KERN HEALTH SYSTEMS

EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (EQIHEC) MEETING

Thursday, September 12, 2024
at 7:15 a.m.

2900 Buck Owens Blvd.
Bakersfield, CA 93308
1st Floor Board Room

For more information, call (661) 664-5000

AGENDA

Executive Quality Improvement Health Equity Committee (EQIHEC) Meeting

Kern Health Systems
2900 Buck Owens Boulevard
Bakersfield, California 93308
1ST Floor Board Room

Thursday, September 12, 2024

7:15 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 2900 Buck Owens Blvd, Bakersfield, CA 93308 during regular business hours, 8:00 a.m.–5:00 p.m., Monday through Friday, following the posting of the agenda. Any supporting documentation that relates to an agenda item for an open session of any regular meeting that is distributed after the agenda is posted and prior to the meeting will also be available for review at the same location.

COMMITTEE MEMBERS: Jennifer Ansolabehere, PHN; Satya Arya, MD; Debra Cox; Danielle C Colayco, PharmD; Todd Jeffries; Allen Kennedy; Michael Komin, MD; Philipp Melendez, MD; Chan Park, MD; Martha Tasinga, MD, CMO, Jasmine Ochoa; Rukiyah Polk

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

CA-3) Executive Quality Improvement Health Equity Committee (EQIHEC) Minutes from May 23, 2024 - APPROVE

CA-4) Behavioral Health Advisory Committee (BHAC) Minutes from March 11, 2024 – APPROVE

CA-5) Behavioral Health Advisory Committee (BHAC) Minutes from April 8, 2024 – APPROVE

CA-6) Health Equity Transformation Steering Committee (HETSC) Minutes from July 1, 2024 – APPROVE

CA-7) Network Advisory Committee (NAC) Minutes from July 19, 2024 – APPROVE

CA-8) Pharmacy Drug Utilization Review (DUR) Minutes from June 24, 2024 – APPROVE

CA-9) Physician Advisory Committee (PAC) Redacted Minutes from April 3, 2024 – APPROVE

CA-10) Physician Advisory Committee (PAC) Redacted Minutes from May 1, 2024 – APPROVE

CA-11) Physician Advisory Committee (PAC) Redacted Minutes from June 5, 2024 – APPROVE

CA-12) Population Health Management Committee (PHMC) Minutes from June 5, 2024 APPROVE

CA-13) Utilization Management Committee (UMC) Minutes from June 19, 2024 - APPROVE

14) Behavioral Health Advisory Committee (BHAC)
- Charter – APPROVE
- Summary – RECEIVE AND FILE

15) Quality Performance (QP)
- Summary Report Q2 2024 – APPROVE
- Policy Update – RECEIVE AND FILE

16) Quality Improvement Committee (QIC)
- QI Workplan Scorecard – APPROVE
- Summary Report Q2 2024 – RECEIVE AND FILE

17) Grievance Summary Report Q2 2024 – APPROVE

18) Utilization Management (UM) Program Report Q2 2024 – RECEIVE AND FILE

19) Network Adequacy Committee (NAC) Report Q3 2024 – APPROVE

20) Population Health Management (PHM) Mid-Report Q1, Q2 2024 – APPROVE

21) Health Equity Transformation Steering Committee (HETSC)
- Strategic Roadmap/Workplan– APPROVE
- RAC Summary – RECEIVE AND FILE
- Health Equity Presentation – RECEIVE AND FILE

ADJOURN MEETING TO THURSDAY, NOVEMBER 14, 2024 @ 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the Board of Directors may request assistance at the Kern Health Systems office, 2900 Buck Owens Blvd. Bakersfield, California or by calling (661) 664-5000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

COMMITTEE: ***EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (EQIHEC)***
DATE OF MEETING: ***MAY 23, 2024***
CALL TO ORDER: ***7:01 AM BY TRACO MATTHEWS, CHAIR***

Members Present On-Site:	Traco Matthews – KHS Chief Health Equity Officer Martha Tasinga, MD – KHS Chief Medical Officer Danielle Colayco, PharmD – Komoto	Todd Jeffries – Bakersfield Community Healthcare Allen Kennedy – Quality Team DME Chan Park, MD – Vanguard Family Medicine	Satya Arya, MD - ENT. Jasmine Ochoa - Health Equity Manager of Public Health Jesus Gonzalez - Executive Director of The Center, CAC Rep
Members Virtual Remote:			
Members Excused=E Absent=A	Debra Cox – Omni Family Health (A) Jennifer Ansolabehere (A) Michael Komin, MD – Komin Medical Group (A)	Philipp Melendez, MD – OB/GYN (A) Rukiyah Polk - CAC Chair	
Staff Present:	Amy Carrillo - Member Services Manager Michelle Curioso - Director of Pop Health Management Dan Diaz, RN - ECM Clinical Manager Pawan Gill - Health Equity Manager Sukhpreet Sidhu, MD – Pop Health Medical Director Anastasia Lester – Sr. Health Equity Analyst Marilu Rodriguez – Sr. Health Equity Analyst	Magdee Hugais – Director of Quality Improvement John Miller, MD – Quality Improvement Medical Director Melissa McGuire – Senior Director of Delegation Kailey Collier - Director of Quality Performance Yolanda Herrera - Credentialing Manager Flor Del Hoyo Galvan - Manager of W&P Maninder Khalsa – Medical Director	Vanessa Nevarez - Health Equity Coordinator Gregory Panero – Provider Network Analytics Abdolreza Saadabadi, MD – BH Medical Director Nate Scott - Senior Director of Member Services Isabel Silva - Senior Director of W&P James Winfrey - Deputy Director of PNM

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Quorum	9 of 13 committee members present; Debra Cox, Jennifer Ansolabehere, Michael Komin, Philipp Melendez, and Rukiyah Polk were absent.	Committee quorum requirements met.	N/A
Call to Order	Traco Matthews, Chair, called meeting to order at 7:01 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. • Traco Matthews acknowledged and welcomed three new EQIHEC members: Jasmine Ochoa, Rukiyah Polk, and Jesus Gonzalez. • Traco Matthews provided a recap of the EQIHEC Charter and reminded members of the need for discussion. • Traco Matthews announced that he and Martha Tasinga, MD will both not vote; only one of them per meeting. • Todd Jeffries thanked KHS for their continued support for Bakersfield Community Healthcare. • Danielle Colayco thanked KHS for the quality grant which allowed Komoto to provide vaccinations to children as well as coloring books in multiple languages. • Martha Tasinga, MD announced that her team is getting ready for their next audit. • Chan Park thanked KHS for sponsoring their May 11th event. • Jesus Gonzalez invited committee members to the Gender and Sexuality Symposium they are hosting for Pride Month on June 14th.	Informational Only.	N/A
Committee Minutes	**Approval of Minutes** CA-3) The Committee's Chairperson, Traco Matthews, presented the EQIHEC Minutes for approval.	**Action:** • Satya A. first, Allen K. second. All aye's. Motion carried.	5/23/24
Old Business	There was no old business to present.	N/A	N/A
New Business	**Consent Agenda Items** CA-4) Physician Advisory Committee (PAC) Q1 Summary of Proceedings CA-5) Drug Utilization Committee (DUR) Q1 Summary of Proceedings	**Action:** • Satya A. first, Allen K. second. All aye's. Motion carried.	5/23/24

	CA-6) Wellness and Prevention (W&P) Activity Report Q1 2024 CA-7) Board Approved New and Existing Contracts Report CA-8) Credentialing and Recredentialing Summary Report Q1 2024 CA-9) Enhanced Case Management (ECM) Program Report Q1 2024 CA-10) Quality Improvement Committee (QIC) Program Report Q1 2024		
	11) Health Equity Transformation Steering Committee • Pawan G. gave an update on the Health Equity Workplan, a preliminary review of the Health Equity Strategic Roadmap, and presented the 2024 Listening Sessions Summary. 12) Quality Performance Summary Report Q1 2024 • Kailey C. presented the Quality Performance Summary Report that covered Q1 2024 data. 13) Grievance Summary Report Q1 2024 • Amy C. presented the Grievance Summary Report that covered Q1 2024 data.	**Action:** • Danielle C. asked what the best practices are for KHS cultural initiatives. • Pawan G. explained that the Health Equity team has conducted employee engagement surveys and employee interviews to determine the best training curriculum for staff. • Chan P. first, Jesus G. second. All aye's. Motion carried. • Satya A. first, Jasmine O. second. All aye's. Motion carried. • Informational only.	5/23/24 5/23/24

	14) Utilization Management Program Report Q1 2024 • Maninder Khalsa, MD presented the Utilization Management Program Report that covered the Q1 2024 data. 15) Network Adequacy Review Q1 2024 • James W. gave a review of the Network Adequacy that covered Q1 2024 data. • Jasmine O. asked James W. what the process of tracking the standard. • Satya A. left the meeting at 8:07am. Quorum still met. 16) Population Health Management Report Q1 2024 • Michelle C. presented the Pop Health Management Report that covered the Q1 2024 data.	• Satya A. first, Todd J. second. All aye's. Motion carried. • James W. explained that the alternative standard is being tracked and posted on the KHS website. He also stated that it is hard to track because the DHCS changed the methodology for reviewing, but it is being done. • Jasmine O. first, Chan P. second. All aye's. Motion carried. • Martha T., MD added that every patient that has surgery is high risk so new mothers receive a name and number they can call upon leaving the hospital; they also receive calls to see if they have any needs. Readmission of mothers are tracked, and meals are provided so new mothers are supported and feel safe in their homes. • Daniella C. asked what the TOC providers with no readmission are and who is managing their medications?	5/23/24 5/23/24 5/23/24 5/23/24

	• Chan Park left the meeting at 8:20am. Quorum still met. <u>17) Behavioral Health Advisory Committee Summary Report Q1 2024</u> • Melinda S. was absent and Behavioral Health was not presented.	• Sukhpreet S., MD responded that there have been zero readmissions in thirty days and that the TOC program handles their medications, as well at the Pharmacy department. • Todd J. first, Allen K. second. All aye's. Motion carried. • Item 17 is tabled until the next EQIHEC meeting, August 8, 2024.	

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Open Forum	• Abdolreza S., MD thanked Martha T., MD for medical mental health awareness and support. • Dan Diaz mentioned that he will present to the UM Committee instead of the EQIHEC and remain on the EQIHEC agenda as receive and file.	Informational only.	N/A
Next Meeting	The next meeting will be held Thursday, August 8, 2024, at 7:00am.	Informational only.	N/A
Adjournment	The Committee adjourned at 8:27am. ***Respectfully Submitted:*** ***Vanessa Nevarez, Health Equity Project Coordinator***	N/A	N/A

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: ***MARCH 11, 2024***
CALL TO ORDER: ***10:06 AM BY MELINDA SANTIAGO, DIRECTOR OF BEHAVIORAL HEALTH - CHAIR***

Members Present On-Site:	Randolph Beasley, LMFT Mesha Muwanga, LMFT – Rhema Therapy Inc.		
Members Virtual Remote:	Matthew Beare, MD – Clinica Sierra Vista Alison Burrowes, Kern Behavioral Hlth & Recovery Srvs	Franco Song, MD - Psychiatric Wellness Center	
Members Excused=E Absent=A	Martha Tasinga MD – KHS CMO (E) Cherilyn Haworth, Psy.D – CSUB (E)		
Staff Present:	Amy Daniel, KHS Executive Health Svcs Coordinator Yolanda Herrera, KHS Credentialing Manager	Courtney Morris – KHS Behavioral Health Supervisor Melinda Santiago – KHS Director of Behavioral Health	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	In the absence of Dr. Martha Tasinga, Melinda Santiago, KHS Director of Behavioral Health called the meeting to order at 10:06 AM.		N/A
Committee Minutes	**Approval of Minutes** Introductory meeting only – There are no past minutes to approve.	☑ **CLOSED**: Not applicable.	N/A
OLD BUSINESS	There was no old business to present	N/A	*N/A*
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Melinda Santiago, KHS Dir. Of Behavioral Health thanked and welcomed the members of BHAC to the meeting. Melinda informed the members that unfortunately, Dr. Tasinga was not able to attend	☑ **CLOSED**: Informational discussion only.	*3/11/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	today's meeting unexpectedly. Members and KHS Staff introduced themselves and from the facility/organization they are representing. Representatives from the following network providers included: • Mesha Muwanga, Network Provider LMFT • Randolph Beasley, Network Provider LMFT & FQHC Representative • Franco Song, MD – Network Provider Psychiatrist • Matthew Beare, MD – Network Provider Primary Care • Alison Burrowes, LCSW – Kern Behavioral Health Recovery Services • LEA – representation form an educational setting was identified however, there was a conflict in meeting scheduled and Melinda is working to identify an alternative LEA provider who can serve on the committee.		
	Committee Charter Melinda presented the committee charter outlining the committee responsibilities, roles of the committee members and program description. The following highlights were noted: • The Behavioral Health Advisory Committee (BHAC) will be a subcommittee of the EQIHEC Committee. • The BHAC will support, review, and evaluate behavioral health interventions, promote collaboration strategies that align between KHS and the County Behavioral Health Programs with Kern Behavioral Health Recovery Services, Clinica Sierra Vista, California State University Bakersfield, Psychiatric Wellness Center, Rhema Therapy. • Screening of the SBIRT (spell out) and medication assisted treatments will be conducted. • Provide feedback on clinical guidelines, UM criteria and behavioral health technologies. • MCAS focus indicators as identified. • Coordinating medical and behavioral health services identifying methods of data exchange, sharing information, medication treatment and referrals between mental and behavioral health providers. Members requested additional information related to the level of commitment outside of this meeting to be explained. Melinda informed the members that a majority of the work, as described in the Program Description, will be conducted by internal KHS BH Staff, and presented to the BHAC for review, input, feedback and if	☑ **CLOSED**: Informational discussion only.	*3/11/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	appropriate, approval. Melinda informed the members she is requesting a 2-year commitment from each of the BHAC membership to fully see the transformation of the program.		
	Program Description Melinda informed the members that the Program Description for BH program is still in process and will be presented at the next meeting.	☑ **CLOSED**: Informational discussion only.	*April Mtg*
	BH Satisfaction Survey Melinda presented some statistical information of KHS member population, age, race, and geographical demographic information. Additionally, KHS Behavioral Health Department is fairly new and established in January 2023. The BH Department has grown from a staff of 3 to a full staff of 10. In January 2024, KHS implemented the Electronic Management System that allows the BH Department to enter their patient population into an electronic database. Member stratification for low, medium, and high categories has allowed the department to identified approximately 41,000 members in need of mental or behavioral health services. Several focus groups are underway include high risk members and members in active treatment. Melinda presented the Adult Mental Health Survey that is being drafted to send to members as an additional mechanism to gain an understanding of the services being provided, member expectation and overall satisfaction. The survey results will allow the BH Department to set up areas of improvement and development needs. Members were asked to review and provide input into this survey. Members provided additional input and feedback; the following suggestions were captured: • Survey Process: Melinda informed the members that she is working with a 3rd Party Vendor who will assist in contacting members by phone and email using a QR Code that would take the member to the survey questions. Members provided input that the use of a QR Code may be an impediment for some members and an incentive to complete the survey by mail may gain more participation. • Incentive: Members agreed that having an incentive for the	☑ **CLOSED**: Informational discussion only. **Melinda agreed to work with Survey Vendor to consolidate questions that are lengthy and make more concise removing repetitive language. Melinda will also research the idea of an incentive for completing the survey.**	*3/11/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	members to complete a lengthy survey would be beneficial as the survey itself will aid in assisting the plans efforts and direction of services needed. • Shorten & Consolidate Survey Questions: Members also agreed that the questions might be shortened and consolidated to so that there is an opportunity to touch on each of the targeted questions – At times, lengthy surveys lose their audience who quit if questions seem repetitive.		
OPEN FORUM	**<u>Open Forum</u>** Members of the committee asked if a provider survey or input from network providers will be performed. Melinda indicated that a provider survey is slated for next year. Members of the committee informed Melinda that it will be beneficial to hear the results of the survey to identify any barriers to access that the providers can improve and overcome to the members satisfaction. Additional discussion on whether or not the members will have access to the data of the survey analysis. Melinda informed the members that her department will conduct data analysis including an qualitative analysis report and present to the BHAC, possibly in July.	☑ **CLOSED**: Informational discussion only.	*3/11/24*
NEXT MEETING	Next meeting will be held Monday, April 8, 2024 at 10:00 am	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 11:15 AM ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Behavioral Health Advisory Committee Minutes 03/11/24

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: **APRIL 8, 2024**
CALL TO ORDER: **10:05 AM BY MELINDA SANTIAGO, DIRECTOR OF BEHAVIORAL HEALTH - CHAIR**

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements not 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 March 11, 2024 meeting.	☑ **APPROVED**: Minutes were accepted as presented with no changes.	4/8/24
OLD BUSINESS	**BH Satisfaction Survey** Melinda presented the condensed surveys that were narrowed down and reduced significantly after receiving feedback from the members at the last meeting and work with Dr. Tasinga. Pediatric	☑ **CLOSED**: Informational discussion only	4/8/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	surveys were condensed to 33 questions and Adult surveys condensed to 28 questions. All surveys were cleaned up and sent to DHCS for approval with anticipated launch date the end of April 2024. Melinda informed the members that groups of members have been identified to survey in both English and Spanish, including 5-major categories and race/ethnicity. The first 400 surveys received will be entered into a raffle and 10 members will be selected to receive $100 gift card. By providing incentives it is anticipated that more members will participate which will allow for a year-to-year analysis and benchmarking to see where interventions, needs, and access is needed.		
NEW BUSINESS	**<u>NCQA Accreditation Standards</u>** Melinda presented the National Committee for Quality Assurance (NCQA) Accreditation Standards and efforts for QI4 – Continuity and Coordination between Medical Care and Behavioral Healthcare. Melinda provided the committee members with information the 6 factors that will be covered in QI4 including the Healthcare Effectiveness Data and Information Set (HEDIS) Measures and Medi-Cal Managed Care Accountability Sets (MCAS). Melinda informed the members that we are currently creating the infrastructure for how to gather this information, create upgrades to our electronic management system and create a provider portal that has capacity for bi-directional coordination within the system for the PCP and BH Providers to access BH specific information that is needed to support coordination and continuity of care. Additional information shared included: • Creating a dashboard to identify the high-risk members based on co-morbidities; collecting data to do quantitative analysis to determine interventions. • Antidepressant AMM / ADD / SSD – MCP is not held to minimum performance levels (MPL) standards at this time, and efforts will be made with submission for we continue to review our performance. Committee discussed the benefits and process to sharing this information between the MCP and MHP.	☑ **CLOSED**: Informational discussion only.	4/8/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• 18+ Antidepressant Medication management – National benchmark 60.9 and KHS is at 60.44 and will continue to look to see where we can improve. • ADD follow-up care children prescribed ADHD medication national standard is 40.4 and KHS is at 39.78 – we will continue to look to see where we can improve. • SSD – Diabetes screening with people with schizophrenia or bipolar disorder who are on antipsychotic medications national standard is 70 and KHS is 79.36 – KHS is doing good in this standard. • Complex Case Management within PHM – high risk comorbidity members reviewing to see how many members behavioral health diagnosis has been referred to behavioral health or visits to behavioral health and determine if any interventions based on that information is needed. • ME 7E – annual assessment of BH Care and Services – survey is the assessment and services will work with our grievance team to show how that information is broken down within grievances and identify patterns and provide interventions. • ME 7E – Provider Survey – two specific questions for provider feedback to come up with provider interventions.		
OPEN FORUM	**<u>Open Forum</u>** Members discussed the 12 and under members who have been diagnosed with ADHD receiving actual medication effort with therapy and/or medication management, compliance with medication. Most of these members are being treated by the Mental Health Plan, Kern Behavioral Health & Recovery Services (KBHRS) receiving outpatient treatment. Director of KBHRS, Alison Burrowes reported that collecting data has been challenging. since their transition to Smart Care. The committee discussed the challenges with ADHD being treated at the PCP level, due to providers capacity and scope of services. KHS has started to look at the school base services, identifying. prevention and early intervention/prevention programs. Melinda discussed the Student Behavioral Health Incentive Program (SBHIP) and the plan for school-based services in 2025. Melinda informed the committee that the state is currently working with Cohort 1 for the children and youth Behavioral Health Initiative	☑ **CLOSED**: Informational discussion only.	4/8/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	(CYBHI) statewide multi payer school-linked fee schedule. KHS is supporting the selected LEAs through SHIP to build the programs that will support the school-based fee schedule. Members asked if a provider survey or input from network providers will be performed. Melinda indicated that a provider survey is slated for next year.		
NEXT MEETING	Next meeting will be held Monday, July 10, 2024. Melinda inquired if the set day and time still work for the members. Discussed options for morning, afternoon, evening, and preferences for days of the week. Committee shared that Monday and Friday may not be the best days. Melinda agreed to send out survey to all committee members to vote on best option for next meeting in July.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 11:10 am. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*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: ***July 1, 2024***
CALL TO ORDER: ***3:06pm - Pawan Gill, Health Equity Manager – CHAIR***

Staff Present:	• Jackie Byrd, Senior Marketing and Communication Specialist • Lela Criswell, Member Engagement Manager • Pawan Gill, Health Equity Manager • Anastasia Lester, Senior Health Equity Analyst • Traco Matthews, Chief Health Equity Officer • Finster Paul III, Manager of Community Health and Wellness	• Marilu Rodriguez, Senior Health Equity Analyst • Daisy Torrez, Member Engagement Supervisor • James Winfrey, Deputy Director of Provider Network • Adriana Salinas, Director of Community and Social Services	• Dalia Fontaine, Community and Social Services Manager • Frankie Gonzalez, Employee Relations Manager • Vanessa Nevarez, Health Equity Coordinator • Cecilia Flores, Community Engagement Coordinator
Staff Virtual:	• Amy Carrillo, Member Services Manager • Jake Hall, Senior Director of Contracting and Quality Performance • Gregory Panero, Provider Network Analyst Program Manager • Stephen Wuertz, Business Intelligence Data Insight and Analyst Manager • Nate Scott, Senior Director of Member Services		

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 3:06pm.	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) Community Advisory Committee (CAC)- PRESENTAION** Anastasia Lester provided a detailed overview of the Community Advisory Committee 2024-2026.	• Adriana Salinas referred to slide 8 of Anastasia Lester's presentation and asked what "dual aged" means. Lela Criswell explained that they are members that are covered by both plans in the senior category. • Finster Paul commented that he would like to attend the next CAC meeting. Anastasia Lester stated anyone is welcome as it is a public meeting. • Stephen Wuertz commented that he liked the presentation and feeling involved. • Amy Sanders commented that she enjoys attending the CAC meetings because of the feedback that comes out of them.	N/A N/A N/A N/A
	2) Regional Advisory Committee (RAC)- PRESENTATION Anastasia Lester provided a detailed overview of the RACs that took place in quarter 2. Anastasia Lester noticed a common theme at all locations. There was very good representation and feedback at the meetings, especially Ridgecrest. The discussion topics at the RACs included education, medical facilities, providers, transportation, healthy food, and special needs services.	• Jackie Byrd asked if KHS departments can collaborate and work on marketing efforts to help coordinate messages. Anastasia Lester responded that yes, that is the plan. • Traco Matthews commented that the presentation was great, and the data is excellent. • Adriana Salinas commented that Community and Social Services would like to partner with an organization that specializes in healthy foods. • Lela Criswell mentioned that text messaging will be used for the quarter 3 RACs so we will be able to see the difference in	N/A N/A N/A N/A

		attendance.	
		• Finster Paul asked if updates and outcomes are given back to the communities where the RACs were held. Pawan Gill responded that once feedback is received and reviewed, the information does not have to wait until the next RAC to be given, a meeting can be called with key players at any time to solve an issue. Pawan Gill continued that we want to build and maintain trust within the communities; we can end the meeting with a "Did you know?" and highlight a service we may offer.	N/A
		• Stephen Wuertz asked if our members have good access to internet and cell phones. Anastasia Lester responded that there are areas where that is challenging and if a member doesn't have the correct phone, it may affect their telehealth experience; we can give this feedback to our providers.	N/A
		• Finster Paul asked if our members are given a survey after they attend the RACs. He mentioned that there seemed to be a low turnout in Oildale where is would have seemed there would be a great turnout. Anastasia Lester explained that the date changed a few times and Oildale apologized for that; they have since invited KHS to go back another time.	N/A
		• Jackie Byrd commented that Health Equity should evaluate how KHS currently operates to find gaps and to see how Health Equity can improve.	N/A
	3) 2024 Health Equity Strategic Roadmap - PRESENTATION	• Item tabled until the next HETSC meeting on September 12th, 2024, due to time restraints.	07/01/24

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
OPEN FORUM	Pawan opened the floor for announcements.	• Pawan Gill announced that Kern Health Equity Partnership (KHEP) is looking for externs that can help find out when doctors are in and when services are provided. She also announced that Health Equity is looking for externs to help with SOGI data entry.	N/A
NEXT STEPS	Pawan reported out on next steps.	• Pawan Gill will send out a document for each department to complete that tracks health equity, population and focus, and the name of the program. • Pawan Gill has asked all departments for their contracts.	N/A
NEXT MEETING	Next meeting will be held Thursday, September 12th, 2024, at 2:00pm.	• Review 2024 Health Equity strategic roadmap.	N/A
ADJOURNMENT	The Committee adjourned at 4:04pm ***Respectfully submitted:*** ***Vanessa Nevarez, Health Equity Coordinator***	N/A	N/A

For Signature Only – HETSC Minutes 07/01/24

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: **July 19, 2024**
CALL TO ORDER: **1:01 PM by James Winfrey, KHS - Deputy Director of Provider Network Management, Chair**

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
CALL TO ORDER	- James Winfrey called the meeting to order at 1:01 PM - Quorum/Attendance	- Committee quorum requirements met.	N/A
APPROVAL OF MINUTES	- James Winfrey presented the Q2 2024 Network Adequacy Committee meeting minutes for approval.	☑ **CLOSED**: The committee members in attendance approved Q2 2024 Network Adequacy Minutes.	*7/19/24*
OLD BUSINESS	- No items.	☑ **CLOSED**: Informational only.	*7/19/24*
NEW BUSINESS	Provider Network Management, Q2 2024 Quarterly Network Review - Greg Panero presented the Provider Network Management Q2 2024 Quarterly Network Review. o After Hours Survey Results: Emergency Access at 99% compliant, Urgent Care Access at 99% compliant. Reviewed trending results and discussed Plan follow up action. o Provider Accessibility Monitoring Survey: Plan compliant with all standards (appointment availability, hours of operation, phone answering	☑ **CLOSED**: The committee members in attendance approved Provider Network Management, Q2 2024 Quarterly Network Review.	*7/19/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	timeliness, in-office wait times) based on results of Q2 2024 Survey. ▪ Alan Avery inquired about what is done when there is a low compliance percentage and how often the surveys are completed. Greg Panero explained this is done quarterly and when a provider is found to be non-compliant for the first time a letter is sent out and outreach and education is completed by their Provider Relations Representative. The following quarter a follow up survey is completed and if a provider is non-compliant a second time a letter is sent out and outreach and education is done by PNM management. If the provider is non-compliant for a third consecutive quarter a CAP is issued as outlined in policy 4.30-P Accessibility Standards. Alan Avery asked if this timeframe has ever received pushed back from regulators. James Winfrey confirmed this has not received push back and went over some reasons for the time frame and explained the provider education has been working. Alan Avery asked if the PR representative can visit the site. James Winfrey advised that is done as well. James Winfrey also explained the regional breakdown is new and one of the reasons percentages may be lower in the South region is because of the amount of specialist available in that area. Melissa McGuire also added when the PR reps reach out they address any concerns and access standards are provided. Sometimes there is confusion and providers may schedule appointment types differently and may not always disclose that they accept walk ins as well. ○ Access Grievance Review: The Plan has 269 access grievances found in favor of the member in Q4		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	2023, for a total of .29 grievances for every 1,000 members. ▪ James Winfrey discussed the South region potentially facing access issues. 23 members with in the South region had an access grievance and 2 out of the 3 specialist in the region were compliant with appointment availability. This will be further investigated and monitored. James also pointed out that based on the Access Grievances Per 100 Members chart members in the East region are more impacted. o Geographic Accessibility & DHCS Network Certification: The Plan is in compliance with DHCS Network Standards or maintains a DHCS-approved access standard when non-compliance identified. ▪ During discussion Alan Avery asked at what point does the plan follow up with DHCS regarding the AAS. Greg Panero explained the 343 AAS submitted was about seven times more than the plan usually has. The reason for that was the DHCS ran their own analysis of time and distance including outlying areas where people may not actually live. When these AAS were submitted, approval was received for the AAS submitted a year prior. There is no time frame. Melissa McGuire asked if there has been any push back from other Plans about DHCS's new methodology. Greg Panero explained there was a meeting held by the DHCS where they reported that this is an ever-evolving methodology, at this time the methodology will not be changing. o Network Adequacy & Provider Counts: ▪ FTE PCP ratio at 1:1809 ▪ FTE Physician ratio 1:294 ▪ PCP Accepting new members: 87% ▪ NPMH accepting new members: 96%		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	▪ NPMH locations accepting new members: 95% ▪ PCP Count: 476 ▪ Specialist Provider Count: 3031 ▪ Mental Health Provider Count: 145 • James Winfrey added that a Significant Network Change filing is in process. This is needed any time there is a 10% network change and went over some of that process. ○ Significant Network Change: In Q1 2024, the DMHC approved the plan's significant network change filing on February 15th, 2024. The plan initiated the filing on December 9, 2021, and continued to work respond to comment letters ending on December 14, 2023. The Plan will be working to submit a new significant network change beginning in Q2 2024. ○ DHCS Quarterly Monitoring Report/Response Template (QMRT): On 5/23/2024 the Plan's Provider Network Management Department was advised that the DHCS will not be providing a Q1 2024 QMRT due to data issues the DHCS encountered. On 6/7/2024, the DHCS notified the Plan that they will be working on expanding the Timely Access portion of the QMRT and potentially removing it from the QMRT. ▪ James Winfrey added that per an email from DHCS their timely access monitoring activities are going to be increasing and will be more resource intensive for the Plan. ○ MY 2023/RY2024 DMHC Timely Access Reporting: Per the DMHC MY 2023/RY 2024 PAAS Methodology, KHS surveyed five provider types: Primary Care Providers, Specialists, Ancillary, Non-Physician Mental Health, and Psychiatrists over Q3 and Q4 2023. Results of the survey were reported per provider type, and then within each provider		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	type, per county. Due to a DHCS audit finding, the Plan notified all noncompliant providers via mail and provided the appointment standards. The Plan has updated policy 4.30-P Accessibility Standards to require notification to noncompliant providers going forward. ▪ Melissa McGuire and Amisha Pannu discussed Telehealth having lower rate of compliance than in person. Melissa McGuire also reviewed amount of specialty providers in Tulare.		
OPEN FORUM	**Open Forum** - No items.	☑ **CLOSED**: Informational only.	*7/19/24*
NEXT MEETING	Next meeting will be held Friday, October 18, 2024.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 1:37 PM. ***Respectfully submitted: James Winfrey; Deputy Director of Provider Network Management***	**N/A**	*N/A*

For Signature Only – AADVOC Minutes 07/19/24

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: **JUNE 24, 2024**
CALL TO ORDER: **6:34 P.M. BY MARTHA TASINGA, MD - CHAIR**

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirement met.	*N/A*
APPROVAL OF MINUTES	The Committee's Chairperson, Martha Tasinga MD, presented the meeting minutes for approval.	☑ **ACTION**: Pat Person moved to approve minutes of March 18, 2024, seconded by Alison Bell. 7 approved, 0 nays.	*06/24/24*
OLD BUSINESS	• Incontinent Supplies Audit	• Dr. Miller and Dr. Sidhu are still working on developing the verification audits to comply with our current policies.	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	• Report of Plan Utilization Metrics Dr. Tasinga brought up concerns regarding the Rheumatologists pushing back on self-injected meds and Biosimilars. Many of these drugs would actually flow to Medi-Cal Rx. KHS desires the medications if infused, to be done at an Infusion Center. Dr. Gehlawat asked about Home Health Agencies. That too is acceptable, but there is possible non-compliance and also push-back from the specialists. • Educational Articles The State DUR Educational Article on Aspirin use was shared. We also share this information with the KHS Network. • NCQA Bruce indicated that NCQA requires criteria to be developed and named. NCQA also requires policies explaining how criteria is used. The following was presented the committee members: Policy 13.24-P Step-Therapy Considerations for Pharmacy Services – Criteria This is not new criteria, it is just renamed and formatted to meet NCQA standards. The principles reflect procedures and standards in place since the formation of the Health Plan. Molluscum Contagiosum Treatment -- Cantharidin (Ycanth) Criteria KHS states that the CDC recommendations are to leave alone unless the infection is in sensitive areas on the body and/or causing issues. The condition resolves without scarring on its own. Dr. Gehlawat inquired who was requesting. Bruce indicated mainly Pediatric Dermatologists. Dr. Srinivas stated that she often uses it. Bruce replied, her patients would fall under the sensitive areas category and therefore is indicated more frequently.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Dr. Gehlawat wanted to know if CCS covers this drug. Bruce replied that CCS covers specific conditions, however, not so much medications. If it met the condition, it would be covered. Dr. Srinivas and Dr. Gehlawat stated they often use other medications, that are off-label use to treat the condition. That agrees with the statement that CDC put out as well for the management of Molluscum Contagiosum. Multiple Sclerosis (MS) Treatment Criteria was also presented to the committee. • DHCS/Executive Order N-01-09 Medi-Cal Medi-Cal Rx will now be accepting specific ICD-10 codes to satisfy the Code I requirements for chronic weight management prescription requests. Medi-Cal Rx will now cover the GLP-1 specifically FDA indicated for weight management.		
OPEN FORUM	There were no topics presented during open forum.	☑ **ACTION**: N/A	*06/24/24*
NEXT MEETING	Next meeting will be held Monday, September 30, 2024 at 6:30 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned 7:26 pm.	☑ **ACTION**: Kim Hoffmann moved to adjourn the meeting. It was seconded by Alison Bell. 8 Ayes, 0 Nays.	*06/24/24*

Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator

For Signature Only – Drug Utilization Review Committee Minutes 06/24/24

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: ***APRIL 3, 2024***
CALL TO ORDER: ***7:01 AM BY MARTHA TASINGA, MD - CHAIR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Atul Aggarwal, MD - Network Provider, Cardiology	Miguel Lascano – Network Provider, OB/GYN Gohar Gevorgyan, MD – Network Provider, FP	Ashok Parmar, MD– Network Provider, Pain Medicine Raju Patel, MD - Network Provider, Internal Medicine
Members Virtual Remote:		David Hair, MD - Network Provider, Ophthalmology	
Members Excused=E Absent=A	(E) Hasmukh Amin, MD – Network Provider, Pediatrics		
Staff Present:	Alan Avery, KHS, Chief Operating Office Abdolreza Saadabadi MD – KHS BH Medical Director Amy Daniel, KHS Executive Health Svcs Coordinator	Jake Hall, KHS, Deputy Director of Contracting Yolanda Herrera, KHS Credentialing Manager	Magdee Hugais – KHS Director of QI Bruce Wearda, KHS 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 7:01 am.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. Tasinga presented the meeting minutes for approval.	☑ **ACTION**: Dr. Patel moved to approve minutes of March 7, 2024, seconded by Dr. Parmar. Motion carried.	*4/3/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Peer Review Reports **CREDENTIALING REPORT** **Mental Health Pre-Approvals from 4/01/24:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on 4/01/2024 Credentialing Report, all meeting clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **4/03/2024**: There was (1) initial application presented for comprehensive review. • [redacted] **RECREDENTIALING REPORT** **Recredentialing Providers List Dated 4/03/2024:** Recredentialing meeting clean file review were accepted as presented with no additional questions or alternative actions. Recredentialing with comprehensive reviews were conducted for the listed providers below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous three years:	☑ **ACTION**: Dr. Lascano moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated April 3, 2024, seconded by Dr. Parmar. Motion carried.	*4/3/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• [redacted] • [redacted] • [redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated April 2024 (Board of Directors Meeting) were accepted as presented with no additional questions or comments by the committee members. **MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:** There were no additional providers added to monthly monitoring due to licensing issues, adverse events or sanctioned/excluded to report to the committee members.		
OLD BUSINESS	**Delegated Credentialing 2023 Tertiary Audit Summary**	☐ **PENDING**: Ms. Herrera will monitor CHLA and UCLA Medical Groups for their pending CAP and will present to the PAC upon	*Pending*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
		receipt.	
	Bariatric Surgery Quality of Care Issues	☐ **PENDING**: Dr. Miller conduct random 10-case review in 6-months as follow-up on this issue.	*10/2/24*
NEW BUSINESS	**Advanced Practice Pharmacist Credentialing Criteria** Yolanda presented a request to credential Advanced Practice Pharmacist (APP) as a new provider type into the provider network. APPs are being introduced to expand access to patients by accessing a clinical pharmacist provider and groups are requesting the ability to credential and bill for these services provided by their APPs. The APP Scope of Practice per Business and Professions Code Section 4052.6 was provided along with the recommended credentialing criteria. Extensive discussion ensued regarding the exception for some groups that have an inpatient hospital/clinic setting are not allowed to utilize pharmacist under AB1114. B&P Code 4052.6 allows APPs to bill certain codes, such as E&M Codes 99213; however, the scope of practice is vague in oversight requirements, collaboration practice agreements and communication to patients PCP. **Pharmacy Criteria** Bruce Wearda, KHS Director of Pharmacy, presented the following Pharmacy Criteria including initial therapy criteria, exclusion criteria and criteria for continued coverage for the following: • Multiple Sclerosis Treatment • Osteoporosis Criteria It was requested that the pricing amounts be removed from the final version of the criteria.	☐ **PENDING**: Dr. Tasinga requested this item be tabled pending further analysis and will discuss with other healthplan's Chief Medical Officers to confirm credentialing requirements, collaboration agreements and if they are utilizing this provider type in their network. ☑ **ACTION**: Dr. Aggarwal moved to approve the Pharmacy Criteria for Multiple Sclerosis Treatment and Osteoporosis Criteria, seconded by Dr. Parmar. Motion carried	*Pending*
OPEN FORUM	No Discussion in Open Forum.	**N/A**	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEXT MEETING	Next meeting will be held Wednesday, May 1, 2024	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 7:56 am. ***Respectfully submitted: Amy L. Daniel, Executive Health Services Coordinator***	**N/A**	*4/3/24*

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: ***MAY 1, 2024***
CALL TO ORDER: ***7:01 AM BY MARTHA TASINGA, MD - CHAIR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Hasmukh Amin, MD – Network Provider, Pediatrics	Miguel Lascano – Network Provider, OB/GYN Gohar Gevorgyan, MD – Network Provider, FP	Ashok Parmar, MD– Network Provider, Pain Medicine Raju Patel, MD - Network Provider, Internal Medicine
Members Virtual Remote:		David Hair, MD - Network Provider, Ophthalmology	
Members Excused=E Absent=A	Atul Aggarwal, MD - Network Provider, Cardiology (E)		
Staff Present:	Alan Avery, Chief Operating Officer Michelle Church, Pharmacist Michelle Curioso, Director of PHM	Amy Daniel, Executive Health Services Coordinator Yolanda Herrera, Credentialing Manager Magdee Hugais – Director of QI	John Miller, MD QI Medical Director Abdolreza Saadabadi, MD BH Medical Director 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 7:04 am.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. Tasinga presented the meeting minutes for approval.	☑ **ACTION**: Dr. Patel moved to approve minutes of April 3, 2024, seconded by Dr. Parmar. Motion carried.	*5/1/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Peer Review Reports **CREDENTIALING REPORT** **Mental Health Pre-Approvals from 5/01/24:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on 5/01/2024 Credentialing Report, all meeting clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **5/01/2024**: There was (1) initial application presented for comprehensive review. • [redacted] **RECREDENTIALING REPORT** **Recredentialing Providers List Dated 5/01/2024:** Recredentialing meeting clean file review were accepted as presented with no additional questions or alternative actions. Recredentialing with comprehensive reviews were conducted for the listed providers below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous three years:	☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated May 1, 2024, seconded by Dr. Parmar. Motion carried.	*5/1/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		
	NEW VENDOR CONTRACTS New Vendor Contracts List Dated May 2024 (Board of Directors Meeting) were accepted as presented with no additional questions or comments by the committee members.		
	MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS: The April 2024 monthly monitoring report that includes licensing disciplinary issues, adverse events, or sanctioned/excluded providers to be reviewed by the committee members. • [redacted]	☑ **ACTION**: Monthly Monitoring to ensure there are no member grievances and to monitor KM actions related to this provider's status.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• [redacted]	☑ **ACTION**: Monthly Monitoring to ensure group complies with QI Corrective Action Plan.	
OLD BUSINESS	**Delegated Credentialing 2024 Audit Summary** Audit Results for ConferMed (E-Consults Peer to Peer) KHS Credentialing conducted desk top audit for ConferMed on 4/15/2024. • **Results:** ConferMed scored 100% utilizing the HICE Accredited-Certified Audit Tool • **Opportunity for Improvement:** Incorporate AB2581 BH Application Turnaround w/in 60-days (Met); however, notification of complete mental health/behavioral health application to the provider was not met. AB2581 All Plan letter was provided to ConferMed and will be added to their credentialing program within 60-90days.	☑ **ACTION**: Dr. Amin moved to approve the Delegated Credentialing 2024 Audit Summary report regarding ConferMed. Motion carried. ☐ **PENDING**: ConferMed's Opportunity for Improvement will be presented to PAC upon receipt.	*5/1/24* *Pending*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Delegated Credentialing 2024 Audit Summary – Opportunity for Improvements and/or Corrective Actions **CHLA Medical Group (Survey Date 12/7/23)** • **Opportunity for Improvement:** Lacked evidence to confirm file verification receipt date and notification meeting the 60-Day Turn-around-time frame for mental/behavioral health applications (Example: Application date stamp page and approval letter to confirm 60-day TAT • **Delegates Response:** 4/8/2024_EVID-COMPLIANT: BH Application submitted 2/2/2024 and approved 3/14/2024 (MR, DO Ped Psych) File evidence provided. **UCLA Medical Group (Survey Date 1/30/24) Opportunity for Improvement** • **Opportunity for Improvement:** Recommendations to updated Ongoing Monitoring for Opt Out to new CMS Medicare Opt Out Affidavit and ensure P&P includes notification with 7-business days of BH Applications are complete or incomplete per CA AB2581 • **Delegates Response:** Pending	☑ **ACTION**: Dr. Amin moved to approve the Delegated Credentialing 2024 Audit Summary report follow-up regarding CHLA Medical Group. Motion carried. ☐ **PENDING**: UCLA Medical Group's Opportunity for Improvement will be presented to PAC upon receipt.	*5/1/24* *Pending*
	Bariatric Surgery Quality of Care Issues	☐ **PENDING**: Dr. Miller conduct random 10-case review in 6-months as follow-up on this issue.	*10/2/24*
	Advanced Practice Pharmacist Credentialing Criteria At the last meeting, Dr. Tasinga volunteered to inquire with other health plan CMOs to see if they are utilizing and/or credential Advanced Practice Pharmacist (APP) as a new provider type into their provider network. Dr. Tasinga informed the members that she did not find any other sister plan utilizing APPs. Dr. Tasinga stated that the PharmDs in the FQHCs are also not functioning in this capacity or	☐ **PENDING**: Dr. Tasinga requested that KMs proposal and request to utilize Advanced Practice Pharmacist be escalated to legal for review and analysis.	*Pending*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	level to which KM is requesting. As CMO of KHS, Dr. Tasinga bares the responsibility to reduce risk to the organization and feels it is necessary to escalate to legal for review pursuant to KMs request to utilize the APPs in their clinics.		
NEW BUSINESS	**Pharmacy Criteria** Michelle Church, KHS Pharmacy, presented the following Pharmacy Criteria including initial therapy criteria, exclusion criteria and criteria for continued coverage for the following: • Step Therapy Members discussed self-injectable medications which may be administered at home; however, if a member is unable to self-inject, there must be an alternate arrangement noted for members to get injections from an outpatient infusion center which is preferred.	☑ **ACTION**: Dr. Parmar moved to approve the Pharmacy Criteria for Step Therapy Criteria, seconded by Dr. Amin. Motion carried	*5/1/24*
OPEN FORUM	**Nursing Home Rounding**: Dr. Patel inquired on the changes in the nursing home rounding and how confusing it has been to know which provider group is rounding on members. Dr. Tasinga informed the members that upon discharge from acute care services, and member going to SNF, they are to be seen by Premier Valley Medical Group (Dr. Brar). Those members in long-term care are being seen by Medical Associates of Bakersfield (Drs. Farrer & Memon)	☑ **CLOSED**: Informational discussion only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, June 5, 2024	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:00am ***Respectfully submitted: Amy L. Daniel, Executive Health Services Coordinator***	**N/A**	*N/A*

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: ***JUNE 5, 2024***
CALL TO ORDER: ***7:09 AM BY MARTHA TASINGA, MD - CHAIR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Atul Aggarwal, MD – Network Provider, Cardiology Hasmukh Amin, MD – Network Provider, Pediatrics	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		Gohar Gevorgyan, MD – Network Provider, FP (E) Miguel Lascano – Network Provider, OB/GYN (E)	
Staff Present:	Alan Avery, Chief Operating Office Michelle Curioso, Director of PHM Amy Daniel, Executive Health Services Coordinator Jake Hall, Deputy Director of Contracting	Yolanda Herrera, Credentialing Manager Magdee Hugais, Director of Quality Improvement John Miller MD, Quality Improvement Medical Director	Abdolreza Saadabadi MD, BH Medical Dir. (R) Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director Bruce Wearda, Pharmacy 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 7:09 am.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. Tasinga presented the meeting	☑ **ACTION**: Dr. Amin moved to approve minutes of May 1, 2024,	*6/5/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	minutes for approval.	seconded by Dr. Patel. Motion carried.	
	Peer Review Reports **CREDENTIALING REPORT** **Mental Health Pre-Approvals from 6/03/24:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on 6/03/2024 Credentialing Report, all meeting clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **6/05/2024**: There was (1) initial application presented for comprehensive review. • [redacted] **RECREDENTIALING REPORT** **Recredentialing Providers List Dated 6/05/2024:** Recredentialing meeting clean file review were accepted as presented with no additional questions or alternative actions. Recredentialing with comprehensive reviews were conducted for	☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated June 5, 2024, seconded by Dr. Patel. Motion carried.	*6/5/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	the listed providers below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous three years: • [redacted] • [redacted] • [redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated May 2024 (Board of Directors Meeting) were accepted as presented with no additional questions		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	or comments by the committee members.	☑ **ACTION**: Dr. Amin moved to approve the Delegation of Credentialing Activities from the reports dated June 5, 2024, seconded by Dr. Patel. Motion carried.	
	DELEGATION OF CREDENTIALING ACTIVITIES – 4TH QUARTER 2023 REPORTS Ms. Herrera reported 4th Quarter 2023 Delegation of Credentialing activities for CHLA Medical Group, ConferMed, Kaiser, Valley Children's ChildNet, VSP, UCLA Medical Group and USC Medical Group have been received. There were no significant changes in credentialing program, policies/procedures, or provider network.	☑ **ACTION**: Monthly Monitoring new events were received and reviewed by the Committee members with no additional requests at this time. Providers will continue to be monitored monthly with any additional reporting to the committee as it is received.	*6/5/2024*
	MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS: The May 2024 monthly monitoring report that includes licensing disciplinary issues, adverse events, or sanctioned/excluded providers to be reviewed by the committee members. New monitoring activities were presented as follows: • [redacted]		*6/5/2024*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• [redacted]		
OLD BUSINESS	**Delegated Credentialing 2024 Audit Summary – Opportunity for Improvements and/or Corrective Actions** **ConferMED** (E-Consults Peer to Peer) submitted their evidence of compliance for their opportunity for improvement as follows: • **Opportunity for Improvement:** Incorporate AB2581 BH Application Turnaround w/in 60-days (Met); however, notification of complete mental health/behavioral health application to the provider was not met. AB2581 All Plan letter was provided to ConferMed and will be added to their credentialing program within 60-90days. • **Delegates Response: 5/8/2024 Evidence of compliance received updated Credentialing Policy and Procedure Section 2.2 for Behavioral Health applications completion pursuant to AB2581. Closed/Compliant.**	☑ **ACTION**: Dr. Amin moved to approve the Delegated Credentialing 2024 Audit Summary report follow-up regarding ConferMed, seconded by Dr. Aggarwal. Motion carried.	*6/5/24*
	UCLA Medical Group (Survey Date 1/30/24) Opportunity for Improvement • **Opportunity for Improvement:** Recommendations to updated Ongoing Monitoring for Opt-Out to new CMS Medicare Opt-Out Affidavit and ensure P&P includes notification with 7-business days of BH Applications are complete or incomplete per CA	☑ **ACTION**: Dr. Amin moved to approve the Delegated Credentialing 2024 Audit Summary report follow-up regarding UCLA Medical Group, seconded by Dr. Aggarwal. Motion carried.	*6/5/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	AB2581 • **Delegates Response: 5/28/2024 Evidence of compliance KHS received updated Credentialing Policy and Procedure Section 14.5 Medicare Opt-Out revised and corrected language and Section 8.4 for Behavioral Health application process pursuant to AB2581 added. Closed / Compliant.**		
	Bariatric Surgery Quality of Care Issues	☐ **PENDING**: Dr. Miller conduct random 10-case review in 6-months as follow-up on this issue.	***10/2/24***
	Advanced Practice Pharmacist Credentialing Criteria At the last meeting, Dr. Tasinga volunteered to inquire with other health plan CMOs to see if they are utilizing and/or credential Advanced Practice Pharmacist (APP) as a new provider type into their provider network. Dr. Tasinga informed the members that she did not find any other sister plan utilizing APPs. Dr. Tasinga stated that the PharmDs in the FQHCs are also not functioning in this capacity or level to which KM is requesting. As CMO of KHS, Dr. Tasinga bares the responsibility to reduce risk to the organization and feels it is necessary to escalate to legal for review pursuant to KMs request to utilize the APPs in their clinics.	☐ **PENDING**: Dr. Tasinga requested that KMs proposal and request to utilize Advanced Practice Pharmacist be escalated to legal for review and analysis.	*Pending*
NEW BUSINESS	**Pharmacy Criteria** Bruce Wearda, KHS Pharmacy Director, presented the following Pharmacy Criteria including initial therapy criteria, exclusion criteria and criteria for continued coverage for the following: • Cantharidin (Yeanth) Criteria Members discussed this topical medication and that only Dermatologist prescribe it; however, there was a question raised regarding some PCPs have also prescribed this medication as well and would be beneficial to disseminate this information to both the Dermatologist and Primary Care Physicians regarding these criteria.	☑ **ACTION**: Dr. Amin moved to approve the Pharmacy Criteria for Cantharidin (Yeanth), seconded by Dr. Aggarwal and to fax blast these criteria to the dermatology providers and primary care physicians. Motion carried. Yolanda Herrera Credentialing Manager will ensure criteria is faxed to the stated providers.	*6/5/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	No additional information presented or discussed.	☑ **CLOSED**	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, August 7, 2024	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 7:55am **Respectfully submitted: Amy L. Daniel, Executive Health Services Coordinator**	**N/A**	*N/A*

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: ***JUNE 5, 2024***
CALL TO ORDER: ***11:01 AM BY SUKHPREET SIDHU, MD - CHAIR***

Members Present On-Site:	Maria Bermudez, Asst. Director at Dept. of Human Services Lordes Bucher, Administrator at KCSOS Brynn Carrigan, Director at KC Public Health Valerie Civelli, MD at LTC Premier Valley Med. Group	Babita Datta, MD OB/GYN at Wasco Medical Plaza Paula De La Riva-Barrera, Manager at First 5 Kern Dixie Denmark-Speer, SS Director at Height Street SNF Minty Dillon, Administrator at Premier Valley Medical Grp Desiree Escobedo, Admissions at Height Street SNF	Lito Morillo, Executive Director at KC Human Services Jasmine Ochoa, Manager at KC Public Health Cody Rasmussen, Administrator at Height Street SNF Curt Williams, Director Homeless/Foster at KCSOS
Members Virtual Remote:	Kristine Khuu, Assistant Director at Kern Regional Ctr. Ashok Parmar MD, Pain Mgmt.		
Members Excused=E Absent=A	Christopher Boyd, Licensed Clinical Psychologist (E) Cristina Castro, Recovery Specialist at KCBHRS (E) Babita Datta, MD OB/GYN at Wasco Medical Plaza (E) Minty Dillon, Administrator at Premier Valley Med. (E) Laura Hasting, NP at Priority Urgent Care (E)	Gina Lascon, DON at Delano SNF (E) Alissa Lopez, Administrator at KCBHRS (E) Colleen Philley, Program Director at KC Aging & Adult (E) Celia Pinai, Kern Regional Center (E) Vivek Radhakrishan, MD Primary Care @ Premier (E)	Martin Reynoso, Supervisor at KC Aging & Adult (E) Jennie Sill, Administrator at KCBHRS (E) Jay Tamsi, President/CEO Hispanic Chamb of Comm. (E) Alejandra Vargas, BOM at Height Street SNF (E)
Staff Present:	Desiree Buena, RN PHM Supervisor Missy Clendenen, RN PHM LTC Case Manager Michelle Curioso, Director of PHM Amy Daniel, Executive Health Services Coordinator	Russell Hasting, PHM Manager of CM Yolanda Herrera, Credentialing Manager Magdee Hugais, KHS Director of QI Jacinto Marcelo II, Director of Special Programs John P. Miller, MD QI Medical Director	Noehmi Morfin, RN PHM Clinical Auditor & Trainer Courtney Morris, Behavioral Health Supervisor Marilu Rodriguez, Senior Health Equity Analyst 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	Sukhpreet Sidhu, MD, KHS PHM Medical Director called the meeting to order at 11:01 AM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of March 6, 2024 were presented for review and approval.	☑ **ACTION**: Lito Morillo moved to approve minutes of March 6, 2024, seconded by Curt Williams. Motion carried.	N/A
OLD BUSINESS	There was no old business to present	N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Members and KHS Staff introduced themselves and from the facility/organization they are representing.	☑ **CLOSED**: Informational discussion only.	*6/5/24*
	Review and Approval of Policy **INTERMEDIATE CARE FACILITY FOR DEVELOPMENTALLY DISABLED** Michelle Curioso, Director of PHM, presented the ICF/DD Policy outlining the care coordination to ensure there are no duplication of efforts along with Quality Improvement Team. The policy is for internal use describing the care management and coordination responsibilities. **SUBACUTE CARE POLICY** Jacinto Marcelo II, Director of Special Programs presented the Subacute Care Policy after meeting with management and avoid duplication of efforts, the policy was developed to assist in the care management coordination of care to sub-acute facilities. Since there is no local sub-acute for pediatrics the internal policy will be beneficial for navigating outside our service area. Members acknowledged the appreciation for this type of coordination and outreach. **COMPLEX CASE MANAGEMENT** Michelle Curioso, Director of PHM, presented the Complex Case Management Policy which is a requirement of NCQA and DHCS. This policy is a detailed guide on patient stratification for the Complex Case Management Program, nurse assessment requirements and patient individual care plans.	☑ **ACTION**: Curt Williams moved to approve the ICF/DD Internal Policy, seconded by Cody Rasmussen. Motion carried. ☑ **ACTION**: Cody Rasmussen moved to approve the Sub-Acute Internal Policy, seconded by Curt Williams. Motion carried. ☑ **ACTION**: Lito Morillo moved to approve the Sub-Acute Internal Policy, seconded by Cody Rasmussen. Motion carried.	*6/5/24*
	Long-Term Care Quality Assurance Performance Improvement Missy Clendenen, LTC Case Manager, RN presented the Quality Assessment Performance Improvement report for 2023. Using the last 3 Quarters of data, it was identified that patient falls are the major outlier, second is pressure injuries, and third are UTIs. Using the QAPI algorithm, it was identified that the patient Hoyer Lift was broken. A systematic root/cause/analysis was conducted. Collaboration with the staff was ideal to help with the needed changes required in real time. It was identified that there was no clear process to report damaged/broken equipment.	☑ **ACTION**: Lordes Bucher moved to approve the Long-Term Care Quality Assessment Report, seconded by Dr. Ashok Parmar. Motion carried.	*6/5/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	KHS's goal and commitment is to assist our LTC providers with education, and training, assist with facility issues, and become compliant with regulatory issues. Next Steps with Falls will be education and training on how to avoid falls. Pressure Injuries for patients unable to ambulate will require periodic rounds to rotate the patient frequently to minimize skin breakdown and prevent loss of circulation. UTI guideless will continue to be modified to account for the various factors required to treat this diagnosis. Mr. Rasmussen discussed the responsibility with mitigating falls and the difficulty to get physicians to follow criteria. KHS has assigned specific physicians to round at the contracted facilities as a way to engage practitioners' assignment to KHS members following approved criteria and/or guidelines. Dr. Valerie Civelli confirmed that applying protocol to patients, drug resistance as well as nurse experience is all taken into consideration in the treatment of the patient types in these facilities.		
	<u>Palliative Care Services</u> Russell presented the Palliative Care Service Report conducted over the last year as a result of SB1004 in 2018. DHCS established standards and requirements for technical assistance with Palliative Care. Criteria was developed outlining Palliative Care versus Hospice along with staff Training. KHS hired Masters Level License Care Social Worker who received 30-hours training at the Shirley Haynes Institute for Palliative Care. The Team of Social Workers conduct outreach, assessment/screenings, and patient plans of care. There is also a dedicated Clinical Medical Assistant who assists with patient scheduling, and mailings. After launching the Program in October 2023, efforts began to develop EMR tool, training team members and the pilot program was rolled out in November 2023. In January 2024 the full program was launched working with local community providers, primary care physicians and determining the member needs specific to palliative care versus hospice care. Currently, there have been 124 members accepted into the Palliative Care Program through member screenings as well as from other referral sources. In March 2024 a formal program summit will be held networking with other plans aimed to ensure best practices are being used to ensure members receive the appropriate care.	☑ **ACTION**: Paula De La Riva-Barrera moved to approve the Palliative Care Report, seconded by Dr. Ashok Parmar. Motion carried.	*6/5/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Provider Engagement and Capacity Report including the services provided. In collaboration with Aasta and Hoffman both have developed program goals and expectations through our interdisciplinary team meetings. Provider education will be large component to the success of this program and our team has been diligently working on newsletters and provider bulletins to our provider network informing them of our criteria and guidelines. Additional next steps will include reporting and oversight of local vendors, identifying resource needs assessment and information exchange ideally with the goal of having referrals in the patient portal. Committee members expressed concern that most patients fear being sent home to expire with no medications or education; however, Committee members commended PHM Staff for this strategic program to deliver care, provide education to our local venders, physicians and staff.		
	Transitional Care Services/PHM Role/Updates Jacinto Marcelo II presented the Transition of Care Special Programs Report. The purpose of this program is to ensure a smooth transition for a patient being transferred from one setting to another level of care setting. The program's goal is to transfer the patient to the least restrictive level that will support the patient with the services required for that patient. In 2023 requirements changed requiring a Registered Nurse for all High-Risk Members. This has now been implemented for all member transfers 2024 and forward. Additionally, the RN will have a Certified Medical Assistant to assign with the transfers and the focus will be to automate our process by end of year 2024.	☑ **ACTION**: Kurt Williams moved to approve the Transition of Care Report, seconded by Dr. Ashok Parmar. Motion carried.	*6/5/24*
	PHM Survey Responses Michelle Curioso presented the feedback received from the PHM Survey Responses sent to our providers during the last quarter. Mental Health was identified as the top issue of concern for our providers. Next quarter will invite the Behavioral Health Department to share information on available resources and how to send referrals to better assist our network providers. Transportation and Rural Communities were also identified as areas of concern and will be reviewed for next steps and how best PHM can provide assistance.	☑ **CLOSED**: Informational discussion only.	*6/5/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	**Open Forum** No additional items presented for discussion.	☑ **CLOSED**: Informational discussion only.	*6/5/24*
NEXT MEETING	Next meeting will be held Wednesday, September 4th, 2024 at 11:00 am	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 12:02 PM ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Quality Improvement Committee Minutes 06/05//24

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: ***JUNE 19, 2024***
CALL TO ORDER: ***12:11 PM BY MANINDER KHALSA, MD, UM MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Parikshat Sharma, MD – Outpatient Provider Ashok Parmar, MD - Specialist	Philipp Melendez, MD – OB/GYN Maninder Khalsa, MD – KHS UM Medical Director	
Members Virtual Remote:			
Members Excused=E Absent=A			
Staff Present:	Linda Corbin, KHS Health Services Consultant (Remote) Lela Criswell, Member Engagement Manager Amy Daniel, Executive Health Services Coordinator	Loni Hill-Pirtle, Director of Enhanced Case Mgmt Traco Matthews, Chief Health Equity Officer Melinda Santiago, Director of Behavioral Health	Nate Scott, Director of Member Services Sukhpreet Sidhu, MD, PHM Medical Director Isabel Silva, Director of Health & Wellness

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were not met as the composition as described in the committee charter are still in development and recruiting participating providers.	N/A
Call to Order	Dr. Maninder Khalsa, KHS UM Medical Director called the meeting to order at 12:11 PM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of March 20, 2024 were presented for review and approval.	☑ **ACTION**: Dr. Sharma moved to approve minutes of March 3, 2024, seconded by Dr. Patel. Motion carried.	N/A
OLD BUSINESS	There was no old business to present.	N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Dr. Khalsa welcomed the members of UM Committee meeting and reviewed the outline of the agenda.	☑ **CLOSED**: Informational discussion only.	*6/19/24*
	UM Policy and Procedure Review Linda Corbin presented the following UM Policy and procedures submitted with revisions: • KHS Policy 3.31-P Emergency Services – Redline revision for this policy was only relevant to Access Section 1.D. • KHS Policy 3.33-P Admission, Discharge, Concurrent Review and Authorization Notification Process – Redline revision for this policy was only relevant to the same topic regarding Emergency and Post Stabilization Admissions Section C.5.	☑ **ACTION**: Dr. Sharma moved to approve revisions to P&P #3.31 Emergency Services, seconded by Dr. Parmar. Motion carried. ☑ **ACTION**: Dr. Sharma moved to approve revisions to P&P #3.33 Admission, Discharge, Concurrent Review and Authorization Notification Process, seconded by Dr. Parmar. Motion carried.	*6/1924*
	2024 Quarter 1 UM Reporting Dr. Khalsa presented the 2024 1st Quarter UM Report. The PowerPoint presentation was shared with the members and the following highlights were noted: • Turn Around Time – KHS remains compliant with both routine 100% and urgent 99.6 UM Timeliness of Decisions in comparison to past quarters. • UM Referral Notification – KHS remains compliant with UM Referral notifications in comparison to past quarters. • Total Referrals Received = 1st Q4 quarter revealed a significant increase in referrals at 93648 in comparison to Q3 which was 74253. • Adult & Specialty Referrals = 72994 (Adult) Specialty CSS 3453, ECM 447 and Transplant 341 • Inpatient Numbers & Inpatient Statistics • SNF / Rehab – information shared with members no significant trends or patterns identified. • Mental Health – 1st Qtr Mental Health Claims were presented. Melinda Santiago ask what specific CPT Codes are being referred to when presenting this particular data? Dr. Kalsha stated the ICD codes drive some of the separation but is a better question for Claims Dept.	☑ **ACTION**: Dr. Sharma moved to approve revisions to P&P #3.33 Admission, Discharge, Concurrent Review and Authorization Notification Process, seconded by Dr. Parmar. Motion carried. ☐ **FOLLOW-UP**: Dr. Khalsa to discuss data with Director of Claims to identify the Mental Health data to determine the separation, if any between ABA and BHT Services and whether or not non-specialty mental health services are included. ☐ **FOLLOW-UP**: Dr. Khalsa to follow-up to ensure if the ECM Referrals are only those that get to UM level of review since JIVA system is auto authorizing and may not go into our baseline statistics.	*6/19/24* *Pending* *Pending*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Audit Numbers – Numbers by month for 1st Quarter were reviewed and no significant trends or patterns identified. Loni Hill-Pirtle questioned the audit numbers for ECM referrals and feels that number may be significantly low as ECM is authorizing somewhere near 500 to 1000 referrals.		
	2024 UM Program Description/Regulatory Compliance Linda presented the previously approved 2024 UM Program Description with brief overview of the regulatory compliance aspects to ensure UM Staff review the inpatient program as required. • Dr. Khalsa provided a brief summary indicating the need to ensure the UM Program Description and our UM Policies align to how we practice complete the UM functions and processes. Dr. Khalsa further explained that KHS is reviewing the differences between Medicare, NCQA and DHCS and adopting the toughest requirement or process that will then meet all requirements of these regulatory bodies for KHS to have the most conservative process.	☑ **CLOSED**: Informational discussion only.	*6/19/24*
	Quarterly Completion of Milliman Care Guidelines Inter-Rater Reliability (MCG-IRR) • Held until next meeting.	☑ **CLOSED**: The committee members in attendance approved the 2024 UM Program Description as presented with no additional discussion.	*Pending*
OPEN FORUM	**Open Forum** Dr. Parmar asked if KHS Members are assigned to specific specialist. Dr. Khalsa informed the Committee that specialists are not assignable, and, in many cases, a prior authorization is not required; however, referrals are sent to the patient when directed or approved to see a specialist. Dr. Sidhu informed the Committee that Network Providers are encouraged to utilize the Portal as an additional mechanism and tool to ensure the members are receiving the proper care. The KHS Patient Portal is constantly being upgraded and enhanced to try and meet the needs of our provider population and network providers.	☑ **CLOSED**: Informational discussion only.	*6/19/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Christine Pence informed the Committee that KHS is currently in contract phase with AllMed and working to define the scope of work that will be delegated to AllMed. As the scope of work is defined, the UM Committee will be updated with any changes to our process, procedures and policies affected with this delegation of services and if required, approval by this committee and Board of Directors will be presented as needed.		
NEXT MEETING	Next meeting will be held Wednesday, September 11, 2024 at 12:00 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 12:45 PM ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Utilization Management Committee Minutes 06/19/24

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

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

To: EQIHEC

From: Melinda Santiago, Director of Behavioral Health

Date: 07/31/24

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.

Meetings Held:
- March 11, 2024
- April 8, 2024
- July 10, 2024

Discussion Items:
- Behavioral Health Presentation
- Behavioral Health Member Experience Survey
    - Review of survey templates
    - Updates DHCS approval of surveys, member letters and incentive plan
- Charter provides information about the Population Health Management Committee (PHMC) which includes the following:
    - Description of PHMC
    - Function
    - Composition
    - Frequency of Meetings
    - 2024 Meeting Schedule
- National Committee for Quality Assurance (NCQA) Accreditation Standards
    - QI 4 – Continuity and Coordination Between Medical Care and Behavioral Healthcare
    - ME 7E – Annual Assessment of Behavioral Healthcare and Services

Fiscal Impact: None

Requested Action: Review for approval.

KERN HEALTH SYSTEMS

Behavioral Health Advisory Committee (BHAC)

Charter

Description of Committee

Kern Health Systems (KHS) Behavioral Health Advisory Committee (BHAC) is a subcommittee to the Executive Quality Improvement Health Equity Committee (EQIHEC) and is charged with facilitating collaborative coordination of medical and behavioral health services.

The committee will support, review, and evaluate interventions to promote collaborative strategic alignment between KHS as Managed Care Plan (MCP) 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, and provide resources for members with mental illness and/or substance use disorder.

Function

The activities of the Behavioral Health Advisory Committee include the following, but not limited to the following:

1. Review quality monitoring activities conducted by the Plan to measure compliance for network providers, corrective actions, and regulatory requirements regarding behavioral health services, network accessibility and delegation oversight.
2. Provide feedback on implementation of BH clinical guidelines and UM criteria, new BH technology, quality monitoring tools, site/chart review(s), tracking access to care standards, and treatment innovations.
3. Review Plan's adherence and achievement of Medi-Cal Managed Care Accountability Set (MCAS) targets focused on BH.
4. Review Plan's adherence to the quantitative and qualitative analysis for the Evaluation of BH member complaints, appeals, and experience.
5. Review Plan's process for continuity and coordination medical and behavioral health services, methods to exchange information.
6. Review and approve the BH Program Description annually.
7. Review Plan's compliance with overseeing MOU with KBHRS.
8. Provides support to KHS management based on their regular and direct interactions with KHS Members receiving BH Services.

