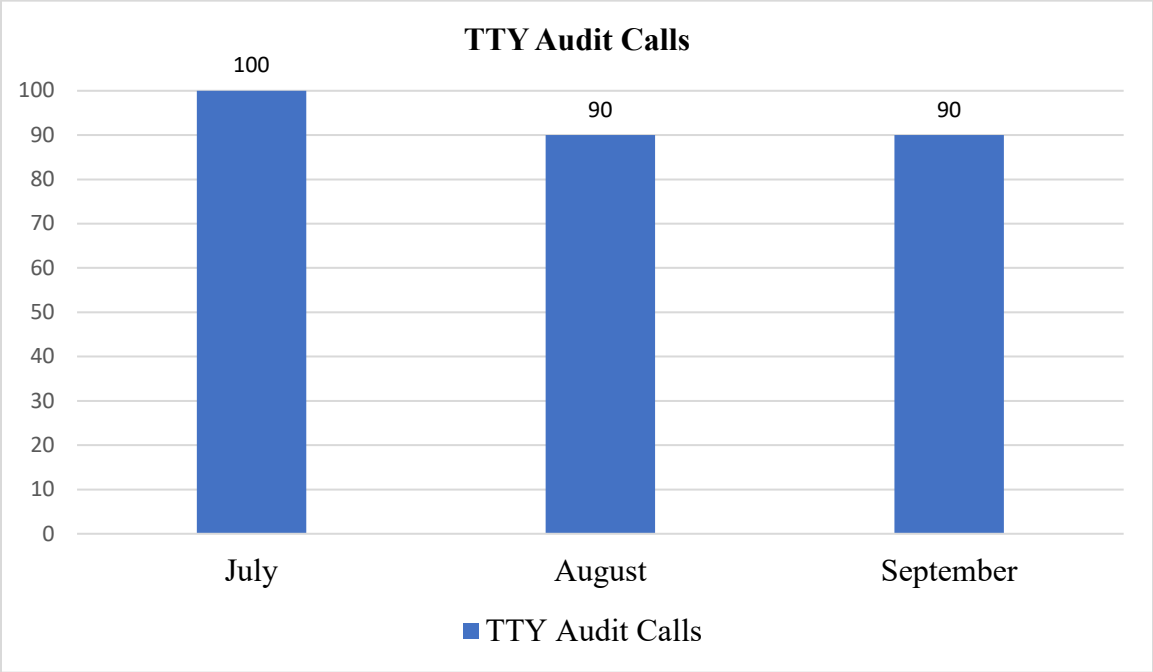
During this quarter, a total of 122 survey responses were received from KHS member-facing department staff regarding their satisfaction with our vendor Language Line Services concerning over-the-phone interpretation. Findings revealed that 99% of KHS staff are satisfied with the linguistic performance of our vendors' interpreters.



TTY (711 Relay)

KHS Cultural and Linguistics' staff conducted an audit on the line Telecommunications Relay Services (TTY) by dialing 711 or 800-735-2922. This service permits individuals with hearing or speech disability to use the telephone system via a text (TTY) or other devices to call people with or without such disabilities. Audits measured whether they were easily connected to a communications representative quickly and efficiently.

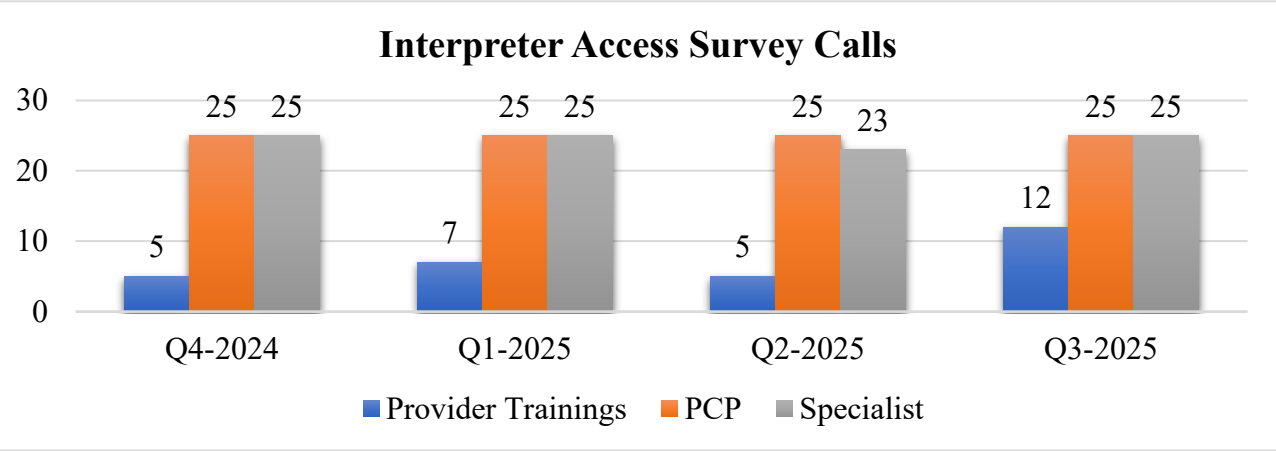
In Quarter 3 of 2025, the TTY system audit calls showed 2 unsuccessful calls out of 31 total call attempts. This represents a 93% success rate. Similarly, testing was conducted for the numbers of 31-711, 3-711.


TTY Audit Calls
100
90
90
100
90
80
70
60
50
40
30
20
10
0
July
August
September
TTY Audit Calls

C&L Trainings

Interpreter Access Survey Calls

Each quarter, the Provider Network Management (PNM) department conducts an interpreter access survey among KHS providers. During Q3, 25 PCPs and 25 Specialists participated in this survey. Of these providers, 12 needed refresher training on KHS C&L services.



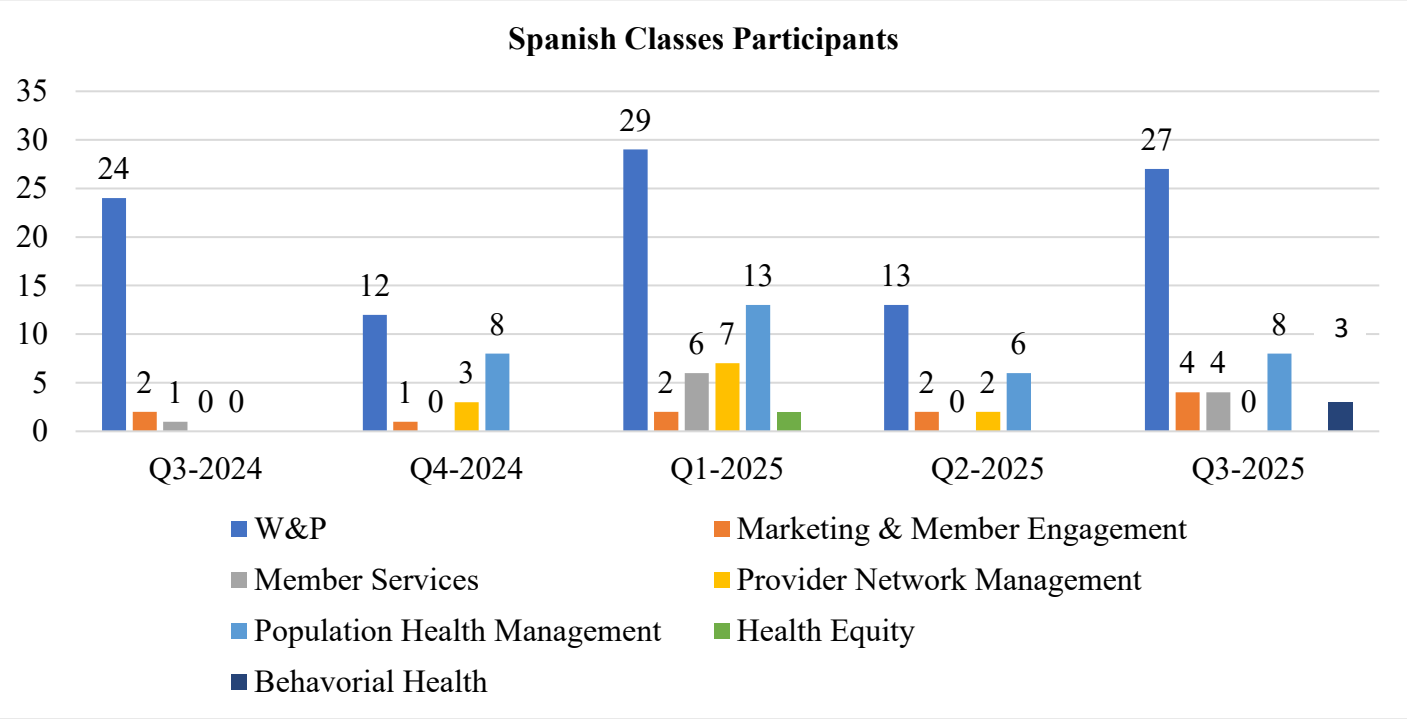
KHS Bilingual Staff Training

The C&L Department supports the professional development of all KHS internal staff, with the focus on bilingual employees, by offering a series of Spanish language training sessions to enhance their skills. During Q3 2025, four classes were held in person and one online with a total of 46 participants, representing several KHS departments, including PHM, C&L, W&P, Member Engagement, Behavioral Health, and Marketing.

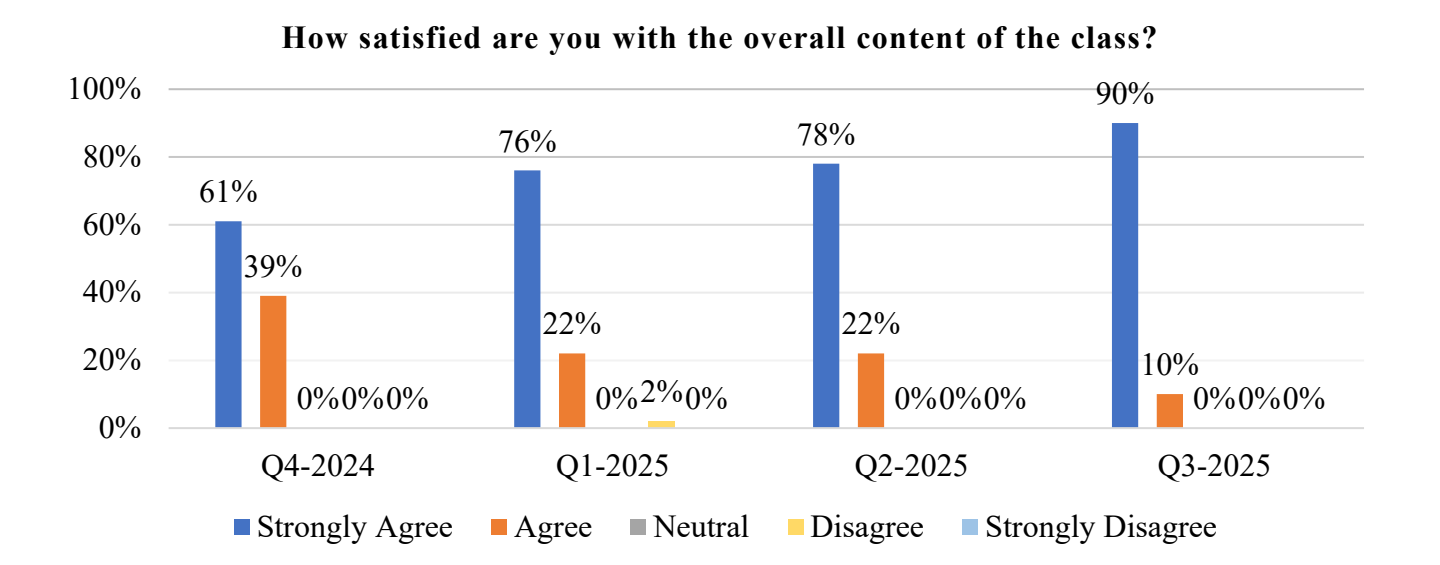
The classes provide participants with the opportunity to practice the four skills of a language: reading, writing, speaking, and listening. This quarter's classes focused on Phone Etiquette/Customer Service Skills Basics and understanding False Friends. Participants engaged in listening, reading, and writing exercises, as well as speaking activities that involved practicing conversations using the correct Spanish verb conjugations.

Compared to the class offered in Q2, attendance increased by 23 participants due to the addition of two classes during this quarter. All attendees completed a pre-and-a-post survey, which provided valuable insights into their expectations, satisfaction levels, and areas of improvement.

Spanish Class Participants:



Spanish Class Satisfaction Survey:



KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: Pawan Gill, Health Equity Manager

Date: December 16, 2025

Re: Health Equity Office (HEO) Updates

Background:

During the last EQIHEC meeting, we presented four programs that have been added to the workplan including the 2025 EPT (Equity Practice Transformation) Deliverable (Cycle 2 & 3), Intimate Partner Violence – Community of Practice, Cervical Cancer Screening – Asian/Pacific Islander and Chlamydia Screening Measure Intervention – Hispanic; rural focus. No additional items have been added thus far, and our focus is on identifying other departments working on similar efforts to maximize effectiveness and ensure alignment. The HEO/HETSC presentation update provides information on key programs and activities that the HEO is currently focusing on.

Discussion Items:

- Q3 HEO/HETSC Updates
- Q3 RAC Report
- Q3 RAC Presentation
- Q3 EPT/HEAL Update

Fiscal Impact:

None.

Requested Action:

2025 Q3 HEO/HETSC Updates – Receive & File
2025 Q3 EPT & HEAL - Receive & File
2025 Q3 RAC Presentation - Receive & File
2025 Q3 RAC Report - Receive & File

KERN HEALTH SYSTEMS

Health Equity Office Updates

EQIHEC

November 2025

EPT Program Highlights

Kern Family Health Care®

Key Deliverables:

- **Data Exchange Enhancements:** Worked with practices to worked on improving how practices capture and share key clinical data related to Blood pressure, BMI and visit scheduling data

- **Pre Visit Screening & Improved workflows:** Improved patient interactions with pre-visit screening workflow including preventive care prompts, vitals capture, behavioral health screenings

IHI-DHCS Child Health Equity Collaborative 2.0

- In partnership with QP, we will continue with Phase 2 of the IHI-DHCS Child Health Equity Collaborative. The overall goal is to increase W30 and CIS rates by 5% from September 2025 rates.
- Clinical Partner, Omni Family Health
- PDSA #1: Expand Appt Access; PDSA #2 Optimizing Work Flows, PDSA #3 Build Systems Understanding, PDSA #4 Identify & Link with Existing Transportation Systems to Improve Access
- Intervention 2, Milestone 1:PDSA #3, #4 – Focus on Transportation/Access:
    - Transportation magnet for members
    - Provider staff training on transportation benefits
    - Long term, partner with chambers across the five regions of Kern on hosting presentation on how to become a transportation provider and contract with KHS.

NCQA Innovation Summit & ACAP Presentation

Kern Family Health Care®

In today's complex health care landscape, delivering high-quality, equitable care requires a deep understanding of member experiences, needs and barriers. This session explores how health plans and providers can strategically blend quantitative data (claims, HEDIS®, risk stratification, utilization) with qualitative insights (member stories, focus groups, call center feedback, community engagement) to design programs that are more responsive, equitable and effective.

Participants will gain a practical framework that uses storytelling to humanize metrics, and targeted interventions to improve clinical outcomes and member

satisfaction. Real-world examples from Kern Health Systems will illustrate the power of data integration.

Learn How To:

Combine quantitative and qualitative data to create a comprehensive view of member needs and care gaps.

Leverage member stories and insights to humanize metrics and shape more meaningful interventions.

Design programs that drive both clinical outcomes and member satisfaction.

Apply a data integration framework for health plans and providers to enhance engagement and reduce disparities.

97

Thank You

Kern Family Health Care®

Kern Family Health Care®

QUARTER 3

TRANSPORTATION

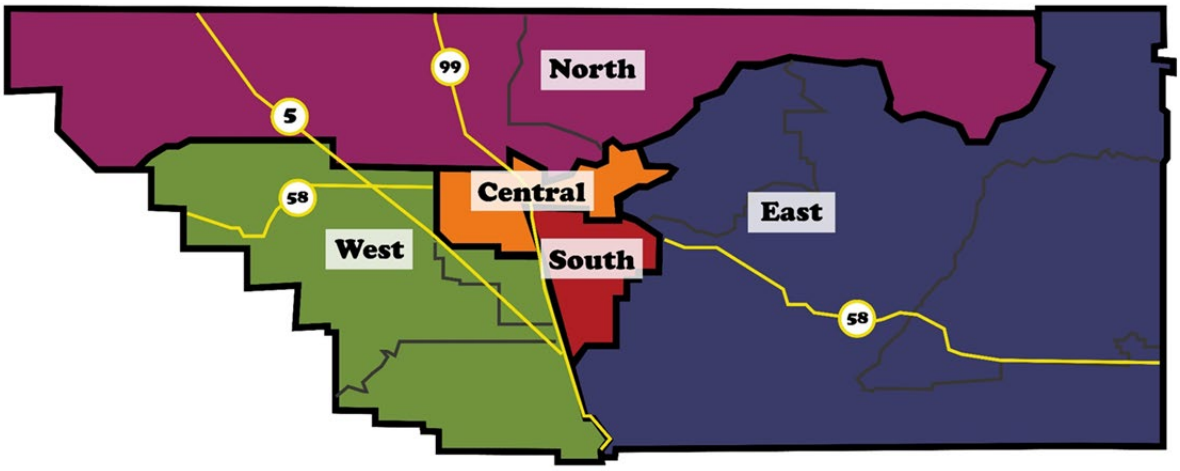
REGIONAL ACCESS COMMITTEES

Quarter 3 Meetings

The Regional Access Committees (RACs) are an opportunity to learn from and educate the communities of Kern County on topics impacting their health and lives. In the second quarter of the year, the topic was Transportation. Each quarter a different topic is chosen and is presented and discussed in the five regions of the county. Every quarter of a different city is chosen to represent the region.

In quarter two, the RACs were held in the following cities:

- Central – Bakersfield – September 9, 2025
- South – Vineland – September 11, 2025
- West – Taft – September 17, 2025
- North – Delano – September 18, 2025
- East – Lake Isabella – September 25, 2025



Each quarter a collaborative team from Kern Health Systems facilitates the RACs. The team includes members from the following departments:


Community Engagement


Cultural and Linguistics


Health Equity


Member Engagement


Member Services

Each department provides an invaluable piece of the RAC. Community and Member Engagement teams provide the transportation presentation, registration, childcare, and note taking during the meeting. The Cultural and Linguistic team provide Spanish interpretation/translation and coordinate interpreter/translation services for languages other than Spanish. The Member Services team provides the community with an opportunity to address them membership needs while at the RAC with a live person. Health Equity coordinates each of the RACs and facilitates the meetings.

BAKERSFIELD

Date: September 9, 2025
Location: Dr. Martin Luther King, Jr. Center
Attendees: 14
- 7 KFHC Members

Predominate Culture: Black
Families: 7
Staff: 7

The meeting began with a presentation on what types of transportation services are available to the community through Kern Family Health Care and how to access and utilize them. A discussion was then facilitated by Anastasia Lester, Sr. Health Equity Analyst.

Anastasia Lester began the discussion by asking the community if they knew about transportation services prior to the presentation. Only three attendees knew of this service. The other attendees thought they oversaw taking themselves to appointments and stated they were surprised at all of the options that were included.

Transportation Options

Ms. Lester then asked the community what transportation was used to get to appointments. The community stated transportation was influenced by age. The younger attendees felt comfortable using the bus or walking. The older attendees did not want to use the bus, due to fear and negative stigma. They preferred getting a ride from a trusted person or shuttle service, where more trust is given to this system.

> *"If we knew it [transportation] was a service, we would have got the word out and tried it."*

Transportation Challenges

Ms. Lester asked based on the presentation what issues do they foresee being challenges. The top three issues were wheelchair access and having gas and maintenance for vehicle transportation. Buses and shuttles are not always equipped with the correct size ramps for varying wheelchairs. When using a personal vehicle to provide transportation to a family member or self, there is still a challenge of having enough gas to get the member to an appointment. The other challenge is to have a vehicle that is in good enough working condition to reach the appointment location.

Timeliness

Ms. Lester asked the community about the issue with timeliness and the buses. The community stated the routes were no longer close to the community and to get to appointments could take 2 hours or more. If the buses were late, then they would be late for their appointments and be asked to reschedule once they arrived. The participants wanted it noted that the appointment had taken weeks to obtain initially and could not afford to wait another 2-3 weeks for the next availability.

> *"If there was a way to not have to travel for hours to get to an appointment, then I would be more likely to use the bus option [for transportation services]."*

Key Takeaways

- Educate the community of transportation options
- Address access barriers for services:
    - Size of wheelchair
    - Gas for cars
    - Maintenance for cars
- Work with bus routes for timeliness concerns
- Possible incentives for attendance

VINELAND

Date: September 11, 2025
Location: Vineland Family Resource Center
Attendees: 12
- 1 KFHC Members

Predominate Culture: Hispanic
Families: 6
Staff: 8

The meeting began with a presentation on what types of transportation services are available to the community through Kern Family Health Care and how to access and utilize them. A discussion was then facilitated by Anastasia Lester, Sr. Health Equity Analyst.

Ms. Lester began the conversation by asking the participants if they knew about transportation services prior to the presentation. Most of the participants did not know about the service. A participant explained how important transportation services are to this region. Most school districts provide transportation to students, even outside of buses. To get to appointments, if it weren't family or friends, the option was United Way's Ride United Program with specifics requirements to participate.

Mobile Units

A participant mentioned that there were mobile units who serviced the region, but that there were a lot of no-shows because the community doesn't have the transportation to the mobile units. KHS's Member Service team provided information that the members could arrange transportation to these appointments.

> *"Most families in rural areas do not have vehicles. Families need transportation to the mobile units."*

Outreach

Ms. Lester asked the participants how to educate the community on the services Kern Family Health Care has to offer. The participants stated it was important to create both flyer and social media posts, which was referred to as "doubling down." The region stated that each community has their own local social media pages and district pages to spread the word.

> *"In multi-generational houses, 'doubling down' allows everyone in the household to get the same information."*

Accessing Transportation Services

A participant asked how to access the transportation services. KHS staff reviewed the process. A discussion ensured around other ways to get transportation. One suggestion was to place it on the website so that members could schedule it. Another was to have an option for members to place a transportation request virtually and then receive a call back. It was mentioned that even with some digital divide issues in the region, these options would still assist people in making the arrangements. Ms. Lester stated she would reflect on the suggestions in her report, including the issues of the digital divide.

Key Takeaways

- Explore transportation request options
- Addressing the digital divide
- Work with local social media platforms for outreach
- Possible collaboration with United Way

TAFT

Date: September 17, 2025
Location: Westside Recreation and Parks
Attendees: 17
- 10 KFHC Members

Predominate Culture: Hispanic
Families: 12
Staff: 7

The meeting began with a presentation on what types of transportation services are available to the community through Kern Family Health Care and how to access and utilize them. A discussion was then facilitated by Anastasia Lester, Sr. Health Equity Analyst.

Ms. Lester started the discussion by asking who knew about transportation services prior to the presentation. Almost all the participants had not heard of the services. The few that did think it was only for emergency services. The participants asked questions and scenarios where they might be able to access transportation services.

Pharmacy Services

The scenario that recorded the biggest impact was the discussion around pharmacy services in the region. In Taft, both pharmacies closed and to receive medication took almost two weeks by mail. The participants stated learning that they could receive their medication in a timely manner would be life changing.

"It took my dad two weeks to get his medication mailed to the house and he got very sick while waiting."

How To Get the Word Out

Me. Lester asked the participants how to get the word out about transportation services to their region. There were differing opinions. Some participants felt that social media was how they learned, but that it needed to be either the local page or through trusted partners like the schools. The other opinion was to make sure that the KFHC members had the text option, so they could have it on their phone and be able to access it when they want.

There were two suggestions for outreach that had not been discussed in other regions. The first was to print the information on flyers and place them on the light posts around the community. The participants stated they were a walking community and at bus stops and other places, they read the material posted and would be drawn to read a flyer with a logo that they recognized.

"I'm going to tell my whole family. This will change our health because we haven't been able to make our appointments or get our medications."

The other suggested outreach was to work with the local providers. When the members leave the appointments or call to get an appointment, the provider could suggest calling KFHC if they needed a ride or provide the phone number to call. The participants stated this would not only help remind them to call for transportation but that they would be more likely to attend their appointments knowing they had a ride.

Take Aways

- Pharmacy access is critical
- Work with Providers for transportation prompt
- Educate the community of services through community-based social media, flyer posted throughout the community and text services

DELANO

Date: September 18, 2025
Location: Adventist Health Community Center
Attendees: 16
- 13 KFHC Members

Predominate Culture: Hispanic
Families: 13
Staff: 7

The meeting began with a presentation on what types of transportation services are available to the community through Kern Family Health Care and how to access and utilize them. A discussion was then facilitated by Anastasia Lester, Sr. Health Equity Analyst.

Ms. Lester began the conversation by asking the participants if they knew about transportation services prior to the presentation. Most of the participants did not know about the service.

During the discussion, it was mentioned and agreed that if they had transportation, they would be more likely to make their appointments. The participants explained that most of their current transportation was provided by family or friends, who could not always follow through.

Transportation Concerns

MS. Lester asked if the participants felt there were still challenges when it came to transportation, now that they were aware of the benefit. The participants discussed a couple of concerns. The first was using transportation services and them being late; would they be changed for the missed appointment and would there be any support to get to see the provider. The other concern was the timeliness of the transportation options, especially taking Greyhound out of town and coordinating the rideshare. KHS staff providing information on these concerns.

"Greyhound takes a longer time than driving. I wouldn't want to miss my appointment."

How to Get the Word Out

Ms. Lester asked the participants if they would be willing to share how their region would best receive information about this service or other services provided by Kern Family Health Care. There were four channels discussed. The first was through 92.5, radio La Compesenia, which was the main way the community gets their information, especially in the fields. The next channels were through local and school social media platforms. The final channel was through text message, which the participants were unaware was an option and asked how to sign up.

Trust

In the discussion of outreach options, it was brought to Ms. Lester's attention that none of these options mattered if there was no trust. In order to build trust in the agency, local champions need to vouch for the services, allow word of mouth to spread, and have representation, like the navigator's presence known and assessable to the community.

"Word of mouth has more of an impact within our community. Maybe if we had a key representative that speaks within the community [that would build trust]."

Key Takeaways

- Communication material for navigators
- Locate local champions
- Outreach through media
- Create communication channels with local social media platforms

LAKE ISABELLA

Date: September 25, 2025
Location: Wallace Middel School
Attendees: 19
- 5 KFHC Members

Predominate Culture: White
Families: 14
Staff: 8

The meeting began with a presentation on what types of transportation services are available to the community through Kern Family Health Care and how to access and utilize them. A discussion was then facilitated by Anastasia Lester, Sr. Health Equity Analyst.

Ms. Lester began the conversation by asking the participants if they knew about transportation services prior to the presentation. Approximately fifty percent of the participants knew but commented that they did not know all the services. Through more conversation, the community felt was important to understand all the transportation options for the community; Dial-A-Ride, Kern Valley Hospital, Family Resource Center, Clarvida, and Kern Family Health Care.

Mobile Units

Currently there are very few mobile clubs that provide services to the region. The participants stated the only constant unit was for mammogram as it is coordinated by Kern Valley Hospital. The Kern Valley Hospital stated they stopped providing a mobile unit because due to limited provider resources, more families could be serviced in the clinic than on the mobile unit. There was also a conversation about accessing a mobile unit, as transportation was still a barrier just to get to the mobile units.

"Mobile units only work in this region if appointments are made ahead of time and there is transportation to get to them. But unless it is for specialty care, they are not cost effective."

OBGYN Services

In discussing transportation, the participants emphasized the challenges in OB services. The region stated the Navy was paying for the OB in Ridgecrest but was not sure that will continue in the new year. This will cause greater strain on the pregnant population needing services and getting transportation to Bakersfield to see an OB. There was also some concern about how H.R.1 would impact the region.

Behavioral Health Services

The other major challenge discussed by the participants was getting behavioral health services, especially for children. In the region, Clarvida is the only service locally and it is promoted that they provide transportation, yet every participant stated this was not true. The participants also inquired about KFHC members receiving transportation to and from school for appointments.

"Our kids are not getting the [behavioral] services they need because there is not transportation to take them, parents don't want to miss work, and there are no school site services."

Take Aways

- Transportation to Mobile Units
- Transportation to and from school for appointments
- Transportation and access to OBGYN services
- Understanding transportation options in region
- Impact on H.R. 1 for the region

REGIONAL OVERVIEW:

- Unknown Benefit
- Impact of H.R. 1
- Timeliness of Transportation
- Work with communities to determine local transportation options
- Need for student transportation
- Need transportation to mobile units
- Promote services via local social media platforms
- Pharmacy services are needed
- OBGYN services are needed
- Determine other options to get transportation services, such as online
- Digital Divide
- Training for app navigation
- Need for trust in KHS services

RECOMMENDATIONS:

EDUCATION

- Transportation Options
- Impact of H.R. 1
- Local Transportation Options
- KHS App Training

SERVICES

- OBGYN
- Pharmacy
- General Testing

MARKETING

- Use alternative methods to promote services:
  - Radio
  - Local social media
  - Placement of flyers
- Locate Local Champions
- Addressing the Digital Divide

NEXT QUARTER:

California Advancing and Innovating Medi-Cal (CalAIM SERVICES)

West – Tejon/Lebec
El Tejon School
October 7, 2025

East – Tehachapi
Adventist Health Medical Center
October 14, 2025

South – Greenfield
Greenfield Family Resource Center
October 16, 2025

North – Shafter
Shafter Veteran's Hall
October 16, 2025

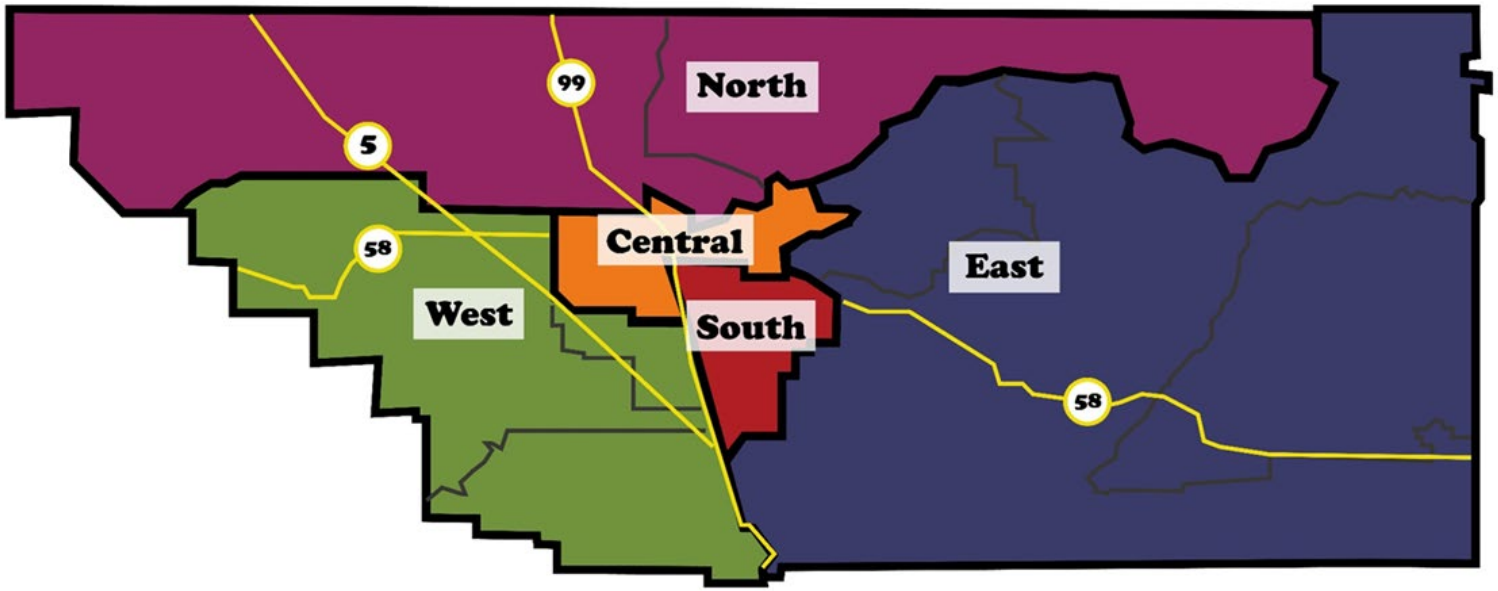
Central – Bakersfield
Boys and Girls Club – Armstrong Center
October 28, 2025

QUARTER 3 RACS - TRANSPORTATION

Presented by Health Equity

FIVE REGIONS

- Central - Dr. Martin Luther King, Jr.
- North - Delano
- East - Lake Isabella
- West - Taft
- South – Vineland



THE TEAM

COMMUNITY ENGAGEMENT

CULTURAL AND LINGUISTICS

HEALTH EQUITY

MEMBER ENGAGEMENT

MEMBER SERVICES

FRCS/COLLABORATIVES

COMMUNITY PARTNERS

BAKERSFIELD - CENTRAL REGION

- Attendees: 14
    - 7 KFHC Members
- Predominate Culture: Black
- Families: 7
- Staff: 7

- Educate the community of transportation options
- Address access barriers for services:
    - Size of wheelchair
    - Gas for cars
    - Maintenance for cars
- Work with bus routes for timeliness concerns
- Possible incentives for attendance

DELANO - NORTH REGION

- Attendees: 16
  - 13 KFHC Members
- Predominate Culture: Hispanic
- Families: 13
- Staff: 7

- Communication material for navigators
- Locate local champions
- Outreach through media
- Create communication channels with local social media platforms

LAKE ISABELLA - EAST REGION

- Attendees: 19
    - 5 KFHC Members
- Predominate Culture: White
- Families: 14
- Staff: 8

- Transportation to Mobile Units
- Transportation to and from school for appointments
- Transportation and access to OBGYN services
- Understanding transportation options in region
- Impact on H.R. 1 for the region

TAFT - WEST REGION

- Attendees: 17
    - 10 KFHC Members
- Predominate Culture: Hispanic
- Families: 12
- Staff: 7

- Pharmacy access is critical
- Work with Providers for transportation prompt
- Educate the community of services through community-based social media, flyer posted throughout the community and text services

VINELAND - SOUTH REGION

- Attendees: 12
    - 1 KFHC Adult Members
- Predominate Culture: Hispanic
- Families: 6
- Staff : 8

- Explore transportation request options
- Addressing the digital divide
- Work with local social media platforms for outreach
- Possible collaboration with United Way

REGIONAL OVERVIEW - COMMON THEMES FOR ALL RAC MEETINGS

- Unknown Benefit
- Impact of H.R. 1
- Timeliness of Transportation
- Work with communities to determine local transportation options
- Need for student transportation
- Need transportation to mobile units
- Need for trust in KHS services
- Promote services via local social media platforms
- Pharmacy services are needed
- OBGYN services are needed
- Determine other options to get transportation services, such as online
- Digital Divide
- Training for app navigation

RECOMMENDATIONS

- Education
  - Transportation Options
  - Impact of H.R. 1
  - Local Transportation Options
  - KHS App Training
- Services
  - OBGYN
  - Pharmacy
  - General Testing
- Marketing
  - Use alternative methods to promote services:
    - Radio
    - Local social media
    - Placement of flyers
  - Locate Local Champions
  - Addressing the Digital Divide

QUARTER 4 - CAL AIM

- North - Shafter
- East - Tehachapi
- South - Greenfield
- West - Lebec/Tejon
- Central - Bakersfield - Boys and Girls Club


QUESTIONS

KERN HEALTH SYSTEMS

Equity and Practice Transformation (EPT) Payment Program

Q3 update

Kern Health Systems Update

November 2025

EPT Quick Refresher

How EPT program began:

- Population Health Management Capabilities Assessment Tool (PhmCAT) to establish each practice's baseline.
    - The PhmCAT assessment: Link to document.
- Identified gaps in workflows, data collection, staffing, and patient engagement
- Provided a clear picture of each practice's current state
- Informed development of customized workflows and equity-focused improvements

Data Exchange Advancements

- In Q3, we continued supporting practices with the Data Exchange milestone. Strengthened relationships with EPT practices leading to additional BI team collaboration.

We worked on improving how practices capture and share key clinical data:

  - Blood pressure,
  - BMI,
  - Visit scheduling data

- We've been helping practices understand how this data connects to quality improvement and how it supports care gap closure.

Total Medi-Cal Patients For Measure	WCV 18-21YO WCV 12-17 YO	NUMERATOR	DENOMINATOR	RATE
		232	951	24.4%

Total Medi-Cal Patients	NUMERATOR	DENOMINATOR	RATE
Total Medi-Cal Patients	967	2,146	45.1%

Breakdown By Race/Ethnicity For Measure

RACE/ETHNICITY	NUMERATOR	DENOMINATOR	RATE
AMERICAN INDIAN AND ALASKAN NATIVE	2	4	50.0%
ASIAN	11	28	39.3%
BLACK OR AFRICAN AMERICAN	36	102	35.3%
HISPANIC OR LATINO	806	1,726	46.7%
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	1	0.0%
UNKNOWN	53	138	38.4%
WHITE	59	147	40.1%
TOTAL	967	2,146	45.1%

Primary Spoken Language

LANGUAGE	NUMERATOR	DENOMINATOR	RATE
ENGLISH	508	1,264	40.2%
OTHER	2	7	28.6%
SPANISH	457	875	52.2%
TOTAL	967	2,146	45.1%

Pre-Visit Screening and Improved Workflows

Kern Family Health Care®

- Improved patient interactions
    - Pre-visit screening workflow including
        - Preventive care prompts
        - Vitals capture
        - Behavioral health screenings

How EPT current work supports 2026 & beyond

- Tools and standardized approaches can be shared with practices who were not in the original EPT cohort.

- In 2026, we'll be able to use these models to bring more practices into equity-aligned work without requiring them to start from scratch.

- EPT has shifted how practices think about and address patient needs.

Next Steps:

- Continue supporting practices with EPT milestones in final year 2026.
- Continuing to refine tools and prepare to scale what we've learned across our network.
- Maintain strong communication with participating practices and community.

Thank You

Kern Family Health Care®

KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: John Miller, M.D.

Date: December 16, 2025

Re: Quality Improvement Workgroup (QIW)

Background:

The 4th Quarter meeting of the Kern Health Systems (KHS) Quality Improvement Workgroup (QIW) was held on December 8, 2025. The QIW, which reports to the Executive Quality Improvement Health Equity Committee (EQIHEC), includes providers and community representatives. The agenda focused on key updates regarding quality and safety initiatives, site review performance, appeals and grievances, NCQA accreditation progress, culture and linguistics, member wellness and prevention, and developments in the Enhanced Care Management (ECM) program.

Discussion:

During this session, quorum was met.

1. Quality Performance Updates

- **FSR/MRR Performance:**
  - 100 percent of Facility Site Reviews (FSR) passed YTD; 40 initial and periodic reviews completed.
  - 96 percent of Medical Record Reviews (MRR) passed; 2 of 54 sites failed initially but passed after education and CAP completion.
- **PARS:**
  - Six Physical Accessibility Review Surveys (PARS) completed in Q3.
- **Performance Improvement Projects:**
  - W30 African American well-child Performance Improvement Project (PIP) continues intervention testing; weekend/evening clinics and mobile unit partnerships active.
  - Behavioral Health PIP (FUA/FUM) advancing with BH, UM, and PHM.
- **MCAS Performance:**
  - 13 of 18 measures improved compared to last year.
  - 5 measures meeting MPL; 2 within 5 percent of MPL.
  - W30 (0–15 mo) showing significant YOY decline; BI reviewing root cause.

2. Quality of Care & Safety Oversight

- **Grievances & PQIs:**
  - PQIs continue trending at acceptable levels (<30/month).
  - Classification and triage processes function with timely MD review.
- **Appeals:**
  - Clinical reviews supported by RN team; MDs issue final decisions.
- **Audits:**
  - Readmission audit process restructured due to JIVA documentation gaps.
  - New COSA analytics-driven process improves detection of transition-of-care opportunities.
- **Safety Monitoring:**
  - Asthma, Telehealth, IHA, and lead screening audits completed.
  - IHA timeliness and education remain priority improvement areas.

3. Enhanced Care Management (ECM)

- **Enrollment:**
  - ECM population reached 14,683 members, continuing steady growth since 2023.
- **Utilization Trends:**
  - Q3 ED utilization: 6,234 unique ED visits among 14,683 members.
  - Department aims for five percent quarterly reduction in ED utilization.
- **Incentive Program:**
  - Sites ranked by normalized utilization metrics for UC, ED, and inpatient utilization per 1,000 members.
- **Clinical Measures (MCAS):**
  - Focused work on BCS and CCS with provider-level drill downs.
- **Member Satisfaction:**
  - 2025 ECM experience surveys show more than 90 percent satisfaction across domains (friendliness, follow-up, answering questions, access).
- **Grievances:**
  - Q3 2025 shows an increase in total grievances, prompting ECM to set a five percent reduction benchmark.

4. Cultural & Linguistic Services

- **High Performance in Linguistic Access:**
  - 98 percent of bilingual staff did not struggle communicating in non-English languages.
  - 93 percent satisfaction in post-call Spanish surveys.
- **Interpreter Services:**
  - 100 percent of over-the-phone interpreter calls met expectations across 11 languages.
- **Member Satisfaction:**

- Strong engagement across surveys, showing accessible and high-quality linguistic services.

5. Member Wellness & Prevention

- **Service Audit:**
  - All reviewed domains achieved 100 percent compliance.
- **Class Satisfaction:**
  - Members valued practical content, nutrition education, and instructor quality.
  - Suggestions focused on additional sessions and simplified explanations.

6. QI Work Plan Scorecard

- All 3rd Quarter 2025 initiatives were reported as complete or in progress with no identified barriers.

Conclusion & Next Steps

- No additional issues were raised during the open forum.
- The next QIW meeting is scheduled for February 2026.

Fiscal Impact:

None.

Requested Action:

Review and approval.

KERN HEALTH SYSTEMS

QUALITY IMPROVEMENT WORKGROUP (QIW) MEETING

Monday, December 8, 2025
at
12:00 pm

2900 Buck Owens Blvd.
Bakersfield, CA 93308
2nd Floor - Bear Mountain Room

For more information, call (661) 664-5000

KERN HEALTH SYSTEMS

Quality Improvement Workgroup Subcommittee (QIW)
AGENDA – December 8, 2025

AGENDA ITEM	AGENDA TOPIC	PRESENTER	TIME	ACTION
CALL TO ORDER	Call meeting order / Attendance-Quorum	***Dr. Miller MD, KHS Medical Director, Chair***	*1 min*	*N/A*
APPROVAL OF MINUTES	September 2025 Minutes	***All Voting Members***	*2 min*	*Approval*
OLD BUSINESS	1. Follow-up:	None		*Discussion*
NEW BUSINESS	1. Quality & Safety of Clinical Care a. MCAS b. PIPs c. FSR/PARs/Medical Records d. QOC Grievances & PQIs 2. Quality of Service a. Appeals & Clinical Network 3. Cultural and Linguistics Monitoring Q3 4. Member Wellness and Prevention Program Monitoring Q3 5. CHW/APS Audits 6. ECM Report 7. Workplan Scorecard – Q3	Kailey Collier, QP Dir Magdee Hugais, QI Dir Kalpna Patel, QI Sup Cynthia Cardona, C&L Mgr Flor Del Hoyo Galvan, W&P Mgr Tiffany Chatman, W&P Mgr Dan Diaz, ECM Mgr Magdee Hugais, QI Dir	*10 min* *5 min* *5 min* *5 min* *5 min* *5 min* *5 min* *5 min*	*Approval* *Approval* *Approval* *Approval* *Approval* *Approval* *Approval* *Approval*
OPEN FORUM	Open Forum / Committee Members Announcements / Discussion	***Open to all Members***	*5 min*	*Discussion*
NEXT MEETING	Next meeting will be held Thursday, **February 26, 2026 at 12:00 pm**	Informational only		*N/A*
ADJOURNMENT	Meeting Adjournment	***Dr. Miller MD, KHS Medical Director, Chair***		*N/A*

661-664-5000
661-664-5151
kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

KERN HEALTH SYSTEMS

COMMITTEE: ***QUALITY IMPROVEMENT WORKGROUP***
DATE OF MEETING: ***SEPTEMBER 11, 2025***
CALL TO ORDER: ***12:05 PM BY JOHN P. MILLER, MD, QI MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Dr. John Paul Miller, KHS QI Medical Director, Chair		
Members Virtual Remote:	Danielle Colayco, PharmD, Executive Director Komoto	Carmelita Magno, Kern Medical Process Improvement Dir.	
Members Excused=E Absent=A	Dr. Mansukh Ghadiya, Family Practice (E) Dr. Joseph Hayes, MD – CMO Omni (E)	Dr. Irving Ayala-Rodriguez, CSV (E)	
Staff Present:	Monique Barrios, QP Clinical Supervisor Kailey Collier, RN, Director of Quality Performance Lela Criswell, Member Engagement Supervisor Michelle Curioso, Director of PHM Amy Daniel, Executive Health Services Coordinator Aurora De La Torre, QP Manager	Flor Del Hoyo Galvan, Manager of Member Wellness Dan Diaz, RN, ECM Clinical Manager Alma Garcia, NCQA Accreditation Specialist Yolanda Herrera, Credentialing Manager Kulwant Kaur, UM Outpatient Clinical Manager Maninder Khalsa, MD, UM Medical Director	Kalpna Patel, QI Supervisor Loni Hill-Pirtle, Director of Enhanced Case Management Magdee Hugais, Director of QI Steven Kinnison, NCQA Manager Melinda Santiago, Director of Behavioral Health

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were met.	9/11/25
Call to Order	Dr. John Paul Miller, KHS QI Medical Director called the meeting to order at 12:03 PM.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. John Miller, presented the May 22, 2025 meeting minutes for approval.	☑ **ACTION**: Danielle Colayco made a motion to approve minutes of May 22, 2025, seconded by Carmi Magno. Motion carried.	9/11/25
OLD BUSINESS	**No Old Business presented.**		N/A
NEW BUSINESS	**ECM Report & Program Description** Dan Diaz, ECM Manager, presented the Q2 2025 ECM Report and Program Description. Some key highlights included: • Closed the loop on referrals to ECM and this process has been added to the program description.	☑ **ACTION**: Danielle Colayco moved to approve the ECM 2nd Quarter 2025 Report and Red-lined Program Description, seconded by Carmi Magno. Motion carried.	9/11/25

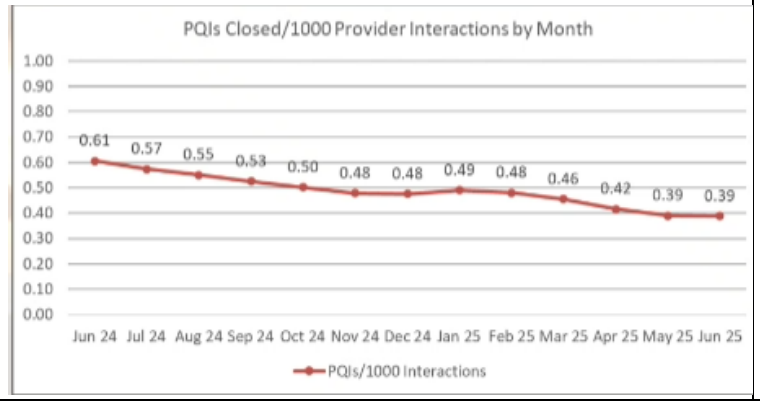
AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Organization chart pending possible development of new job descriptions to describe our current state • Added new Child Welfare Liaison position to support community services • Streamlined authorizations for contracted providers to be able to authorize in 30 days. • ECM has a total of 12,272 members enrolled • ECM interventions have decreased the total number of unique emergency room visits for members enrolled by 5% • Overall ECM satisfaction has increased from 2024 to present. • Red-lined revisions to the ECM Program Description were reviewed with no significant questions from the committee members.		
	Quality & Safety of Clinical Care **MCAS Update**: Kailey Collier, Director of QP, presented the 3rd Quarter Quality Improvement Report including Trending Performance for MY2025 vs MY2024. Some key highlights included: • Purchased multiple lead screening machines for providers in rural regions • 5 mobile unit providers deployed across Kern County • Partnerships with more than 15 school districts • Weekend and evening clinics with two local pediatricians • Streamline member rewards for behavioral health and children's services • Dedicated outreach team focused on children's health, specifically driven by need for annual well-care visits **Site Review Updates**: Kailey also presented the QP Site Review updates. For 2025 YTD, 100% of the Initial and Periodic site reviews passed. Highlights included: • YTD there were 40 site reviews completed by early September 2025 • All Site Reviews completed timely and thoroughly for Q3 2025 • There are no open CAPs pending follow up actions • CMT participates in multiple statewide workgroups focused on updating CDPH trainings to supplement provider education of Children's screenings. • Collaborating with PNM and Learning & Development to share with PCPs.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	9/11/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	OOC Grievances & PQIs Magdee Hugais, QI Director presented the Quality-of-Care Grievances and Potential Quality of Care issues for 2nd Quarter 2025. Magdee reported there were no QOC concern identified to warrant further investigation or additional action.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	9/11/2025

Quarter	Total Grievances Received for PQOC	Grievances Classified as PQOCs	Grievances Classified as Non-PQOCs	Total Grievances Closed
Q3 2024	1007	598	409	2755
Q4 2024	924	505	419	2355
Q1 2025	659	444	215	3006
Q2 2025	968	644	324	1719

Severity Level	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025
Level 0 - No Quality Concern	129	85	18	74	73	67
Level 1 - Potential for Harm	108	75	95	94	71	48
Level 2 - Actual Harm	0	2	0	2	0	0
Level 3 - Actual Morbidity	0	0	0	0	0	0
Total	237	162	113	170	144	115

Appeals and Clinical Network:
Kalpna Patel, QI Supervisor presented the Appeals for 2nd Quarter. PQIs Closed per 1000 Provider Interactions by Month continue to trend downwards and turn-around-time in 30-days is continue to trend downwards.



AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	NCQA Accreditation Steven Kinnison reported that KHS received accreditation in both Health Plan Accreditation and Health Equity. Both accreditations are for 3 years. There was one point missed, and the organization has already closed the gap in complying with the provider manual data elements.	☑ **CLOSED**: Informational Only.	9/11/25
	Cultural and Linguistics Monitoring 1st Quarter 2025 Flor Del Hoyo Galvan W&P Manager presented the C&L Monitoring for 2nd Quarter Report**.** • Bilingual staff call audits 30-Calls Audited with 98% compliance with no difficulty communicating. • 94% of members were satisfied with the linguistic performance • 100% of audited calls for OPI Interpreter Service met expectations. • Overall members were very satisfied with KFHC Services	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	9/11/25
	Member Wellness and Prevention Flor Del Hoyo Galvan, W&P Manager presented the Wellness and Prevention Report 2nd Quarter 2025. Report accepted as presented and available for review due to time constraints.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	9/11/25
	QI Workplan Scorecard Magdee presented the KHS Quality Improvement Annual Work Plan Scorecard. Due to time constraints members were directed to review the report and if any questions to direct those to Magdee.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	9/11/25
OPEN FORUM	**Open Forum** No additional questions or issues were presented for open forums.	☑ **CLOSED**: Informational only.	N/A
NEXT MEETING	Next meeting will be held Wednesday, December 8, 2025 at 12:00 noon.	☑ **CLOSED**: Informational only.	N/A
ADJOURNMENT	The Committee adjourned at 1:00 PM. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	N/A

For Signature Only – Quality Improvement Committee Minutes 09/11/25

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

To: KHS Quality Improvement Workgroup (QIW)

From: Kailey Collier, Director of Quality Performance (QP)

Date: November 2025

Re: Quality Performance Q3 2025 Report

Background

The QP team develops a quarterly report to outline, monitor, and evaluate our ongoing departmental activities. This report also serves as an opportunity for committee members to provide input regarding our work. This report reflects activities and outcomes for the third quarter of 2025.

Discussion

See page 2 of this document

Fiscal Impact

The fiscal impact of not achieving and maintaining satisfactory MCAS rates may be severe to the health plan. This includes sanctions which may come in the form of monetary fines, reduction in default assignment, reduction in membership, and ultimately revocation of the plan from the Medi-Cal program. Another cost is utilization and increased costs of care associated with the lack of preventive care, that turns preventable conditions into chronic conditions. The ultimate cost is paid by the membership in the form of reduced health status and diminished quality of life. Access to high quality and equitable care is what MCAS drives, and what we as a plan are striving to deliver to the more than 400,000 lives we cover.

Requested Action

Review and approval of the report

KERN HEALTH SYSTEMS

Quality Performance Department
Executive Summary
3rd Quarter 2025

I. Facility Site Reviews (FSR) and Medical Record Review (MRR) (pages 2-10)

5 Initial Facility Site Reviews and 4 Initial Medical Record Reviews were completed in Q3 2025. 8 Periodic FSRs and 8 periodic MRRs were also completed. 100% of Facility Site Reviews passed and 96% YTD of Medical Record Reviews passed. 2 of 54 sites failed the first review, however Corrective Action Plans were completed and closed. QP also conducts mid-cycle interim reviews of facilities to monitor facility compliance. The QP department also conducts Physical Accessibility Review Surveys (PARS) and 6 were completed in Q3 2025.

II. Quality Improvement Projects (pages 11-12)

A. ***Performance Improvement Projects (PIPs)***

The current PIPs began in August 2023 and run through 2026. The first PIP is focused on the W30 MCAS measure, specific to Health Equity of the 0-15 months African American Population in Kern County. The second PIP is considered a non-clinical Behavioral Health PIP, specific to the FUA and FUM measures. We are partnering with KHS' Behavioral Health Department to ensure success of this PIP. The first submission for both PIPs were approved by HSAG. We are currently in the second phase of the PIP, which focuses on interventions and testing. We have developed a provider notification process for ED visits related to Behavioral Health and Substance Use Disorders. For the W30 PIP, we are leveraging activities from mobile units and the IHI/DHCS collaborative focused on well-care visits for the 0-15 months, African American babies.

Two pilot providers are offering weekend and evening appointments to increase adherence to well-child visits for African American babies ages 0-21 years of age. The Sprint Team responsible for the IHI collaborative is exploring opportunities to distribute member rewards for this population of focus for scheduling the visit. As part of the MERP, additional rewards are provided for closing the gaps in care. We have also identified a need for a single page handout for next steps following well care visits in children and adolescents.

III. Managed Care Accountability Set (MCAS) Updates (Pages 13-17)

The QP team continues with MCAS specific initiatives in support of improving all measures for current measurement year with a heavy focus on the Children's domain of care. As of September 2025, 13 of 18 measures have improved compared to last year. Based on administrative data, we are currently meeting MPL for 5 measures. We are within 5% MPL for 3 additional measures. These rates are reflective of year-to-date administrative data only. We anticipate changes as we near the annual MCAS audit, which will kick off in October for completion of the roadmap.

Quality Performance Updates

Q3 2025

2025 Quality Initiatives

- Purchased multiple lead screening machines for providers in rural regions
- 5 mobile unit providers deployed across Kern County
  - Partnerships with more than 15 school districts
- Weekend and evening clinics with two local pediatricians
- Streamline member rewards for behavioral health and children's services
- Dedicated outreach team focused on children's health, specifically driven by need for annual well-care visits
- IHI and DHCS Collaborative

KERN HEALTH SYSTEMS

Quality Initiatives Cont'd.

KERN HEALTH SYSTEMS

- Text message campaigns to promote member rewards and educate on importance of well-care visits
- Routine data exchange process developed - KHS receives monthly provider usage report
- Training on the Provider Learning Module System (PLMS) for EPSDT services
- Partnership with CDPH team to educate providers on importance of lead screening and fluoride varnish
- Rapport established with the California Immunization Registry (CAIR)
  - Routine data exchange process developed - KHS receives monthly provider usage report

MY2025 vs. MY2024 Trending Performance

13 measures are trending higher than the previous year at the same point in time.

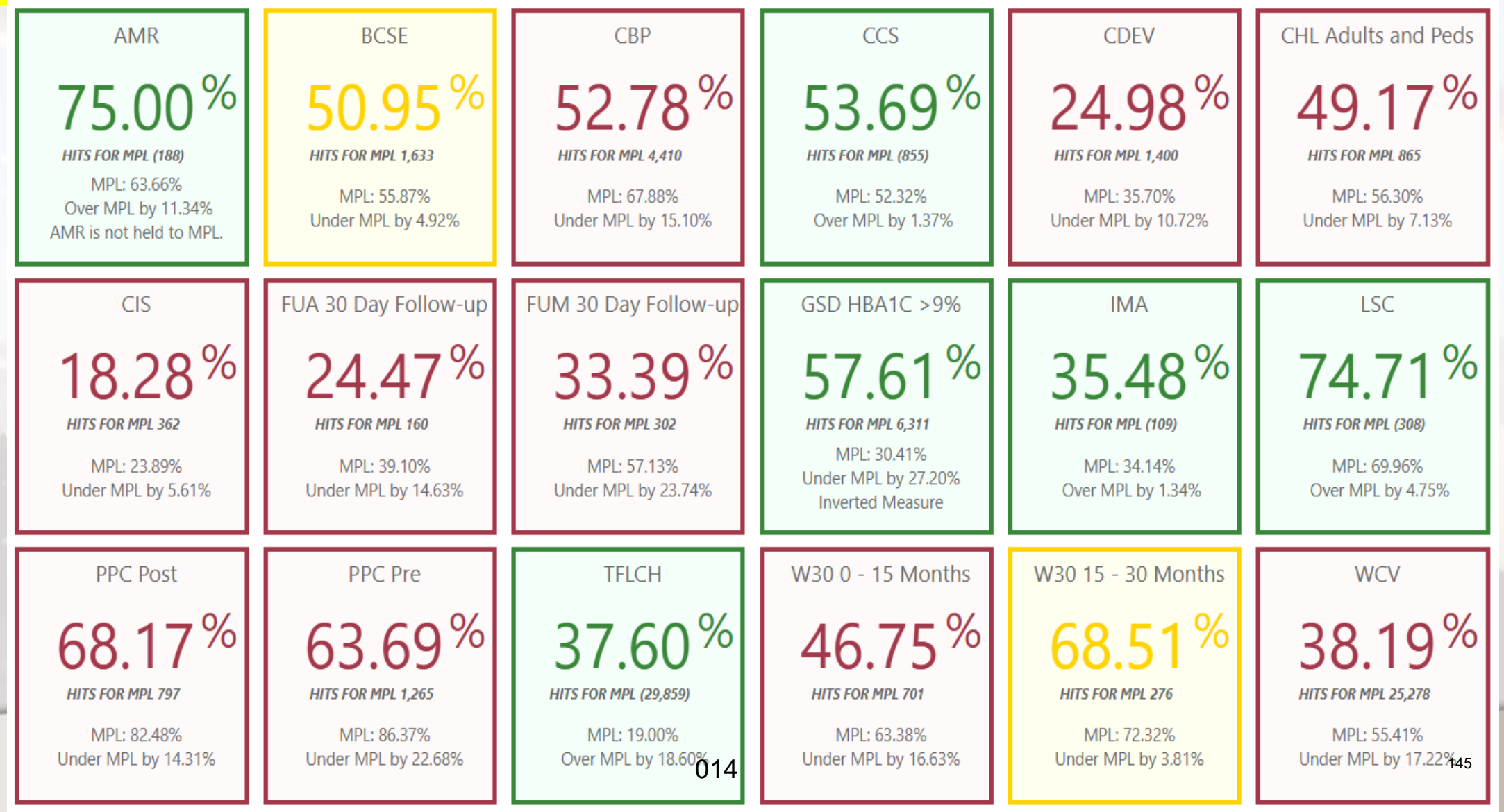
AMR	BCSE	CBP	CCS	CDEV	CHL Adults and Peds
75.00%	50.95%	52.78%	53.69%	24.98%	49.17%
HITS FOR MPL (188)	*HITS FOR MPL 1,633*	*HITS FOR MPL 4,410*	*HITS FOR MPL (855)*	*HITS FOR MPL 1,400*	*HITS FOR MPL 865*
+1.59 % change	-4.61 % change	+7.38 % change	+5.20 % change	+4.71 % change	-3.75 % change
Sep'24 73.41%	Sep'24 55.56%	Sep'24 45.40%	Sep'24 48.49%	Sep'24 20.27%	Sep'24 52.92%

CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	GSD HBA1C >9%	IMA	LSC
18.28%	24.47%	33.39%	57.61%	35.48%	74.71%
HITS FOR MPL 362	*HITS FOR MPL 160*	*HITS FOR MPL 302*	*HITS FOR MPL 6,311*	*HITS FOR MPL (109)*	*HITS FOR MPL (308)*
-0.49 % change	+1.57 % change	+13.89 % change	+5.30 % change	+2.60 % change	+6.81 % change
Sep'24 18.77%	Sep'24 22.91%	Sep'24 19.50%	Sep'24 62.92%	Sep'24 32.88%	Sep'24 67.90%

PPC Post	PPC Pre	TFLCH	W30 0 - 15 Months	W30 15 - 30 Months	WCV
68.17%	63.69%	37.60%	46.75%	68.51%	38.19%
HITS FOR MPL 797	*HITS FOR MPL 1,265*	*HITS FOR MPL (29,859)*	*HITS FOR MPL 701*	*HITS FOR MPL 276*	*HITS FOR MPL 25,278*
+3.52 % change	+15.50 % change	+1.84 % change	-4.95 % change	+2.39 % change	-0.54 % change
Sep'24 64.65%	Sep'24 48.18%	Sep'24 35.76%	Sep'24 51.70%	Sep'24 66.12%	Sep'24 38.73%

MY2025 YTD Performance

- ✓ Meeting MPL for 5 measures
- ✓ Within 5% of MPL for 2 measures



**GSD is an inverse rate*

Site Review Updates

- For 2025 YTD, 100% of the Initial and Periodic site reviews passed.
- YTD there were 40 site reviews completed by September 2025
- All Site Reviews completed timely and thoroughly for Q3 2025
- There are no open CAPs pending follow up actions
- CMT participates in multiple statewide workgroups focused on updating CDPH trainings to supplement provider education of Children's screenings.
    - Collaborating with PNM and Learning & Development to share with PCPs.

For additional Information, please contact:

Kailey Collier, Director of Quality Performance

KERN HEALTH SYSTEMS

QUALITY PERFORMANCE DEPARTMENT

QUARTERLY EQIHEC COMMIITTEE REPORT

Q3 2025

KERN HEALTH SYSTEMS
Quality Performance Department Quarterly EQIHEC Committee Report
Q3 2025

The purpose of this report is to provide a summary of the quarterly activities and outcomes for the QI department. It provides a window into the performance of the Quality Improvement Program and Department. It serves as an opportunity for programmatic discussion and input from the QI-UM Committee members. Areas covered in the report include:

I. Facility Site & Medical Record Reviews
   A. Initial Site & Medical Record Reviews
   B. Periodic Site & Medical Record Reviews
   C. Critical Elements
   D. Initial Health Appointments (IHAs)
   E. Interim Reviews
   F. Follow-up Reviews Completed after Corrective Action Plans (CAPs)

II. Quality Improvement Projects

A. Performance Improvement Projects (PIPs)

B. Red Tier & Strike Team

V. Managed Care Accountability Set (MCAS) Updates

VI. Policy and Procedures

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

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

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

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

Critical Elements:

Based on DHCS recommendation, changes were made and implemented to existing critical elements to align with the new tools and standards on 7/1/2022. Below is the updated list of critical elements related to the potential for adverse effect on patient health or safety, previously there were 9 now they are 14:

1. Exit doors and aisles are unobstructed and egress (escape) accessible.
2. Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag
3. Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of ESIP needles/syringes and alcohol wipes.
4. Only qualified/trained personnel retrieve, prepare, or administer medications.
5. Physician Review and follow-up of referral/consultation reports and diagnostic test results
6. Only lawfully authorized persons dispense drugs to patients.
7. Drugs and Vaccines are prepared and drawn only prior to administration.
8. Personal Protective Equipment (PPE) for Standard Precautions is readily available for staff use.

9. Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport, or shipping.
10. Needlestick safety precautions are practiced on site.
11. Cold chemical sterilization/high level disinfection: a) Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.
12. Cold chemical sterilization/high level disinfection: c) Appropriate PPE is available, exposure control plan, Material Safety Data Sheets and clean up instructions in the event of a cold chemical sterilant spill.
13. Autoclave/steam sterilization c) Spore testing of autoclave/steam sterilizer with documented results (at least monthly)
14. Autoclave/steam sterilization Management of positive mechanical, chemical, and biological indicators of the sterilization process.