KERN HEALTH SYSTEMS

Composition

The BHAC is a collaborative group that is chaired by KHS Chief Medical Director and Director of Behavioral Health. The members are comprised of behavioral health practitioners and credentialed providers participating in KHS network. The BHAC will require two-thirds of the members to be present to establish a quorum.

Appointed members include, at a minimum:

- 1 Participating Behavioral Health Network Practitioner (Licensed Clinician)
- 1 Participating Behavioral Health Network Practitioner (M.D.)
- 1 Participating Medication Assisted Treatment Provider (PCP)
- 1 Kern Behavioral Health and Recovery Services Administrator or designee
- 1 Provider or Representative from a contracted Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or other Safety Net Provider (SNP)
- 1 Local Education Authority Representative

Other KHS attendees:

- Other KHS clinical staff may attend the meeting but are neither considered part of the Committee nor voting members.

Meetings

The BHAC meets quarterly with additional meetings as necessary.

Meeting Schedule 2024

Months	**Day**
March	2nd Monday of the Month
April	2nd Monday of the Month
July	2nd Monday of the Month
October	2nd Monday of the Month

Behavioral Health Advisory Committee 2024

KERN HEALTH SYSTEMS

B H A C

- **Behavioral Health Advisory Committee -**

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.

- **Reports Executive Quality Improvement Health Equity Committee (EQIHEC)**

BHAC Structure

- 1 Participating Network BH Practitioner (Licensed Clinician)
- 1 Participating Network BH Practitioner (M.D. Psychiatrist)
- 1 Participating Network Medication Assisted Treatment Provider (PCP)
- 1 Participating Network FQHC representative (Licensed Clinician)
- 1 Local Education Agency (LEA) representative (Licensed Clinician)
- 1 Behavioral Health Plan (BHP) Representative (Licensed Clinician)

BHAC Duties

- Review quality monitoring activities conducted by the Plan to measure compliance for network providers, corrective actions, and regulatory requirements regarding behavioral health services, network accessibility and delegation oversight.
- Provide feedback on implementation of BH clinical guidelines and UM criteria, new BH technology, quality monitoring tools, site/chart review(s), tracking access to care standards, and treatment innovations.
- Review Plan's adherence and achievement of Medi-Cal Managed Care Accountability Set (MCAS) targets focused on BH.
- Review Plan's adherence to the quantitative and qualitative analysis for the evaluation of BH member complaints, appeals, and experience.
- Review Plan's process for continuity and coordination medical and behavioral health services, methods to exchange information.
- Review and approve the BH Program Description annually.
- Review Plan's compliance with overseeing MOU with KBHRS.
- Provides support to KHS management based on their regular and direct interactions with KHS Members receiving BH Services.

Input Topics

- Culturally appropriate service or program design
- Priorities for behavioral health education and outreach program
- Member Experience satisfaction survey results
- Quality Improvement
- Quality Performance
- Carved Out Services
- Coordination of Care
- Health Equity
- Accessibility of Services

KERN HEALTH SYSTEMS

New Year – New Process

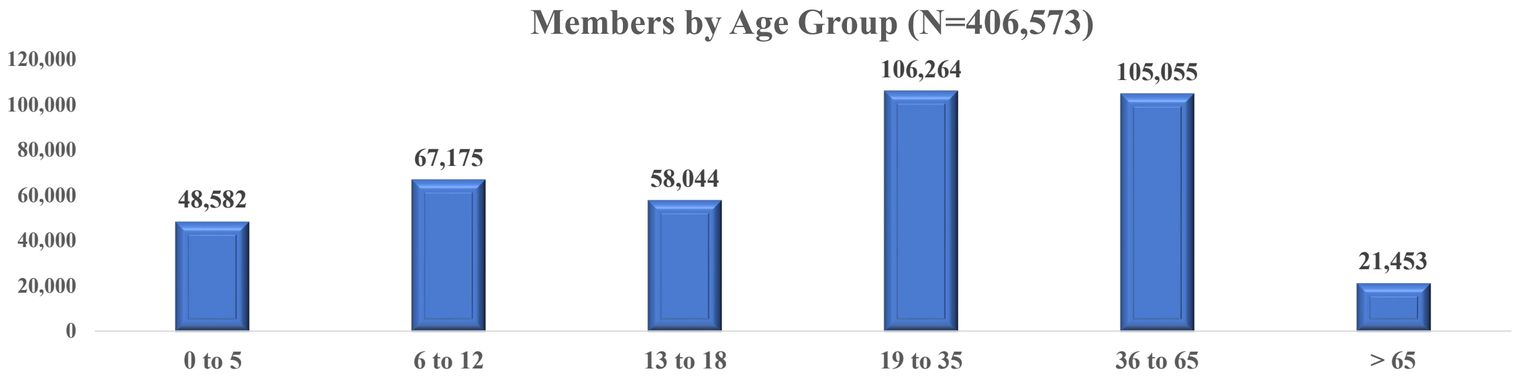
- National Committee for Quality Assurance (NCQA) Accreditation Standards
- 2 – year term begins in 2024
- Chair and Co-chair will be the KHS Chief Medical Officer and Director of Behavioral Health
- Other KHS clinical staff may attend the meeting but are neither considered part of the Committee nor voting members.
- Stipend for Committee Members

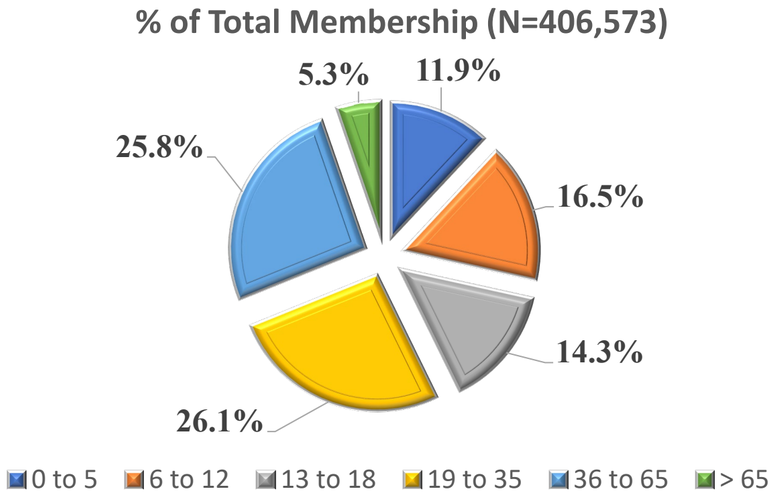
Executive Quality Improvement Health Equity Committee EQIHEC

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

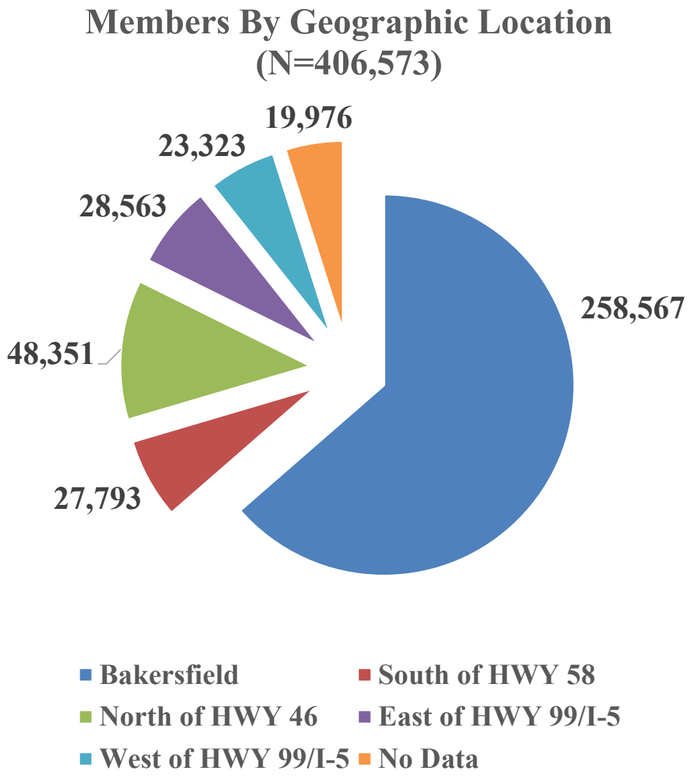
The EQIHEC consists of actively participating clinical and non-clinical providers. The physicians are voting members for clinical decision making. The EQIHEC is comprised of internal and community participants. This process promotes an interdisciplinary and inter-departmental and community approach and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

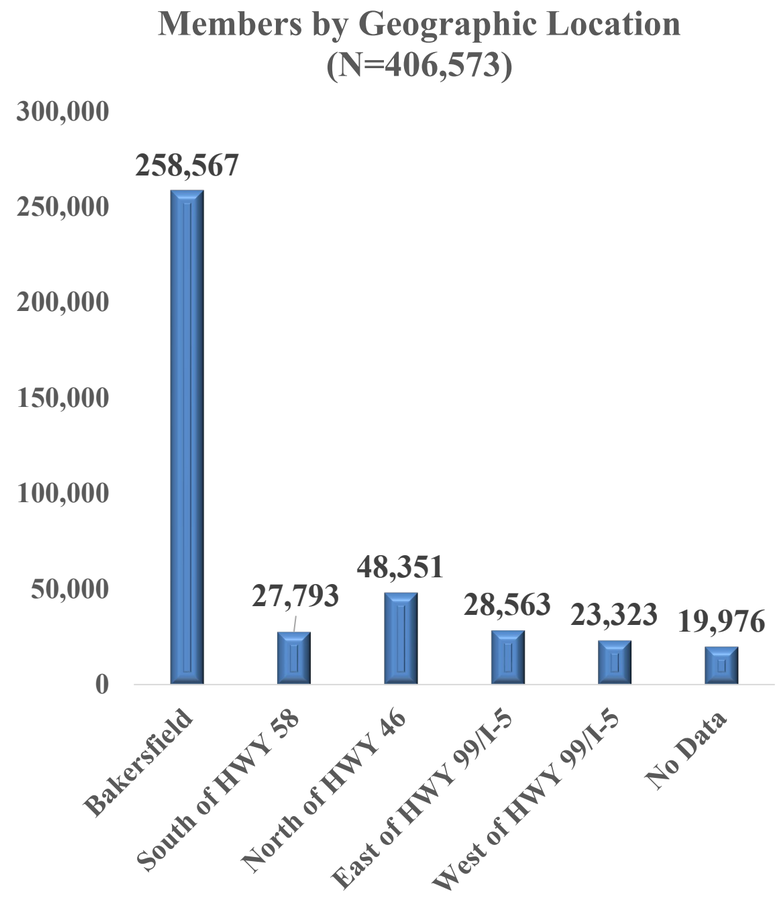
Member Demographic


Members by Age Group (N=406,573)
120,000
100,000
80,000
60,000
40,000
20,000
0
48,582
67,175
58,044
106,264
105,055
21,453
0 to 5
6 to 12
13 to 18
19 to 35
36 to 65
> 65

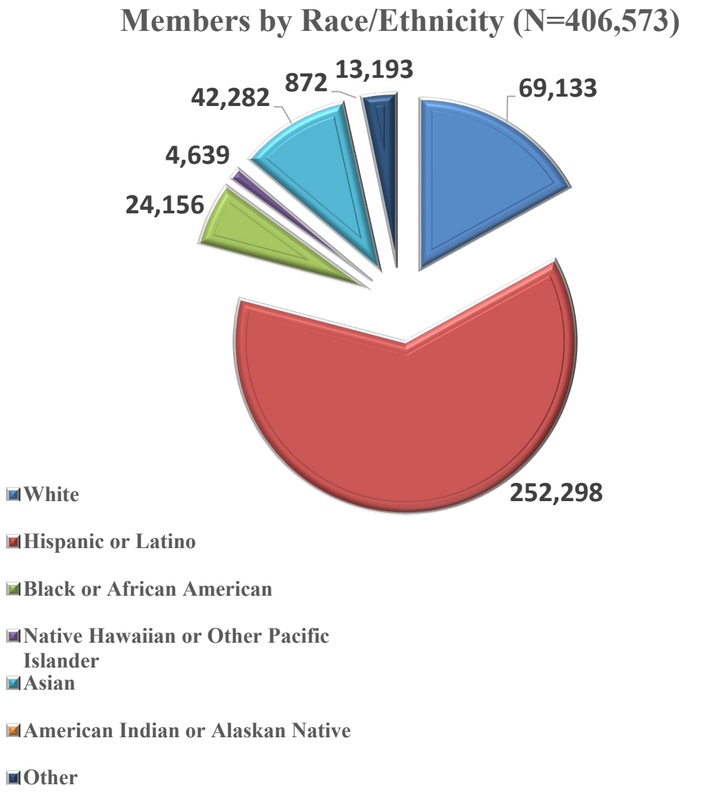

% of Total Membership (N=406,573)
5.3%
11.9%
25.8%
16.5%
14.3%
26.1%
0 to 5
6 to 12
13 to 18
19 to 35
36 to 65
> 65

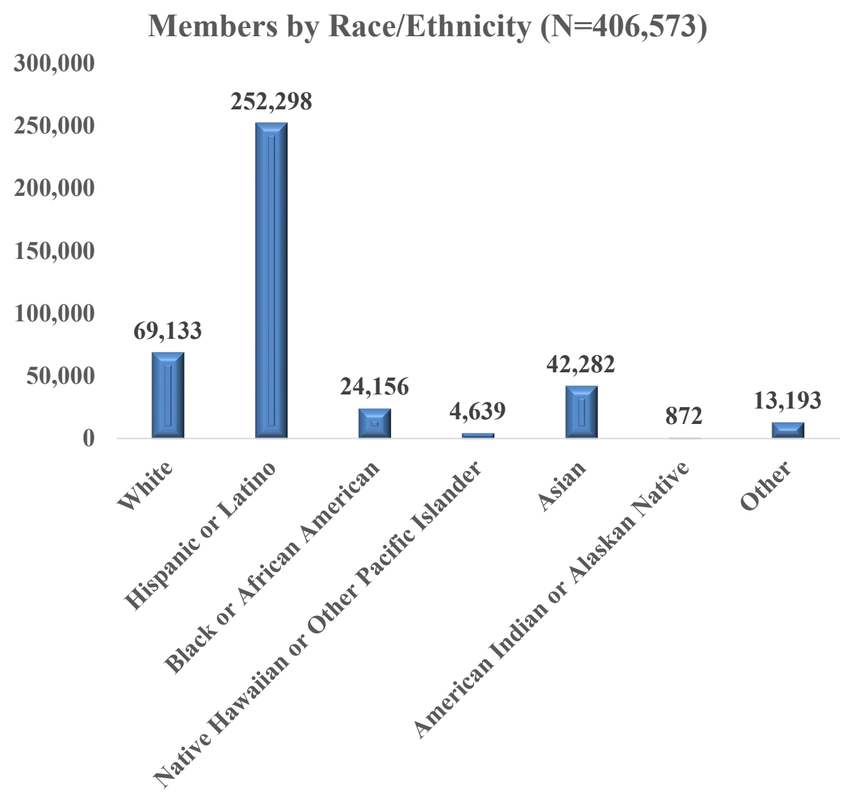
Geographic Location





Members by Race-Ethnicity





Behavioral Health Department

Highlights

- KHS launched the Behavioral Health Department on January 1, 2023
- KHS has been responsible for the provision of Non-Specialty Mental Health Services (NSMHS) since January 1, 2014.
- KHS has contracts with 40 Non-Specialty Mental Health Providers
- Number of referrals and providers linked
- In January 2024, our department went live in our electronic management system creating episodes of care, tracking members who are being linked to NMSHS, SMHS and SUD services.

BH Member Specific Populations

- Non-Specialty Mental Health Services (NSMHS)
- Specialty Mental Health Services (SMHS)
- Substance Use Disorder (SUD)

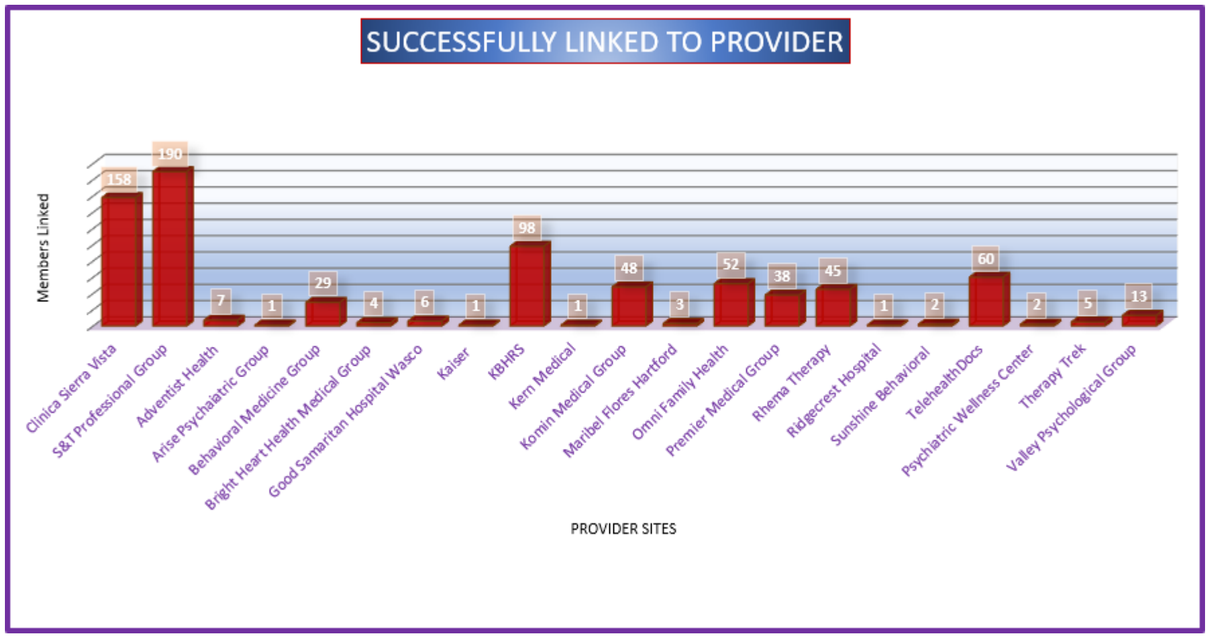
BH Member Stratification

Demographics									
Total Population	Specialty Mental Health	High Risk	Medium Risk	Low Risk	Member Participation				
					Avg Years KHS Enrollment	Avg Member Months	SOC Compliance Rate	% Members Disenrolled	% Members Deceased
41,524	7,573	22,555	6,668	4,728	6.17	11.52	0.00%	0.92%	0.01%

Member Referrals

Referrals to BH since launching department: 1187

Successfully Linked	Count of Successfully Linked
Clinica Sierra Vista	158
S&T Professional Group	190
Adventist Health	7
Arise Psychaiatric Group	1
Behavioral Medicine Group	29
Bright Heart Health Medical Group	4
Good Samaritan Hospital Wasco	6
Kaiser	1
KBHRS	98
Kern Medical	1
Komin Medical Group	48
Maribel Flores Hartford	3
Omni Family Health	52
Premier Medical Group	38
Rhema Therapy	45
Ridgecrest Hospital	1
Sunshine Behavioral	2
TelehealthDocs	60
Psychiatric Wellness Center	2
Therapy Trek	5
Valley Psychological Group	13
Grand Total	764



Care Coordination Overview

- Complete BH DHCS Screening for Referral of members to correct MH system of care for assessment and assignment to level of care
- Submit DHCS Screening to appropriate referral party for linkage of services
- Referrals to BH during all phases of care to refer and link members to BH providers
- Follow up and validate linkage and ongoing monitoring
- Liaison with MHP for SMHS referral, linkage and coordination
- Collaboration and participation in Interdisciplinary Care Team (ICT) meetings for members with BH concerns

Care Management Overview

- Review potential high risk BH members for interim support, emergency/safety needs
- Provide direct coordination, advocacy and assistance with navigating systems of care, reconnecting with providers, or making connections to providers
- Educate and Support Members empowerment for engagement with in their BH care
- Educate members on system of care, BH diagnosis state, available services, expectations, and support for concerns
- Reorientation or recommending additional use resources, services for BH members during all phases of care
- Coordinate behavioral health care for members after linkage to provider
- Managing high risk BH populations and TOC members; Target populations: Pregnant members, Eating Disorder, Concurrent, TOC, and SMI
- Providing support to KHS BH Providers with TOC, member specific concerns, referrals, or system navigation

THANK YOU

Questions?

KERN HEALTH SYSTEMS

Kern Family Health Care®

SURVEY INSTRUCTIONS

- Answer each question by marking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

  ☒ Yes ➔ ***If Yes, Go to Question 1***
  ☐ No

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-866-975-6709.

PERSONAL OR FAMILY COUNSELING

People can get counseling, treatment or medicine for many different reasons, such as:

- *For feeling depressed, anxious, or "stressed out"*
- *Personal problems (like when a loved one dies or when there are problems at work)*
- *Family problems (like marriage problems or when parents and children have trouble getting along)*
- *Needing help with drug or alcohol use*
- *For mental or emotional illness*

YOUR COUNSELING AND TREATMENT IN THE LAST 12 MONTHS

*The next questions ask about **your** counseling or treatment. **Do not** include counseling or treatment you got during an overnight stay or from a self-help group.*

1. In the last 12 months, did you call someone to get professional counseling for yourself?

☐ Yes ➔ ***If Yes, Go to Question 2***
☐ No ➔ ***If No, Go to Question 3***

2. In the last 12 months, how often did you get the professional counseling you needed?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

3. In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

4. In the last 12 months, not counting the times you needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

5. In the last 12 months, how many times, if any, did you go to an emergency room or crisis center to get counseling or treatment for yourself?

- ☐ None
- ☐ 1
- ☐ 2
- ☐ 3 or more

6. In the last 12 months, how often were you seen within 15 minutes of your appointment?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

The next questions are about all the counseling or treatment you got in the last 12 months during office, clinic, and emergency room visits as well as over the phone. Please do the best you can to include all the different people you went to for counseling or treatment in your answers.

7. In the last 12 months, how often did the people you went to for counseling or treatment listen carefully to you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

8. In the last 12 months, how often did the people you went to for counseling or treatment explain things in a way you could understand?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

9. In the last 12 months, how often did the people you went to for counseling or treatment show respect for what you had to say?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

10. In the last 12 months, how often did the people you went to for counseling or treatment spend enough time with you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

11. In the last 12 months, did you take any prescription medicines as part of your treatment?

- ☐ Yes ➔ ***If Yes, Go to Question 12***
- ☐ No ➔ ***If No, Go to Question 13***

12. In the last 12 months, were you told what side effects of those medicines to watch for?

- ☐ Yes
- ☐ No

13. In the last 12 months, how often were you involved as much as you wanted in your counseling or treatment?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

14. In the last 12 months, were you given information about your rights as a patient?

- ☐ Yes
- ☐ No

15. In the last 12 months, did you feel you could refuse a specific type of medicine or treatment?

- ☐ Yes
- ☐ No

16. Using any number from 0 to 10, where 0 is the worst counseling or treatment possible and 10 is the best counseling or treatment possible, what number would you use to rate all your counseling or treatment in the last 12 months?

Worst counseling or treatment possible — Best counseling or treatment possible

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

The next questions ask about your experience with the company or organization that handles your benefits for counseling or treatment.

17. In the last 12 months, did you call customer service to get information or help about counseling or treatment?

- ☐ Yes ➔ ***If Yes, Go to Question 18***
- ☐ No ➔ ***If No, Go to Question 19***

18. In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called customer service?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem

REASONS FOR COUNSELING OR TREATMENT

19. In the last 12 months, was any of your counseling or treatment for help with alcohol use or drug use?

- ☐ Yes
- ☐ No

ABOUT YOU

20. In general, how would you rate your overall mental health now?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

21. And, in general, how would you rate your overall physical health now?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

We'd like to end this survey by asking a few general background questions. This will help us understand the results and allow us to describe the characteristics of everyone who fills out the survey. All of your answers are completely confidential.

22. What is your age now?

- ☐ 18–24
- ☐ 25–34
- ☐ 35–44
- ☐ 45–54
- ☐ 55–64
- ☐ 65–74
- ☐ 75 or older

23. Are you male or female?

- ☐ Male
- ☐ Female

24. What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

25. Are you of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

26. What is your race? (*Please mark one or more*)

- ☐ White
- ☐ Black or African-American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Other

27. Did someone help you complete this survey?

- ☐ Yes ➔ ***If Yes, Go to Question 28***
- ☐ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

28. How did that person help you? (*Mark all that apply*)

- ☐ Read the questions to me
- ☐ Wrote down the answers I gave
- ☐ Answered the questions for me
- ☐ Translated the questions into my language
- ☐ Helped in some other way

Thank you for participating in our survey!
Please mail the survey back in the enclosed postage-paid, self-addressed reply envelope or send to:
Press Ganey • P.O. Box 7313
South Bend, IN 46699-0457

If you have any questions, please call 1-866-975-6709.

Kern Family Health Care®

SURVEY INSTRUCTIONS

- Answer each question by marking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☒ Yes ➔ ***If Yes, Go to Question 1***
☐ No

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have tosend you reminders.

If you want to know more about this study, please call 1-866-975-6709.

PERSONAL OR FAMILY COUNSELING

Children can get counseling, treatment or medicine for many different reasons, such as:

For problems related to attention deficit hyperactivity disorder (ADHD) or other behavior problems

- *Family problems (like when parents and children have trouble getting along)*
- *For mental or emotional illness*
- *For autism or other developmental conditions*
- *Needing help with drug or alcohol use*

YOUR CHILD'S COUNSELING AND TREATMENT IN THE LAST 12 MONTHS

The next questions ask about your child's counseling or treatment. Do not include counseling or treatment during an overnight stay or from a self-help group.

1. In the last 12 months, how often did you get the professional counseling your child needed on the phone?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

2. In the last 12 months, when your child needed counseling or treatment right away, how often did he or she see someone as soon as you wanted?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

3. In the last 12 months, not counting times your child needed counseling or treatment right away, how often did your child get an appointment for counseling or treatment as soon as you wanted?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

4. In the last 12 months, how many times did your child go to an emergency room or crisis center to get counseling or treatment?

☐ None
☐ 1
☐ 2
☐ 3 or more

5. In the last 12 months, how often was your child seen within 15 minutes of his or her appointment?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

The next questions are about all the counseling or treatment your child got in the last 12 months in your home, during office, clinic, and emergency room visits as well as over the phone. Please do the best you can to include all the different people your child saw for counseling or treatment in your answers.

6. In the last 12 months, how often did the people your child saw for counseling or treatment listen carefully to you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

7. In the last 12 months, how often did the people your child saw for counseling or treatment explain things in a way you could understand?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

8. In the last 12 months, how often did the people your child saw for counseling or treatment show respect for what you had to say?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

9. In the last 12 months, how often did the people your child saw for counseling or treatment spend enough time with you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

10. In the last 12 months, did your child take any prescription medicines as part of his or her treatment?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 12***

11. In the last 12 months, were you told what side effects of those medicines to watch for?

- ☐ Yes
- ☐ No

12. In the last 12 months, how often were you involved as much as you wanted in your child's counseling or treatment?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

13. In the last 12 months, how often did your family get the professional help you wanted for your child?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

14. Does your child's language, race, religion, ethnic background or culture make any difference in the kind of counseling or treatment he or she needs?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 16***

15. In the last 12 months, was the care your child received responsive to those needs?

- ☐ Yes
- ☐ No

16. Using <u>any number from 0 to 10</u>, where 0 is the worst counseling or treatment possible and 10 is the best counseling or treatment possible, what number would you use to rate all your child's <u>counseling or treatment</u> in the last 12 months?

- ☐ 0 Worst counseling or treatment possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best counseling or treatment possible

17. In general, how would you rate your child's <u>overall mental health now</u>?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

YOUR CHILD'S HEALTH PLAN FOR COUNSELING OR TREATMENT

*The next questions ask about your experience with your child's health plan for **counseling or treatment**.*

18. In the last 12 months, did you call the health plan's <u>customer service</u> to get information or help about counseling or treatment for your child?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 20***

19. In the last 12 months, how much of a problem, if any, was it to <u>get the help you needed for your child</u> when you called the health plan's customer service?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem

REASONS FOR COUNSELING OR TREATMENT

20. In the last 12 months, was any of your child's counseling or treatment for <u>problems related to ADHD or other behavior problems</u>?

- ☐ Yes
- ☐ No

21. In the last 12 months, was any of your child's counseling or treatment for <u>family problems or mental or emotional illness</u>?

- ☐ Yes
- ☐ No

22. In the last 12 months, was any of your child's counseling or treatment for <u>autism or other developmental problems</u>?

- ☐ Yes
- ☐ No

23. In the last 12 months, was any of your child's counseling or treatment for help with <u>alcohol use</u> or <u>drug use</u>?

- ☐ Yes
- ☐ No

ABOUT YOU AND YOUR CHILD

24. What is <u>your child's</u> age now?

- ☐ Less than 1 year old

☐☐ YEARS OLD (*write in*)

25. Is your child male or female?

- ☐ Male
- ☐ Female

26. Is your child of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

27. What is your child's race? (*Please mark one or more*)

- ☐ White
- ☐ Black or African-American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Other

28. What is your age now?

- ☐ 18–24
- ☐ 25–34
- ☐ 35–44
- ☐ 45–54
- ☐ 55–64
- ☐ 65–74
- ☐ 75 or older

29. Are you male or female?

- ☐ Male
- ☐ Female

30. What is the highest grade or level of school that you have <u>completed</u>?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

31. How are you related to the child?

- ☐ Mother or father
- ☐ Grandparent
- ☐ Aunt or uncle
- ☐ Older sibling
- ☐ Other relative
- ☐ Legal guardian

32. Did someone help you complete this survey?

- ☐ Yes ➔ ***If Yes, Go to Question 33***
- ☐ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

33. How did that person help you? (*Mark all that apply*)

- ☐ Read the questions to me
- ☐ Wrote down the answers I gave
- ☐ Answered the questions for me
- ☐ Translated the questions into my language
- ☐ Helped in some other way (*Please print*)

_____

_____

_____

_____

Thank you for participating in our survey! Please mail the survey back in the enclosed postage-paid, self-addressed reply envelope or send to:
Press Ganey • P.O. Box 7313
South Bend, IN 46699-0457

If you have any questions, please call 1-866-975-6709.

KERN HEALTH SYSTEMS

To: KHS EQIHEC

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

Date: August 2024

Re: Quality Performance Q2 2024 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 second quarter of 2024.

Discussion

See pages 2-4 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 quality, 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
2nd Quarter 2024

I. Facility Site Reviews (FSR) and Medical Record Review (MRR) (pages 2-11)

4 Initial Facility Site Reviews and 3 Initial Medical Record Reviews were completed in Q2 2024. 5 Periodic FSRs and 5 periodic MRRs were also completed. 100% of Facility Site Reviews passed and 85% YTD of Medical Record Reviews passed. 2 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. Of which, 18 were completed in Q2 2024. The QP department also conducts Physical Accessibility Review Surveys (PARS) and 5 were completed in Q2 2024.

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 will be 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 developing the second phase of the PIP, which will focus on interventions and testing. We are developing 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.

We are working with two pilot providers 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.

III. Managed Care Accountability Set (MCAS) Updates (Pages 12-17)

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 June 2024, 16 of 18 measures have improved compared to last year.

The 2023 MCAS audit was completed at the end of June. KHS met MPL for 8 of 18 measures for MY2023 and HPL for 1 of those measures In comparison, 5 of 15 measures met MPL for MY2022.

QUALITY PERFORMANCE DEPARTMENT

QUATERLY EQIHEC COMMIITTEE REPORT

Q2 2024

KERN HEALTH SYSTEMS
Quality Performance Department Quarterly EQIHEC Committee Report
Q2 2024

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

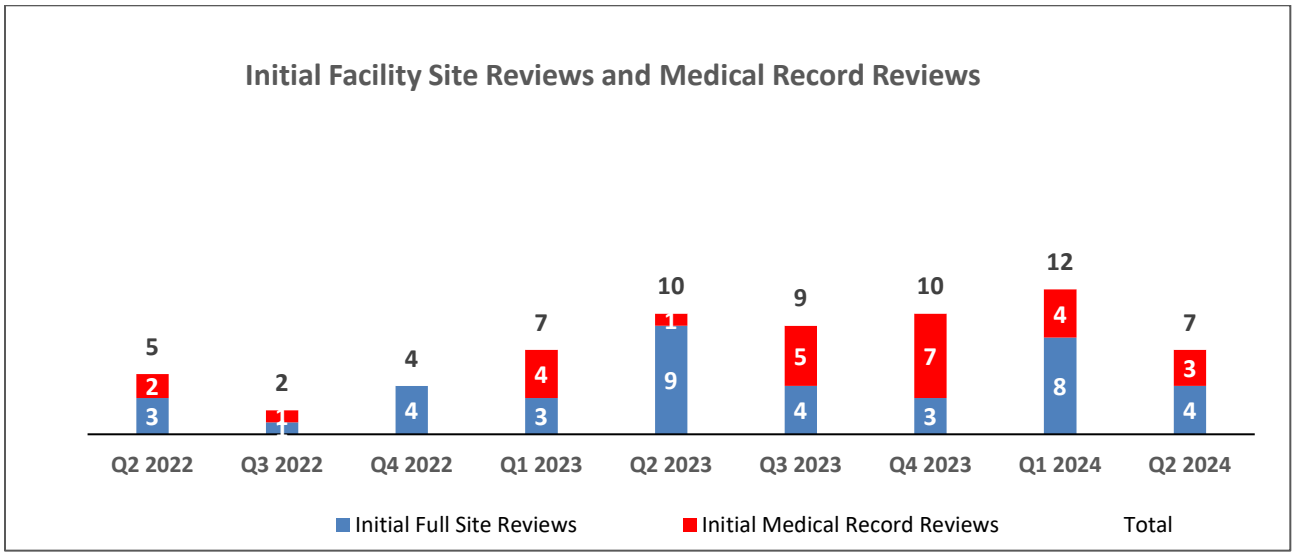
Provider sites that receive an FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are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

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

Corrective Action Plans (CAPs)

A CAP is issued when an initial, periodic, or focus review has deficiencies identified. DHCS requires follow up at 10 days for failure of any critical element, follow up for other failed elements at 45 days, and if not corrected by the 45 day follow up, at 90 days after a CAP has been issued. Most CAPs issued are corrected and completed within the 45 Day follow up period. Providers are encouraged to speak with us if they have questions or encounter issues with CAP completion. QI nurses provide education and support during the CAP resolution process.

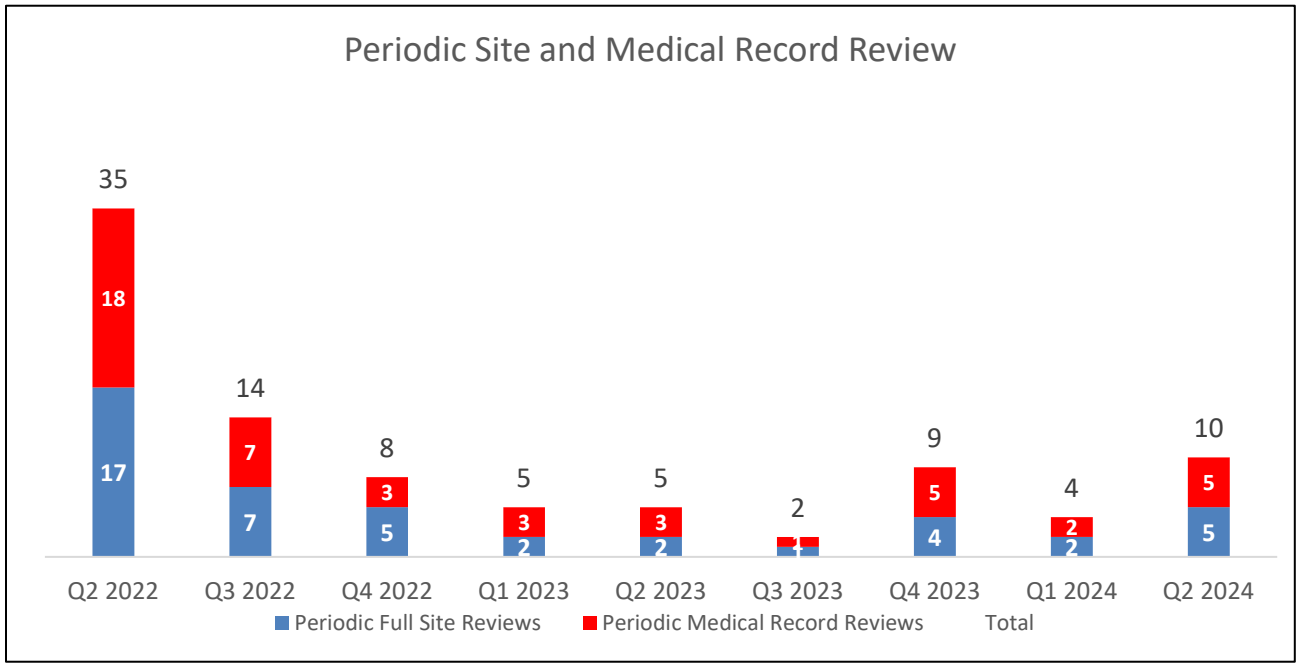
A. Initial Facility Site Review and Medical Record Review Results:



The number of initial site and medical record reviews is determined by the number of new providers requesting to join KHS' provider network. There were 4 IFSRs and 3 IMRRs completed in Q2 of 2024.

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.

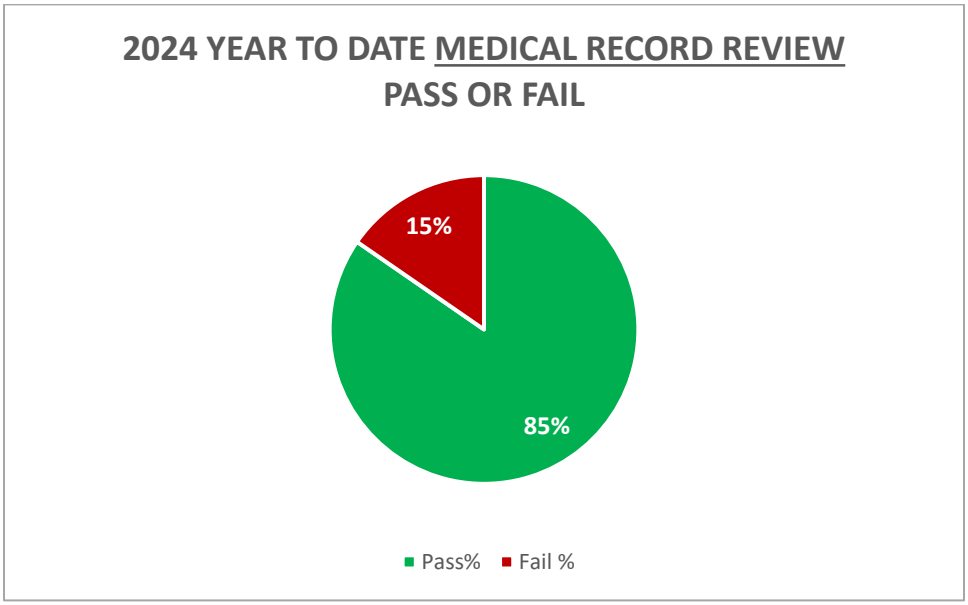


The above chart reflects the number of Periodic Full Site Reviews and Medical Record Reviews that were due and completed for each quarter.

Year to Date (YTD) Initial and Periodic <u>FSR</u> 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 2024 YTD, 100% of the Initial and Periodic site reviews performed passed. YTD there were 19 site reviews completed by the end of June 2024. Due to low volume of site reviews completed YTD, this data is considered statistically not significant.



For 2024 YTD, 85% of the Initial and Periodic medical record reviews performed passed. YTD there were 13 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. Due to low volume of medical record reviews completed YTD, this data is considered statistically not significant. We will continue to monitor this for any trends.

For Q2 2024, top #3 deficiencies identified for Opportunities for improvement in site reviews are:

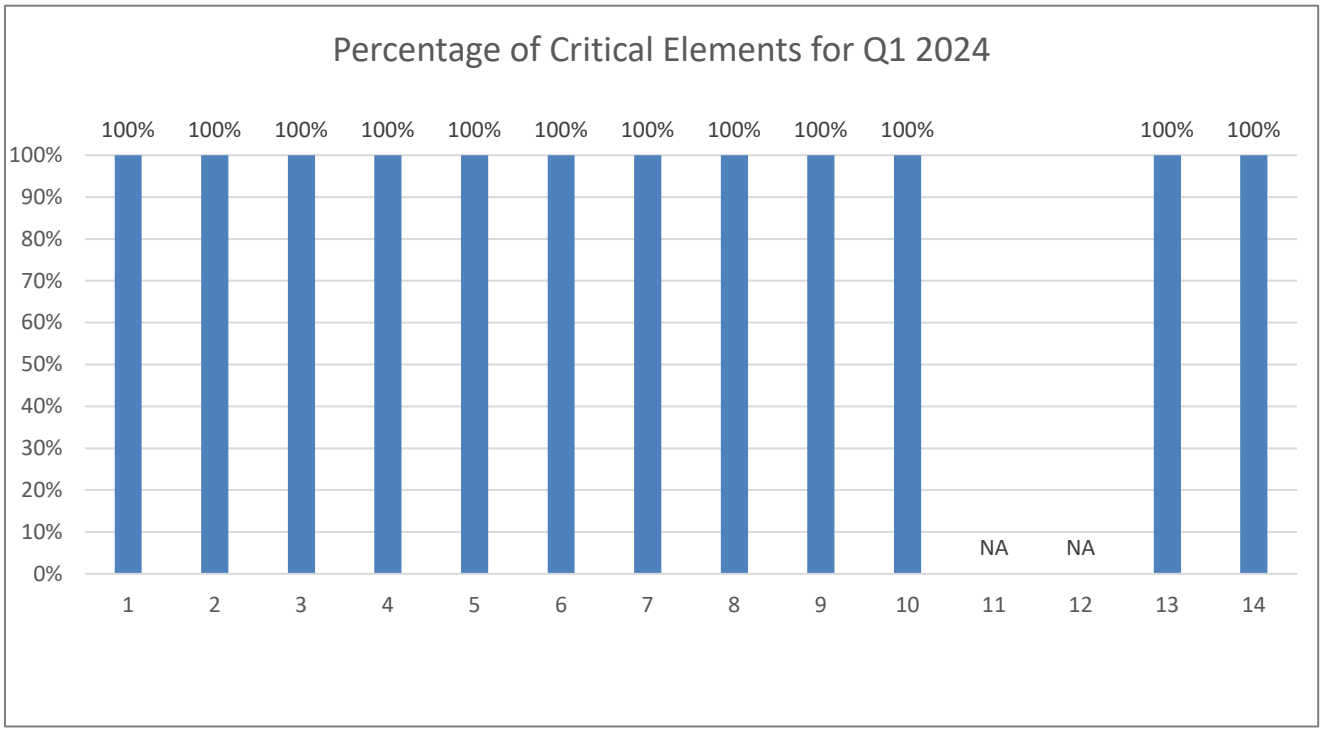
1. Calibration of Equipment not done.
2. Site does not utilize California Immunizations Registry (CAIR).
3. Fire fighting equipment in accessible location-no tags.

For Q1 2024, top #3 deficiencies identified for Opportunities for improvement in Medical Record Reviews are:

1. Yearly HIV Screening not being given to patients, for both Adults and Pediatrics
2. STI Screening and counseling not being assessed for both Adults.
3. Dyslipidemia screening not being assessed for Pediatrics.

There were few common deficiencies 'Site does not utilize California Immunizations Registry (CAIR)', 'HIV Screenings not performed' and 'Calibration of Equipment not done" identified from previous quarter to this quarter. We will continue to monitor for any trends.

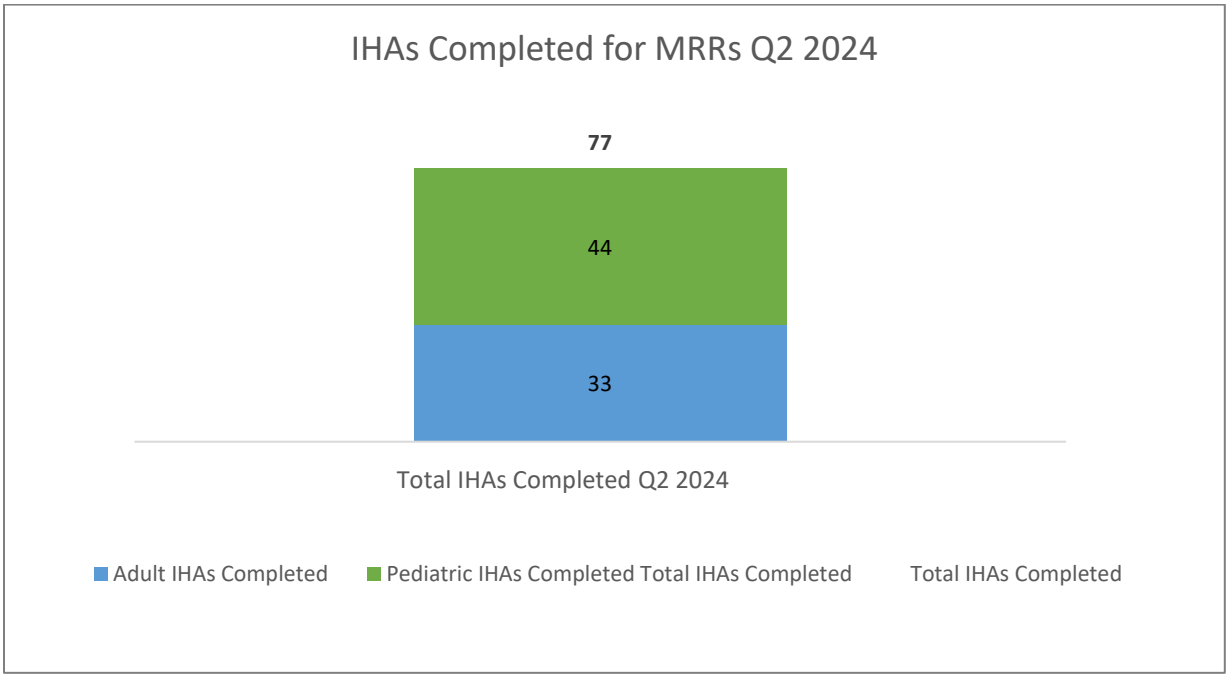
C. Critical Elements (CE) Percentage for Site Reviews:



There were 9 FSRs completed for Q2 2024, and all the sites have passed the critical elements.

The site review team is working closely with sites. CE 11 and 12 were not applicable (NA) for any of the sites completed during the second quarter, hence it does not display any score.

D. IHA's percentage for MRRs:



***Percentage-of IHAs completed = IHEBA+SHA's**

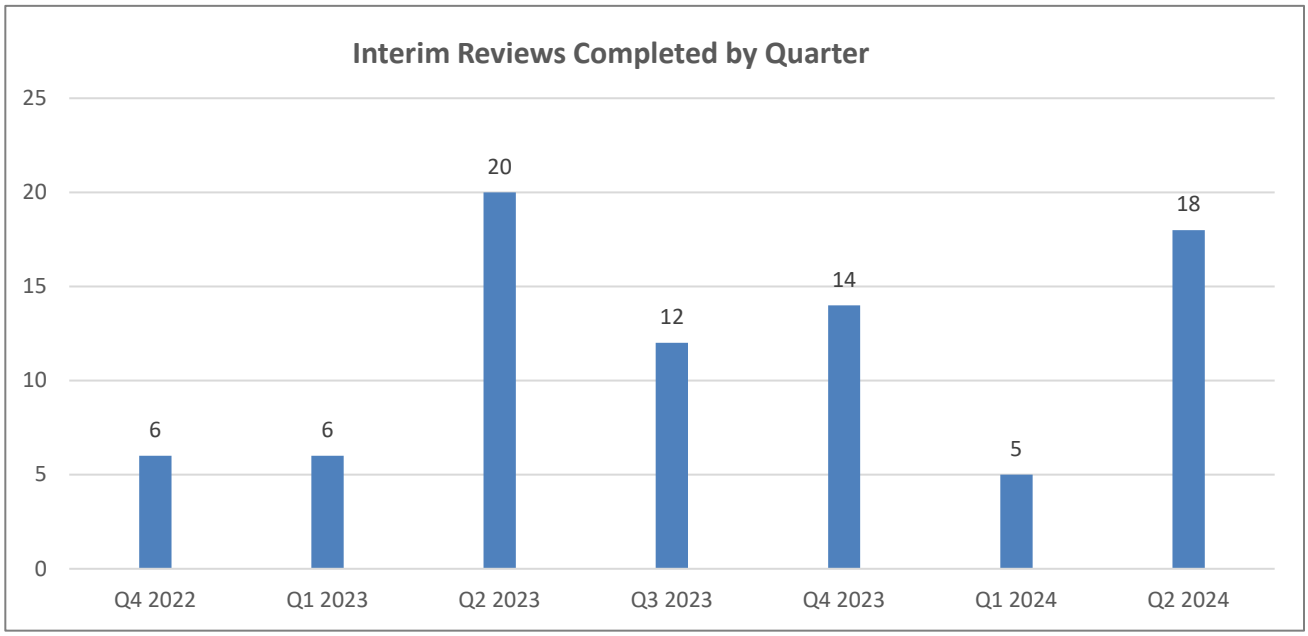
For Q2 2024, based on the medical record reviews, 77 IHA's were completed. 44 total pediatric charts and 33 adult charts. 36 out of the 44 pediatric charts were compliant and 8 were non-compliant. Out of all the 33 Adult charts, 29 adult charts were found to be compliant and 4 were non-compliant. Education 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 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.

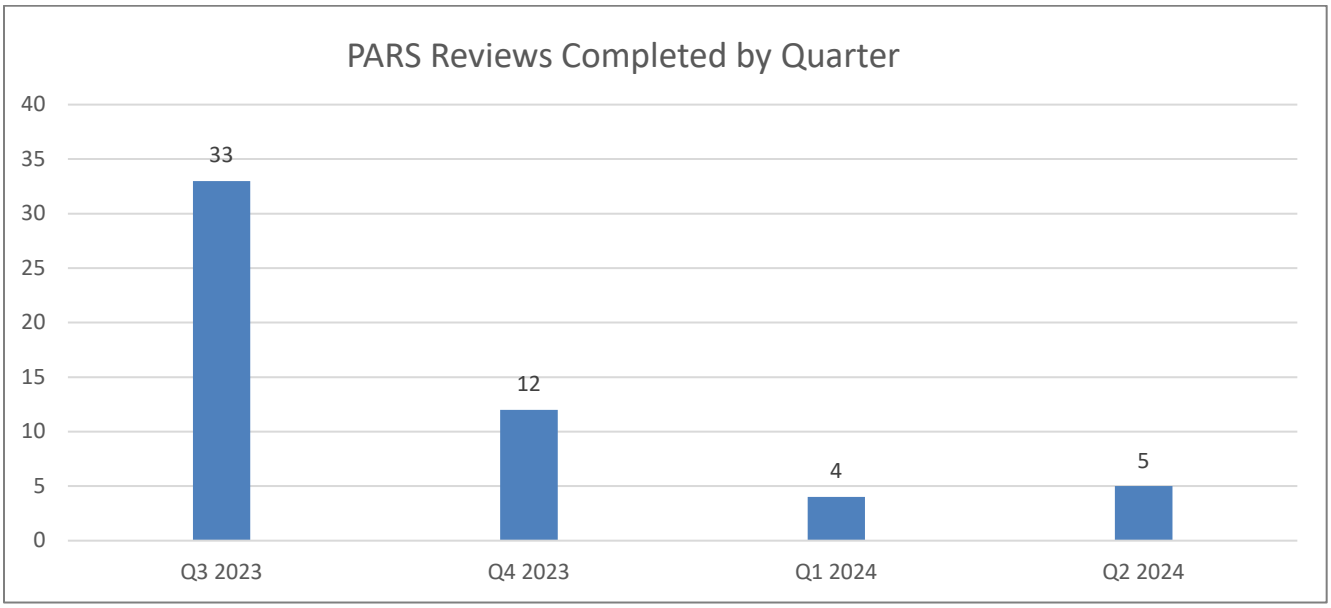


For the Q2 2024, there were 18 Interim reviews completed.

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 Q2 2024, we had 2 Focused MRRs completed.

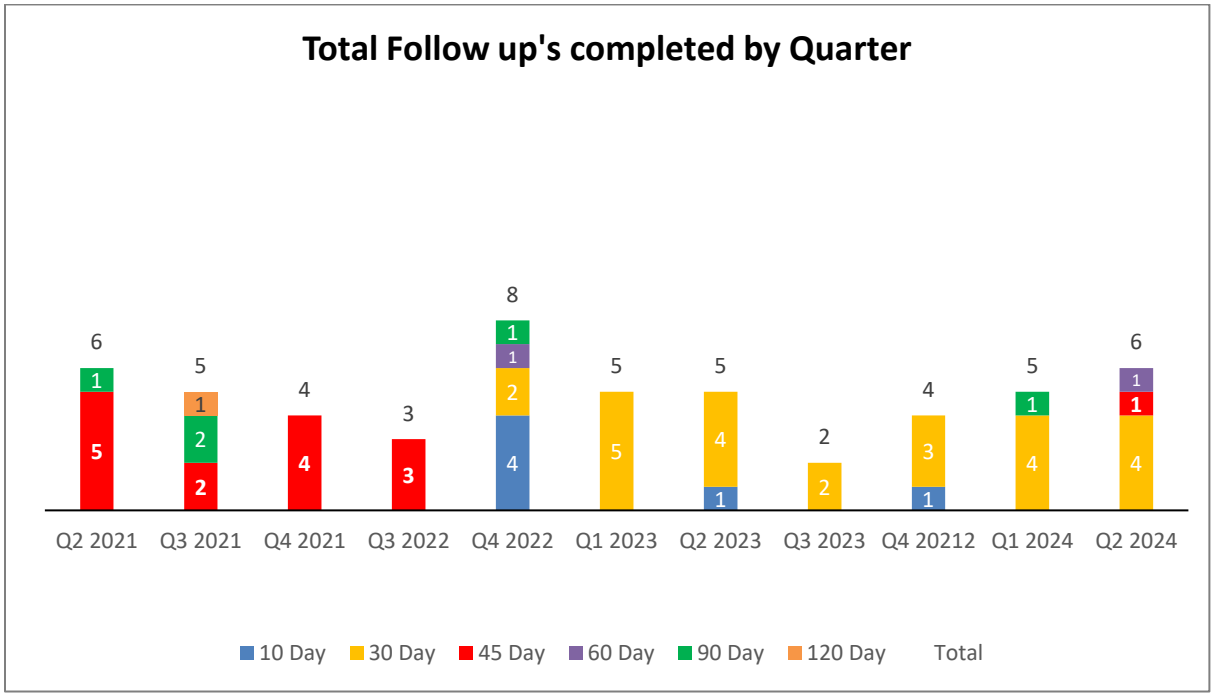
G. Physical Accessibility Review Survey (PARS):

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 Q2 2024, 5 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 Q2 2024, there were 4 30-day, 1 90-Day, and 1 60 Day follow-ups 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 and will run 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 2 Maternal Health Disparities Webinars. Participated in the maternal health disparities webinars and met with PIP team leadership to plan our next steps. We have worked on developing a process map and completed key driver's diagram. Continued efforts on how to track data (member service outreach on W30, text reminders of WBVs, Mobile unit WBV events). Worked on development of Process Map, revised Fishbone Diagram. Researching on obtaining race/ethnicity data and Black women's experiences in health care. Continued aiding in IHI-DHCS Children's Health Collaborative, which has crossover ideas with this PIP. Brainstorming PDSA with Dr. Okezie's office after determining they have the highest ratio of eligible population to membership (after Dr. Dixon's office, which is already a pilot clinic for the IHI-DHCS Collab).

Non-Clinical PIP:

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

We will be partnering with the Behavioral Health Department, UM, PHM, and any other necessary stakeholders. We are working with BI to get an updated ADT report as per the PIP requirement. 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 on strategies for FUA/FUM measures. PIP team is working with BI Department to develop process to track notifications to the provider.

Currently working on developing on Key driver's diagram and interventions. We will continue PIP efforts to ensure timely submission in 2024 to outline our interventions and testing plans.

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 Touchpoints: The QP team has initiated monthly and quarterly meetings with assigned providers. Met with various scheduled and ad hoc provider groups to discuss rates and questions.

- Dr. Duggal is continuing the program to manage Diabetic members. The goal of the program is to improve members'A1C levels with the appropriate interventions. This is an incentive-based reimbursement structure similar to other programs, such as Covid vaccines and the BCS pilot with CBCC. The QP leadership team is in the process of establishing an API to allow appointment scheduling for this population directly with Dr. Duggal's office.

- Kern Medical, CSV, Komoto, and Premier Valley Medical Group (PVMG) are all operational and on track with grant milestones. Various initiatives partnering with school districts and community organizations focused on children's domain of care.

- Member Engagement Reward Program (MERP) Campaigns:
    - Text Messages to members encouraging the scheduling of 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
    - Targeted efforts for CCS, W30, and WCV text messaging for the month of June.
    - 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):

The MY2023/RY2024 MCAS annual audit has been initiated by HSAG. The QP team is currently engaged in actively conducting abstractions and monitoring retrievals from Cotiviti. The virtual audit with HSAG concluded and was successful. We are on track with the upcoming preliminary rate submissions, which is due to HSAG by April 12th. Simultaneously, workgroups and project meetings are underway to streamline the MCAS audit process, aiming to ensure efficiency across all audit components and to identify areas for improvement.

Currently for MY2023:

MY2023/RY2024 MCAS annual audit has been completed. We have Finalized our rates and completed attestation in June 2024. Anticipate receiving the final Audit report from HSAG in mid-July.

For MY2023 MCAS Reporting, we have

- Met MPL for 8 out of 18 measures:
    - AMR, BCS-E, CCS, CHL, CBP, HBD, PPC-Pre and PPC-Post.
    - Met HPL for PPC-Post

- 16 out of 18 measures showed improvement compared to previous year MY2022: CCS, HBD, CBP, IMA-2, PPS-Post, LSC, AMR, BCS-E, CHL, DEV, FUA, FUM, TFL, W30 (0-15), W50(15-30) and WCV.

- 2 out of 18 measures showed slight decrease compared to MY2022.

	Measure	Admin/Hybrid/ECDS	MY2023 Rate	MPL Rate	HPL Rate	MY2023 Rate vs MPL	Hits Needed	MY 2022 Rate	MY 2022 vs MY2023
Behavioral Health Domain Measures									
FUM	Follow-Up After ED Visit for Mental Illness – 30 days*	Administrative	19.12	54.87	73.26	-35.75	226	18.80	▲ 0.32
FUA	Follow-Up After ED Visit for Substance Abuse – 30 days*	Administrative	18.85	36.34	53.44	-17.49	229	15.74	▲ 3.11
Children's Health Domain Measures									
WCV	Child and Adolescent Well – Care Visits*	Administrative	46.55	48.07	61.15	-1.52	1936	40.64	▲ 5.91
CIS-10	Childhood Immunization Status – Combination 10*	Hybrid/Admin**	24.82	30.9	45.26	-6.08	25	27.98	▼ -3.16
DEV	Developmental Screening in the First Three Years of Life	Administrative	25.94	34.70	N/A	-8.76	1163	13.47	▲ 12.47
IMA-2	Immunizations for Adolescents – Combination 2*	Hybrid/Admin**	34.31	34.31	48.8	0.00	0	29.68	▲ 4.63
LSC	Lead Screening in Children	Hybrid/Admin**	58.64	62.79	79.26	-4.15	17	47.45	▲ 11.19
TFL-CH	Topical Fluoride for Children	Administrative	16.44	19.30	N/A	-2.86	3829	12.27	▲ 4.17
W30-6+	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	Administrative	39.21	58.38	68.09	-19.17	570	37.12	▲ 2.09
W30-2+	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits*	Administrative	63.74	66.76	77.78	-3.02	171	55.12	▲ 8.62
Chronic Disease Management Domain Measures									
AMR	Asthma Medication Ratio*	Administrative	71.20	65.61	75.92	5.59	0	69.48	▲ 1.72
CBP	Controlling High Blood Pressure*	Hybrid/Admin**	65.21	61.31	72.22	3.90	0	60.58	▲ 4.63
HBD	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	Hybrid/Admin**	32.85	37.96	29.44	5.11	0	39.17	▲ -6.32
Reproductive Health Domain Measures									
CHL	Chlamydia Screening in Women	Administrative	56.87	56.04	67.39	0.83	0	53.67	▲ 3.20
PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	Hybrid/Admin**	87.10	84.23	91.07	2.87	0	87.35	▼ -0.25
PPC-Pst	Prenatal and Postpartum Care: Postpartum Care*	Hybrid/Admin**	86.37	78.1	84.59	8.27	0	83.94	▲ 2.43
Cancer Prevention Domain Measures									
BCS-E	Breast Cancer Screening*	ECDS & Admin***	59.30	52.60	62.67	6.70	0	56.68	▲ 2.62
CCS	Cervical Cancer Screening	Hybrid/Admin**	57.18	57.11	66.48	0.07	0	52.80	▲ 4.38

* Measures must be stratified by race/ethnicity per NCQA categorizations.
** Hybrid/Admin: MCPs/PSPs have the option to choose the methodology for reporting applicable measure rates

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

The below chart displays trending rates for MY2023 and MY2024:

MCAS MY2023 & MY2024 Performance Trending Metrics

Measure	Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	2023	65.58%	73.73%	70.48%	71.81%	69.12% ▼	67.27%	67.08%	66.59%	68.51%	68.21%	68.51%	67.71%
	2024	70.00%	77.54%	75.46%	74.40%	75.00% ▲	75.96%						
BCS	2023	41.95%	43.55%	44.97%	46.30%	47.22% ▼	49.59%	51.15%	52.41%	54.02%	55.63%	56.92%	57.78%
	2024	44.23%	45.63%	47.44%	48.73%	50.08% ▲	51.42%						
CBP	2023	7.85%	17.19%	24.42%	28.47%	32.36% ▼	35.72%	38.24%	40.51%	42.21%	42.90%	43.54%	43.77%
	2024	9.26%	18.53%	25.05%	29.78%	33.20% ▲	39.86%						
CCS	2023	43.40%	44.19%	45.37%	46.35%	47.38% ▲	48.37%	49.43%	50.22%	51.24%	52.46%	53.39%	54.16%
	2024	37.99%	36.76%	38.23%	39.55%	40.91% ▼	42.09%						
CDEV	2023	3.89%	6.53%	8.95%	10.68%	12.49% ▼	14.20%	15.45%	16.27%	17.05%	18.00%	18.65%	19.06%
	2024	6.26%	9.14%	11.74%	13.71%	15.54% ▲	17.08%						
CHL	2023	21.50%	29.69%	35.35%	39.38%	42.65% ▼	45.26%	47.69%	50.29%	51.61%	53.68%	54.85%	56.29%
	2024	22.15%	33.05%	35.23%	37.90%	39.96% ▲	45.63%						
CIS-10	2023	11.04%	12.93%	14.34%	16.13%	16.92% ▲	17.47%	17.74%	17.89%	18.07%	18.65%	19.40%	19.76%
	2024	10.01%	11.62%	12.17%	12.53%	12.42% ▼	13.04%						
FUA 30Day follow up	2023	6.41%	10.36%	0.00%	10.71%	10.05% ▼	11.58%	11.33%	10.81%	12.45%	12.39%	12.06%	12.85%
	2024	20.00%	16.11%	20.59%	19.96%	18.78% ▲	21.75%						
FUM 30Day follow up	2023	20.51%	11.50%	0.00%	13.15%	13.97% ▼	15.37%	16.23%	15.44%	16.89%	17.55%	17.29%	17.13%
	2024	9.09%	25.00%	21.88%	17.86%	15.56% ▲	18.68%						
GSD*	2023	98.02%	94.51%	86.56%	76.35%	74.48% ▲	69.80%	65.31%	63.51%	60.59%	58.10%	56.43%	55.09%
	2024	98.80%	93.82%	87.06%	79.96%	75.10% ▼	71.29%						
IMA-2	2023	18.94%	20.59%	21.93%	23.64%	24.51% ▼	26.37%	27.52%	28.74%	29.60%	30.05%	30.54%	31.06%
	2024	20.41%	21.78%	23.08%	24.49%	25.82% ▲	27.71%						
LSC	2023	42.64%	46.09%	48.51%	50.07%	52.51% ▼	53.47%	54.06%	54.96%	55.11%	55.53%	55.70%	55.87%
	2024	54.60%	57.84%	60.05%	62.04%	63.05% ▲	64.95%						
PPC-Pre	2023	21.77%	23.83%	26.43%	28.58%	30.12% ▼	34.28%	37.92%	40.41%	41.91%	42.15%	42.16%	42.42%
	2024	25.10%	26.84%	28.68%	30.70%	33.22% ▲	37.55%						
PPC-Post	2023	45.41%	52.00%	56.72%	59.55%	58.08% ▼	59.88%	59.89%	63.24%	64.56%	68.75%	72.58%	73.16%
	2024	47.47%	52.40%	57.47%	59.72%	61.74% ▲	63.16%						
TFL-CH	2023	5.68%	8.54%	8.58%	11.21%	17.49% ▼	17.55%	23.50%	25.69%	25.90%	30.20%	32.40%	34.84%
	2024	14.64%	17.16%	20.65%	23.68%	26.00% ▲	29.18%						
W30 (0-15M)	2023	12.79%	15.81%	19.48%	22.46%	27.87% ▲	36.89%	39.59%	39.21%	41.55%	43.27%	44.00%	44.34%
	2024	25.77%	30.66%	35.79%	39.69%	43.12% ▼	14.72%						
W30 (15-30M)	2023	42.49%	46.54%	50.24%	53.15%	55.58% ▼	57.89%	59.44%	60.40%	61.68%	62.20%	62.58%	62.68%
	2024	52.29%	55.22%	57.87%	60.08%	62.54% ▲	62.11%						
WCV	2023	1.98%	5.24%	9.16%	12.62%	16.22% ▼	22.30%	26.44%	31.54%	35.92%	39.56%	42.78%	45.66%
	2024	2.80%	6.13%	10.59%	15.01%	19.77% ▲	24.31%						

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 June 2024, **14 out of 18 measures showed improvement** compared to this month last year:

- AMR - Asthma Medication Ratio
- BCS- Breast Cancer Screening
- CBP- Controlling High Blood Pressure <140/90 mm Hg.
- CDEV- Developmental Screening in the First 3 Years of Life
- CHL- Chlamydia Screening in Women Ages 16 – 24
- GSD- Glycemic Status Assessment for Patients with Diabetes
- FUA- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence 30-Day Follow up.
- IMA-2- Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)
- LSC- Lead Screening in Children
- TFL-CH- Topical Fluoride for Children
- PPC-Post- Prenatal & Postpartum Care – Postpartum Care
- 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.
- WCV- Child and Adolescent Well-Care Visits

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

- CIS-10- Childhood Immunization Status- Combo 10
- CCS - Cervical Cancer Screening
- GSD- Glycemic Status Assessment for Patients with Diabetes
- 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.

Please note we identified a significant decrease in W30 (0-15 months) rate for June 2024, BI is looking at the issue.