Scoring and Corrective Action Plans

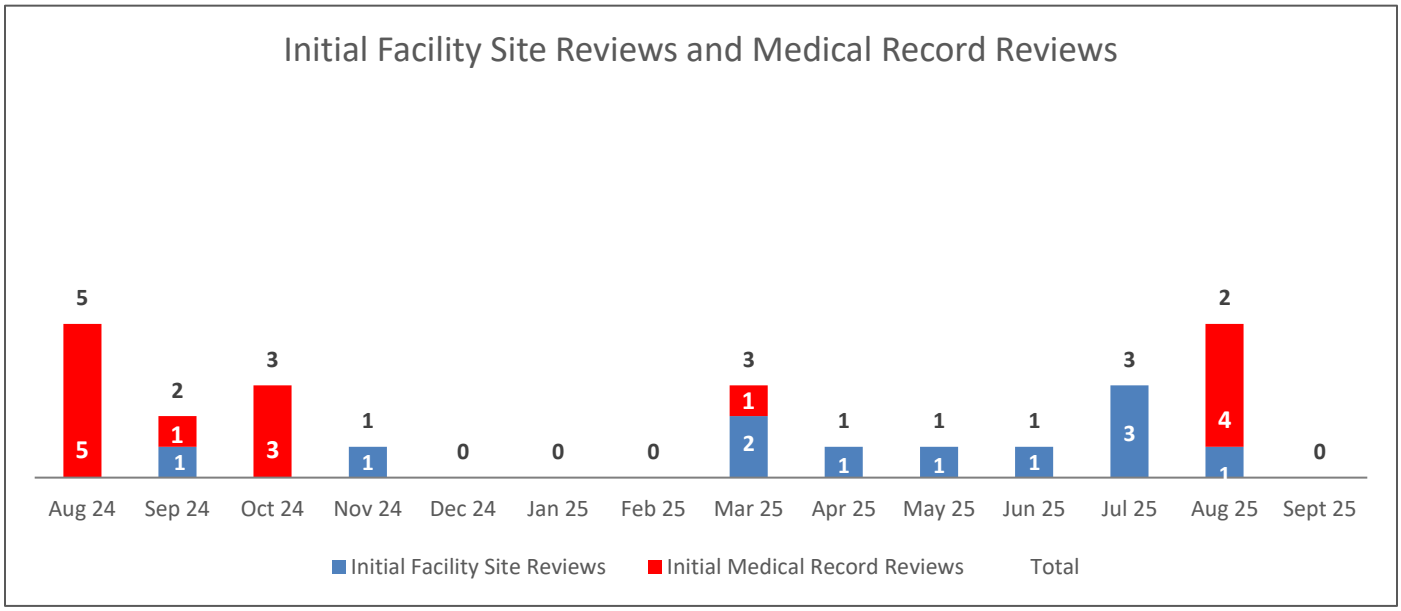
Provider sites that receive an FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are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

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

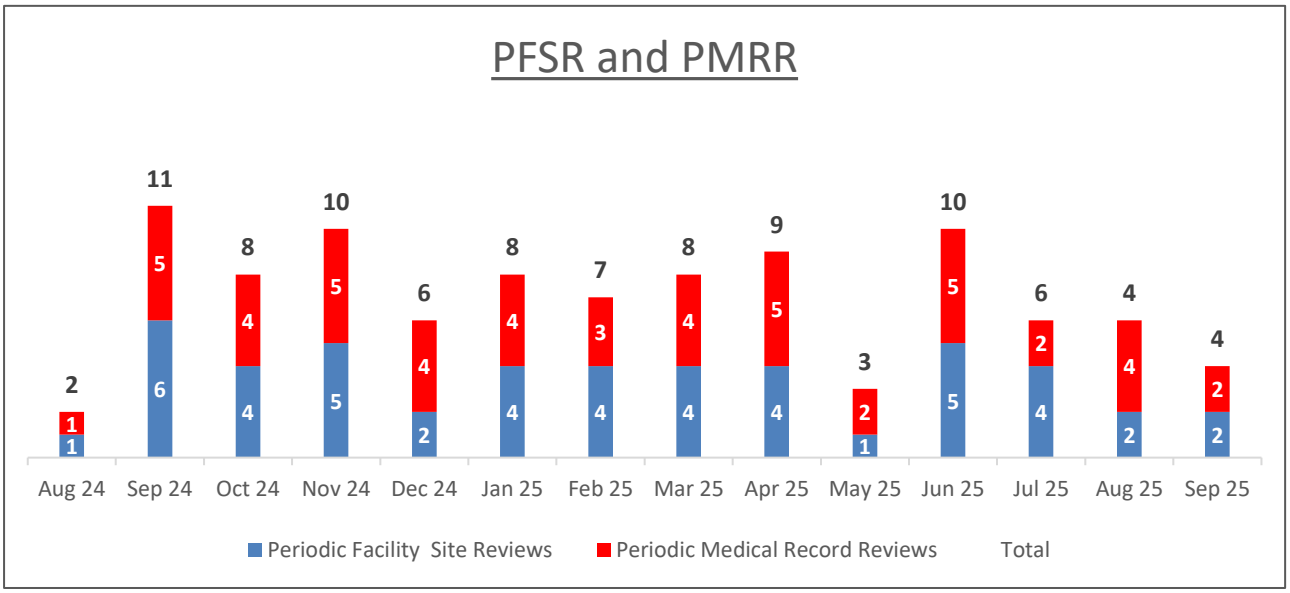
Corrective Action Plans (CAPs)

A CAP is issued when an initial, periodic, or focus review has deficiencies identified. DHCS requires follow up at 10 days for failure of any critical element, follow up for other failed elements at 30 days, and if not corrected by the 30 day follow up, at 90 days after a CAP has been issued. Most CAPs issued are corrected and completed within the 30 Day follow up period. Providers are encouraged to speak with us if they have questions or encounter issues with CAP completion. QI nurses provide education and support during the CAP resolution process.

A. Initial Facility Site Review and Medical Record Review Results:

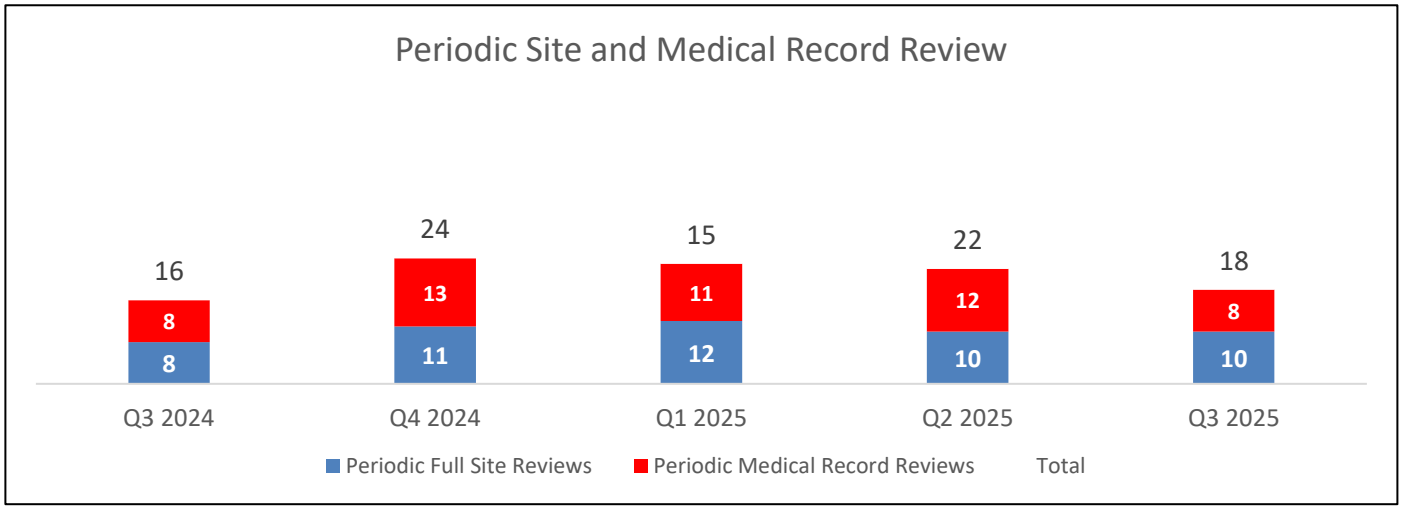


The number of Initial Facility Site and Medical Record Reviews is determined by the number of new providers requesting to join KHS' provider network. There were 1 IFSRs and 4 IMRR completed in Q3 of 2025 (YTD).



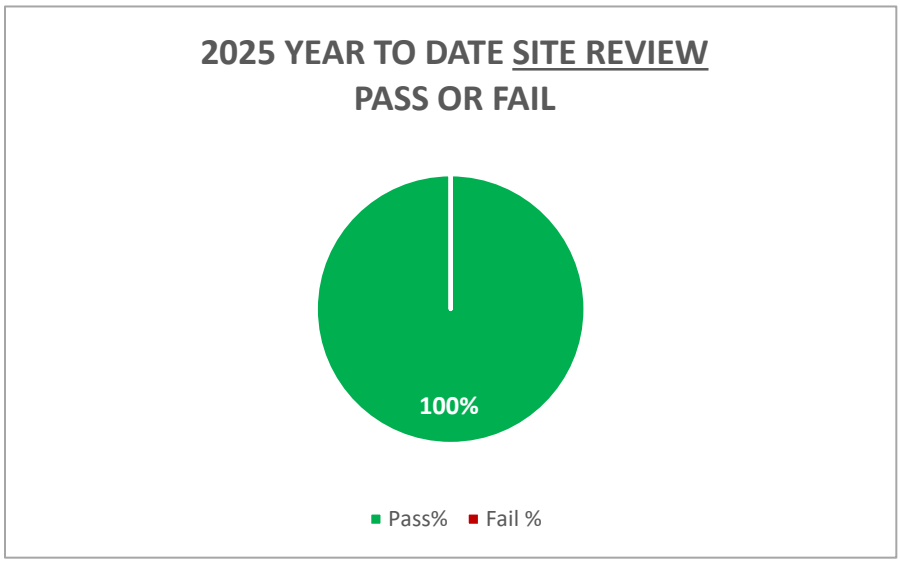
B. Periodic Full Site and Medical Record Reviews

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

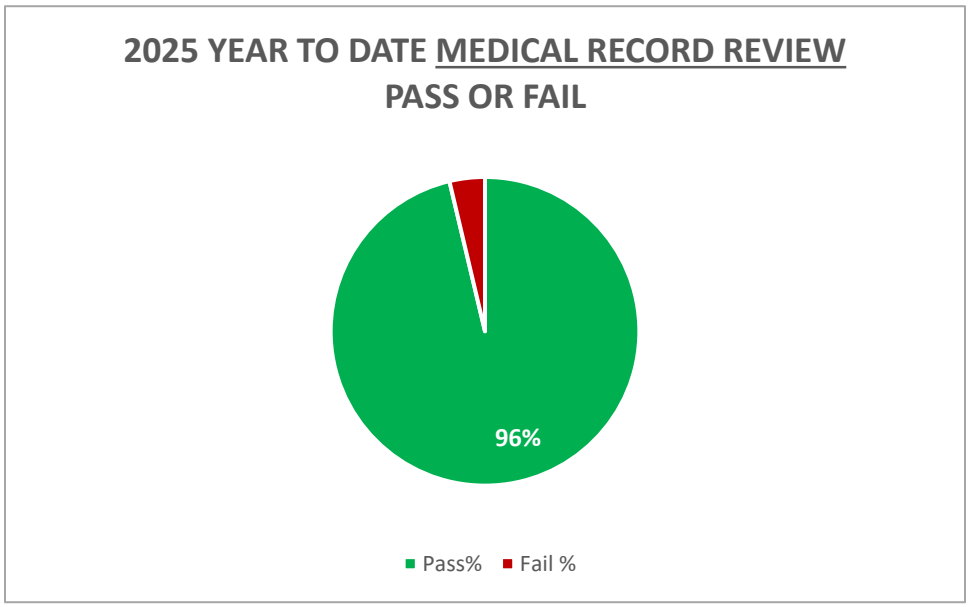


The above chart shows the number of Periodic Full Site Reviews and Medical Record Reviews that were due and completed for each quarter to date.

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



Based on DHCS' standard 80% or higher is considered as passed. Scoring 80% - 89% is considered a "conditional pass" and requires a CAP only for the elements that were non-compliant. A score below 80% is considered a Fail and requires a CAP for the entire site or medical record review.
For 2025 YTD, 100% of the Initial and Periodic site reviews performed passed. YTD there were 40 site reviews completed by early September 2025.



For 2025 YTD, 96% of the Initial and Periodic Medical Record Reviews performed passed. YTD there were 54 medial record reviews completed, 2 of these reviews failed in the first audit. However, following the failed review, additional education was provided, and CAPs were issued to correct deficiencies.

For Q3 2025, the top 3 deficiencies identified for Opportunities for improvement in Facility Site Reviews are:

1. Sites are not utilizing the California Immunization Registry (CAIR) or the most current version.
2. Standardized Procedures, Practice Agreements and Supervisory Guidelines are revised, updated and signed by the supervising physician and NPMP when changes in scope of services occur.
3. Standardized Procedures provided for Nurse Practitioners (NP) and/or Certified Nurse Midwives (CNM).

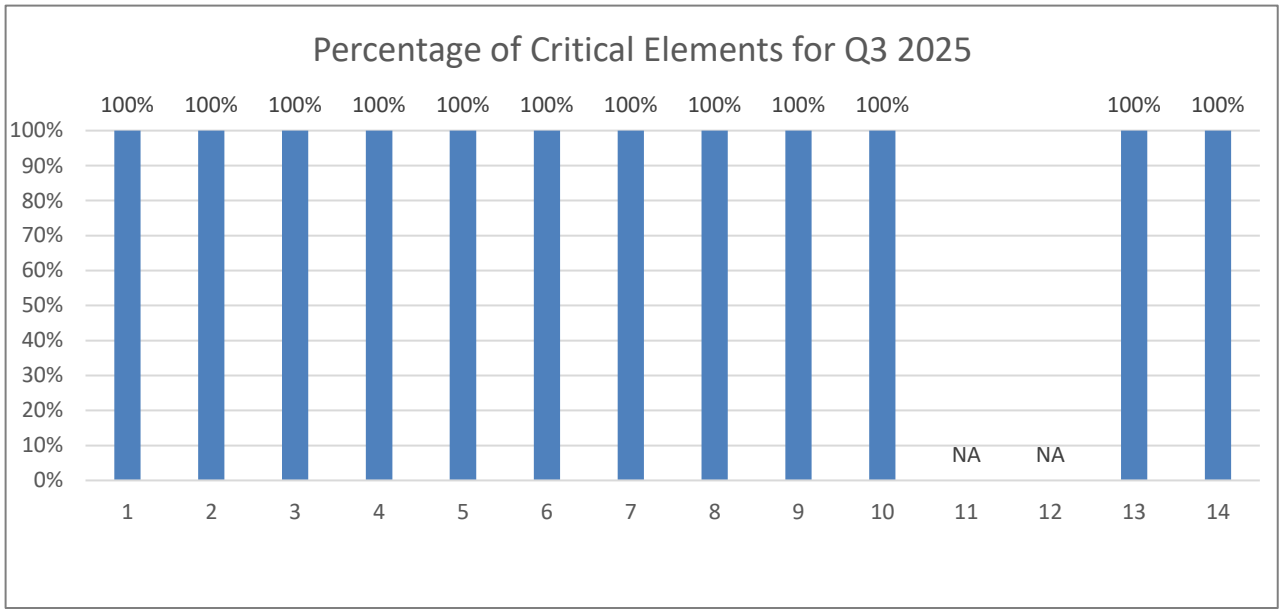
There were no deficiencies in Q3. We will continue to monitor for any new trends.

For Q3 2025, the top #3 deficiencies identified for Opportunities for improvement in Medical Record Reviews are:

1. Member Risk Assessment not being completed in both adult and pediatrics.
2. Hepatitis B Screening is not being completed in both adult and pediatrics.
3. Tuberculosis screening is not being completed in both adult and pediatrics.

Education was provided regarding these deficiencies. We will continue to monitor for any trends.

C. Critical Elements (CE) Percentage for Site Reviews:



There were 8 FSRs completed for Q3 2025, and 8 sites have passed the critical elements.

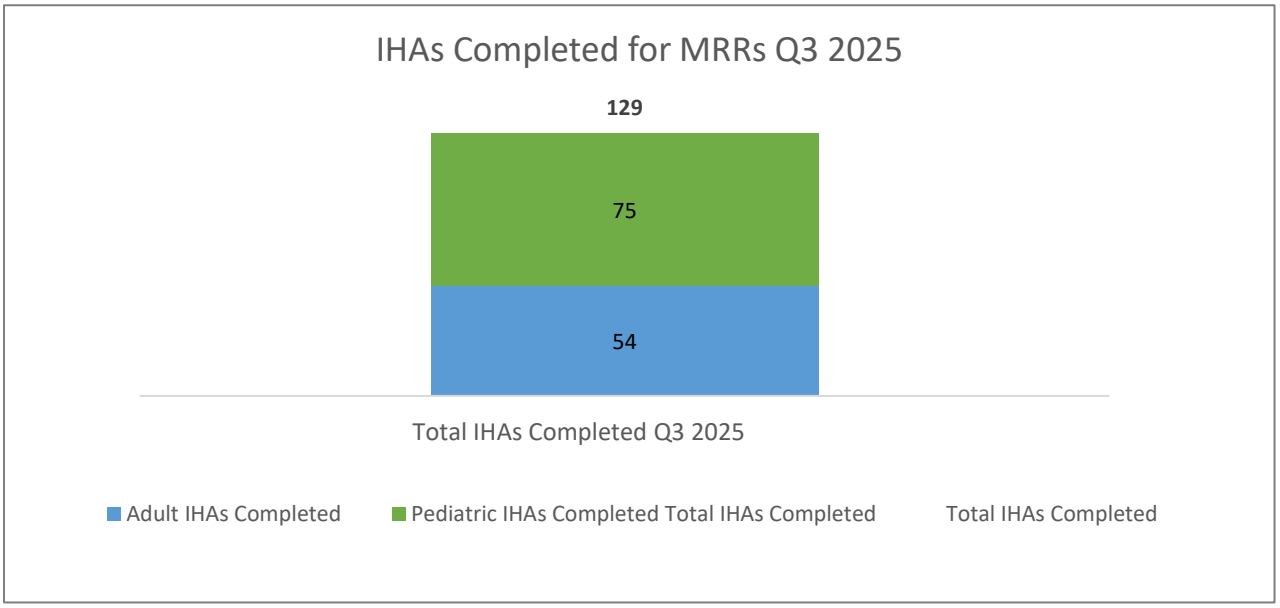
The site review team is working closely with sites by proving ongoing education to ensure compliance.

D. IHA's percentage for MRRs:

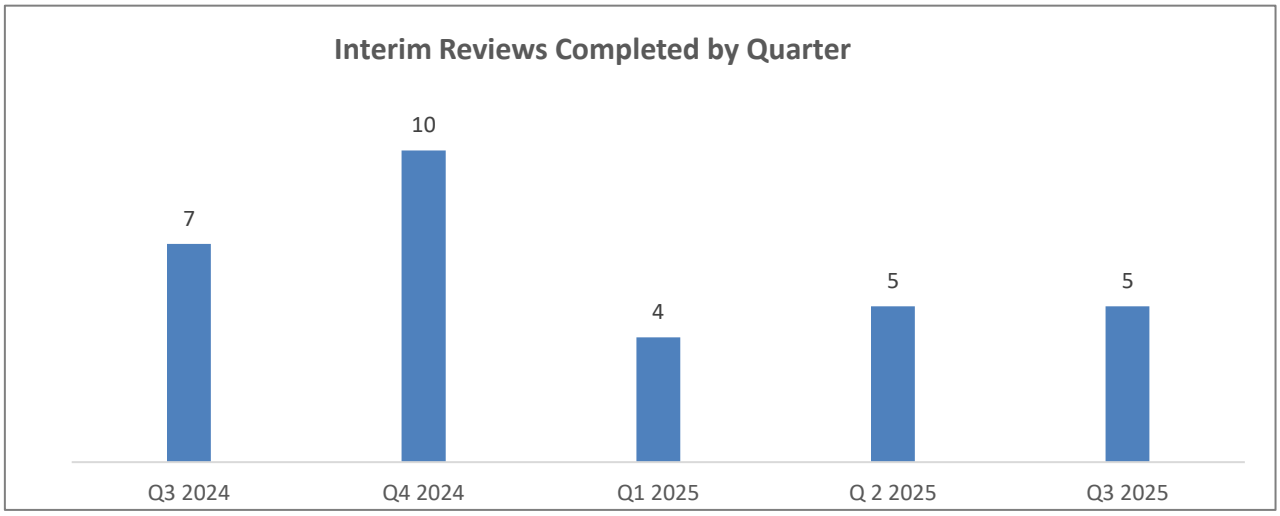
For Q3 2025, based on the medical record reviews, 129 IHA's were completed. 75 total pediatric charts and 54 adult charts. 66 out of the 75 pediatric charts were compliant and 9 were non-compliant. Out of all the 54 Adult charts, 45 adult charts were found to be compliant and 9 were non-compliant. Education was provided for the non-complaint charts.

Effective January 2023, an Initial Health Appointment replaced the Initial Health Assessment. Changes to the IHA no longer requires providers to utilize the age-appropriate Staying Healthy Assessment (SHA). An IHA must include all the following:

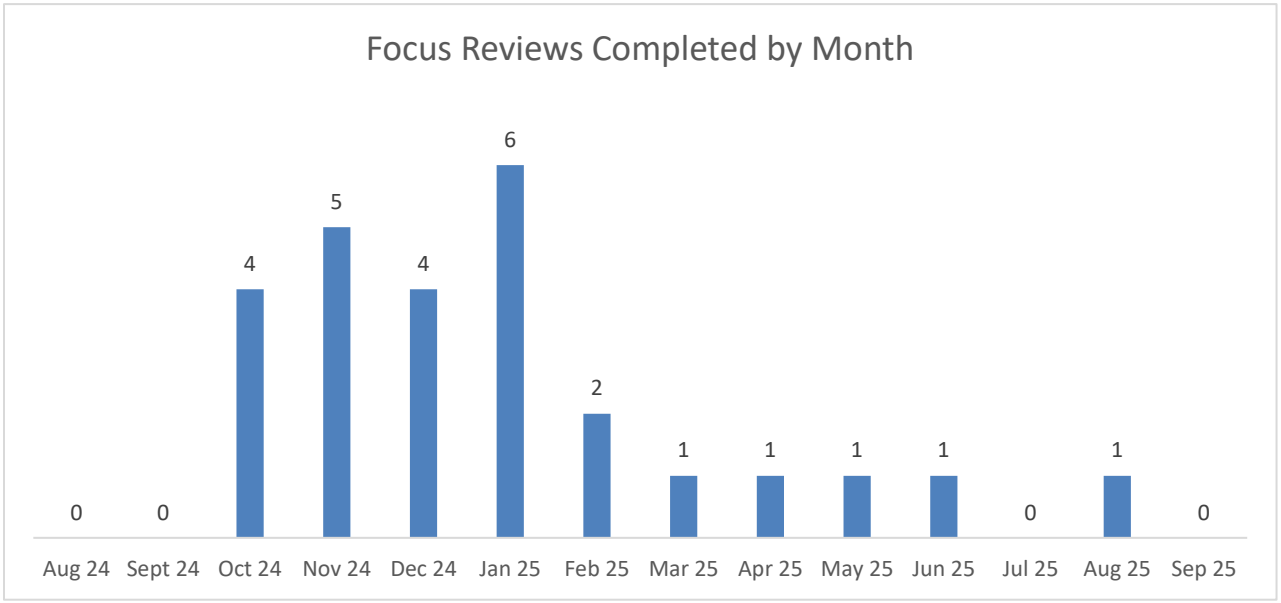
- A history of the Member's physical and mental health.
- An identification of risks.
- An assessment of the need for preventive screens or services.
- Health education; and
- The diagnosis and plan for treatment of any diseases.



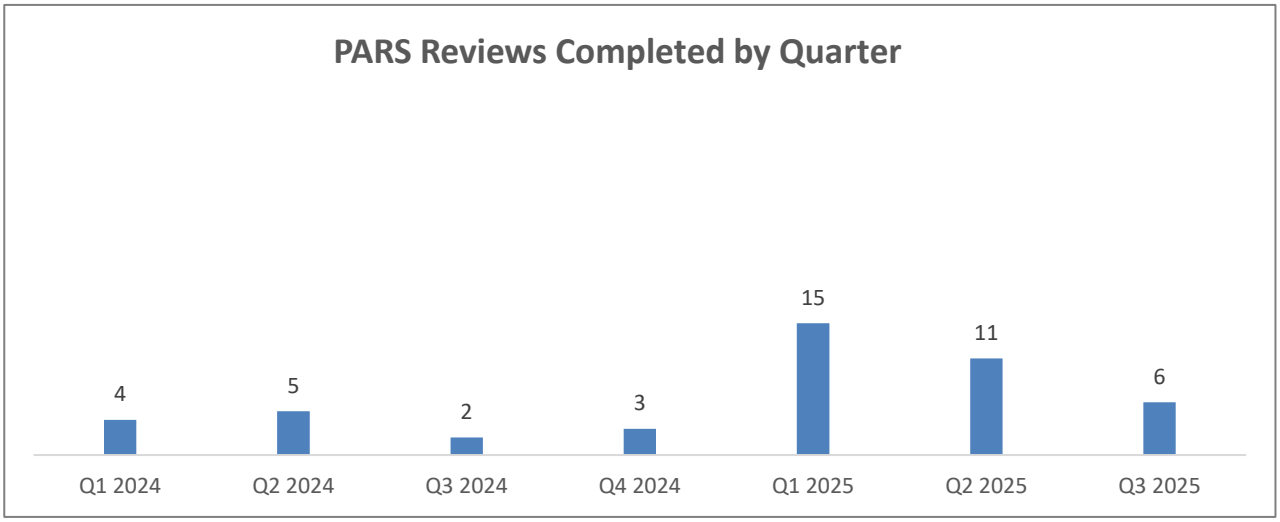
E. Interim Reviews: Interim Reviews are conducted between Initial and first Periodic Full Site Reviews or between two Periodic Full Site Reviews. Typically, they occur about every 18 months. These reviews are intended to be a check-in to ensure the provider is compliant with the 14 critical elements and as a follow-up for any areas found to be non-compliant in the previous Initial or Periodic Full Site Review. For Q3 2025, there were 5 Interim reviews completed to date.



F. Focus Reviews: Focused reviews are conducted when a site fails their review as a follow up to ensure elements are maintained. The focused review consists of FSR and MRR elements and is completed within 3-6 months of the failed review. For Q3 2025, we had 1 Focused MRRs completed. 19 Focused MRRs have been completed YTD.



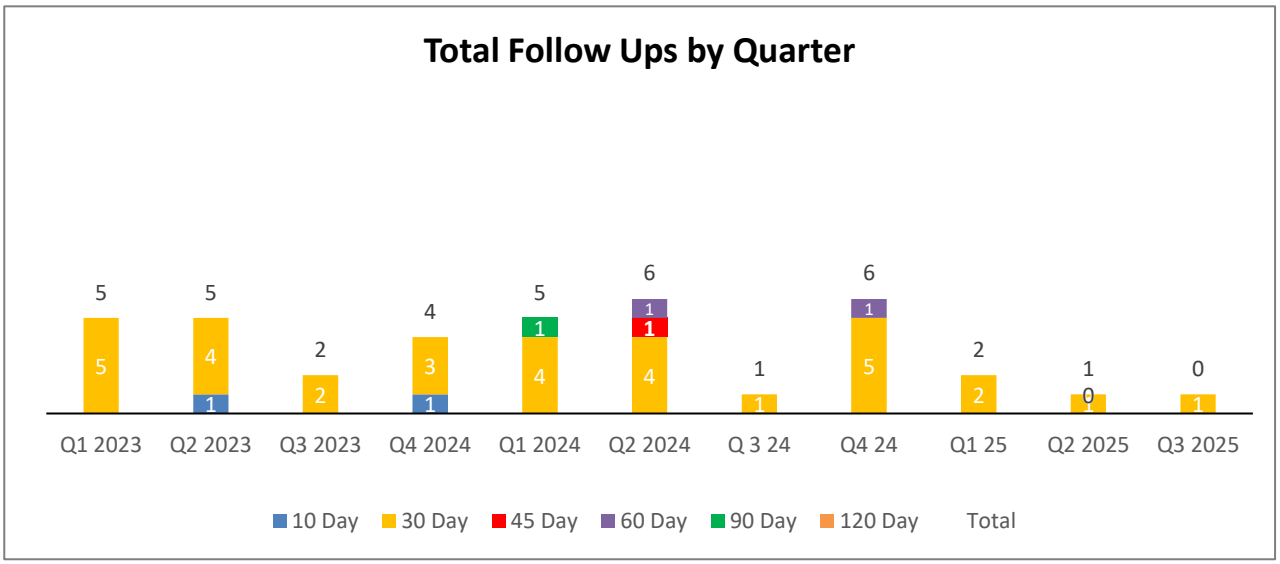
G. Physical Accessibility Review Survey (PARS):



PARS is completed alongside Initial Reviews, and the purpose is to review the accessibility of the site. PARS are completed every 3 years unless an Attestation is completed.

For Q3 2025, 6 PARS were completed.

H. Follow-up Reviews after a Corrective Action Plan (CAP):



The above chart reflects the total number of follow-ups completed for each quarter. For Q3 2025, there was 1 30-day follow-up completed.

II. Quality Improvement Projects:

A. Performance Improvement Projects (PIPs):

The Department of Health Care Services (DHCS) requires MCPs to annually report performance measurement results and conduct ongoing Performance Improvement Projects (PIPs) specific to measures that did not meet MPL.

Clinical PIP:

The new cycle of PIPs began in August 2023 through 2026. The clinical PIP will be focused on Health Equity, specific to the W30 0-15 months African American population.

The PIP team Attended two Maternal Health Disparities Webinars, participated in the maternal health disparities webinars, and met with PIP team leadership to plan next steps. We have worked on developing a process map and completed key drivers diagram.

All QI Tools completed, including Process Map. This was completed in collaboration with QP, Member Services, Member Outreach, and Marketing. Continued efforts on how to track data (member services outreach on W30, text reminders, mobile unit events). Work on the clinical PIP progresses, as we continue with intervention development and testing. These include weekend clinics with pilots' pediatric sites to close well visit gaps in care, and educational and supportive items, such as diaper bags for new parents and magnets to track well baby visits. The August 2025 submission was accepted with minimal feedback from HSAG.

Input and updates continue to be given for DHCS projects, while awaiting feedback from DHCS regarding the Accountability Project strategies and action items.

Non-Clinical PIP:

The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health teamt for support of interventions.

We have partnered with the Behavioral Health Department, UM, PHM, and various stakeholders. PIP work continues as we continue with 2025 efforts and development of additional initiatives. The August submission was accepted with minimal feedback by HSAG.

Ongoing meetings are scheduled to ensure success and to remain on track with deliverables. The PIP team is planning to meet with Kern Medical to discuss strategies for FUA/FUM measures.

B. MCAS Initiatives

The purpose of this report is to provide an update on interventions put into place to improve the compliance rates of the MCAS measures.

Interventions to improve our performance in MCAS:

- Provider Touchpoint Updates:
    - Meeting with top 20 providers per membership volume
    - The Big 3 providers and team meet every other month to review MCAS rates, improvements, focus targets and any barriers
    - Scheduled ad hoc provider groups to discuss rates, focus measures and questions.
        - Full set of resources given, including Provider Guide, Coding Card, 2024 MCAS measures list, Member Rewards, and Transportation Benefits.
        - Touching base with providers via email, via teams, and in-person meetings

- Met with IHI and DCHS collaboration team for a coaching call to refine and submitted Progress for the Children's Health Collaborative
- Opportunities to collaborate with Member Engagement for Health Fairs
- Opportunities to collaborate with community-based organizations continue and scheduling with mobile units around Kern County
- Dr. Duggal effort is continuing to improve patients' health that are dealing with Diabetes decreasing A1c's
- Adolescent Well Visit Smart Watch have completed the first launch and will continue through 2025 pending DHCS approval
- Incentive with postpartum mother to engage with W30 and establish care with provider at Kern Medical
- Kern Medical mobile unit was at the Kern Health Systems building providing well-visit for our summer interns, there was a successful turnout of 21 members
- Organized four Saturday clinics with two providers for children needing well child visits, who received POC gift card directly after their visit with a member engagement rep on sit
- Completed final review for Provider Guide and Coding Card for MY2025, with leadership approval and hand off to Marketing team for upload to the KHS external website
- The Member Services team supported calling applicable members that have a gap in care for W15-W30 to schedule their appointment with PCP, efforts of success were 20.83%.

- Member Engagement Reward Program (MERP):
    - IHA
    - BCS
    - CCS
    - CHL

  - GDS (HBD)
  - LSC
  - PPC Pre/ Post
  - W30
  - WCV
- Text Messages Campaign goes out to members encouraging them to schedule their appointments for gaps in care with a focus on:
  - Breast Cancer Screening
  - Blood Lead Screening
  - Initial Health Appointment
  - Chlamydia Screening
  - Cervical Cancer Screening
  - Prenatal & Postpartum Care
  - Well-Care Visits
  - Well-Baby Visits in first 30 Months of Life
- Robocalls will be sent out to members that do not receive text messages.

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

	Measure Acronym	Performance Measure	Measure Type (Methodology)	MY2024 Rate	MPL Rate	HPL Rate	MY2024 Rate vs. MPL	Hits Needed	MY2023 Rate	MY2024 vs MY2023
Chronic Disease Management Domain Measures										
1	AMR	Asthma Medication Ratio	Admin	75.02%	66.24%	76.65%	8.78%	0	71.66%	▲ 3.36%
2	CBP	Controlling High Blood Pressure	Admin, Hybrid	51.94%	64.48%	72.75%	-12.54%	3,664	48.39%	▲ 3.55%
3	GSD	Glycemic Status Assessment for Patients With Diabetes (>9%)[1]	Admin, Hybrid	58.50%	33.33%[2]	27.01%[2]	-25.17%	5,807	54.41%	4.09%
Cancer Prevention Domain Measures										
4	BCS-E	Breast Cancer Screening	ECDS	50.53%	52.68%	63.48%	-2.15%	712	58.61%	▼ -8.08%
5	CCS	Cervical Cancer Screening	Admin, Hybrid	53.44%	57.18%	67.46%	-3.67%	2,285	51.71%	
Children's Health Domains Measures										
6	TFL-CH	Topical Fluoride for Children	Admin	35.87%	19.00%	N/A	16.87%	0	39.53%	▲ -3.66%
7	W30–6+	Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	Admin	46.04%	60.38%	69.67%	-14.34%	604	52.20%	▲ 6.16%
8	W30–2+	Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits	Admin	68.30%	69.43%	79.94%	-1.13%	81	65.87%	▲ 2.43%
9	DEV	Developmental Screening in the First Three Years of Life	Admin	24.71%	34.70%	N/A	-10.99%	1,435	20.93%	▲ 3.78%
10	WCV	Child and Adolescent Well-Care Visits	Admin	34.07%	51.81%	64.74%	-14.00%	20,550	49.77%	▼ -15.70%
11	CIS–10	Childhood Immunization Status—Combination 10	Admin, Hybrid	18.26%	27.49%	42.34%	-9.23%	596	19.45%	▼ -1.19%
12	IMA–2	Immunizations for Adolescents—Combination 2	Admin, Hybrid	35.40%	34.30%	48.66%	1.10%	0	34.25%	▲ 1.15%
13	LSC	Lead Screening in Children	Admin, Hybrid	74.58%	63.84%	79.51%	10.74%	0	69.11%	▲ 5.47%
Behavioral Health Domain Measures										
14	FUM	Follow-Up After Emergency Department Visit for Mental Illness (30-Day Follow-Up)	Admin	53.82%	53.82%	73.12%	-12.35%	129	34.75%	▲ 19.07%
15	FUA	Follow-Up After Emergency Department Visit for Substance Use (30-Day Follow-Up)	Admin	23.83%	36.18%	49.40%	-20.38%	246	22.84%	▲ 0.99%
Reproductive Health Domain Measures										
16	CHL	Chlamydia Screening in Women	Admin	48.83%	55.95%	69.07%	-7.12%	846	57.05%	▼ -8.22%
17	PPC–Post	Prenatal and Postpartum Care—Postpartum Care	Admin, Hybrid	67.99%	80.23%	86.62%	-12.24%	667	74.66%	▼ -6.67%
18	PPC–Pre	Prenatal and Postpartum Care—Timeliness of Prenatal Care	Admin, Hybrid	66.45%	84.55%	91.85%	-18.10%	988	49.27%	▲ 17.18%

[1] A lower rate indicates better performance for this measure.
* Measures must be startified by race/ ethinicity per NCQA categorizations
**Hybrid/Admi: MCPs/PSPs have the option to choose the methodology for reporting applicable measures reates

Measure Met MPL
Measure Met HPL
▲ Measure increased compared to last year same time
▼ Measure decreased compared to last year same time

The chart below displays trending rates for MY2024 and MY2025:

MCAS MY2024 & MY2025 Performance Trending Metrics

Measure	Year	Jan	Feb	Mar	Apr	May	Jun	Jul		Aug	Sep	Oct	Nov	Dec
AMR	2024	70.00%	77.96%	75.70%	74.17%	75.00%	76.02%	74.53%	▼	73.80%	73.41%	73.16.%	72.32%	71.66%
	2025	52.94%	79.80%	78.56%	75.48%	74.80%	75.87%	75.82%	▲	75.42%				
BCS	2024	44.23%	45.63%	47.44%	48.73%	50.08%	51.42%	52.66%	▲	54.29%	55.56%	56.51%	57.69%	58.61%
	2025	42.71%	43.76%	46.66%	48.52%	49.89%	47.39%	48.54%	▼	49.41%				
CBP	2024	9.26%	18.53%	25.05%	29.78%	33.20%	39.86%	43.20%	▼	44.26%	45.40%	46.51%	47.43%	48.39%
	2025	10.99%	22.57%	32.06%	38.27%	42.30%	45.56%	48.48%	▲	49.73%				
CCS	2024	37.99%	36.76%	38.23%	39.55%	40.91%	42.09%	46.05%	▼	47.50%	48.49%	49.70%	50.69%	51.71%
	2025	45.81%	46.30%	47.70%	48.96%	50.43%	500.80%	51.80%	▲	52.50%				
CDEV	2024	6.26%	9.18%	11.86%	13.90%	15.79%	17.40%	18.80%	▼	19.66%	20.27%	20.64%	20.84%	20.93%
	2025	7.42%	10.97%	14.21%	17.12%	20.09%	21.79%	23.36%	▲	23.89%				
CHL	2024	22.15%	33.05%	35.23%	37.90%	39.96%	45.63%	48.75%	▲	51.25%	52.92%	54.37%	55.75%	57.05%
	2025	25.79%	34.17%	38.95%	43.18%	46.56%	45.43%	46.65%	▼	47.56%				
CIS-10	2024	10.01%	11.62%	12.17%	12.53%	12.42%	13.04%	13.14%	▲	18.61%	18.77%	19.03%	19.33%	19.45%
	2025	10.16%	12.47%	13.82%	14.27%	15.05%	17.93%	18.05%	▼	18.13%				
FUA 30Day follow up	2024	20.00%	16.11%	20.27%	19.10%	18.59%	20.93%	22.50%	▲	23.91%	22.91%	23.16%	23.13%	23.34%
	2025	16.25%	16.43%	19.51%	21.14%	21.36%	21.65%	23.75%	▼	23.13%				
FUM 30Day follow up	2024	9.09%	25.00%	21.88%	17.86%	15.91%	19.74%	20.82%	▼	20.25%	19.50%	20.53%	21.45%	20.72%
	2025	9.80%	13.91%	17.83%	17.03%	17.26%	30.56%	32.83%	▲	32.59%				
GSD*	2024	98.79%	92.48%	85.96%	80.56%	75.65%	71.23%	67.63%	▲	66.71%	62.92%	61.58%	59.61%	54.41%
	2025	96.31%	88.14%	74.38%	67.74%	64.57%	61.03%	59.85%	▼	59.64%				
IMA-2	2024	20.41%	21.78%	23.08%	24.49%	25.82%	27.71%	29.52%	▼	32.00%	32.88%	33.54%	34.06%	34.25%
	2025	23.52%	25.63%	27.62%	28.83%	30.65%	32.07%	33.33%	▲	34.26%				
LSC	2024	54.60%	57.84%	60.05%	62.04%	63.05%	64.95%	66.60%	▼	67.25%	67.90%	68.60%	68.96%	69.11%
	2025	64.57%	67.38%	69.66%	71.31%	72.55%	73.44%	73.99%	▲	74.25%				
PPC-Pre	2024	25.10%	26.84%	28.68%	30.70%	33.22%	37.55%	43.83%	▼	46.35%	48.18%	49.63%	49.44%	49.27%
	2025	27.34%	30.00%	60.25%	61.72%	63.46%	64.71%	65.78%	▲	66.38%				
PPC-Post	2024	47.47%	52.40%	57.47%	59.72%	61.74%	63.15%	67.75%	▼	64.29%	64.65%	71.15%	74.06%	74.66%
	2025	53.97%	59.25%	60.25%	64.83%	65.32%	65.48%	66.72%	▲	66.69%				
TFL-CH	2024	14.64%	17.16%	20.65%	23.68%	26.00%	29.18%	31.71%	▼	33.47%	35.76%	37.77%	9.36%	39.53%
	2025	16.98%	16.82%	23.76%	23.94%	26.90%	29.40%	33.94%	▲	34.06%				
W30 (0-15M)	2024	24.72%	29.30%	34.04%	37.92%	41.33%	44.51%	47.26%	▲	49.52%	51.70%	53.09%	53.62%	52.20%
	2025	21.56%	24.94%	28.57%	31.99%	35.59%	38.29%	41.26%	▼	44.45%				
W30 (15-30M)	2024	51.49%	54.30%	56.86%	59.32%	61.71%	63.56%	64.36%	▼	65.26%	66.12%	66.53%	66.71%	65.87%
	2025	53.86%	57.50%	60.60%	63.10%	65.28%	66.60%	67.69%	▲	67.98%				
WCV	2024	2.80%	6.13%	10.59%	15.01%	19.77%	24.31%	29.14%	▲	34.53%	38.73%	43.19%	46.72%	49.77%
	2025	2.75%	6.25%	10.67%	15.71%	20.67%	25.71%	27.55%	▼	29.76%				

GSD is an inverse measure, where a lower rate indicates better performance.*
Please note the above rates are based on admin and supplemental data, they do not include medical record review.

- Green arrow indicates an increase compared to previous year.
- Red arrow indicates a decrease compared to previous year.

As of September 2025, **13 out of 18 measures showed improvement** compared to this month last year:

- AMR - Asthma Medication Ratio
- CBP- Controlling High Blood Pressure <140/90 mm Hg.
- CCS - Cervical Cancer Screening
- CDEV- Developmental Screening in the First 3 Years of Life
- FUM- Follow-Up After Emergency Department Visit for Mental Illness
- GSD- Glycemic Status Assessment for Patients with Diabetes
- IMA-2- Immunizations for Adolescents – Combo 2 (Meningococcal, Tdap, HPV)
- LSC- Lead Screening in Children
- PPV- Pre- Prenatal & Postpartum Care –Prenatal Care
- PPC-Post- Prenatal & Postpartum Care – Postpartum Care
- TFL-CH- Topical Fluoride for Children
- W30 (15-30M)- Well Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

5 Measure that have not shown improvement compared to this month last year:

- BCS- Breast Cancer Screening
- CHL- Chlamydia Screening in Women Ages 16 – 24
- CIS-10- Childhood Immunization Status- Combo 10
- FUA- Follow-Up After Emergency Department Visit for Substance Abuse
- W30- (0-15M)- Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.
- WCV- Child and Adolescent Well-Care Visits

Please note we identified a significant decrease in W30 (0-15 months) rate for this year, BI is looking at the issue.

IV. Policy Updates: There were no policy updates in Q3 2025.

Quality Improvement Department

The purpose of this report is to provide a quarterly summary of the activities and outcomes for the QI department. It provides a window into Quality-of-Care Grievances and Potential Quality of Care Issues and serves as an opportunity for programmatic discussion and input from the EQIHEC Committee members. Areas covered in the report include:

Contents

1. Grievances and Quality-of-Care (QOC) Classifications
2. Potential Quality Issue (PQI) Notifications
3. Appeals
4. Claims & Disputes
5. IHA Audit
6. LSC Audit
7. Grievance Classification Audit
8. Readmissions
9. Telehealth

Quality Improvement Department

What Does QI do?

- **Quality Program Infrastructure:** Maintain the Quality Program Description, Annual Workplan, and Annual Evaluation of KHS quality activities, including reporting through EQIHEC.
- **Member Safety:** Review potential Quality of Care concerns, Potential Quality Issues (PQIs), and Potentially Preventable Conditions (PPCs).
- **Member/Provider Appeals:** Conduct clinical reviews for medical necessity using additional clinical information.
- **NCQA Accreditation Activities:** Ensure alignment with NCQA standards, supports accreditation readiness, and sustains continuous compliance.
- **Clinical Network Oversight:** Audit the provider network for compliance with DHCS APLs, best practices, and evidence-based standards of care..
- **Delegate Audits:** Perform audits of delegated entities to confirm adherence to KHS policies, procedures, and quality requirements.

Quality Improvement Department

Grievances identified as potential QOC are referred to the Quality Improvement Department for further classification. The QI RNs classify grievances received as Potential QOC for further review, or send back to Grievance coordinators as non-PQOC. Grievances classified as Potential QOC are reviewed and can be closed in favor of the member and referred to the QI Department for further investigation as a Potential Quality Issue (PQI). Potential QOC grievances resolved in favor of the provider are not referred to QI, as this resolution means there was no QOC concern identified to warrant further investigation.

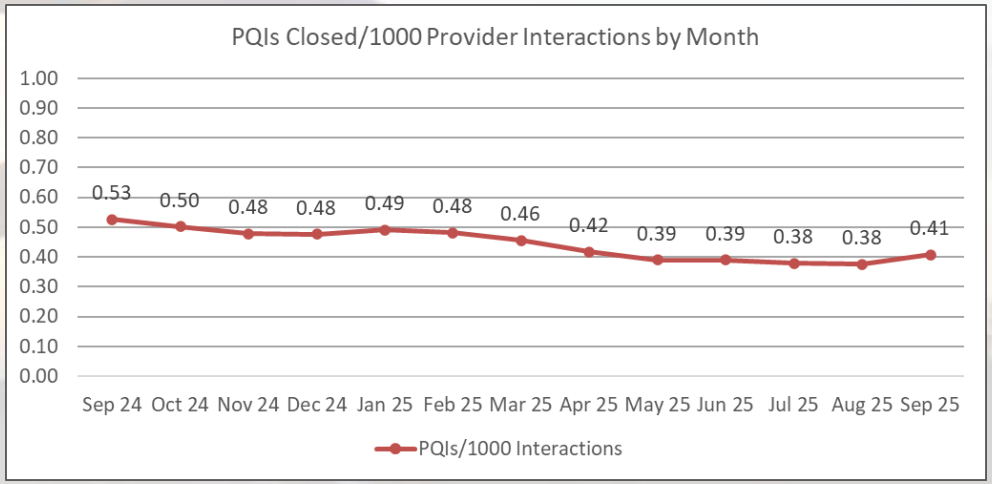
Quarter	Total Grievances Received for PQOC	Grievances Classified as PQOCs	Grievances Classified as Non-PQOCs	Total Grievances Closed
Q3 2024	1007	598	409	2755
Q4 2024	924	505	419	2355
Q1 2025	659	444	215	3006
Q2 2025	968	644	324	1719
Q3 2025	1182	799	383	1142

Quality Improvement Department

Potential Quality Issues (PQI): QI receives notifications from various sources to review for PQI notifications. On receipt of a PQI notification, a QI RN completes a high-level review to determine what level of Potential Quality Issue exists. PQIs are assigned a level based on the outcome of the review.

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

Severity Level	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025
Level 0 - No Quality Concern	129	85	18	74	73	67	66
Level 1 - Potential for Harm	108	75	95	94	71	48	93
Level 2 - Actual Harm	0	2	0	2	0	0	1
Level 3 - Actual Morbidity	0	0	0	0	0	0	0
Total	237	162	113	170	144	115	115



Quality Improvement Department

Appeals

- Grievance team receives an appeal for denied or modified adverse determination on prior authorizations. Clinical team reviews for medical necessity and sent to Medical Director (MD) for final determination and resolution.

Month	Appeals Completed	Appeals Upheld	Appeals Overturned	% Overturned
Jan 25	59	39	20	34%
Feb 25	71	41	30	42%
Mar 25	59	44	15	25%
Apr 25	42	33	9	21%
May 25	51	43	8	16%
Jun 25	37	27	10	27%
Jul 25	67	52	15	22%
Aug 25	81	71	10	12%
Sep 25	112	101	11	10%

Month	Average TAT (days)	Completed Over 30 (TAT) days
Jan 25	20	3
Feb 25	20	8
Mar 25	17	0
Apr 25	13	0
May 25	13	1
Jun 25	10	0
Jul 25	11	0
Aug 25	7	1
Sep 25	7	0

Safety Monitoring Activities

1. Readmission
2. Asthma
3. Telehealth
4. Blood Lead Screening
5. Initial Health Appointment

Readmission

Objective: verify if true readmission and determine if quality of care issues are involved.

Methodology	**Findings**	**Interventions**
Medical Record review of 10 files during the 1st quarter	a) 6 cases readmitted within 7 days, 4 readmitted within 14 days b) 6 /10 cases had no home health assessment c) No evidence that d/c summaries were received by members' PCPs d) 7 /10 cases had hx of drug abuse, alcoholism, psych disorder, no mental health follow-up.	Meeting with PHM Director in Qtr 2 (April 2025) to discuss findings, opportunities for improvement Collaborate with Behavioral Health Dept
PQI	None identified	

Readmission

2nd Quarter: No file reviews conducted.

The process was changed. The JIVA platform did not evidence sufficient documentation regarding post-hospitalization care and associated patient outcomes.

New process:

COSA Analytics team will generate admission / readmission reports that will capture audit elements such as referrals to case management, transition of care, PCP notification and follow-up care and outreach.

Identification of PQIs:

Of the 50 charts reviewed in Qtr 1, 43 were level zero, one level 1, and 6 exclusions.

Asthma

Objective: Provide members with education about asthma and promote self-management and self-monitoring skills and control.

Methodology	**Findings**	**Interventions**
1. Claims review by Wellness and Prevention team	No results for clinical outcomes	Conducted focused audit about admission/readmission , co-morbidities, referrals to PHM, CM
2. Focused medical record audits of 20 charts	Urgent Care/ER admissions = 25% Referrals to PHM/CM = 30% Co-morbidities = 35%	Analyze the data generated by COSA Analytics team
3. Analysis of COSA generated reports.	1. Inpatient data included non-acute care admissions. 2. Hospital, ER and urgent care encounters revealed decreased trends in qtr 2 compared to qtr 1.	COSA team to generate new sets of data using specific codes.

Telehealth

Objective: To educate the practitioners regarding the requirements of DHCS and the policy of Kern Health System.

Methodology	**Findings**	**Intervention**
Chart reviews by Clinical Network Oversight team	Providers lacked full knowledge of the telehealth requirements	Information about the requirements on telehealth were disseminated to the providers, along sample consent form.

Initial Health Appointment (IHA)

Objective: To ensure all new members have IHA administered within 120 days of enrollment.

Methodology	**Findings**	**Intervention**
Medical record review including hx of member's physical and mental health, identification of risks, assessment of need for preventive services, health education / counseling, and documentation of diagnosis and plan of care	Qtr 1 = 34 of the 44 (77%) provider regions met the score of 90% and above Qtr 2 = 34 of the 45 (76%) provider regions met the 90% score or above	Provider bulletin

Blood Lead Screening

Objective: Ensure blood lead screening is administered to children ages 12 and 24 months

Methodology	**Findings**	**Intervention**
Medical reviews of at least 5 charts in each provider region	Qtr 1 = Of the 21 provider regions audited, only 1 met the 90% threshold Qtr 2 = Out of the 10 audited, only one region met the 90% goal.	1. Provider Bulletin 2. Collaborate with Provider Network , Wellness and Prevention, and Quality Performance teams in sending educational materials and information to provider groups. 3. Continue to track and trend audit results

Cultural & Linguistic Services Quarterly Audit Findings

Q3 2025

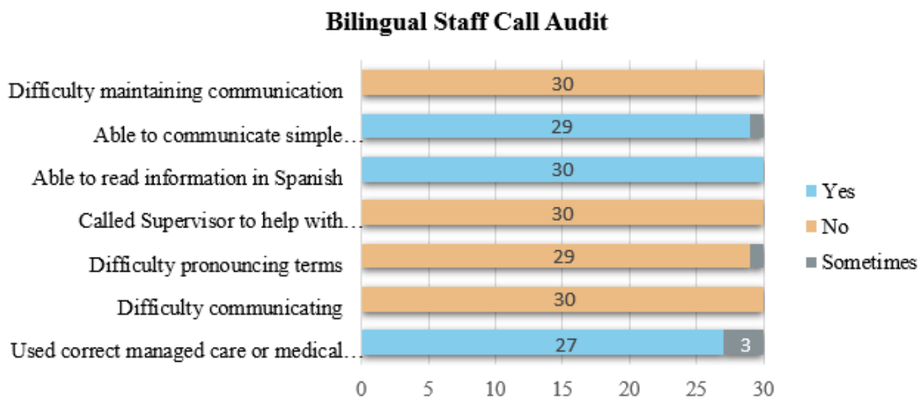
KERN HEALTH SYSTEMS

C&L Services Audit

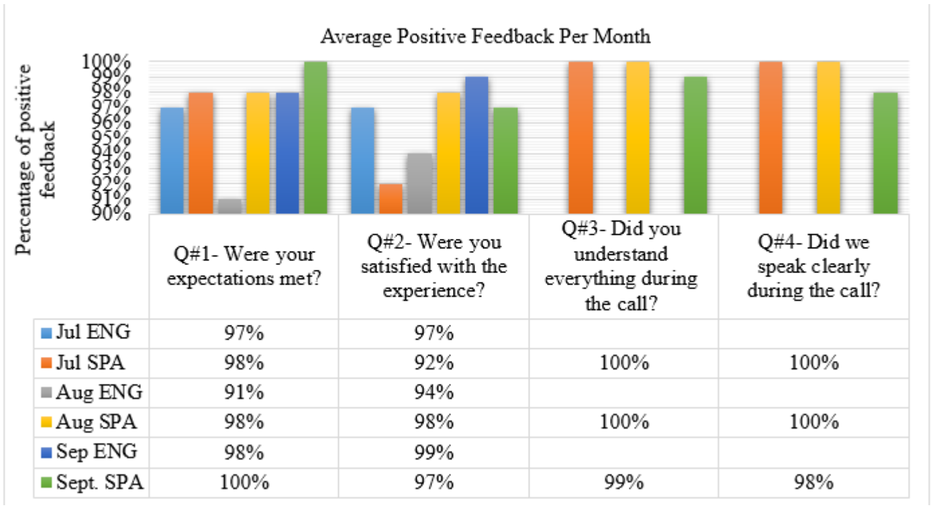
- Bilingual Staff Call Audit
- Post Call Surveys
- Vendor Bilingual Call Audits
- LLS OPI Interpreter Call Monitoring Audit
- Onsite Interpreting Member Satisfaction Survey
- Member Satisfaction for Over-the-phone (OPI) & Video Remote Interpreting (VRI)
- Translation Member Satisfaction Survey
- KHS Staff Satisfaction Survey for OPI services

Bilingual Call Audits

- **Bilingual Staff Call Audits**
  - 30 Spanish Calls Audited
  - 98% did not have difficulty communicating with members in a non-English language.



- **Post Call Surveys**
  - 10,680 Spanish Post Call Surveys
  - 93% of members are satisfied with the linguistic performance of bilingual staff.

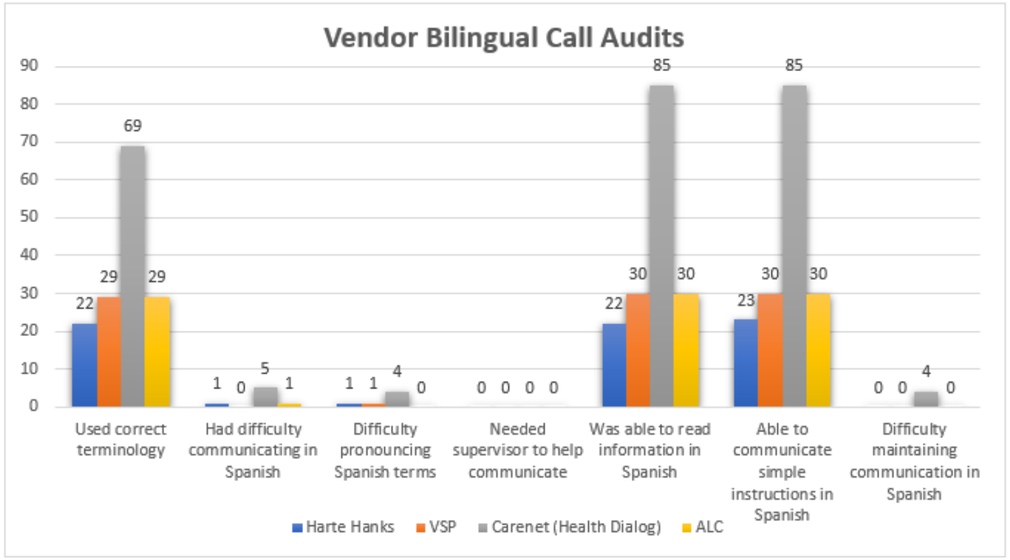


	Q#1- Were your expectations met?	Q#2- Were you satisfied with the experience?	Q#3- Did you understand everything during the call?	Q#4- Did we speak clearly during the call?
Jul ENG	97%	97%		
Jul SPA	98%	92%	100%	100%
Aug ENG	91%	94%		
Aug SPA	98%	98%	100%	100%
Sep ENG	98%	99%		
Sept. SPA	100%	97%	99%	98%

Vendor Bilingual Call Audits

149 Spanish Audio Call Audits

- American Logistics (ALC)
- Vision Services Provider (VSP)
- Harte Hanks
- Carenet



- *93% of Bilingual staff did not have difficulty communicating with members in a non-English language*

LLS Interpreter Call Monitoring Audit

- 30 OPI Interpreter Service Calls
  - *Hindi*
  - *Punjabi*
  - *Spanish*
  - *Vietnamese*
  - *Romanian*
  - *Farsi*
  - *Arabic*
  - *Mixteco*
  - *Farsi*
  - *Laotian*
  - *Korean*
  - *Ilocano*
- 100% of Audited calls “Met Expectations”

Call Number	Interpreter ID	Language	Medical Interpreter Skills Assessment Date	Medical Interpreter Skills Assessment Result	QA Observation Date	QA Observation Score
CR-0560189876	406999	SPANISH	1/23/2023	Pass	7/24/2025	3/3
CR-0560204587	391351	SPANISH	5/25/2022	Pass	7/3/2025	3/3
CR-0560194737	468350	SPANISH	2/10/2025	Pass	7/23/2025	3/3
CR-0560205626	461981	PUNJABI	12/4/2024	Pass	9/19/2025	3/3
CR-0560204566	442637	MIXTECO	9/20/2024	Pass	8/27/2025	3/3
CR-0560202300	474541	PUNJABI	5/27/2025	Pass	8/12/2025	3/3
CR-0560207513	453697	PUNJABI	9/23/2024	Pass	7/10/2025	3/3
CR-0560211583	401727	ARABIC	12/9/2022	Pass	7/11/2025	3/3
CR-0560209597	466921	SPANISH	1/31/2025	Pass	9/12/2025	3/3
CR-0560214062	413329	SPANISH	10/13/2023	Pass	8/15/2025	3/3
CR-0565594180	401035	FARSI	11/7/2022	Pass	9/17/2025	3/3
CR-0565638531	420159	ARABIC	8/5/2023	Pass	7/7/2025	3/3
CR-0566168408	201355	LAOTIAN	1/6/2014	Pass	9/3/2025	3/3
CR-0566802741	401263	VIETNAMESE	12/7/2022	Pass	8/5/2025	3/3
CR-0568280289	219639	KOREAN	2/1/2011	Pass	9/4/2025	3/3
CR-0568590588	10085	ILOCANO	3/2/2022	Pass	4/28/2022	Pass
CR-0571683827	476416	SPANISH	6/27/2025	Pass	7/8/2025	3/3
CR-0571702547	479677	SPANISH	8/8/2025	Pass	9/2/2025	3/3
CR-0571722249	478790	SPANISH	7/28/2025	Pass	9/12/2025	3/3
CR-0571719716	399654	SPANISH	11/11/2022	Pass	7/16/2025	3/3
CR-0573189776	434951	PUNJABI	4/25/2024	Pass	7/11/2025	3/3
CR-0573195939	371422	ROMANIAN	3/18/2021	Pass	7/22/2025	3/3
CR-0573207707	464233	SPANISH	12/23/2024	Pass	7/21/2025	3/3
CR-0573213614	478272	SPANISH	7/21/2025	Pass	9/26/2025	3/3
CR-0573227404	467545	HINDI	2/3/2025	Pass	8/6/2025	3/3
CR-0573262683	480629	SPANISH	8/25/2025	Pass	9/11/2025	3/3
CR-0573268129	447779	SPANISH	3/18/2025	Pass	8/6/2025	3/3
CR-0573271461	444704	SPANISH	5/31/2024	Pass	9/30/2025	3/3
CR-0573292180	376320	SPANISH	11/2/2021	Pass	8/26/2025	3/3
CR-0573312277	478862	SPANISH	7/29/2025	Pass	9/19/2025	3/2

CommGap Onsite Interpreter Survey

21 Onsite Interpreter Service Surveys Completed

1. Interpreter Arrived on Time
2. Interpreter was Professional
3. Interpreter was Polite & Respectful
4. Did you understand everything that the interpreter said before, during, and after your appointment?

Survey Outcome

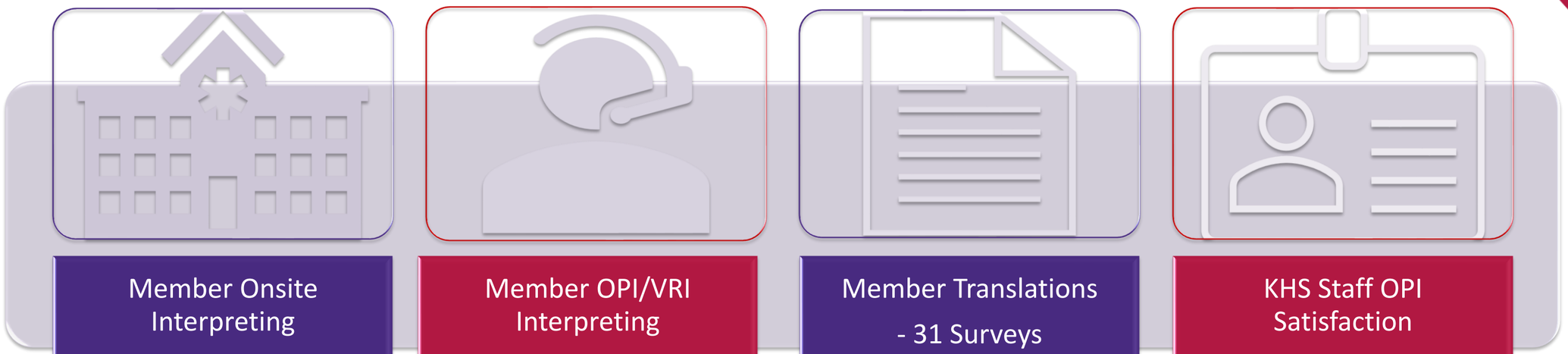
- 100% “Strongly Agree”

Positive Member Feedback:

- Excellent Overall Communication
- Level of interpreter knowledge
- Very professional

Category						Notes
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	
CommGap Interpreter arrived on time	0	21	0	0	0	
CommGap Interpreter was professional	0	21	0	0	p	
CommGap Interpreter was polite and respectful	0	21	0	0	0	
Did you understand everything that your Interpreter said before, during and after your appointment?	0	21	0	0		

Satisfaction Surveys



Member Onsite Interpreting

- 34 Surveys
- 100% reported “Strongly Agreed” Satisfaction

Member OPI/VRI Interpreting

- 30 Surveys
- -100% “Strongly Agreed” Satisfaction

Member Translations

- 31 Surveys
- 97% “Very Satisfied” Satisfaction

Finding: 5 MBRs Reported not receiving an NOA Translation

KHS Staff OPI Satisfaction

- 129 Surveys
- 98% “Strongly Agreed” Satisfaction

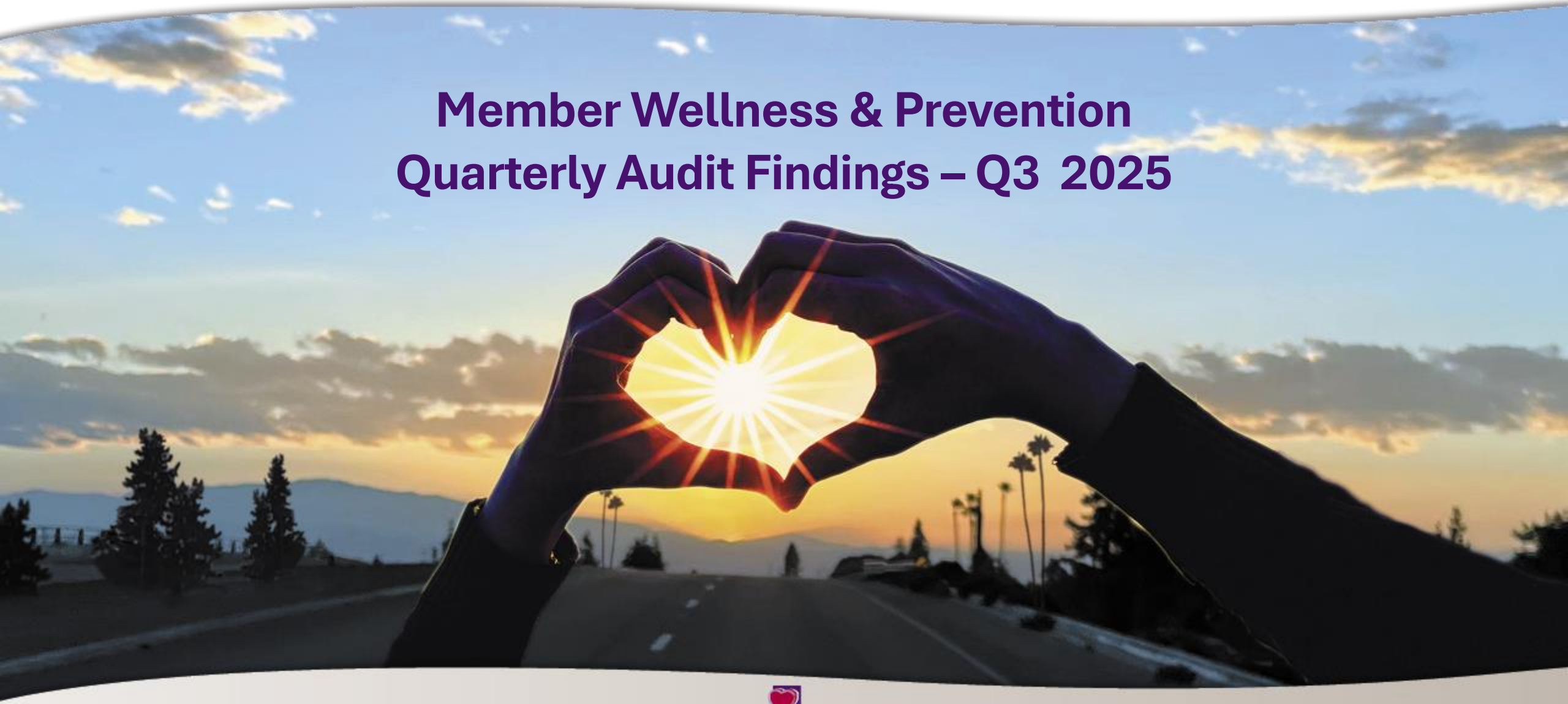
THANK YOU.!