IV. Policy Updates: Policy 20.50-I was updated to align with new DHCS APL 24-004 requirements.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Medi-Cal Managed Care Quality, Performance Improvement, and Health Equity Program Requirements				POLICY #: 20.50-I	
DEPARTMENT: Quality Performance					
Effective Date: 01/2005	Review/Revised Date: 05/17/2024	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Compliance and Fraud Prevention Officer

_____ Date _____
Senior Director of Contracting & Quality Performance

_____ Date _____
Medical Director, Utilization Management

_____ Date _____
Medical Director, Quality Improvement

_____ Date _____
Director of Quality Improvement

_____ Date _____
Director of Quality Performance

POLICY[1]:

This policy is developed in response to All Plan Letter 24-004which delineates the requirements for Quality, Performance Improvement, and Health Equity Program requirements of Medi-Cal managed care health plans (MCPs).

Title 28 of the California Code of Regulations (CCR) section 1300.70, 1 Title 42 of the Code of Federal Regulations (CFR) section 438.330, 2 and KHS' contract with the Department of Health Care Services (DHCS) require that we establish and implement an ongoing Quality Improvement System through which MCPs monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered to our members.

On an annual basis, KHS reports on a set of required quality performance measures selected by DHCS for the evaluation of health plan performance. This set of performance measures is known as the Managed Care Accountability Set (MCAS). The MCAS measures are comprised of select Centers for Medicare and Medicaid Services' (CMS) Adult and Child Health Care Quality Measures for Medicaid (Adult and Child Core Sets). Many of these measures are also part of National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data Information Set (HEDIS®).

DHCS determines which Core Set measures MCPs must exceed the Minimum Performance Level (MPL). The MPL for each required MCAS measure that is also an NCQA measure is the national Medicaid 50th percentile, as reported in NCQA's Quality Compass. When national Medicaid results are not available for a required MCAS measure, DHCS may establish alternative benchmarks. When a MCAS measure is below the MPL, KHS utilizes the Plan Do Study Act (PDSA) tool to test change through rapid-cycle improvement. DHCS determines the number of required PDSAs based on the MCP's overall performance in that Measurement Year (MY). When KHS fail to meet MPLs are subject to sanctions by DHCS and may also be subject to Corrective Action Plans (CAPs) issued by DHCS.

KHS reports MCAS annual performance measures results to DHCS and will produce a Plan-Do-Study-Act (PDSA) Cycle Worksheet for poor performance as applicable. KHS shall use the most current version of DHCS' PDSA worksheet and guidelines. The plan will conduct ongoing performance improvement project (PIPs) and participates in the administration of consumer satisfaction surveys every three years.

PURPOSE:

The purpose of this policy is to ensure alignment for internal quality and health equity efforts with DHCS' Comprehensive Quality Strategy (CQS) Report, monitor, and report quality performance measures as detailed through MCAS measures, and also review and act of items identified through various DHCS reports.

PROCEDURES:

1.0 MCAS Performance Measures (MCAS)

1.1 General Requirements

KHS's primary contact for performance measurement is the Director of Quality Performance (QP), or designee. This contact also serves as the lead for Performance Improvement activities. . Secondary or back-up contact is the MCAS Program Manager, or designee.

The Quality Performance (QP)t Department, including the primary and secondary contacts participates in all technical assistance conference calls. Other appropriate subject matter experts from other KHS departments are invited to participate in these calls based on subject matter, including but not limited to the Health Equity Office (HEO). KHS is required to implement and annually report a QIHETP plan that address clinical quality of physical, behavioral health, access and engagement of providers continuity and coordination across settings and all levels of care, and member experience.

KHS must develop or leverage a dedicated Regional Quality and Health Equity Team which supports quality improvement and health equity work for all county(ies) the MCP is responsible.

Annually, Kern Health Systems (KHS) collects and reports rates for MCAS measures as defined by DHCS. Currently, the Healthcare Effectiveness Data and Information Set (HEDIS) and CMS Adult and Child Core Set of Health Care Quality Measures are used as a standardized method to objectively evaluate delivery of services. KHS also reports rates for any statewide collaborative measure chosen by DHCS when applicable. DHCS disseminates the list of MCAS measures for each measurement year. KHS shall use the most current list of measures provided by DHCS annually.

KHS participates in an annual performance measure validation audit with the designated EQRO. The audit consists of an assessment of KHS's information system capabilities, followed by an evaluation of KHS's ability to comply with HEDIS and non-HEDIS specifications. The EQRO follows NCQA HEDIS Compliance Audit methodology to assure standardization reporting.

KHS uses the Department of Healthcare Services (DHCS)-selected contractor for conducting the performance measure validations. The Compliance Audits are performed by an External Quality Review Organization (EQRO) at DHCS's expense. Health Services Advisory Group (HSAG) was selected in 2020 as the EQRO for the Medi-Cal Managed Care (MCMC) program. The EQRO may conduct the future audits or may subcontract with one or more firms licensed by the National Committee of Quality Assurance (NCQA) to conduct some of the MCAS audits.

2.0 MCAS REPORTING REQUIREMENTS

2.1 Calculating and Reporting Rates

KHS will calculate its rates for the required performance measures and these rates will be audited by the EQRO or its subcontractor and reported to DHCS. KHS will report the results for each of the performance measures required while adhering to HEDIS®

or other specifications for the reporting year to the EQRO. KHS will follow NCQA's timeline for collecting, calculating, and reporting rates.

2.2 Reporting Units

KHS calculates and reports performance measure rates at the county level.

2.3 Public Reporting of Performance Measurement Results

DHCS will publicly report the audited results of HEDIS® and other performance measure rates for each MCP, along with the Medi-Cal managed care average and comparisons to national data, as applicable, for each DHCS-required performance measure.

2.4 Stratification

KHS will stratify performance measures by race and ethnicity:

Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino
- Asked but No Answer
- Unknown

Race

- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Some other race
- Two or more races
- Asked but no answer
- Unknown

3.0 MCAS PERFORMANCE STANDARDS ESTABLISHED by DHCS

3.1 Minimum Performance Levels (MPLs):

KHS strives to exceed the DHCS established MPL for each required MCAS measure MCPs are accountable to meet. KHS strives to meet the DHCS established High Performance Level (HPL) for each required performance measure.

4.0 MCP PERFORMANCE RESULTS and COMPLIANCE

4.1 KHS will submit and comply with DHCS quality and health equity related activity requirements, including but not limited to a minimum of two Performance Improvement Projects (PIP) as directed and approved by DHCS and CMS mandates.

For MCAS measures with rates that do not meet the MPL or are given an audit result of "Not Reportable." The due date is set by DHCS. PDSA Cycle Worksheets to DHCS' quality mailbox at: dhcsquality@dhcs.ca.gov.

4.2 MCPs that perform below DHCS' established MPLs are required to conduct additional QI and HE improvement projects as determined in the MCAS: QI and HE Framework Policy Guide at the discretion and direction of DHCS.

4.3 MCPs with No Measures with Rates below the MPLs.

If KHS's rates for all measures meet or exceed the MPLs, KHS may not be required to conduct additional quality activities. DHCS will communicate requirements to the Quality Performance team. KHS will continue to evaluate ongoing quality and health equity efforts on a quarterly basis. Evaluation will include but is not limited to indicators with rates that are declining or showing worsening trends. KHS will work proactively to address these indicators. Quarterly updates and reviews will be conducted at the Executive Quality Improvement and Health Equity Committee (EQIHEC).

4.4 Development of PIPs and/or PDSA Cycle.

The PIP and/or PDSA cycle development will include the setting of a Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) objective; establishing measures; selecting, testing and implementing interventions; and spreading changes. KHS will follow the guidelines from DHCS and/or the EQRO, which aligns with the CMS protocol.

4.5 Corrective Action Plans (CAPs).

A CAP is required and issued by DHCS when multiple indicators have rates below the MPL, or when DHCS determines that a CAP is necessary. CAP requirements may include, but are not limited to:

a. Triannual reporting of MCAS PDSA Cycle Worksheets with corresponding, continuous, rapid-cycle improvement activities

b. Additional PIPs or DHCS quality activities

c. Additional technical assistance calls.

d. In-person meetings between MCP and DHCS executive staff.

4.6 Sanctions

Welfare and Institutions Code section 14197.7 and the MCP contracts authorize DHCS to impose sanctions on MCPs that fail to meet the required MPLs on any of the applicable MCAS measures, in any reporting unit. Sanctions may include financial penalties or auto-assignment withholds. The level and type of sanction will depend on the number of deficiencies and the severity of the quality issues identified and is determined by DHCS.

4.7 Reporting Requirements.

a. Timeline
DHCS will notify KHS of submission due dates and requirements.

b. **Submission**
KHS will submit DHCS required activities to the assigned DHCS Nurse Consultant or designee.

4.8 Delegation Quality Requirements

MCPs are accountable for all QI and equity functions that are fully delegated to Subcontractors and Downstream Subcontractors as detailed below:

• Perform continuous oversight, monitoring, and evaluation of a Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's quality and equity activities, which include MCAS performance assessments, quarterly reporting at the minimum, and reviews of report findings followed by any actions taken. • Conduct and report CAHPS survey results annually for all Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors.

• Monitor compliance of Fully Delegated Subcontractors' and Downstream Fully Delegated Subcontractors' departmental contractual requirements for QI, equity improvement requirements, and MCAS rate calculation and reporting to DHCS.

• MCPs must report annually to DHCS all Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's certified MCAS measure rates.

5.0 CONSUMER SATISFACTION SURVEYS

Full scope MCPs are required to cooperate in EQRO conducted member satisfaction surveys at intervals determined by DHCS, as per the contract.

5.1 Survey Instrument

DHCS uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys to assess member satisfaction with MCPs. DHCS may additional customized survey questions, in compliance with NCQA standards, to assess specific problems and/or special populations.

5.2 CAHPS® Survey Administration

The EQRO administers the CAHPS® survey every two years for the adult and child Medicaid population and annually for the Children's Health Insurance Program Medicaid population, which includes children with chronic conditions.

5.3 Reporting of Survey Results

In years when DHCS's EQRO administers the CAHPS® surveys, the EQRO will provide a reporting unit-level analysis for each MCP, when applicable, in the CAHPS® Summary

Report. Reporting unit-level analysis allows DHCS, MCPs, and other stakeholders to better understand how member satisfaction and MCP services vary among counties/regions.

6.0 PIPs

6.1 Number of Required PIPs

MCPs are required to conduct a or participate in a minimum of two PIPs every three years. DHCS will provide guidance to each MCP on topic selection.

6.2 PIP Topic Selection.

MCPs will choose PIP topics in consultation with DHCS. PIP topics should align with demonstrated areas of poor performance, such as low MCAS scores, and/or DHCS/EQRO recommendations.

a. Topic Proposal Timelines and Format

DHCS will notify MCPs of the due date for PIP topic selection and the format to use for selection proposal.

b. Topic Proposal Submission

Each MCP must submit its completed PIP topic proposal form to the MCP's assigned DHCS Nurse Consultant or designee.

c. DHCS's Approval of PIP Topic

After receiving an MCP's proposed PIP topic, DHCS will send the MCP a notice of approval, a request for additional information, or suggest that the MCP participate in a technical assistance call with the EQRO.

6.3 PIP Module Submissions

The rapid-cycle PIP process requires the submission of four modules. DHCS' EQRO will provide timelines and due dates for annual PIP submissions. . DHCS' EQRO will conduct technical assistance calls as needed to assist MCPs through the process. The EQRO will review module submissions and provide feedback to MCPs. MCPs will have opportunities for technical assistance with both DHCS and the EQRO throughout the entire PIP process.

6.4 PIP Duration

DHCS will notify MCPs regarding the length of the PIP cycle. PIPs Typically last three (3) years and follow the CMS protocol.

6.5 Assessment of Results.

Upon completion of each PIP, the EQRO provides a confidence level on the validity and reliability of the results.

6.6 Special Considerations

a. **New MCPs and Existing MCPs Expanding into a New County/Region:** DHCS requires new and existing MCPs with new county/regional start-ups to participate on a technical assistance conference call with DHCS and the EQRO to discuss the appropriateness of PIP topics and the timeline for their initial PIP submissions. DHCS and its EQRO may adjust reporting requirements for new and existing MCPs/SHPs with new county start-ups to accommodate the particular circumstances of the MCP's date of start-up in relation to the reporting cycle. MCPs should contact the EQRO or their DHCS Nurse Consultant for step-by-step instructions about the initial PIP process.

b. **Multiple Counties:** MCPs that serve multiple counties under a single contract may submit a PIP that addresses the same improvement topic in more than one county, provided the targeted improvement is relevant in more than one county covered by the MCP Contract.

6.7 Communication and Meetings with DHCS and Among MCPs

a. **Designated Contacts**

MCPs must provide DHCS with one primary contact (PIP lead) and at least one backup contact for each PIP who is familiar enough with the PIP to step in during the PIP lead's absence. Only under certain circumstances will DHCS approve an MCP's request for an extension of time to submit PIP-related documentation due to staff absence. KHS' designated contact is the QP Director and MCAS Program Manager, or designee.

b. **Technical Assistance**

To ensure that PIPs are valid and result in real improvements in the care and services provided to MCP members, DHCS periodically holds technical assistance conference calls for all MCPs to: (1) present changes in methodologies or processes; and, (2) assist MCPs that are having difficulties with a PIP. MCPs are required to participate in these technical assistance calls.

7.0 Focus Studies

DHCS may require MCPs to participate in focus studies of specific quality priority areas by submitting data or participating in surveys.

8.0 Patient-Level Reporting

MCPs are required to submit patient-level data as specified by the EQRO as part of the performance measurement audit process.

9.0 Health Equity Promotion

MCPs are required to align health equity goals with DHCS' Health Equity Framework within the Comprehensive Quality Strategy Report. MCPS are required to participate in DHCS mandated statewide collaborations and/or other initiatives that may support improvement of quality and equity of care for assigned members.

a. MCAS

MCPs are required to stratify DHCS-selected MCAS measures by various demographics including, but not limited to age, gender, race/ethnicity, and primary language.

b. **Population Health Management**

MCPs are required to incorporate the county or region-specific Population Needs Assessment, as detailed in the Population Health Management Guide, build community partnerships, and improve Member participation to fully understand the barriers preventing all populations from receiving care and preventive services as well as social drivers of health.

c. KHS' Health Equity Office (HEO) will lead the Regional Quality and Health Equity Team (RQHET) to leverage existing regional quality and health equity teams to support the QI/QP and health equity work for the county across various DHCS designated region (Kern). The regional team will develop partnerships within their designated regions that include at a minimum, Network Providers, partner MCPs, county Behavioral Health Plans (BHP), local health departments, community-based organizations (CBOs), local governmental agencies (e.g., department/county of social services, Women, Infant, and Children agencies, child welfare departments), regional centers, home and community-based service programs, continuum of care programs, First 5 programs, Area Agencies of Aging, caregiver resource centers, local education agencies, Individual Family Service Plans, and Members. The regional teams must participate in state-driven collaborative meetings and projects to improve partnerships in these regions.

10.0 ADDRESSES FOR ELECTRONIC SUBMISSIONS

a. **EQRO's File Transfer Protocol (FTP) Website**

DHCS's EQRO, Health Services Advisory Group (HSAG) uses an FTP website. All current MCPs have identified FTP users who have been assigned usernames and passwords by HSAG to access each MCP's specific folder. To establish additional user profiles or remove previous users, MCP staff should contact the EQRO or the MCP's Nurse Consultant.

b. **DHCS's Submission E-Address**

DHCS's quality mailbox: dhcsquality@dhcs.ca.gov.

ATTACHMENTS:

- Attachment A: PIP Submission Form

REFERENCE:

Revision 2024-6: Updates made by the Director of Quality performance **Revision 2024-05:** Updates made to signatories. **Revision 2024-02:** Per CMO, updates made to signatories to include QI and QP Directors and remove CMO. **Revision 2023-12:** Updates made to Procedures section by Directors of Quality Improvement and Quality Performance. **Revision 2023-09:** Updates made to comply with DMHC APL 22-028, Health Equity and Quality Measure Set and Reporting Process. Per state regulators, this policy and attachment do not need to be filed with DMHC and will not need to be reviewed by DHCS. **Revision 2021-09:** Updated policy to align with APL 19-017; Updated aspects of MCAS measures' reporting and compliance requirements, CAPs and Sanctions. Removed list of MCAS Measures that were Attachment A; Replaced Attachment B that was the PDSA Worksheet with the latest version and made it the new Attachment A. **Revision 2018-02:** Updated by QI Supervisor to meet APL 17-014 verbiage. **Revision 2017-06:** Policy reviewed by Compliance Auditor to comply with APL 16-018. Reviewed by QI Supervisor, no revisions required. Revision **2016-08:** Revisions to conform to APL 15-024, Rename Attachment A and update with final requirements. Add Attachment 2, PDSA Cycle Worksheet.
[1] **Revision 2015-06:** Revisions to conform to APL 14-003. Update Attachment A with 2015-2016 requirements (draft), removed Attachment B and Attachment C. **Revision 2011:** Updated attachment, "Required Hedis Measures for 2010-2011. **Revision 2009-09:** Policy reviewed against MMCD Letter 08-009. **Revision 2005-02:** No revision needed per Quality Improvement Manager. Revision 2004-02: MMCD Letter 03-01 (June 5, 2003)

DHCS APL 24-004 Quality improvement and Health Equity Transformation Requirements
APL 22-028 Health Equity and Quality Measure Set and Reporting
APL 19-017 Quality and Performance Improvement Requirements
Title 28 of the California Code of Regulations (CCR) section 1300.70, 1
Title 42 of the Code of Federal Regulations (CFR) section 438.330, 2

KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: John Miller, M.D.

Date: August 8, 2024

Re: Quality Improvement Workgroup

Background

The 2nd Quarter meeting of the KHS Quality Improvement Workgroup, formerly QIC, took place on June 27, 2024. This committee is part of the new reporting structure that flows up to the Executive Quality Improvement Health Equity Committee. Committee members include representatives from the community. The goal of the committee is to monitor the KHS QI workplan throughout the year and provide input on the direction and future of the Quality Program and workplans.

Discussion

During this session quorum was met and the committee reviewed the results of the annual priority list. The QI Workgroup voted: 1. Equitable healthcare, 2. Access to safe, effective, high quality, timely care as the two top priorities. The priorities are included in the Quality Program description and continue to be in the description for the 2025 year.

Quality Performance (QP) was presented including results from Q1 Facility Site Reviews, Medical Record Reviews, and Physical Accessibility Review surveys. No issues of concern. A Performance Improvement Projects update was also presented. The first submission for both PIPs were approved by HSAG and the projects are in the next phase.

MCAS: Currently, we are meeting 8 of 18 measures for MY2023 compared to 5 of 15 measures for MY2022. For the current year, 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 March 2024, 14 of 18 measures have improved compared to last year.

Grievance data was presented by the Quality Improvement (QI) Department. There was a 37% increase in the Total Grievance volume in Q1 2024 compared to the previous quarter. QI will continue to monitor for any trends.

Potential Quality Issues was presented by the QI Department. Compared to the previous quarter, in Q1 2024 the notifications decreased by about 2%. The PQI volume has decreased over the last year and there were no issues identified. QI will continue to monitor for any trends. The fifty 30-day readmission reviews conducted each quarter were completed timely for Q1 2024. There were no trends identified.

NCQA standard QI 3 Continuity and coordination of medical care data was presented. The QI department selected to present 1. Office visits within 7 days of inpatient discharge, and 2. Eye exam for patients with diabetes (EED). The workgroup conducted a qualitative discussion and analysis of the data presented. Opportunities for improvement were identified.

2024 NCQA readiness was presented. Health Plan readiness is at 76%. Health Equity readiness is at 43%. Next steps include completing the remaining reports, quarterly mock file reviews, and operations readiness.

KHS Enhanced Care Management (ECM) presented a Corrective Action Plan (CAP) Workflow for the workgroup's approval. Once a ECM site has completed services for one quarter, they would be subject to an audit. Failure to meet specified requirements would result in a CAP. The document outlined the CAP process. The workgroup approved the workflow.

The QI Workplan Scorecard with Q1 results was presented. Issue for concern is the MCAS measures where goal was set to meet Minimum performance for all 18 measures, and as previously mentioned only 14 of 18 measures have improved compared to last year. Other issue for concern is speed of answer and call abandonment rate, both not meeting targets.

Fiscal Impact
None

Requested Action
Approval of committee proceedings.

Kern Health Systems
2024 Quality Improvement Program Work plan
Last Updated: 6/27/2024

	On Track
	In Jeopardy
	Barrier
	Complete

Source	Key Performance Measure	Metrics	Measurable Goals	Actions/Improvement Activities	Status	Q1 Comments
QUALITY PROGRAM STRUCTURE						
NCQA 1A	QI Program Description	QI Program description of committee accountability, functional areas and responsibilities, reporting relationship, resources and analytical support	Annual approval by the QIC and the BOD	Presentation of the QI Program to BOD and QIC for review and approval.	**Complete**	2024 Program Description presented to QIC and EQIHEC. 2025 Program description will be prepared for December-2024 presentation and will combine the QI and Health Equity programs.
NCQA 1B	Annual QI Work Plan	Yearly planned objectives and activities	Annual approval by the QIC and the BOD	Presentation of the QI Work Plan to BOD and QIC for review and approval.	**Complete**	2024 Workplan presented to QIC and EQIHEC
NCQA 1C	Annual QI Evaluation	Summary of completed and ongoing QI activities, trending of results and overall evaluation of effectiveness	Annual approval by the QIC and the BOD	Presentation of the QI Evaluation to BOD and QIC for review and approval	**Complete**	2023 Evaluation presented to EQIHEC
NCQA; DHCS	Policies and Procedures	Review of organization's policies and procedures	Annual approval by the QIC	Presentation of the QI Evaluation to QIC for review and approval		Need to complete by end of year. QI and QP policies are currently under review. Department in conjuction with compliance has developed a biweekly cadence for reviews.
NCQA 1A	Quality Improvement Health Equity Committee (QIHEC)	Quarterly meetings and maintenance of minutes	Conduct quarterly meetings, as required by the QM Program	Meet quorum of voting members +at every meeting		Meeting invites sent out for rest of year
Quality of Clinical Care						
DHCS	MCAS Measures	18 MCAS measures mandated by DHCS to meet minimum performance levels (MPLs)	All DHCS- mandated MCAS measures must meet the MPL at the 50th percentile 1. Timely Submission of all 18 measures. 2. Meet MPL for all 18 measures we are held accountable.	Based on the Fishbone diagram submitted to DHCS (RED Tier) a) Data management b) Training and resources c) Collaboration and communication		2023 MCAS submission completed timely. 8 of 18 measures met MPL. 2024 MCAS, as of March 2024, 14 of 18 measures have improved compared to last year.
DHCS	Performance Improvement Projects (PIPs)					
	Clinical PIP: The clinical PIP will be focused 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.	Use MY2023 W30 (0-15months) baseline data to develop PIP interventions and get Annual Approval by HSAG.	Interventions to be established in 2024		Leveraging activities from mobile units and the IHI/DHCS collaborative focused on well-care visits for the 0-15 months, African American babies.
	Non-Clinical PIP: The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health department and interventions.	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 visist.	Use MY2023 baseline data to develop interventions that includes a process for notifying PCPs of ED visits for eligible population. Annual Approval by HSAG	Interventions to be established in 2024		Developing a provider notification process for ED visits related to Behavioral Health and Substance Use Disorders.
DHCS	Potential Quality of care Issue (PQI)	Monitoring of PQI volume month over month.	Monitor if the volume is below the median value of last 12 months.	Monitor Trending Reports		Volume is trending down.
		PQI Volume by Provider and by Severity	Monitor Total PQI volume with severity level 2 and 3 is below 30 for rolling 12month period.	Monitor Trending Reports		0 Level 2/3 for Q1.
		PQI Volume by Ethnicity and by Severity	Monitor Total PQI volume with severity level 2 and 3 is below 30 for rolling 12month period.	Monitor Trending Reports		0 Level 2/3 for Q1.
NCQA QI 3	Continuity and Coordination of Medical Care - Transitions of Care:	*Collecting data, identifying improvement opportunities and measuring effectiveness*	Will establish baseline for NCQA requirements	Interventions to be established in 2024		Data collected on two measures, quantitative and qualitative analysis completed. Opportunities identified. Next step is to complete the report for presentation.
	a) Movement of Members Between	examples – consult report received by PCPs	Will establish baseline for NCQA requirements	Interventions to be established in 2024		Eye exam for diabetics (EED) measure selected. Quantitative & Qualitative analysis completed

	Practitioners	example – consult report received by PCPs	Will establish baseline for NCQA requirements	Interventions to be established in 2024		Quantitative & Qualitative analysis completed. Results need to be presented to QIC.
	b) Movement of Members Across Settings	example – post partum rate	Will establish baseline for NCQA requirements	Interventions to be established in 2024		Office visits within 7 days of inpatient discharge measure selected.
NCQA QI 4	Continuity and Coordination Between Medical Care and Behavioral Healthcare –	*Collecting data, identifying improvement opportunities and evaluation of effectiveness that improve coordination of behavioral and general medical care:*	Will establish baseline for NCQA requirements	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		In-progress, will be presented at Q3 meeting.
	a) Exchange of information	*Ambulatory Medical Record Review* : Example - Presence of consult reports Example – PCP survey regarding satisfaction with coordination of care with BH practitioners	Will establish baseline for NCQA requirements	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		In-progress, will be presented at Q3 meeting.
	b) Appropriate diagnosis, treatment and referral of BH disorders seen in primary care	Example – Antidepressant Medication Management (AMM) Example – Follow-up Care or Children Prescribed ADHD medications (ADD)	Increase MCAS result by 2 percentage points from previous year	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		In-progress, will be presented at Q3 meeting.
	c) Appropriate use of psychotropic medications	Examples: AMM ; ADD Analysis of pharmaceutical data for appropriateness of a psychopharmacological medication	Increase MCAS result by 2 percentage points from previous year	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		In-progress, will be presented at Q3 meeting.
	d) Management of coexisting medical and behavioral disorders	Example: FUH	Will establish baseline for NCQA requirements	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		In-progress, will be presented at Q3 meeting.
	a) Primary or secondary preventive behavioral healthcare implementation	Examples: Data on need for stress management program for adults Data on need for prevention of substance abuse program Data on the need for developmental screening of children in primary care settings Data on the need for ADHD screening of children in primary care settings Data on the need for postpartum depression screening	Will establish baseline for NCQA requirements	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		In-progress, will be presented at Q3 meeting.
	b) Special needs of members with serious mental illness or serious emotional disturbance	Example: HEDIS measure Diabetes Monitoring for People with Diabetes and Schizophrenia	Will establish baseline for NCQA requirements	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		In-progress, will be presented at Q3 meeting.
Safety of Clinical Care						
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*	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	CSR will schedule and complete reviews timely.		8 initial and 2 periodic FSR completed. 100% pass rate
DHCS	Physical Accessibility Review Survey (PARS)	Conduct PARS audit with FSR	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	QP Senior coornator will schedule and complete all PARS due 2024		4 completed in Q1
DHCS	Medical Record Review	Conduct medical record review of practitioners due for facility site reviews	Achieve medical record review score of 85% for each practitioner	CSR will schedule and complete reviews timely.		4 initial and 2 periodic medical record reviews. 83% pass rate
Kern	Drug Utilization Review	TAR PAD	Turnaround Time Timeliness - reviewed and returned in 1 business day TAR=24hrs PAD=5 days routine 3days=urgent	None		Data presented at Drug Utilization Review Committee. Goals are being met. No issues of concern.
NCQA	Credentialing/Recredentialing	Credential/recredential practitioners timely	100% timely credentialing/recredentialing of practitioners	Review of trends for Grievances and PQIs, QOC look back review Q3 years		All credentialing/recredentialing for Q1 completed on time
Quality of Service						
NCQA; DHCS	Grievance and Appeals	a) Timeliness of acknowledgment letters	Within 5 calendar days			Goal met for Q1
		b) Timeliness of resolution	Within 30 calendar days			Goal met for Q1
DHCS; NCQA	Potential Quality of Care Issues (PQI)	a) Timeliness of acknowledgment letters	Within 5 calendar days			Goal met for Q1
		b) Timeliness of resolution	Within 30 calendar days			Goal met for Q1
		PCP access for preventive, routine care, urgent care, and after-hours access				

NCQA; DHCS	Access to Care - PCP	Urgent care – w/in 48 hrs Routine care – 10 business days	80%	Provider Accessibility Monitoring Survey		Goal met. 87%.
	Access to Care - SCP	*Access to specialty care* Urgent care – w/in 48 hrs a) Routine care – 15 business days	80%	Provider Accessibility Monitoring Survey		Goal met. 93%
DHCS; NCQA	Telephone access to Member Services	a) Speed of answer	≤ 30 seconds	Perform quarterly telephone access audit		2:22
		b) Call abandonment rate	5%			10%
Members' Experience						
Kern	CAHPS survey	Adult and Child Medicaid Survey	Monitor CAHPS Resutls and establish basline for Getting Care needed measure	Trending report on CAHPS results by survey questions		Satisfaction surveys underway
	Member Engagement / Rewards	Establish year-round, member outreach program focused on members with gaps in care. Redesign MCAS member rewards program to increase motivation for compliance with obtaining preventive health services and follow through with chronic condition self-care.	Increase the included MCAS Measure Rates by 2% points by end of the year.	a) Text Messages to members encouraging the scheduling of 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 oRobocalls will be sent out to members that do not receive text messages FUM Got Approved for incentives for MY2024. FUA is Pending Approval		Volume of incentives provided has increased.
Provider Engagement						
Kern	Provider Satisfaction Survey			Trend PSS results by survey questions		Satisfaction surveys underway
	Provider Incentive Program	Improve HBD Measure rate	Improve HBD A1C level	Dr. Duggal began a pilot for members with Diabetes. With this pilot, Dr. Duggal is provided a group of members with uncontrolled Diabetes and help get their A1C controlled with the appropriate interventions. This will be an incentive-based reimbursement structure.		Continuation of program with Dr. Duggal. API in process to provide direct scheduling for KHS outreach team.
	Provider education	Improve MCAS Measure Rates	Meet Providers Quarterly	QI cordinator meet Providers to update them on the MCAS Measure Rate performance		Q1 meetings completed with top 20 providers.

KERN HEALTH SYSTEMS

QUALITY IMPROVEMENT COMMITTEE (QIC) MEETING

Thursday, June 27, 2024
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 Committee (QIC)
AGENDA – June 27, 2024

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	March 2024 Minutes Review, Discussion, Motion to Approve **March 29, 2024**	***All Voting Members***	*3 min*	*Approve*
OLD BUSINESS	1. Survey Results & discussion	Magdee Hugais, QI Dir	*5 min*	*Discussion*
NEW BUSINESS	1. Quality of Clinical Care • MCAS/QP Report Q1 • PIPs • QOC Grievances & PQIs • Standard QI3: across settings - PCR Qualitative Analysis • Standard QI3: across practitioners	Kailey Collier, QP Dir Magdee Hugais, QI Dir Dr. Miller MD, Med Dir	*5 min*	*Informational*
	2. Safety of Clinical Care • FSR/PARs/Medical Records	Kailey Collier, QP Dir	*5 min*	*Informational*
	3. NCQA Accreditation	Steven Kinnison, NCQA Mgr	*5 min*	*Informational*
	4. ECM CAP process	Dan Diaz, ECM Mgr	*5 min*	*Approval*
	5. Workplan Scorecard – Q1	Magdee Hugais, QI Dir	*1 min*	*Informational*
OPEN FORUM	Open Forum / Committee Members Announcements / Discussion	***Open to all Members***	*2 min*	*Discussion*
NEXT MEETING	Next meeting will be held Thursday, **September 26, 2024 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 COMMITTEE***
DATE OF MEETING: ***MARCH 29, 2024***
CALL TO ORDER: ***12:03 PM BY MARTHA TASINGA, MD, CHIEF MEDICAL OFFICER - CHAIR***

Members Present On-Site:	Dr. John Paul Miller, KHS QI Medical Director, Chair Carmelita Magno, Kern Medical Process Improvement Dir.		
Members Virtual Remote:	Danielle Colayco, PharmD, Executive Director Komoto Jennifer Culbertson, Director of Clinical Quality CSV	Dr. Mansukh Ghadiya MD, Family Medicine Dr. Joseph Hayes, CMO of Omni Family Health	Dr. Michael Komin, MD Shafter Family Medicine
Members Excused=E Absent=A			
Staff Present:	Kailey Collier, RN, KHS Director of Quality Performance Michelle Curioso, KHS Director of PHM Amy Daniel, Executive Health Svcs Coordinator	Pawan Gill, KHS Health Equity Manager Loni Hill-Pirtle, Director of Enhanced Case Mgmt Magdee Hugais, KHS Director of QI	Steven Kinnison, KHS NCQA Manager Courtney Morris, KHS Behavioral Health Supervisor Isabel Silva, Director of Health & Wellness

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. John Paul Miller, KHS QI Medical Officer called the meeting to order at 12:01 PM.		N/A
Committee Minutes	**Approval of Minutes** Introductory meeting only – There are no past minutes to approve.	☑ **CLOSED**: Not applicable.	N/A
OLD BUSINESS	There was no old business to present	N/A	N/A
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Dr. Miller welcomed the members of QI Committee. Members and KHS Staff introduced themselves and from the facility/organization they are representing. Representatives from the following network providers included: • Danielle Colayco, PharmD, Executive Director Komoto	☑ **CLOSED**: Informational discussion only.	*3/29/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Jennifer Culbertson, Director of Clinical Quality CSV • Dr. Mansukh Ghadiya MD, Family Medicine • Dr. Joseph Hayes, CMO of Omni Family Health • Dr. Michael Komin, MD Shafter Family Medicine • Carmelita Magno, Kern Medical Process Improvement Director KHS Staff introduced themselves and the departments they represent.		
	Committee Charter Dr. Miller presented the committee charter outlining the committee responsibilities, roles of the committee members and program description. The QI Activities will include: • Responsible for approving the QI Program Description, annual work plan and previous year's work plan. • Ensuring compliance with DHCS facility site review requirements. • Review aggregate data of potential quality of care issues, improvements, and oversight. • Monitoring the identification of quality-of-care trends and recommend corrective actions as needed. • Facilitate HEDIS & Managed Care Accountability Set (MCAS) audits and make appropriate recommendations. • Monitor member satisfaction outcomes and address measures and dissatisfaction. **Committee Composition** The composition as described in the committee charter was fulfilled as identified. The QI Committee composition requirements include: • KHS Quality Medical Director, Chairperson • 2 participating contracted providers • 2 representatives from FQHCs • 1 representative from a contracted Pharmacy • 1 representative from Kern Medical • Ex-Officio Staff Members from KHS **Meetings** Meetings will be held four (4)-times per year.	☑ **CLOSED**: Informational discussion only.	*3/29/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	2024 QI Program & Work Plan Magdee presented the 2024 QI Program & Plan that included the purpose, objectives, scope of care, program structure, and activities to take the most effective action to address any improvements, appropriateness, safety, and outcomes delivered by our providers to our members.	☑ **CLOSED**: Due to the committee restructure for NCQA, the EQIHEC is the formerly the QI/UM Committee. Dr. Miller informed the QIC committee members that the 2024 QI Program and Work Plan have previously been presented and approved by the EQIHEC.	*3/29/24*
	2024 MCAS OVERVIEW Kailey presented the 2024 MCAS Goals and Initiatives that KHS will be focusing on for the year. The following activities were noted: 1. Member Outreach Team efforts. 2. Mobile Units in rural areas and focus on Street Medicine. 3. Quality Grants to develop innovated partnerships. 4. Data Exchange and EMR Access amongst our providers. 5. Pediatric focus and measures with increase access on school campuses. 6. Address Verification to target specific patient populations. 7. Direct Appointment Access partnering with providers to access schedules and book appointments directly for members.	☑ **CLOSED**: Informational/discussion only.	*3/29/24*
	NCQA Accreditation Steven presented the NCQA Accreditation Plan. The following highlights were noted: • DHCS requires that all Medi-Cal Managed Care Plans (MCPs) achieve the NCQA Health Plan Accreditation and Health Equity Accreditation by January 1, 2026. • Health Plan Accreditation (HPA) – Survey Date: 4/8/2025 • Health Equity Accreditation (HEA) – Survey Date: 6/10/2025	☑ **CLOSED**: Informational/discussion only.	*3/29/24*
	Your Role (Committee Members) Dr. Miller informed the members of their role as a member of the QI Committee. Their attendance is vital to the success of the QI Program to help drive the QI initiatives, activities and to bring their ideas and suggestion for improvements.	☑ **CLOSED**: Informational/discussion only.	*3/29/24*
OPEN FORUM	**Open Forum** Pawan Gill, KHS Health Equity Manager, thanked the committee for opening the invitation to have Health Equity involved in the QI Committee and to be part of the improvement initiatives for better health outcomes for our members.	☑ **CLOSED**: Informational discussion only.	*3/29/24*

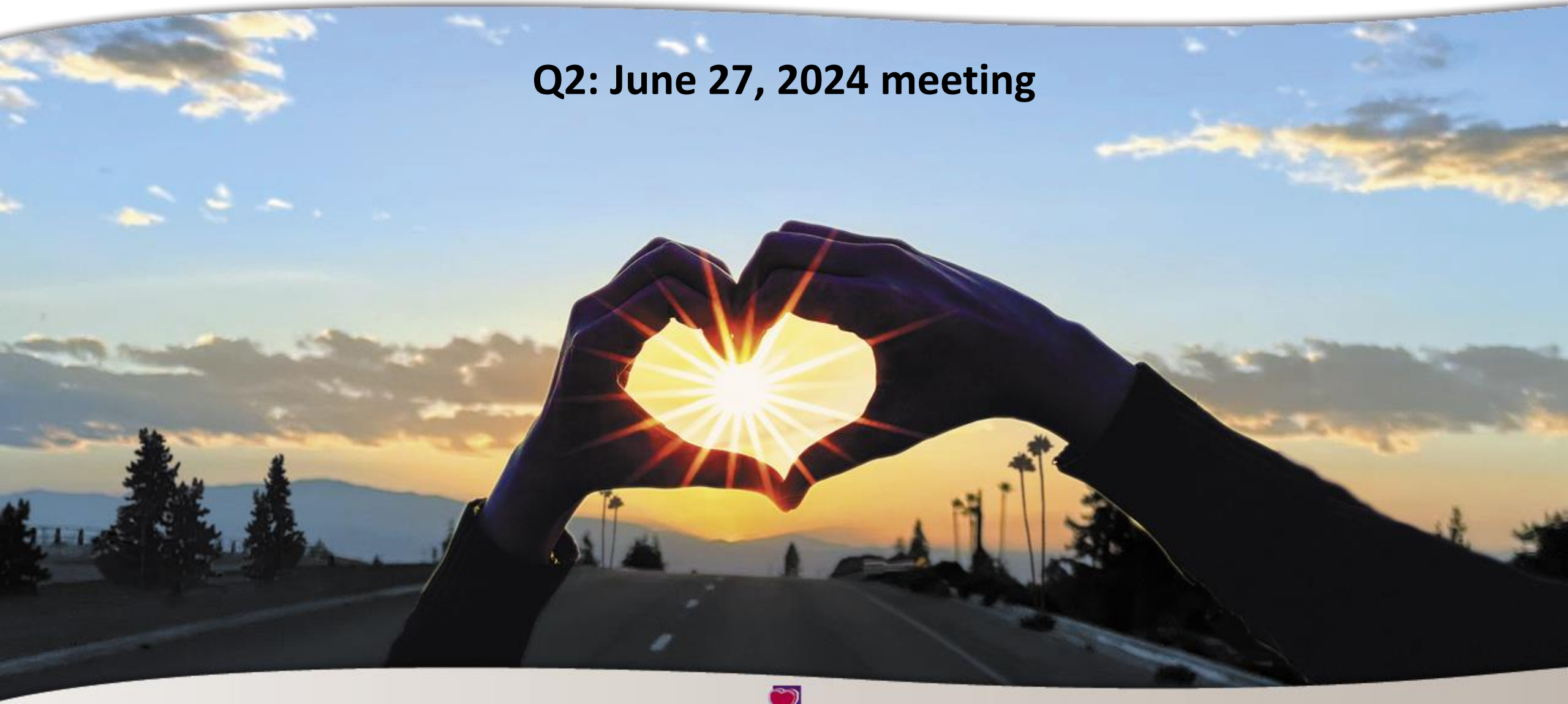
AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Danielle C., Komoto Pharmacy, commented on the expansion of allowing Community Health Workers in the provider offices which has been an exceptional resource and tool in attaining their goals and initiatives.	☑ **CLOSED**: Informational discussion only.	
NEXT MEETING	Next meeting will be held Wednesday, June 27, 2024 at 12:00 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 12:50 PM ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Quality Improvement Committee Minutes 03/29/24

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

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

KHS Quality Improvement Committee (QIC)



Q2: June 27, 2024 meeting

KERN HEALTH SYSTEMS

Agenda

- Welcome
- Review Agenda
- Introductions
- Charter
- Review QI Program and Plan
- NCQA Accreditation
- Your Role
- Open Discussion

Introductions

- Chair: Dr John Miller
- Committee Members
  - Dr Ghadiya
  - Dr Hayes
  - Dr Komin
  - Carmelita Magno
  - Dr Ayala Rodriguez *(New)*
  - Danielle Colayco
- Internal Members
  - Dr Tasinga
  - Dr Khalsa
  - Dr Sidhu
- Jake Hall
- Magdee Hugais
- Kailey Collier
- Melinda Santiago
- Loni Hill-Pirtle
- Steven Kinnison
- Isabel Silva
- Bruce Wearda
- Michelle Curioso
- Pawan Gill
- Lela Criswell
- Amy Daniel

KERN HEALTH SYSTEMS

Survey

- What do you see as the top priority to improve the overall quality of healthcare in our community?

- Link to Survey

Survey

- What do you see as the top priority to improve the overall quality of healthcare in our community?

Results (7 responses):

- Equitable healthcare x3
- Access to safe effective care/high quality/timely x3
- Provider accountability
- Investing in Value based systems

To: KHS QIC

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

Date: June 2024

Re: Quality Performance Q1 2024 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 first quarter of 2024.

Discussion

See pages 2-4 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 quality, 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
1st Quarter 2024

I. Facility Site Reviews (FSR) and Medical Record Review (MRR) (pages 2-11)

8 Initial Facility Site Reviews and 4 Initial Medical Record Reviews were completed in Q1 2024. 2 Periodic FSRs and 2 periodic MRRs were also completed. 100% of Facility Site Reviews passed and 83% YTD of Medical Record Reviews passed. 1 site 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. Of which, 5 were completed in Q1 2024. The QP department also conducts Physical Accessibility Review Surveys (PARS) and 4 were completed in Q1 2024.

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 will be 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 developing the second phase of the PIP, which will focus on interventions and testing. We are developing 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.

III. Managed Care Accountability Set (MCAS) Updates (Pages 12-17)

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 March 2024, 14 of 18 measures have improved compared to last year.

The 2023 MCAS audit is underway with completion anticipated at the end of May. The QP team is anticipating abstraction reviews to end the first week in May. Currently, we are meeting 8 of 18 measures for MY2023 compared to 5 of 15 measures for MY2022.

QUALITY PERFORMANCE DEPARTMENT

QUATERLY EQIHEC COMMIITTEE REPORT

Q1 2024

KERN HEALTH SYSTEMS
Quality Performance Department Quarterly EQIHEC Committee Report
Q1 2024

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

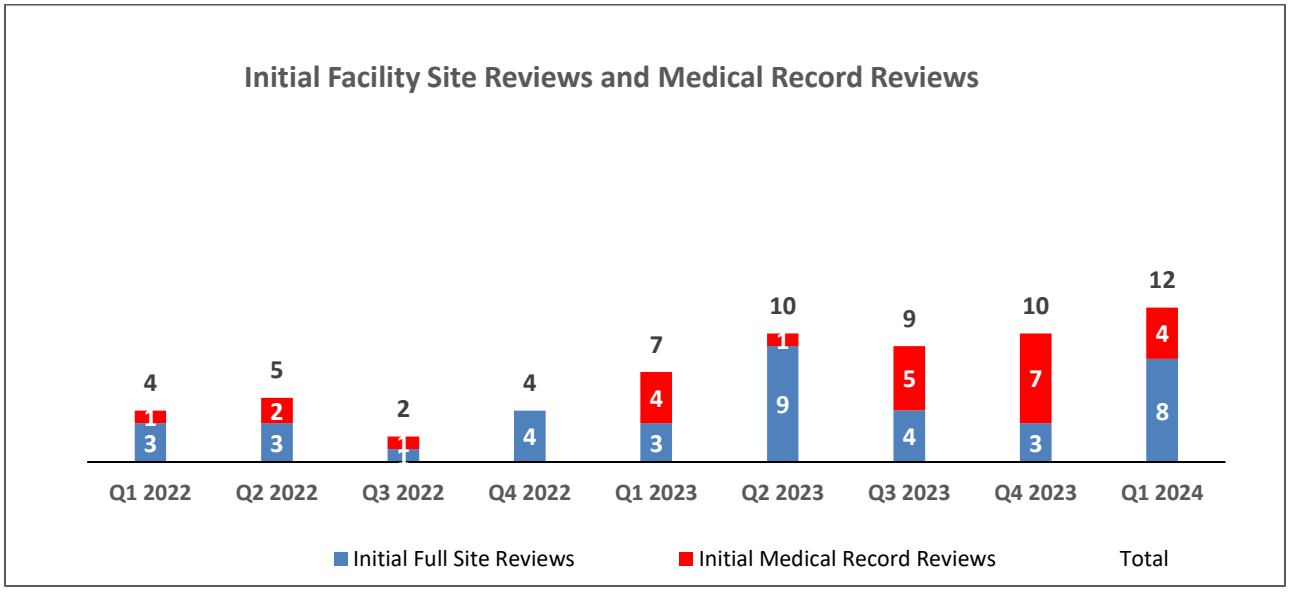
Provider sites that receive an FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are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

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

Corrective Action Plans (CAPs)

A CAP is issued when an initial, periodic, or focus review has deficiencies identified. DHCS requires follow up at 10 days for failure of any critical element, follow up for other failed elements at 45 days, and if not corrected by the 45 day follow up, at 90 days after a CAP has been issued. Most CAPs issued are corrected and completed within the 45 Day follow up period. Providers are encouraged to speak with us if they have questions or encounter issues with CAP completion. QI nurses provide education and support during the CAP resolution process.

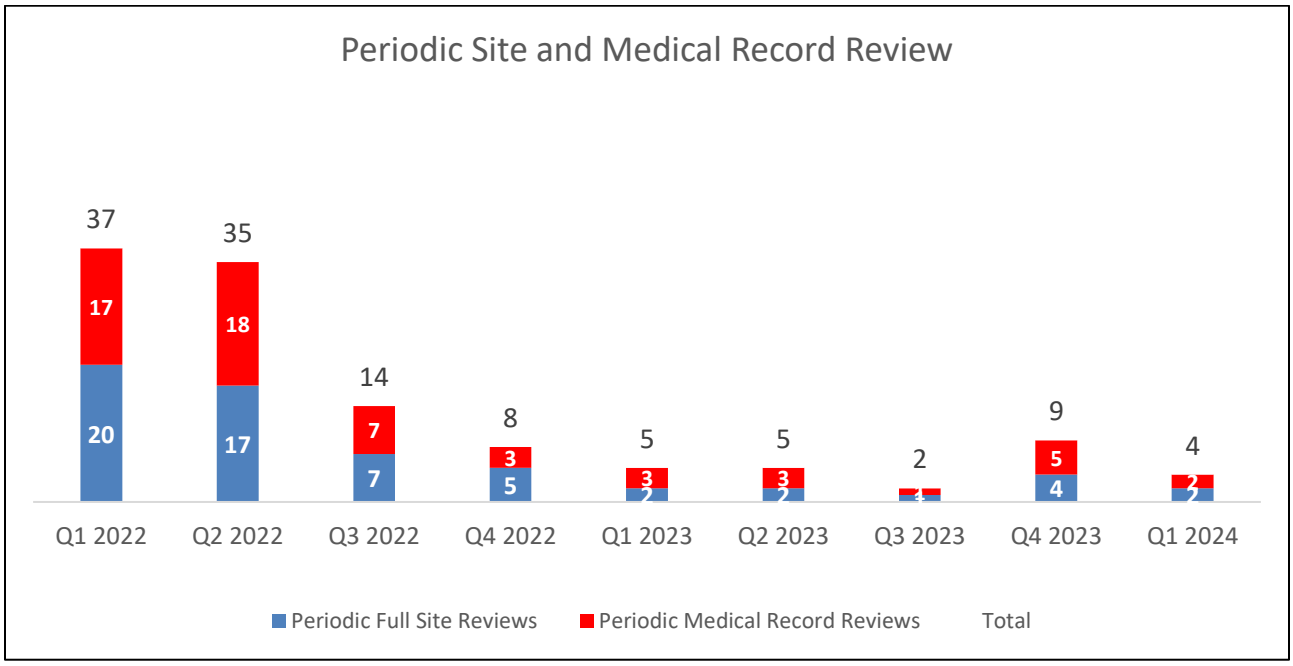
A. Initial Facility Site Review and Medical Record Review Results:



The number of initial site and medical record reviews is determined by the number of new providers requesting to join KHS' provider network. There were 8 IFSRs and 4 IMRRs completed in Q1 of 2024.

B. Periodic Full Site and Medical Record Reviews

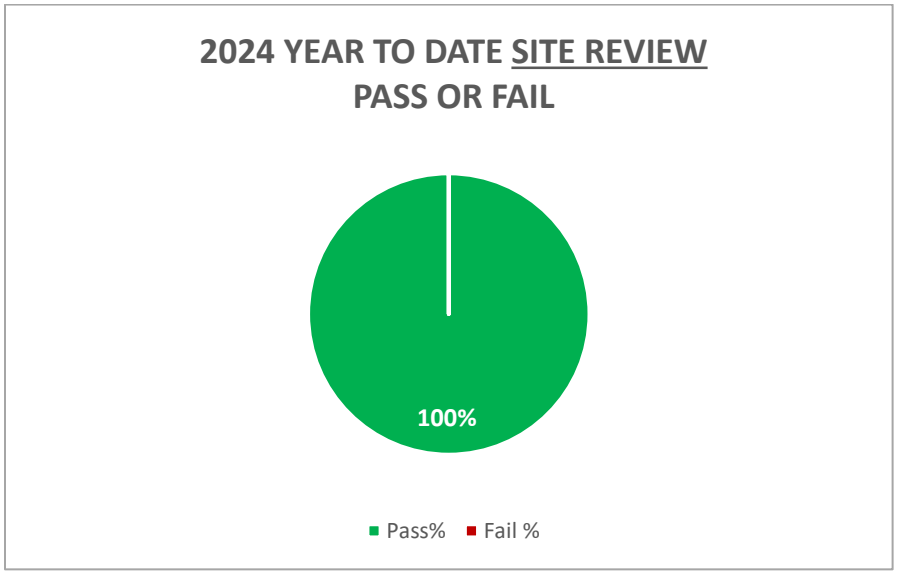
Periodic reviews are required every 3 years. The due date for Periodic FSRs is based on the last Initial or Periodic FSR that was completed. The volume of Periodic Reviews is not controlled by KHS. It is based on the frequency dictated by DHCS.



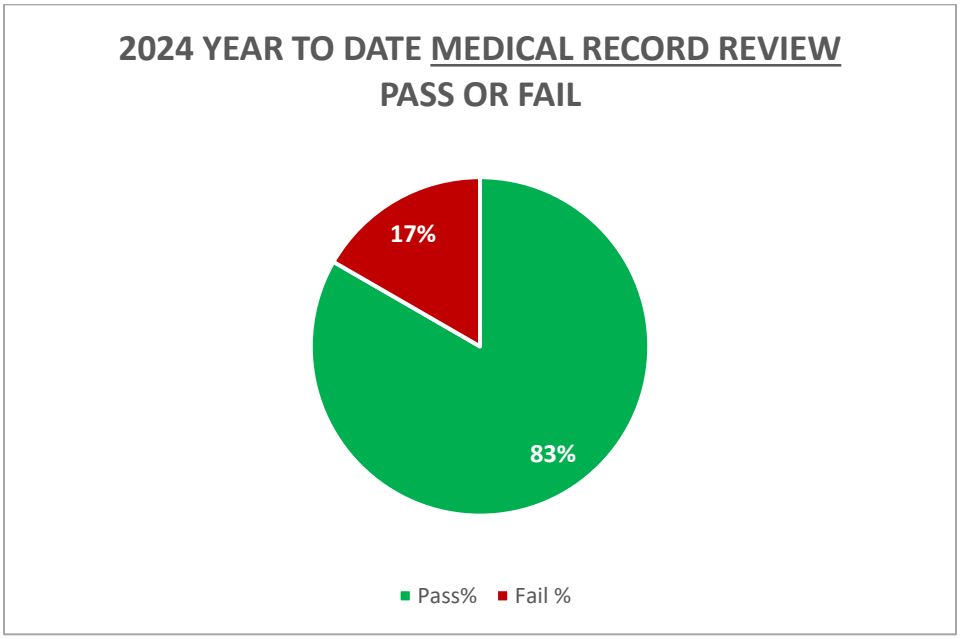
The above chart reflects the number of Periodic Full Site Reviews and Medical Record Reviews that were due and completed for each quarter.

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 2024 YTD, 100% of the Initial and Periodic site reviews performed passed. YTD there were 10 site reviews completed by the end of March 2024. Due to low volume of site reviews completed YTD, this data is considered statistically not significant.



For 2024 YTD, 83% of the Initial and Periodic medical record reviews performed passed. YTD there were 6 medial record reviews completed, 1 of these reviews failed in the first audit. Following the failed review, CAPs were issued to correct deficiencies. Due to low volume of medical record reviews completed YTD, this data is considered statistically not significant. We will continue to monitor this for any trends.

For Q1 2024, top #3 deficiencies identified for Opportunities for improvement in site reviews are:

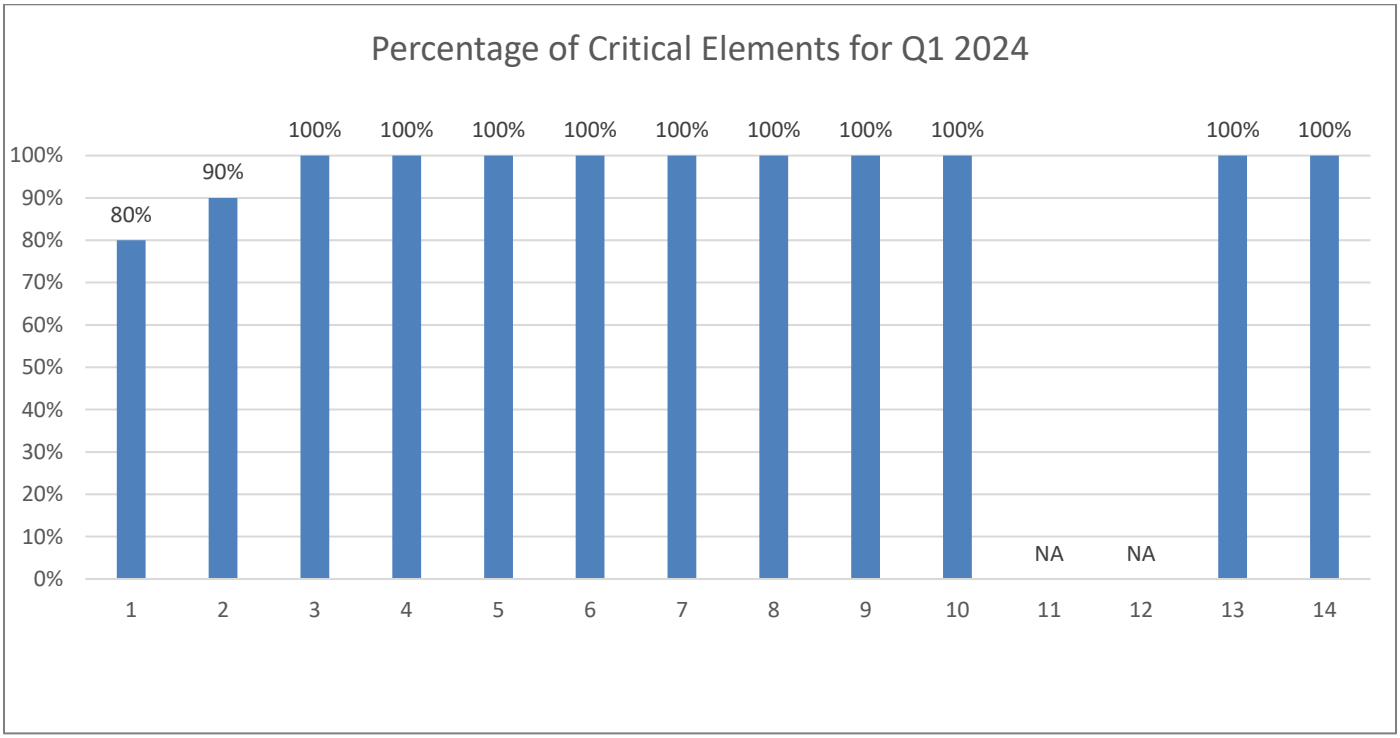
1. Calibration of Equipment not done
2. Clearly diagramed Evacuation Routes are not in visible locations.
3. Site does not utilize California Immunizations Registry (CAIR)

For Q1 2024, top #3 deficiencies identified for Opportunities for improvement in medical record reviews are:

1. Yearly HIV Screening not being given to patients, for both Adults and Pediatrics
2. Tuberculosis Screening not being assessed for both Adults and Pediatrics
3. Signed copy of Notice of Privacy not collected from patients.

There were few common deficiencies 'Site does not utilize California Immunizations Registry (CAIR)', 'HIV Screenings not performed' and 'Signed copy of Notice of Privacy not collected from patients' identified from previous quarter to this quarter. We will continue to monitor for any trends.

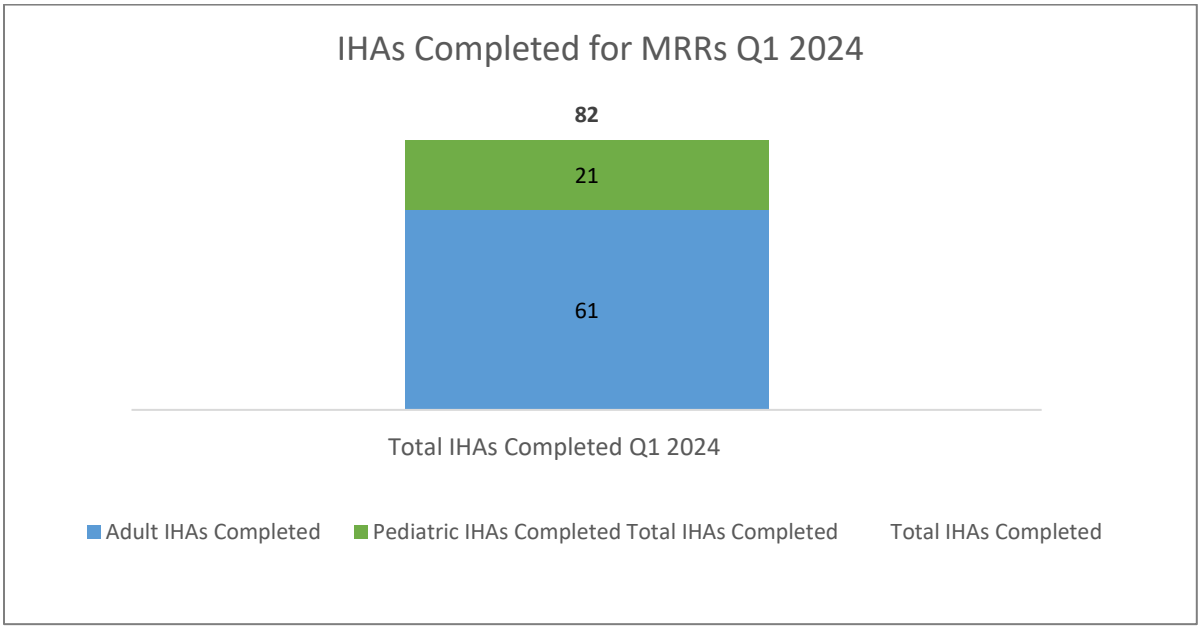
C. Critical Elements (CE) Percentage for Site Reviews:



There were 10 FSRs completed for Q1 2024, and all the sites have passed the critical elements, except two.

Out of the two failed sites, CE CAPs were issued and closed timely for one site. The second site is a mobile unit with an open CAP pending completion. The site review team is working closely with this site to ensure the CAP is closed timely. CE 11 and 1212 were not applicable (NA) for any of the sites completed, hence it does not display any score.

D. IHA's percentage for MRRs:



***Percentage-of IHAs completed = IHEBA+SHA's**

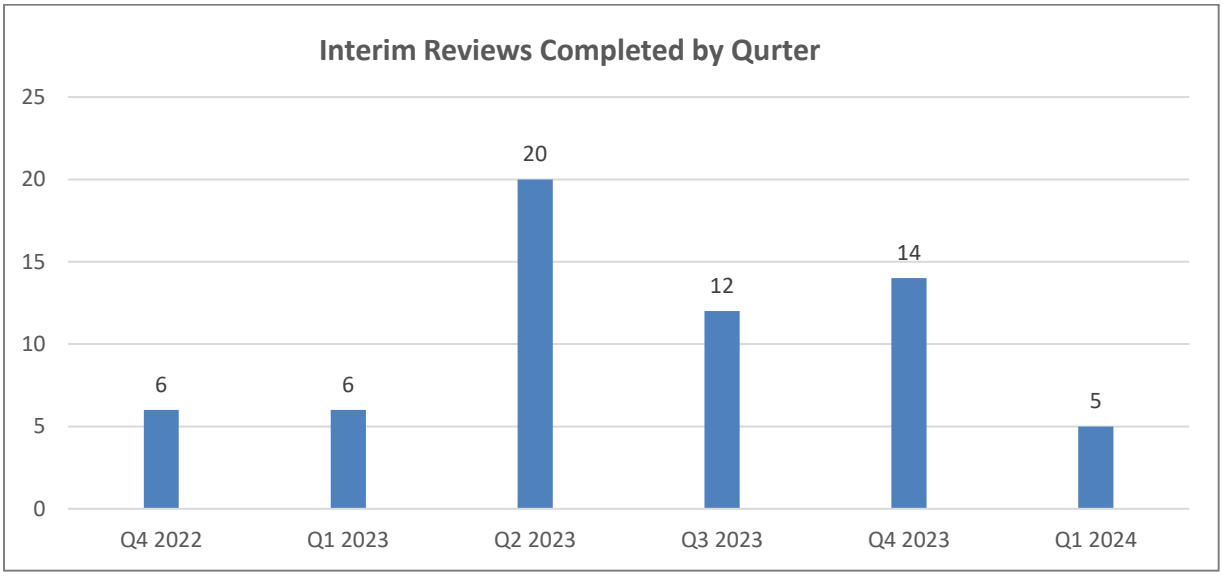
For Q1 2024, based on the medical record reviews, 82 IHA's were completed. 21 total pediatric charts and 61 adult charts. 19 out of the 21 pediatric charts were compliant and 2 were non-compliant. Out of all the 61 Adult charts, 55 adult charts were found to be compliant and 6 were non-compliant. Education 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 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.

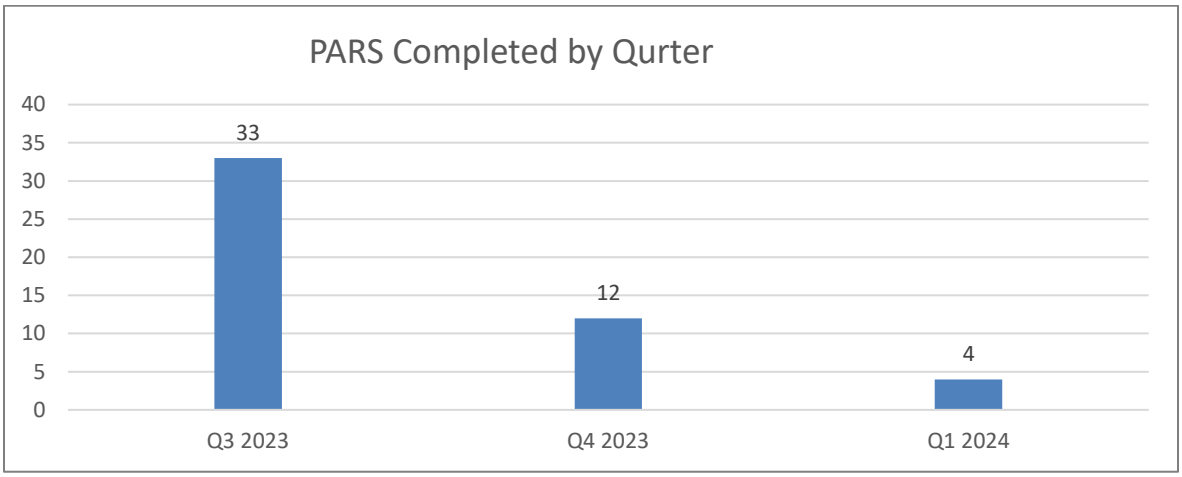


For the Q1 2024, there were 5 Interim reviews completed.

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 Q1 2024, we had 4 focused MRRs completed.

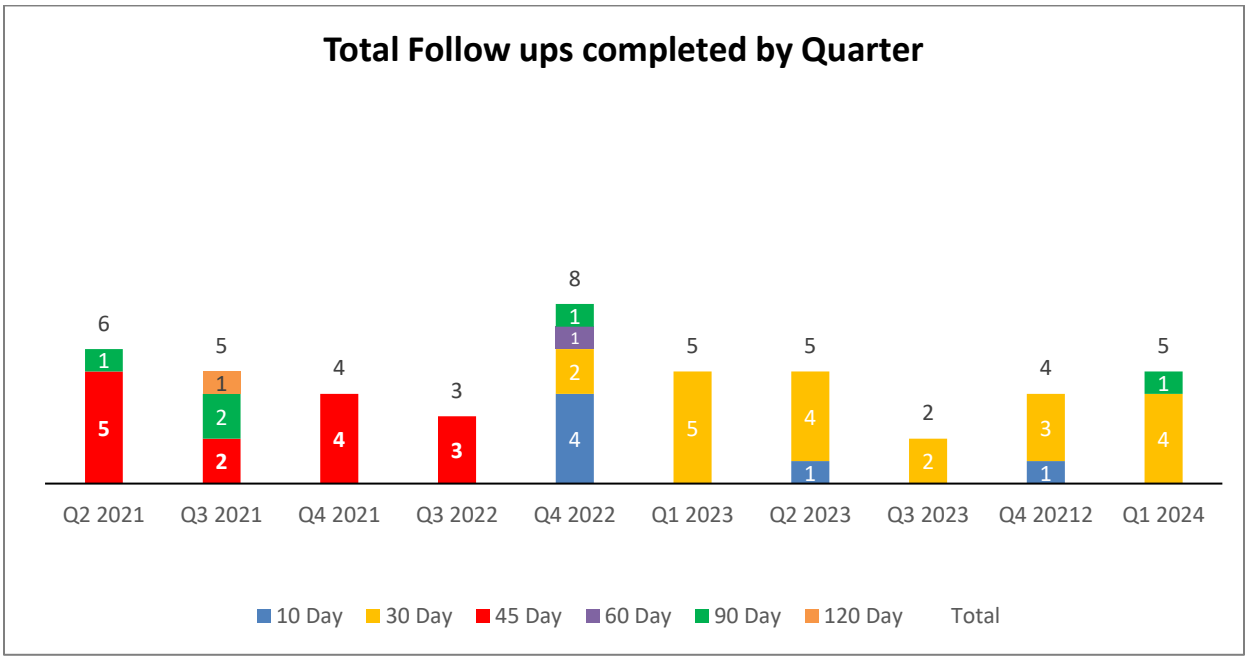
G. Physical Accessibility Review Survey (PARS):

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 Q1 2024, 4 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 Q1 2024, there were 4 30-day, and 1 90-Day follow-ups 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 and will run through 2026. The clinical PIP will be focused on Health Equity, specific to the W30 0-15 months African American population.