Cynthia Cardona

Cultural & Linguistics Services Manager

KERN HEALTH SYSTEMS

Member Wellness & Prevention Quarterly Audit Findings – Q3 2025



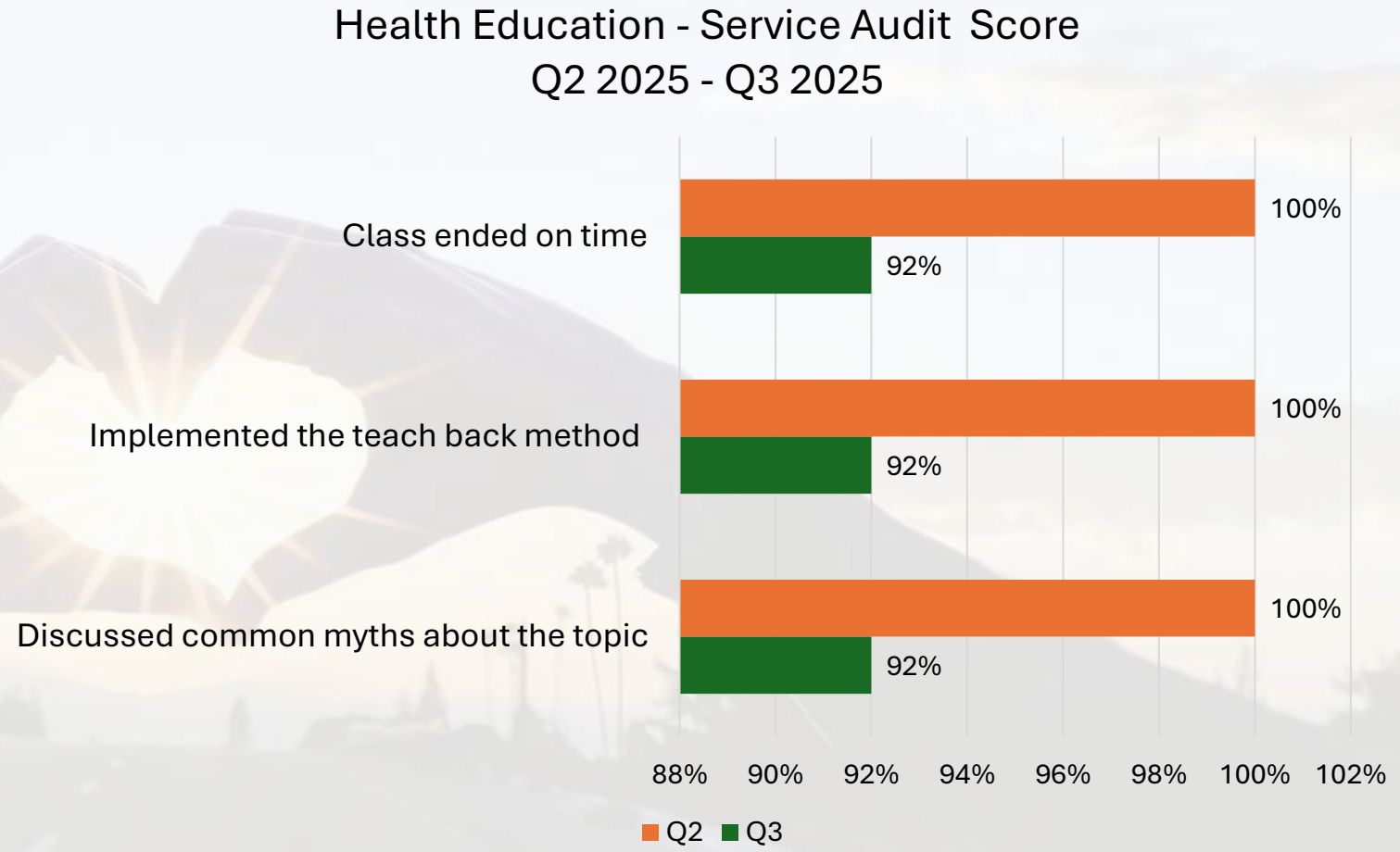
Health Education Services

- Service Audit
- Satisfaction Survey
- Class Effectiveness

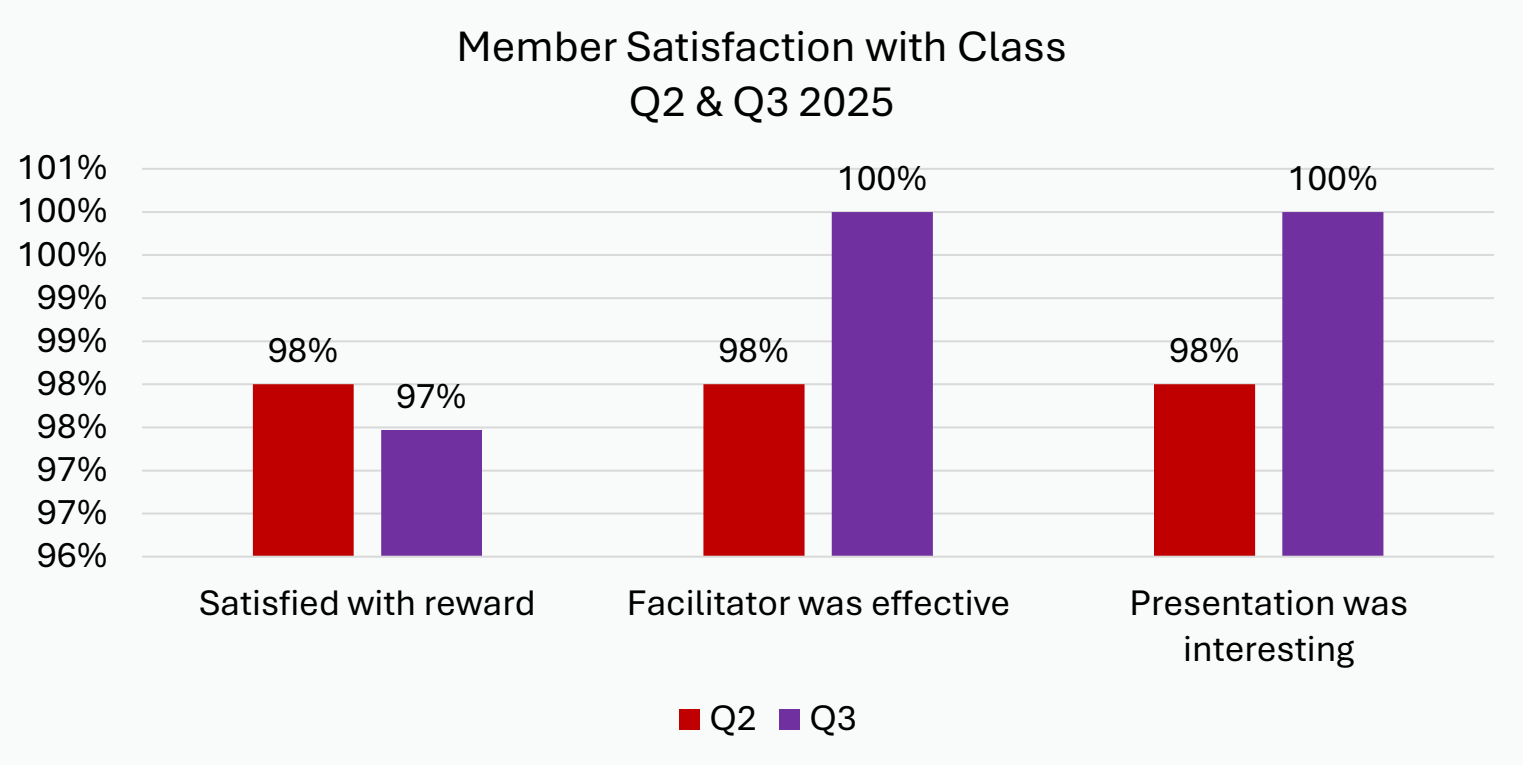
Service Audit

- Areas at 100%
  - Facilitator checklist/agenda
  - Participants signed in
  - Covered SMART goals
  - Providing examples for difficult concepts
  - Demonstrating activities
  - Completed all activities
  - Checked for participant questions
  - Engaged participants in various ways

- Areas below 80% - None



Satisfaction Survey



Satisfaction Survey

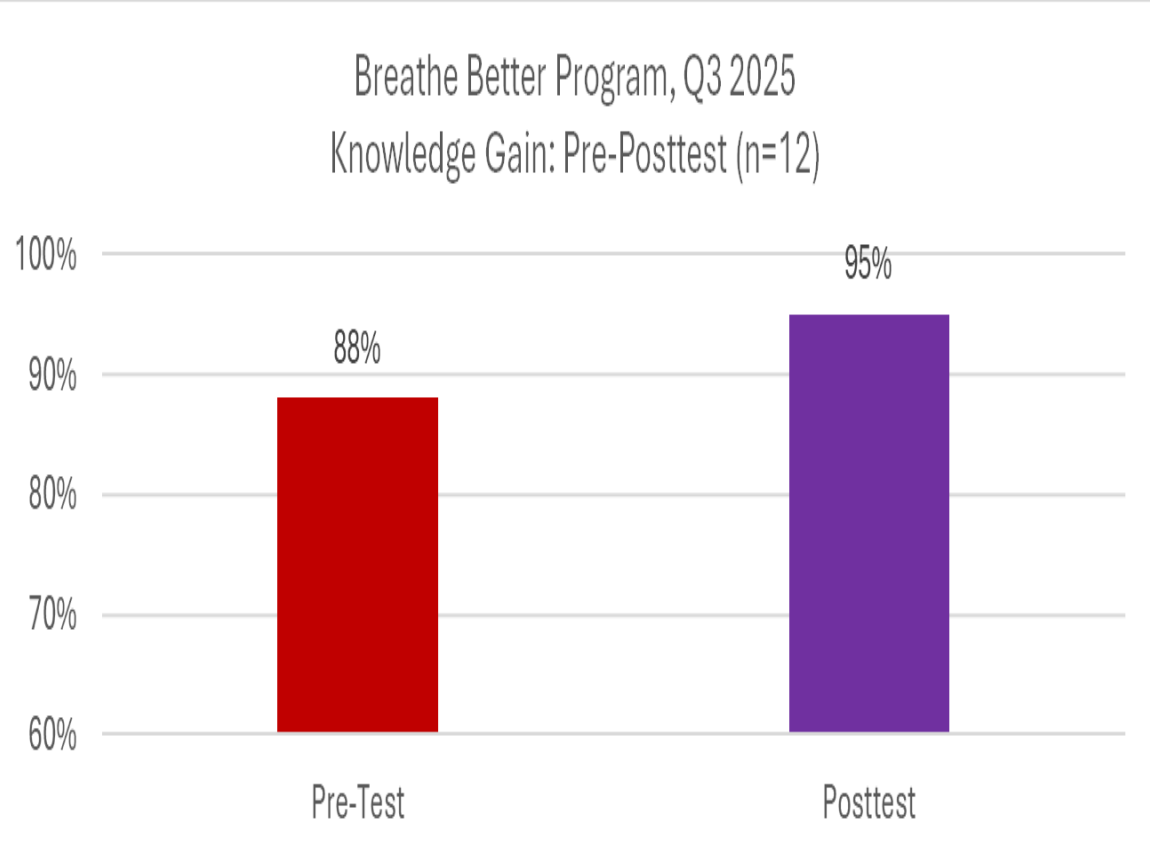
What did you like most about the class?

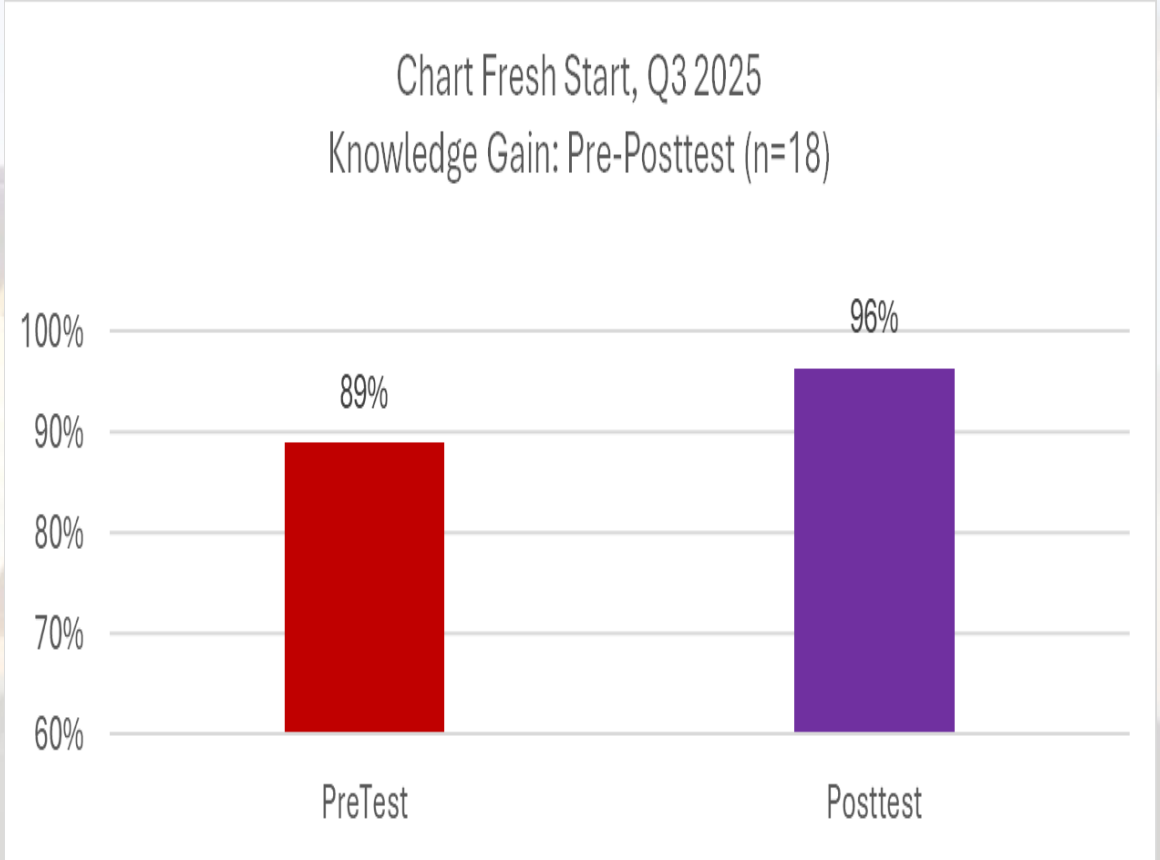
- Value the useful and informative nature of the material, especially regarding nutrition, healthy habits, and wellness.
- Appreciate the instructor's clarity, knowledge, and presentation style.
- Enjoy opportunities for participation, interaction, and discussion.
- Learn applicable knowledge for daily life—diet, physical activity, and grocery habits.
- Found the lessons relevant to their goals, motivating them toward healthier living.

How could we improve the class?

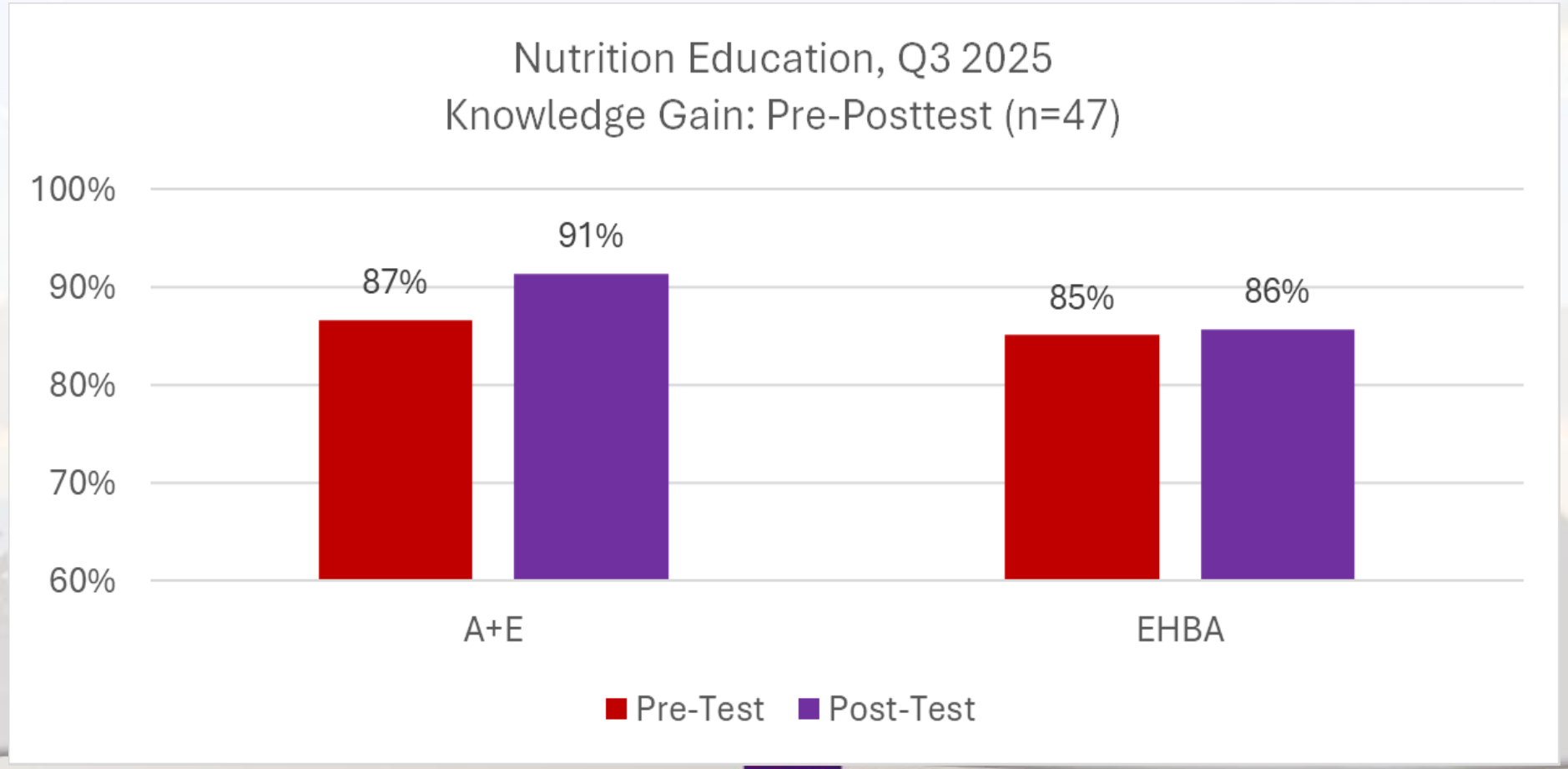
- Wanting additional health-related tips or reinforcement of concepts.
- Simplifying or ensuring clear communication for all participants.
- The desire to continue with more sessions or follow-ups.

Class Effectiveness





Class Effectiveness



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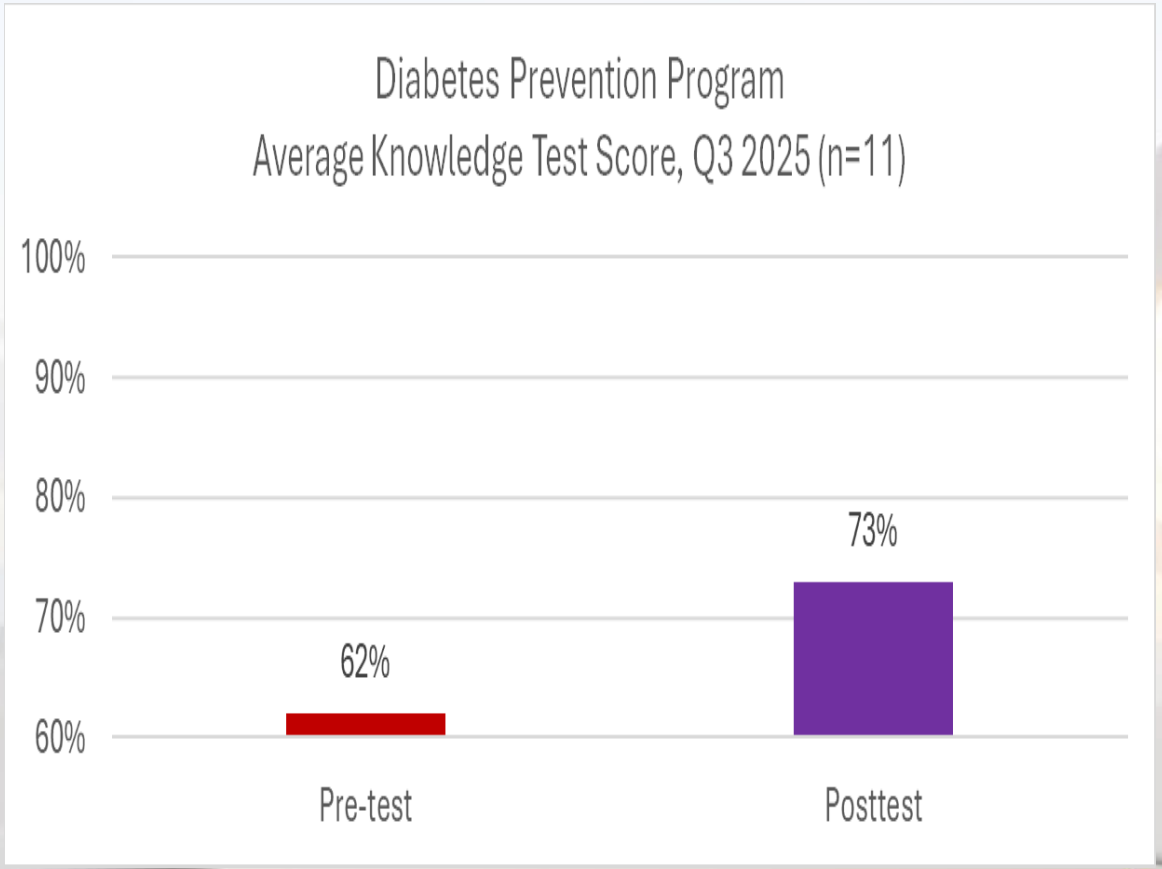
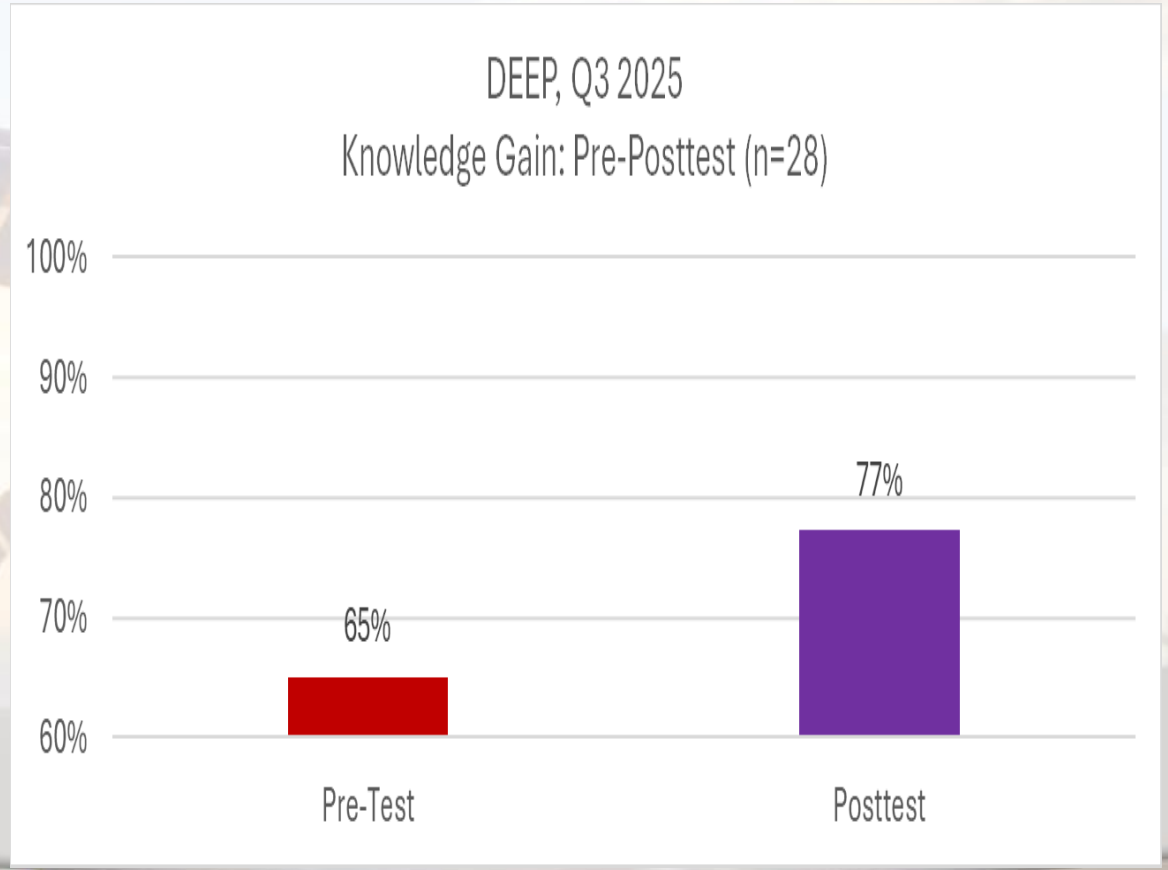
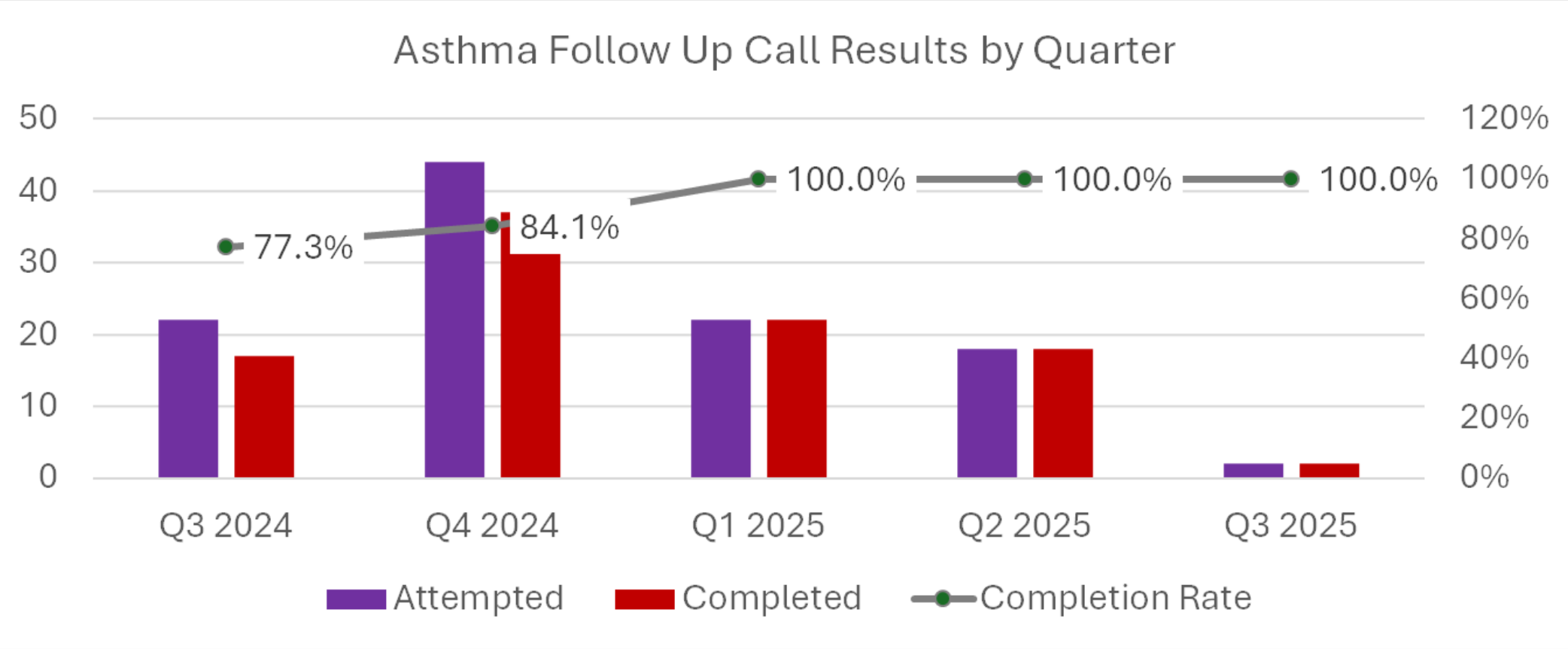
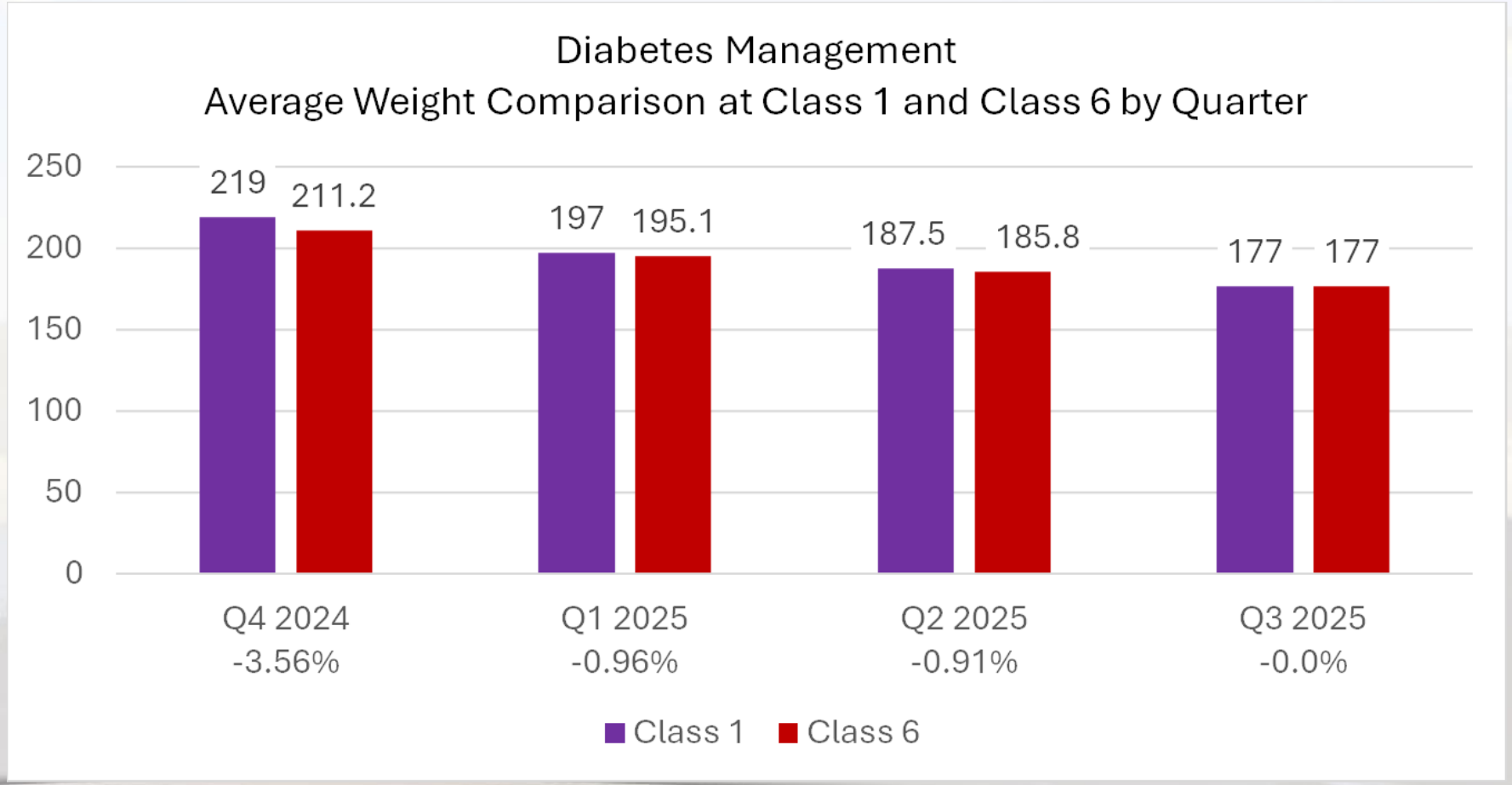




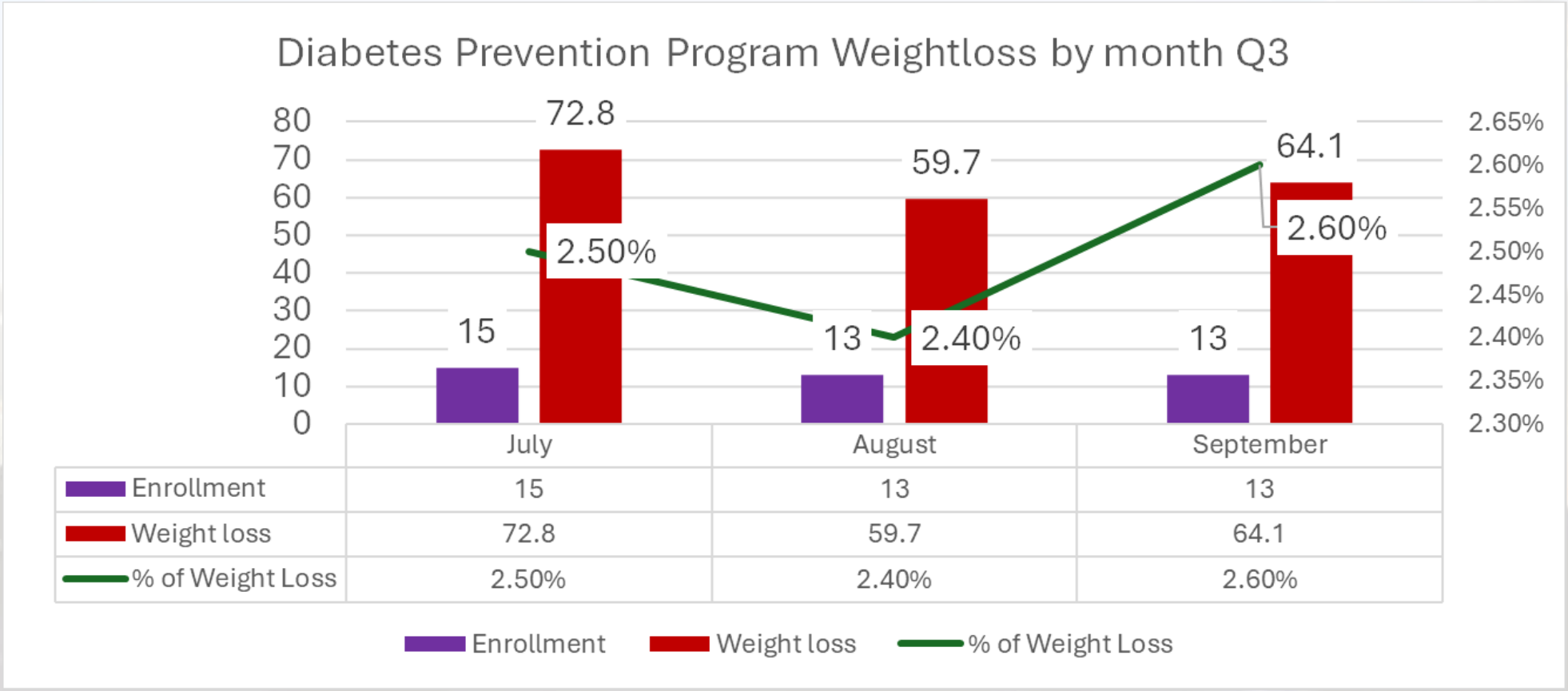
Class Effectiveness



Class Effectiveness



Class Effectiveness



You + Us = **a better day!**

Community Health Worker (CHW) & Asthma Preventive Services (APS) Audits

Tiffany Chatman
Manager of Wellness & Prevention Partnerships
Wellness and Prevention Department

Tiffany.Chatman@khs-net.com
11.20.25

CHW Audit Process

CHW Providers

- KHS Eligibility Log

W&PP Team

- Master CHW Spreadsheet
- Quantification Claims Report
- Select Claim Sample Size
  - 30 if > 2,000
  - 10 if < 2,000
- QNXT/JIVA
- Share CHW CAP (if needed)

TEMPLATE

Kern Family Health Care

KHFC Corrective Action Plan (CAP)

Provider Name:	
CAP Issued Date:	
Follow-up Review Date:	
MCP Representative Signature:	

Corrective Action Details

Findings	Violation of	MCP Recommendations

- MCP Follow-Up Notes:
- Provider Comments:

SAMPLE

Kern Family Health Care

KHFC Corrective Action Plan (CAP)

Provider Name:	
CAP Issued Date:	10/13/2025
Follow-up Review Date:	10/24/2025
MCP Representative Signature:	

Corrective Action Details

Findings (Sample size of 30 claims per month)	Code/Policy/APL	MCP Recommendations	Status
Feb – Aug 2025 eligibility logs had CHWs NOT credentialed by KHS to provide CHW services to KFHC members	Not aligned to APL 24-006 language on page 11: "MCPs must develop and submit P&Ps for how they will ensure that Providers and Subcontractors that serve as CHW Supervising Providers are certifying that their CHWs have the appropriate training, qualifications, and supervision."	(Provider Name) review CHW roster to ensure their credentialing status with KHS prior to rendering services to KFHC members. Only use credentialed CHWs to render CHW services to KFHC members.	
Eligibility logs for July 2025 and August 2025 had subcontractors NOT credentialed by KHS	See KHS CHW application. See Section 6.18 of KHS Provider Services Agreement to see subcontractor obligations.	KHS informed (Provider Name) of credentialed persons during June 2025 operations meeting.	
Eligibility Logs submitted prior to April 2025 have no provider recommendations listed	APL 24-006 on pages 5-6: "CHW services require a written recommendation submitted to the MCP by a physician or other licensed practitioner of the healing arts within their scope of practice under state law... the required recommendation can be provided by a written	Please provide member's record showing provider recommendation for services before April 2025.	

APS Audit Process

W&PP Team

- Run Quantification Claims Report
- Select KFHC member sample
- Add to APS audit tracker
- Request APS documentation from Provider

APS Providers

- SFTP transfer w/ member documentation

W&PP Team

- Complete APS Audit Tracker
- Share APS Audit Summary

APS Audit Summary Form

SAMPLE

	Audit Period:	Jan-Mar 2024 Q1 2024	April-June 2024 Q2 2024	July-Sept 2024 Q3 2024	Oct-Dec 2024 Q4 2024	Jan-Mar 2025 Q1 2025	April-June 2025 Q2 2025
APS Provider and Paid Claims Summary	Number of APS providers included in the audit:	7	6	5	4	N/A (not enou	6
	Percent of APS claims with a KHS credentialed APS provider:	42.86%	66.67%	68.8%	100%	N/A (not enou	100%
	Number of members included in the audit:	10	15	15	15	N/A (not enou	15
	Number of paid claims included in the audit:	13	16	16	15	N/A (not enou	15
	Number of paid claim services included in the audit:	18	27	25	28	N/A (not enou	15
	Percent of paid APS claims with an asthma diagnosis documented:	100%	100%	100%	100%	N/A (not enou	100%
	Percent of paid APS claims with an asthma diagnosis code in the audit documentation:						26.7%
	Percent of paid APS claims with documentation of poorly controlled asthma	85%	94%	100%	100%	N/A (not enou	100%
Asthma Education	Number of paid APS asthma education claims:	13	16	16	15	N/A (not enou	15
	Percent of paid APS asthma education claims with documentation that APS asthma education was recommended by a licensed health care provider	15.38%	50.00%	75.00%	93.33%	N/A (not enou	100%
	Number of members with more than 8 paid units or 2 paid visits of APS asthma education in the past 12 months:	0	1	3	2	N/A (not enou	0
	Number of members with more than 4 paid units of APS asthma education in one day in the past 12 months:	0	0	0	0	N/A (not enou	0
	For any members that exceeded a limit, was a referral or prior authorization request approved by KHS for all members?	N/A	No	No	No	N/A (not enou	N/A
	Percent of paid APS asthma education claims with a description of nature of service documented:	15.38%	37.50%	25.0%	100%	N/A (not enou	100%
Home Trigger Assessment	Number of paid APS home assessments:	5	11	9	13	N/A (not enou	14
	Percent of APS home assessments with documentation of poorly controlled asthma	100%	100%	100%	100%	N/A (not enou	100%
	Percent of APS home assessments with documentation that an in-home environmental trigger assessment was recommended by a health care provider	40.0%	72.73%	88.89%	92.31%	N/A (not enou	100%
	Number of members with more than 2 home assessments in the past 12 months:	0	0	0	0	N/A (not enou	0
	For any members that exceeded a limit, was a referral or prior authorization request approved by KHS for all members?	N/A	N/A	N/A	N/A	N/A (not enou	N/A
	Percent of APS home assessment claims with a description of nature of service documented:	20.0%	54.5%	44.4%	100%	N/A (not enou	100%

	90-100% compliance.
	70-89% compliance. Improvement is needed.
	50-69% compliance. Improvement is needed.
	0-49% compliance. Improvement is needed.
	Information or documentation is needed to determine outcome.

APS Evaluation*

- APS Provider & Paid Claims Summary Metrics
- Asthma Education Questions
- Home Trigger Assessment Questions
- Auditor's Recommended Areas of Improvement/Changes

CHW Evaluation*

- Credentialed CHWs rendering services
- Services not exceeding unit limit w/o TAR
- Billing Discrepancies
- Reasonable justification for CHW services rendered
- Auditor's Recommendations

*MUST Adhere to APL 24-006 & Provider Manuals

Enhanced Care Management Quarter III 2025 QIW Report

Background:

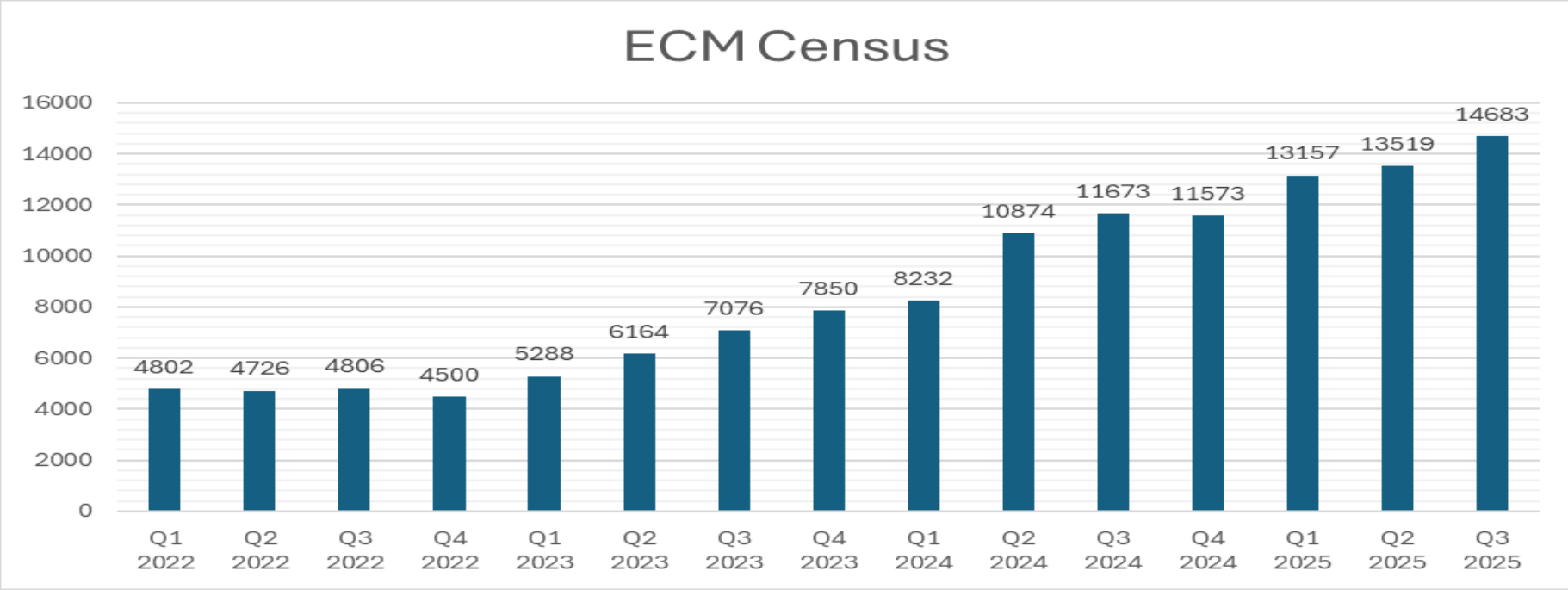
Enhanced Care Management (ECM) is a whole-person, team-based approach to care that looks at both medical and non-medical needs. It is designed for Medi-Cal members who are high-risk, high-needed, and often some of the most vulnerable. ECM connects people to the right services through close coordination and hands-on, community-based support. It's all about meeting members where they are and making sure their care is well-organized and truly centered around them. Those who qualify for ECM are grouped into specific categories called "Populations of Focus":

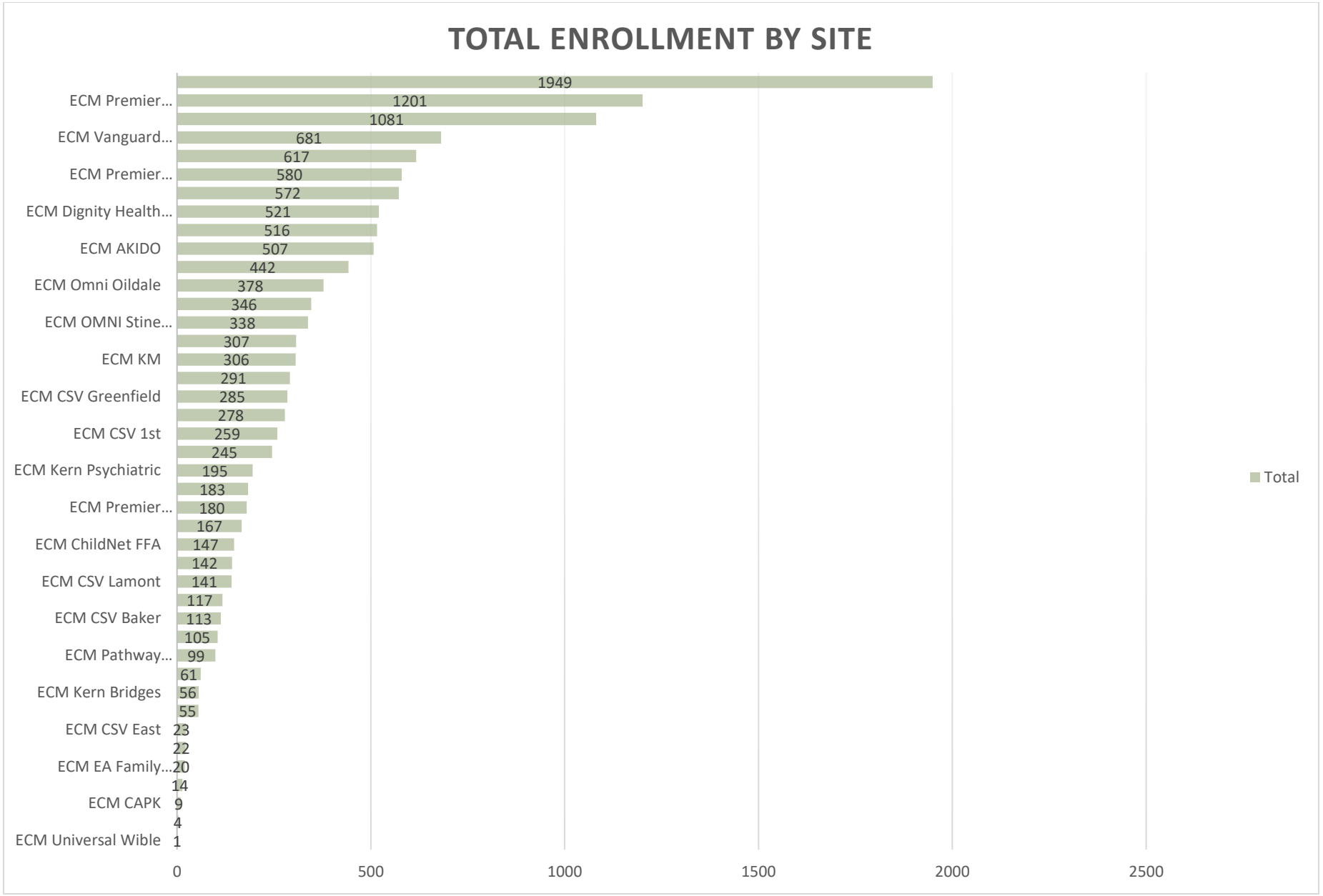
	ECM Populations of Focus	Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	✓	
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

ECM Demographic Data

As of November 11, 2025, ECM had a total of 14,683 members currently enrolled in Enhanced Care Management services.

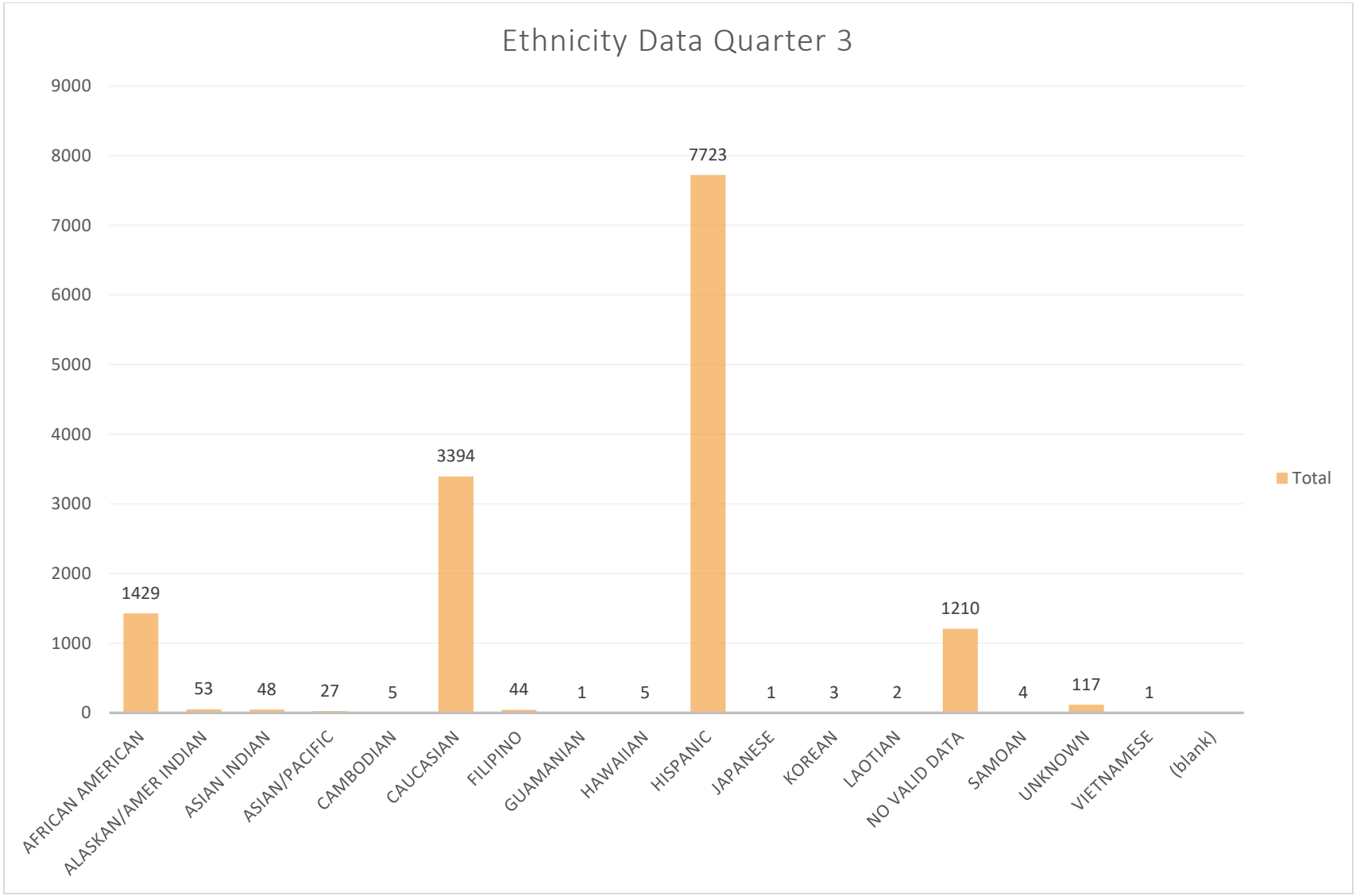
Overall population growth from Q1 2023 – Q3 2025




TOTAL ENROLLMENT BY SITE
ECM Premier...
ECM Vanguard...
ECM Premier...
ECM Dignity Health...
ECM AKIDO
ECM Omni Oildale
ECM OMNI Stine...
ECM KM
ECM CSV Greenfield
ECM CSV 1st
ECM Kern Psychiatric
ECM Premier...
ECM ChildNet FFA
ECM CSV Lamont
ECM CSV Baker
ECM Pathway...
ECM Kern Bridges
ECM CSV East
ECM EA Family...
ECM CAPK
ECM Universal Wible
1949
1201
1081
681
617
580
572
521
516
507
442
378
346
338
307
306
291
285
278
259
245
195
183
180
167
147
142
141
117
113
105
99
61
56
55
23
22
20
14
9
4
1
0
500
1000
1500
2000
2500
Total

Ethnicity

In the Enhanced Care Management program, we pride ourselves on maintaining the alignment in values shared throughout Kern Family Health Care in serving a diverse population. As denoted in the below graph (Ethnicity table), the largest ethnic group served by our ECM providers is the Hispanic population which constitutes 56 % of the total ECM population (as of Q3 2025), while a smaller population identify as other ethnic groups such as African American, Caucasian, Alaskan/American Indian, etc. We proudly boast a robust bilingual staff serving our membership throughout all 40+ of our locations and continue to look at ways to be more equitable to all our ethnic groups in ECM.


Ethnicity Data Quarter 3
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
1429
53
48
27
5
3394
44
1
5
7723
1
3
2
1210
4
117
1
AFRICAN AMERICAN
ALASKAN/AMER INDIAN
ASIAN INDIAN
ASIAN/PACIFIC
CAMBODIAN
CAUCASIAN
FILIPINO
GUAMANIAN
HAWAIIAN
HISPANIC
JAPANESE
KOREAN
LAOTIAN
NO VALID DATA
SAMOAN
UNKNOWN
VIETNAMESE
(blank)
Total

ECM cost saving measure:

Transition of care is a core service of Enhanced Care Management, and we continually process improve our member outreach strategy alongside our sites to increase the velocity and success of engagement with our members when transitions occur from one care setting to another. Our goal is to prevent the probable causes of repeat emergency department or inpatient utilization, achievable by a three-prong approach of engagement, education, and health behavior modeling. In the event the member utilizes services for whatever cause, our sites are trained (and incentivized) to use utilization reports and internal tracking mechanisms to get in contact with the relevant site for coordination of safe discharge and to contact within 48 hours of discharge to help identify any outpatient barriers to access or variables. Below is the site-by-site quarter outlay of total utilization of emergency room visits by engaged ECM members through all our sites as generated by our internal Business Intelligence team. We leverage our monthly site meetings and auditing periods to present emergency room utilization trends and totals to the providers and continue to work synergistically to find innovative ways to engage these members in the post discharge event and strategize on ways to prevent the over-utilization of emergency department services.

More recently, we have revamped our ECM incentive package to garner a more metric, outcome-based approach in looking at three domains of utilization (avoidable urgent care, inpatient and emergency department visits). At the time of this report, these incentives are being ratified by our internal leadership and will be presented to QIW for further review once approved.

Quarter III 2025 Total ED Utilization by episode status:

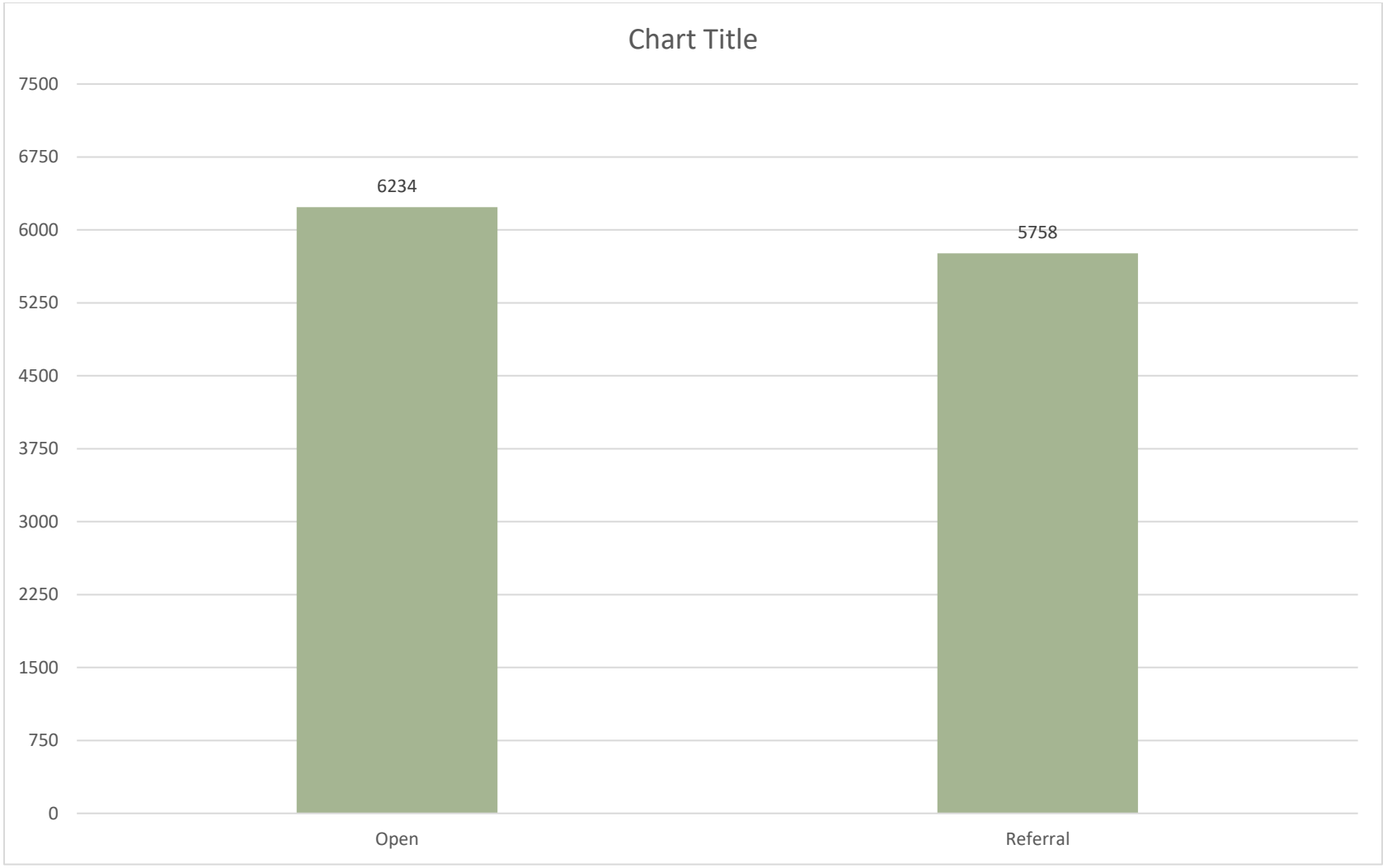


Chart Title
7500
6750
6000
5250
4500
3750
3000
2250
1500
750
0
6234
5758
Open
Referral

Benchmark:

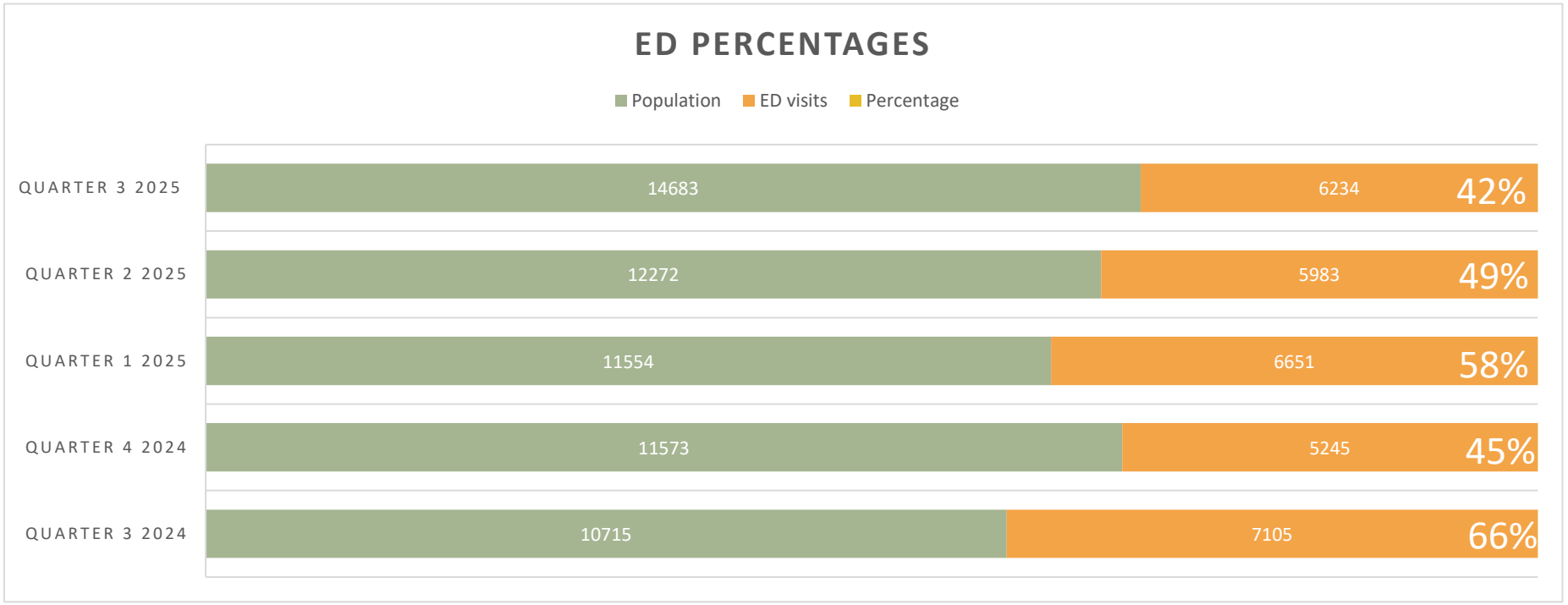
Through the above listed interventions, our ECM team in collaboration with the relevant ECM site will seek to decrease the total number of unique emergency room visits for members who are enrolled in ECM services by 5% in the coming quarter and subsequent quarters. As always we will work closely with our internal reporting team to obtain as realtime of data as possible to vet our interventions.

Outcomes:

- For our baseline measurement of Quarter III's 'Open' population we experienced 7,105 unique ED visits for the total open population of 10,715.
- For Quarter IV's 'Open' population we expereinced 5,245 unique ED visits for the total population of 11,573.
- For Quarter I's 'Open' population we experienced 6,651 unique ED visits for the total populatioon of 11,554.
- For Quarter II's 'Open' population we experienced 5,983 unique ED visits for the total population of 12,272.
- For Quarter IIII's 'Open' population we experienced 6,234 unique ED visits for the total population of 14,683.

Quarter III 2025 Progress:

To standardize this:



Q2 2025 Utilization Incentive Program Overview

In the second quarter of 2025, a four-pronged incentive approach was implemented to drive improvements in utilization management across sites. The program centered on three key utilization metrics and one MCAS measure, the utilization metrics were as follows:

- **Urgent Care utilization**
- **Emergency Room (ER) utilization**
- **Inpatient utilization**

Eligibility Criteria

To qualify for incentive consideration, sites were required to meet two baseline conditions:

1. **Census Threshold:** Maintain a member census of over 100.
2. **Audit Compliance:** Have successfully passed the previous quarter's audit.

Measurement and Ranking

Eligible sites were evaluated and ranked based on performance in each of the three utilization metrics. To ensure equitable comparisons across sites with differing population sizes, the metrics were normalized to a per 1,000 member rate in collaboration with the Business Intelligence team. A free ranking method was then used to identify the top 10 performing sites for each utilization category.