The PIP team is currently investing additional efforts towards causal and barrier analysis. This concentrated effort allows us to identify key challenges and opportunities for improvement. Furthermore, our team engaged in group discussions focused on steps 7 and 8 for the forthcoming PIP submission scheduled for September. We convened with Member Services to explore minor adjustments to a Gap-in-Care Spreadsheet, ensuring the inclusion of W30 members. Moreover, our involvement in the Black Family Wellness Expo on March 16, 2014, provided valuable insights and connections within the community. Lastly, we received updates from Anastacia Lester regarding the BIMHI/KHS plan, particularly regarding reviewing access to care for various regions within Kern County.

Non-Clinical PIP:

The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health department for support of interventions. We will be partnering with the Behavioral Health Department, UM, PHM, and any other necessary stakeholders. We are working with BI to get an updated ADT report as per the PIP requirement. 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 on strategies for FUA/FUM measures.

Both PIPs were submitted and approved by HSAG for the first annual review. We will continue PIP efforts to ensure timely submission in 2024 to outline our interventions and testing plans.

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 Touchpoints: The QP team has initiated monthly and quarterly meetings with assigned providers. We are working with assigned PNM representatives to begin scheduling meetings for Omni and Coastal Kids by end of March, and Dr. Okezie's office by June.

- Dr. Duggal began a pilot for Diabetic members. With this pilot, Dr. Duggal is managing a group of members with uncontrolled Diabetes. The goal of the program is to improve members'A1C levels with the appropriate interventions. This is an incentive-based reimbursement structure similar to other programs, such as Covid vaccines and the BCS pilot with CBCC. The QP leadership team is in the process of establishing an API to allow appointment scheduling for this population directly with Dr. Duggal's office.
- Komoto Pharmacy completed their first mobile unit at the Black Family Wellness Expo on March 16th, 2024. KHS is supporting this effort with a targeted call campaign for African American families within three miles of the event.
- Total of four mobile unit providers are operational with a focus on closing gaps in care. The Children's domain of care is a priority for mobile efforts. KHS is fostering partnerships between school districts and mobile providers to meet our members where they are and provide quality, accessible care.
- Funding lead screening kits for various pediatricians and PCPs to increase compliance with the LSC measure
- Submitted DHCS request for approval to incentivize and encourage members to follow up after ED visit for mental Illness and substance abuse- before their 30 days from hospital discharge, and approval for incentivizing members to complete HgA1C testing.
    - FUM- Approved
    - FUA- Approved
    - HBD- Approved

- Working with Blackhawk regarding new MERP Incentives. FUA, FUM, and HBD accounts to be setup and completed.
- Member Engagement Reward Program (MERP) Campaigns:
    - Adding FUA, FUM, and HBD text messages to the campaign list once final approval is received from Compliance.
    - Working with BI for configuration on FUA, FUM, and HBD.
    - Text Messages to members encouraging the scheduling of 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):

The MY2023/RY2024 MCAS annual audit has been initiated by HSAG. The QP team is currently engaged in actively conducting abstractions and monitoring retrievals from Cotiviti. The virtual audit with HSAG concluded and was successful. We are on track with the upcoming preliminary rate submissions, which is due to HSAG by April 12th. Simultaneously, workgroups and project meetings are underway to streamline the MCAS audit process, aiming to ensure efficiency across all audit components and to identify areas for improvement.

Currently for MY2023:

- Met MPL for 8 out of 18 measures: CBP, HBD, PPC-Pre, PPC-Post, AMR, BCS-E and CHL.
  - PPC-Post we met HPL as well.
  - One measure we are very close to meet MPL, CCS we need 1 more hits to MPL.
- 16 out of 18 measures showed improvement compared to previous year MY2022: CCS, HBD, CBP, IMA-2, PPS-Post, LSC, AMR, BCS-E, CHL, DEV, FUA, FUM, TFL, W30 (0-15), W50(15-30) and WCV.
- 2 out of 18 measures showed slight decrease compared to MY2022: CIS-10 and PPC-Pre 0.25%.

MCAS MY2023 Measure Rates_As of 4/26/2023

	Measure	Admin/Hybrid/ECDS	MY2023 Rate	MPL Rate	HPL Rate	MY2023 Rate vs MPL	Hits Needed	MY 2022 Rate	MY 2022 vs MY2023
Behavioral Health Domain Measures									
FUM	Follow-Up After ED Visit for Mental Illness – 30 days*	Administrative	19.12	54.87	73.26	-35.75	226	18.80	▲ 0.32
FUA	Follow-Up After ED Visit for Substance Abuse – 30 days*	Administrative	18.85	36.34	53.44	-17.49	229	15.74	▲ 3.11
Children's Health Domain Measures									
WCV	Child and Adolescent Well – Care Visits*	Administrative	46.54	48.07	61.15	-1.53	1949	40.64	▲ 5.90
CIS-10	Childhood Immunization Status – Combination 10*	Hybrid/Admin**	24.82	30.9	45.26	-6.08	25	27.98	▼ -3.16
DEV	Developmental Screening in the First Three Years of Life	Administrative	25.94	34.70	N/A	-8.76	1163	13.47	▲ 12.47
IMA-2	Immunizations for Adolescents – Combination 2*	Hybrid/Admin**	34.31	34.31	48.8	0.00	0	29.68	▲ 4.63
LSC	Lead Screening in Children	Hybrid/Admin**	58.64	62.79	79.26	-4.15	17	47.45	▲ 11.19
TFL-CH	Topical Fluoride for Children	Administrative	16.44	19.30	N/A	-2.86	3829	12.27	▲ 4.17
W30-6+	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	Administrative	39.21	58.38	68.09	-19.17	570	37.12	▲ 2.09
W30-2+	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits*	Administrative	63.74	66.76	77.78	-3.02	171	55.12	▲ 8.62
Chronic Disease Management Domain Measures									
AMR	Asthma Medication Ratio*	Administrative	71.20	65.61	75.92	5.59	0	69.48	▲ 1.72
CBP	Controlling High Blood Pressure*	Hybrid/Admin**	65.45	61.31	72.22	4.14	0	60.58	▲ 4.87
HBD	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	Hybrid/Admin**	33.33	37.96	29.44	4.63	0	39.17	▲ -5.84
Reproductive Health Domain Measures									
CHL	Chlamydia Screening in Women	Administrative	56.87	56.04	67.39	0.83	0	53.67	▲ 3.20
PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	Hybrid/Admin**	87.10	84.23	91.07	2.87	0	87.35	▼ -0.25
PPC-Pst	Prenatal and Postpartum Care: Postpartum Care*	Hybrid/Admin**	86.37	78.1	84.59	8.27	0	83.94	▲ 2.43
Cancer Prevention Domain Measures									
BCS-E	Breast Cancer Screening*	ECDS & Admin***	59.30	52.60	62.67	6.70	0	56.68	▲ 2.62
CCS	Cervical Cancer Screening	Hybrid/Admin**	56.93	57.11	66.48	-0.18	1	52.80	▲ 4.13

* Measures must be stratified by race/ethnicity per NCQA categorizations.

** Hybrid/Admin: MCPs/PSPs have the option to choose the methodology for reporting applicable measure rates

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

The below chart displays trending rates for MY2023 and MY2024:

MCAS MY2023 & MY2024 Performance Trending Metrics

Measure	Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMR	2023	65.58%	73.73%	▼ 70.48%	71.81%	69.12%	67.27%	67.08%	66.59%	68.51%	68.21%	68.51%	67.71%
	2024	67.48%	31.11%	▲ 75.46%									
BCS	2023	41.95%	43.55%	▼ 44.97%	46.30%	47.22%	49.59%	51.15%	52.41%	54.02%	55.63%	56.92%	57.78%
	2024	44.23%	45.63%	▲ 47.44%									
CBP	2023	7.85%	17.19%	▼ 24.42%	28.47%	32.36%	35.72%	38.24%	40.51%	42.21%	42.90%	43.54%	43.77%
	2024	9.26%	18.53%	▲ 25.05%									
CCS	2023	43.40%	44.19%	▲ 45.37%	46.35%	47.38%	48.37%	49.43%	50.22%	51.24%	52.46%	53.39%	54.16%
	2024	37.99%	36.76%	▼ 38.23%									
CDEV	2023	3.89%	6.53%	▼ 8.95%	10.68%	12.49%	14.20%	15.45%	16.27%	17.05%	18.00%	18.65%	19.06%
	2024	6.26%	9.14%	▲ 11.74%									
CHL	2023	21.50%	29.69%	▲ 35.35%	39.38%	42.65%	45.26%	47.69%	50.29%	51.61%	53.68%	54.85%	56.29%
	2024	22.15%	33.05%	▼ 35.23%									
CIS-10	2023	11.04%	12.93%	▲ 14.34%	16.13%	16.92%	17.47%	17.74%	17.89%	18.07%	18.65%	19.40%	19.76%
	2024	10.01%	11.62%	▼ 12.17%									
FUA 30Day follow up	2023	6.41%	10.36%	▼ 0.00%	10.71%	10.05%	11.58%	11.33%	10.81%	12.45%	12.39%	12.06%	12.85%
	2024	20.00%	16.11%	▲ 20.59%									
FUM 30Day follow up	2023	20.51%	11.50%	▼ 0.00%	13.15%	13.97%	15.37%	16.23%	15.44%	16.89%	17.55%	17.29%	17.13%
	2024	0.00%	25.00%	▲ 21.88%									
GSD*	2023	98.02%	94.51%	▲ 86.56%	76.35%	74.48%	69.80%	65.31%	63.51%	60.59%	58.10%	56.43%	55.09%
	2024	98.80%	93.82%	▼ 87.06%									
IMA-2	2023	18.94%	20.59%	▼ 21.93%	23.64%	24.51%	26.37%	27.52%	28.74%	29.60%	30.05%	30.54%	31.06%
	2024	20.41%	21.78%	▲ 23.08%									
LSC	2023	42.64%	46.09%	▼ 48.51%	50.07%	52.51%	53.47%	54.06%	54.96%	55.11%	55.53%	55.70%	55.87%
	2024	54.60%	57.84%	▲ 60.05%									
PPC-Pre	2023	21.77%	23.83%	▼ 26.43%	28.58%	30.12%	34.28%	37.92%	40.41%	41.91%	42.15%	42.16%	42.42%
	2024	25.10%	26.84%	▲ 28.68%									
PPC-Post	2023	45.41%	52.00%	▼ 56.72%	59.55%	58.08%	59.88%	59.89%	63.24%	64.56%	68.75%	72.58%	73.16%
	2024	47.47%	52.40%	▲ 57.47%									
TFL-CH	2023	5.68%	8.54%	▼ 8.58%	11.21%	17.49%	17.55%	23.50%	25.69%	25.90%	30.20%	32.40%	34.84%
	2024	14.64%	17.16%	▲ 20.65%									
W30 (0-15M)	2023	12.79%	15.81%	▼ 19.48%	22.46%	27.87%	36.89%	39.59%	39.21%	41.55%	43.27%	44.00%	44.34%
	2024	25.77%	30.66%	▲ 35.79%									
W30 (15-30M)	2023	42.49%	46.54%	▼ 50.24%	53.15%	55.58%	57.89%	59.44%	60.40%	61.68%	62.20%	62.58%	62.68%
	2024	52.29%	55.22%	▲ 57.87%									
WCV	2023	1.98%	5.24%	▼ 9.16%	12.62%	16.22%	22.30%	26.44%	31.54%	35.92%	39.56%	42.78%	45.66%
	2024	2.80%	6.13%	▲ 10.59%									

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 March 2024, **14 out of 18 measures showed improvement** compared to this month last year:

- AMR - Asthma Medication Ratio
- BCS- Breast Cancer Screening
- CBP- Controlling High Blood Pressure <140/90 mm Hg.
- CDEV- Developmental Screening in the First 3 Years of Life
- CHL- Chlamydia Screening in Women Ages 16 – 24
- GSD- Glycemic Status Assessment for Patients with Diabetes
- FUA- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence 30-Day Follow up.
- IMA-2- Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)
- LSC- Lead Screening in Children
- TFL-CH- Topical Fluoride for Children
- PPC-Post- Prenatal & Postpartum Care – Postpartum Care
- 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.
- 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.
- WCV- Child and Adolescent Well-Care Visits

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

- CIS-10- Childhood Immunization Status- Combo 10
- CCS - Cervical Cancer Screening
- GSD- Glycemic Status Assessment for Patients with Diabetes
- CHL- Chlamydia Screening in Women Ages 16 – 24

IV. Policy Updates: There were no policy updates in Q1 2024.

KHS Quality Improvement Dept Report

Q2: June 27, 2024 meeting

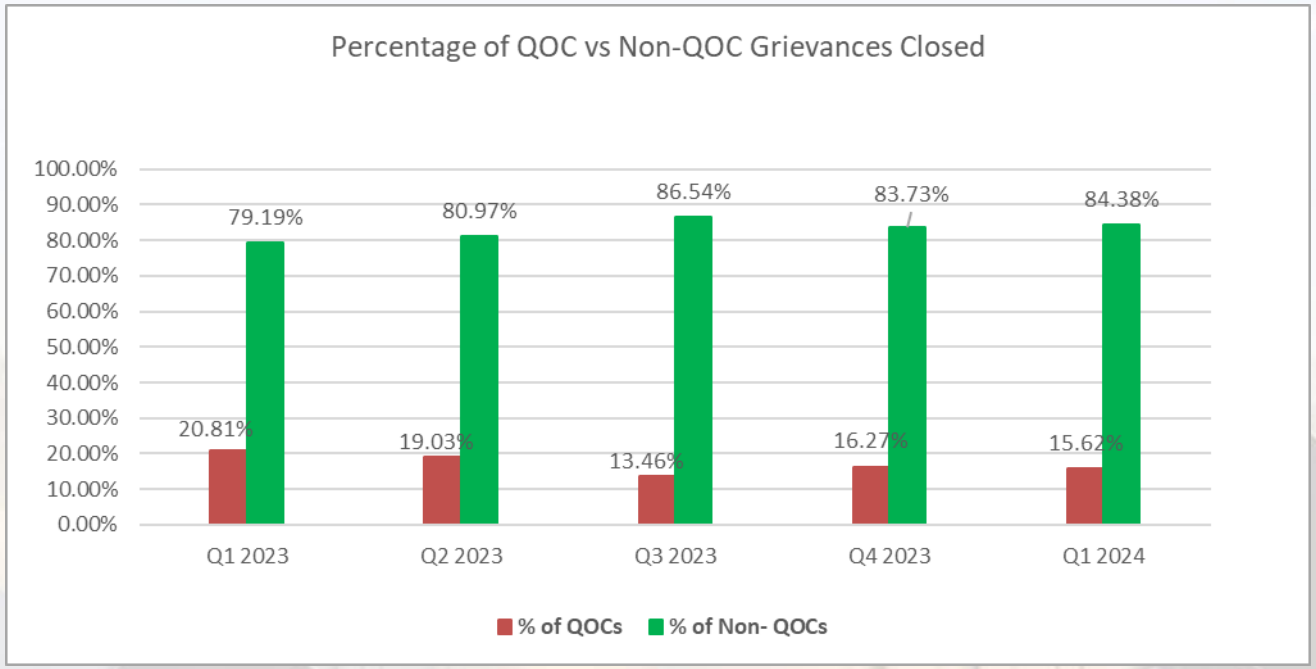
KERN HEALTH SYSTEMS

Quality Improvement Dept Functions

- Quality-of-Care Grievances
- Potential Quality Issues
- Clinical Network Oversight
- Claims, Disputes & Appeals

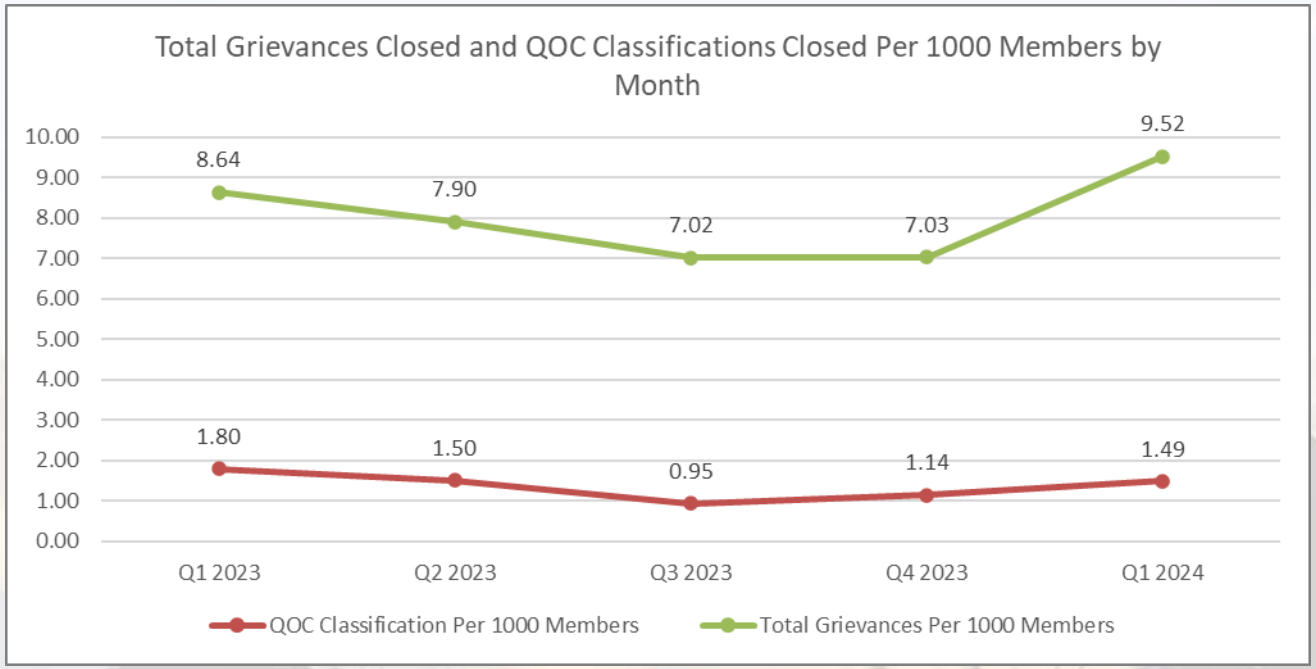
Quality-of-Care Grievances

- Quality-of-Care Grievances



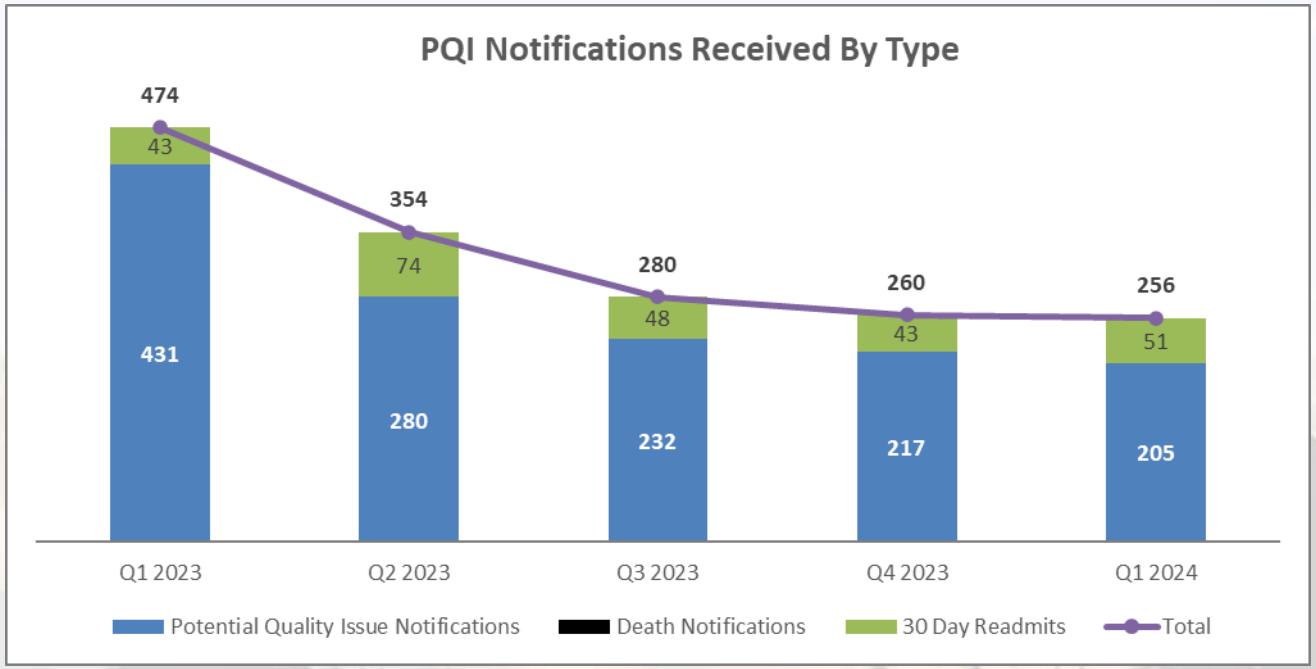
Quality-of-Care Grievances

- Quality-of-Care Grievances



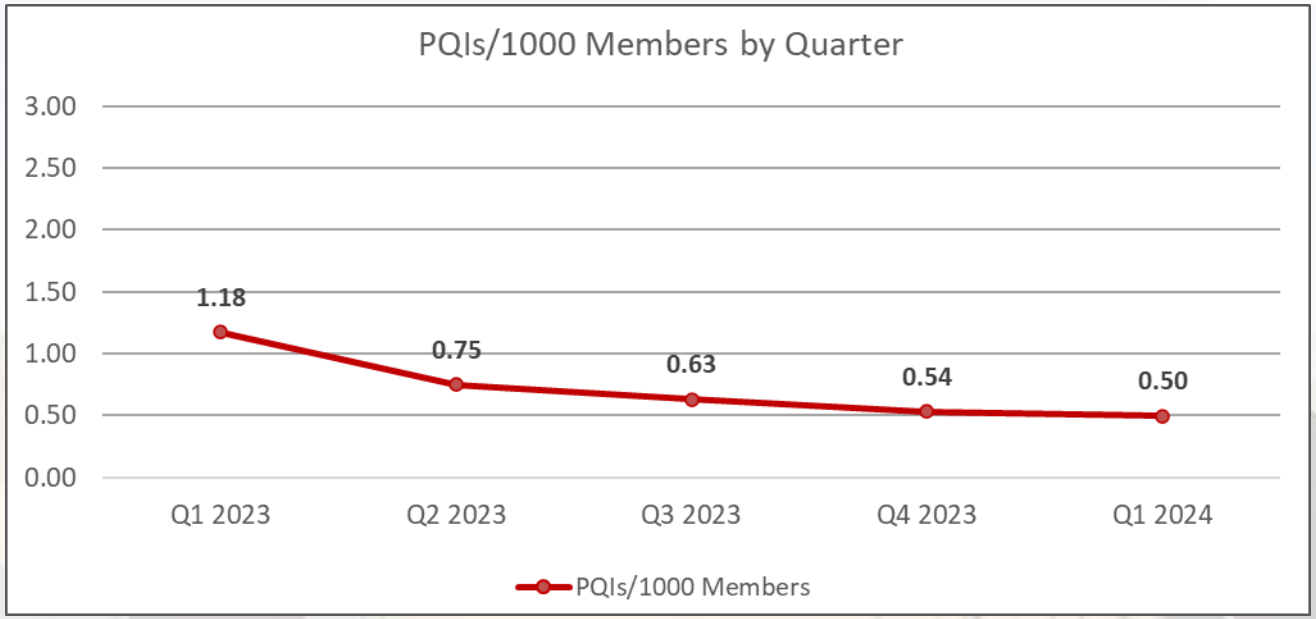
Potential Quality Issues

- Potential Quality Issues



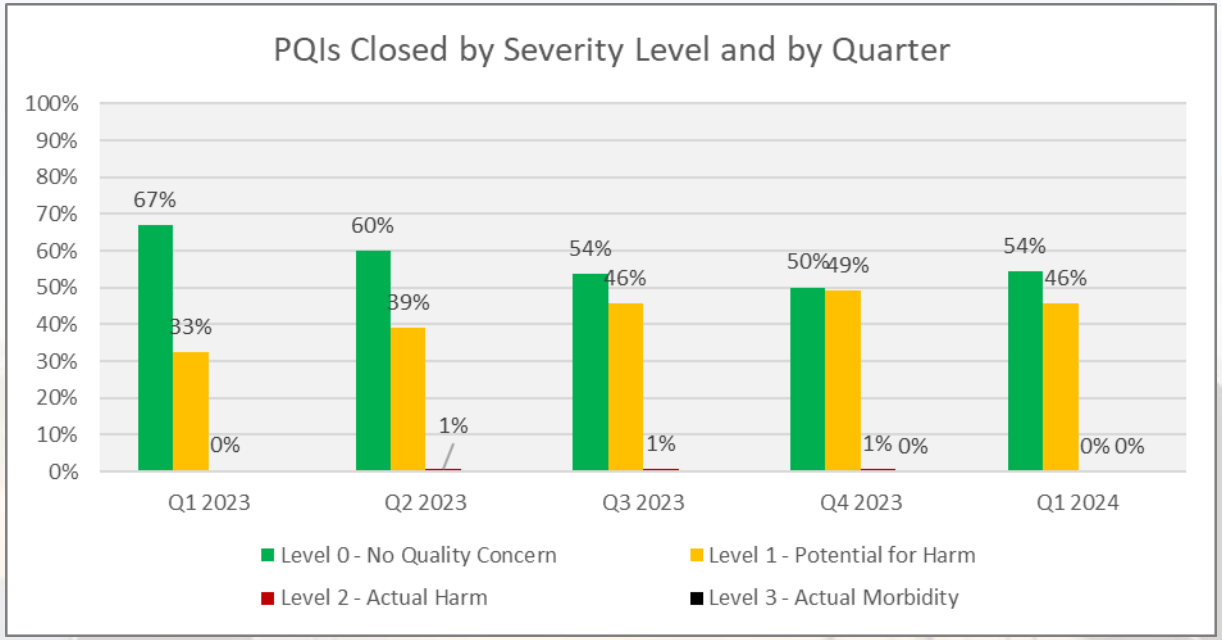
Potential Quality Issues

- Potential Quality Issues



Potential Quality Issues

- Potential Quality Issues



QUALITY IMPROVEMENT DEPARTMENT

QUARTERLY EQIHEC COMMIITTEE REPORT

Q1 2024

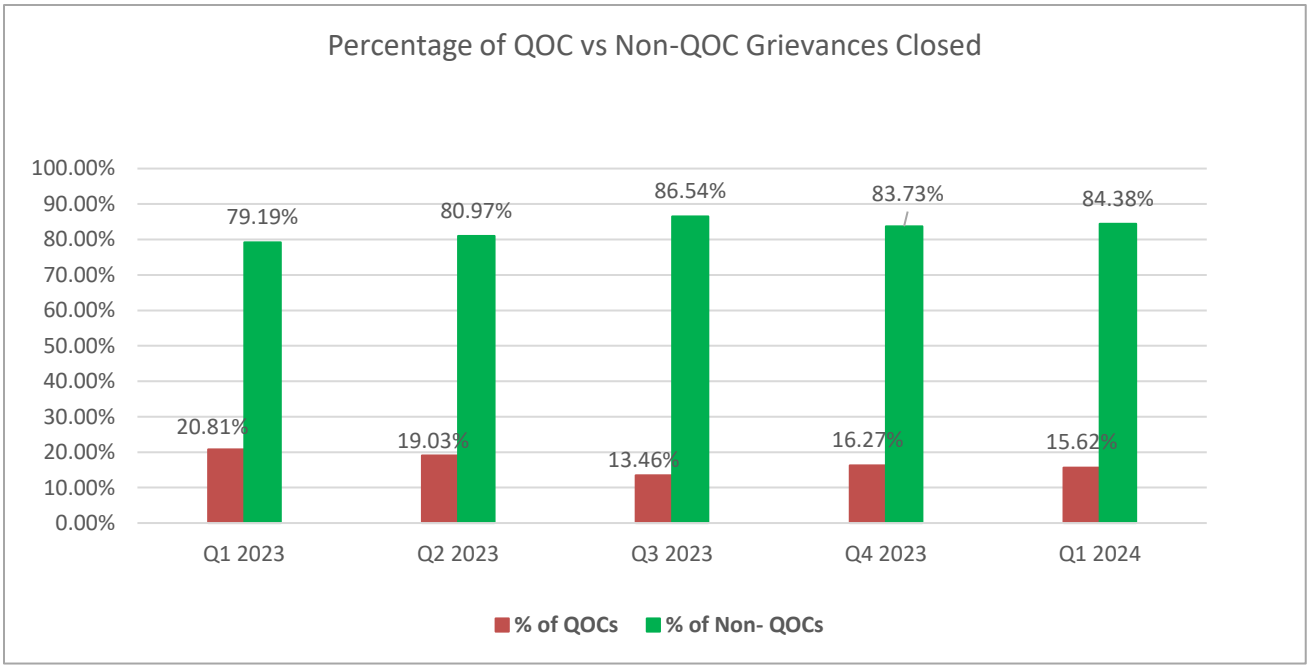
KERN HEALTH SYSTEMS
Quality Improvement Department Quarterly EQIHEC Committee Report
Q1 2024

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 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

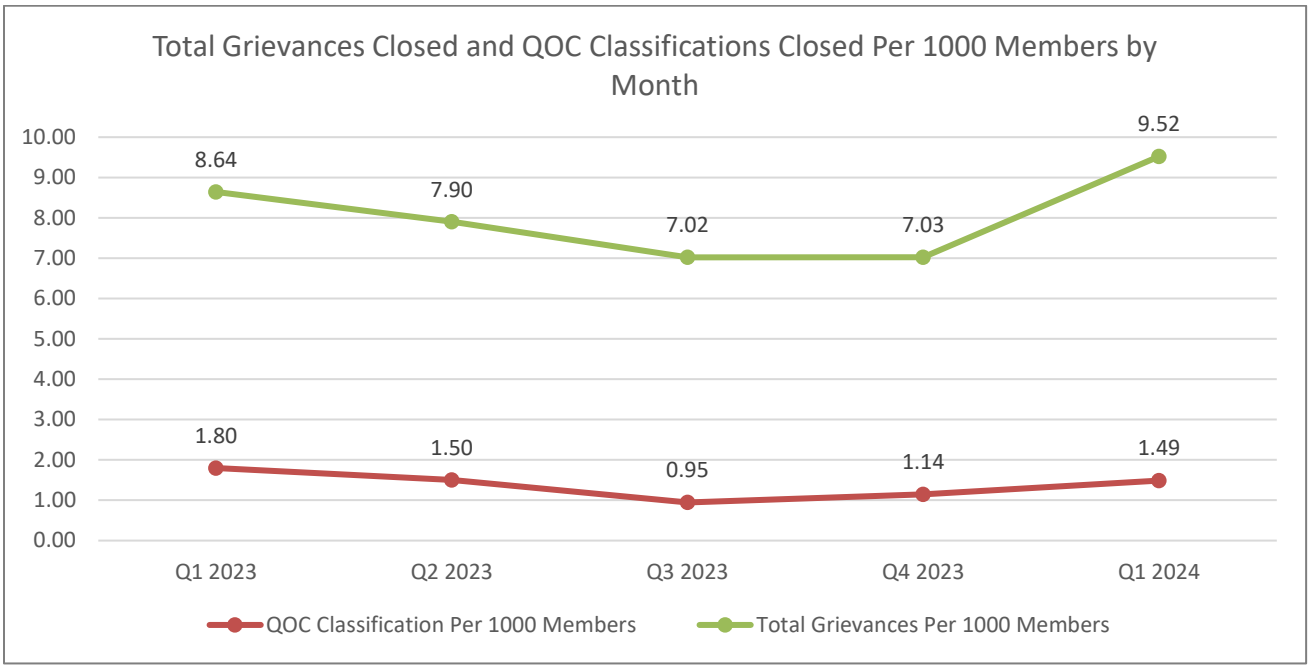
I. Grievances and Quality-of-Care (QOC) Classifications:

Grievances classified as QOC and closed in favor of the member are referred to the QI Department for further investigation as a Potential Quality Issue (PQI). 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. There are no significant trends identified.



Quarter	Grievances Closed as QOCs	Closed as Non-QOCs	Total Grievances Closed
Q1 2023	659	2507	3166
Q2 2023	560	2383	2943
Q3 2023	346	2224	2570
Q4 2023	463	2382	2845
Q1 2024	610	3295	3905

For Q1 2024, QI closed a total of 3905 Grievances of which 610 (15.62%) were classified as Quality-of-Care (QOC) Grievances. There was a 37% increase in the Total Grievance volume in Q1 2024 compared to the previous quarter. QI will continue to monitor for any trends.



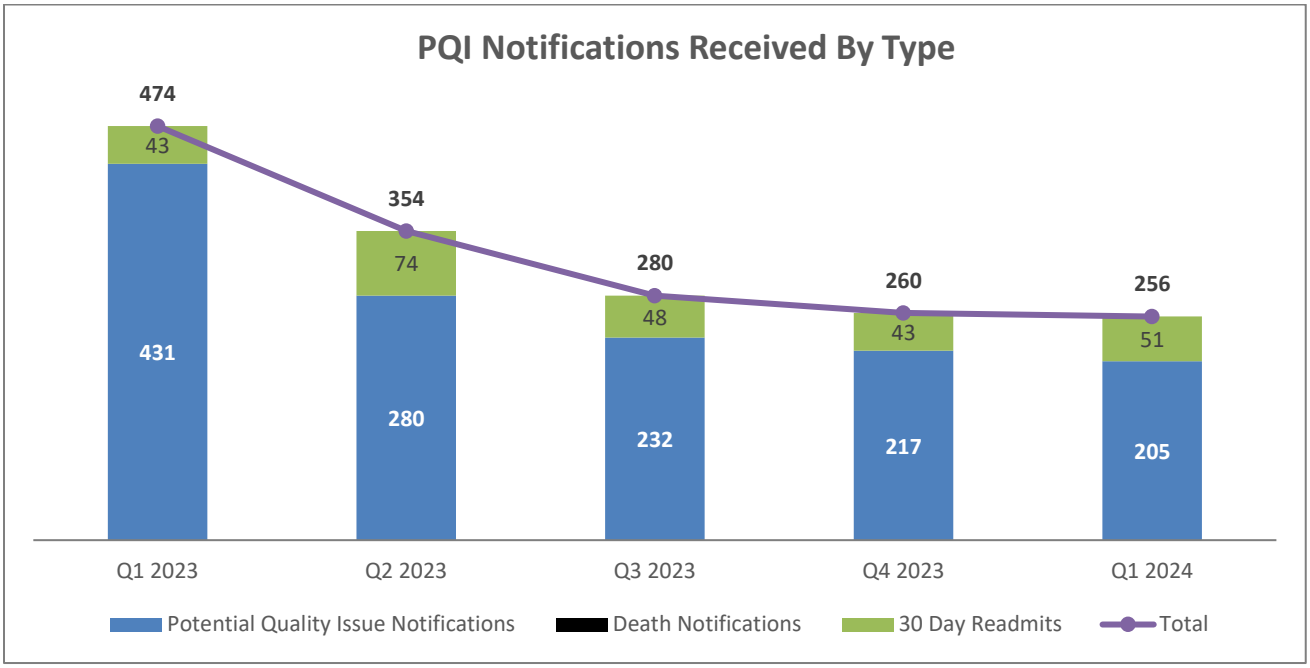
The above chart represents a comparison of total Grievances Closed and QOC classifications Closed per 1000 KHS members. The QOC classifications remain fairly consistent and similar to one year ago this time. The total grievances have increased, and this can be due to the increase in membership. There are no current trends identified.