Outcomes:

Urgent Care:

Urgent Care Measure Site Rank	Qualifying ECM Site	UC Visits per 1,000
1	ECM Premier McFarland	21.3
2	ECM CSV Delano	23.7
3	ECM Westside Taft	44.1
4	ECM AKIDO	45.8
5	ECM Open Door Network	54.2
6	ECM Premier Arvin	55.5
7	ECM Adventist Health	61.1
8	ECM CSV Lamont	65.2
9	ECM CSV 1st	69.3
10	ECM Universal MSO	73.1

Emergency Room:

Emergency Room Measure Site Rank	ECM Site	ER Visits per 1,000
1	ECM Premier Arvin	47.8
2	ECM Open Door Network	61.5
3	ECM Westside Taft	79.3
4	ECM CSV Lamont	80.7
5	ECM Omni Shafter	83.3
6	ECM OMNI Stine Road	85.0
7	ECM Omni Mall View	93.3
8	ECM Vanguard Medical	95.6
9	ECM Premier	95.9
10	ECM Universal Health	95.9

Inpatient:

Inpatient Measure Site Rank	ECM Site	Admits per 1,000
1	ECM Premier Arvin	4.6
2	ECM Be Finally Free	6.7
3	ECM CSV Delano	8.9
4	ECM Universal Health	10.0
5	ECM Omni Mall View	11.5
6	ECM Premier McFarland	11.6
7	ECM Vanguard Medical	11.7
8	ECM CSV Greenfield	13.8
9	ECM Open Door Network	14.5
10	ECM OMNI Stine Road	16.3

ECM clinical measure:

Site by Site Focused MCAS Outcomes

Process:

As an ECM department, we have monthly meetings with all of our sites and have a standalone section in these meetings to review MCAS performance with them. There is a concerted prioritization on MCAS measures of BCS and CCS, as they have shown the greatest percentage of impact on our populations. From there, the department sends applicable sites a drill down list of all members who are “non-compliant” and need certain screenings.

From there we do quarterly audits where we have another section dedicated to their ability and efforts to close these gaps in care. Additionally, as a desk level procedure to all sites. We train them to use the member profile through the provider portal an leverage the available data to identify these measures per patient.

Cervical Cancer Screening

Measure Description: Women who had the following age-appropriate cervical cancer screenings: • Women 21 to 64 years of age who had cervical cytology performed within the last 3 years.

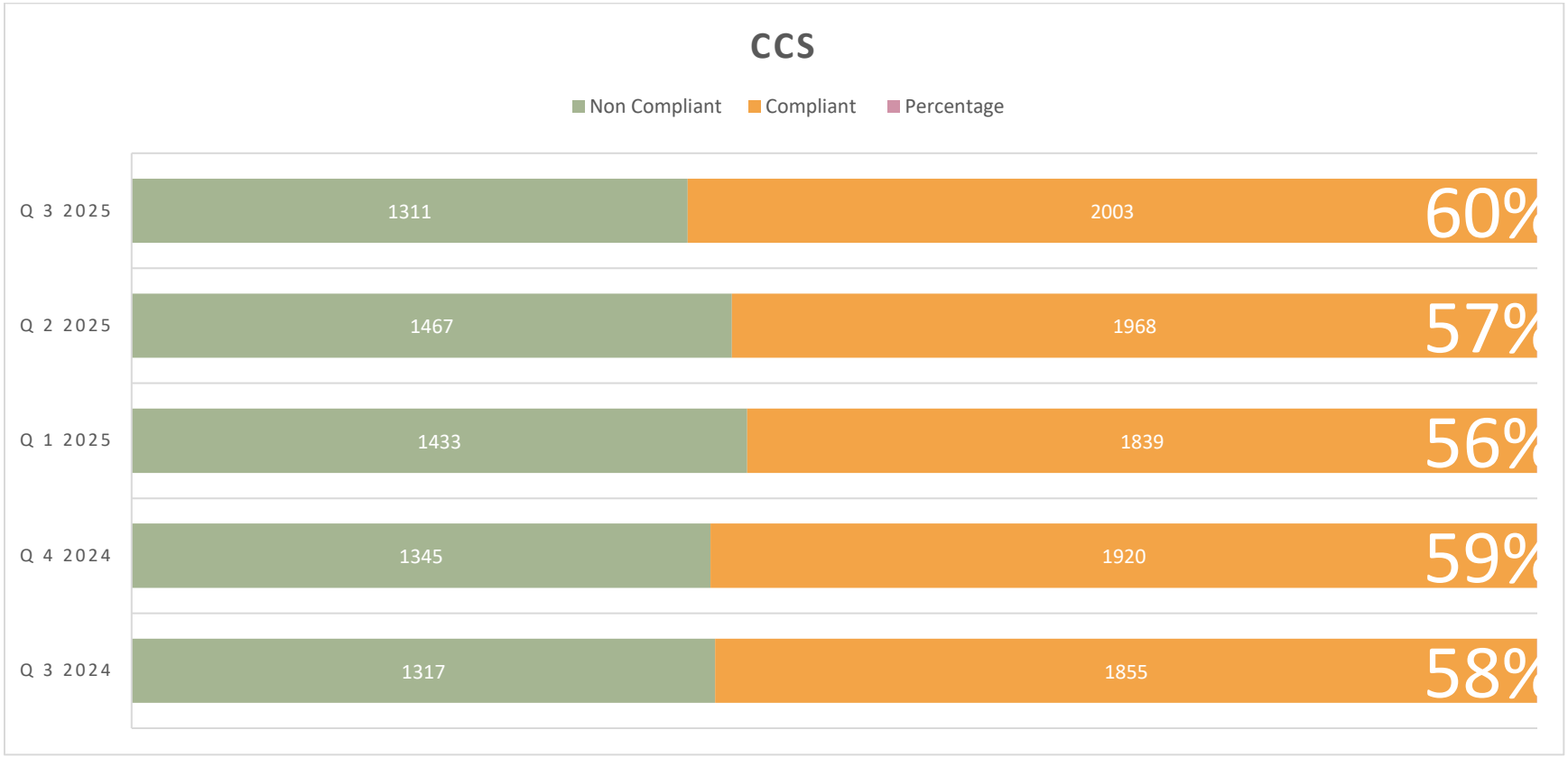
OR

• Women 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years and were 30 years of age or older on the date of the test.

Benchmark:

Through the above listed interventions, our ECM team in collaboration with the relevant ECM site will seek to decrease the total number members needing service by 5% in the coming quarter. As always we will work closely with our internal reporting team to obtain as realtime of data as possible to vet our interventions.*

**Variables to be taken into account would include fluctuations in census and disenrollments per respective site.*

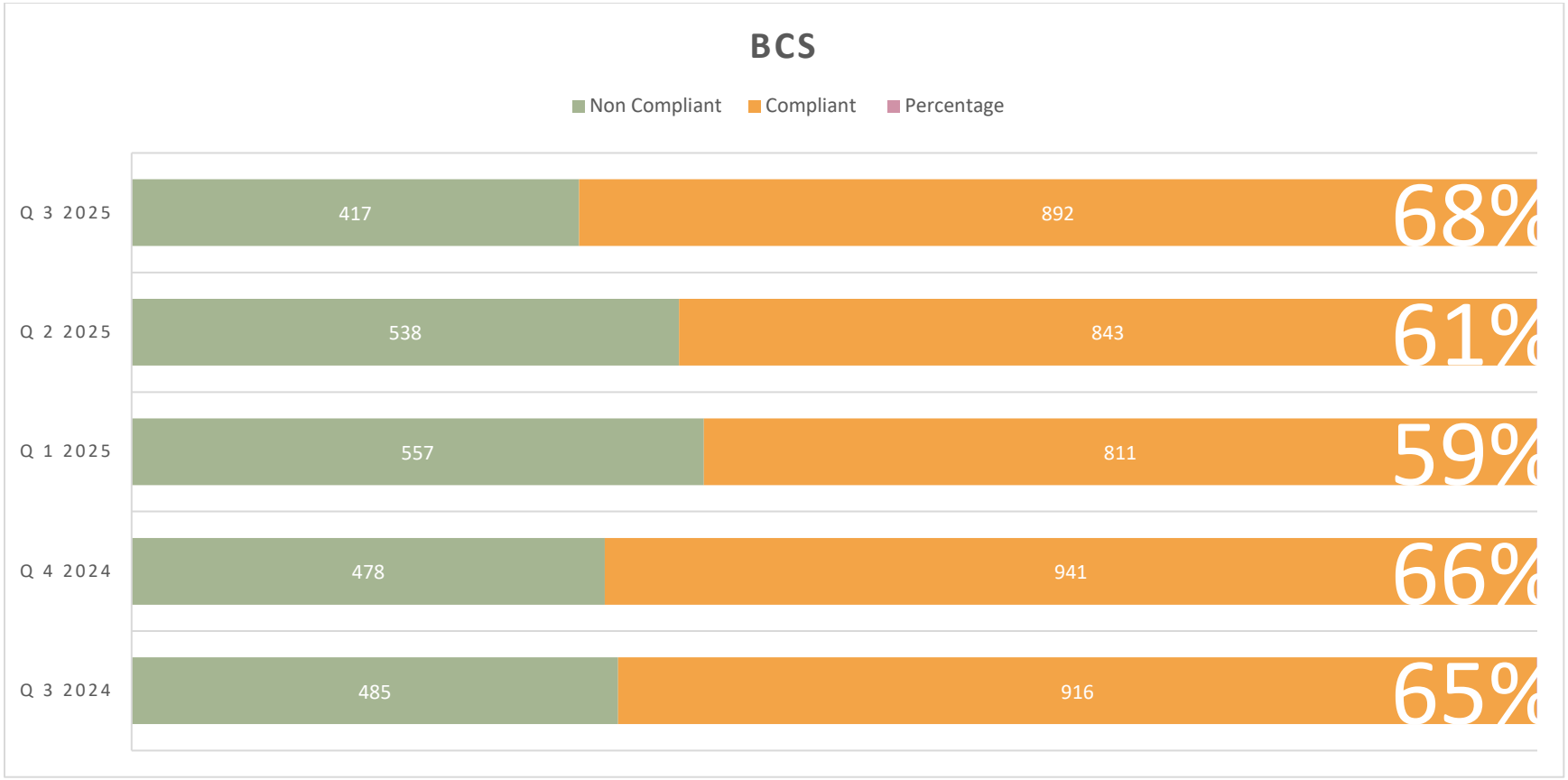

CCS
Non Compliant
Compliant
Percentage
Q 3 2025
1311
2003
60%
Q 2 2025
1467
1968
57%
Q 1 2025
1433
1839
56%
Q 4 2024
1345
1920
59%
Q 3 2024
1317
1855
58%

Breast Cancer Screening

Measure Description: Women ages 50 to 74 years of age who had one or more mammograms to screen for breast cancer any time on or between October 1, two years prior to the measurement year, and December 31 of the measurement year.

Benchmark:

Through the above listed interventions, our ECM team in collaboration with the relevant ECM site will seek to decrease the total number members needing service by 5% in the coming quarter. As always we will work closely with our internal reporting team to obtain as realtime of data as possible to vet our interventions.



**Variables to be taken into account would include fluctuations in census and disenrollments per respective site.*

Patient Satisfaction:

Survey Data

The Enhanced Care Management team has historically sent an experience satisfaction survey out to its members for resubmission to the plan. As of the date of submission to the QIW, we have received our 2025 surveys from our membership. This data has also been partitioned by site for more drill down on-site specific performance.

Questionnaire. Press Ganey (PG) worked with Kern Health Systems to develop the survey instrument. The survey was designed to be administered in English and Spanish, via mail and telephone.

Data collection. Data collection information is detailed in the table below.

Sample design.

- Qualified respondents. The population surveyed includes members who have participated in the ECM Program.
- Sample source. Kern Health Systems supplied the sample, including name, language and contact information for 6,015 eligible members. PG processed the sample through NCOA, and phone append process. After deduping by address and phone number, a stratified random sample of 3,500 members was drawn.
- Sample size and response rate.

Data processing and tabulation. PG performed all data entry, data cleaning and verification, and produced detailed tables that summarize the results.

Note:

- Percentages less than 5.0% are not shown in graphs where space does not permit.
- T2B refers to the top-two-box score, which is the percentage of respondents selecting a response from the two most favorable scale options (for example, Very Satisfied or Satisfied).
- Totals reported in graphs and tables may not be equal to the sum of the individual components due to the rounding of all figures.

2023 Survey Response Rate:

- **Sample size and response rate.**

Sample size	Total undeliverable records	Completed surveys			Response rate	Adjusted response rate
		Total	Mail	Phone		
3,500	183	488	281	207	13.9%	14.7%

2024 Survey Response Rate:

- **Sample size and response rate.**

Sample size	Total undeliverable records	Completed surveys			Internet	Response rate	Adjusted response rate
		Total	Mail	Phone			
3,308	151	879	233	577	69	26.6%	27.8%

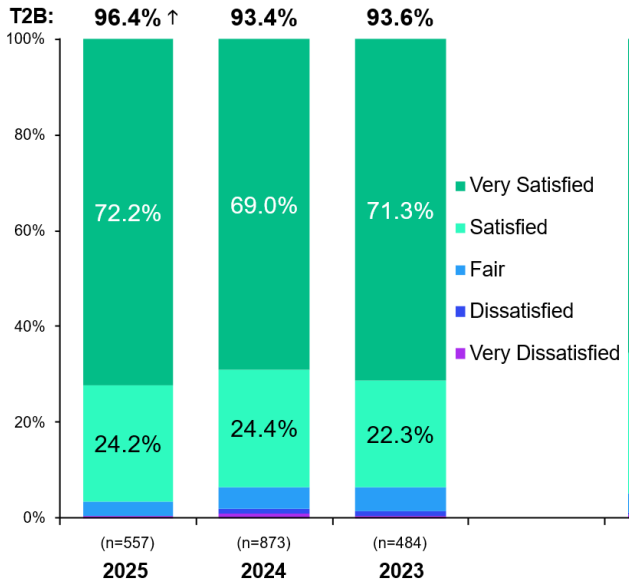
2025 Survey Response Rate:

Sample size	Total undeliverable records	Completed surveys				Response rate	Adjusted response rate
		Total	Mail	Phone	Internet		
2,782	156	566	230	272	64	20.3%	21.6%

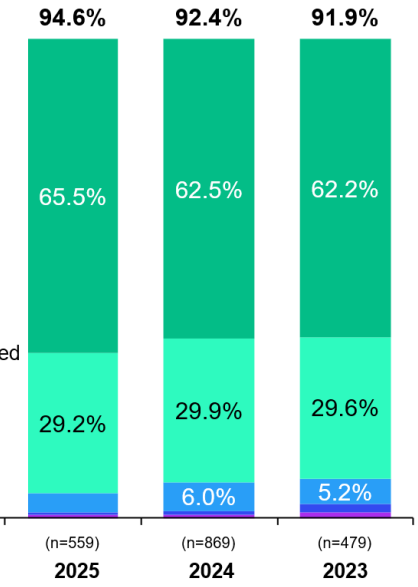
Overall satisfaction

The percentage who are satisfied with Kern Family plan and are likely to refer the ECM Program increased significantly from 2 024. The vast majority are satisfied with the ECM Program.

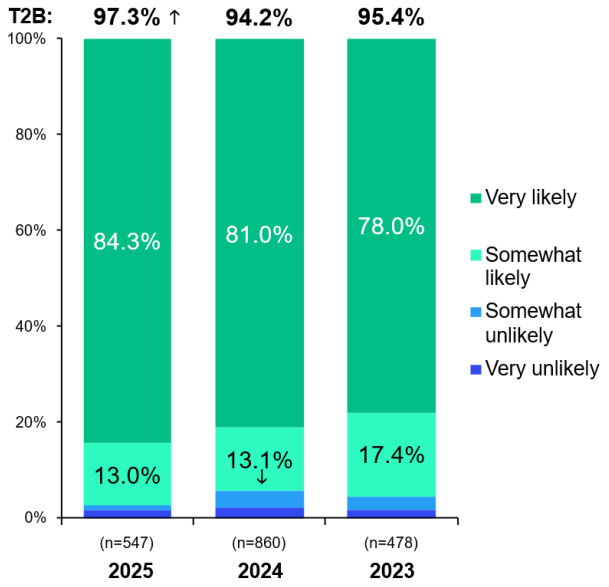
Satisfaction with Kern Family plan



Satisfaction with ECM Program



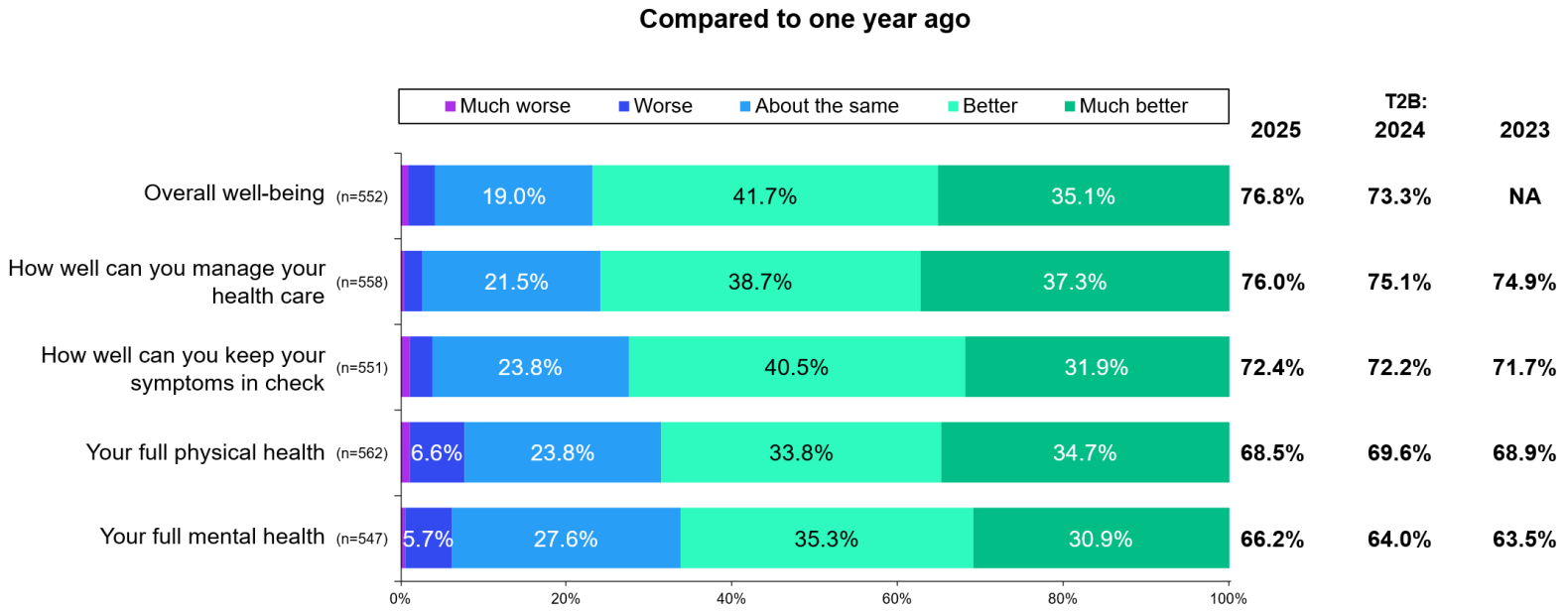
Likelihood to refer the ECM Program to family or friends



Q9. How satisfied are you with Kern Family as your health insurance plan? Q10. How satisfied are you with your overall experi ence with your Kern Health ECM Program? Q11. How likely are you to refer Kern Health's ECM Program to family or friends? An arrow (↑ ↓) indicates a significantly different result from the previous year.

Outcomes

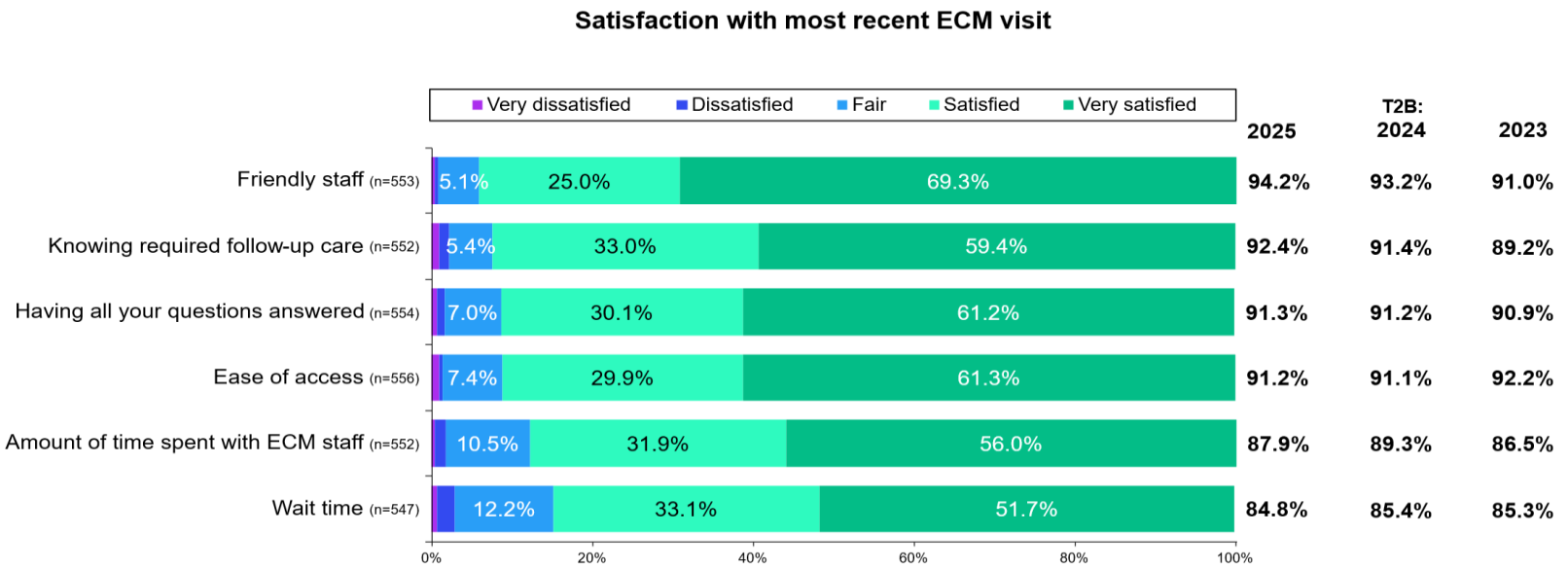
The percentage who indicated that their overall well -being is better compared to one year ago increased slightly from 2024. Scor es for the remaining measures are consistent with 2024.



Q12. Compared to 12 months ago, how would you rate…? An arrow (↑↓) indicates a significantly different result from the previous year.

Experience with ECM visit

The majority are satisfied with each aspect of their most recent ECM visit.

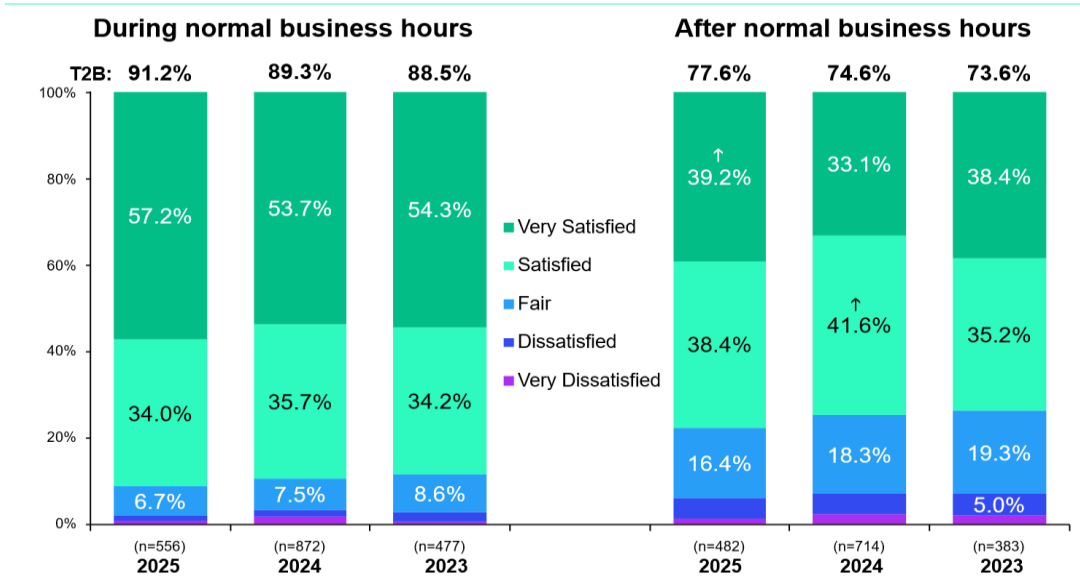


Q6. Please rate your overall satisfaction with the following aspects of your most recent ECM visit: An arrow (↑↓) indicates a significantly different result from the previous year.

Responsiveness

More than nine in 10 are satisfied that they can speak to someone from the program in a timely manner during normal business hours, while more than three in four are satisfied with the timeliness of the after -hours response.

Satisfaction with timeliness of speaking to someone from ECM Program



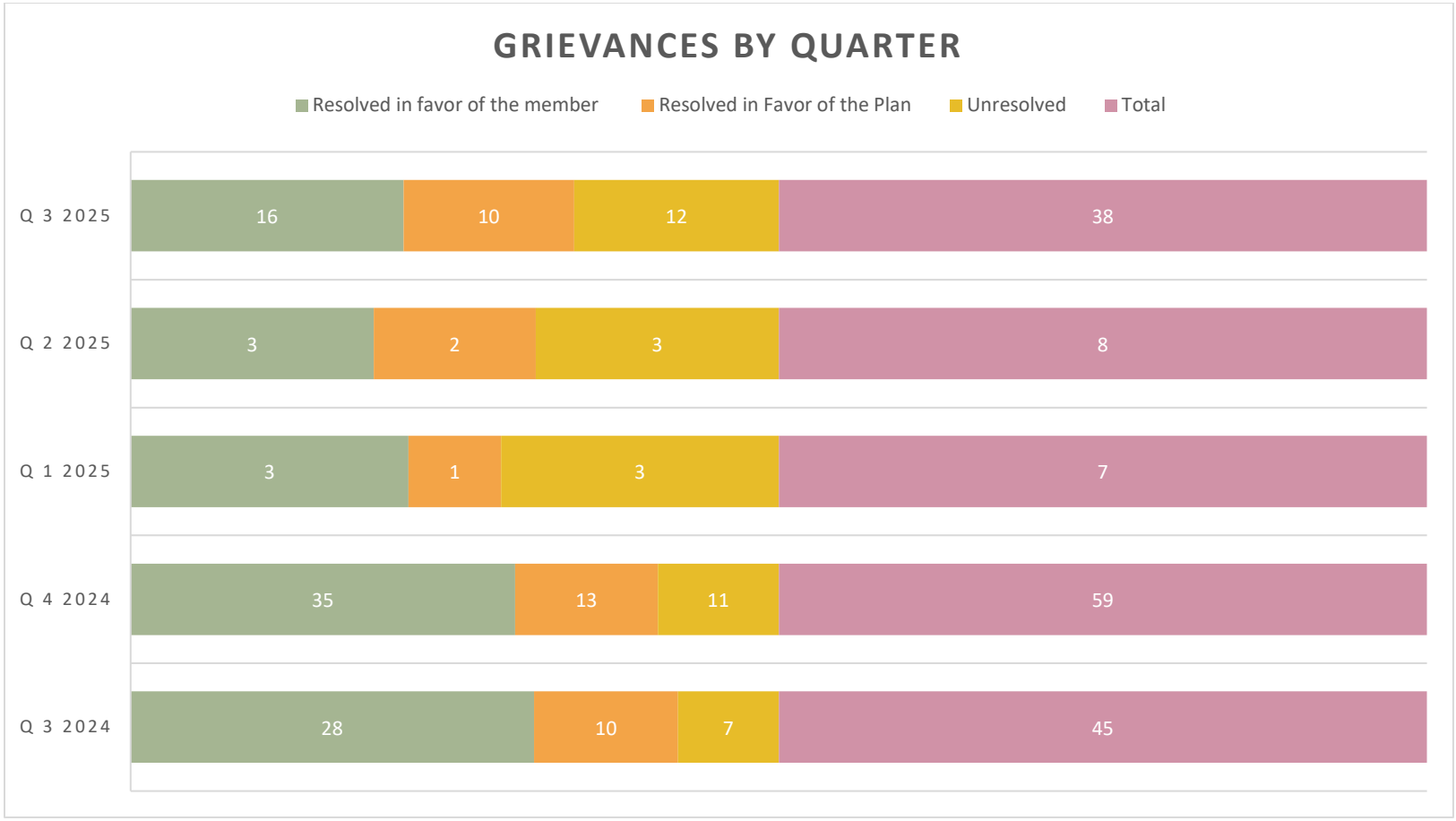
Q7. How satisfied are you when you are able to speak to someone from the ECM Program in a timely manner about any issues? An arrow (↑↓) indicates a significantly different result from the previous year.

Grievances

In the Enhanced Care management department, we make a concerted effort to keep our fingers on the patient experience pulse by not only sending the above survey to our members but also keeping tabs on all ECM related grievances. On top of being a mainstay in the grievance committee meetings, we have standing agenda items for grievance follow up as they pertain to the site. In this effort we not only wish to continue to track and trend all issues related to ECM sites but make the data actionable and directly accessible to our sites for more real time response and action planning.

Benchmark:

For our benchmark goals going forward, through the above listed interventions, we aim to reduce the total quarterly grievance rate by 5% by the next quarter and future quarters going forward. We will continue to accrue all data related to ECM related grievances and report outcomes to this committee.


GRIEVANCES BY QUARTER
Resolved in favor of the member
Resolved in Favor of the Plan
Unresolved
Total
Q 3 2025
16
10
12
38
Q 2 2025
3
2
3
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Q 1 2025
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Q 4 2024
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Q 3 2024
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Kern Health Systems Quality Improvement Annual Work Plan - 2025

Work Plan Update - Q3

Complete
In Progress or No Update
Risk
Barrier

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff	Q1 Update
I. Quality Program Structure								
NCQA 1D	QIHE Governance	Conduct quarterly EQIHEC Meetings	No issues identified	Meet quorum of voting members at every meeting		12/31/2025	Quality Improvement Director & Health Equity Manager	**Q1 - 3/18/2025 - Completed Q2 - 6/17/2025 - Completed Q3 - 9/2025 - Completed Q4 - 12/2025**
NCQA 1C	Annual QI Evaluation of 2024	Summary of completed and ongoing QI activities, trending of results and overall evaluation of effectiveness	No issues identified	Annual approval by the EQIHEC and the BOD		4/17/2025	Quality Improvement Director	**Complete**
NCQA 1A	2025 Quality Improvement Health Equity Program Description	QIHE Program description of committee accountability, functional areas and responsibilities, reporting relationship, resources and analytical support	QI and HE Programs were previously two separate documents.	Annual approval by the EQIHEC and the BOD	Combine QI and HE Program documents and update for 2025	4/17/2025	Quality Improvement Director & Health Equity Manager	**Complete**
NCQA 1B	2025 Annual Quality Improvement Health Equity Work Plan	Yearly planned objectives and activities	No issues identified	Annual approval by the EQIHEC and the BOD		4/17/2025	Quality Improvement Director	**Complete**
DHCS	Policies and Procedures	Annual review of KHS Quality Improvement P&Ps	No issues identified	100% of policies reviewed and updated as needed		12/31/2025	Quality Improvement Director	**In Progress**
NCQA	NCQA Health Plan Accreditation	Attain Health Plan Accreditation	Initial Accreditation	Attain Full Health Plan Accreditation by 1/1/2026		12/31/2025	Quality Improvement Director	**Complete**
NCQA	NCQA Health Equity Accreditation	Attain Health Equity Accreditation	Initial Accreditation	Attain Full Health Equity Accreditation by 1/1/2026		12/31/2025	Health Equity Manager	**Complete**
II. Quality of Clinical Care								
DHCS	MCAS Measures	AMR	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	BCS	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	CHL	Not Meeting MPL	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	CCS	Not Meeting MPL	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	CIS-10	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Risk**
DHCS	MCAS Measures	CBP	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	DEV	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Risk**
DHCS	MCAS Measures	IMA-2	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	LSC	Not Meeting MPL	Meet minimum performance levels (MPLs)	QI Senior Coordinators reached out to Top 10 provider that have less than 150 members to complete Lead Screening in Children before the 2 years of age (LSC)	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	FUA-30Day follow up	Not Meeting MPL	Meet minimum performance levels (MPLs)	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	8/31/2025	Quality Performance Director	**Risk**
DHCS	MCAS Measures	FUM-30Day follow up	Not Meeting MPL	Meet minimum performance levels (MPLs)	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	8/31/2025	Quality Performance Director	**Risk**
DHCS	MCAS Measures	GSD	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	PPC-Pre	Met MPL for MY2022/RY2023. Did not meet MPL for MY2023/RY 2024. No issue	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	PPC-Post	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Met MPL**

Kern Health Systems Quality Improvement Annual Work Plan - 2025

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff	Q1 Update
DHCS	MCAS Measures	TFL-CH	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	W30(0-15M)	Not Meeting MPL, but significant YOY improvement over the last two years.	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Risk**
DHCS	MCAS Measures	W30(15-30M)	Not Meeting MPL, but significant YOY improvement over the last two years.	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	WCV	Not Meeting MPL, but significant YOY improvement over the last two years.	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Risk**
DHCS	Clinical PIP: Focus on Health Equity, specific to the W30 0-15 months African American Population	2023-2026 performance improvement project (PIP) overseen by HSAG focused on increasing the number of children ages 0 - 15 months old with completing an annual well care visit.	Did not meet MPL for multiple measures in Children's Domain of Care	Use MY2023 W30 (0-15months) baseline data to develop PIP interventions and get Annual Approval by HSAG.		12/31/2025	Quality Performance Director	**In Progress**
DHCS	Non-Clinical PIP: Specific to FUA and FUM measures	2023-2026 performance improvement project (PIP) overseen by HSAG focused on improving Behavioral Health measures throug provider notivications with in 7-days of the ER visit.	Did not meet MPL for FUA and FUM measures	Use MY2023 baseline data to develop interventions that includes a process for notifying PCPs of ED visits for eligible population. Annual Approval by HSAG		12/31/2025	Quality Performance Director	**In Progress**
IHI/DHCS	Health Equity Sprint Collaborative	Completion of well-care visits for African-American babies and children for W30 and WCV MCAS measures	Did not meet MPL for WCV or W30	Utilize MY2023 data to develop strategic provider partnerships to improve compliance for targeted population	2 provider partnerships and 1 CBO partnership in support of well-care visits	4/1/2025	Quality Performance Director	**Complete**
III. Safety of Clinical Care								
	Patient Safety Program/Clinical Network Oversight	Conduct Quarterly Audits of select measures (IHA, Lead Screening, etc.)	Baseline monitoring. No system of tracking provider performances.	Conduct quarterly monitoring of provider performance	Conduct quarterly monitoring of provider performance	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director	**In Progress**
DHCS	Potential Quality of Care Issue (PQI)	Monitoring of PQI volume month over month	No issues identified	<30/month	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director	**24/month**
DHCS	Potential Quality of Care Issue (PQI)	PQI Rates by Provider	Baseline monitoring	Baseline monitoring	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director	**0.41/1000 Provider Interactions**
DHCS	Potential Quality of Care Issue (PQI)	PQI Rates by ethnicity, english as a second language, sexual orientation, gender identity	Baseline monitoring	Baseline monitoring	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director	**In Progress**
DHCS	Potential Quality of Care Issue (PQI)	Timeliness of resolution	No issues identified	Within 120 calendar days	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director	**100%**
DHCS	Facility Site Review	Conduct on site reviews at the time of initial credentialing or contracting, and every three years thereafter, as a requirement for participation in the California state Medi-Cal Managed Care (MMCD) Program	Issues were identified in Critical Elements while conducting FSR.	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	CSR will schedule and complete reviews timely.	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Performance Director	**100%**
DHCS	Physical Accessibility Review Survey (PARS)	Conduct PARS audit with FSR	No issues identified	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	QP Senior coorninator will schedule and complete all PARS due 2025	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Performance Director	**100%**
DHCS	Medical Record Review	Conduct medical record review of practitioners due for facility site reviews	Previously identified issues from MRR: 1.Emergency contact not documented 2.Dental/Oral Assessment not documented 3.HIV infection screening not documented	Achieve medical record review score of 85% for each practitioner	CSR will schedule and complete reviews timely.	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Performance Director	**100%**

Kern Health Systems Quality Improvement Annual Work Plan - 2025

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff	Q1 Update
	Drug Utilization Review	Treatment Authorization Request (TAR)	No issues identified	72 hrs for urgent, 5 days for routine	Continue quarterly monitoring & report findings to DUR	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Pharmacy Director	**N/A Since 1/1/2025**
	Drug Utilization Review	Physician Administered Drugs (PAD)	No issues identified	72 hrs for urgent, 5 days for routine	Continue quarterly monitoring & report findings to DUR	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Pharmacy Director	**100%**
NCQA	Credentialing/Recredentialing	Credential/recredential practitioners timely	No QOC trends for provider re-credentialing in 2024 to prevent moving forward from a QI perspective	100% timely credentialing/recredentialing of practitioners	Review of trends for Grievances and PQIs, QOC look back review 3 years	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Credentialing Manager	**100%**
IV. Quality of Service								
DHCS	Grievance & Appeals	Timeliness of acknowledgement letters	No issues identified	90% Within 5 calendar days	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director	**91%**
DHCS	Grievance & Appeals	Timeliness of resolution	No issues identified	90% within 30 calendar days and 72 hours for expedites	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director	**77%**
DHCS	Access to Care - PCP	Urgent Care within 48 hours	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director	**92%**
DHCS	Access to Care - PCP	Routine Care - 10 business days	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director	**96%**
DHCS	Access to Care - SCP	Urgent Care within 48 hours	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director	**92%**
DHCS	Access to Care - SCP	Routine Care - 15 business days	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director	**92%**
DHCS	Telephone Access to Member Services	Speed of Answer	No issues identified	< 30 seconds	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director	**46 seconds**
DHCS	Telephone Access to Member Services	Call abandonment rate	No issues identified	< 5%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director	**3%**
V. Member Experience								
	CAHPS Survey	Adult and Child Medicad Survey	Getting Needed Care scored lowest in the Adult Survey	Monitor CAHPS Resutls and establish basline for Getting Care needed measure	Trending report on CAHPS results by survey questions	12/31/2025	Member Engagement Manager	**No Update**
VI. Provider Engagement								
	Provider Satisfaction Survey	Would Recommend	No issues identified	Maintain 98th Percentile	Report survey results to QIW annually	9/30/2025	Provider Network Management Director	**No Update**
	Provider Satisfaction Survey	Utilization and Quality Management	No issues identified	Maintain 97th Percentile	Report survey results to QIW annually	9/30/2025	Provider Network Management Director	**No Update**
	Provider Satisfaction Survey	Degree to which the plan covers and encourages preventive care and wellness	No issues identified	Maintain 96th Percentile	Report survey results to QIW annually	9/30/2025	Provider Network Management Director	**No Update**
	Provider Education	Host at least one educational conference for Providers	No issues identified	Host one educational conference for Providers	Medical Management of Obesity for Primary Care Providers Conference	11/30/2025	Quality Improvement Medical Director	**Rheumatology Conference 6/3/2025- Completed**

KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: Kailey Collier, Director of Quality Performance (QP)

Date: December 16, 2025

Re: Quality Performance Q3 2025 Report

Background:

The QP team develops a quarterly report to outline, monitor, and evaluate our ongoing departmental activities. This report also serves as an opportunity for committee members to provide input regarding our work. This report reflects activities and outcomes for the third quarter of 2025.

Discussion:

See page 2 of this document.

Fiscal Impact:

The fiscal impact of not achieving and maintaining satisfactory MCAS rates may be severe to the health plan. This includes sanctions which may come in the form of monetary fines, reduction in default assignment, reduction in membership, and ultimately revocation of the plan from the Medi-Cal program. Another cost is utilization and increased costs of care associated with the lack of preventive care, that turns preventable conditions into chronic conditions. The ultimate cost is paid by the membership in the form of reduced health status and diminished quality of life. Access to high quality and equitable care is what MCAS drives, and what we as a plan are striving to deliver to the more than 400,000 lives we cover.

Requested Action:

Review and approval.

KERN HEALTH SYSTEMS

Quality Performance Department
Executive Summary
3rd Quarter 2025

I. Facility Site Reviews (FSR) and Medical Record Review (MRR) (pages 2-10)

5 Initial Facility Site Reviews and 4 Initial Medical Record Reviews were completed in Q3 2025. 8 Periodic FSRs and 8 periodic MRRs were also completed. 100% of Facility Site Reviews passed and 96% YTD of Medical Record Reviews passed. 2 of 54 sites failed the first review, however Corrective Action Plans were completed and closed. QP also conducts mid-cycle interim reviews of facilities to monitor facility compliance. The QP department also conducts Physical Accessibility Review Surveys (PARS) and 6 were completed in Q3 2025.

II. Quality Improvement Projects (pages 11-12)

A. ***Performance Improvement Projects (PIPs)***

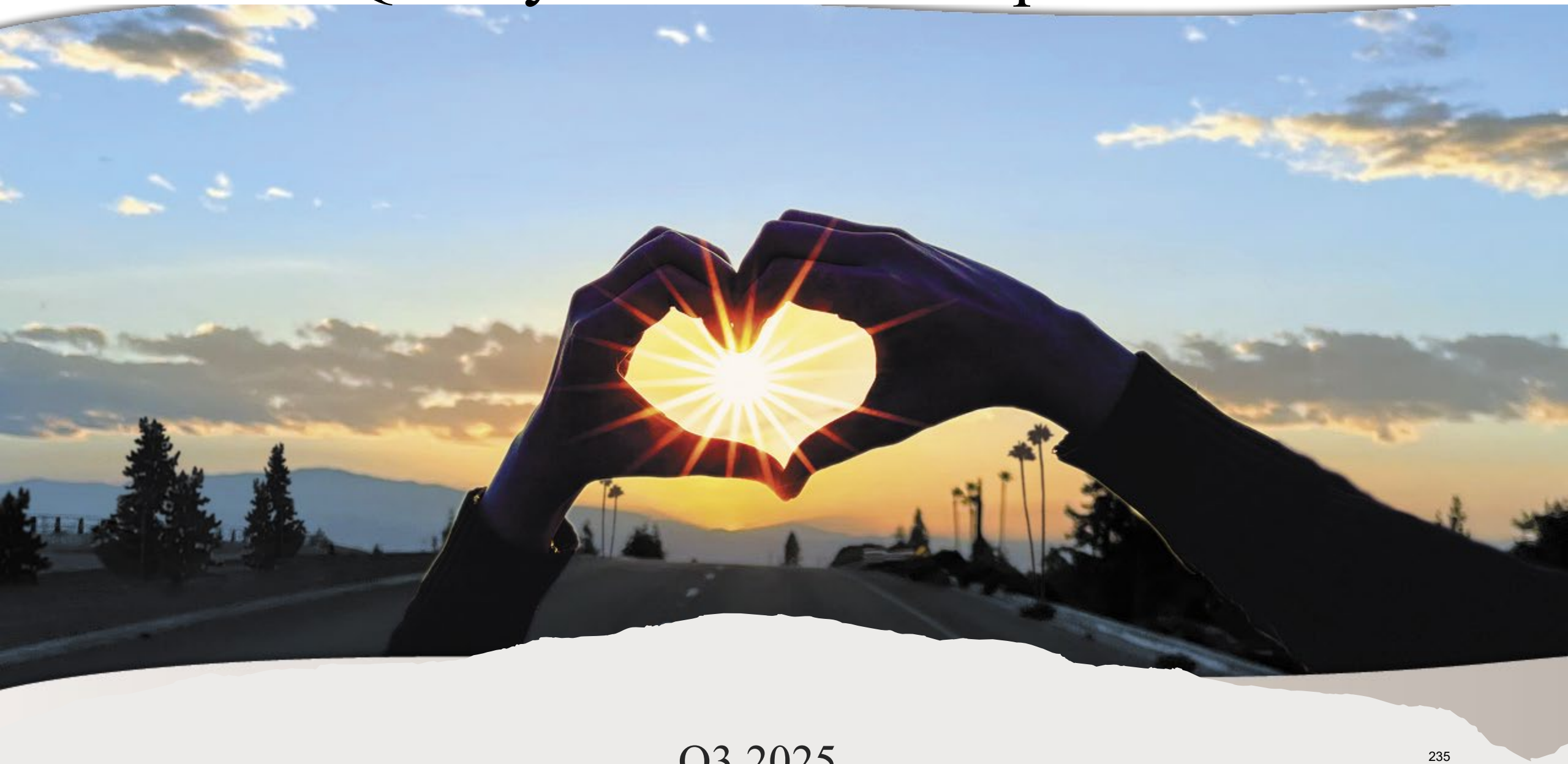
The current PIPs began in August 2023 and run through 2026. The first PIP is focused on the W30 MCAS measure, specific to Health Equity of the 0-15 months African American Population in Kern County. The second PIP is considered a non-clinical Behavioral Health PIP, specific to the FUA and FUM measures. We are partnering with KHS' Behavioral Health Department to ensure success of this PIP. The first submission for both PIPs were approved by HSAG. We are currently in the second phase of the PIP, which focuses on interventions and testing. We have developed a provider notification process for ED visits related to Behavioral Health and Substance Use Disorders. For the W30 PIP, we are leveraging activities from mobile units and the IHI/DHCS collaborative focused on well-care visits for the 0-15 months, African American babies.

Two pilot providers are offering weekend and evening appointments to increase adherence to well-child visits for African American babies ages 0-21 years of age. The Sprint Team responsible for the IHI collaborative is exploring opportunities to distribute member rewards for this population of focus for scheduling the visit. As part of the MERP, additional rewards are provided for closing the gaps in care. We have also identified a need for a single page handout for next steps following well care visits in children and adolescents.

III. Managed Care Accountability Set (MCAS) Updates (Pages 13-17)

The QP team continues with MCAS specific initiatives in support of improving all measures for current measurement year with a heavy focus on the Children's domain of care. As of September 2025, 14 of 18 measures have improved compared to last year. Based on administrative data, we are currently meeting MPL for 5 measures. We are within 5% MPL for 4 additional measures. These rates are reflective of year-to-date administrative data only. We anticipate changes as we near the annual MCAS audit, which will kick off in October for completion of the roadmap.

Quality Performance Updates



Q3 2025

2025 Quality Initiatives

- Purchased multiple lead screening machines for providers in rural regions
- 5 mobile unit providers deployed across Kern County
  - Partnerships with more than 15 school districts
- Weekend and evening clinics with two local pediatricians
- Streamline member rewards for behavioral health and children's services
- Dedicated outreach team focused on children's health, specifically driven by need for annual well-care visits
- IHI and DHCS Collaborative

KERN HEALTH SYSTEMS

Quality Initiatives Cont'd.

KERN HEALTH SYSTEMS

- Text message campaigns to promote member rewards and educate on importance of well-care visits
- Routine data exchange process developed - KHS receives monthly provider usage report
- Training on the Provider Learning Module System (PLMS) for EPSDT services
- Partnership with CDPH team to educate providers on importance of lead screening and fluoride varnish
- Rapport established with the California Immunization Registry (CAIR)
    - Routine data exchange process developed - KHS receives monthly provider usage report

MY2025 vs. MY2024 Trending Performance

13 measures are trending higher than the previous year at the same point in time.

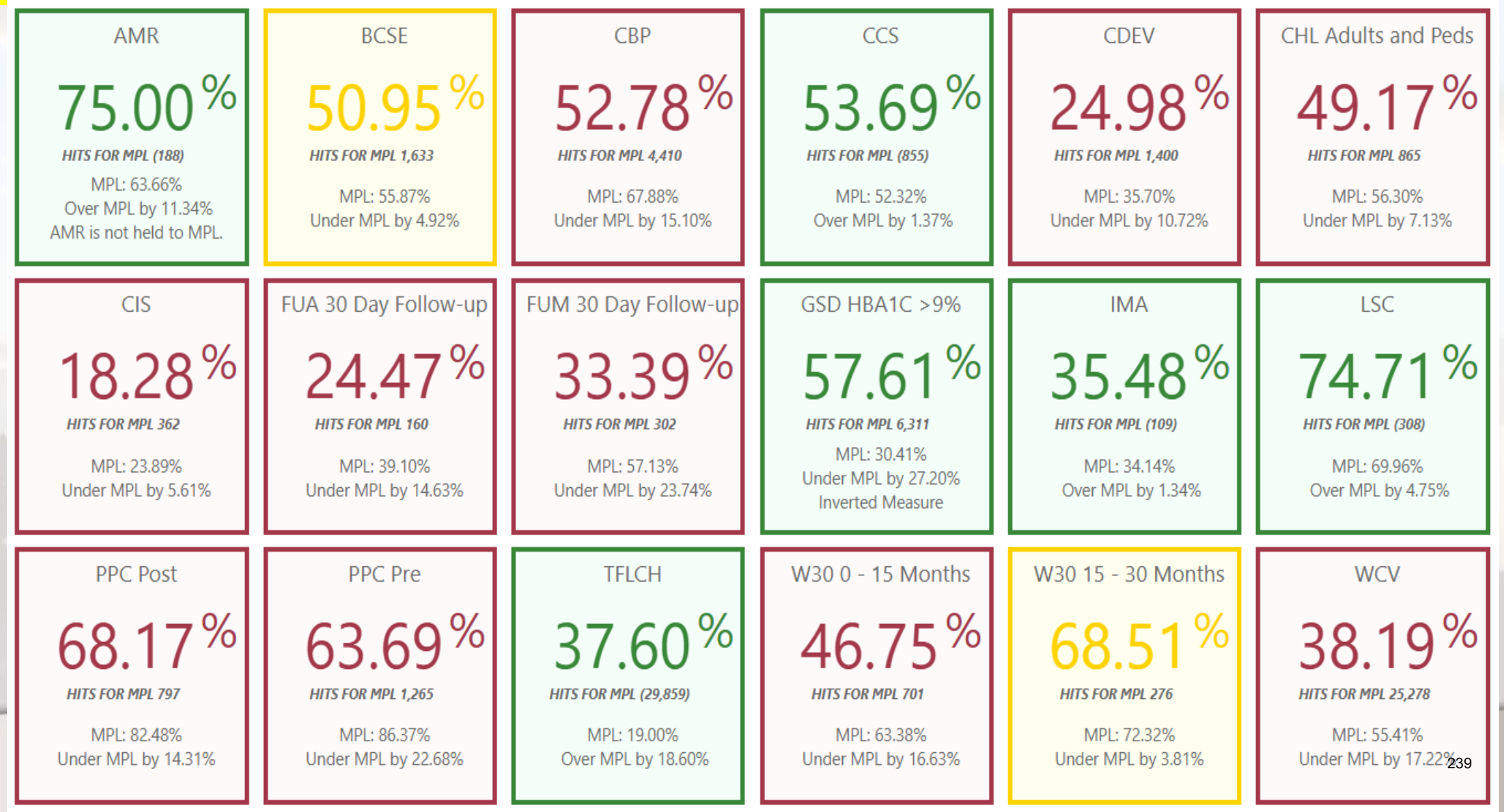
AMR	BCSE	CBP	CCS	CDEV	CHL Adults and Peds
75.00%	50.95%	52.78%	53.69%	24.98%	49.17%
HITS FOR MPL (188)	*HITS FOR MPL 1,633*	*HITS FOR MPL 4,410*	*HITS FOR MPL (855)*	*HITS FOR MPL 1,400*	*HITS FOR MPL 865*
+1.59 % change	-4.61 % change	+7.38 % change	+5.20 % change	+4.71 % change	-3.75 % change
Sep'24 73.41%	Sep'24 55.56%	Sep'24 45.40%	Sep'24 48.49%	Sep'24 20.27%	Sep'24 52.92%

CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	GSD HBA1C >9%	IMA	LSC
18.28%	24.47%	33.39%	57.61%	35.48%	74.71%
HITS FOR MPL 362	*HITS FOR MPL 160*	*HITS FOR MPL 302*	*HITS FOR MPL 6,311*	*HITS FOR MPL (109)*	*HITS FOR MPL (308)*
-0.49 % change	+1.57 % change	+13.89 % change	+5.30 % change	+2.60 % change	+6.81 % change
Sep'24 18.77%	Sep'24 22.91%	Sep'24 19.50%	Sep'24 62.92%	Sep'24 32.88%	Sep'24 67.90%

PPC Post	PPC Pre	TFLCH	W30 0 - 15 Months	W30 15 - 30 Months	WCV
68.17%	63.69%	37.60%	46.75%	68.51%	38.19%
HITS FOR MPL 797	*HITS FOR MPL 1,265*	*HITS FOR MPL (29,859)*	*HITS FOR MPL 701*	*HITS FOR MPL 276*	*HITS FOR MPL 25,278*
+3.52 % change	+15.50 % change	+1.84 % change	-4.95 % change	+2.39 % change	-0.54 % change
Sep'24 64.65%	Sep'24 48.18%	Sep'24 35.76%	Sep'24 51.70%	Sep'24 66.12%	Sep'24 38.73%

MY2025 YTD Performance

- ✓ Meeting MPL for 5 measures
- ✓ Within 5% of MPL for 2 measures



**GSD is an inverse rate.*

Site Review Updates

KERN HEALTH SYSTEMS

- For 2025 YTD, 100% of the Initial and Periodic site reviews passed.
- YTD there were 40 site reviews completed by September 2025
- All Site Reviews completed timely and thoroughly for Q3 2025
- There are no open CAPs pending follow up actions
- CMT participates in multiple statewide workgroups focused on updating CDPH trainings to supplement provider education of Children's screenings.
    - Collaborating with PNM and Learning & Development to share with PCPs.

For additional Information, please contact:

Kailey Collier, Director of Quality Performance
Aurora de la Torre, Manager of Quality Performance

KERN HEALTH SYSTEMS

QUALITY PERFORMANCE DEPARTMENT

QUARTERLY EQIHEC COMMIITTEE REPORT

Q3 2025

KERN HEALTH SYSTEMS
Quality Performance Department Quarterly EQIHEC Committee Report
Q3 2025

The purpose of this report is to provide a summary of the quarterly activities and outcomes for the QI department. It provides a window into the performance of the Quality Improvement Program and Department. It serves as an opportunity for programmatic discussion and input from the QI-UM Committee members. Areas covered in the report include:

I. Facility Site & Medical Record Reviews
   A. Initial Site & Medical Record Reviews
   B. Periodic Site & Medical Record Reviews
   C. Critical Elements
   D. Initial Health Appointments (IHAs)
   E. Interim Reviews
   F. Follow-up Reviews Completed after Corrective Action Plans (CAPs)

II. Quality Improvement Projects

A. Performance Improvement Projects (PIPs)

B. Red Tier & Strike Team

V. Managed Care Accountability Set (MCAS) Updates

VI. Policy and Procedures

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

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

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

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

Critical Elements:

Based on DHCS recommendation, changes were made and implemented to existing critical elements to align with the new tools and standards on 7/1/2022. Below is the updated list of critical elements related to the potential for adverse effect on patient health or safety, previously there were 9 now they are 14:

1. Exit doors and aisles are unobstructed and egress (escape) accessible.
2. Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag
3. Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of ESIP needles/syringes and alcohol wipes.
4. Only qualified/trained personnel retrieve, prepare, or administer medications.
5. Physician Review and follow-up of referral/consultation reports and diagnostic test results
6. Only lawfully authorized persons dispense drugs to patients.
7. Drugs and Vaccines are prepared and drawn only prior to administration.
8. Personal Protective Equipment (PPE) for Standard Precautions is readily available for staff use.

9. Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport, or shipping.
10. Needlestick safety precautions are practiced on site.
11. Cold chemical sterilization/high level disinfection: a) Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.
12. Cold chemical sterilization/high level disinfection: c) Appropriate PPE is available, exposure control plan, Material Safety Data Sheets and clean up instructions in the event of a cold chemical sterilant spill.
13. Autoclave/steam sterilization c) Spore testing of autoclave/steam sterilizer with documented results (at least monthly)
14. Autoclave/steam sterilization Management of positive mechanical, chemical, and biological indicators of the sterilization process.

Scoring and Corrective Action Plans

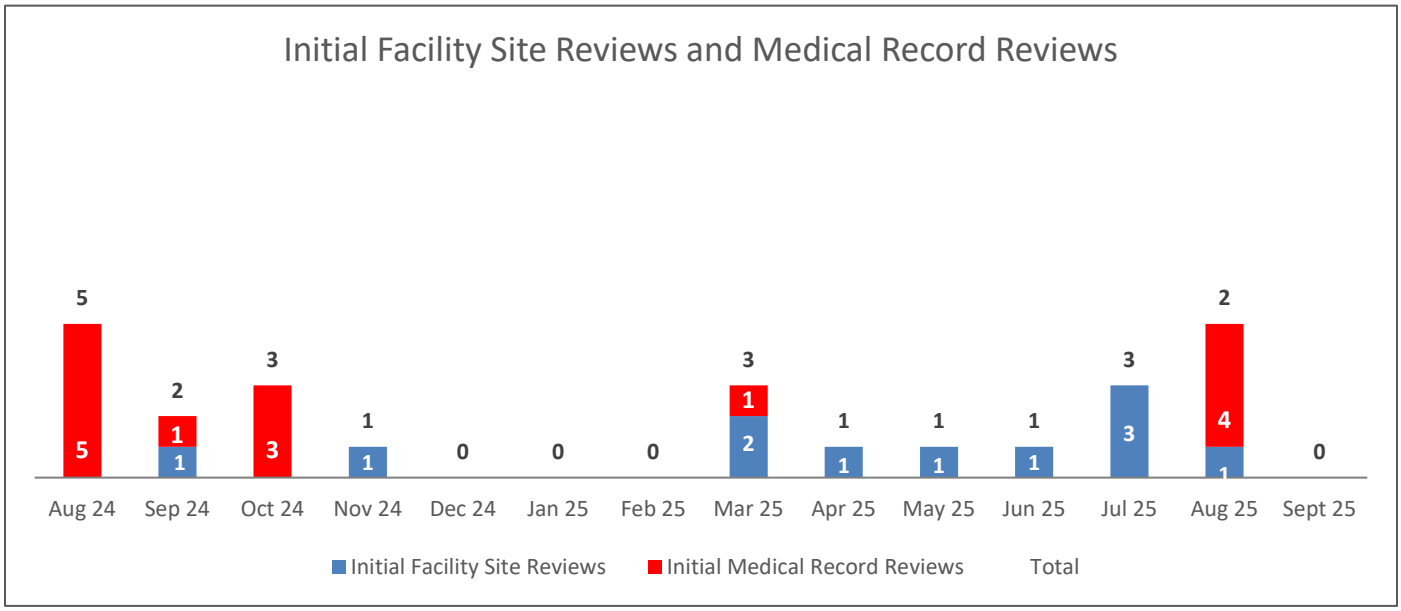
Provider sites that receive an FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are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

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

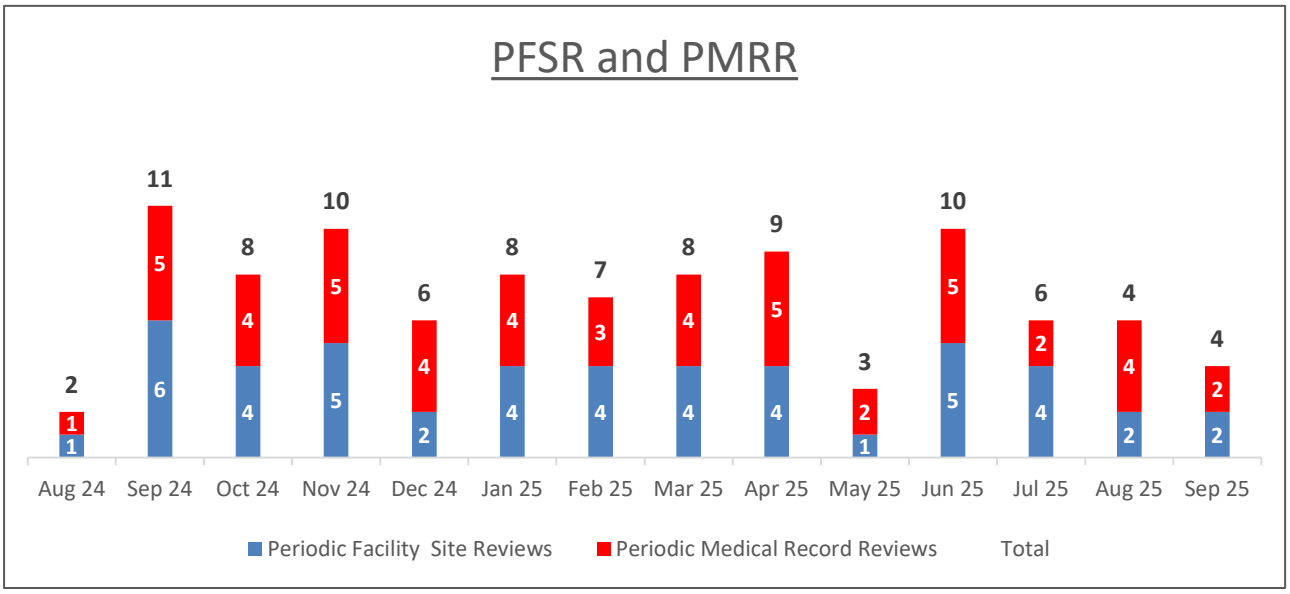
Corrective Action Plans (CAPs)

A CAP is issued when an initial, periodic, or focus review has deficiencies identified. DHCS requires follow up at 10 days for failure of any critical element, follow up for other failed elements at 30 days, and if not corrected by the 30 day follow up, at 90 days after a CAP has been issued. Most CAPs issued are corrected and completed within the 30 Day follow up period. Providers are encouraged to speak with us if they have questions or encounter issues with CAP completion. QI nurses provide education and support during the CAP resolution process.

A. Initial Facility Site Review and Medical Record Review Results:

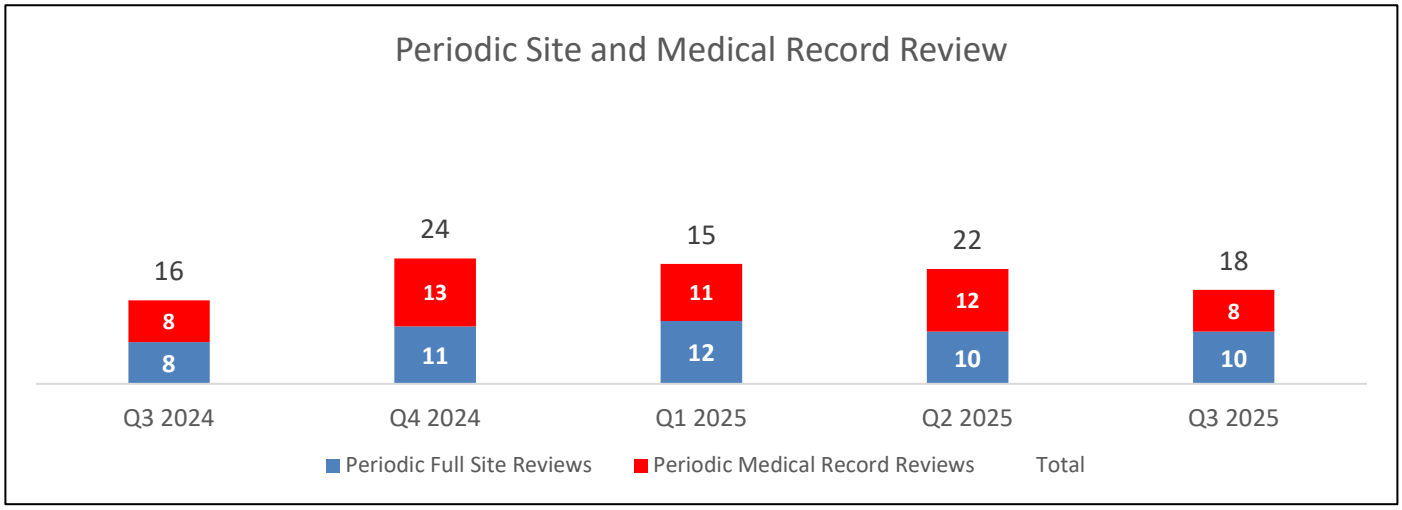


The number of Initial Facility Site and Medical Record Reviews is determined by the number of new providers requesting to join KHS' provider network. There were 1 IFSRs and 4 IMRR completed in Q3 of 2025 (YTD).



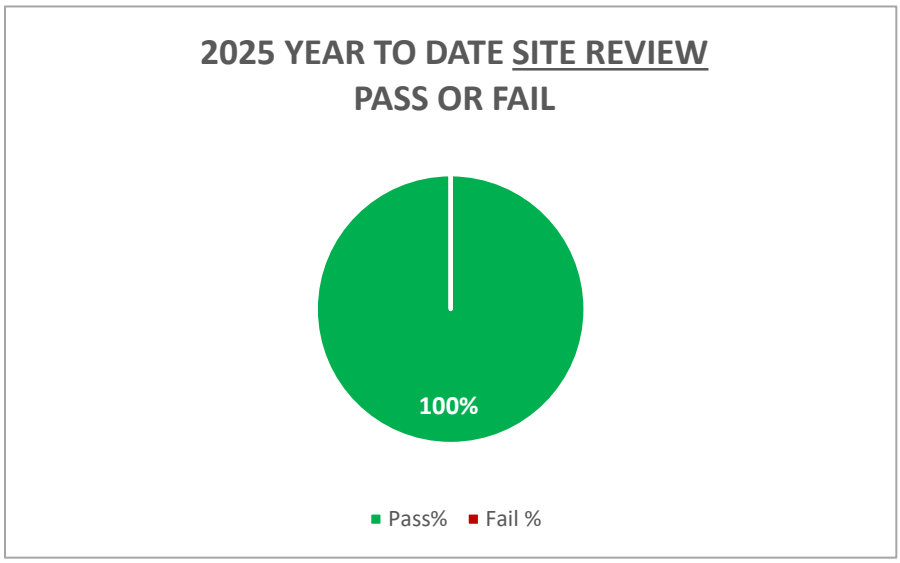
B. Periodic Full Site and Medical Record Reviews

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

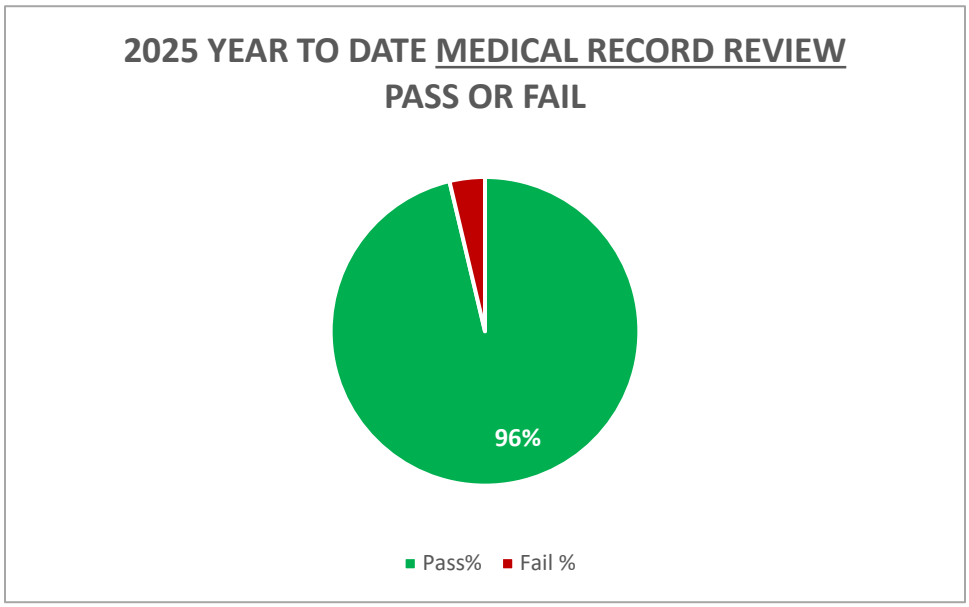


The above chart shows the number of Periodic Full Site Reviews and Medical Record Reviews that were due and completed for each quarter to date.

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



Based on DHCS' standard 80% or higher is considered as passed. Scoring 80% - 89% is considered a "conditional pass" and requires a CAP only for the elements that were non-compliant. A score below 80% is considered a Fail and requires a CAP for the entire site or medical record review.
For 2025 YTD, 100% of the Initial and Periodic site reviews performed passed. YTD there were 40 site reviews completed by early September 2025.



For 2025 YTD, 96% of the Initial and Periodic Medical Record Reviews performed passed. YTD there were 54 medial record reviews completed, 2 of these reviews failed in the first audit. However, following the failed review, additional education was provided, and CAPs were issued to correct deficiencies.

For Q3 2025, the top 3 deficiencies identified for Opportunities for improvement in Facility Site Reviews are:

1. Sites are not utilizing the California Immunization Registry (CAIR) or the most current version.
2. Standardized Procedures, Practice Agreements and Supervisory Guidelines are revised, updated and signed by the supervising physician and NPMP when changes in scope of services occur.
3. Standardized Procedures provided for Nurse Practitioners (NP) and/or Certified Nurse Midwives (CNM).

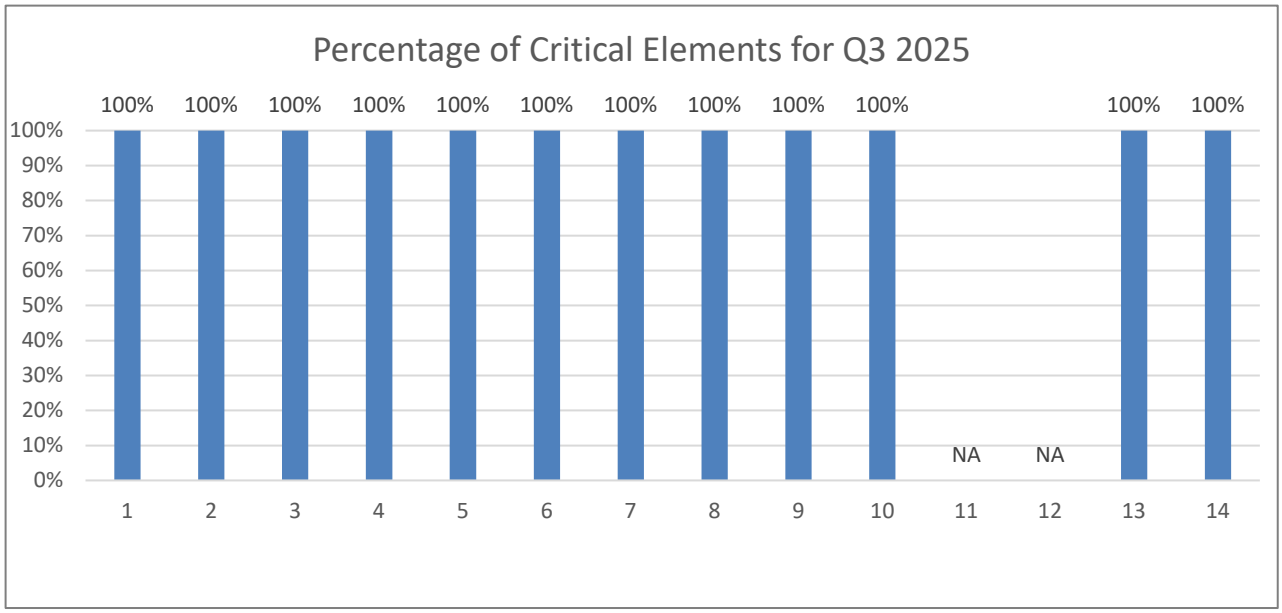
There were no deficiencies in Q3. We will continue to monitor for any new trends.

For Q3 2025, the top #3 deficiencies identified for Opportunities for improvement in Medical Record Reviews are:

1. Member Risk Assessment not being completed in both adult and pediatrics.
2. Hepatitis B Screening is not being completed in both adult and pediatrics.
3. Tuberculosis screening is not being completed in both adult and pediatrics.

Education was provided regarding these deficiencies. We will continue to monitor for any trends.

C. Critical Elements (CE) Percentage for Site Reviews:



There were 8 FSRs completed for Q3 2025, and 8 sites have passed the critical elements.

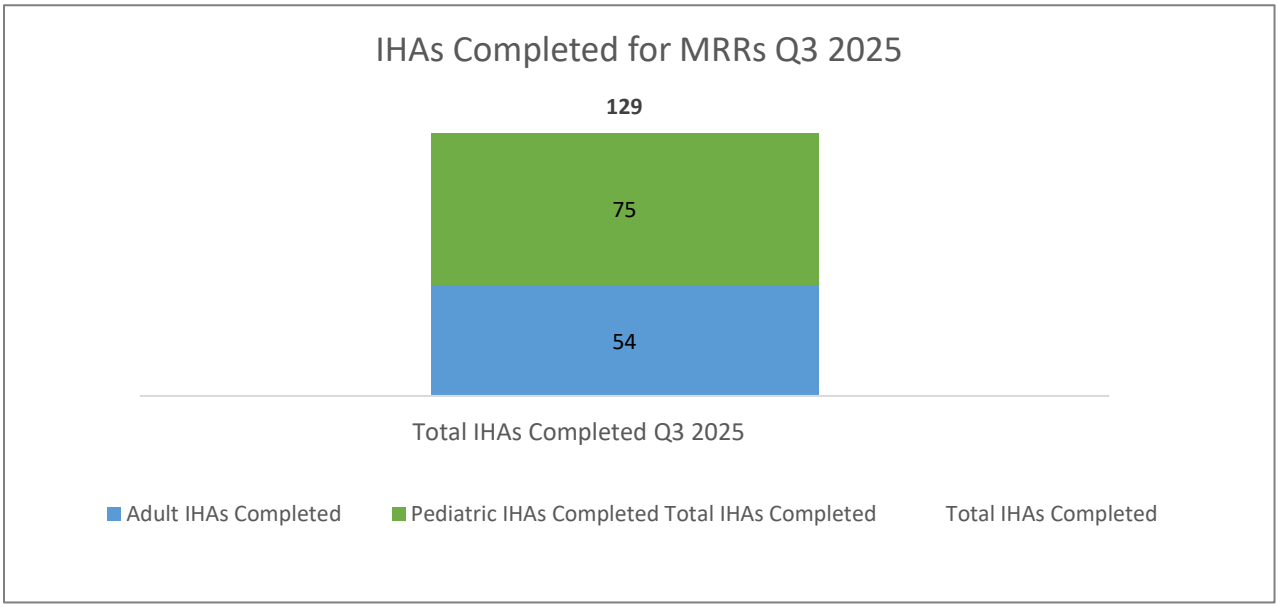
The site review team is working closely with sites by proving ongoing education to ensure compliance.

D. IHA's percentage for MRRs:

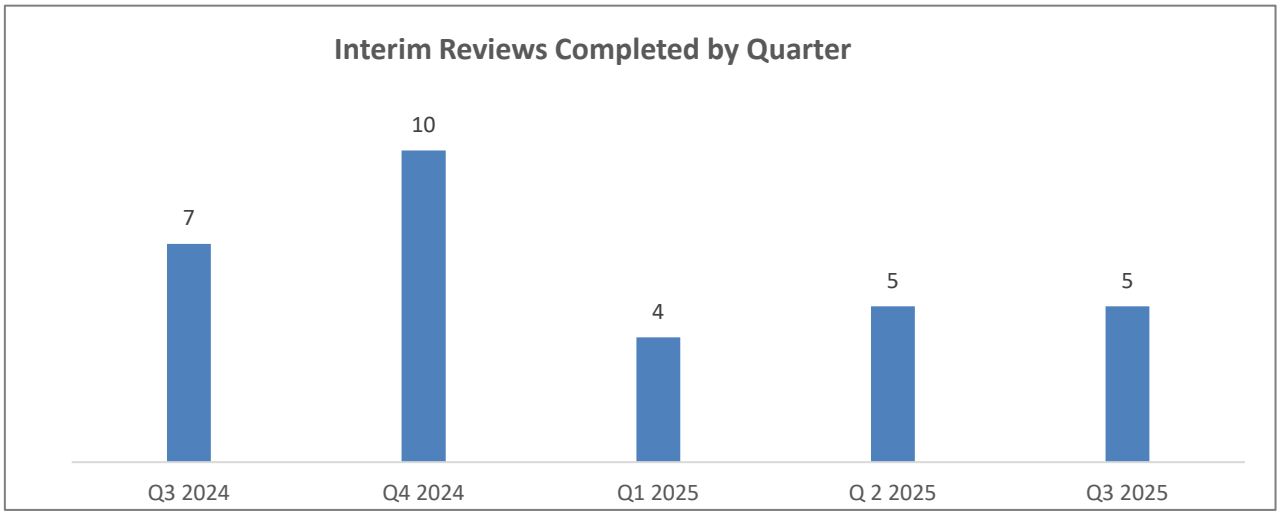
For Q3 2025, based on the medical record reviews, 129 IHA's were completed. 75 total pediatric charts and 54 adult charts. 66 out of the 75 pediatric charts were compliant and 9 were non-compliant. Out of all the 54 Adult charts, 45 adult charts were found to be compliant and 9 were non-compliant. Education was provided for the non-complaint charts.

Effective January 2023, an Initial Health Appointment replaced the Initial Health Assessment. Changes to the IHA no longer requires providers to utilize the age-appropriate Staying Healthy Assessment (SHA). An IHA must include all the following:

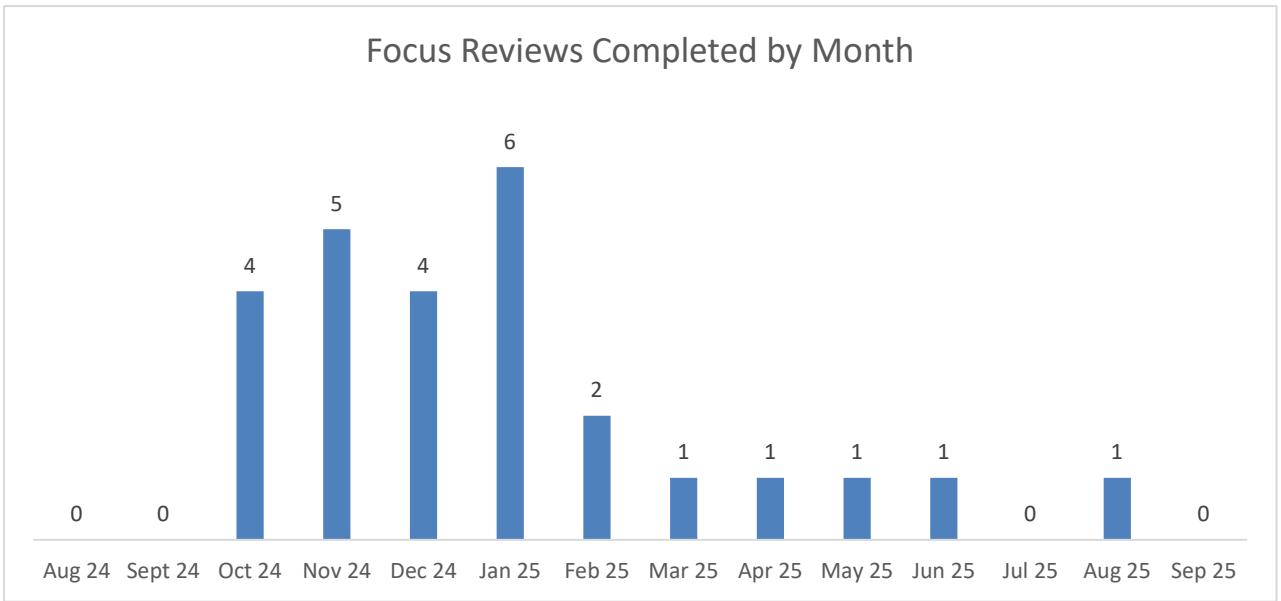
- A history of the Member's physical and mental health.
- An identification of risks.
- An assessment of the need for preventive screens or services.
- Health education; and
- The diagnosis and plan for treatment of any diseases.



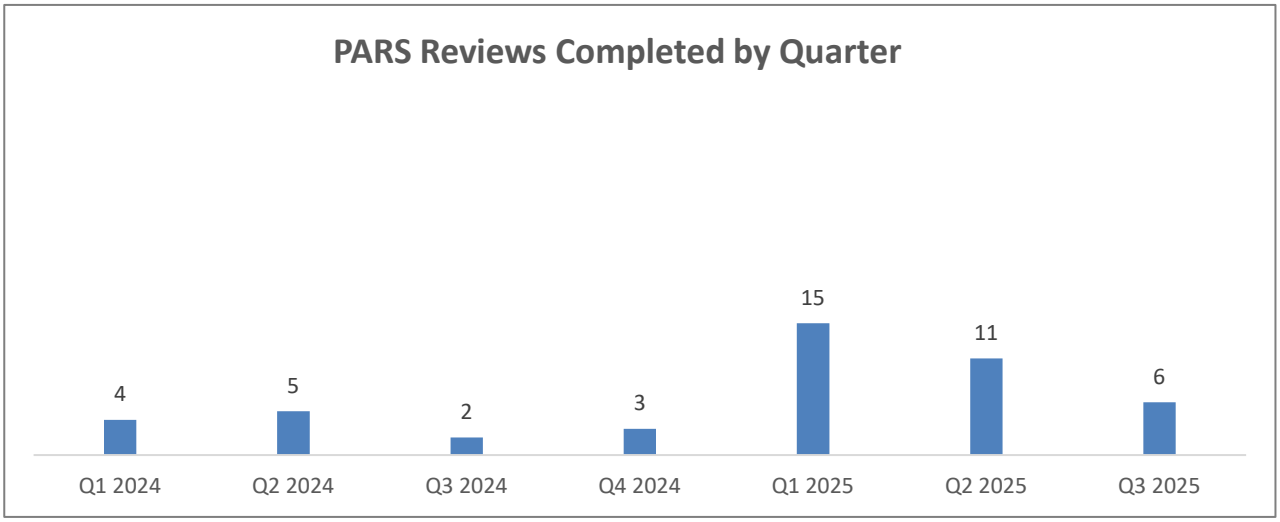
E. Interim Reviews: Interim Reviews are conducted between Initial and first Periodic Full Site Reviews or between two Periodic Full Site Reviews. Typically, they occur about every 18 months. These reviews are intended to be a check-in to ensure the provider is compliant with the 14 critical elements and as a follow-up for any areas found to be non-compliant in the previous Initial or Periodic Full Site Review. For Q3 2025, there were 5 Interim reviews completed to date.



F. Focus Reviews: Focused reviews are conducted when a site fails their review as a follow up to ensure elements are maintained. The focused review consists of FSR and MRR elements and is completed within 3-6 months of the failed review. For Q3 2025, we had 1 Focused MRRs completed. 19 Focused MRRs have been completed YTD.



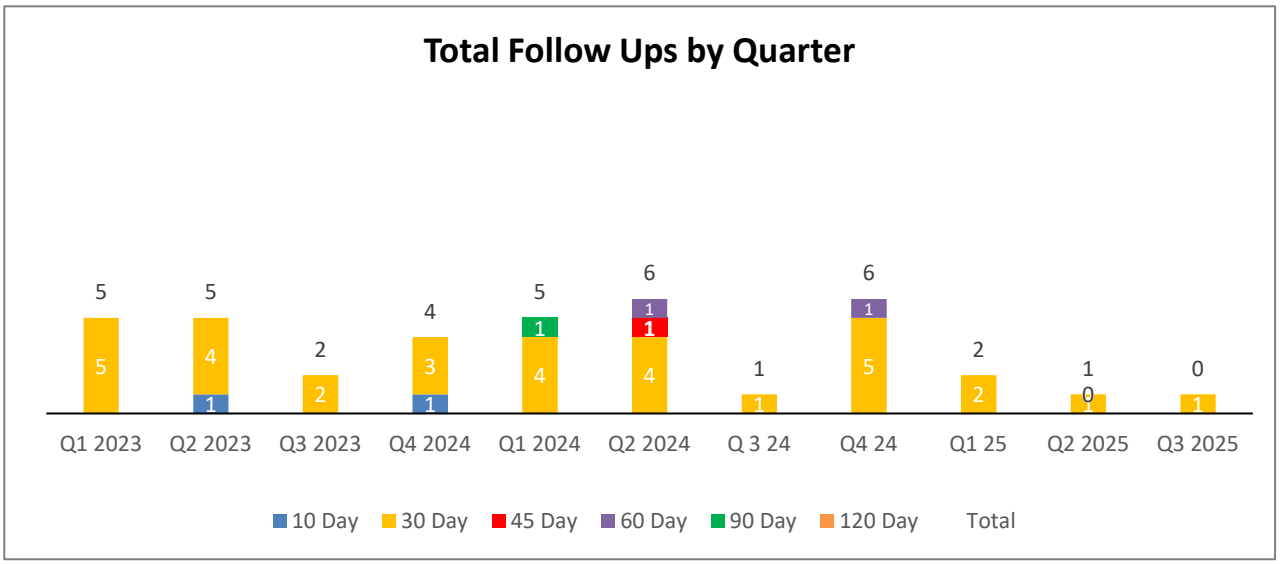
G. Physical Accessibility Review Survey (PARS):



PARS is completed alongside Initial Reviews, and the purpose is to review the accessibility of the site. PARS are completed every 3 years unless an Attestation is completed.

For Q3 2025, 6 PARS were completed.

H. Follow-up Reviews after a Corrective Action Plan (CAP):



The above chart reflects the total number of follow-ups completed for each quarter. For Q3 2025, there was 1 30-day follow-up completed.

II. Quality Improvement Projects:

A. Performance Improvement Projects (PIPs):

The Department of Health Care Services (DHCS) requires MCPs to annually report performance measurement results and conduct ongoing Performance Improvement Projects (PIPs) specific to measures that did not meet MPL.

Clinical PIP:

The new cycle of PIPs began in August 2023 through 2026. The clinical PIP will be focused on Health Equity, specific to the W30 0-15 months African American population.

The PIP team Attended two Maternal Health Disparities Webinars, participated in the maternal health disparities webinars, and met with PIP team leadership to plan next steps. We have worked on developing a process map and completed key drivers diagram.

All QI Tools completed, including Process Map. This was completed in collaboration with QP, Member Services, Member Outreach, and Marketing. Continued efforts on how to track data (member services outreach on W30, text reminders, mobile unit events). Work on the clinical PIP progresses, as we continue with intervention development and testing. These include weekend clinics with pilots' pediatric sites to close well visit gaps in care, and educational and supportive items, such as diaper bags for new parents and magnets to track well baby visits. The August 2025 submission was accepted with minimal feedback from HSAG.

Input and updates continue to be given for DHCS projects, while awaiting feedback from DHCS regarding the Accountability Project strategies and action items.

Non-Clinical PIP:

The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health teamt for support of interventions.

We have partnered with the Behavioral Health Department, UM, PHM, and various stakeholders. PIP work continues as we continue with 2025 efforts and development of additional initiatives. The August submission was accepted with minimal feedback by HSAG.

Ongoing meetings are scheduled to ensure success and to remain on track with deliverables. The PIP team is planning to meet with Kern Medical to discuss strategies for FUA/FUM measures.

B. MCAS Initiatives

The purpose of this report is to provide an update on interventions put into place to improve the compliance rates of the MCAS measures.

Interventions to improve our performance in MCAS:

- Provider Touchpoint Updates:
    - Meeting with top 20 providers per membership volume
    - The Big 3 providers and team meet every other month to review MCAS rates, improvements, focus targets and any barriers
    - Scheduled ad hoc provider groups to discuss rates, focus measures and questions.
        - Full set of resources given, including Provider Guide, Coding Card, 2024 MCAS measures list, Member Rewards, and Transportation Benefits.
        - Touching base with providers via email, via teams, and in-person meetings

- Met with IHI and DCHS collaboration team for a coaching call to refine and submitted Progress for the Children's Health Collaborative
- Opportunities to collaborate with Member Engagement for Health Fairs
- Opportunities to collaborate with community-based organizations continue and scheduling with mobile units around Kern County
- Dr. Duggal effort is continuing to improve patients' health that are dealing with Diabetes decreasing A1c's
- Adolescent Well Visit Smart Watch have completed the first launch and will continue through 2025 pending DHCS approval
- Incentive with postpartum mother to engage with W30 and establish care with provider at Kern Medical
- Kern Medical mobile unit was at the Kern Health Systems building providing well-visit for our summer interns, there was a successful turnout of 21 members
- Organized four Saturday clinics with two providers for children needing well child visits, who received POC gift card directly after their visit with a member engagement rep on sit
- Completed final review for Provider Guide and Coding Card for MY2025, with leadership approval and hand off to Marketing team for upload to the KHS external website
- The Member Services team supported calling applicable members that have a gap in care for W15-W30 to schedule their appointment with PCP, efforts of success were 20.83%.

- Member Engagement Reward Program (MERP):
    - IHA
    - BCS
    - CCS
    - CHL

  - GDS (HBD)
  - LSC
  - PPC Pre/ Post
  - W30
  - WCV
- Text Messages Campaign goes out to members encouraging them to schedule their appointments for gaps in care with a focus on:
  - Breast Cancer Screening
  - Blood Lead Screening
  - Initial Health Appointment
  - Chlamydia Screening
  - Cervical Cancer Screening
  - Prenatal & Postpartum Care
  - Well-Care Visits
  - Well-Baby Visits in first 30 Months of Life
- Robocalls will be sent out to members that do not receive text messages.

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

	Measure Acronym	Performance Measure	Measure Type (Methodology)	MY2024 Rate	MPL Rate	HPL Rate	MY2024 Rate vs. MPL	Hits Needed	MY2023 Rate	MY2024 vs MY2023
Chronic Disease Management Domain Measures										
1	AMR	Asthma Medication Ratio	Admin	75.02%	66.24%	76.65%	8.78%	0	71.66%	▲ 3.36%
2	CBP	Controlling High Blood Pressure	Admin, Hybrid	51.94%	64.48%	72.75%	-12.54%	3,664	48.39%	▲ 3.55%
3	GSD	Glycemic Status Assessment for Patients With Diabetes (>9%)[1]	Admin, Hybrid	58.50%	33.33%[2]	27.01%[2]	-25.17%	5,807	54.41%	4.09%
Cancer Prevention Domain Measures										
4	BCS-E	Breast Cancer Screening	ECDS	50.53%	52.68%	63.48%	-2.15%	712	58.61%	▼ -8.08%
5	CCS	Cervical Cancer Screening	Admin, Hybrid	53.44%	57.18%	67.46%	-3.67%	2,285	51.71%	
Children's Health Domains Measures										
6	TFL-CH	Topical Fluoride for Children	Admin	35.87%	19.00%	N/A	16.87%	0	39.53%	▲ -3.66%
7	W30–6+	Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	Admin	46.04%	60.38%	69.67%	-14.34%	604	52.20%	▲ 6.16%
8	W30–2+	Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits	Admin	68.30%	69.43%	79.94%	-1.13%	81	65.87%	▲ 2.43%
9	DEV	Developmental Screening in the First Three Years of Life	Admin	24.71%	34.70%	N/A	-10.99%	1,435	20.93%	▲ 3.78%
10	WCV	Child and Adolescent Well-Care Visits	Admin	34.07%	51.81%	64.74%	-14.00%	20,550	49.77%	▼ -15.70%
11	CIS–10	Childhood Immunization Status—Combination 10	Admin, Hybrid	18.26%	27.49%	42.34%	-9.23%	596	19.45%	▼ -1.19%
12	IMA–2	Immunizations for Adolescents—Combination 2	Admin, Hybrid	35.40%	34.30%	48.66%	1.10%	0	34.25%	▲ 1.15%
13	LSC	Lead Screening in Children	Admin, Hybrid	74.58%	63.84%	79.51%	10.74%	0	69.11%	▲ 5.47%
Behavioral Health Domain Measures										
14	FUM	Follow-Up After Emergency Department Visit for Mental Illness (30-Day Follow-Up)	Admin	53.82%	53.82%	73.12%	-12.35%	129	34.75%	▲ 19.07%
15	FUA	Follow-Up After Emergency Department Visit for Substance Use (30-Day Follow-Up)	Admin	23.83%	36.18%	49.40%	-20.38%	246	22.84%	▲ 0.99%
Reproductive Health Domain Measures										
16	CHL	Chlamydia Screening in Women	Admin	48.83%	55.95%	69.07%	-7.12%	846	57.05%	▼ -8.22%
17	PPC–Post	Prenatal and Postpartum Care—Postpartum Care	Admin, Hybrid	67.99%	80.23%	86.62%	-12.24%	667	74.66%	▼ -6.67%
18	PPC–Pre	Prenatal and Postpartum Care—Timeliness of Prenatal Care	Admin, Hybrid	66.45%	84.55%	91.85%	-18.10%	988	49.27%	▲ 17.18%

[1] A lower rate indicates better performance for this measure.

* Measures must be startified by race/ ethinicity per NCQA categorizations

**Hybrid/Admi: MCPs/PSPs have the option to choose the methodology for reporting applicable measures reates

Measure Met MPL

Measure Met HPL

▲ Measure increased compared to last year same time

▼ Measure decreased compared to last year same time

The chart below displays trending rates for MY2024 and MY2025:

MCAS MY2024 & MY2025 Performance Trending Metrics

Measure	Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	2024	70.00%	77.96%	75.70%	74.17%	75.00%	76.02%	74.53% ▼	73.80%	73.41%	73.16.%	72.32%	71.66%
	2025	52.94%	79.80%	78.56%	75.48%	74.80%	75.87%	75.82% ▲	75.42%				
BCS	2024	44.23%	45.63%	47.44%	48.73%	50.08%	51.42%	52.66% ▲	54.29%	55.56%	56.51%	57.69%	58.61%
	2025	42.71%	43.76%	46.66%	48.52%	49.89%	47.39%	48.54% ▼	49.41%				
CBP	2024	9.26%	18.53%	25.05%	29.78%	33.20%	39.86%	43.20% ▼	44.26%	45.40%	46.51%	47.43%	48.39%
	2025	10.99%	22.57%	32.06%	38.27%	42.30%	45.56%	48.48% ▲	49.73%				
CCS	2024	37.99%	36.76%	38.23%	39.55%	40.91%	42.09%	46.05% ▼	47.50%	48.49%	49.70%	50.69%	51.71%
	2025	45.81%	46.30%	47.70%	48.96%	50.43%	500.80%	51.80% ▲	52.50%				
CDEV	2024	6.26%	9.18%	11.86%	13.90%	15.79%	17.40%	18.80% ▼	19.66%	20.27%	20.64%	20.84%	20.93%
	2025	7.42%	10.97%	14.21%	17.12%	20.09%	21.79%	23.36% ▲	23.89%				
CHL	2024	22.15%	33.05%	35.23%	37.90%	39.96%	45.63%	48.75% ▲	51.25%	52.92%	54.37%	55.75%	57.05%
	2025	25.79%	34.17%	38.95%	43.18%	46.56%	45.43%	46.65% ▼	47.56%				
CIS-10	2024	10.01%	11.62%	12.17%	12.53%	12.42%	13.04%	13.14% ▲	18.61%	18.77%	19.03%	19.33%	19.45%
	2025	10.16%	12.47%	13.82%	14.27%	15.05%	17.93%	18.05% ▼	18.13%				
FUA 30Day follow up	2024	20.00%	16.11%	20.27%	19.10%	18.59%	20.93%	22.50% ▲	23.91%	22.91%	23.16%	23.13%	23.34%
	2025	16.25%	16.43%	19.51%	21.14%	21.36%	21.65%	23.75% ▼	23.13%				
FUM 30Day follow up	2024	9.09%	25.00%	21.88%	17.86%	15.91%	19.74%	20.82% ▼	20.25%	19.50%	20.53%	21.45%	20.72%
	2025	9.80%	13.91%	17.83%	17.03%	17.26%	30.56%	32.83% ▲	32.59%				
GSD*	2024	98.79%	92.48%	85.96%	80.56%	75.65%	71.23%	67.63% ▲	66.71%	62.92%	61.58%	59.61%	54.41%
	2025	96.31%	88.14%	74.38%	67.74%	64.57%	61.03%	59.85% ▼	59.64%				
IMA-2	2024	20.41%	21.78%	23.08%	24.49%	25.82%	27.71%	29.52% ▼	32.00%	32.88%	33.54%	34.06%	34.25%
	2025	23.52%	25.63%	27.62%	28.83%	30.65%	32.07%	33.33% ▲	34.26%				
LSC	2024	54.60%	57.84%	60.05%	62.04%	63.05%	64.95%	66.60% ▼	67.25%	67.90%	68.60%	68.96%	69.11%
	2025	64.57%	67.38%	69.66%	71.31%	72.55%	73.44%	73.99% ▲	74.25%				
PPC-Pre	2024	25.10%	26.84%	28.68%	30.70%	33.22%	37.55%	43.83% ▼	46.35%	48.18%	49.63%	49.44%	49.27%
	2025	27.34%	30.00%	60.25%	61.72%	63.46%	64.71%	65.78% ▲	66.38%				
PPC-Post	2024	47.47%	52.40%	57.47%	59.72%	61.74%	63.15%	67.75% ▼	64.29%	64.65%	71.15%	74.06%	74.66%
	2025	53.97%	59.25%	60.25%	64.83%	65.32%	65.48%	66.72% ▲	66.69%				
TFL-CH	2024	14.64%	17.16%	20.65%	23.68%	26.00%	29.18%	31.71% ▼	33.47%	35.76%	37.77%	9.36%	39.53%
	2025	16.98%	16.82%	23.76%	23.94%	26.90%	29.40%	33.94% ▲	34.06%				
W30 (0-15M)	2024	24.72%	29.30%	34.04%	37.92%	41.33%	44.51%	47.26% ▲	49.52%	51.70%	53.09%	53.62%	52.20%
	2025	21.56%	24.94%	28.57%	31.99%	35.59%	38.29%	41.26% ▼	44.45%				
W30 (15-30M)	2024	51.49%	54.30%	56.86%	59.32%	61.71%	63.56%	64.36% ▼	65.26%	66.12%	66.53%	66.71%	65.87%
	2025	53.86%	57.50%	60.60%	63.10%	65.28%	66.60%	67.69% ▲	67.98%				
WCV	2024	2.80%	6.13%	10.59%	15.01%	19.77%	24.31%	29.14% ▲	34.53%	38.73%	43.19%	46.72%	49.77%
	2025	2.75%	6.25%	10.67%	15.71%	20.67%	25.71%	27.55% ▼	29.76%				

GSD is an inverse measure, where a lower rate indicates better performance.*
Please note the above rates are based on admin and supplemental data, they do not include medical record review.

- Green arrow indicates an increase compared to previous year.
- Red arrow indicates a decrease compared to previous year.

As of September 2025, **14 out of 18 measures showed improvement** compared to this month last year:

- AMR - Asthma Medication Ratio
- CBP- Controlling High Blood Pressure <140/90 mm Hg.
- CCS - Cervical Cancer Screening
- CIS-10- Childhood Immunization Status
- CDEV- Developmental Screening in the First 3 Years of Life
- FUA- Follow-Up After Emergency Department Visit for Substance Use
- FUM- Follow-Up After Emergency Department Visit for Mental Illness
- GSD- Glycemic Status Assessment for Patients with Diabetes
- IMA-2- Immunizations for Adolescents – Combo 2 (Meningococcal, Tdap, HPV)
- LSC- Lead Screening in Children
- PPC- Pre- Prenatal & Postpartum Care –Prenatal Care
- PPC-Post- Prenatal & Postpartum Care – Postpartum Care
- TFL-CH- Topical Fluoride for Children
- W30 (15-30M)- Well Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

4 Measure that have not shown improvement compared to this month last year:

- BCS- Breast Cancer Screening
- CHL- Chlamydia Screening in Women Ages 16 – 24
- W30- (0-15M)- Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.
- WCV- Child and Adolescent Well-Care Visits

Please note we identified a significant decrease in W30 (0-15 months) rate for this year, BI is looking at the issue.

IV. Policy Updates: There were no policy updates in Q3 2025.

To: KHS EQIHEC

From: Melinda Santiago, Director of Behavioral Health

Date: December 16, 2025

Re: Behavioral Health Advisory Committee (BHAC)

Background:

KHS has formed a Behavioral Health Advisory Committee to help us enhance the Behavioral Health services for our members. Subcommittee that is comprised of behavioral health practitioners. The committee will support, review, and evaluate interventions to promote collaborative strategic alignment between KHS and the County Behavioral Health Plan (BHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). Kern Behavioral Health and Recovery Services (KBHRS) administers both the BHP and DMC-ODS, treating KHS members with the goal to maintain continuity, reduce barriers to access, linkage to appropriate services, opportunities to integrate care with medical care, and provide resources for members with mental illness and/or substance use disorder. This report reflects activities and outcomes for the third of 2025.

Meetings Held:

- October 16, 2025

Discussion Items:

- Behavioral Health Quarter 3 2025 Updates
  - Strategy 1: Internal Behavioral Health Department Development
  - Strategy 2: Mental Health Provider Network Evaluation
  - Strategy 3: County Behavioral Health Coordination
  - Strategy 4: Primary Care Provider Roles with SUD/MAT
- Q1 RAC Takeaways
- Proposed Provider Portal enhancements
- Reporting:
  - EPSDT Reporting
  - FUM and FUA Reports
  - Inpatient Reports
- Member Experience Surveys
- ABA Audit Tool –
- BHAC Calendar: 2026 Schedule

Fiscal Impact:

None.

Requested Action:

Review for approval.

KERN HEALTH SYSTEMS

BEHAVIORAL HEALTH ADVISORY COMMITTEE (BHAC) MEETING

Wednesday, October 16, 2024
at
12:00 pm

2900 Buck Owens Blvd.
Bakersfield, CA 93308
2nd Floor – Bear Mountain Conference Room

For more information, call (661) 664-5000

KERN HEALTH SYSTEMS

Behavioral Health Advisory Committee (BHAC)
AGENDA – October 16, 2024

AGENDA ITEM	AGENDA TOPIC	PRESENTER	ACTION
CALL TO ORDER	Call meeting order / Attendance-Quorum	Dr. Martha Tasinga, CMO and Melinda Santiago, BH Dir	*N/A*
APPROVAL OF MINUTES	July 2024 Minutes Review, Discussion, Motion to Approve	***All Voting Members***	*Approve*
OLD BUSINESS	Follow-up Agenda Item – Discuss Grievance Process Concerns brought up by committee. Follow-up meeting with Dr. Sidhu, Dr. Tasinga and Dr. Rao to work on this suggested algorithm. Dr. Rao suggested including Marlena Tanner, RD in this meeting as she has guidelines for eating disorders.	Melinda Santiago, BH Dir	*Informational*
NEW BUSINESS	a. National Committee for Quality Assurance (NCQA) Accreditation Standards i. QI 4 AB – Continuity and Coordination Between Medical Care and Behavioral Healthcare – Review qualitative and quantitative analysis • Discussion on selected opportunities ii. NCQA ME 7B (BH) Grievance and Appeal – Review qualitative and quantitative analysis • Discussion on selected opportunities iii. ME 7E – Annual Assessment of Behavioral Healthcare and Services – Review (BH) Member Experience Surveys qualitative and quantitative analysis • Discussion on selected opportunities	Melinda Santiago, BH Dir	*Approve*
OPEN FORUM	Open Forum / Committee Members Announcements / Discussion • APL 24-012 (SB 1019)	***Open to all Members***	*Discussion*
NEXT MEETING	Next meeting will be held Wednesday, **January 15, 2025, at TBD**	Informational only	*N/A*
ADJOURNMENT	Meeting Adjournment	Dr. Martha Tasinga, CMO and Melinda Santiago, BH Dir	*N/A*

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KERN HEALTH SYSTEMS

COMMITTEE: **BEHAVIORAL HEALTH ADVISORY COMMITTEE**
DATE OF MEETING: **July 10, 2024**
CALL TO ORDER: **8:08 AM BY MELINDA SANTIAGO, DIRECTOR OF BEHAVIORAL HEALTH - CHAIR**

Members Present On-Site:	Randolph Beasley, LMFT- Clinica Sierra Vista Alison Burrowes, Kern Behavioral Hlth & Recovery Srvs Mesha Muwanga, LMFT – Rhema Therapy Inc.	Melinda Santiago, KHS Director of Behavioral Health Martha Tasinga MD, KHS Chief Medical Officer	
Members Virtual Remote:	Cherilyn Haworth, CSUB Anuradha Rao, MD - Omni		
Members Excused=E Absent=A	Matthew Beare, MD – Clinica Sierra Vista (E) Franco Song, MD – Psychiatric Wellness Center (A)		
Staff Present:	Amy Daniel, KHS Executive Health Services Coordinator Andrea Gomez, KHS BH Intern Vanessa Hernandez, KHS Senior Support Clerk	Yolanda Herrera, KHS Credentialing Manager Annie Hirokawa, KHS BH Intern Courtney Morris, KHS Behavioral Health Supervisor	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga, CMO and Melinda Santiago, KHS Director of Behavioral Health called the meeting to order at 10:05 AM.		N/A
Committee Minutes	**Approval of Minutes** Approval of Minutes from April 8, 2024, meeting.	☑ **APPROVED**: Minutes were accepted as presented with no changes.	4/8/24
OLD BUSINESS	**BH Satisfaction Survey** Melinda informed the committee that the recommended changes were completed and that she appreciated everyone suggestions. The surveys will be going out this month.	☑ **CLOSED**: Informational discussion only	7/10/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	**<u>NCQA Grievance Category Report</u>** Melinda presented the Behavioral Health Complaints for 2023, in total there were 131 complaints filed and as of March 2024, there are 22 behavioral health complaints filed. Overall, KHS has maintained compliance with this performance goal. Dr. Tasinga reviewed with the committee the KHS Grievance process and how this information is received through Member Services. There were additional comments from committee members specific to how grievances are flagged and how are grievance handled when there are consistent concerns, from a member, with a certain provider. Dr. Rao informed the committee that when her patient is having an emergency and is in the Emergency Department or admitted to the hospital, she gets an email in her inbox which has been a very helpful notification. It was also request that perhaps having a follow-up item on the agenda explain the grievance process and how best KHS would like the providers to handle these types of grievances. Melinda informed the members that she would like to develop a tracking and trending on all behavioral health grievances from last year 2023 and 2024.	☑ **CLOSED**: Informational discussion only. ☑ **ACTION**: Follow-up Agenda Item – Discuss Grievance Process Concerns brought up by committee.	7/10/24
	<u>Quality of Clinical Care</u> Melinda provided a summary of the QI Performance Improvement Project (PIPs). The first submission for PIPs was approved by HSAG and the second PIP is considered a non-clinical Behavioral Health PIP which will be specific to FUA and FUM measures.	☑ **CLOSED**: Informational discussion only.	7/10/24
	<u>MCAS/QP Report Quarter 1 2024</u> Melinda presented the MCAS/QP 1st Quarter 2024 Report with the following highlights; however, she did not that the Director of Quality Improvement will present to future committee meetings on the Behavioral Health items: • QP Team continues the MCAS initiative supporting the	☑ **CLOSED**: Informational discussion only.	7/10/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	improvement of all measures • Continued focus on children's domain of care • QP Team will be abstracting the reviews by first week of May. Members discussed the FUA – Follow-up after Emergency Department Visit for Alcohol and other drug abuse or dependency and/or Mental Illness in patients 6-years and older measures. The State expects continuous improvement in this area requiring the health plans to get to these types of members quickly in assisting the member with necessary treatments and services. Members shared their experiences in notifications from other Hospital Eds which helps make contacting the member easier and getting them into the required program and/or services. Members discussed issues surrounding how best to get ahold of members and members who are "no-shows". Melinda asked if the committee members utilize the portal, and most do not. Melinda informed the committee that they will be working to improve to the Portal.		
	MOU with MHP Melinda presented information on combining all mental health services under one single MOU with KBHRS including the exchange of information and sharing of data. There will be quarterly meeting between KHS, KBHRS and Anthem in a public posted meeting that will be available on our website. Eating disorders is a new category and is a medical responsibility for the health plan to provide a seamless transition between both services. KHS is working to develop guidelines. Dr. Rao suggested developing an algorithm to share amongst other hospitals.	☑ **ACTION**: Follow-up meeting with Dr. Sidhu, Dr. Tasinga and Dr. Rao to work on this suggested algorithm. Dr. Rao suggested including Marlena Tanner, RD in this meeting as she has guidelines for eating disorders.	
OPEN FORUM	**<u>Open Forum</u>** Alison Burrowes added an update on SB-43 to the committee.	☑ **CLOSED**: Informational discussion only.	4/8/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEXT MEETING	Next meeting will be held October 16, 2024.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 9:30 am. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Behavioral Health Advisory Committee Minutes 7/10/2024

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

National Committee for Quality Assuance (NCQA) Continuity and Coordination Between Medical and Behavioral Health Care
July, 2023

Overview:

Kern Health Systems' (KHS) Behavioral Health (BH) Department has the mission of ensuring members receive equitable, timely, appropriate, and integrated behavioral health services through referrals to appropriate BH providers, wellness and rehabilitative programs; collaborating with Provider Network Management to ensure adequacy and access to BH providers, integrating BH services with medical care when clinically indicated, and analyzing data to measure performances and outcomes of interventions.

KHS provide medically necessary Medi-Cal covered physical health care services to Plan members requiring specialty mental health services and substance use disorder services delivered by designated Kern County Medi-Cal programs for these services.

Non-Specialty Health Services (NSMHS) are those services that KHS must provide when they are medically necessary and provided by Primary Care Provider (PCP) or mental health network providers within their scope of practice. KHS is directly responsible for providing covered non-specialty mental health services for beneficiaries with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders.

At any time, members can choose to seek and obtain a mental health assessment from a licensed mental health provider within the KHS's provider network. PCPs are recommended to complete mental health screenings annually and as needed for their patients. Members with positive screening results should be further assessed. The member may be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP shall refer the member to a behavioral health provider, first attempting to refer within the KHS network.

To ensure the coordination of medically necessary Medi-Cal covered physical, mental health and substance use disorder services, KHS collaborates with Kern Behavioral Health and Recovery Services (Kern BHRS), the designated Mental Health Plan (MHP)and the County Drug Medi-Cal Organized Delivery System (DMC-ODS) to implement protocols to ensure care coordination, data sharing, and non-duplicative services with the Mental Health Plan through mutually agreed upon Memorandum of Understanding (MOU) between parties.

To promote collaboration, the MOU addresses policies and procedures for the management of member's care for both KHS and program providers, including the following:

i. KHS developed policies and procedures for the timely and frequent exchange of:
   a. Member information and data, including behavioral and medical health data.
   b. Maintaining the confidentiality of exchanged information and data
   c. Bi-directional monitoring of data exchange
   d. Process for obtaining member consent

ii. KHS implemented processes for establishing medical necessity determination, care coordination, creating closed loop referral systems, and exchange of medical information between KHS and the MHP and DMC-ODS.
iii. KHS and Kern BHRS institute policies and procedures to address and document QI activities for services covered under the MOU, including applicable performance measures, such as:
    a. QI initiatives and reports that track cross-system referrals, member engagement and service utilization.
    b. Facilitating member access to medically necessary services and network providers during non-business hours.
iv. KHS is implementing closed loop referral systems referrals.
v. KHS covers medical necessity Non-Specialty Mental Health Services (NSMHS)
    a. For individuals under 21 years of age, a service is medically necessary if the service meets the EPSDT standard set forth in Section 1396d(r)(5) of Title 52 of the United States Code. Services that sustain, support, improve, or make more tolerable a behavioral health condition is considered to ameliorate the condition, and are thus medically necessary and are covered as EPSDT services.
    b. For individuals 21 years old and over, a service is medically necessary when it is reasonable and necessary to protect life, to prevent severe illness or disability, or to alleviate severe pain.

Non-Specialty Mental Health Services:

i. Mental health evaluation and treatment, including individual, group or family psychotherapy.
ii. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
iii. Outpatient services for the purpose of monitoring drug therapy.
iv. Psychiatric consultation.
v. Outpatient laboratory, drugs, supplies and supplements.
vi. Substance Use Disorder (SUD), including Drug and Alcohol Screening, Brief Intervention and Referral to Treatment (SABIRT) services. (P&P 21,03-P Alcohol and Substance Use Disorder Treatment Services.
vii. Coordination of care for maternal mental health

Care Coordination Activities:
The Director of Behavioral Health works with liaisons of Kern BHRS to facilitate member access to specialized programs and services to promote coordination and communication between specific County programs and services.

Procedures for accessing behavioral health services, referral processes and care coordination with Kern BHRS are outlined in KHS' policies and procedures.

KHS uses DHCS-approved Screening Tools for youth under age 21 and adults 21 and over to offer timely screening for all members. These tools are used for members who are not currently receiving mental health services to determine the most appropriate system of care for initial mental health assessment.

Care Management:

KHS retains responsibility for performing all BH care coordination activities related to direct BH-contracted providers. The medical management system is used to track and trend members needing care management and those with catastrophic or potential high-risk BH conditions to ensure appropriate follow-up and intervention.

BH staff participate in Kern BHRS interdisciplinary care team (ICT) meetings for specific target populations for complex cases to ensure members are connected to appropriate services. On an as needed basis, BH staff attend ICT meetings with KHS's Population Health Management (PHM) for complex cases to ensure members are connected to medically necessary services.

Continuity of Care:
KHS' BH staff facilitates continuity and coordination of care for members accessing behavioral health care. BH staff follows procedures to coordinate the exchange of information between PCPs, inpatient admitting physicians, specialists, BH providers, surgical centers, home health agencies, Out of Network (OON) providers, and skilled nursing facilities to ensure continuity of care.

Transition of Care:
KHS reviews and processes the DHCS-approved Transition of Care Tools to support timely and coordinated care for members who are currently receiving mental health services from either the MCP or MHP. This tool is used when completing a transition of services to the other delivery system or when adding a service from the other delivery system to their existing mental health treatment.

Coordination of Care Between Medical and Behavioral Health Care:

Lack of communication and coordination between medical and behavioral health care can lead to poor quality and unsuccessful patient outcomes, while well-integrated care increases patient satisfaction and produces better clinical results. Gaps in care occur when a patient is admitted to mental health facility due to lack of data sharing and coordination between the MHP and MCP.

Coordinating care for specialty mental health services, where they are carved-out to the MHP, presents challenges due to differences in systems, behavioral health structure, levels of authorities for contacts, and overall difficulties in communication between medical providers and behavioral health providers. Defining the scope of coverage of non-specialty mental health services versus specialty health services oftentimes add to the inconsistencies and confusion to the PCPs in determining what is appropriate referral and in navigating the financial payment systems.

The importance of training, education and collaboration are crucial to efficient care coordination. BH providers may not be familiar with the process of sharing protected health information (PHI) with primary care practitioners and vice versa. The issue of privacy and confidentiality, trusts and handling of sensitive records pose hesitancy on the part of BH practitioners to share records when it comes to treatment, case management, and coordination of care. The HIPAA standards allow for medication prescription and monitoring, the modalities and frequencies of treatment furnished, results of clinical tests, and summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

At KHS, strategies were put in place to assure members receive quality behavioral health services while receiving medical care. Process improvement activities are being implemented to ensure open

communication and coordinated care between medical and behavioral health care providers, as well as with the MHP facilities.

Population Assessment:

Kern County, the 11th largest county in California, has 49% of the population living in poverty. Kern County consistently ranks low in major health indicators from birth outcomes, mortality, communicable and chronic diseases, air quality, healthcare coverage, and food insecurity.

Opportunities for Coordination Between Medical and Behavioral Health Care

KHS collaborates with the MHP System of Care to provide members with equitable and high-quality integrated care, to collect and analyze data, and to improve coordination between medical care and behavioral health care.

The data on the opportunities below were collected from 2023, so this report is a baseline study.

QI 4 Element A Factors 1-6

Element A	Targeted Measures	Methodology for Data Collection
Exchange of Information	Provider Satisfaction Survey	Survey results
Appropriate Diagnosis, Treatment, and Referral of Behavioral Health Disorders Commonly Seen in Primary Care	Anti-depression Medication Management	HEDIS, Encounter data, claims, pharmacy data
Appropriate Use of Psychotropic Medications	Pharmacy Drug Utilization Review for Patients With ADHD	HEDIS, Encounter data, claims, pharmacy data
Management of Treatment Access and Follow-Up for Members with Co-Existing Medical and Behavioral Health Disorders	Multiple Medical Conditions at Risk for Behavioral Health Issues	Encounter data, claims data
Primary or Secondary Preventive Behavioral Healthcare Program Implementation	Maternal Mental Health	Encounter data, claims data
Special Needs of Members with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED)	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Claims data

QI 4 Element A Factor 1

Exchange of Information

A. Activity

Provider Satisfaction Survey

B. Description and Relevance:

Complete and timely exchange of medical information is essential to the treating practitioner, whether it is behavioral health clinician or a primary care physician.

Studies show that inadequate continuity of care between BH providers and PCPs is a particular concern for providers, especially the lack of integrated BH and medical care for those whom mental health services are carved out. In this case, there is no standardized communication protocols between behavioral health specialists and PCP, and real and perceived barriers affect the transfer of information between behavioral health services and medical care services.

The Provider Satisfaction Survey is a means of assessing the primary care practitioner's experience and satisfaction with continuity and coordination of care with behavioral health specialists and vice versa.

C. Goal:

The immediate goal is to achieve a 5% year over year improvement on the selected criteria on the provider satisfaction survey tool. The ultimate goal is to achieve 80% rating on the selected criteria.

D. Methodology:

The Provider Satisfaction Survey was conducted by the Press Ganey Group, a nationally recognized vendor for developing and distributing patient satisfaction surveys. The providers surveyed were a mixture of PCPs, specialists, behavioral health, and others. The 'others' respondents were not defined.

There are two attributes related to behavioral health:

1. Timeliness of feedback/reports from BH providers.
2. Access to BH non-urgent care

E. Results

a. Quantitative Analysis:

QI 4 Element B Factor 2

(1) Survey Response:

Respondents	# Who Responded	2023 Response Rates	2022 Response Rates
PCPs	41	7.9%	13.0%
Specialists	80	14.1%	15.4%
Behavioral Health	20	9.5%	10.5%

Others	41	20.3%	24.3%
Total	182		
Sample Size	1500	12.1%	14.6%

Overall, there was a decrease in the number of PCP respondents in 2023. The response rate was 5.1 percentage points lower in 2023 compared to 2022. A slight decrease for specialists and behavioral health was noted. Respondents called "Others" were not identified, and a four-percentage point decrease was also noted in 2023.

(2) Criteria:

Questions	2022 Result	2023 Result	Percentage-Point Change	Percent Change
Timeliness of feedback/reports from BH provider	45.1%	47.6%	2.5	+ 5.54 %
Timeliness of feedback/reports from Specialists to BH provider	48.00%	57.14%	9.14	+ 19.73%
Access to BH non-urgent care	39.2%	48.8%	9.6	+ 24.49 %

The 2023 result showed an increase of 5.47 % on the timeliness of feedback/reports from BH provider from 2022. Similarly, access to BH non-urgent care showed an increase of 24.49% in 2023 compared to 2022. **The ultimate goal of 80% satisfaction was not met.**
However, the immediate goal of increasing year over year improvement of selected criteria by 5% was met for both criteria.

QI 4 Element B Factor 2

b. Qualitative Analysis:

The primary reason for the dissatisfaction with the exchange of information may be influenced by the following factors:

i. There is no clear process for effective practitioner communication
ii. PCP is not aware of BH referral
iii. PCP has no contact information for the BH practitioner
iv. BH practitioner is hesitant to share information because of confidentiality, privacy and trust
v. BH practitioner lacks understanding of regulatory and ethical standards for care coordination
vi. BH practitioner is hesitant to share any information because the member refuses to give consent for his/her record to be shared with the PCP.
vii. There is insufficient coordination and communication among internal departments within KHS.
viii. Information exchange systems between providers are not optimal for ease of sharing member information. Many practitioners don't have access to the Health Information Exchange (HIE). This can be a major barrier in cases where a member switches providers and medical history is not shared in a timely manner.
ix. The BH practitioners and medical practitioners are rarely on the same EMR system which means that they are not able to see the relevant clinical information needed to better manage their patient.

a. In cases where external EMRs are not accessible, a practitioner must rely on the member or family for information.
b. School districts with BH practitioners can't record member information into accessible EMRs.
c. External BH provider EMRs are typically not accessible as they it is a closed EMR system that does not allow access to external EMR systems.

F. Barriers and Opportunities

QI 4B Factor 3

Barriers	Opportunities
There is no pathway of communication between medical practitioners and behavioral health practitioners	There is an opportunity to develop a process that will facilitate exchange of information between medical and BH practitioners.
Lack of education regarding the importance of collaboration among providers involved in patient care.	There is an opportunity to provide training and education to practitioners.
Lack of interdepartmental collaboration	There is an opportunity to integrate efforts to provide quality care and service to members and providers.

QI 4 Element B Factor 5

G. Planned Interventions:

i. KHS will leverage the enhancement of the Provider Portal to promote the exchange of information between the primary care practitioners and behavioral health providers.
   a. The Care Coordination Form will be posted on the portal to be used by the PCPs when making referrals to the BH practitioner. In the same manner, the BH practitioner can use the form to provide update and/or plan of care once referral is done. The goal is for all PCPs and contracted specialty providers to utilize the Provider Portal not only for updates and directives from KHS but be a source of member information that is beneficial to all clinicians involved in the member's care.

   b. Continue to promote the Provider Portal to all practitioners via
      i. newsletters
      ii. joint operations meetings with KHS provider network and primary practitioners
      iii. provider meetings and forums
      iv. quarterly provider dinners

   c. Promote the Care Coordination of Care Forms by introducing and disseminating to offices, educating the office staff and providers on the objective and purpose of the Continuity of Care (CoC) form.

d. Provide other tools, such as behavioral tool kits, Healthcare Effective Data and Information Set (HEDIS) information resources to increase physicians' knowledge about the requirements of specific HEDIS measures.

ii. Continue to gather the departments that are most likely to impact the provider satisfaction survey and improve the exchange of information between providers. Establish a cadence of meetings with business owners to discuss survey results and develop strategies to improve exchange of information among practitioners and increase their satisfaction.

iii. Emphasize to the members the importance of collaboration between practitioners involved to provide continuity of care in a safe and efficient manner. These activities would be through member newsletters, providing updates to the website, the use of social media with content specific to member engagement, community engagement efforts and partnerships with local organizations and health fairs. By implementing these outreach and education strategies, we aim to foster a collaborative relationship between patients and providers, ultimately leading to better continuity of care and improved health outcomes. Presenting the benefits of exchanging information between providers to help with preventative care, determining risk factors, treatment planning, and empowering the individual to engage actively in monitoring their own care.

QI 4 Element A Factor 2

Appropriate Diagnosis, Treatment, and Referral of Behavioral Health Disorders Commonly Seen in Primary Care

A. Activity

Antidepressant Medication Management (AMM)

B. Description and Relevance

Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects.

Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated, as well. (NCQA)

Studies revealed that the need to monitor treatment adherence and condition severity across providers, further supports the critical importance of communication between MHPs/KHS BH practitioners and PCPs. Evidence suggests that persons with mental illnesses are less likely to receive appropriate testing and adequate intervention and monitoring.

C. Methodology -

KHS uses HEDIS data collection for the methodology:

a. HEDIS Data

The HEDIS AMM measure assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. (NCQA)

Two rates are reported:

- Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks).
- Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months).

b. Pharmacy Process

KHS will utilize claims, encounter and HEDIS data or provider profile to identify those members who were prescribed antidepressants. These data will be reconciled with the pharmacy data to determine who refilled the prescription for at least 12 weeks during the acute phase, and those who continue to refill the medication for at least six months for the continuing phase.

To promote communication among providers and continuity of care, KHS pharmacy will collaborate with the BH Department, notify the PCPs and treating behavioral health practitioners of the utilization patterns of their members who are on antidepressants and identify those who are outliers.

The pharmacy department will send utilization data of the prescription to the members' respective practitioners.

D. Goals

1. Achieve the 50th percentile of NCQA's Quality Compass (QC) benchmark for the AMM measure.
2. Send notification to PCPs and BH practitioners regarding their patients' utilization patterns of prescribed antidepressants.
    a. Identify outliers

QI 4 Element B Factor 2

E. Results

Quantitative Analysis:

1. **HEDIS Data:**

Name	MY 2023 Rate	HEDIS 2022 Benchmark	2022 Rate	2021
(AMM) Antidepressant Medication Management – acute phase	65.03% (1294/1990)	60.9	55.79	52.05
(AMM) Antidepressant Medication Management – continuation phase	47.29% (941/1990)	43.9	40.71	34.58

The rate for MY 2023 showed improvement for the acute and continuation phases over two years. The rate in MY2023 surpassed the established goal and national benchmark.

Qualitative Analysis:

i. KHS has no mechanism for tracking members who were referred to BH providers for depression, were prescribed medications and who were compliant with antidepressant medications.

   a. BH practitioners and PCPs are not aware of the drug utilization patterns of their patients. Non-compliance is common to those members who fail to see their doctors regularly

ii. The exchange of information between healthcare providers may not be fully effective, impacting the sharing of member details. Many practitioners lack access to Health Information Exchanges (HIE), creating challenges when a member changes providers and their medical history is not promptly transferred. This issue is particularly problematic if the initial prescription was given by a behavioral health provider, as primary care providers who later care for the member might not receive crucial medical information. Consequently, they may either not continue necessary medication or inadvertently duplicate prescriptions, disrupting treatment and diminishing care effectiveness.

iii. Primary care providers (PCPs) may not know that a member is taking depression medications because they have not received this information from behavioral health (BH) providers. A key obstacle is the need for a completed release of information form, which is often misunderstood in relation to HIPAA regulations and remains a significant barrier.

iv. PCPs sometimes discontinue medication if a member experiences side effects or seems to have improved, without consulting the BH practitioners.

v. Members' perceptions of their treatment's effectiveness can also affect their adherence to antidepressant therapy. If members believe their medications are not working, they might stop taking them. Alternatively, if they feel their condition has improved too quickly, they may discontinue treatment. Additionally, side effects from antidepressants can be bothersome, leading members to stop treatment altogether.

vi. Behavioral health and medical practitioners frequently use different Electronic Medical Record (EMR) systems, preventing them from accessing each other's relevant clinical information, which is essential for effective patient management.

vii. Although stigma around mental health has decreased, some members may still feel judged by their medical providers or communities, leading them to discontinue treatment to avoid perceived judgment.

Conclusion Based on Qualitative Analysis

The identified barriers, including continuity and coordination of care issues, have been recognized as significant factors contributing to the low rates and failure to meet the goals for the AMM measure.

F. Barriers and Opportunities

Barriers	Opportunities
Lack of collaboration between PCPs and BH specialists.	There is an opportunity to facilitate communication between PCPs and BH specialists.
	There is an opportunity to educate PCPs and BH providers regarding the importance of collaboration to promote equitable care for members.
PCPs are not aware of the BH referrals	There is an opportunity to promote the provider portal among PCPs where member information is available. There is an opportunity for departmental collaboration to develop strategies in promoting communication between PCPs and BH specialists.
MHP providers do not have access to provider platform to share information to PCP.	There is an opportunity to create data exchange with MCP with coordination information that includes

G. Planned Interventions

i. Team Collaboration, such as workgroup meetings
   a. Gather the business owners that are most likely to contribute to the improvement of the AMM measure, e.g., QI dept, pharmacy, Medical Director, provider network, and PHM dept to discuss root causes for low rates and develop strategies to improve performance.

ii. Continue to collaborate with the pharmacy department to keep primary care practitioners aware of the utilization of prescribed medications for their members.

iii. Consistently collaborate with PHM department to improve tracking of PHQ9 forms and tracking the follow of the referrals to appropriate BH providers.

iv. Make available the standards of practice, i.e., clinical practice guidelines for use in primary care settings.

QI 4 Element A Factor 3

Appropriate Use of Psychotropic Medications

A. Activity

Follow-Up Care for Children Prescribed with ADHD Medication

B. Description and Relevance

Attention-deficit/hyperactivity disorder (ADHD) is one of the most common mental disorders affecting children. Eleven percent (11%) of American children have been diagnosed with ADHD. The main features include hyperactivity, impulsiveness and an inability to sustain attention or concentration. Of these children, 6.1% are taking ADHD medication.

When managed appropriately, medication for ADHD can control symptoms of hyperactivity, impulsiveness and inability to sustain concentration. To ensure that medication is prescribed and managed correctly, it is important that children be monitored by a pediatrician with prescribing authority. (NCQA)

Studies revealed that the need to monitor treatment adherence and condition severity across providers further supports the critical importance of communication between MHPs and PCPs. Evidence suggests that persons with mental illnesses are less likely to receive appropriate testing and adequate intervention and monitoring.

C. Methodology

HEDIS Data:

The two rates of this HEDIS measure assess follow-up care for children prescribed an ADHD medication:

- *Initiation Phase*: Assesses children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.

- *Continuation and Maintenance Phase*: Assesses children between 6 and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days and had at least two follow-up visits with a practitioner in the 9 months after the Initiation Phase.

D. Goal

The goal is to achieve the 50th percentile of NCQA's Quality Compass benchmark for the ADD measure:

QI 4 Element B Factor 2

E. Results

Quantitative Analysis:

Name	MY 2023 Rate	HEDIS 2022 Benchmark	2022 Rate	2021
(ADHD) Follow-Up Care for Children Prescribed with ADHD Medication Management – initiation phase	43.83% (174/397)	43.6	40.50	31.27
(ADHD) Follow-Up Care for Children Prescribed with ADHD Medication Management –	41.64% (112/269)	53.1	41.60	28.00

continuation and maintenance phase				

Compared to the rates in 2022 and 2021, there has been a steady increase in MY 2023 for both initiation and continuation/maintenance phases. The MY 2023 rate did not meet the established and national benchmark for the continuation/maintenance phase.

Qualitative Analysis:

i. KHS has no mechanism for tracking members who were referred to BH providers for ADHD, were prescribed medications and who were compliant with ADHD medications.

ii. BH practitioners and PCPs are not aware of the drug utilization patterns of their patients. Non-compliance is common to those members who fail to see their doctors regularly

a. The exchange of information between healthcare providers may not be fully effective, impacting the sharing of member details. Many practitioners lack access to Health Information Exchanges (HIE), creating challenges when a member changes providers and their medical history is not promptly transferred. This issue is particularly problematic if the initial prescription was given by a behavioral health provider, as primary care providers who later care for the member might not receive crucial medical information. Consequently, they may either not continue necessary medication or inadvertently duplicate prescriptions, disrupting treatment and diminishing care effectiveness.
b. Primary care providers (PCPs) may not know that a member is taking ADHD medications because they have not received this information from behavioral health (BH) providers. A key obstacle is the need for a completed release of information form, which is often misunderstood in relation to HIPAA regulations and remains a significant barrier.
c. PCPs sometimes discontinue medication if a member experiences side effects or seems to have improved, without consulting the BH practitioners.
d. Members' perceptions of their treatment's effectiveness can also affect their adherence to therapy. If members believe their medications are not working, they might stop taking them. Alternatively, if they feel their condition has improved too quickly, they may discontinue treatment.
e. Behavioral health and medical practitioners frequently use different Electronic Medical Record (EMR) systems, preventing them from accessing each other's relevant clinical information, which is essential for effective patient management.
f. Although stigma around mental health has decreased, some members may still feel judged by their medical providers or communities, leading them to discontinue treatment to avoid perceived judgment.

Conclusion Based on Qualitative Analysis

The identified barriers, including continuity and coordination of care issues, have been recognized as significant factors contributing to the low rates and failure to meet the goals for the ADD measure.

F. Barriers and Opportunities:

Barriers	Opportunities:
Not all children are screened for behavioral health services	Ensure provision of all screening, preventive and medically necessary diagnostic and treatment services for members under 21 years of age.
PCPs are not aware of BH services	There is opportunity to promote the availability of provider portal to gather member information. Upgrades to the provider portal to include BH information on Provider Practice. All providers have assigned members to them. Adding have BH diagnosis, members referred to BH, members linked to BH provider, name of assigned BH provider, list of psychotropic medications, and Rx provider.
	There is an opportunity for team collaboration to find ways to improve communication among practitioners.
MHP providers do not have access to provider platform to share information to PCP.	There is an opportunity to create data exchange with MCP with coordination information that includes

- Primary care providers (PCPs) are not effectively coordinating care with behavioral health (BH) practitioners, which can lead to inadequate management of patients with ADHD.
  - Some PCPs discontinue ADHD medications if patients experience side effects or show symptom improvement, without consulting BH practitioners.
  - PCPs might not be as comfortable with certain ADHD medications as BH practitioners.
  - PCPs may be unsure about the appropriate frequency of follow-ups or may lack time to conduct them due to heavy workloads.
  - Some PCPs believe they can manage ADHD on their own and may consider further follow-up with BH practitioners unnecessary or burdensome for their counterparts.

- Information exchange systems between providers are often inadequate, affecting the sharing of member information. Many practitioners lack access to Health Information Exchanges (HIE), which becomes problematic when a member changes providers and their medical history is not shared promptly. When a prescription is initially provided by a BH provider, subsequent care from primary care providers may lack crucial medication information, leading to potential issues such as discontinuing necessary medication or duplicating prescriptions, thus disrupting treatment and affecting care effectiveness.

- PCPs may not be aware that a member is on ADHD medication because this information has not been provided by BH providers. A major barrier is the need for a completed release of information form,

which is often misunderstood in relation to HIPAA regulations but remains a significant obstacle. PCPs might improperly stop medication due to side effects or perceived improvements without consulting BH practitioners.

- Member perceptions of treatment effectiveness can also impact adherence to ADHD medication. Members who believe their medication is ineffective may stop taking it, while those who think their condition has improved too quickly might discontinue treatment. Additionally, side effects from ADHD medications can be bothersome, leading members to stop treatment.

- Behavioral health and medical practitioners often use different Electronic Medical Record (EMR) systems, making it difficult to access relevant clinical information needed for effective patient management.
  - When external EMRs are inaccessible, practitioners must rely on information from the member or their family.
  - School districts with BH practitioners may not be able to record member information in accessible EMRs.
  - External BH provider EMRs are typically closed systems, preventing access from other EMR systems.
  - Medication lists in EMRs are often outdated, as they are not updated with information from other practitioners.
  - There may be uncertainty regarding the initial diagnosis or decisions made.
  - Confirming whether follow-up care occurred can be challenging.

- Despite reduced stigmatization of mental health, some members may still feel judged by medical providers or their communities, leading them to avoid continuing treatment to prevent judgment or due to parental pressure.

G. Planned Interventions:

i. Proactively promote EPSDT and AAP Bright Futures preventive services to members and families.

ii. Connect with First 5 and other organizations that promote preventative screenings.

iii. Conduct ongoing training, at least once every two years for network providers on required preventive healthcare services (SS 3.2.5.A) to ensure full utilization of EPSDT services.

iv. Team Collaboration, such as workgroup meetings
   a. Gather the business owners that are most likely to contribute to the improvement of the ADD measure, e.g., QI dept, pharmacy, Medical Director, provider network, and PHM dept to discuss root causes for low rates and develop strategies to improve performance.

v. Continue to educate the PCPs and BH specialists regarding the importance of communicating to share plan of care for the benefit of the members.

vi. Educate the members through counseling during their clinic visits the importance of allowing certain information to be shared by BH specialist with the PCP or vice-versa to promote continuity of care.

vii. Educate the BH practitioners to use a **Consultation Letter**. This is to be prepared by a BH practitioner. This provides information about the diagnosis and the medications they are taking to any other provider following up on the member and can assist them in ordering follow up care.

QI 4 Element A Factor 4

Management of Treatment Access and Follow-Up for Members with Co-Existing Medical and Behavioral Health Disorders

A. Activity

Multiple Medical Conditions at Risk for Behavioral Health Issues

B. Description and Relevance

Research findings have shown that patients seeking mental health care have considerable unmet needs, and patients with mental illness are more likely than other patients to have multiple medical illnesses.

C. Methodology

With the understanding that members with multiple chronic conditions are considered high risk for behavioral health disorders, these members are stratified and based on criteria for high-risk conditions, KHS will outreach patients and link to PCPs and BH practitioners (identify gaps in care).

Using the John Hopkins Adjusted Clinical Groups (ACG) System and Predictive Modeling for stratification of members with co-existing medical and behavioral health conditions are referred to complex case management. The objective is to evaluate treatment accessibility and follow-up of the care provided.

Members identified with co-existing medical and behavioral health conditions are offered complex case management services. Members are given the option to opt out of the service.

Criteria:
Denominator:
Number of members identified through the ACG model who have co-existing medical condition and behavioral health diagnosis

Numerator:
Number of members identified through the ACG model who were enrolled in complex case management (CCM) program.

QI 4 Element B Factor 2

D. Goal -

The goal is to increase enrollment of the identified members to CCM by 10%.

E. Results

Quantitative Analysis:

Eligible Population	# enrolled in CCM	Rate (%)	# stayed in program >=3 mos.	Retention Rate >=3 mos.

Data Analysis:

- Out of the 588 members listed,
- 173 are enrolled in Complex Case Management (CCM),
- Of the 173 members enrolled in CCM,
  - 24 members = ages 6-20 yrs old
  - 79 members = ages 21-40
  - 41 members = ages 41-60
  - 20 members = ages 61-70
  - 9 members = ages 71-89
- Majority of the members are Hispanics, followed by Caucasians, there were those identified as Asian descent. At least 17 members are of unknown origin.
- Members are assigned to individual practitioners but most of them are assigned to CSV Care Centers (27) and Omni Health Centers (50).

Qualitative Analysis:

This is a baseline study. The data revealed that 70% of the members who were enrolled in CCM are in the 21-60 age group, while those who were not enrolled are also high in the same age bracket but are dispersed throughout ages 5-70.

Because the data is limited, there is a need to understand the medical conditions that are commonly seen among our members with behavioral/mental problems. For those who opted for the service, we need to understand the outcomes of their care under complex case management. We may also need to survey those members under CCM care to evaluate their satisfaction and to assess the effectiveness of our programs.

F. Barriers and Opportunities:

Barriers	Opportunities
Limited data	There is an opportunity for collaboration with CCM staff /PHM Dept to explore more criteria and identify areas that can be improved.

Lack of knowledge among members	There is an opportunity to educate members about the benefits of enrolling in CCM program.
Lack of knowledge of providers	There is an opportunity to promote member benefits and programs to practitioners

G. Planned Interventions:

i. BH will continue to collaborate with Case Management in the PHM Department to ensure high risk members are offered the option to be referred to BH.
ii. Continue workgroup meetings to eliminate silos and provide coordinated care for the members.
iii. Promote CCM program to the members, its benefits, process for enrolling, available resources via member newsletters, or leaflets in physicians' offices.
iv. Promote CCM program and strategies among practitioners.
v. Improve data collection process including gathering related data from other internal and external sources.

QI 4 Element A Factor 5

Primary or Secondary Preventive Behavioral Healthcare Program Implementation

A. Activity

Perinatal and Postpartum Depression Screening

B. Description and Relevance

Rates of depression for postpartum women range from 12%-15%, with postpartum depression rates in some U.S. areas estimated to be as high as 20%. Women with untreated depression during pregnancy are at risk for developing severe postpartum depression and suicidality, and of delivering premature or low birth-weight infants.

Postpartum depression is most prevalent among American Indian/Alaska native (16.6%), Blacks (13.4%), Whites (11.7%), Hispanics (11.5%), Native Hawaiian/Pacific Islander (11.4%), and Asians (7.4%).

Studies have found that patient outcomes improve when there is collaboration between a primary care provider, case manager and a mental health specialist to screen for depression, monitor symptoms, provide treatment and refer to specialty care as needed. (NCQA)

Studies also reveal that even with routine screening, women diagnosed with postpartum depression (PPD) often experience delays in treatment with consequences affecting mother, infant, families and communities. A collaborative care management (CCM) approach may provide more timely, effective

and higher quality of care for women suffering from postpartum depression. (National Library of Medicine)

C. Methodology

Perinatal and postpartum women eligible with KHS were identified through claims and encounter data. These members were offered to participate in the Baby Steps Program, an initiative managed by Population Health Management team (PHM). Using the PHQ 9 tool, the risk for prenatal and postpartum depression were identified.

Tracking PHQ 9 Forms

The Patient Health Questionnaire-9 (PHQ-9) is a multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression.

The PHQ-9 consists of nine questions, each of which is scored from 0 to 3 based on the frequency of the symptoms. The scores are assigned as follows:

vi. Not at all: 0 points
vii. Several days: 1 point
viii. More than 3 points

The total score is calculated by adding up the scores for each question and can range from 0 to 27. The PHQ-9 scores of 5, 10, 15, and 20 represent mild, moderate, moderately severe, and severe depression, respectively.

Population Health Management Department (PHM) administers the PHQ 9 forms to potential adult members experiencing depression. In majority of the cases, the PCPs are required to administer the PHQ 9s. Referrals from PCP are submitted to BH.

D. Goal

1. All pregnant women will be assessed for depression using PHQ 9 or other applicable BH tool.
2. All women with scores 10 or more in their PHQ 9 will be referred for behavioral health services.

E. Results

QI 4 Element B Factor 2

Quantitative Analysis:

Criteria - Performance	Qtr 1, 2024	Qtr 2 2024	Qtr 3 2024	Qtr 4 2024
Total # of Eligible pregnant members				
# of pregnant members that were screened using PHQ 9	2	5	3	4
# of postpartum members with (+) PHQ 9	13	5	8	74
# of pregnant members who were referred to BH	1		1	4

Qualitative Analysis

The reason for low performance is the lack of process for obtaining the PHQ 9 from providers, lack of awareness of OB / PCPs regarding the referral process to the behavioral health department for follow up. Members not engaged in care at onset of pregnancy resulting in inconsistent screenings. Member may also not return to OB / PCP after delivery resulting in inconsistent screenings.

F. Barriers and Opportunities:

Barriers	Opportunities
No collaboration between PCPs / OBs and BH.	There is an opportunity for collaboration among OB physicians, PCPs and BH specialists.
Insufficient tracking and effective monitoring of depression among pregnant women	There is an opportunity for close collaboration between PHM and BH Departments
No notification of delivery	There is an opportunity to promote the provider portal and enhancement for alerts on delivery.

Understanding of HIPAA Regulations:

- **Misinterpretation**: BH and Non BH office staff often misunderstand HIPAA regulations, leading to reluctance to share information with other providers without a signed release of information form from the member.
- **Uncertainty Without Release Forms**: Without a release form, office staff may be unsure about their ability to share information and with whom it should be shared.
- **Confidentiality Concerns**: Staff might believe that a BH diagnosis requiring treatment is protected information that cannot be shared without explicit consent from the member.
- **Training Deficiencies**: HIPAA regulations can be complex, and staff often lack adequate training to fully understand the requirements. Although information can be shared without consent for continuity of care, staff may not know whom to send it to without the proper release form.

G. Planned and Ongoing Interventions:

1. Continue to promote communication between PCPs and OB specialists focusing on the mental well-being of the pregnant women.
2. Provide education to the practitioners and staff regarding the importance of identifying depression in pregnancy.
3. Track and conduct follow-up of those members identified with postpartum depression for further management and care.
4. Encourage collaboration among the providers involved in the care of the member.

QI 4 A Factor 6

Special Needs of Members with Serious Mental Illness or Serious Emotional Disturbance

A. Activity

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

B. Description and Relevance:

Individuals with serious mental illness who use antipsychotics are at risk for diabetes. Diabetes is the seventh leading cause of death in the United States. Diabetes screening for members with schizophrenia, schizoaffective disorder or bipolar disorder who take antipsychotic medications is important for early detection and management.

NCQA states that challenges to measuring the quality of behavioral healthcare include lack of standardization in treatment protocols, limited standardized data sources to capture outcomes and lack of linked electronic health information.

Collaboration and care coordination are crucial in transitioning patients from the inpatient services back to the community. Communication between behavioral health and PCPs is equally important, especially when requesting test results or scheduling an appointment for testing.

The government recognizes the complex needs of SMI/SED/SUD members. Section 1115 Demonstration Waiver was instituted to address the complexity of care and services required to provide these members.

C. Methodology:

HEDIS Data:
The HEDIS measure for SSD requires annual diabetes screening for members 18 to 64 years old with schizophrenia, schizoaffective disorder or bipolar disorder, if they receive an antipsychotic medication at any time during the year. The HEDIS measure recommends screening with either glucose or HgbA1c test and documenting the result.

Criteria:
Numerator:
Members who had glucose test or HBA1c test during the measurement year.

Denominator:

Members 18-64 years of age with schizophrenia or bipolar disorder and dispensed an antipsychotic medication.

D. Goal:

Achieve the 50th percentile of NCQA's Quality Compass benchmark for the total SSD measure.

The internal goal is to achieve an aggregate goal of 80% compliance on each of the private clinics and community health centers that take care of these members.

E. Results

QI 4 Element B Factor 2

a. Quantitative Analysis:

Measure	Eligible Population (Denominator)	Compliant (Numerator)	MY 2023 Rate	HEDIS 2022 Benchmark
SSD	1523	1186	77.87%	79%

This is a baseline study.
Organization-wide, the rate for the SSD measure was 77.8%. The MY 2023 rate did not meet the established and national benchmark.

From the HEDIS data, there were 348 providers and facilities who had eligible members for SSD. The membership was widely dispersed, and the majority of the practitioners have very minimal members. We focused our attention on the Omni Community Health Centers, which had a total of 559 members. The average compliance score from these facilities was 71%.

			Eligible Pop	Compliant	Rate
SSD	SSD	OMNI - BRIMHALL COMMUNITY HEALTH CENTER	68	52	76%
SSD	SSD	OMNI - BRIMHALL TWO COMMUNITY HEALTH CENTER	8	8	100%
SSD	SSD	OMNI - BUTTONWILLOW HEALTH AND DENTAL CENTER	3	1	33%
SSD	SSD	OMNI - CALIFORNIA AVE	19	12	63%
SSD	SSD	OMNI - DELANO #2 COMMUNITY HEALTH CENTER	7	6	86%
SSD	SSD	OMNI - H STREET	1	0	0%
SSD	SSD	OMNI - LOST HILLS COMMUNITY HEALTH CENTER	2	2	100%
SSD	SSD	OMNI - MALL VIEW ROAD	6	6	100%
SSD	SSD	OMNI - MING AVENUE HEALTH CENTER	46	35	76%
SSD	SSD	OMNI - NILES	1	1	100%
SSD	SSD	OMNI - NORTH CHESTER COMMUNITY HEALTH CENTER	131	100	76%
SSD	SSD	OMNI - OILDALE COMMUNITY HEALTH CENTER	32	24	75%
SSD	SSD	OMNI - RIDGECREST COMMUNITY MEDICAL AND DENTAL CEN	19	13	68%
SSD	SSD	OMNI - ROSEDALE COMMUNITY HEALTH CENTER	21	15	71%
SSD	SSD	OMNI - TAFT COMMUNITY MEDICAL CENTER	21	16	76%
SSD	SSD	OMNI - WHITE LANE COMMUNITY HEALTH CENTER	18	14	78%
SSD	SSD	OMNI FAMILY HEALTH - PANAMA	80	54	68%
SSD	SSD	OMNI- MEXICALI DRIVE	24	18	75%
SSD	SSD	OMNI SHAFTER 2 MEDICAL AND BH	1	0	0%

SSD	SSD	OMNI SHAFTER COMMUNITY MEDICAL AND DENTAL CENTER	8	6	75%
SSD	SSD	OMNI TEHACHAPI COMMUNITY MEDICAL AND DENTAL CENTE	31	21	68%
SSD	SSD	OMNI WASCO MEDICAL AND DENTAL CENTER	12	11	92%

QI 4 Element B Factor 2

b. Qualitative Analysis:

One of the possible reasons for low performance is the lack of awareness of PCPs regarding the treatment provided by the behavioral health specialist. Non-communication of clinicians involved is likely to produce an unfavorable outcome in the care of the members. On the other hand, the member may have stopped going to the PCP because he/she is now under the care of behavioral specialist. The BH specialist may not be aware of the recommended screening for diabetic members taking antipsychotic medications.

F. Barriers and Opportunities:

QI 4 Element B Factor 4

Barrier	Opportunities
PCPs' lack of knowledge about the importance of screening diabetic patients with mental illness.	There is an opportunity to educate practitioners on the recommended screening of diabetic members who were on antipsychotic medications for mental illness.
PCPs are not aware of BH services	There is opportunity to promote the availability of provider portal to gather member information. Upgrades to the provider portal to include BH information on Provider Practice. All providers have assigned members to them. Adding have BH diagnosis, members referred to BH, members linked to BH provider, name of assigned BH provider, list of psychotropic medications, and Rx provider.
	There is an opportunity for team collaboration to find ways to improve communication among practitioners.
MHP providers do not have access to provider platform to share information to PCP.	There is an opportunity to create data exchange with MCP with coordination information that includes

• Primary care providers (PCPs) and other behavioral health (BH) providers are often unaware if their members are taking antipsychotics due to insufficient communication from prescribing BH providers. This lack of information sharing can lead to missed opportunities for necessary diabetes screenings.

• Several factors contribute to the inadequate sharing of information from BH practitioners to PCPs and other BH providers:

- **Low SSD Rates**: PCPs are often not informed that a member is on antipsychotics, so they do not order essential tests to monitor diabetes.
- **Assumptions about Responsibility**: Psychologists and psychiatrists may assume that members are seeing a PCP and believe it is the PCP's responsibility to conduct glucose and LDL monitoring.
- **Communication Gaps**: Due to ineffective communication between practitioners, members may not receive the necessary metabolic monitoring tests.

• Understanding of HIPAA Regulations:

- **Misinterpretation**: BH office staff often misunderstand HIPAA regulations, leading to reluctance to share information with PCPs without a signed release of information form from the member.
- **Uncertainty Without Release Forms**: Without a release form, BH staff may be unsure about their ability to share information and with whom it should be shared.
- **Confidentiality Concerns**: Staff might believe that a BH diagnosis requiring antipsychotic treatment is protected information that cannot be shared without explicit consent from the member.
- **Training Deficiencies**: HIPAA regulations can be complex, and staff often lack adequate training to fully understand the requirements. Although information can be shared without consent for continuity of care, staff may not know whom to send it to without the proper release form.

• Staffing Challenges:

- **Turnover Issues**: High staff turnover at BH facilities can disrupt processes and negatively impact care coordination. The healthcare industry is facing a significant shortage of BH staff, which exacerbates these issues.

QI 4 Element B Factor 6

G. Planned Intervention:

1. Continue to educate and train practitioners regarding the requirements of the SSD measure.
2. Encourage collaboration among practitioners – make available the names and titles of all clinicians involved in the member's care.
3. Train the practitioners to use the provider portal as it may provide more information about the member.
4. Utilize data exchange systems to deliver lab result notifications to the PCPs and BH practitioners.
5. Educate the BH practitioners to use a Consultation Letter. This is to be prepared by a BH practitioner. This provides information about the diagnosis and the medications they are taking to any other provider following up on the member and can assist them in ordering follow-up care. This encourages members to share glucose monitoring results with other practitioners managing their care.
6. Utilize enhanced BH case management teams to facilitate PCP access, clean data collection, and conduct follow up work to ensure members get the necessary follow-up tests and care.

Selected Opportunities

The Behavioral Health Advisory Committee (BHAC) met on October 16, 2024, to review the opportunities for Continuity of Care standard.

Identifying and selecting one opportunity for improvement from Element A.

Identifying and selecting a second opportunity for improvement from Element A.

Describe the Barriers

Action Plan:

Taking collaborative action to address one identified opportunity for improvement from Element A.

Taking collaborative action to address a second identified opportunity for improvement from Element A.

When will it start... If it is a one-time event give the due date or timeline.

List of Participants:

Name	Title / Department
Martha Tasinga, MD	Chief Medical Officer
Melinda Santiago	Director of Behavioral Health
John Monahan	Business Intelligence Analyst IV
Bruce Wearda	Director of Pharmacy
Kailey Collier	Director of Quality Performance
Michelle Curioso	Director of Population Health Management
James Winfrey	Deputy Director of Provider Network

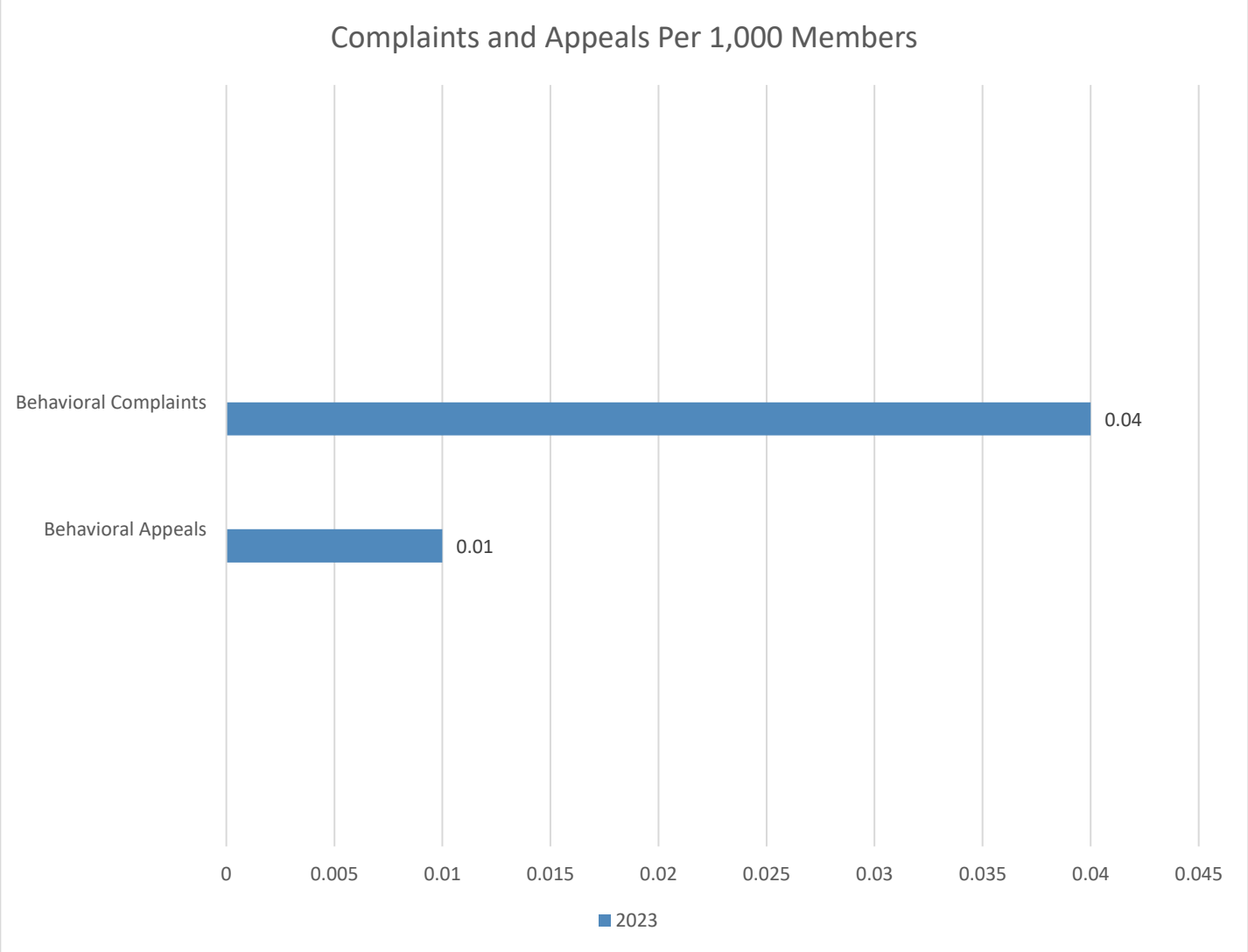
Resources:

MOU Requirements KHS and Specialty Substance Use Disorder, # 21.07-P
W&I Codes, 14059.5 and 141.84.402
BH Program Description
Policy and Procedure, Care Coordination and Care Management, # 21.02-P
Policy and Procedure, Scope of Services, #21.05
Policy and Procedure, Adult and Youth Screening and Transition of Care, # 21.01-P
American Psychiatric Association, 2018

NCQA Qualitative Data Analysis Report

Behavioral Health Complaints and Appeals

Year 2023



Behavioral Healthcare Complaints

The following tables provides data on non-behavioral healthcare complaints filed in 2023. Kern Health Systems (KHS) has an overall behavioral health grievance goal of 10 per 1000 members per year and 2 per 1000 members per year for each grievance category.

Table 1: Complaint Volume Report – Behavioral Healthcare

Category	2023

	Complaints Total	Complaints per 1,000 members	Performance Goals	Performance Goals Met?
Access	49	0.01	<2	Yes
Attitude and Service	65	0.02	<2	Yes
Billing and Financial Issues	0	0	<2	Yes
Quality of Care	17	<0.01	<2	Yes
Quality of Practitioner Office Site	0	0	<2	Yes
Total	**131**	**0.04**	**<10**	**Yes**

Quantitative Analysis: In 2023, a total of 131 behavioral healthcare complaints were filed, totaling 0.04 complaints per 1000 members. KHS met our goals of <10 grievances per 1000 members per year and <2 grievances per 1000 members per grievance category for the year. Overall, Kern Health Systems maintained the overall category and per category performance goal.

Behavioral Healthcare Appeals

The following tables provides data on non-behavioral healthcare appeals filed in 2023. Kern Health Systems has overall category goal of 10 per 1000 members per year and 2 per 1000 members per year for each grievance category.

Table 1: Appeal Volume Report – Behavioral Healthcare

Category	2023			
	Appeals Total	**Appeals per 1,000 members**	**Performance Goals**	**Performance Goals Met?**
Access	0	0	<2	Yes
Attitude and Service	0	0	<2	Yes
Billing and Financial Issues	0	0	<2	Yes
Quality of Care	4	<.01	<2	Yes
Quality of Practitioner Office Site	0	0	<2	Yes
Total	**4**	**.01**	**<10**	**Yes**

Quantitative Analysis: In 2023, there were 4 behavioral healthcare appeals filed, totaling less than .01 appeals per 1000 members per year, with <1 grievance per 1000 members per grievance category per year. Overall,

Kern Health Systems maintained the overall grievance and per category performance goal. Overall, Kern Health Systems maintained the overall category and per category performance goal.

Qualitative Analysis: In 2023, the top three categories for grievances and appeals were Access, Attitude and Service and Quality of Care. When reviewed against the 2024 ECHO Member Satisfaction Survey, we found common deficiencies in these categories. For Access, KHS was able to promote telehealth services, and provide multiple provider options for members. KHS has increased provider capacity working with Provider Network Management (PNM). PNM has a Provider Recruitment Specialist to assist with ongoing recruitment efforts. Grants and Special Programs launched the Provider Recruitment & Retention Grant (R&R) to improve access and increase provider capacity/ appointment within BH. BH has increased providers by %. Attitude and Service was addressed by implementing the following improvement strategies based on the ECHO Member Satisfaction Survey results

- Regional Advisory Committees (RAC) meetings. Engaging a gathering of members and community residents who share their personal experiences with health care in their region.
- Learn ways to expand member engagement activities to assist members with coordination of care
- Discover opportunities for ways to improve member and provider communication through technology using multiple modalities.

As a result of the ECHO Member Satisfaction Survey, Quality of Care is being addressed by educating and engaging providers to encourage improvement for how well providers communicate with members.

To: KHS EQIHEC
From: Michelle Curioso, Director of Population Health Management
Date: December 16, 2025
Re: Addressing Comprehensive Care for High-Risk Members through Population Health Management

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Background:
The following reports address PHM programs aimed at reducing health disparities, improving the quality of care, and optimizing resource utilization:

1. Palliative Care Program – Designed to improve quality of life for members with serious illness, reduce unnecessary emergency-department use, and address both medical and social needs.
2. High Resource Utilizers – Evaluates members with high utilization to ensure they receive timely, appropriate care through coordinated efforts of our interdisciplinary care team (ICT).
3. PHM Birthing Care 2025 – Outlines KHS's implementation of the DHCS Birthing Care Pathway, ensuring culturally competent, member-centered maternal care from conception through 12 months postpartum.

Discussion:
These initiatives demonstrate Kern Health Systems' commitment to addressing the complex needs of underserved populations through an integrated approach that aims to improve health outcomes and reduce disparities.

- Palliative Care Program: By addressing both medical and social needs, the program achieved a 15% reduction in emergency department visits, decreasing from 1,163 to 990. This indicates that members are receiving better, more supportive care in non-emergency settings. In October, the program's best practices were presented at the Coalition for Compassionate Care of California's annual summit, where outcomes and lessons learned were shared with healthcare providers, government agencies, and other statewide stakeholders.
- High Resource Utilizers**:** The interdisciplinary care team (ICT) has identified members with high resource utilization and connected them to appropriate services. The team meets weekly to assess and address the medical and social needs of these members.
- PHM Birthing Care 2025: The Birthing Care Pathway provides maternal care that is both medically effective and culturally responsive. By supporting members throughout the prenatal and postpartum periods, the program seeks to reduce maternal and infant mortality and ensure access to essential services for a healthy pregnancy and early parenthood.

Fiscal Impact:
None.

Requested Action:
Review and approval.

KERN HEALTH SYSTEMS

Bridging Gaps: A Population Health Approach to Palliative Care Coordination

Background

The Palliative Care Coordination Program (PCCP) offers significant benefits in reducing emergency department (ED) utilization by proactively managing care and addressing the social determinants of health that impact individuals with serious illnesses.

- With the support of two trained social workers (SWs), PCCP facilitates meaningful conversations about palliative care, ensuring that members understand their options, access necessary palliative services, and are connected to community resources.

Kern Health Systems provides Medi-Cal managed care to over 400,000 members, half of Kern County's total population of approximately 922,529 residents.

- The member population is diverse, with a predominantly Hispanic community, reflecting the cultural and linguistic needs that must be addressed to provide effective care coordination.

Kern County spans approximately 8,163 square miles, with diverse terrain that includes the southern Sierra Nevada mountains, the San Joaquin Valley, and parts of the Mojave Desert. Members living in outlying areas often face long travel distances to access care, compounding existing barriers such as limited transportation and provider shortages.

- This scale and diversity emphasize both the importance and potential impact of programs like PCCP, which are designed to improve health outcomes and reduce avoidable utilization among a large, underserved population.

Problem Statement

The problem is that low-income and underserved Medi-Cal members with serious illnesses who need palliative care often lack access to appropriate services, resulting in delayed care and an overreliance on emergency departments for basic health needs.

- This access gap is driven by a shortage of palliative care providers, limited transportation options, and long travel distances across the county's 8,163 square miles—particularly impacting those living in outlying areas. These structural barriers make it difficult for members to receive timely outpatient or community-based care.
- Further compounding the issue is a widespread misunderstanding of palliative care, with many members equating it to hospice, leading to fear or reluctance to engage in supportive services that could improve their quality of life. Without proper education and coordinated care, these individuals continue to fall through the cracks, unable to receive the right care at the right time.

Purpose

Managed Care Members project is to explain and evaluate the success of the Palliative Care Coordination Program (PCCP) in reducing emergency department (ED) utilization and improving care outcomes for Medi-

Cal Managed Care Members in Kern County. By bridging gaps in healthcare access and addressing both medical and social needs, the program seeks to enhance quality of life for low-income, underserved populations while reducing unnecessary strain on the healthcare system.

Significance of the Project

This project is significant because it highlights how a population health approach tailored to Medi-Cal members in Kern County can address healthcare disparities while improving system-wide efficiency. The project is significant for several key stakeholders:

- For patients, the program promotes better quality of life, improved emotional and social support, and reduced reliance on emergency services.
- For healthcare leaders, the program provides evidence of cost savings and better resource use, supporting data-driven decisions to optimize healthcare systems.
- For healthcare practitioners**,** the program enhances patient care by fostering holistic, coordinated approaches that address both medical and social needs.
- For scholars and researchers, the program adds to the academic understanding of palliative care, social work, and care coordination's role in healthcare utilization. It provides opportunities for future research on scalable models in similar regions.

Importantly, it provides evidence that integrating palliative care coordination into Medi-Cal managed care models can address health inequities in underserved communities such as Bakersfield.

Literature Review

- Hughes et al. (2023), in a systematic review of community-based palliative care programs, found that components such as social worker involvement, care coordination, and symptom management improved patient outcomes and reduced healthcare utilization among older adults with serious illnesses.
- Nummedal et al. (2024) examined interventions outside the ED aimed at reducing unnecessary visits and highlighted the importance of care coordination and addressing social determinants of health, including transportation, food insecurity, and housing instability.
- Loo et al. (2025), through implementation of social determinants of health (SDoH) screening in U.S. emergency departments, identified limited access to primary care, behavioral health diagnoses, and social vulnerabilities as key drivers of high ED utilization.
- Pinakidis et al. (2025) and Johnson et al. (2025), through narrative reviews and observational studies, emphasized that population health approaches, including early identification of high-risk members and structured palliative care coordination, can reduce avoidable utilization and improve quality of life.
- Gruzden et al. (2025) conducted a cluster randomized clinical trial testing the initiation of palliative care in the ED for older adults with serious, life-limiting illnesses. Although hospital admission rates did not significantly change, patient-centered outcomes such as symptom management, satisfaction, and care planning improved—demonstrating the potential value of ED-based palliative interventions.

Research Questions

RQ1:
How do social workers within the Palliative Care Coordination Program (PCCP) identify and address social determinants of health—such as housing instability, transportation barriers, and food insecurity—among Medi-Cal members?

RQ2:
How do social workers in the PCCP identify and engage high-risk members who were not referred by providers but meet the criteria for palliative care?

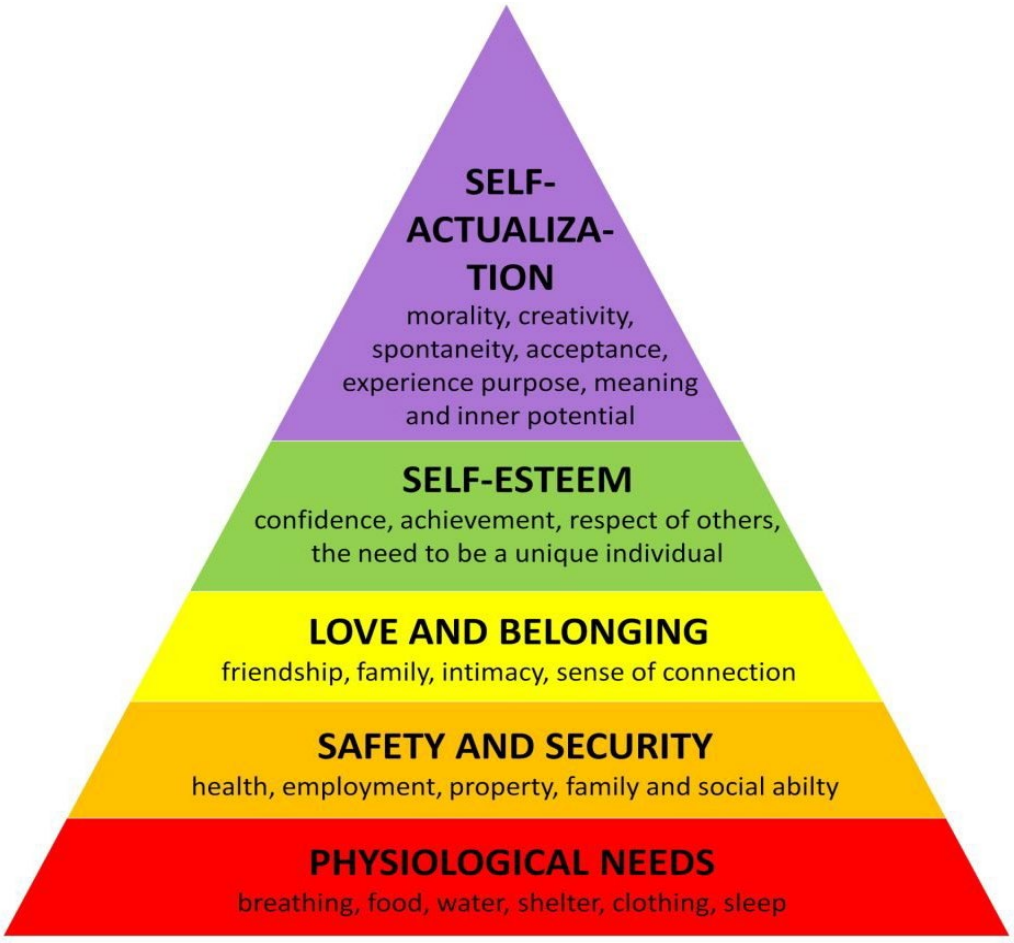
RQ3:
How do interdisciplinary care coordination efforts within PCCP support the integration of medical and social services to reduce barriers to care for underserved populations in Kern County?

Conceptual Framework

Applying Maslow's Hierarchy of Needs highlights how the Palliative Care Coordination Program (PCCP) delivers whole-person care beyond clinical treatment. See pyramid below. The program addresses:

- Physiological and safety needs by connecting members to food, housing, transportation, and consistent medical care.
- Belonging and esteem needs through trusted relationships with social workers and care coordinators, fostering respect and emotional support.
- Self-actualization by empowering members with personalized care plans and education to make informed, value-based decisions.

By meeting needs at every level, PCCP enhances health outcomes, emotional resilience, dignity, and autonomy for Medi-Cal members—reducing emergency department use, improving care engagement, and advancing health equity in Kern County.



Method

This project used a retrospective comparative study design to evaluate the impact of the Palliative Care Coordination Program (PCCP) on healthcare utilization. Program data was analyzed for 986 Medi-Cal managed care members who received PCCP case management services. Healthcare utilization metrics examined included:

- Office visits
- Emergency department visits
- Urgent care visits

Utilization was assessed six months before and six months after enrollment in the PCCP. Changes in per episode and total costs were calculated to determine relative increases or decreases across categories.

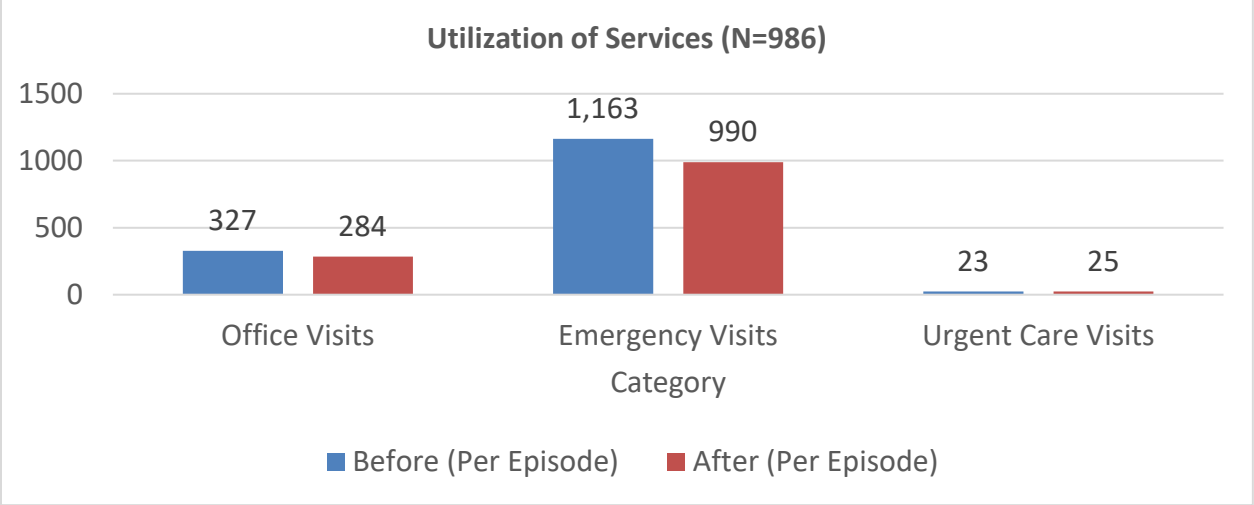
The analysis also incorporated insights from case management documentation, member demographics, and program activity reports to contextualize the quantitative data. By integrating both utilization metrics and qualitative program elements (e.g., social work interventions, palliative care education, and community referrals), this approach provides a comprehensive view of PCCP's effectiveness in reducing avoidable healthcare utilization while improving member outcomes.

Results

Table 1: Enrolled Members Comparison (6 Months Before vs. 6 Months After Care Coordination Services) Time Period: March 2024 through December 2024 (N=986)

Category	Before (Per Episode)	After (Per Episode)	% Change
Office Visits	327	284	-13% decrease
Emergency Visits	1,163	990	-15% decrease
Urgent Care Visits	23	25	+8% increase

Table 2: Enrolled Members Comparison (6 Months Before vs. 6 Months After Care Coordination Services). Time Period March 2024 through December 2024



Innovation and Uniqueness

1. Tailors to the needs of Medi-Cal managed care members in Kern County, a low-income and medically underserved population with limited access to specialty care.
2. Applies a population health lens by identifying at-risk members early and engaging them before their conditions escalate into crises requiring emergency care.
3. Embeds trained social workers who address critical non-clinical factors such as housing instability, food insecurity, and transportation barriers.
4. Bridges the gap between healthcare and community-based services. This includes connecting members to KHS benefits such as medically tailored meals, caregiver respite services, personal care, and homemaker services**,** creating a stronger, more sustainable support network for members.
5. Designs with sensitivity to Kern County's diverse population, ensuring that care coordination is not only accessible but also relevant to members' cultural, linguistic, and social contexts.
6. Emphasizes palliative care education, helping members understand that palliative care is not synonymous with hospice care. It focuses on improving quality of life, symptom relief, and providing supportive resources, helping reduce fear and misconceptions about palliative services.
7. Partners with various palliative care providers and participates in interdisciplinary care team meetings. During these meetings, social workers and care coordinators discuss member needs, review care plans, and ensure timely access to appropriate services.

Next Steps and Opportunities for Improvement

Focus Area	Next Steps
Data & Impact Analysis	Review and analyze other utilization metrics such as inpatient, urgent care and outpatient. Compare utilization metrics between enrolled versus non-enrolled members to capture the full impact of PCCP.
Education & Awareness	Implement targeted campaigns to raise awareness of palliative care services; clarify the distinction between palliative care and hospice to reduce stigma and improve engagement.
Member Experience	Conduct satisfaction surveys to gather feedback and identify unmet needs.
Care Coordination	Collaborate with primary care providers, specialists, and community organizations to ensure seamless care transitions and timely resource access.
Provider Development	Provide ongoing training for providers and social workers on best practices and culturally responsive communication.

Assumptions, Limitations & Delimitations

Category	Summary
Assumptions	• Enrolled members reflect Kern County's high-risk Medi-Cal population. • Claims data accurately capture utilization trends. • Reductions in ED use and other metrics are at least partly attributable to PCCP interventions. • Members engaged with social workers and care coordination activities in good faith.
Limitations	• Retrospective design limits ability to establish causality. • Analysis reviewed only change in utilization among enrolled members pre/post enrollment; no concurrent control group was used.

Category	Summary
	• Limited to members who chose to enroll to program. • Claims data may underreport services obtained outside the KHS network. • Findings may not generalize beyond Kern County's Medi-Cal population.
Delimitations	• Analysis limited to a 6-month pre/post enrollment window. • Focused only on utilization of metrics (office, ED, urgent care). • Only Medi-Cal KHS managed care members were included. • Evaluation restricted to palliative care coordination (PCCP) and no other KHS programs.

Success Story

From January 2024 to September 2024, a member with a history of valley fever, diabetes, high blood pressure, CKD, and ESRD benefited from Palliative Care Coordination Program (PCCP). Living in a small apartment with her two daughters, she faced both medical and social challenges. Through PCCP, she was connected to palliative care providers, established consistent follow-up, and received education and support for her medical needs.

- The program also facilitated access to critical social services, including transportation via a wheelchair-accessible van and referrals to In-Home Supportive Services (IHSS).
- In July 2024, she was approved for 125 hours of IHSS, allowing her daughter to serve as her caregiver and bringing an additional $2,000 per month into the household.

Despite barriers related to her undocumented status, the member successfully accessed available resources, initiated dialysis treatment, and established sustainable care routines. By addressing medical, social, and financial needs, PCCP significantly improved her quality of life and empowered her and her family to manage complex health challenges with greater stability.

This story highlights how PCCP goes beyond medical care to provide holistic, person-centered support, improving health outcomes, family well-being, and overall quality of life.

Testimonials

- "*Many of our members feel isolated and lack support systems to help them navigate their care. They need someone they can rely on. My role is to ensure they're connected to the appropriate services, whether that's transportation, medically tailored meals, or other community resources that support their well-being." (MSW)*
- *"The interdisciplinary care team works well because the Palliative Care Team regularly shares updates with us about our members. They also inform us when members are difficult to reach. In those cases, we follow up, engage the members, and help reconnect them to palliative care services." (Manager)*
- *"I receive a list of members eligible for palliative care services and proactively reach out to them to provide education and raise awareness. Some doctors are not very familiar with palliative care and often do not refer eligible patients due to a lack of knowledge. My role is to bridge that gap and ensure these members get connected to the care they need." (MSW)*

Conclusion

The Palliative Care Coordination Program (PCCP) demonstrates a clear, positive impact on reducing emergency department utilization among high-risk Medi-Cal members in Kern County. By embedding trained social workers into the care model, PCCP addresses both clinical and non-clinical barriers—such as transportation, housing, and food insecurity—that often contribute to fragmented and avoidable healthcare use.

Social workers involved in the program report that member engagement improves significantly when education dispels misconceptions about palliative care. The program has enabled more proactive care planning, reduced crisis-driven interventions, and improved quality of life for members.

An essential component of PCCP's success is its interdisciplinary care team approach, which enhances collaboration between the PCCP team and contracted palliative care providers. Regular case conferences and joint care planning sessions ensure alignment, improve communication, and streamline access to services—leading to more coordinated, effective care for members.

While early outcomes, including a 15% reduction in emergency department visits, are promising, there are several opportunities for growth. To fully capture the effectiveness of the PCCP, the program must also expand its data analysis to include additional utilization metrics such as outpatient procedures and inpatient admissions. This broader lens will help assess the program's influence on overall healthcare usage and cost-effectiveness.

PCCP offers a scalable, equity-driven model that integrates social work, interdisciplinary care, and culturally responsive support to meet the complex needs of underserved populations, improving both individual outcomes and system-wide efficiency.

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KERN HEALTH SYSTEMS

High Resource Utilization Members

Purpose

The purpose of reviewing the members with high resource utilization is to ensure they are receiving the right care at the right time and are connected to the services most appropriate to their needs. By identifying members with high utilization, we can better understand underlying barriers, link them to the right resources, and ensure they are supported in the most effective, compassionate, and efficient way possible.

Activities

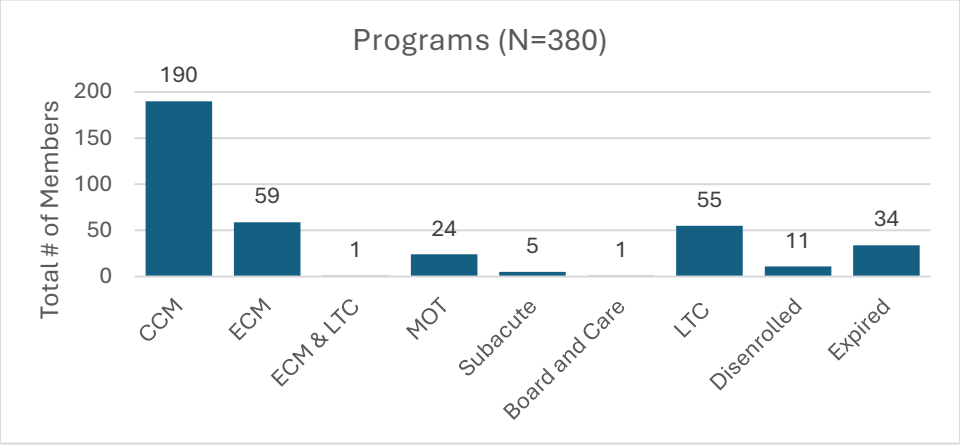
We have established an interdisciplinary care team (ICT), consisting of medical doctors, pharmacists, nurses, social workers, and other KHS specialists, to conduct comprehensive reviews of high-utilization members. The team meets weekly, and when action items are identified, we ensure there is appropriate follow-through.

During ICT meetings, we assess each member's medical and social needs, including their level of family support, ability to care for themselves, housing stability, and willingness to engage in case management or care coordination services. We also evaluate whether members may benefit from additional resources such as palliative care, hospice, behavioral health support, or other community-based services.

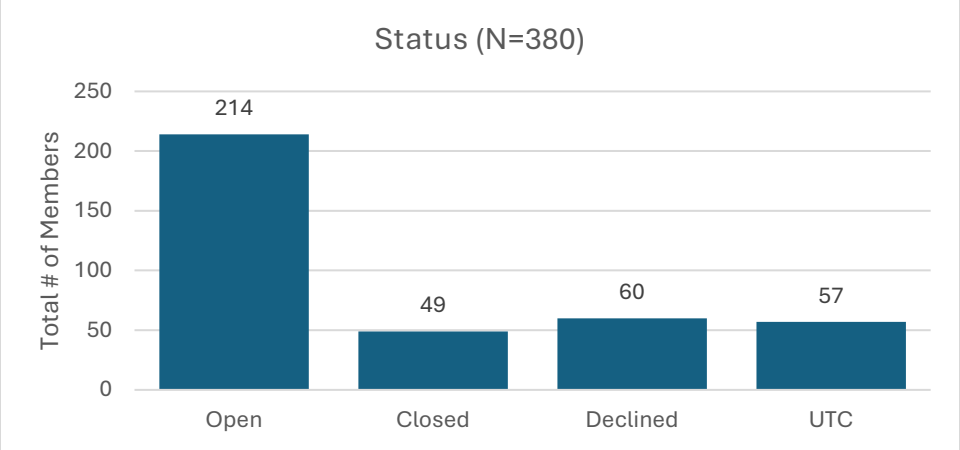
Why This Process Matters

This process improves member outcomes, prevents avoidable crises, reduces unnecessary hospitalization, and ensures that our resources are used in the most effective and compassionate way possible. It strengthens continuity of care, enhances quality, and supports both member well-being and overall organizational sustainability.

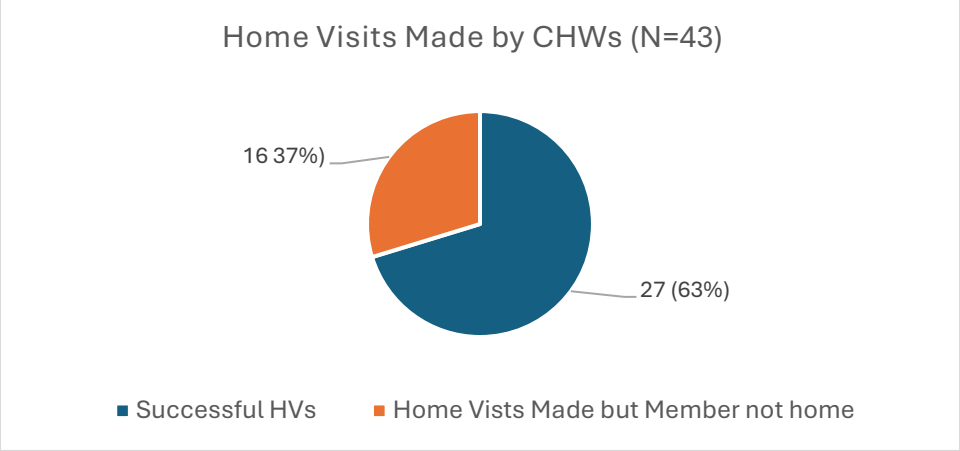
Results



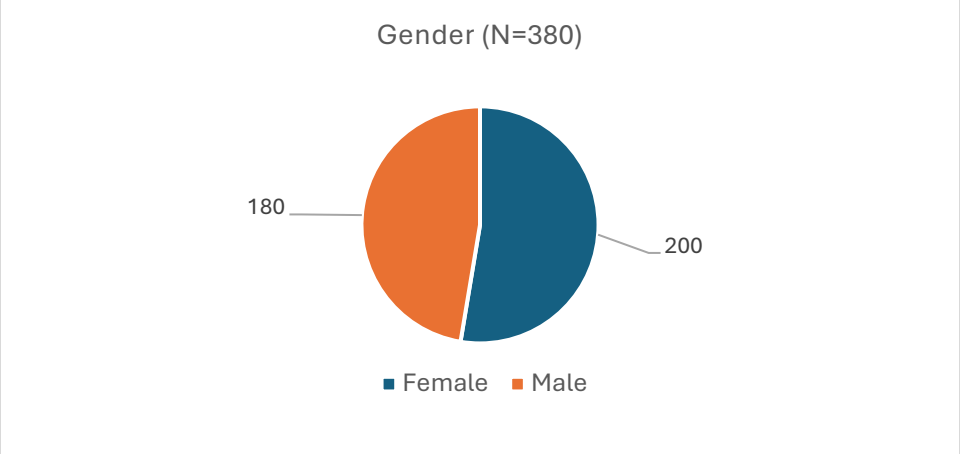
Note: The table shows the distribution of 380 members across various programs, with the highest number (190) enrolled in CCM, followed by ECM (59) and LTC (55). Smaller programs such as ECM & LTC, Board and Care, and Subacute have very few members.



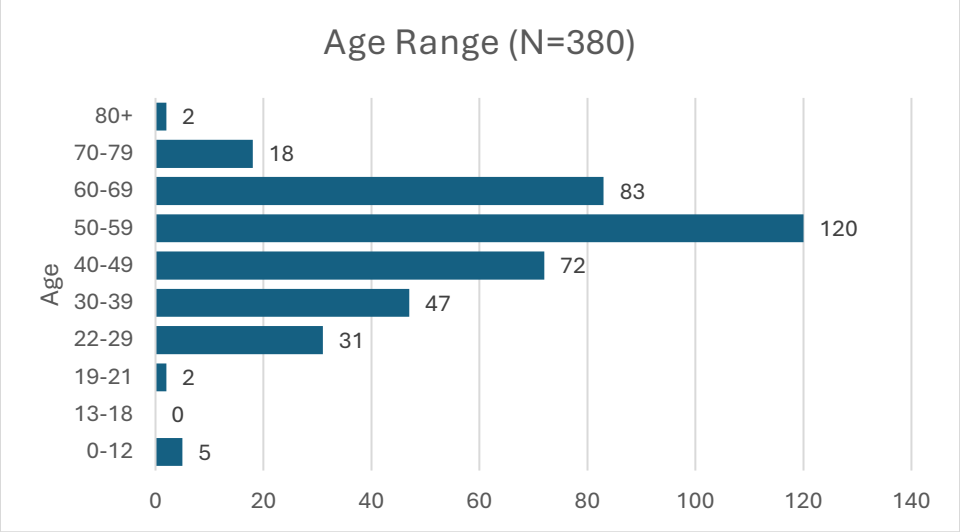
Note: The chart shows that out of 380 members, the majority (214) have an "Open" status, indicating active participation. The remaining members are distributed among "Declined" (60), "UTC" (57), and "Closed" (49) statuses.



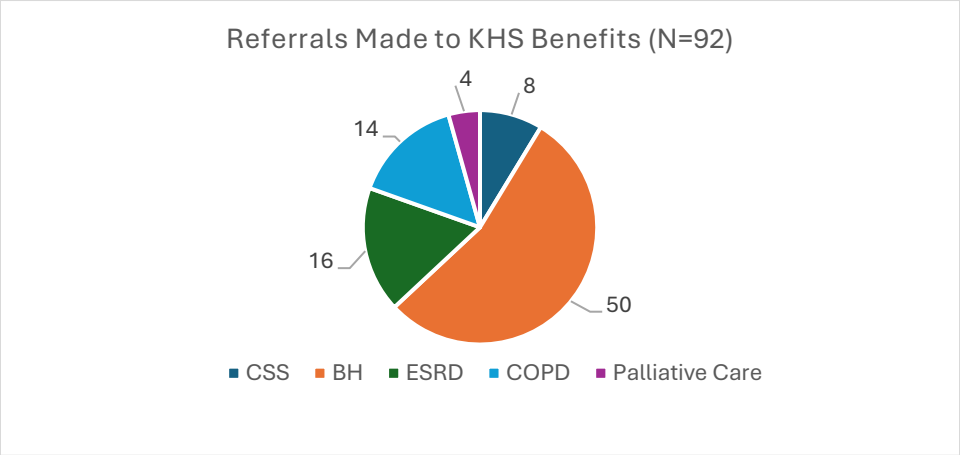
Note: Out of 43 home visits made by CHWs, 27 (63%) were successful. The remaining 16 visits (37%) were unsuccessful because the members were not home.



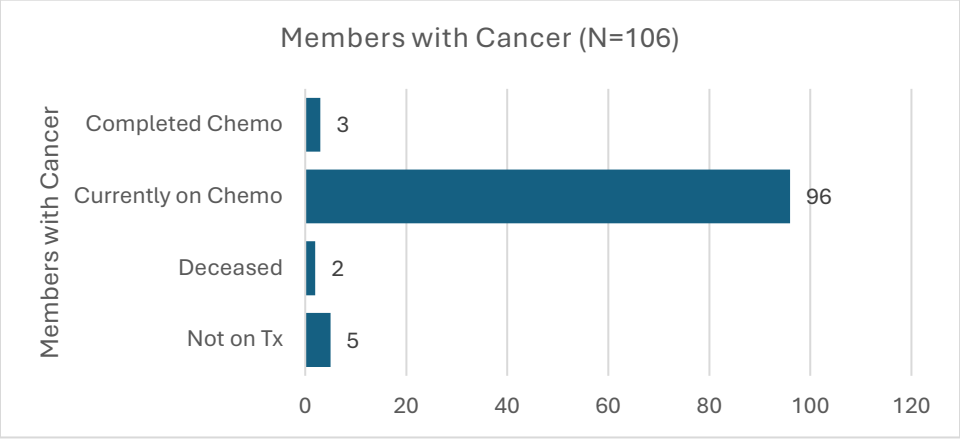
Note*:* The gender distribution of the 380 members, with 180 males (47%) and 200 (53%) females.



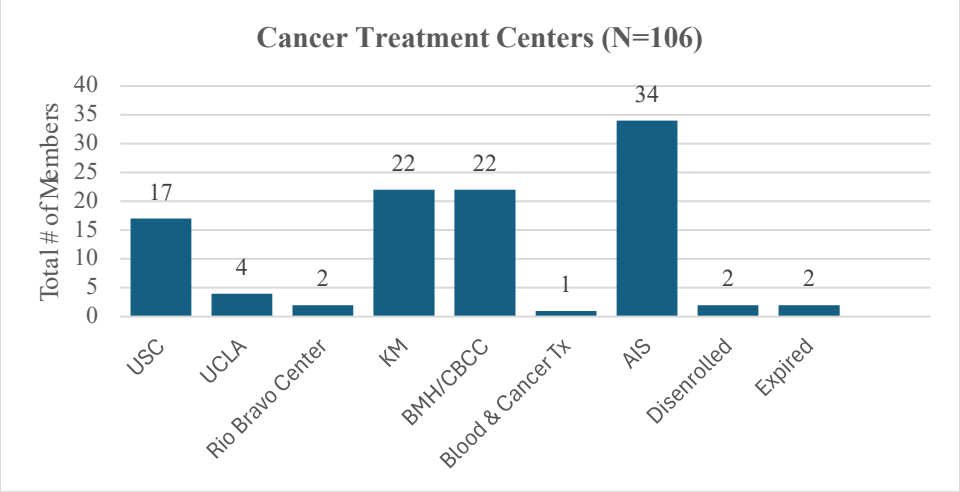
Note: The chart shows the age distribution of 380 participants, with the largest group aged 50–59 (120 individuals). The fewest participants are in the 13–18 and 80+ age groups, with 0 and 2 individuals, respectively.



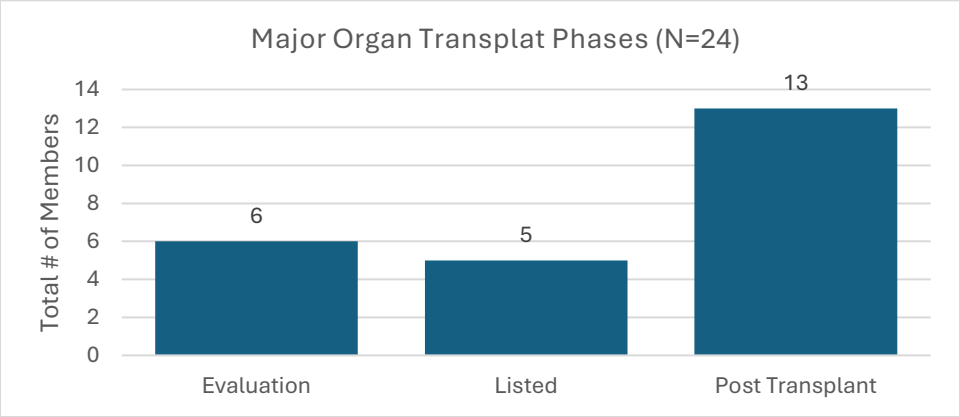
Note: The chart shows the distribution of 92 referrals made to KHS benefits, with the majority (50) referred to Behavioral Health (BH). Other referrals include ESRD (16), COPD (14), CSS (8), and Palliative Care (4).



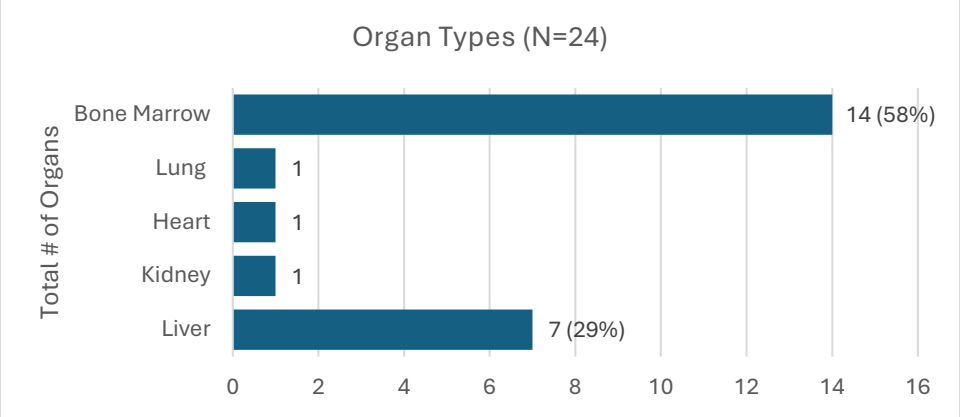
Note: The chart shows that out of 106 members with cancer, the majority (96) are currently undergoing chemotherapy. A smaller number have completed chemo (3), are not on treatment (5), or are deceased (2).



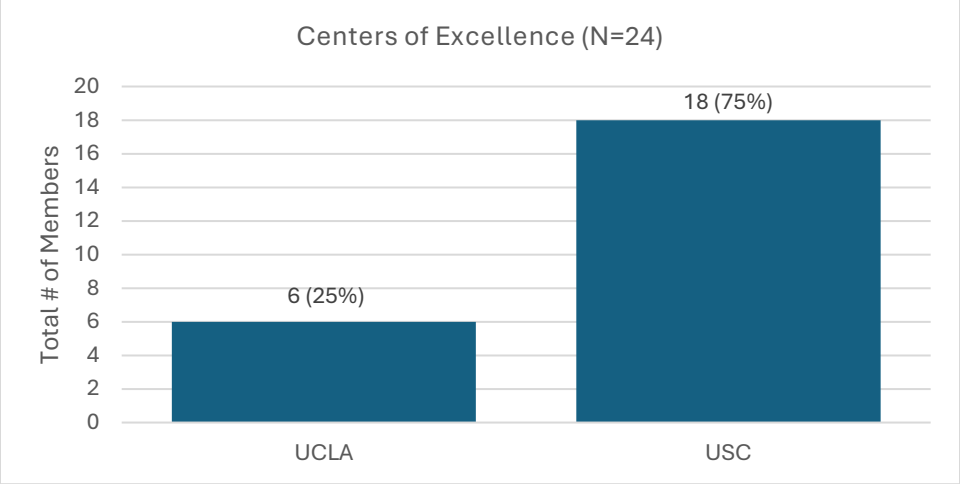
Note: The table shows the distribution of 106 members across cancer treatment centers, with AIS having the highest number at 34 members. KM and BMH/CBCC both have 22 members, while other centers have fewer members ranging from 1 to 17.



Note: The bar chart displays the distribution of 24 members across different MOT (Multi-Organ Transplant) phases. The majority are in the Post Transplant phase (13 members), followed by Evaluation (6 members) and Listed (5 members).



Note: The table shows the distribution of 24 organs by type among members. Bone marrow is the most common organ type with 14 members, followed by liver with 7 members, while lung, heart, and kidney each account for 1 member.



Note: The bar chart shows the distribution of 24 members across two Centers of Excellence. USC has a significantly higher number of members (18) compared to UCLA, which has 6 members.

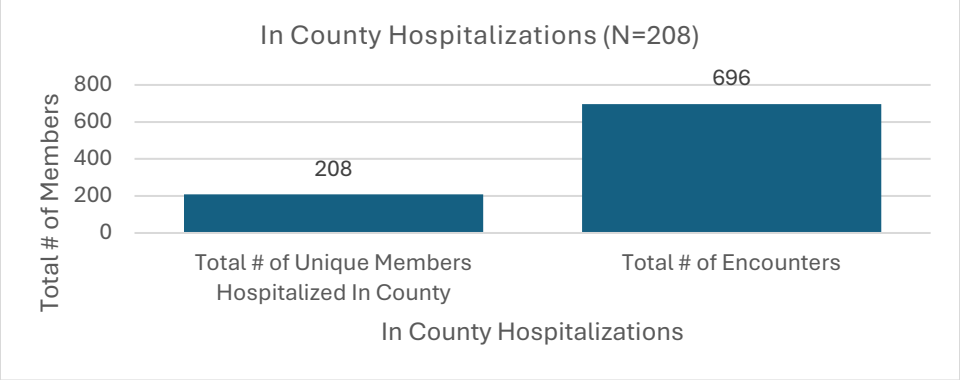
Expired Members Details

This list includes members who have expired, with diagnoses based on the most recent records in Jiva. These diagnoses may be related to the cause of death, though not indicate the cause or manner of death. The age range is from 23 to 88 years old. The top five most common diagnoses at the time of death are:

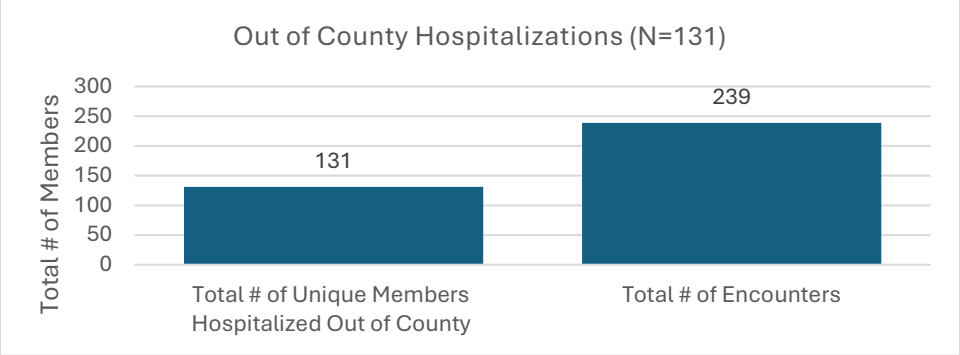
1. Sepsis-related conditions**:** Sepsis and septicemia were common, with multiple cases of sepsis from unspecified organisms.
2. Cancer-related diagnoses**:** Myeloid leukemia was most frequent, along with other cancers such as Hodgkin lymphoma**.**
3. Heart-related conditions**:** Deaths were linked to heart issues, including heart attack**,** end-stage heart failure, and cardiac cirrhosis**.**
4. Respiratory failure**:** Acute respiratory failure**,** hypoxia, and septic shock were notable causes of death.
5. Kidney failure**:** Kidney failure and complications such as acute kidney failure were common, often alongside conditions such as lymphoma or cirrhosis**.**

In County Hospital Locations

Members are transferred to various hospitals for out-of-county care. USC stands out as the most frequent destination, appearing 65 times, making it the dominant choice. UCLA follows with 29 members. In total, there were 10 transfers, primarily to USC (8), with one each to UCLA and Victor Valley Medical Center.



Note: The graph shows that there are 208 unique members who were hospitalized in the county, with a total of 696 hospital encounters. This indicates that, on average, each member had multiple hospital visits.



Note: The graph shows that 131 unique members were hospitalized out of the county, with a total of 239 hospital encounters. This also indicates that, on average, each member had multiple hospital visits out of county.

Lessons Learned

1. Some members with the greatest needs were not initially identified, which highlights the need for continued resource alignment to CCM and ECM. Addressing this allows us to connect them to the appropriate services.
2. Most Members Remain Engaged, but a Significant Portion Declines or Is Hard to Reach
3. Home Visit Success Is Strong but Shows Opportunities for Outreach Optimization
4. Behavioral Health Is the Most Frequent Referral Need
5. Cancer and Transplant Populations Represent Complex, High-Touch Cohorts
6. Transplant members are mostly in the Post-Transplant phase, requiring long-term monitoring and close coordination with USC and UCLA—particularly since referrals are heavily concentrated at USC.
7. Sepsis, cancer, cardiac conditions, respiratory failure, and kidney failure were the top five diagnoses among deceased members. This confirms patterns seen in high-need populations and reflects opportunities for earlier intervention, advance care planning, and palliative care referrals.
8. Hospitalization Patterns Show High Reliance on Out-of-County Specialty Care
    - USC and UCLA are the dominant out-of-county hospital locations, mainly due to transplant and oncology specialty needs. Multiple hospital encounters per member (both in-county and out-of-county) show ongoing instability in chronic conditions and the need for tighter transitions-of-care processes.

Opportunities

1. Strengthening Engagement Strategies for Declined and UTC Members
2. Enhance Care Pathways for Cancer and Transplant Populations
    - Strengthen communication channels with AIS, USC, and UCLA.
    - Create standardized transitions-of-care workflows for chemo starts, post-transplant follow-up, and specialty hospital discharges.
    - Expand palliative care engagement for appropriate members earlier in the process.
3. Prioritize High-Risk Diagnoses for Proactive Interventions
    - Focus on conditions strongly linked to mortality in this cohort:
    - Sepsis prevention and early detection.
    - Heart failure and COPD management strategies.
    - Kidney failure monitoring and early nephrology referral.
    - Advance care planning for members with progressive disease.
4. Develop a Targeted Strategy for Members With Multiple Hospital Encounters

- Conduct root-cause analysis for high-frequency hospital users (care gaps, medication issues, lack of support).
- Implement tighter follow-up within 48–72 hours post-discharge.
- Utilize CHWs or nurses to provide intensive short-term stabilization support.

5. Continue Ongoing ICT Review and Ensure Follow-Through
   - Maintain weekly interdisciplinary reviews.
   - Track action items and outcomes to ensure closure.
   - Use data dashboards to continuously monitor program distribution, referrals, and utilization trends.

Conclusion

The review of our high-resource-utilization members highlights the complex medical and social needs within this population and reinforces the importance of a coordinated, interdisciplinary approach. The data shows clear patterns—such as high engagement levels, significant behavioral health needs, recurrent hospitalizations, and substantial oncology and transplant involvement—that guide where our efforts must be focused.

Through the ICT process, we are better able to identify barriers, connect members to the right services, and intervene earlier to prevent avoidable complications. The lessons learned from this analysis provide valuable insight into where our care coordination model is working well and where additional improvements are needed.

By implementing the outlined next steps—strengthening engagement strategies, enhancing behavioral health integration, refining home visit processes, improving specialty care coordination, and prioritizing high-risk conditions—we will continue to improve member outcomes and ensure our resources are used in the most effective and compassionate way possible.

Population Health Management
Implementation Report: DHCS Birthing Care Pathway 2025

Executive Summary

Kern Health Systems (KHS) has implemented the Department of Health Care Services (DHCS) Birthing Care Pathway, ensuring comprehensive, culturally competent, member-centered maternal care from conception through 12 months postpartum. This implementation aligns with:

- DHCS All Plan Letters (APLs)
- CalAIM Population Health Management (PHM) Policy Guide – DHCS, July 2025
- DHCS 2025 Comprehensive Quality Strategy (CQS), Section 2.3
- American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines
- Comprehensive Perinatal Services Program (CPSP) standards
- Medi-Cal managed care contract requirements
- California Health & Safety Code and Title 22 regulations

KHS maternal health initiatives reflect PHM objectives, aiming to:

- Support all Members in preventive and wellness care
- Identify and assess individual and population-level risks
- Guide care management and care coordination
- Mitigate social drivers of health (SDOH) to reduce disparities

The Bold Goals 50x2025 initiative remains central to KHS strategy, advancing key clinical focus areas:

- Children’s preventive care
- Maternal outcomes and birth equity
- Behavioral health integration

KHS collaborates with external partners such as Medi-Cal Health Plans, Local Health Jurisdictions (LHJs), and various internal departments within KHS, including the Health Equity Department, Health and Wellness Department, Member Services, Quality Improvement, Provider Network, and Member Engagement, to advance these goals. This collaboration focuses on addressing disparities in high-risk populations, including African American, Native American, Pacific Islander, and rural members. The Health Equity Department is integral to KHS's commitment to addressing health disparities and works closely with other stakeholders to ensure equitable access to care.

Additionally, KHS collaborates with DHCS, particularly through the Transforming Maternal and Adolescent Health (TMaH) grant, to align efforts and leverage resources to improve maternal health outcomes. KHS also received accreditation in July 2025 for both the National Committee for Quality Assurance (NCQA) and NCQA Health Equity, emphasizing its dedication to providing high-quality, equitable care.

Key interventions in maternal and child health include integrating Community Health Workers (CHWs) for outreach, wellness education, and chronic disease management, along with risk assessments and personalized care plans based on clinical standards. Programs such as case management and care coordination, and Enhanced Care Management (ECM) target high-risk maternal populations. Collaboration with organizations such as First 5 Kern, Kern County Public Health Services, and the Breastfeeding Coalition strengthens advocacy, care, and support, while partnerships with local OB/Gyns, Federally Qualified Health Centers (FQHCs), and delivery hospitals ensure seamless prenatal and postpartum care. Additionally, resources such as Women Infants and Children (WIC) referrals and annual participation in the Kern County Maternal Health Symposium keep staff informed on the latest practices and trends. The quarterly PHM Committee further fosters community partnerships to address maternal health disparities and improve care outcomes.

KHS programs align with statewide Bold Goals while supporting locally driven CHA/CHIP processes, ensuring community perspectives inform maternal health planning. These efforts focus on improving access, quality, and equity across the perinatal continuum, consistent with CQS 2025 Section 2.3 priorities.

Population Health Management
Implementation Report: DHCS Birthing Care Pathway 2025

I. Background

A. Maternal Health Needs in Kern County

1. Analysis of KHS 2025 PNA and Kern County DHCS maternal data highlights persistent disparities:

   a. Racial and ethnic disparities: African American and Native American Members experience lower prenatal/postpartum engagement and worse outcomes; Pacific Islander and Hispanic Members show disparities on select indicators.
   b. Language disparities: English and Spanish speakers had the lowest prenatal and postpartum care rates in 2024.
   c. Rural access barriers: Large geographic area, limited delivery providers, few prenatal/postpartum clinics, and transportation challenges.
   d. Maternal mental health gaps: Low screening and follow-up for perinatal depression.
   e. Immunization gaps: Inadequate influenza and Tdap vaccination rates.

2. Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)

   a. KHS works closely with the Kern County Public Health Services Department and other local Medi-Cal Health Plans to support the CHA and CHIP, ensuring that maternal health needs are identified and addressed through a coordinated, data-driven approach.
   b. This partnership strengthens alignment between countywide priorities and KHS initiatives, particularly in advancing the statewide Bold Goals 50x2025 effort.
   c. KHS and Public Health focus on reducing maternal morbidity and mortality, closing equity gaps for disproportionately impacted populations, and improving access to culturally responsive perinatal care.
   d. Through shared planning, resource coordination, and community engagement, this collaboration ensures that maternal health strategies reflect local needs and drive measurable improvements in outcomes for birthing people and infants across Kern County.

B. Importance of NCQA Accreditation

1. KHS has achieved accreditation from the NCQA, including the NCQA Health Equity Accreditation, further demonstrating its commitment to providing high-quality, equitable care.
   a. NCQA accreditation is a rigorous, industry-recognized process that evaluates health plans based on their ability to deliver the highest standards of care, including their performance on quality measures, member satisfaction, and the management of health outcomes.
   b. This accreditation signifies that KHS meets the highest standards in patient care, safety, and satisfaction, ensuring that services are comprehensive, effective, and accessible to all members.
2. NCQA Health Equity Accreditation highlights KHS's commitment to addressing health disparities and advancing health equity by assessing the plan’s efforts to reduce disparities across various populations.
   a. Achieving this accreditation demonstrates that KHS prioritizes the identification and mitigation of social determinants of health (SDOH) and ensures culturally competent care, especially for underserved communities.

Figure A. This illustration summarizes the maternal care continuum from conception through 12 months postpartum, reflecting KHS's coordinated, culturally competent approach to prenatal, birth, and postpartum services.

II. Current Initiatives

A. Programs

1. KHS offers case management and care coordination for prenatal and postpartum members which provides education and engagement to encourage early and consistent prenatal and postpartum care. KHS also addresses SDOH, offers transportation support, and connects members to providers and community resources.
2. KHS offers ECM for special focus populations including individuals experiencing homelessness, justice-involved Members, youth involved in the child welfare system, and other high-risk maternal populations, including the Birth Equity population of focus for both adults and youth, specific to Black, Pacific Islander, Native American, and/or Alaska Native populations. ECM provides intensive, person-centered care coordination, addressing medical, social, and behavioral health needs, with a focus on improving health outcomes for high-needs Members.
3. KHS works in partnership with the Kern County Public Health Services Department to refer Members to important Maternal, Child, and Adolescent Health (MCAH) programs, such as the Black Infant Health Program, Nurse Family Partnership Program (an evidence-based model that provides nurse home visits for first-time mothers), and Perinatal Outreach Program. These programs provide additional layers of support to address the unique needs of high-risk mothers and children in Kern County.
4. KHS refers eligible Members to the WIC program for health food nutrition, counseling, education, and assistance with breast pumps. The program is a critical resource for improving maternal and child nutrition, promoting breastfeeding, and addressing health disparities.

B. Health Education

1. When Members enroll in these programs, case managers or care coordinators provide comprehensive health education tailored to support healthy pregnancies and positive maternal and infant outcomes.
2. Education topics include the importance of prenatal care, normal body changes during pregnancy, and common pregnancy symptoms.
3. Case managers also review healthy eating habits using the MyPlate guidelines for pregnancy and breastfeeding, toxoplasmosis prevention, and the role of prenatal vitamins and folic acid.
4. Additional education covers fetal development, how to perform fetal kick counts, and the signs and symptoms of preterm birth. Case managers stressed the importance of following providers' instructions for managing conditions such as high blood pressure during pregnancy and gestational diabetes, as well as preparing for labor and delivery.

5. Case managers also provide education on dental care during pregnancy, Family PACT services and birth control options, prenatal and postpartum depression, and the importance of attending postpartum visits.
6. Infant-focused topics include feeding and nutrition, immunizations, car seat safety, SIDS and safe sleep practices, and lead screening.
7. This comprehensive education ensures that Members are equipped with the knowledge and resources needed to support their own health and the health of their infants.

C. Coalitions / Committees

1. KHS collaborates closely with First 5 Kern to advocate for and enhance maternal and child health services in Kern County. This partnership strengthens community-level support for maternal health, particularly for vulnerable populations, ensuring equitable access to resources and services for families.
2. The PHM Committee is a quarterly meeting that brings together representatives from KHS, community agencies, and key stakeholders to address members' medical and social needs, including maternal and child health needs in Kern County.
    a. The committee plays an essential role in guiding KHS' initiatives, promoting community partnerships, leveraging existing resources, and ensuring that maternal health disparities are addressed through collaborative efforts.
    b. The committee members are strong advocates for the health and well-being of the community, working toward shared goals to improve health outcomes.
3. KHS is an active participant in the Breastfeeding Coalition, working closely with community partners to promote breastfeeding education, support, and resources for new mothers.
4. In collaboration with Kern County Public Health Department and First 5 Kern, Black Infant and Maternal Health Initiative (BIMHI) aims to address health disparities for Black mothers and babies in Kern County. The initiative includes local government organizations, community-based groups, non-profits, and community members, working together to reduce racial disparities in maternal health outcomes through education, community outreach, and tailored support services.

D. Community Partnership

1. KHS works closely with contracted OB/Gyn providers to ensure seamless care and coordination for pregnant and postpartum Members. This partnership ensures that Members receive high-quality obstetric care, including prenatal visits, labor, and delivery services.
2. KHS collaborates with local delivery hospitals to ensure that Members have access to comprehensive and safe delivery services. These partnerships are critical for supporting high-quality birth outcomes and ensuring that Members receive coordinated care during labor and delivery.
3. KHS partners with FQHCs to improve access to high-quality prenatal and postpartum care for underserved populations, particularly those in rural areas. FQHCs provide comprehensive services, including medical, behavioral health, and social support, ensuring that Members receive culturally competent and accessible maternal care.
4. To enhance staff knowledge and skills, KHS ensures that key staff members attend the Kern County Annual Maternal Health Symposium. This symposium provides education on the latest trends, research, and best practices in maternal and child health, keeping staff up to date with current guidelines and innovations in care.

E. Transitional Care Services (TCS)

1. As part of the statewide Population Health Management (PHM) initiative and in alignment with CalAIM requirements, KHS has implemented strengthened Transitional Care Services to ensure safe, coordinated transitions for members across care settings.
2. Requirements (by January 1, 2024):
    a. Coordinate care from discharge planning to connection with needed services.
    b. Complete medication reconciliation at discharge and follow-up.

c. Ensure timely post-discharge follow-up care.
d. MCPs remain accountable for full TCS compliance, even if tasks are delegated.

3. High Risk Population: Strengthened TCS are especially critical for pregnant and postpartum members, who are categorically considered high-risk. Timely notifications, medication reconciliation, and coordinated follow-up reduce the risk of obstetric complications, postpartum emergencies, untreated behavioral health needs, and gaps in care. Robust TCS ensure smooth transitions from inpatient delivery to outpatient and community supports, including WIC, doulas, behavioral health care, and ECM, improving safety, continuity, and equity across the birthing care pathway.

D. Memorandum of Understanding (MOU)

MOUs formalize collaboration between KHS and external partners to ensure coordinated, high-quality care, with a particular focus on pregnancy and postpartum members. These agreements are critical for ensuring that high-risk maternal populations receive timely, safe, and comprehensive care, and that care transitions from prenatal, delivery, and postpartum settings are seamless.

1. Key Functions and Importance for Maternal Health:

    a. Facilitate coordination across multiple providers and community partners to support prenatal care, labor and delivery, postpartum follow-up, and ongoing maternal health needs.
    b. Ensure timely exchange of health information for pregnant and postpartum members, including risk factors, medical history, social needs, and behavioral health considerations.
    c. Strengthen continuity of care from hospital discharge to community and home-based supports, reducing complications and readmissions.
    d. Support equity-focused interventions, ensuring that high-risk and underserved populations (e.g., African American, Native American, Pacific Islander, rural, and justice-involved members) receive culturally competent care.
    e. Enable access to essential programs, including WIC, doula services, Nurse Family Partnership, Black Infant Health, and ECM services, ensuring holistic support during the perinatal period.

2. Key MOUs in Place:

    a. Kern Behavioral Health and Recovery Services (KBHRS): Coordinates mental health and substance use services for pregnant and postpartum members, ensuring timely support for behavioral health needs.
    b. Community Action Partnership Kern WIC: Provides nutrition support, breastfeeding education, and resources critical for maternal and infant health.
    c. Clinica Sierra Vista WIC: Ensures access to maternal and child nutrition services for low-income women and children.
    d. Local Health Department: Coordinates immunizations, prenatal/postpartum care, and well-child visits, supporting maternal and infant health continuity.
    e. Targeted Case Management: Supports case management services for high-risk maternal populations, including socially vulnerable or medically complex members.
    f. First 5 Kern: Enhances early childhood education, family wellness, and maternal support programs, ensuring a strong foundation for mothers and babies.

3. Quarterly MOU meetings provide opportunities for KHS and partners to discuss ongoing care coordination, address challenges in maternal care delivery, and optimize services for pregnant and

postpartum members. These agreements are foundational to ensuring that all members receive safe, timely, and comprehensive care throughout the perinatal continuum.

KHS External Partners

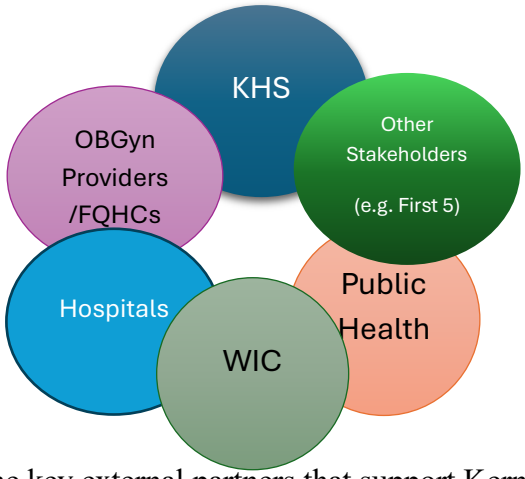


Figure B. This diagram illustrates the key external partners that support Kern Health Systems' maternal health initiatives, including Medi-Cal Health Plans, OB/GYN providers and FQHCs, WIC, Kern County Public Health, and other community stakeholders such as First 5. These partners form a coordinated ecosystem that enhances access, continuity of care, and member support across the perinatal continuum.

E. Quality Improvement and Monitoring

1. Maternal health outcomes tracked via MCAS metrics and internal quality dashboards
2. Alignment with Bold Goals 50x2025 and CQS 2025 population-level outcomes
3. Continuous improvement via CHW engagement, case management and care coordination program evaluation, ECM monitoring, and community partnerships

F. MediCal Connect

Medi-Cal Connect is an integrated platform that consolidates medical, behavioral, dental, and social service information for Medi-Cal members. It provides care teams, health plans, and providers with a comprehensive view of a member's health history, risk factors, and social needs, enabling timely and coordinated interventions.

For maternal health, Medi-Cal Connect is especially critical because it:

- Improves visibility into a member's complete health history during pregnancy and postpartum
- Enables early identification and risk stratification of high-risk pregnancies
- Supports care coordination across providers, health plans, and community partners
- Facilitates proactive outreach and management of medical and behavioral health conditions, such as hypertension and perinatal depression
- Ensures timely connection to supportive services, including WIC, doulas, and ECM
- Strengthens maternal safety, continuity of care, and health equity by providing care teams with comprehensive, real-time information

By consolidating health and social service data, Medi-Cal Connect empowers KHS to deliver more effective, member-centered care across the entire birthing care pathway, from prenatal care through 12 months postpartum.

III. Conclusion

1. KHS demonstrates full implementation of the DHCS Birthing Care Pathway, incorporating:

    a. CalAIM PHM Policy Guide 2025 requirements
    b. Bold Goals 50x2025 objectives
    c. CQS 2025 Section 2.3 PHM principles
    d. CHW-led outreach and care coordination
    e. Culturally competent prenatal/postpartum care
    f. Targeted interventions to address disparities
    g. ECM services to support special focus populations and high-risk Members
    h. Collaboration with First 5 Kern to advocate for maternal and child health
    i. Referral to Kern County Public Health Services MCAH programs for enhanced maternal and child health support
    j. WIC program referrals to ensure nutritional support for mothers and babies
    k. Staff training and development through participation in the Kern County Annual Maternal Health Symposium to enhance skills and stay current with maternal and child health guidelines
    l. Quarterly PHM Committee meetings that bring together community agencies and stakeholders to collaborate, share resources, and advocate for improved maternal and child health outcomes
    m. Active participation in the Breastfeeding Coalition to provide breastfeeding support and education to new mothers
    n. Collaboration with OB/Gyn providers and local delivery hospitals to ensure seamless maternal care from prenatal visits to delivery and postpartum care.
    o. Partnership with FQHCs to improve access to comprehensive care for underserved populations, particularly in rural areas.

Through coordinated care, education, community partnerships, equity-focused programs, and ECM services, KHS ensures all Members have access to high-quality, culturally competent maternal care from conception through 12 months postpartum.

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Addressing Comprehensive Care for High-Risk Members through Population Health Management

Michelle Curioso

Director of Population Health Management

12/16/2025

KERN HEALTH SYSTEMS

Bridging Gaps: A Population Health Approach to Palliative Care Coordination

Purpose

- Reduces emergency department (ED) utilization by proactively supporting individuals with serious illnesses.
- Helps members understand their care options, navigate complex health needs, and address social determinants of health that contribute to avoidable crises.

Activities

- Engages members in meaningful conversations about palliative care, clarify available services, and coordinate access to palliative programs.
- Connects members to community resources, provide ongoing support, and ensure that members' medical and social needs are addressed in a timely, person-centered manner.

KERN HEALTH SYSTEMS

Bridging Gaps: A Population Health Approach to Palliative Care Coordination

Why It Matters

- Decreases unnecessary ED visits, enhances quality of life, and ensures members receive the right care at the right time.
- Addresses both medical and social factors, the program improves care continuity, reduces strain on acute care settings, and supports better overall health outcomes.

KERN HEALTH SYSTEMS

Improving Outcomes for High Resource Utilization

Purpose

- Reviews high resource utilization members ensures they receive timely, appropriate care and are connected to services that address their specific needs.
- Helps identify barriers and link members to the right resources for effective, compassionate, and efficient support.

Activities

- Conducts an interdisciplinary care team (ICT) meeting – including medical doctors, pharmacists, nurses, social workers, and specialists – conducts weekly reviews.
- Evaluates medical, social, and family needs, and assesses whether additional services such as palliative care, hospice, or behavioral health support are necessary.

KERN HEALTH SYSTEMS

Improving Outcomes for High Resource Utilization

Why It Matters

- Enhances member outcomes, reduces avoidable crises and hospitalizations, and optimizes resource use.
- Promotes continuity of care, improves quality, and supports member well-being and organizational sustainability.

KERN HEALTH SYSTEMS

PHM Birthing Care Pathway

Purpose

- Creates a standardized birthing care pathway that ensures pregnant individuals receive consistent, high-quality care throughout pregnancy, delivery, and postpartum.
- Supports early risk identification, promotes safety, and enhances the overall birthing experience.

Activities

- Develops multidisciplinary guidelines that outline recommended assessments, interventions, education, and follow-up at each stage of the perinatal journey.
- Engages obstetric providers, nurses, case managers, and community partners to align processes, integrate best practices, and coordinate needed services such as prenatal care, behavioral health, and postpartum support.

KERN HEALTH SYSTEMS

PHM Birthing Care Pathway

Why It Matters

- A structured birthing care pathway reduces preventable complications, improves maternal and infant outcomes, and ensures timely, appropriate care.
- Enhances care coordination, promotes equitable access to resources, and supports a safer, more positive birthing experience for families.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

To: EQIHEC

From: Christine Pence, Senior Director of Health Services

Date: December 16, 2025

Re: Utilization Management Department Reporting Q3 2025

Background:

Utilization Management (UM) continues to be focused on ensuring KHS members receive medically necessary care at the right time in the most appropriate setting. To achieve this goal, UM works diligently to ensure all department processes are regulatorily compliant, staff are well trained, and all decisions are made based on medical necessity and in accordance with regulatory directive and the Plan contract with DHCS.

Discussion:

This report contains a synopsis of both quantitative and qualitative analytics that reflect the performance of the Utilization Management Department's in the 3rd quarter of 2025.

Fiscal Impact:

None.

Requested Action:

Review and approval.

Quarter 3 2025 Report

Timeliness of Decision Trending

Summary:

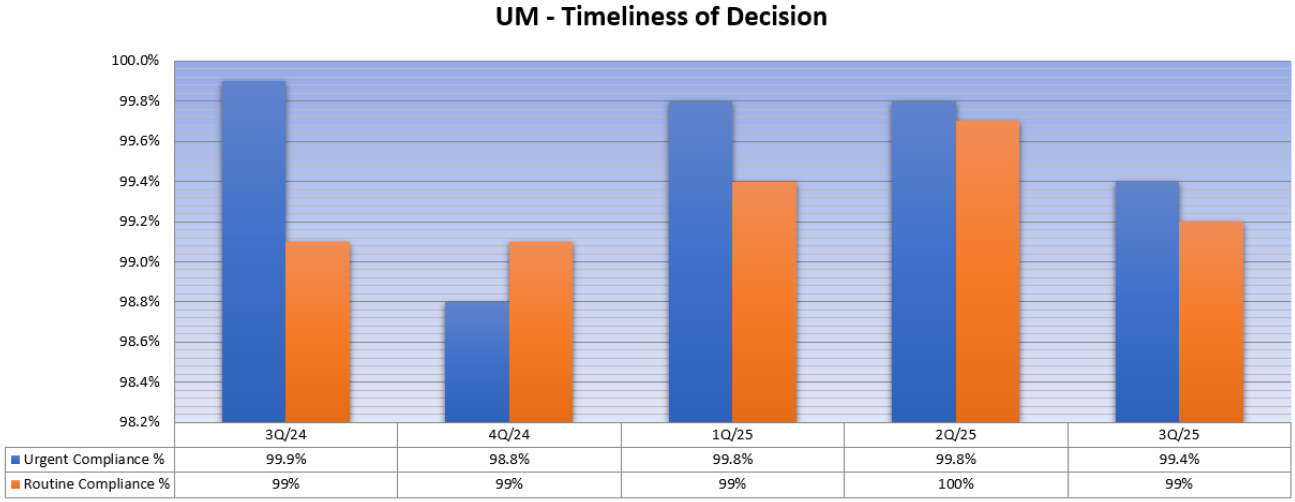
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around times set for each type of referral.

Key Objective #1: Timeliness of decision making and notification to ensure compliance with regulatory standards

Timeliness of Decision Making:
Providers may indicate 'Urgent' on the referrals indicating a decision needs to be made within 3 business days. Routine/non-emergent referrals must be processed within 5 business days. Once an urgent referral has been reviewed it may be downgraded for medical necessity at which time the provider will be notified via letter that the referral has been re-classified as a routine and nurse will clearly document on the referral "re-classified as routine". Random referrals are reviewed every quarter to observe timeliness. 10% of referrals received are reviewed monthly.

For those referrals that are found to be out of compliance with turn-around-timelines, the case manager and support staff are notified, and importance of timeframes discussed to help ensure future compliance.

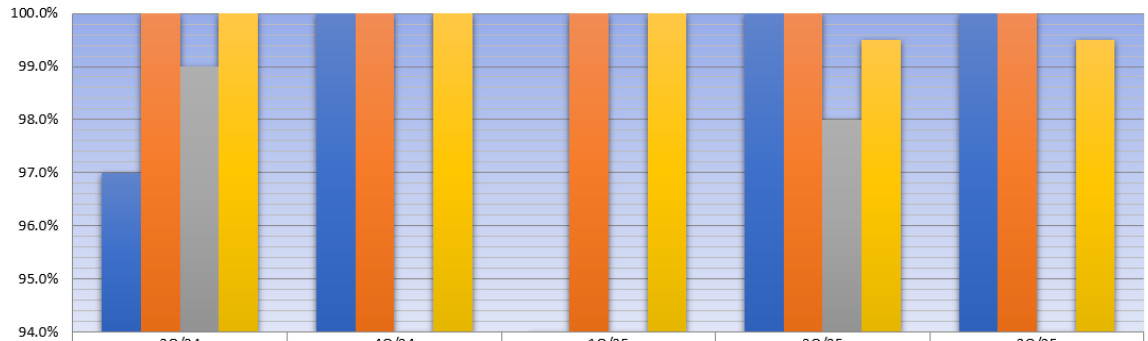
Urgent: Response back to Provider in 72 hours
Routine: Response back to Provider in 5 business days



	3Q/24	4Q/24	1Q/25	2Q/25	3Q/25
Urgent Compliance %	99.9%	98.8%	99.8%	99.8%	99.4%
Routine Compliance %	99%	99%	99%	100%	99%

Member and Provider Notification Compliance:

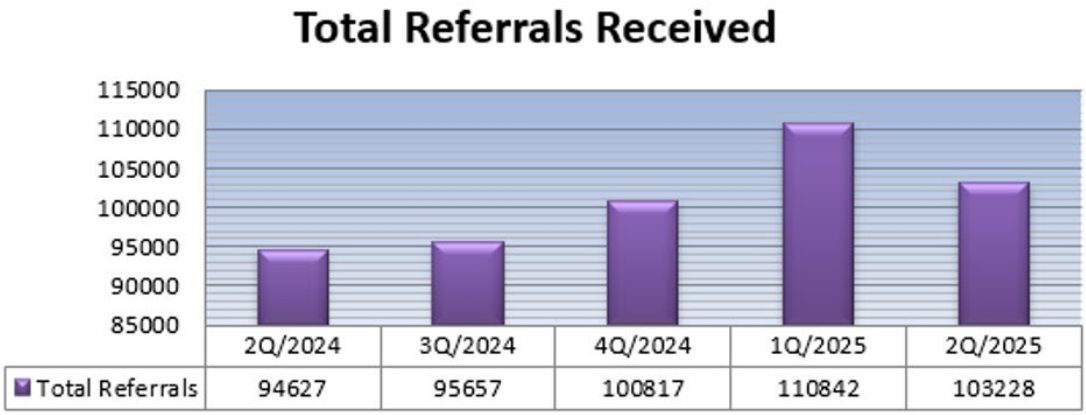
Member Nofication is required to be mailed to member within 48 hours of the decision. Provider Notification is required to occur with 24 hours of the decision. Besides timeliness, we audit to ensure criteria is included with the provider notification for modification and denials and that the MD signature is included on all NOA letters.



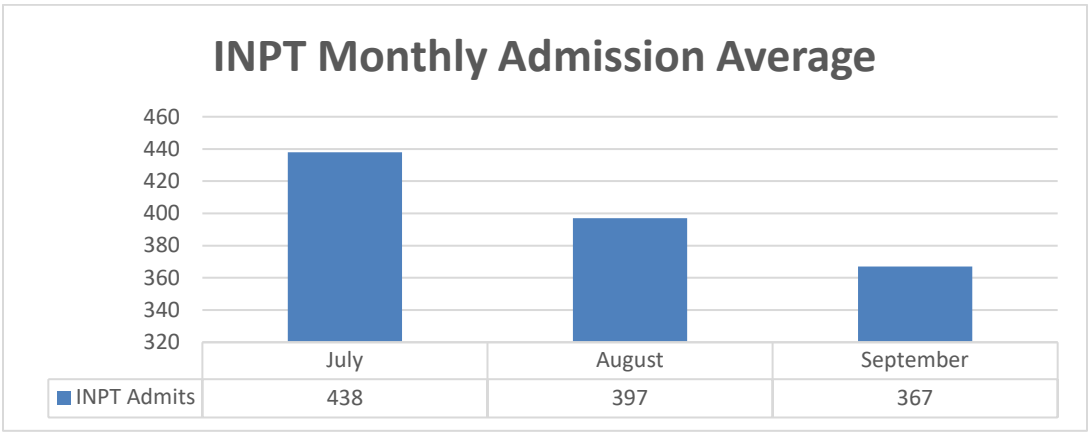
	3Q/24	4Q/24	1Q/25	2Q/25	3Q/25
Member Notification	97.0%	100.0%	91.0%	100.0%	100.0%
Provider Notification	100%	100%	100%	100%	100%
Criteria Included	99%	93%	92%	98%	79%
MD Signature Included	100%	100%	100%	100%	100%

Key Objective #2: Evaluate service utilization to identify potential over and utilization of services and monitor for trends.

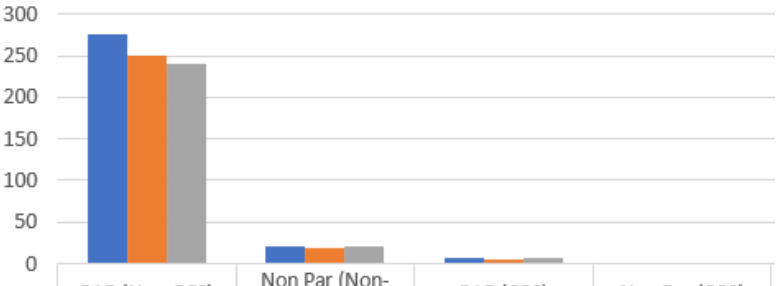
Referrals Received:



Inpatient Utilization

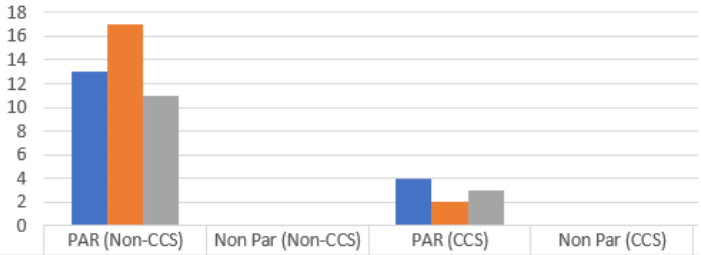


Acute Monthly Average



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)
July	276	20	7	0
August	250	18	6	0
September	241	21	7	0

Tertiary Monthly Average

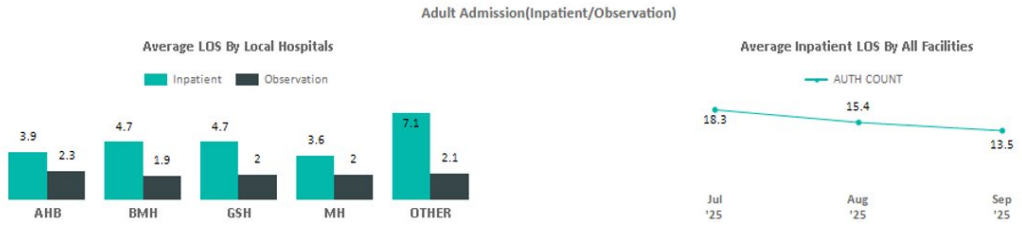


	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)
July	13	0	4	0
August	17	0	2	0
September	11	0	3	0

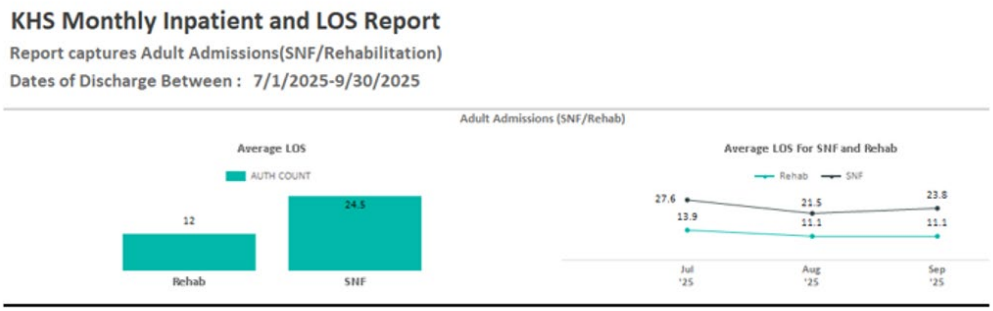
KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(Inpatient/Observation)

Dates of Discharge Between : 7/1/2025-9/30/2025



Post-Acute Statistics:



Key Objective #3: Ensure compliance with regulatory requirements for appropriate processing and communication of decision to provider and member.

Below is a summary of the 2025 Quarter 3 audits from the sample reviewed. A summary of 2024 is also included for comparison and to trend progress.

- UM experienced a consistent number of referrals processed from Quarter 2, the percentage of modified and delayed referrals remained consistent with an increase in the percentage of denied referrals. The increase in percentage of denied referrals is related to changes in Community Support Services guidelines.
- Looking at 2025 Quarter 2 and comparing the trends to 2025 Q3, the errors in mailing notification to members more than 2 days after the decision, missing criteria, errors in referral processing and missing signatures improved. However, the errors in NOA increased, but is improved from Quarter 1 and 2024.
- The UM team, Medical Directors, and Physician Reviewers have continued to focus on the quality of our NOA letters. Our weekly meetings with the Medical Directors continue, where we address specific NOA letter concerns and questions.
- UM Leadership has reviewed the deficiencies with the specific team members that had errors.

Utilization Management Department Internal Audits

Quarter 3

	Quarter 3 Summary
Total Referrals Processed	98,045
Total Referrals Modified	1431
Percent Referrals Modified	1.5%
Total Referrals Denied	5,644
Percent Referrals Denied	5.8%

Total Referrals Delayed	245
Percent Referrals Delayed	0.2%

Quarter 2

	Quarter 2 Summary
Total Referrals Processed	98,956
Total Referrals Modified	1443
Percent Referrals Modified	1.5%
Total Referrals Denied	3,815
Percent Referrals Denied	3.9%
Total Referrals Delayed	290
Percent Referrals Delayed	0.3%

2024 Summary

	2024 Summary
Total Referrals Processed	383,407
Total Referrals Modified	6,502
Percent Referrals Modified	2%
Total Referrals Denied	9,326
Percent Referrals Denied	2%
Total Referrals Delayed	643
Percent Referrals Delayed	0.17%

Quarter 3

	Quarter 3 Summary	Quarterly Percentage Noncompliant
Total Referrals Audited	90	
Mailed > 2 days after decision	1	0.7%
Error in NOA (including > 6th grade)	4	2.7%
Missing citation or criteria	0	0.0%
Errors in processing referral	9	6.0%
Signatures missing	0	0.0%

Quarter 2

	Quarter 2 Summary	Quarterly Percentage Noncompliant
Total Referrals Audited	150	
Mailed > 2 days after decision	2	1.3%
Error in NOA (including > 6th grade)	0	0.0%
Missing citation or criteria	2	1.3%
Errors in processing referral	11	7.3%
Signatures missing	1	0.7%

2024 Summary

	2024 Summary	
Total Referrals Audited	1124	
Mailed > 2 days after decision	48	4.3%
Error in NOA	73	6.5%
Missing citation or criteria	35	3.1%

NOA above 6th grade reading level	90	8.0%
Errors in processing referral	62	5.5%
Signatures missing	0	0.0%

Key Objective #4: Ensure quality utilization management reviews and consistency between utilization management team members

All Utilization Management (UM) staff reviewers must complete and successfully pass quarterly MCG Inter-Rater Reliability (IRR) testing to demonstrate competency and ensure compliance with regulatory standards and guidelines.

All licensed clinical reviewing staff members are given three (3) attempts to complete the assigned case studies with a minimum passing score of 95% or higher.

Outpatient clinical staff reviewers are given a total of five (5) Ambulatory Care (AC) case studies with a minimum of fifteen (15) questions.

Inpatient clinical staff reviewers are given one (1) General Recovery Care (GRC) case study and one (1) Inpatient and Surgical Care (ISC) case study with a minimum of twenty (20) questions.

Medical Directors, Management, and clinical trainers are given four (4) AC cases and one (1) ISC or GRC case with a minimum of twenty (20) questions.

	Number of Staff	Total Questions	Percentage that scored 95% or higher
Nonclinical Intake Coordinators	29	10	100%
OP Nurses	11	3	100%
IP Nurses	16	10	100%
Physician Reviewers	6	10	83%, 1 pending completion
Director/Management/Supervisor	3	10	100%

Key Objective #5: Evaluate health equity in relation to authorization requests and decisions.

Row Labels	Central	Percentage	East	Percentage	North	Percentage	South	Percentage	West	Percentage	Grand Total	Percentage
Approved	72,388	87%	5,536	85%	13,572	88%	5,808	89%	2,791	87%	100,095	87%
Denied	4,650	6%	386	6%	752	5%	289	4%	173	5%	6,250	5%
Modified	894	1%	125	2%	184	1%	63	1%	38	1%	1,304	1%
Voided	5,021	6%	448	7%	841	5%	369	6%	215	7%	6,894	6%
Grand Total	**82,953**		**6,495**		**15,349**		**6,529**		**3,217**		**114,543**	

Policies approved by UM Committee on December 4, 2025

DSNP 002 Separation of Financial Decision Making
DSNP 003 Application of Medical Necessity and Clinical Criteria
DSNP 005 Referral Processing Turn Around Times
DSNP 006 Adverse Determinations
DSNP 007 Specialty Referral and Use of Board Certified Practitioners
DSNP 008 Standing Referrals
DSNP 009 Requests for Experimental treatment
DSNP 011 Lack of Clinical Information
DSNP 012 Organization Determination Mail Policy
DSNP 013 Reopening Service Determinations
DSNP 014 Termination of Medicare Services
DSNP 016 Emergency and Post Stabilization Requirements
DSNP 017 UM Inter-Rater Reliability Audits
DSNP 018 Downgrading UM Referral Requests
DSNP 019 Cancelling, Withdrawing, or Dismissing a UM Service Request
DSNP 020 Request for Medical Policies
DSNP 021 Continuity of Care
DSNP 022 Medicare Certified Facilities
DSNP 023 Reconstructive Procedures
DSNP 027 Second and Third Opinion
DSNP 030 Retrospective Review
DSNP 032 Direct Access to Women's Services
DSNP Discharge Planning
DSNP Onsite Facility Review
DSNP UM Interdisciplinary Care Rounds
DSNP UM Monthly Audits
DSNP Concurrent Review Utilization Management
DSNP Medical Director Referral
DSNP Medical Director Peer to Peer

KERN HEALTH SYSTEMS

To: KHS Executive Quality Improvement Health Equity Committee Meeting

From: James Winfrey, Deputy Director of Provider Network Management

Date: 12/16/2025

Re: Network Adequacy Committee, Q3 2025

Background:
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.

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.

Discussion:
Enclosed is an overview of the Plan's network adequacy standards, monitoring activities, findings, and process improvements discussed during the 3rd Quarter Network Adequacy Committee meeting, including minutes.

Fiscal Impact:
None

Requested Action:
Approve and File.

Network Adequacy Committee, Q3 2025

Executive Quality Improvement Health Equity Committee

December 16, 2025

Network Adequacy Committee

The Network Adequacy Committee (NAC) is delegated by the Executive Quality Improvement Health Equity Committee (EQIHEC) to monitor and report on network adequacy.

Establish Network Standards	• Ensuring network accessibility standards align with regulatory and quality assurance standards
Monitor Network Compliance	• Review monitoring activities conducted by the Plan to measure network compliance with established standards
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.
Steer Continuous Improvement	• Provide feedback on proposed corrective actions and ensure they are appropriate to address identified issues

Q3 Committee Meeting

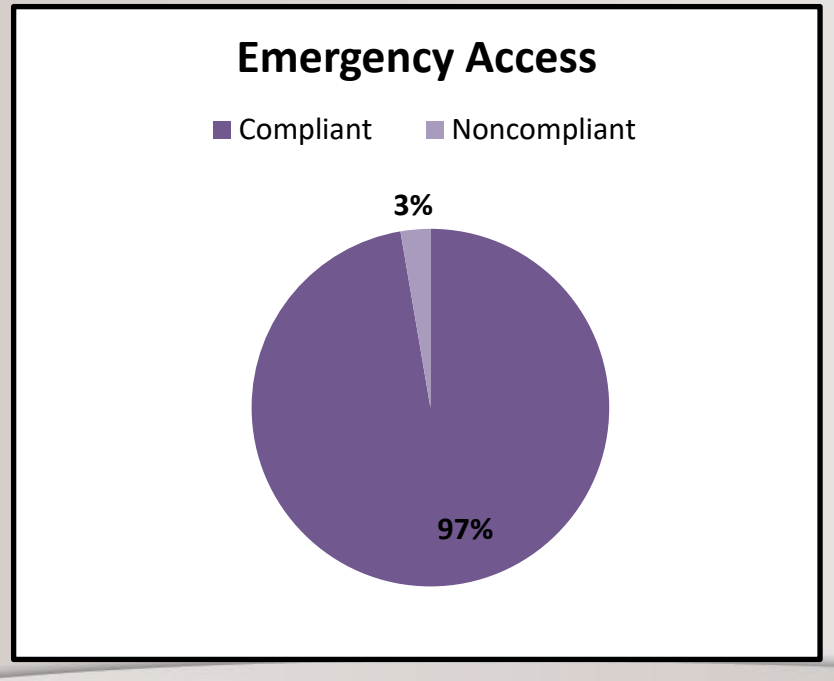
Quarter 3, 2025 Meeting – 7/25/2025

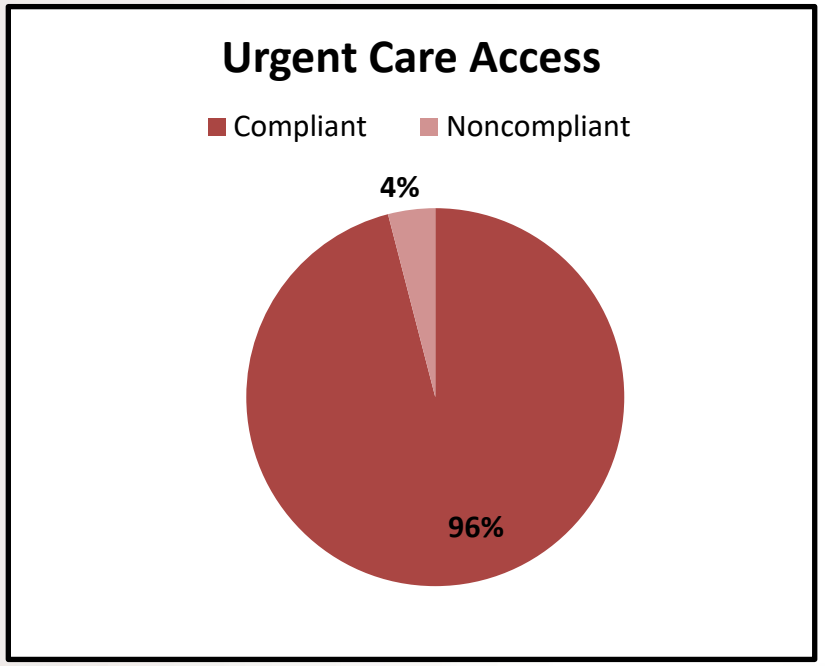
- Reviewed Quarter 2, 2025 Provider Network Management, Quarterly Network Review:
  - After Hours Survey Results
  - Provider Accessibility Monitoring Survey
  - Access Grievance Review
  - Geographic Accessibility & DHCS Network Certification
  - Network Adequacy & Provider Counts
  - Recent Provider Network Reporting

After-Hours Survey Report

Results

During Q2 2025 **149** primary care provider offices were contacted. Of those offices, **145** were compliant with the Emergency Access Standards and **143** were compliant with the Urgent Care Access Standards.





After-Hours Survey Report

Action Taken

Four provider offices were identified as non-compliant with both access standards, and two additional provider offices were identified as non-compliant with the urgent access standard. The provider offices were educated via letter and Plan outreach.

Recommendation

Plan's ongoing outreach and education continues to be successful when instances of noncompliance are identified. Plan will continue to monitor quarterly, and no other action is needed at this time.

Provider Accessibility Monitoring Survey

- The Plan selected a random sample of 25 PCP and 23 Specialty providers by geographic location using the Health Equity Department's regional map -- 5 PCPs and 5 Specialists were select from each geographic region.

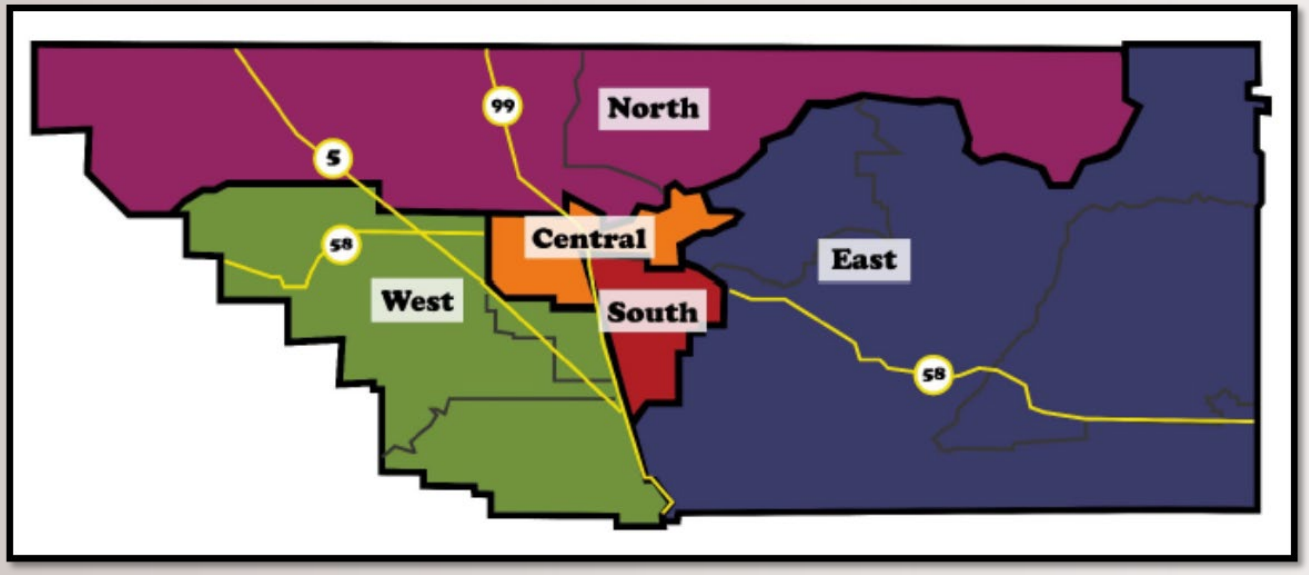
- A random sample of 5 non-physician mental health, 5 ancillary, and 5 OBGYN providers were also contacted to monitor network compliance with accessibility metrics.

Average urgent wait time in hours	Standard	Q2 2025
Primary Care	48 Hours	12.2 Hours
Specialist	96 Hours	39.6 Hours

Average wait time in days	Standard	Q2 2025
Primary Care	10 Business	2.5 Days
Specialist	15 Business	6.7 Days
Non-Physician Mental Health	10 Business	1.2 Days
Ancillary	15 Business	1.6 Days
First Prenatal OB/GYN*	10 Business*	9.4 Days

*The lesser of 10 business days or within 2 weeks

Provider Accessibility Monitoring Survey



Region	Total Members
North	61,053
South	27,813
East	30,161
West	15,484
Central	267,871

	PCPs Surveyed	Urgent Compliant	Compliant Non-Urgent Compliant
North	5	100%	100%
South	5	100%	100%
East	5	100%	100%
West	5	100%	80%
Central	5	80%	80%

	Specialists Surveyed	Urgent Compliant	Compliant Non-Urgent Compliant
North	5	80%	100%
South	3	67%	67%
East	5	100%	100%
West	5	100%	100%
Central	5	100%	100%

Provider Accessibility Monitoring Survey

Analysis

- While instances of non-compliance were identified, at a county/network level the Plan was compliant with accessibility standards.
- In prior quarters, the East and Central regions had lower accessibility. This quarter, those regions were at or above 80% compliance for PCPs and Specialists.
- The Plan had identified that that due to a lack of certain provider types in rural regions, the same providers are being surveyed every quarter for certain regions.

Action Taken

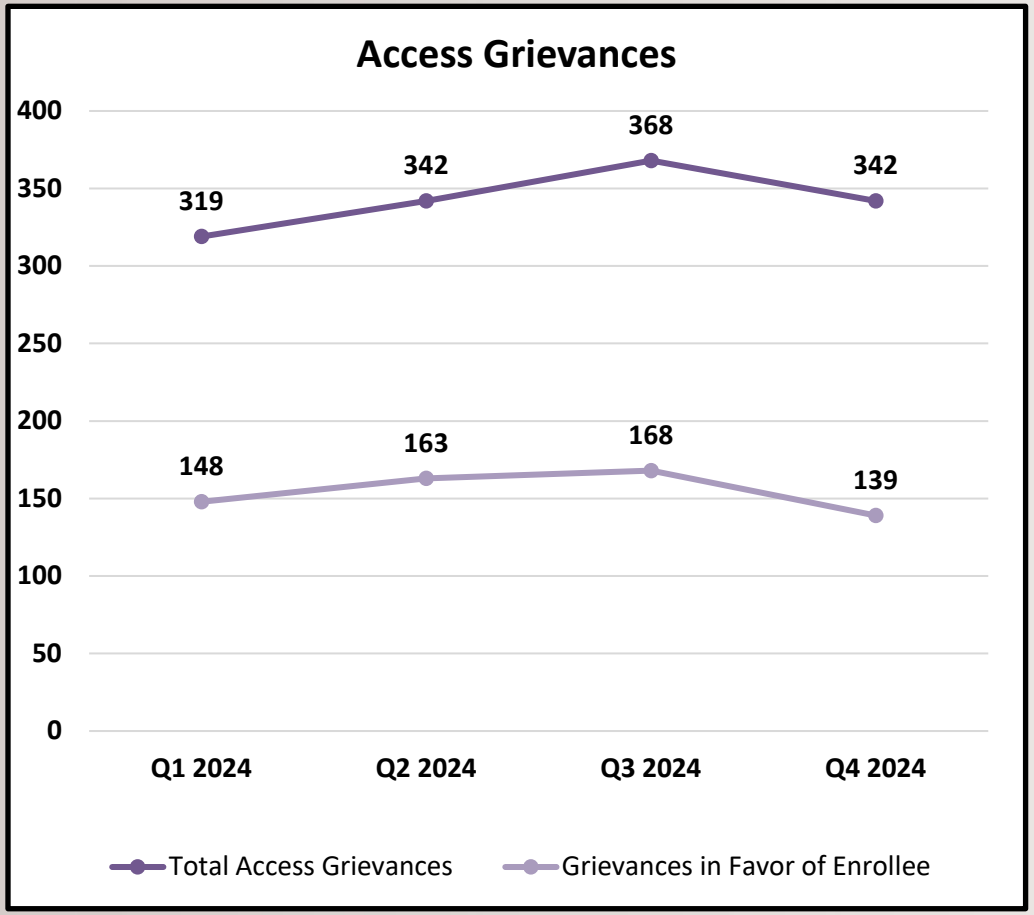
For all providers identified as noncompliant during Q2 2025, the Plan sent letters notifying the providers of the survey results and Plan policy. One provider was noncompliant for 2 consecutive quarters. PNM met with the provider remind them of access standards.

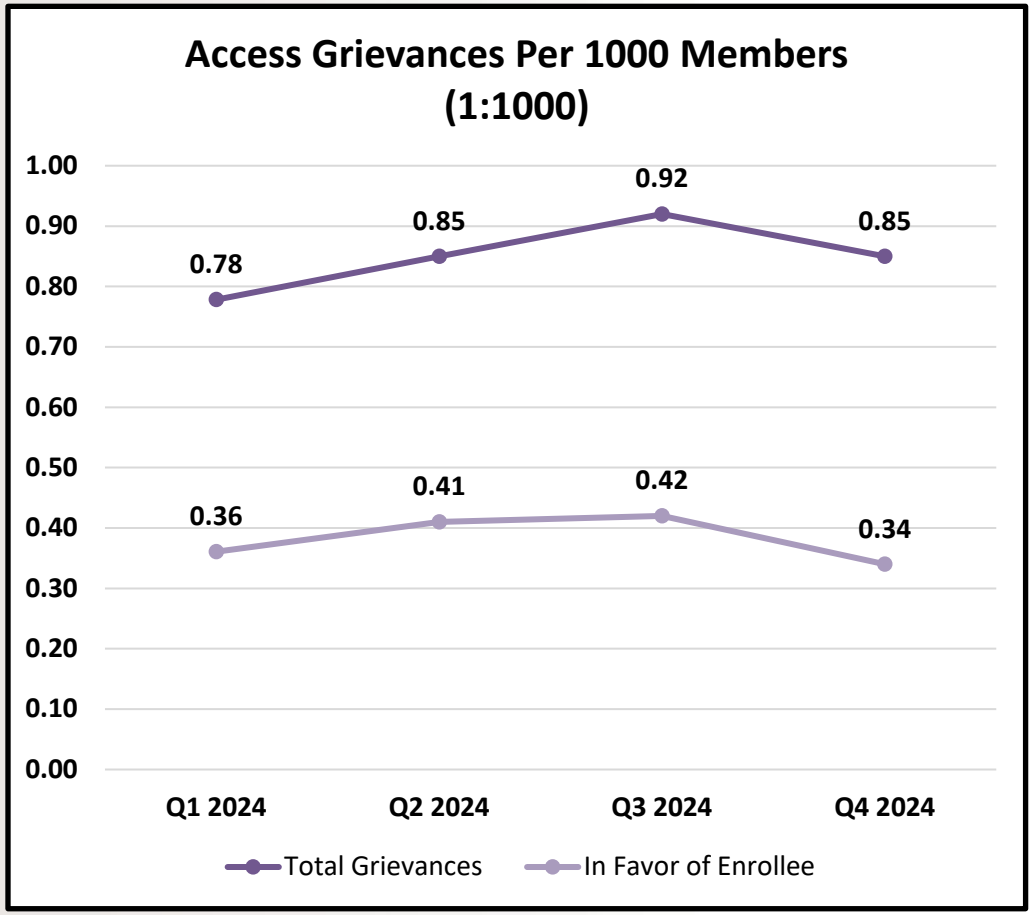
Recommendation

The Plan will resurvey all noncompliant providers in Q3 2025. Plan will continue to monitor quarterly, and no other action is needed at this time.

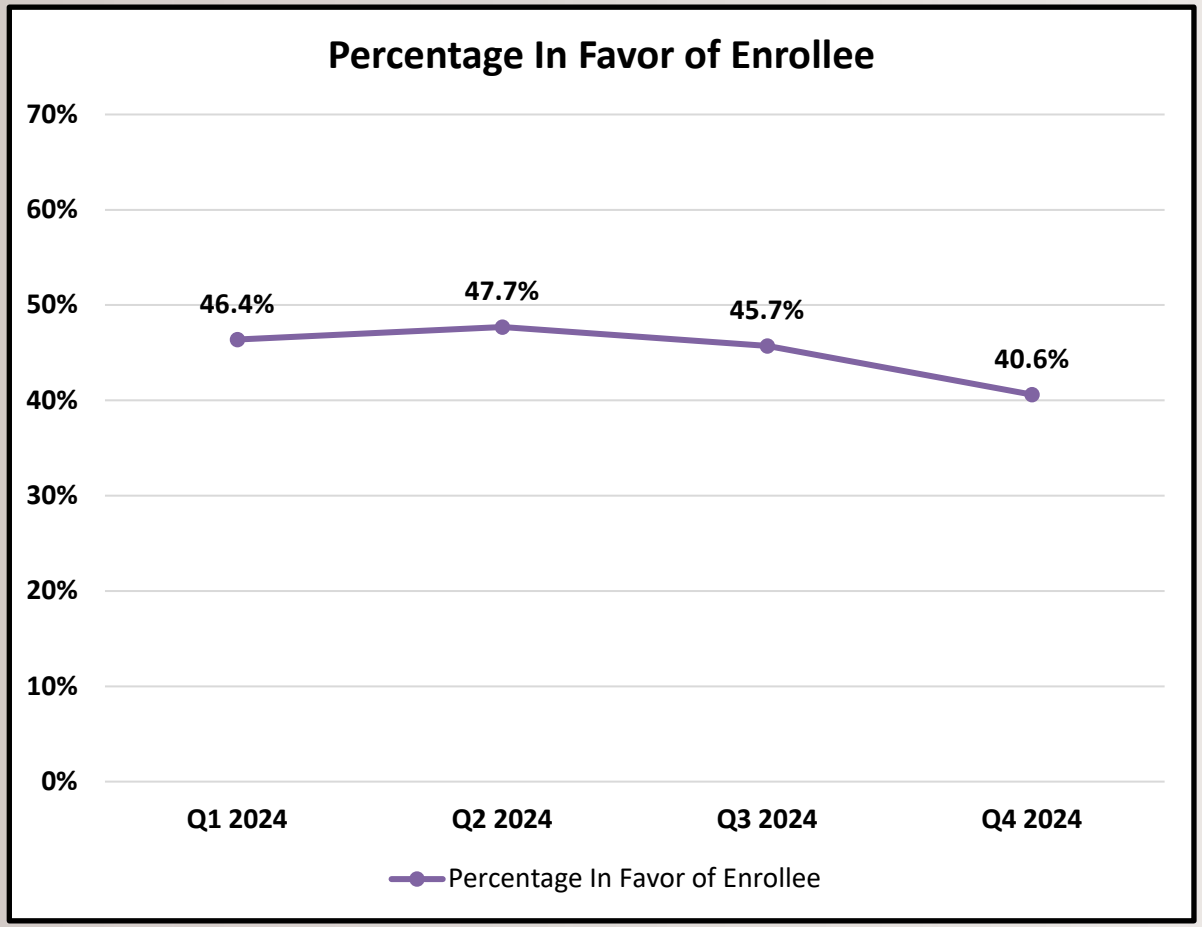
Discuss survey sampling methodology changes related to regional breakout with NAC.

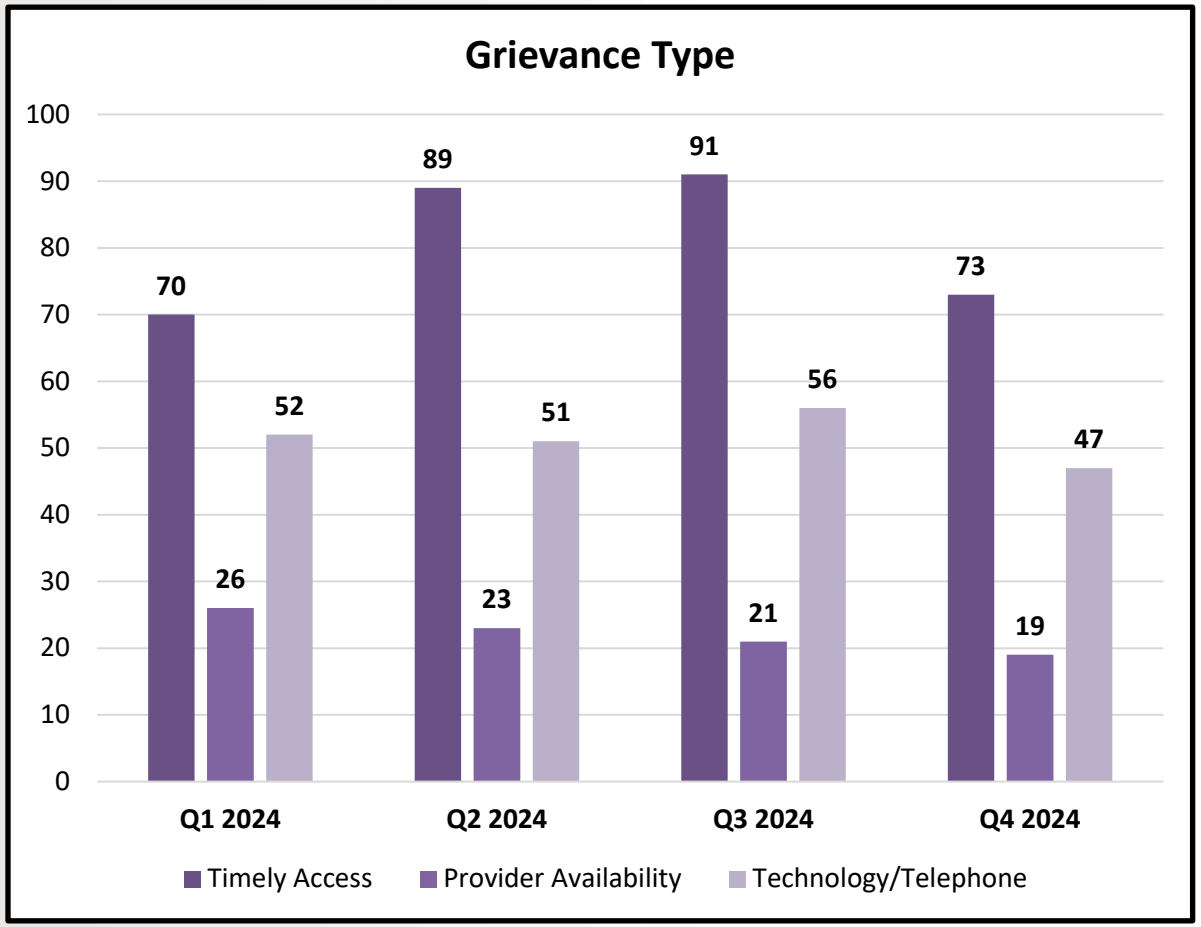
Access Grievance Review



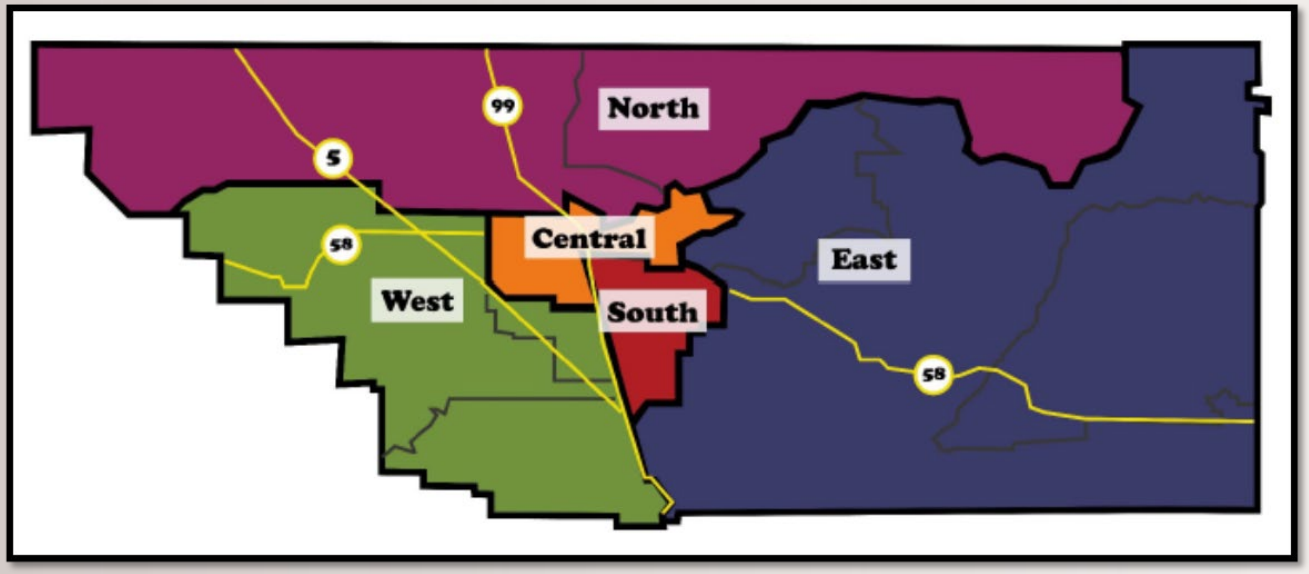


Access Grievance Review





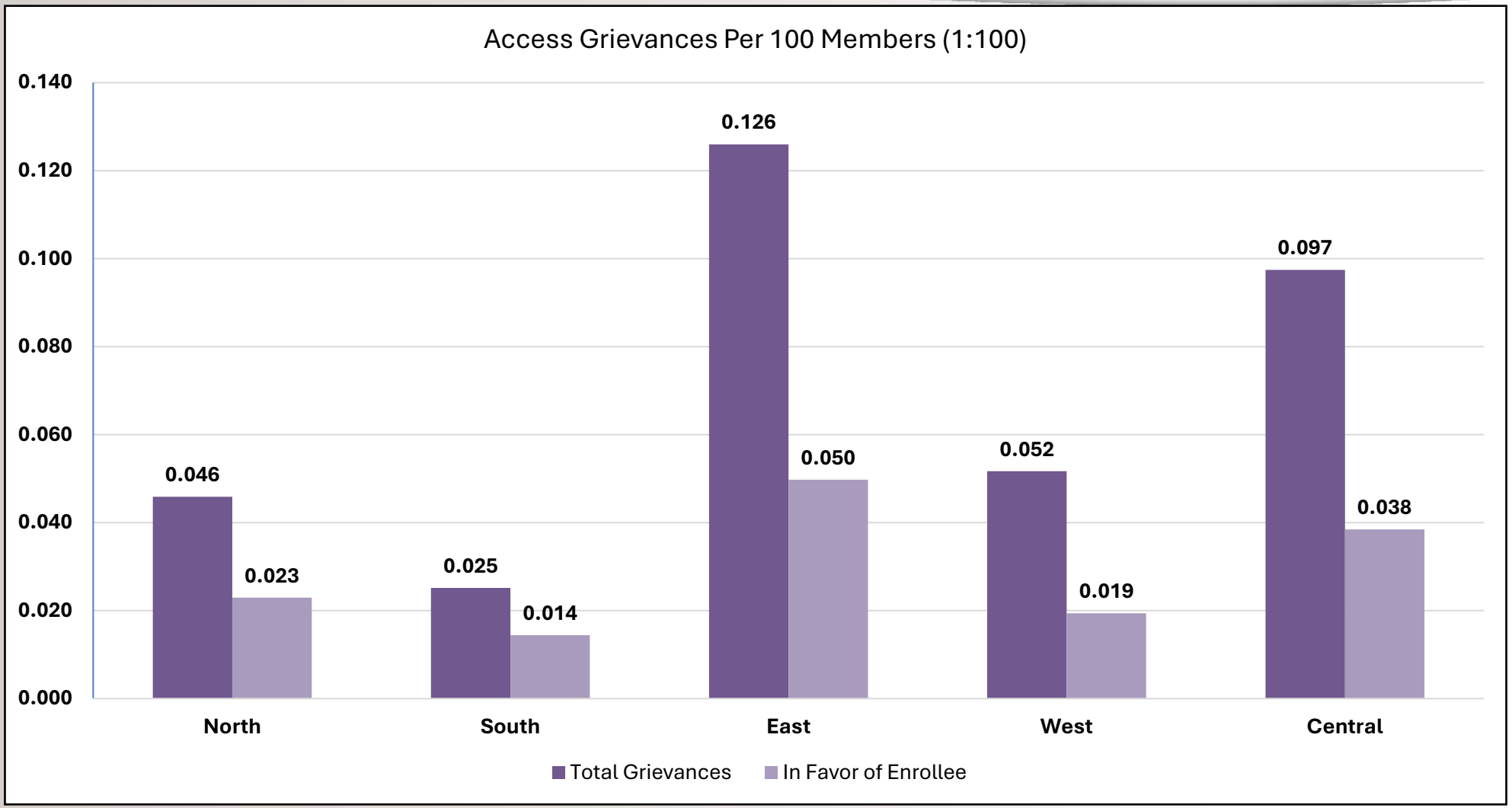
Access Grievance Review



Region	Total Members
North	61,053
South	27,813
East	30,161
West	15,484
Central	267,871

	North	South	East	West	Central	Out-of-Area
Provider	4	1	4	0	113	11
Member	14	4	15	3	103	N/A

Access Grievance Review



Access Grievance Review

Analysis

- After multiple quarters of continued increases, the Plan identified a decrease in both total access grievances and access grievances found in favor of the enrollee. The Plan reviewed historical trending data, and it appears that this is true decrease.
- Upon reviewing the Grievance type breakdown, the decrease was primary amongst the timely access grievances. This is the grievance type that saw increases in the preceding quarters.

Timely Access	Grievance related to timely access to a state plan approved provider within the timeframe requirements based on type of appointment and condition of member's health.

Recommendation

The Plan has an ongoing retention and recruitment grant (Nov 2023 - Nov 2025) to address accessibility issues. The Provider Network Analytics team will continue to monitor access grievances to gauge success of grant.

Ongoing access grievance tracking will also be utilized to determine whether this quarter's decrease represents the beginning of a sustained downward trend.

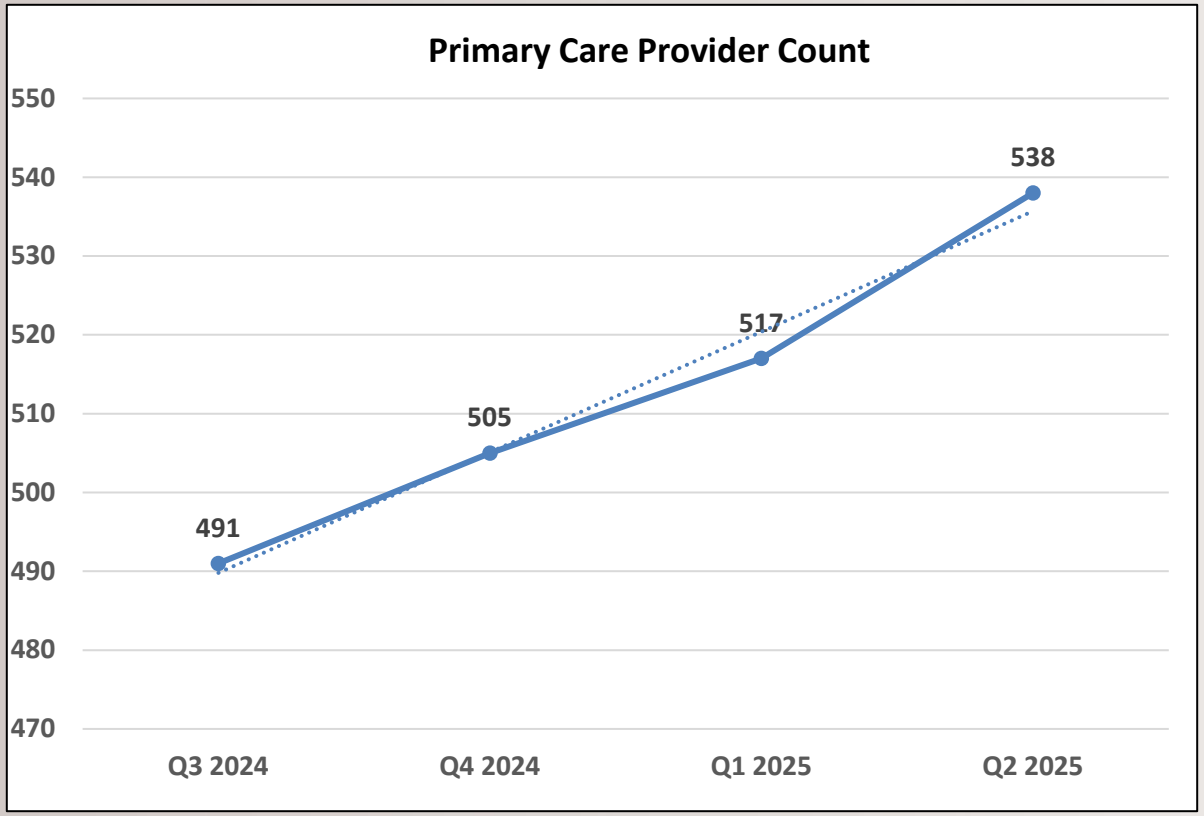
Geographic Accessibility & DHCS Network Certification

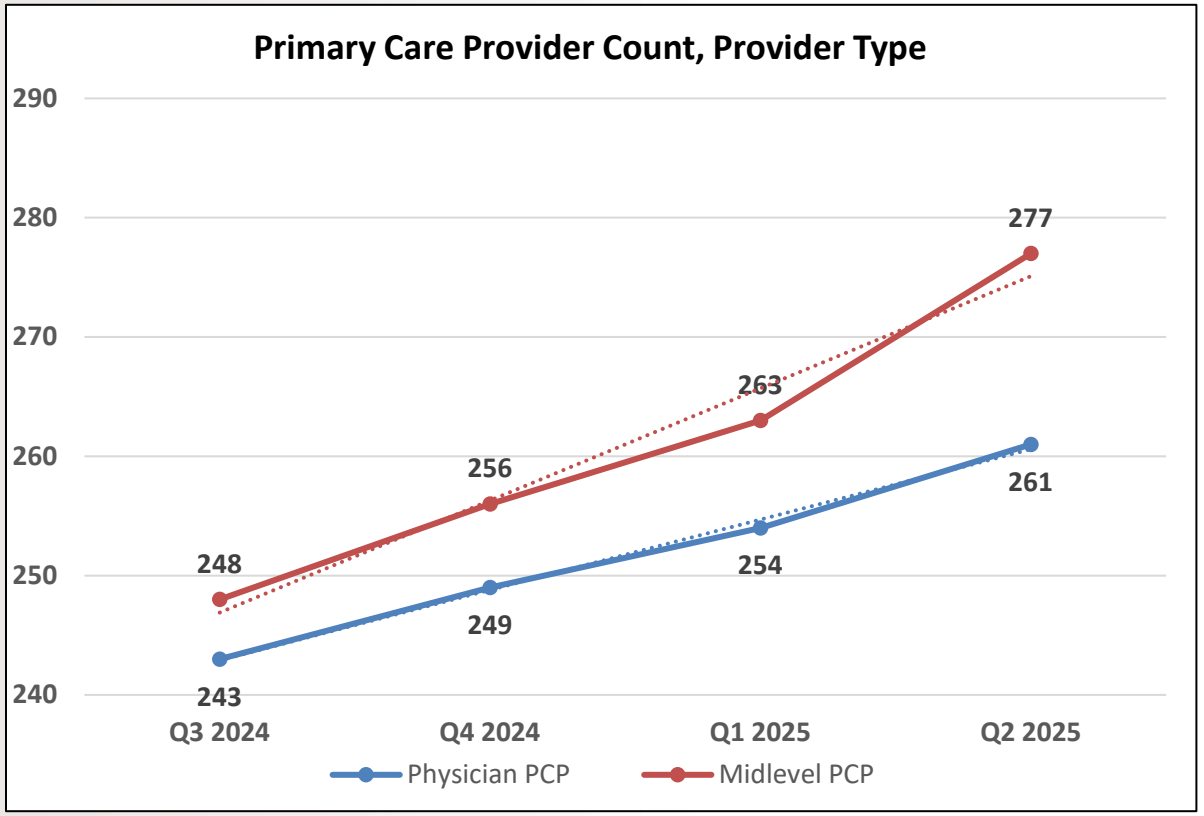
DHCS Annual Network Certification – 2023/2024

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

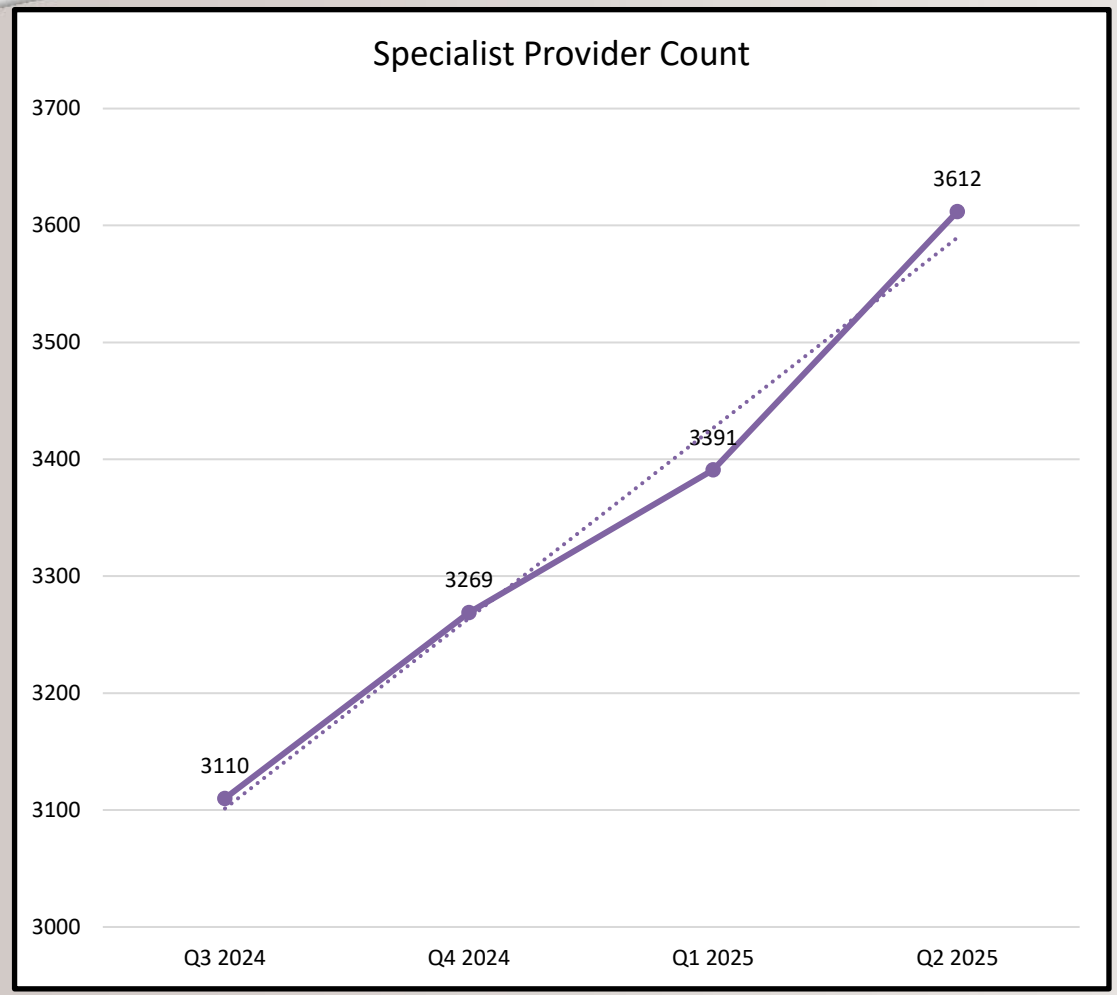
- The Plan submitted 232 AAS requests to the DHCS in Q1 2025. Of these 232 “population points”, 77 “population points” were newly identified for the 2024 ANC and 155 “population points” remained the same from the 2023 ANC.
- The Plan reviews all network deletions and as of the end of Q2 2025, the Plan did not identify terminations any that impacted the Plan’s geographic accessibility.
- **Analysis**: As of Q2 2025, the Plan received an update from DHCS regarding the 2024 Annual Network Certification, indicating that the submission is still under review.
- **Recommendation**: The Plan will continue to monitor geographic access both ongoing and through the DHCS Network Certification process.

Network Adequacy & Provider Counts





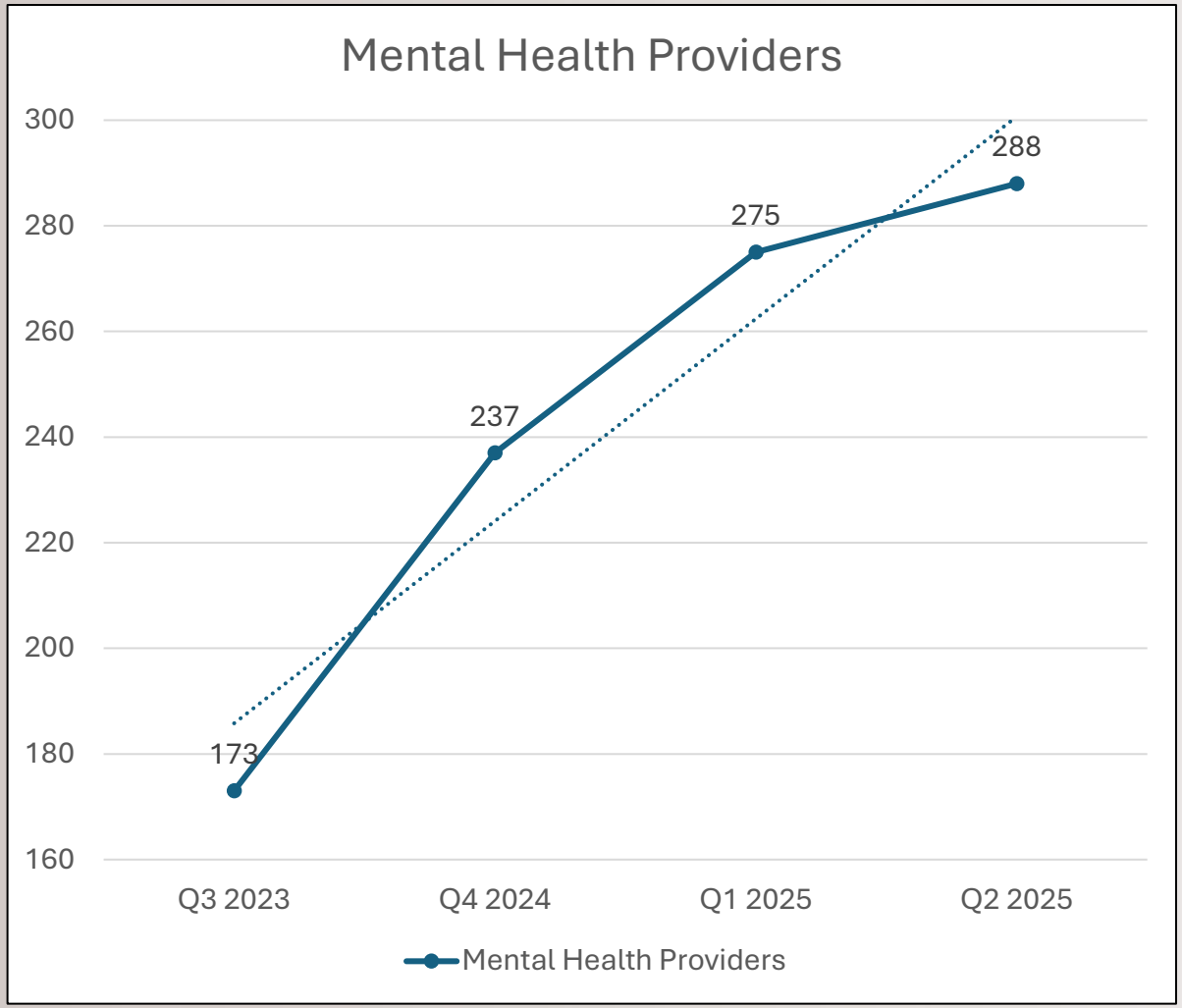
Network Adequacy & Provider Counts

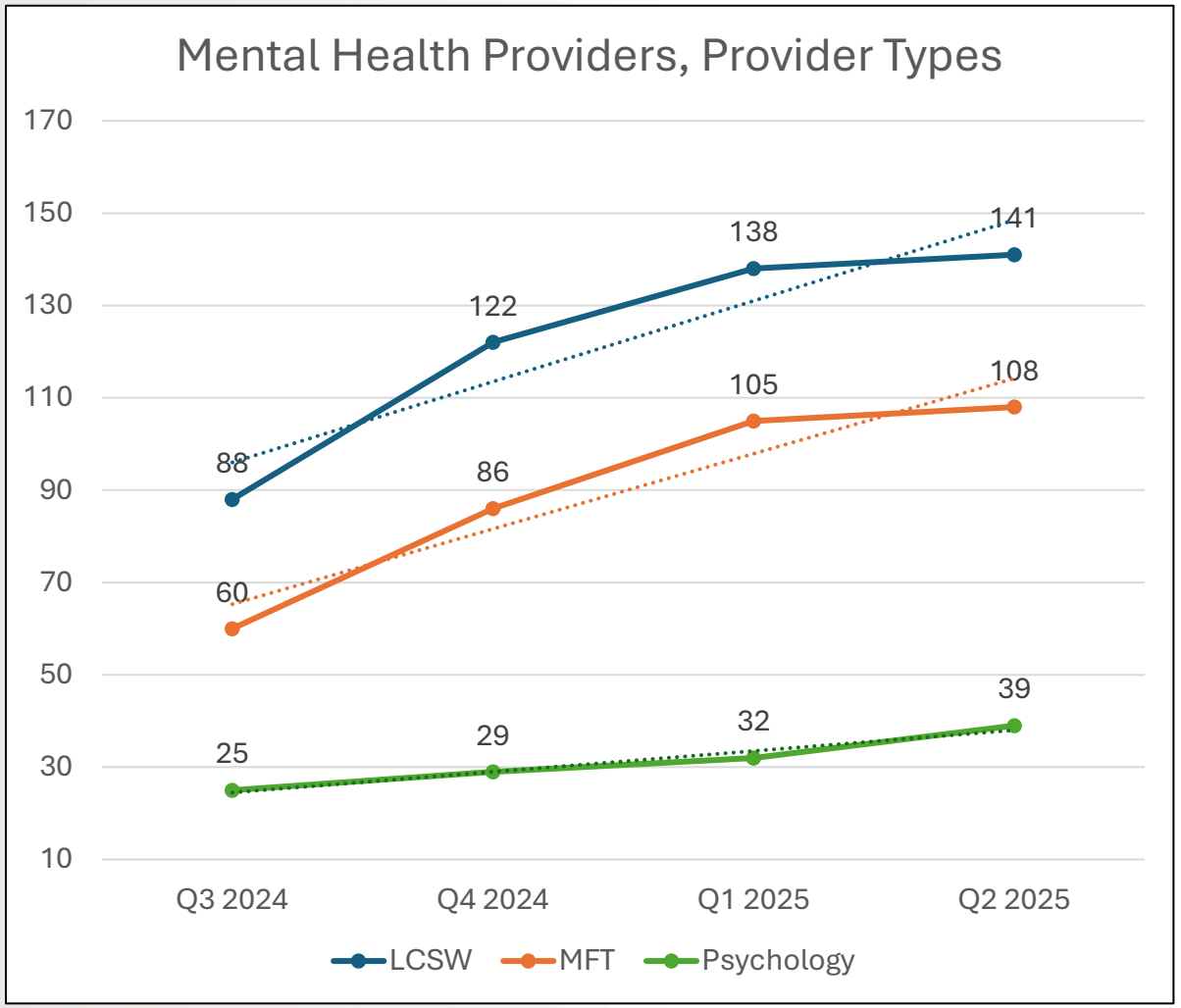


DHCS Core Specialty	Q3 2024	Q4 2024	Q1 2025	Q2 2025
Cardiology	46	45	45	46
Dermatology	50	51	51	54
Endocrinology	29	29	32	33
Gastroenterology	35	36	38	42
General Surgery	63	68	68	71
Hematology	25	28	29	29
Infectious Disease	13	13	13	13
Nephrology	25	24	24	32
Neurology	31	33	33	33
Oncology	30	30	30	32
Ophthalmology	32	30	32	38
Orthopedic Surgery	30	29	28	29
Otolaryngology	15	16	15	16
Physical Med & Rehab	8	8	8	8
Podiatry*	27	28	25	24
Psychiatry	90	95	105	200
Pulmonary Disease	26	24	23	23
Rheumatology*	21	19	21	19
	> 5% Increase		> 5% Decrease	
	≤ 5% Increase		≤ 5% Decrease	

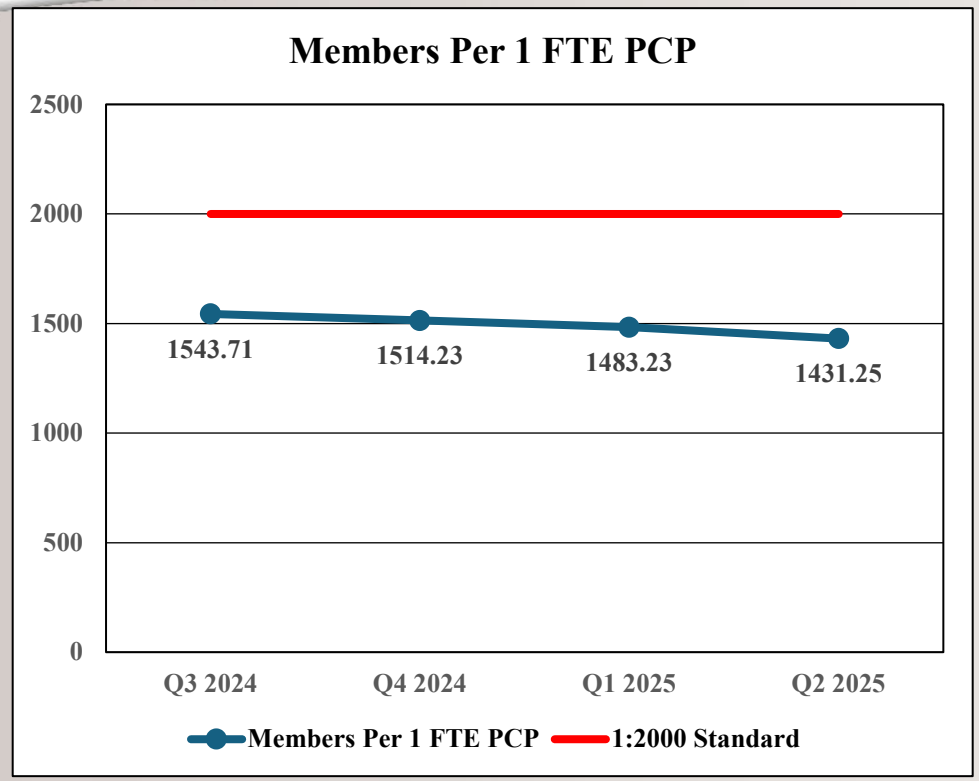
* Internally monitored – not a DHCS Core Specialty

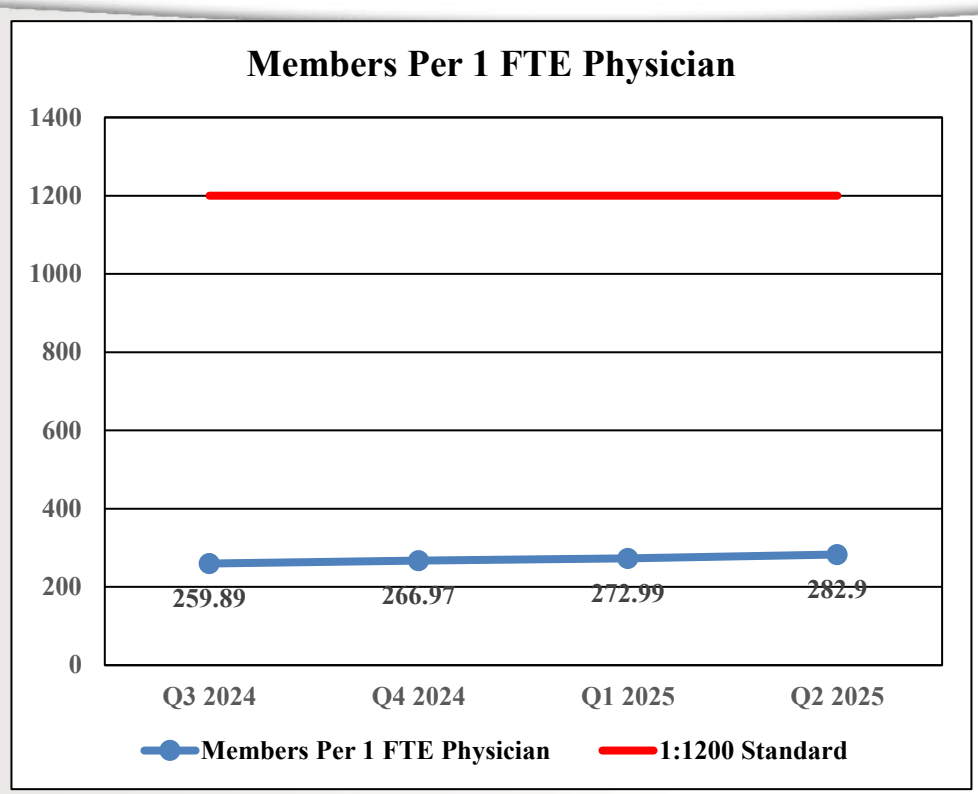
Network Adequacy & Provider Counts





Network Adequacy & Provider Counts





Analysis: Network growth illustrated in the slides above, has resulted in a positive impact on the Plan's network adequacy goals.

Recommendation: The Provider Network Analytics team will continue to monitor network adequacy and growth.

Network Adequacy & Provider Counts

Significant Network Change

- As outlined in California Health and Safety Code, Section 1367.27, subdivision®: *Whenever a plan determines (…) that there has been a 10 percent change in the network for a product in a region, the plan shall file an amendment to the plan application with the department.*

- On April 10, 2025, the Plan received a comment letter from the DMHC. The Plan responded to the comment letter on May 9, 2025.

KERN HEALTH SYSTEMS

To: EQIHEC

From: Nate Scott

Date: December 16, 2025

Re: Executive Summary for Q3 2025 Operation Board Update - Grievance Report

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Background:

When compared to the previous four quarters, the following grievance trends were identified.

- There was an increase in the Plan's grievance volume in the 3rd quarter, 2025, compared to the previous four quarters. The overall volume of Grievances and Appeals increased 13.6% from the 2nd quarter. There was also an increase of Appeals from 43% from quarter two to quarter three. This increase can be attributed to changes in the criteria for several Community Support Services (CSS) benefits and Applied Behavioral Analysis (ABA) therapy services. More information on these appeals below. Access to Care, Quality of Service, and Quality of Care grievances remained the three largest grievance categories. The volume of Exempt grievances increased as well, up 9.5% from the previous quarter. The increase in Exempt grievances can still be attributed to a rise in transportation grievances due to changes in how the Plan schedules rides for members.

- For CSS appeals, KHS conducted a comprehensive evaluation of its Community Support Services, focusing on utilization trends, cost-effectiveness, and member outcomes. The analysis identified consistently high utilization rates across several services but demonstrated a less-than-favorable return on investment. In response, implemented additional oversight for Medically Tailored Meals (MTM) between late May and early June 2025 to better align the service with DHCS eligibility requirements. These refinements ensure that only members with medically sensitive conditions are approved for the benefit. Given the high volume of referrals historically received for this service, KHS anticipated an increase in grievances/appeals from members who no longer qualified under the updated criteria and the additional oversight.

- For ABA appeals, when KHS reviewed clinical services, an audit showed possible overuse of ABA services. A random sample of cases was sent to an Independent Review

Organization approved by the Department of Health Care Services. These files were reviewed by a provider trained in ABA services. Most of the records in the sample did not meet medical necessity. The Department of Health Care Services requires us to investigate possible overuse and put processes in place to prevent it. To meet this requirement, KHS partnered with AllMed, an organization with trained providers who review ABA services for other health plans in California. Since starting this process, we have seen more denials of ABA services. We take this issue very seriously and are making sure denials are appropriate. We are also giving training to ABA providers and to AllMed reviewers to prevent inappropriate denials that could cause more grievances and appeals.

KHS Grievance and Appeals per 1,000 members = 3.34 per month.

Requested Action:

Review and approval.

3rd Quarter 2025 Operational Report

Alan Avery
Chief Operating Officer

3rd Quarter 2025 Grievance Report

Category2	Q3 2025	Status	Issue	Q2 2025	Q1 2025	Q4 2024	Q3 2024
Access to Care	897		Appointment Availability	832	713	603	601
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	385		Questioning denial of service	220	192	241	290
Other Issues	201		Miscellaneous	165	141	134	106
Potential Inappropriate Care	587		Questioning services provided. All PIC identified cases forwarded to Quality Dept.	493	535	476	532
Quality of Service	785		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	702	654	509	525
Discrimination (New Category)	81		Alleging discrimination based on the protected characteristics	78	81	71	62
Total Formal Grievances	2936			2490	2316	2034	2116
Exempt	1088		Exempt Grievances-	985	683	644	858
Total Grievances (Formal & Exempt)	4024			3475	2999	2678	2974

KHS Grievances per 1,000 members – 3.34
LHPC Average 1.0 – 3.99/month

KERN HEALTH SYSTEMS

Additional Insights-Formal Grievance Detail

Issue	Q3 2025 Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	323	223	0	98	2
Coverage Dispute	0	0	0	0	0
Specialist Access	574	329	0	238	7
Medical Necessity	385	332	0	53	0
Other Issues	201	166	0	32	3
Potential Inappropriate Care	587	490	0	94	3
Quality of Service	785	598	0	176	11
Discrimination	81	76	0	2	3
Total	2936	2214	0	693	29

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

To: EQIHEC

From: Nate Scott

Date: December 16, 2025

Re: Executive Summary for Q3 2025 Grievance Summary Report

Background:

The Grievance Summary Report supports the high-level information provided on the Operation Board Report and provides more detail as to the type of grievances KHS receives on behalf of our members.

For the 3rd quarter, 2025, we had four thousand, twenty-four (4,024) Grievances and Appeals (G&A) received. Here are the top three grievance categories:

- Access to Care/Difficulty Accessing Specialists at 22.3% of grievances received.
- Quality of Service at 19.5% of grievances received.
- Quality of Care at 14.6% of grievances received.

Of the 4,024 G&A received:

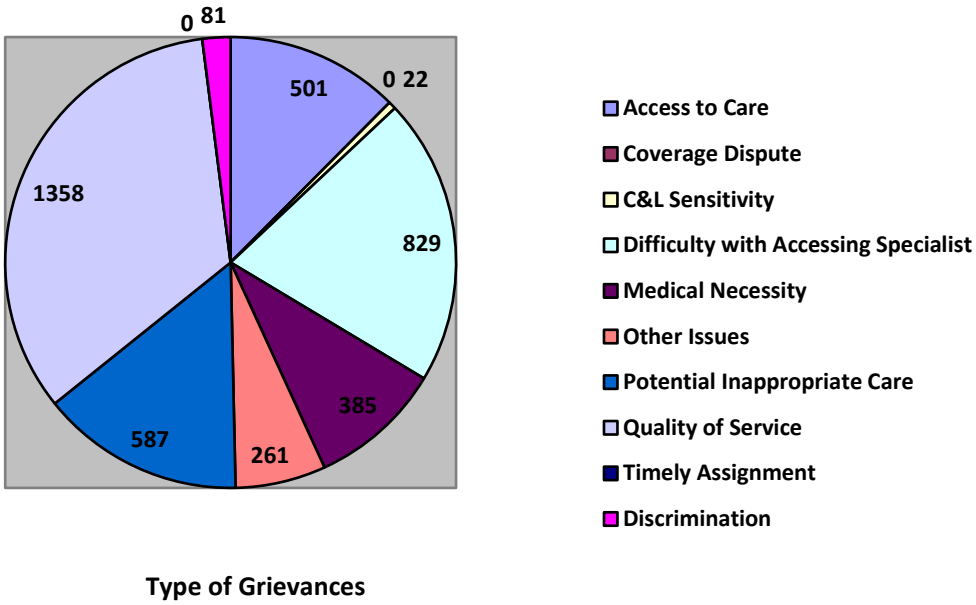
- 2,936 (73%) G&A were Standard Grievances and took up to 30 days to investigate and resolve.
- 1,088 (27%) G&A were Exempt Grievances and were resolved within one business day.
- 1,781 (44.26%) closed in Favor of the Enrollee
- 2,214 (55.02%) closed in Favor of the Plan/Provider
- 29 (.72%) are still open for review.

Requested Action:

Review and approval.

3rd Quarter 2025 Grievance Summary

Issue	Number	In Favor of Health Plan	In favor of Enrollee	Still under review
Access to care	501	217	282	2
Coverage dispute	0	0	0	0
Cultural and Linguistic Sensitivity	22	14	7	1
Difficulty with accessing specialists	829	321	502	6
Medical necessity	385	332	53	0
Other issues	261	166	92	3
Potential Inappropriate care	587	490	94	3
Quality of service	1358	598	749	11
Timely assignment to provider	0	0	0	0
Discrimination	81	76	2	3



Type of Grievances

KHS Grievances and Appeals per 1,000 members = 3.34/month

During the 3rd quarter of 2025, there were four thousand twenty-four grievances and appeals received. Two thousand nine hundred and thirty-six cases were standard, and one thousand eighty-eight cases were exempt and closed within one business day. Two thousand two hundred and fourteen cases were closed in favor of the Plan. One thousand seven hundred and eighty-one cases were closed in favor of the Enrollee. There are twenty-nine cases still under review. Of the four thousand twenty-four, three thousand seven hundred and thirty-one cases closed within thirty days; two hundred and ninety-three cases were pended and closed after thirty days.

3rd Quarter 2025 Grievance Summary

Access to Care

There were five hundred and one grievances pertaining to access to care. Three hundred and sixteen cases were standard, and one hundred and eighty-five were exempt cases that closed within one business day. Two hundred and seventeen cases closed in favor of the Plan. Two hundred and eighty-two cases closed in favor of the Enrollee. There are two cases pending review. The following is a summary of these issues:

One hundred and sixty-two members complained about the lack of available appointments with their Primary Care Provider (PCP). Forty-eight cases closed in favor of the Plan after the responses indicated the offices provided the appropriate access to care based on the Access to Care standards. One hundred and thirteen cases closed in favor of the Enrollee after the responses indicated the offices may not have provided appropriate access to care based on the Access to Care standards. There is one case pending review.

Thirty-nine members complained about the wait time to be seen by a Primary Care Provider (PCP) appointment. Sixteen cases closed in favor of the Plan after the responses indicated the members were seen within the appropriate wait time for a scheduled appointment or the members were at the offices to be seen as a walk-in, which are not held to the Access to Care standards. Twenty-two cases closed in favor of the Enrollee after the response indicated the member was not seen within the appropriate wait time for a scheduled appointment. There is one case pending review.

One hundred and four members complained about the telephone access availability with their Primary Care Provider (PCP). Forty-three cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate telephone access availability. Sixty-one cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate telephone access availability. There are no cases pending review.

One hundred and ninety-two members complained about a provider not submitting a referral authorization request in a timely manner. One hundred and eight cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Eighty-four cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner. There are no cases pending review.

Two members complained about geographic access to a provider. One case closed in favor of the Plan after it was determined the geographic access provided was appropriate. One case closed in favor of the Enrollee after it was determined geographic access may not have been appropriate. There are no cases pending review.

Two members complained about physical access to a provider. One case closed in favor of the Plan after it was determined the physical access was appropriate. One case closed in favor of the Enrollee after it was determined the physical access may not have been appropriate. There are no cases pending review.

3rd Quarter 2025 Grievance Summary

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

There were twenty-two members that complained about the lack of available interpreting services to assist during their appointments. Nineteen were standard cases and three were exempt cases that closed within one business day. Fourteen cases closed in favor of the Plan after the responses from the providers indicated the members were provided with the appropriate access to interpreting services. Seven cases closed in favor of the Enrollee after the responses from the providers indicated the members may not have been provided with the appropriate access to interpreting services. There is one case still under review.

Difficulty with Accessing a Specialist

There were eight hundred and twenty-nine grievances pertaining to Difficulty Accessing a Specialist. Five hundred and sixty-two were standard cases and two hundred and sixty-seven were exempt cases that closed within one business day. Three hundred and twenty-one cases closed in favor of the Plan. Five hundred and two cases closed in favor of the Enrollee. There are six cases still under review. The following is a summary of these issues:

One hundred and two members complained about a provider not submitting a referral authorization request in a timely manner. Fifty-six cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Forty-five cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner. There is one case under review.

Two hundred and fifty-nine members complained about experiencing difficulties in arranging, scheduling, or accessing transportation services. Ninety-seven cases closed in favor of the Plan after the responses indicated the members were provided the appropriate services. One hundred and sixty cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate services. There are two cases under review.

One hundred and thirty-seven members complained about the driver showing up outside of the scheduled pick-up time to transport the member to their appointment. Fifty-one cases closed in favor of the Plan after the response indicated the member was provided with the appropriate wait time for a scheduled appointment. Eighty-four cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate wait time for a scheduled appointment. There are two cases under review.

One hundred and eighty-two members complained about the lack of available appointments with a specialist. Sixty cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate access to specialty care based on the Access to Care Standards. One hundred and twenty-one cases closed in favor of the Enrollee after the responses indicated the offices may not have provided the

appropriate access to care based on the Access to Care standards. There is one case under review.

One hundred and twenty-two members complained about the telephone access availability with a specialist office. Forty-six cases closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access availability. Seventy-six cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate telephone access availability. There are no cases under review.

Twenty-three members complained about the wait time to be seen for a specialist appointment. Eight cases closed in favor of the Plan after the response indicated the member was provided with the appropriate wait time for a scheduled appointment based on the Access to Care Standards. Fifteen cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate wait time for a scheduled appointment based on the Access to Care Standards. There are no cases under review.

One member complained about physical access to a specialist provider. The case closed in favor of the Plan after it was determined the physical access was appropriate. There are no cases under review.

Three members complained about geographic access to a specialist provider. Two cases closed in favor of the Plan after it was determined the geographic access provided was appropriate. One case closed in favor of the Enrollee after it was determined the geographic access provided may not have been appropriate. There are no cases under review.

Medical Necessity

There were three hundred and eighty-five appeals pertaining to Medical Necessity. Three hundred and thirty-two cases were closed in favor of the Plan as it was determined that there was no supporting documentation submitted with the referral authorization requests to support the criteria for medical necessity for the requested specialist or DME item; therefore, the denials were upheld. Of the cases that were closed in favor of the Plan, six were partially overturned. Fifty-three were closed in favor of the Enrollee. There are no cases under review.

Other Issues

There were two hundred and sixty-one grievances pertaining to Other Issues that are not otherwise classified in the other categories. Two hundred and one were standard cases and sixty were exempt cases that closed within one business day. One hundred and sixty-six cases closed in favor of the Plan after the responses indicated the appropriate service was provided. Ninety-two cases closed in favor of the Enrollee after the responses indicated the appropriate service may not have been provided. There are three cases under review.

Potential Inappropriate Care

There were five hundred and eighty-seven standard grievances involving Potential Inappropriate Care issues. These cases were forwarded to the Quality Improvement (QI) Department for their

due process. Upon review, four hundred and ninety cases were closed in favor of the Plan, as it was determined a quality-of-care issue could not be identified. Ninety-four cases were closed in favor of the Enrollee as a potential quality of care issue was identified and appropriate tracking or action was initiated by the QI team. There are three cases still pending further review with QI.

Quality of Service

There were one thousand three hundred and fifty-eight grievances involving Quality of Service issues. Seven hundred and eighty-five were standard cases and five hundred and seventy-three were exempt cases that closed within one business day. Five hundred and ninety-eight cases closed in favor of the Plan after the responses determined the members received the appropriate service from their providers. Seven hundred and forty-nine cases closed in favor of the Enrollee after the responses determined the members may not have received the appropriate services. There are eleven cases still under review.

Timely Assignment to Provider

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

Discrimination

There were eighty-one standard grievances pertaining to Discrimination. Seventy-six cases closed in favor of the Plan as there was no discrimination found. Two cases closed in favor of the Enrollee. There are three cases under review. All grievances related to Discrimination are forwarded to the DHCS Office of Civil Rights upon closure.

KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: Isabel Silva, Senior Director of Wellness and Prevention

Date: December 16, 2025

Re: 3rd Quarter 2025 Wellness & Prevention Department Updates

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Background:

KHS' contract with the DHCS requires that it implements evidence-based wellness and prevention programs inclusive of a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all members.

Discussion:

Enclosed are the 3rd Quarter 2025 Wellness and Prevention Department Updates highlighting the key activities and accomplishments to meet KHS' contractual requirements with DHCS for wellness, prevention and health education services.

Fiscal Impact:

None.

Requested Action:

Review and approval.

Wellness and Prevention Department – Quarter 3 Updates

December 16, 2025

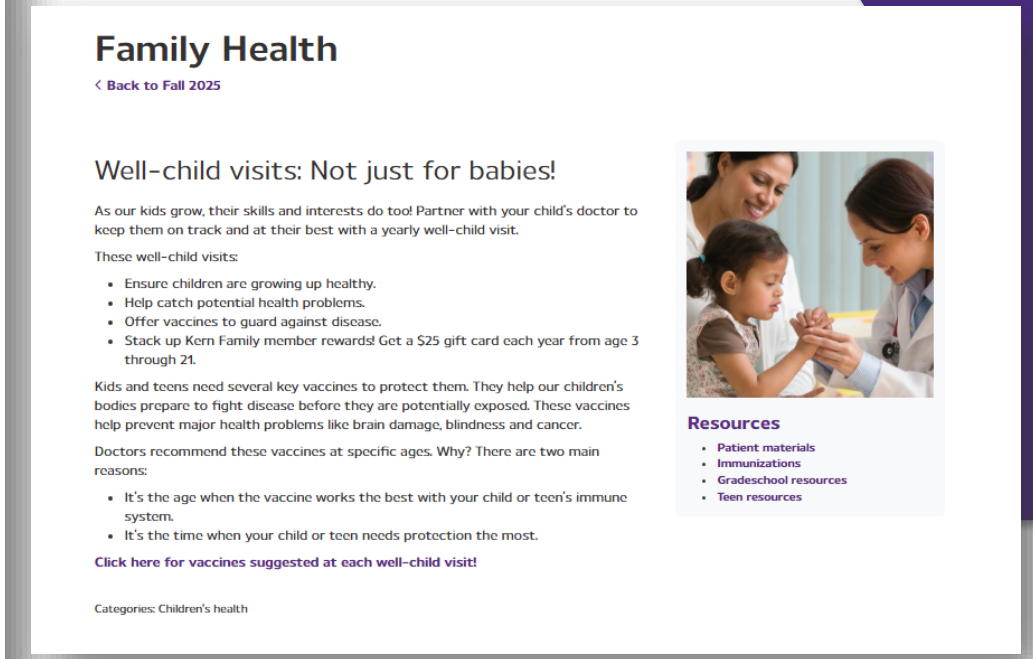
KERN HEALTH SYSTEMS

Member Wellness Highlights

- Member Newsletter articles on preventive care services
- Digital Media Wellness campaigns on preventive care, obesity, immunizations, linguistic services and health literacy
- Departmental in-services with KHS Behavioral Health and Enhanced Care Management departments
- Provider presentation on available health education program services
- Kick It CA Tobacco Cessation Outreach
- Postpartum support group pilot
- Comprehensive Obesity Management Pilot Program

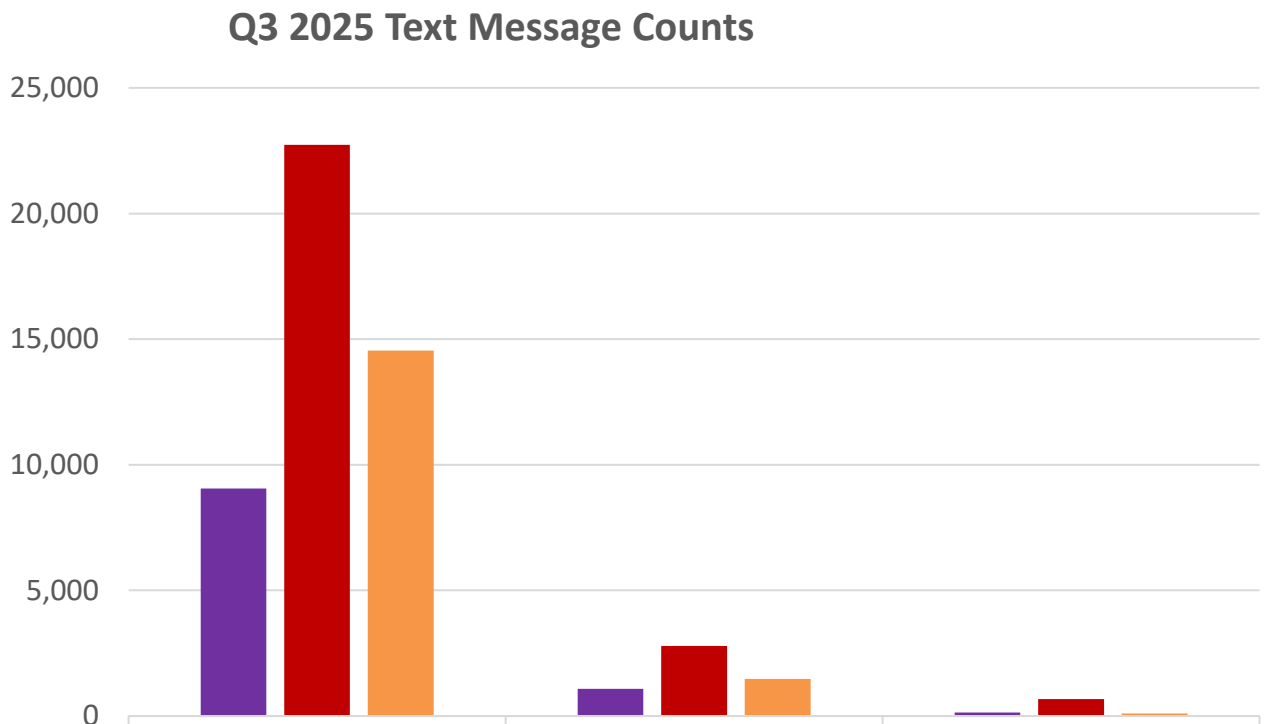
Member Newsletter

- Fall 2025 edition mailed between September 14-18
- 66,018 standard font newsletters mailed
- 3,510 large font newsletters mailed
- First issue sent via text message link among members who opted in
- 17,089 members received text message (11,915 English and 5,275 Spanish)



[Newsletters | Kern Family Health Care]
[Fall 2025 | Kern Family Health Care]

Health Education
Text Message Campaigns



	Delivered Count	Click Count	Actioned Count
July Immunizations	9,061	1,077	147
August Obesity	22,732	2,788	678
September Health Literacy	14,541	1,476	104

Children's Immunizations

July 2025

5.6% engagement rate via Facebook

Is your child's immunization card lost? California's Digital Vaccine Record portal makes it easy to get it replaced.

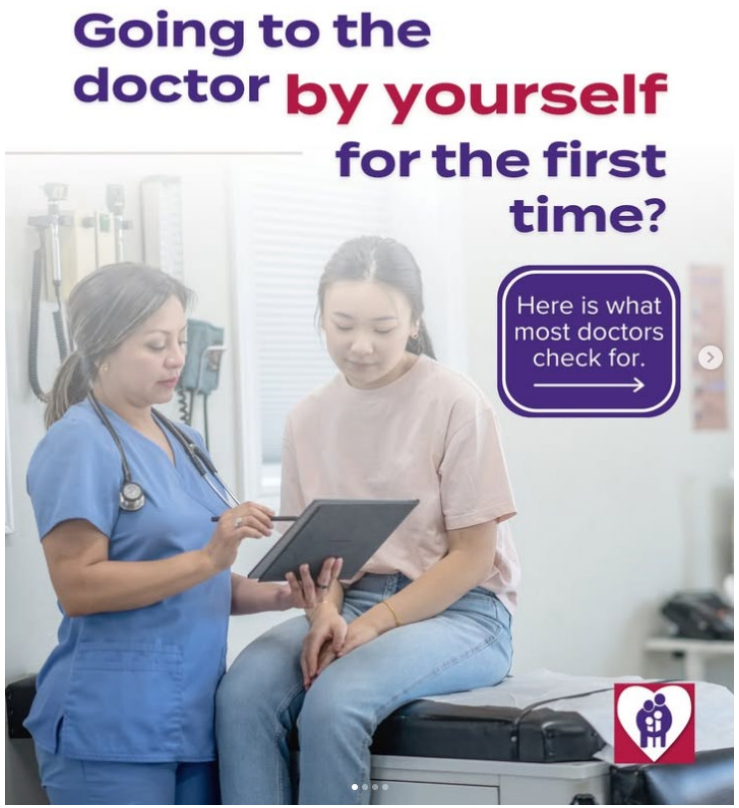
Visit https://myvaccinerecord.cdph.ca.gov to download a secure digital copy in just a few steps. It's free and accepted by schools. You can still be on track this back-to-school season!

#BacktoSchool #KFHCWellness #Immunizations

- Total Posts: 16
- Reactions: 86
- Comments: 2
- Shares: 13
- Impressions: 5,100
- Average Engagement Rate: 2.5%

Well-Child Visits

August 2025



5.4% engagement rate via Facebook

Going to the doctor by yourself can be a little scary, but there is nothing to worry about. Your doctor is here to help you! Here is a list of things doctors check for when you go to your regular annual check-up.

To learn more about the process of setting up an appointment or going to a check-up, visit www.kernfamilyhealthcare.com/ and read our “Member” tab.

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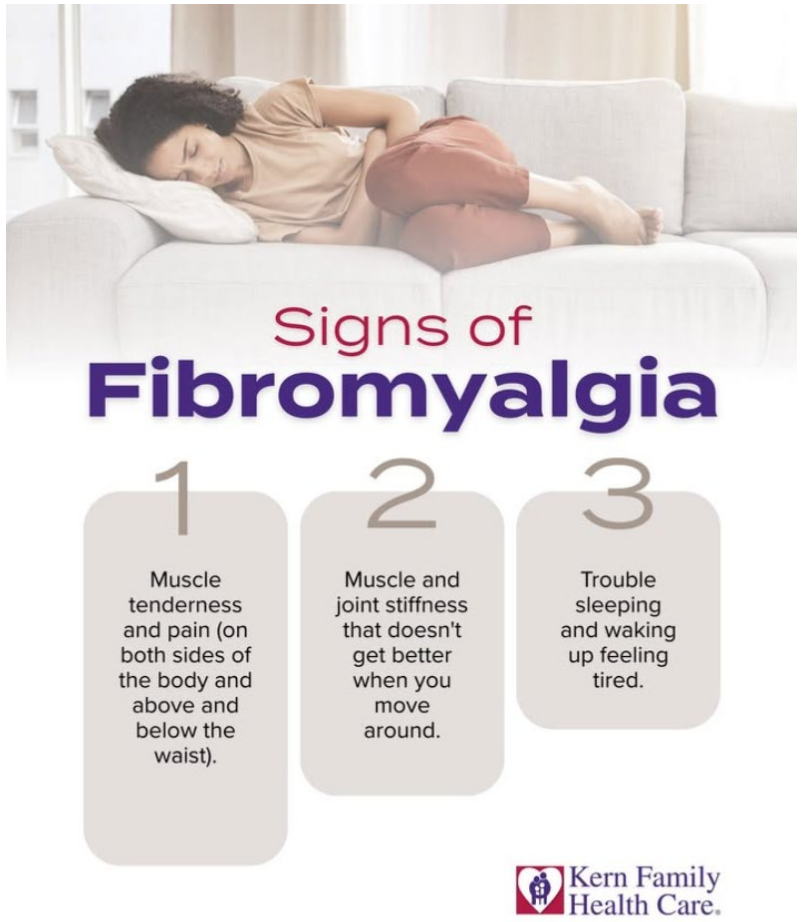
Ir al médico solo puede ser un poco intimidante, pero no hay nada que temer. ¡Su médico está ahí para ayudarle! Aquí tiene una lista de las cosas que los médicos revisan cuando va a su revisión anual.

Para obtener más información sobre el proceso de programar una cita, visite www.kernfamilyhealthcare.com y lea nuestra sección de “Miembros”.

- Total Posts: 14
- Reactions: 63
- Comments: 0
- Shares: 4
- Impressions: 5,438
- Average Engagement rate: 1.9%

Pain Management September 2025



Fibromyalgia can cause pain in the muscles and soft tissues. You feel pain, tenderness, or both, even when there is no injury or inflammation. Talk with your doctor if you've had the following symptoms for several weeks with no clear cause. They can help you get the care and support you need. 🩺 ❤️ #KFHCWellness

- Total Posts: 18
- Reactions: 58
- Comments: 0
- Shares: 8
- Impressions: 9,137
- Average Engagement Rate: 1.5%

7% Engagement rate via Facebook

Kick It California

Tobacco Cessation Partnership

Key Metrics	Total
Referrals	1000
Member Outreach Attempts	998
Enrolled	14
Completed 1st Coaching Call	6
Nicotine Replacement Therapy Mailed	9

Key Metrics	Total
Coach Outreach Attempt (499)	10
Coach Enrollment	2.0%
IVR Outreach Attempt (499)	4
IVR Enrollment	0.8%

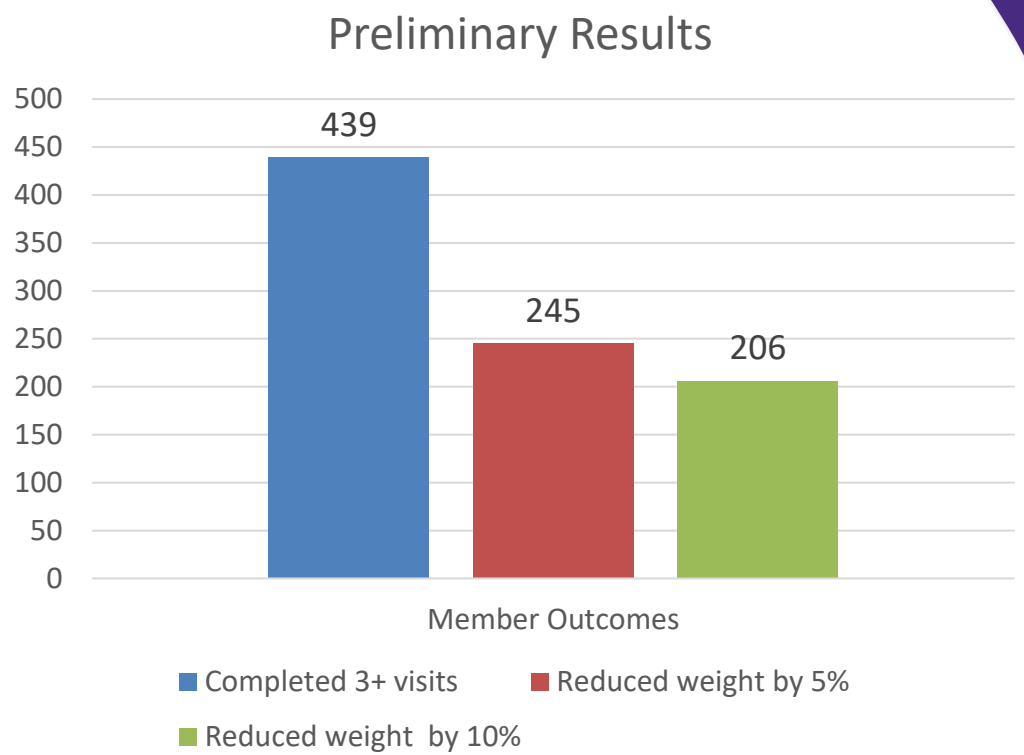
Postpartum Support Group Pilot

- Partnership with The Motherhood Project
- 12 members participated
- 6 weekly sessions held in English
- Sessions Themes:
  - Recognizing Postpartum Depression & Anxiety
  - Overstimulation & Self-Care Tips
  - Blooming into Motherhood
  - Prioritizing Nutrition & Self-Care
  - The Hidden Mental Load of Motherhood
  - Celebration & Creative Closure

- KHS presentations on:
  - Maternal Mental Health
  - Infant Nutrition
  - Wellness exams
  - Car Seat Safety
- Diaper bags, educational material and community resources distributed at last class or at member's home

Comprehensive Obesity Management Pilot Program

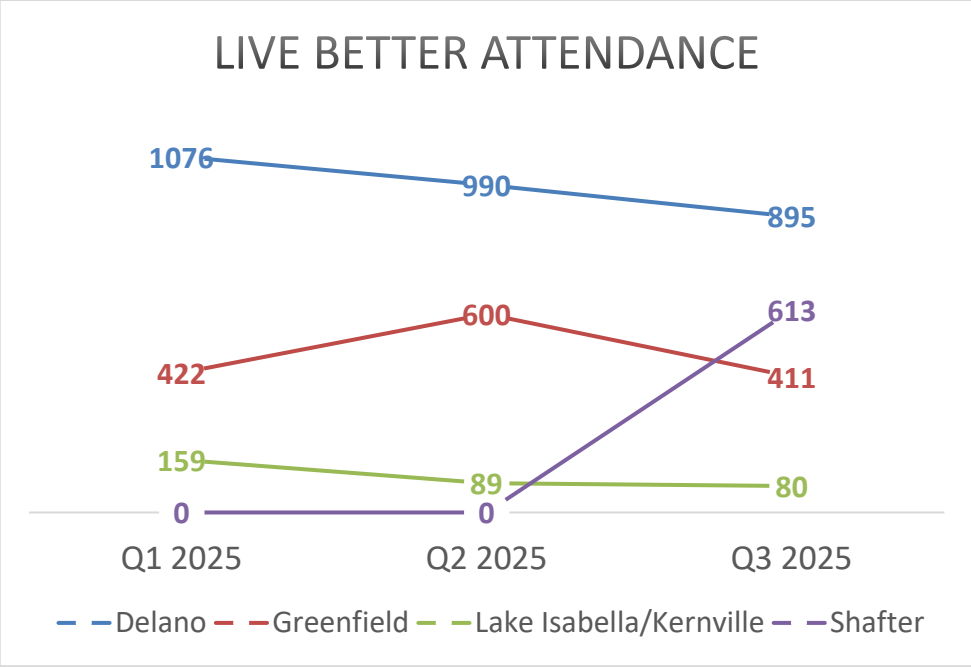
- Partnership with Universal Healthcare Services (June 2025)
- 20,000 members referred
  - 1,040 members enrolled and seen
- Program Components:
  - Medication Management
  - Lifestyle Counseling (Nutrition, Exercise)
  - Monitoring and Support
  - Education & Awareness
- Criteria:
  - 12 years old or older
  - Diagnosed with Diabetes Type 2
  - Diagnosed with Class 2 Obesity or higher (BMI: 35+)
  - Not pregnant
  - Focus areas: Bakersfield, Arvin, Lamont, Shafter, McFarland, Wasco, Delano
- Initial Findings:
  - Average total weight loss per patient: 18.95 lbs
  - Average total weight loss per visit: 4.60 lbs



Community Health and Wellness

Highlights

- **Live Better Program**
  - New site launched in Shafter
- **McFarland Anvros Gym (Iron Valley Fitness)**
  - 69 members enrolled
  - Median of 11 visits a month per member



- **Read Your Beats Kern**
  - 1st site launched: Shafter Library and Learning Center
    - Total BP readings: 44
    - Average BP reading: 123/78
    - Average Pulse reading: 73
  - 2nd launch site: Beale Library (November)

School Wellness Grant
Highlights

Wasco Union High School

Tiger Wellness Corner

Karl Clemens Elementary School (Wasco)

Caring Closet

THANK YOU.!

Questions?

Isabel Silva, MPH

Senior Director of Wellness & Prevention

661-664-5117

isabel.silva@khs-net.com

KERN HEALTH SYSTEMS