II. Potential Quality Issue (PQI) Notifications:

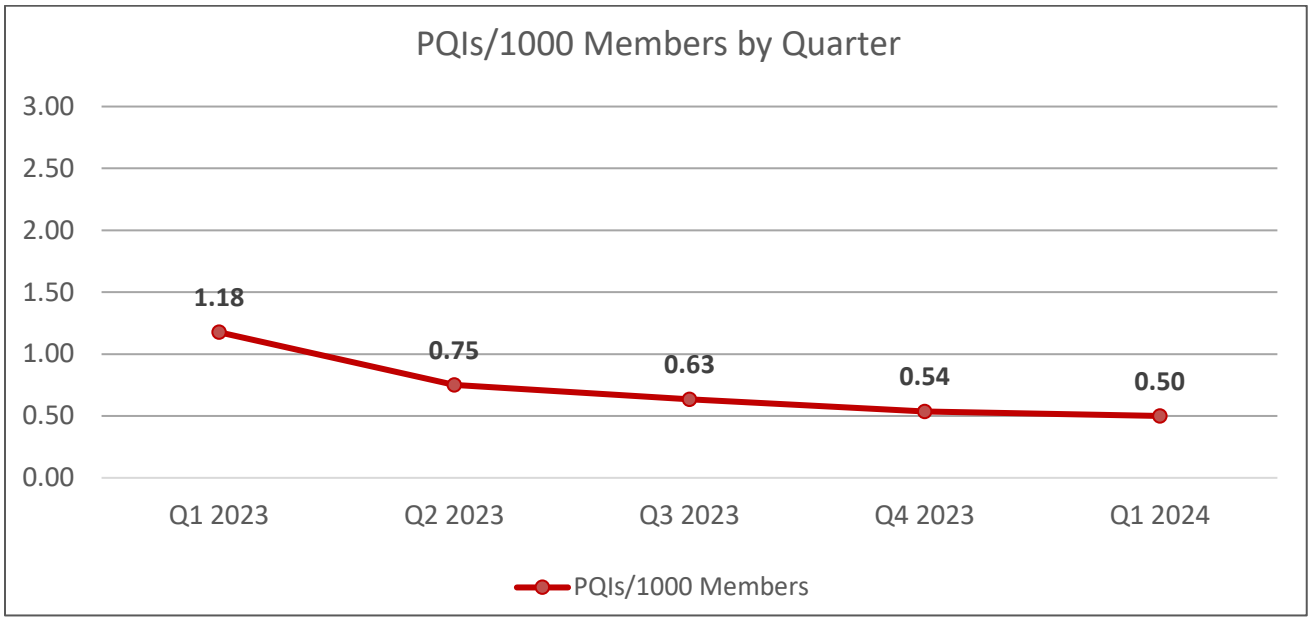
QI receives notifications from various sources to review for PQI notifications. On receipt of a PQI notification, a QI RN completes a high-level review to determine what level of Potential Quality Issue exists. PQIs are assigned a level based on the outcome of the review. The levels assigned are as follows:

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

- Follow-up = Corrective Action Plan plus direction from Medical Director or their designee which is individualized to the specific case or providers

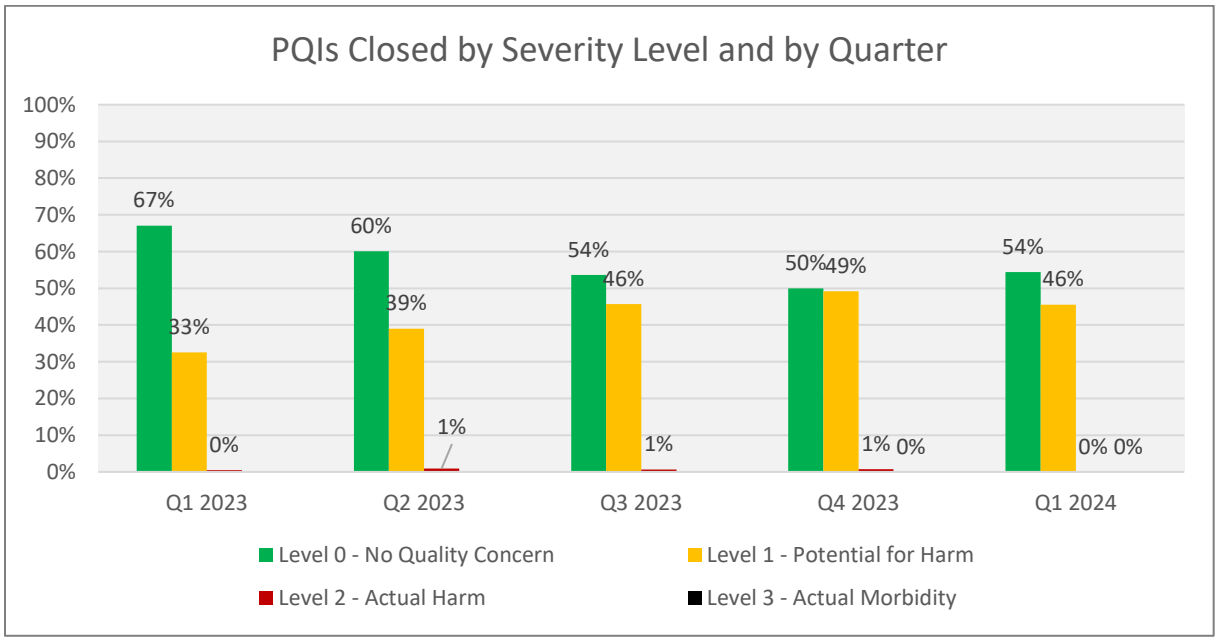


Compared to the previous quarter, in Q1 2024 the notifications decreased by about 2%. The PQI volume has decreased over the last year and there were no issues identified. QI will continue to monitor for any trends. The fifty 30-day readmission reviews conducted each quarter were completed timely for Q1 2024. There were no trends identified.



The above chart represents a comparison of PQI notifications received per 1000 KHS members. This graph contains PQI notifications alone and does not include 30-day readmits. The decrease in PQI/1000 members volume in Q1 2024 is consistent with the previous graph. QI will continue to monitor for any trends.

PQIs Closed by Severity Level:



From the above chart majority of PQIs closed in Q1 2024 were Level – 0 and Level – 1. Since Q1 2023, there has been a decrease in PQIs with the volume being fairly consistent within the year. QI will continue to monitor to identify any trends.

Below is the table with the volume of PQIs closed by severity and by quarter for reference:

Severity Level	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024
Level 0 - No Quality Concern	299	265	162	129	129
Level 1 - Potential for Harm	145	172	138	127	108
Level 2 - Actual Harm	2	4	2	2	0
Level 3 - Actual Morbidity	0	0	0	0	0
Total	446	441	302	258	237

PQIs Trending by Provider:

Based on the trending analysis conducted, below are the top 5 outpatient providers for the rolling 12 months (April 2023 – March 2024). The top 5 providers with PQIs leading to actual harm or morbidity to the member is based on the PQIs per 1000 Outpatient visits.

Top 5 Outpatient Providers with PQIs:

TOP 5 OUT PATIENT PROVIDERS WITH PQIs- April 2023-March 2024

Top 5 Providers with PQIs leading to Actual Harm or Morbidity (Level 2 or 3)	PQIs/1000 Visits					
	Level 0--No Quality Concern PQIs Per 1000 Visits	Level 1- Potential for Harm PQIs Per 1000 Visits	Level 2-- Potential for Harm PQIs Per 1000 Visits	Level 3-Actual Morbidity PQIs Per 1000 Visits	Total Outpatient Visits	Total PQI's Per 1000 Visits
PROVIDER A	0.82	0.0	0.41	0.00	2447	1.23
PROVIDER B	0.00	0.0	0.29	0.00	3399	0.29
PROVIDER C	0.00	0.0	1.53	0.00	652	1.53
PROVIDER D	0.00	0.0	0.13	0.00	7921	0.13
PROVIDER E	0.00	0.0	4.35	0.00	230	4.35

Top 5 Provider for Total PQIs	PQIs/1000 Visits					
	Level 0--No Quality Concern PQIs Per 1000 Visits	Level 1- Potential for Harm PQIs Per 1000 Visits	Level 2-- Potential for Harm PQIs Per 1000 Visits	Level 3-Actual Morbidity PQIs Per 1000 Visits	Total Outpatient Visits	Total PQI's Per 1000 Visits
PROVIDER F	5.50	4.34	0.00	0.00	3,453	9.8
PROVIDER G	0.09	0.24	0.00	0.00	73,829	0.3
PROVIDER H	0.71	1.16	0.00	0.00	11,212	1.9
PROVIDER I	2.82	14.12	0.00	0.00	708	16.9
PROVIDER J	0.28	0.51	0.00	0.00	17733	0.8

From the above data, there were no providers identified with severity Level 3. Provider F had the highest ratio of PQI/1000 visit, of which the majority of PQIs identified were closed as Level 0s - No quality-of-care

issue and Level 1's – Potential for Harm. There were no Level 2's or Level 3's. QI will continue to monitor the data.

Top Inpatient Providers with PQIs:

Top INPATIENT PROVIDERS WITH PQIs- April 2023-March 2024						
	PQIs/1000 Discharges					
Top Providers with PQIs leading to Actual Harm or Morbidity (Level 2 or 3)	Level 0-No Quality Concern PQIs Per 1000 Discharges	Level 1-Potential for Harm PQIs Per 1000 Discharges	Level 2-PQIs Per 1000 Discharges	Level 3-PQI's Per 1000 Discharges	Total Discharges	Total PQI's Per 1000 Discharges
PROVIDER A	2.62	0.0	2.62	0.00	381	5.25
	PQIs/1000 Discharges					
Top 5 Provider for Total PQIs	Level 0-PQIs Per 1000 Discharges	Level 1-PQIs Per 1000 Discharges	Level 2-PQIs Per 1000 Discharges	Level 3-PQI's Per 1000 Discharges	Total Discharges	Total PQI's Per 1000 Discharges
PROVIDER B	3.48	0.7	0.00	0.00	5753	4.17
PROVIDER C	1.64	0.0	0.00	0.00	5480	1.64
PROVIDER D	6.02	6.0	0.00	0.00	332	12.05
PROVIDER E	0.63	0.1	0.00	0.00	9558	0.73
PROVIDER F	1.23	0.2	0.00	0.00	4074	1.47

Only one inpatient provider had a PQI with severity Level - 2 and none had PQIs with severity Level - 3. Due to the low volume, the data is considered statistically not valid. Provider D had the highest ratio of PQIs per 1000 visits but because the total PQI and discharge volume is very low, the data is considered statistically invalid. No issues identified; QI will continue to monitor the data for next rolling 12 months.

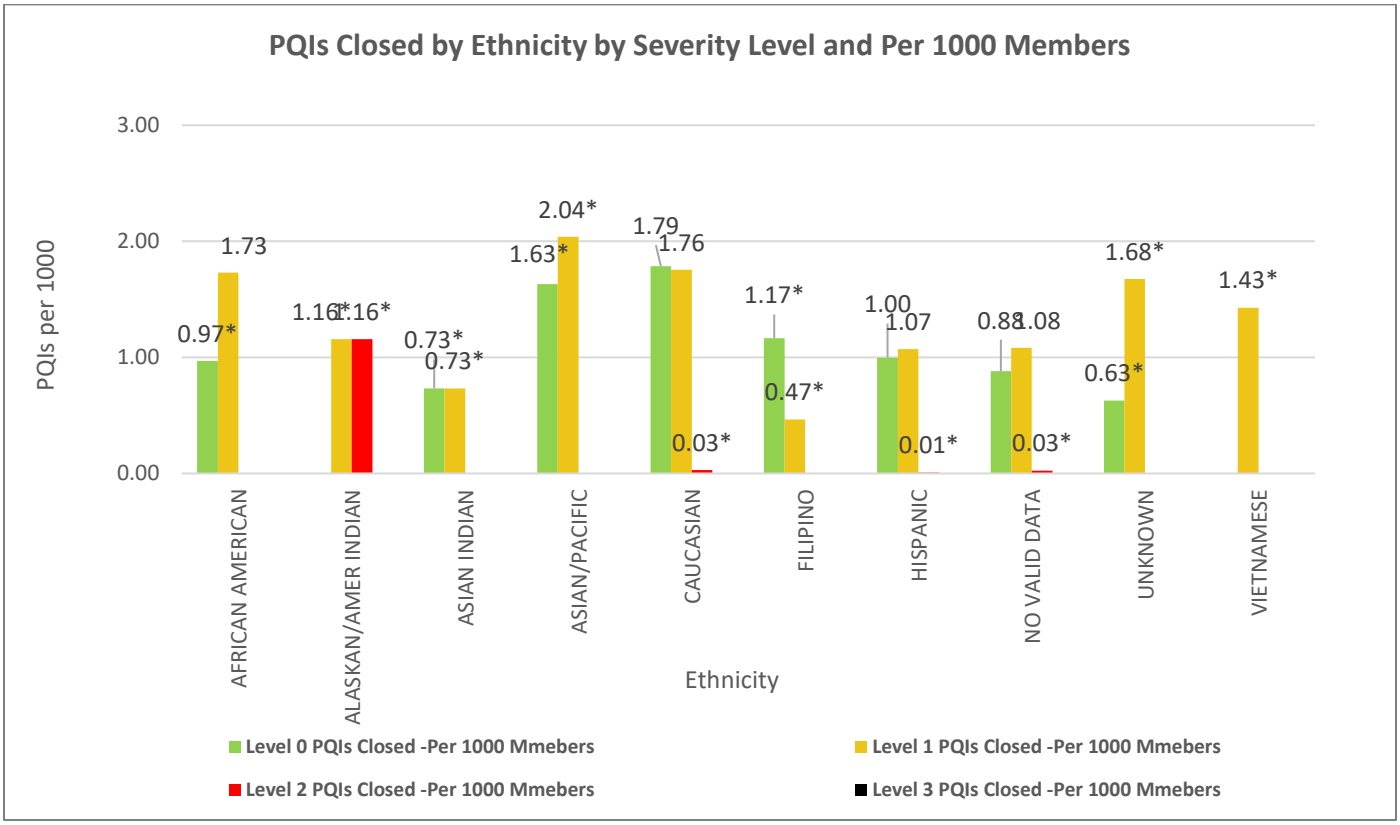
Top 5 Providers with 30-Day Re-admits:

TOP 5 PROVIDERS WITH 30-Day Readmits- April 2023-March 2024						
	PQIs/1000 Visits					
Top 5 Providers for 30-Day Readmit PQIs (with Severity Level's 1-3)	Level 0-PQIs Per 1000 Discharges	Level 1-PQIs Per 1000 Discharges	Level 2-PQIs Per 1000 Discharges	Level 3-PQI's Per 1000 Discharges	Total Discharges	Total PQI's Per 1000 Discharges
PROVIDER A	5.34	0.3	0.1	0.0	9558	5.8
PROVIDER B	5.29	0.5	0.0	0.0	5480	5.8
PROVIDER C	8.10	0.7	0.0	0.0	4074	8.8
PROVIDER D	8.52	0.3	0.0	0.0	5753	8.9
PROVIDER E	7.50	1.1	0.0	0.0	933	8.6

From the above data, none of the providers had a PQI with severity Level 3 - Actual Harm. Majority of 30-day readmits were closed as Level 0s. No concerns identified; QI will continue to monitor for any trends.

PQIs Closed by Ethnicity:

The data below is for the rolling 12 months from April 2023 through March 2024.



* Indicates the PQI volume was not statistically valid as it was <30.

Although the Asian/Pacific population has the highest PQI rate per 1000 members, there were only nine PQIs for this population. Asian/Pacific account for ~0.6% of the total KHS membership, which is why the PQIs per 1000 rate reflects higher compared to other populations. No concerns identified; QI will continue to monitor for any trends.

The statistically valid volumes per ethnic group are Hispanic and Caucasian. Of these groups, the highest is Hispanic with most cases being Level - 0's and Level – 1's. There was a low volume of Level - 2 cases and no trends or concerns to address at this time. QI will continue to monitor these volumes.

Data for QIC 6/27/24

June 24, 2024

NCQA Standard

QI 3: Continuity and Coordination of Medical Care

The organization monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network.

Intent
The organization uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system.

Element A: Identifying Opportunities

The organization annually identifies opportunities to improve coordination of medical care by:
1.Collecting data on member movement between practitioners.
2. Collecting data on member movement across settings.
3. Conducting quantitative and qualitative analysis of data to identify improvement opportunities.
4. Identifying and selecting one opportunity for improvement.
5. Identifying and selecting a second opportunity for improvement.
6. Identifying and selecting a third opportunity for improvement.
7. Identifying and selecting a fourth opportunity for improvement.

KERN HEALTH SYSTEMS

Data

Office Visits within 7 Days of Inpatient Discharge Calendar Year 2023	
4277 (39%)	Had an office visit within 7 days
6659 (61%)	Did **not** have an office visit within 7 days
10,936	Total

Top 4 primary diagnoses of members who did not have an office visit within 7 days of discharge	
189 (3%)	Other sepsis;Sepsis, unspecified organism
160 (2%)	Overweight and obesity;Morbid (sevr)obesity d/t exces calo
124 (2%)	Pneumonia, unspecified organism;Pneumonia, unspecified organism
113 (2%)	Pain in throat and chest;Chest pain, unspecified

KERN HEALTH SYSTEMS

Measure Comparison

Source: Measure Summary Report Booklets 2023-PCR

	Plan All-Cause Readmissions	Certified - 2023					
	MEDI-CAL						
Data Elements	MemberCount and OutlierRate						
	MemberCount	OutlierMemberCount	OutlierRate				
18-44	1963	64	32.6032				
45-54	945	37	39.1534				
55-64	1126	61	54.1741				
18-64	4034	162	40.1587				
	PlanAllCauseReadmissions						
Age	Denominator	ObservedCount	ObservedRate	ExpectedCount	ExpectedRate	CountVariance	OE
18-44	2240	172	7.68%	184.755	8.25%	166.58	0.931
45-54	1131	117	10.34%	117.8644	10.42%	103.0181	0.9927
55-64	1327	136	10.25%	155.8572	11.75%	134.5047	0.8726
18-64	4698	425	9.05%	458.4766	9.76%	404.1028	0.927

There appears to be opportunity to reduce readmits in age groups 45-54 and 55-64

KERN HEALTH SYSTEMS

Potential Barriers – to be discussed at QI Committee (1 of 2)
*focus needs to be on coordination across settings

- PCPs are unaware that a patient has been seen in the Emergency Department (ED) indicating that there is a collaboration or communication issue between practitioners and care settings. ED staff doesn't share the information with the PCP after the member has visited the emergency room. ED staff may not know who the PCP is, so they don't know who to send the information to. ED practitioners often fail to complete a discharge summary on time. Moreover, the PCP typically doesn't get the discharge summary. They don't complete a release of information form with the member, so they don't think they have the right to share information with other providers who are managing the care for the member.

- Staffing Challenges:
  - Staff turnover at Hospital offices can result in a disruption in ongoing processes and affect continuity and coordination of care. Appropriately staffing hospitals has been particularly challenging in today's job market. There is a severe shortage of staffing in the country, and this has more acutely affected the health care industry.

- Understanding of HIPAA Regulation:
  - Hospital staff may misinterpret HIPAA regulations and won't share the information with the PCP if they don't have a release of information form signed by the member. Without a release of information, hospital staff does not think it can share the information, and more importantly, they don't know who to share the information with. The HIPAA regulations themselves are quite complex, and there is insufficient training on the regulations for the staff to be fully aware of all the necessary requirements needed for their job function.

KERN HEALTH SYSTEMS

Potential Barriers – to be discussed at QI Committee (2 of 2)
*focus needs to be on coordination across settings

- Infrastructure Challenges:
  - The Hospitals and outpatient practitioners are rarely on the same Electronic Medical Record (EMR) system which means that they are not able to see the relevant clinical information needed to better manage their patients. There are different kinds of infrastructure established to exchange information between hospitals and PCPs. These include Health information exchanges and Admit, Discharge and Transfer (ADT) feeds. However, due to a lack of resources and staffing to set up these systems, several clinics are not able to utilize these systems. Providers agree that a long-term goal would be to have EMRs that communicate or share information through a data warehouse so that everyone has access to notes with information that they need.
  - Some hospitals may not be connected to the ADT feed system.
    - PCPs may not be getting sufficient information if they don't have access or do not activate their access to the ADT feed system.
    - Even clinics that are connected to Health Information Exchanges (HIEs) and getting ADT feeds have an issue with the providers reviewing these notes once they are received. PCPs who are within those clinics may not be aware that they can get or may not know they are already getting information through ADT feeds.
- Communication between healthcare providers and members may be insufficient.
  - Members are not given clear instructions to share the discharge summaries with their outpatient providers. There is limited provider-member interaction time which could lead to unclear instructions for follow-up care once discharged.
  - Members discharged from the hospital without clear guidance on post-discharge follow-up care, how and when to schedule an appointment with their PCP, medication management, or other essential information may struggle to adhere to treatment plans, increasing the risk of readmission.
- Members may lack awareness of whom to contact for follow-up care, such as their primary care provider or specialist.
  - This lack of clarity could result in members not seeking necessary post-discharge care, leading to complications and an increased risk of readmission.

KERN HEALTH SYSTEMS

Continuity and Coordination of Medical Care

June 27, 2024

NCQA Quality Improvement (QI) Standard 3

- The organization monitors and takes action to improve continuity and coordination of care across the health care network
- Intent: Use information to facilitate continuity & coordination
- Elements:
  1. Collect data on member movement between practitioners
  2. Conduct quantitative and qualitative analysis of data to identify opportunities
  3. Identify and select opportunity for improvement

KERN HEALTH SYSTEMS

Movement between Practitioners - EED

- Eye Exam for Patients with Diabetes (EED)
- **Goal:** reach NCQA Quality Compass Benchmark of 51.5%
- Results:

EED	2022	2023	Quality Compass Benchmark Medicaid HMO
Eligible Population	15619	18738	
Numerator	5110	6307	
Rate	32.72%	33.66%	51.5%

KERN HEALTH SYSTEMS

Movement between Practitioners - EED

- Team reviewed results & opportunities identified
  - East Kern access, geography, and network adequacy was reviewed and was found to be an opportunity
  - PCP referrals not being made and/or member not going eye exam
  - Specialist not returning consult report
  - Lack of established relationship between vision and PCP providers.

KERN HEALTH SYSTEMS

Movement between Practitioners - EED

Barrier	Opportunity
Access	Improve access in East Kern
No referral made	Provider Education to PCPs
Communication between PCP & Specialists	Consult Report Note getting back to PCP
Lack of established relationships between vision service providers and PCPs	Establish relationships between vision providers and PCP

KERN HEALTH SYSTEMS

Questions?

KERN HEALTH SYSTEMS

QI 3A Continuity and Coordination of Medical Care Quantitative & Qualitative Analysis June 2024

Table of Contents

Overview

At KHS, processes are in place to ensure that continuity of care is facilitated through care coordination and collaboration between practitioners and across settings including the following:

- Through facility site reviews (FSR), PCP offices are encouraged to adopt a closed-loop referral system that ensures timely receipt of information from specialists.
- Population Health Management Department's (PHM) Case Management has policies and procedures that promote provider engagement in the smooth transition of care after the member is discharged from a hospital or skilled nursing facility.
- Provider Network Services collaborate with appropriate departments to provide continuous education and training and equip KHS providers with the awareness of the regulatory requirements and provide resources that promote effective communication and coordination of care through avenues such as provider

manuals, provider newsletters, and the availability of tools and other information on the provider portal, as well as regular physician and joint operations meetings.

- Through Population Needs Assessment (PNA), KHS identifies the needs of its members and develops strategies to meet those needs ensuring equality of care, considering cultural diversity, age, gender, religion, and socioeconomic status of the members.
- the Business Intelligence Unit provides pertinent clinical and non-clinical data to track and trend performances over time. This prompts the assessment of the effectiveness of the actions taken and directs KHS to continuously work on those opportunities that can be improved.
- The support of KHS Committees and subcommittees strengthens the organization's efforts in fulfilling its mission of delivering equitable, holistic and coordinated care.

QI 3A.1,2

This report focuses on member movement between practitioners and across settings during care transitions for several clinical measures of performance through the Managed Care Accountability Set (MCAS), which is the annual reporting to DHCS for Medi-Cal plans, and through collecting data on HEDIS measures. These measures are used as an initial indicator to identify areas where additional data is needed to analyze and facilitate improvement in continuity and coordination of medical care.

Factor 1: Member Movement between Practitioners

HEDIS Measure: Eye Exam for Patients with Diabetes (EED) was identified and selected to facilitate improvement in continuity and coordination of medical care between practitioners. This measure we selected because it did not meet the national benchmark for measurement year 2022 nor 2023, and there is an existing arrangement with a leading vision services provider to outreach and schedule eye exams, which should be positively impacting this measure.

Coordination happens when PCPs managing their diabetic patients make the appropriate referrals to ophthalmology/optometry specialists, and these specialists send the visit notes back to the PCP.

Description and Relevance:

Diabetes is a chronic condition marked by high blood sugar due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to serious health conditions, including vision loss and blindness. Diabetes is the leading cause of new cases of blindness among adults 18–64 years of age. Adults with diabetes should receive regular eye exams to help detect and manage visual complications. Regular eye exams are the best way to reduce the risk of blindness and maintain a healthy and productive life. According to The Centers of Disease Control and Prevention (CDC), Diabetes disproportionately affects people of color and the children of often marginalized sub-populations.

Goal:

Our goal is to reach the NCQA Quality Compass benchmark of 51.5% by 2026 for the EED measure.

Methodology:

HEDIS Measure EED provides the percentage of members 18–75 years of age with diabetes (types 1 and 2) who had an annual retinal eye exam.

KHS imports claims and other standard supplemental data to a vendor, which is the same vendor used to retrieve chart data and create an annual MCAS and HEDIS Report. The vendor follows HEDIS & MCAS reporting specifications. The Quality Department reviews the annual report for measures not meeting benchmarks or thresholds and determines the ones for which performance improvement plans (PIPs) will be developed. For QI3A, the KHS Quality Department also looked at measures not meeting benchmark/threshold related to continuity and coordination of medical care to address areas where there are known issues and any other factors which provide an opportunity for improvement.

A request for all the detailed data KHS receives was made to determine if there were any trends or insights into root cause of low scores. An analysis of the detailed data was completed, and a cross-functional group of subject matter experts, including medical directors, Quality, PHM, Behavioral Health, and Business Intelligence was convened to review the data and results. (See table on pg. 11 for names and roles)

Additional data was requested and analyzed further:

- Access report for eye specialists
- Provider analysis
- Information by race/ethnicity, geography, age to see if SDoH could be an issue

- Follow up with vision service provider to determine if consult reports information is getting from vision services provider to PCP

QI 3A.1, 3

Data & Analysis

EED	2022	2023	Quality Compass Benchmark Medicaid HMO
Eligible Population	15619	18738	
Numerator	5110	6307	
Rate	32.72%	33.66%	51.5%

Quantitative Analysis:

Based on two years of data, KHS has maintained 32.72% and 33.66%, which is well below the national benchmark. While there was an improvement of .94% in 2023, a 2 Proportion z test was performed to determine statistical significance of the increase from 2022 to 2023, and the results showed that the improvement is not statistically significant. P value: .06432 @99% confidence.

KHS has not met the goal of 51.5% in MY2023. KHS was below the goal by 18%.

Summary of findings from all the 2022 EED Detailed Data readily available to KHS:

- Of the members who did not have an eye exam:
  - 74% are on insulin
  - 67% had a diabetes prescription filled
  - 47% were between the ages of 51-64

- Top 50% of PCPs of members who did not get an eye exam:

Provider Last Name	# members no eye exam	% of total
Grand Total	**11773**	
KAISER FOUNDATION HEALTHPLAN, INC	497	4%
BICHAI	422	4%
CSV - EAST BAKERSFIELD COMMUNITY HEALTH CENTER	414	4%
OMNI FAMILY HEALTH – PANAMA	384	3%
TIWANA	344	3%
CSV - SOUTH BAKERSFIELD COMMUNITY HEALTH CENTER	291	2%
SINGH	283	2%
CORONA	274	2%
CSV - EAST NILES COMMUNITY HEALTH CENTER	262	2%
CSV - COMPREHENSIVE CARE CENTER	250	2%
CSV - ARVIN COMMUNITY HEALTH CENTER	237	2%
OMNI - MING AVENUE HEALTH CENTER	237	2%
CSV - LAMONT COMMUNITY HEALTH CENTER	232	2%
CSV- DELANO WALK IN CLINC	224	2%
OMNI - NORTH CHESTER COMMUNITY HEALTH CENTER	224	2%
OMNI - BRIMHALL COMMUNITY HEALTH CENTER	220	2%
ABLIN	210	2%
GORDON	205	2%
ALVAREZ	203	2%
OMNI - DELANO #2 COMMUNITY HEALTH CENTER	195	2%
KOMIN	181	2%
CSV - GREENFIELD COMMUNITY HEALTH CENTER	177	2%

- 22 of the 215 providers on the list made up 50% of the members who did not get an eye exam. Of those, 18% were from one PCP practice (CSV).
- 42% of all the members who did not get an eye exam have a PCP in one of two PCP offices (CSV & Omni)

- Breakdown of members who got eye exam by Ethnicity:

Ethnicity	# eye exams	% eye exams
HISPANIC	4314	36%
CAUCASIAN	762	28%
AFRICAN AMERICAN	284	29%
NO VALID DATA	205	29%
ASIAN INDIAN	132	29%
FILIPINO	99	34%
UNKNOWN	55	27%
ASIAN/PACIFIC	53	31%
ALASKAN/AMER INDIAN	14	27%
VIETNAMESE	7	29%
SAMOAN	6	40%
KOREAN	3	25%
CHINESE	2	18%
LAOTIAN	5	45%
GUAMANIAN	2	29%
CAMBODIAN	0	0%
HAWAIIAN	1	25%
JAPANESE	1	50%

5945

Grand Total

Based on the number of members in each ethnicity group, and percent of them who got eye exams, it does not appear that Ethnicity is a factor in not getting an eye exam. Rather, the opportunity is with all ethnicities.

- **Geography:**

Total Members retinal eye exam needed (N=17,718)

Geography	%
City	61%
Rural	26%
East Kern	5%
n/a	8%
	100%

Total Members without Eye Exam (n=11,774)

Geography	%
City	60%
Rural	24%
East Kern	7%
n/a	9%
	100%

The members who did not get an eye exam are not disproportionately different from the total population of members who needed an eye exam. Therefore, there is as much opportunity to improve eye exam rates for people who live in the city as people who do not. Re-word to clearly state its not a factor)

- **Access Report: Ophthalmology**

Appointment Availability

As part of the Annual DMHC Timely Access Survey, the Plan conducted a survey of ophthalmology providers to measure their compliance with meeting appointment standards for urgent and non-urgent appointments. Survey took place during Q3 and Q4 of 2023. The Plan is required to include tertiary providers as part of the survey; the majority of the Outside Kern County survey responses are tertiary provider responses.

Provider Location	Providers Contacted	Providers Responded to Urgent Survey Question	Compliant with Urgent	Urgent Compliance %	Providers Responded to Non-urgent Survey Question	Compliant with Non-urgent	Non-Urgent Compliance %
Kern County	21	17	15	**88%**	17	16	**94%**
Outside Kern County	34	23	2	9%	21	1	5%

Total	55	40	17	43%	38	17	45%

Geographic Standard

KHS Policy *4.30-P Accessibility Standards* requires the Plan to maintain a network that meets the following geographic access standard:

Specialty	Geographic Standard	Goal
Ophthalmology	1 Provider within 45 miles	90%

As of April 2024, **97.3%** of the Plan's membership live within 45 miles of an Ophthalmology Provider.

East Kern Breakdown:

Geographic Area	Members Total	% of Members within 45 miles of Ophthalmology	# who did not get an eye exam/total who needed one	% of members who did NOT get an eye exam
California City (93505)	5126	99%	122/144	85%
Edwards (93523)	442	100%	2/2	100%
Inyokern (93527)	713	0%	8/8	100%
Johannesburg (93528)	65	0%	2/2	100%
Mojave (93501)	2226	100%	77/85	91%
Ridgecrest (93555)	9340	0%	182/192	95%
Rosamond (93560)	4676	100%	88/101	87%

289 of the 481 (60%) members in East Kern County who needed an eye exam live within 45 miles of an ophthalmologist. So geography is not an issue for 60% of members in East Kern, but it is a problem for those in Inyokern, Johannesburg and Ridgecrest.

Network Adequacy

KHS Policy *4.30-P Accessibility Standards* requires the Plan to maintain a network that meets the following network adequacy standard:

Specialty	Ratio Standard
Ophthalmology	1 Provider to every 7,500 Members

As of April 2024, the Plan exceeds the Ophthalmology ratios:

1 Provider to every 4381 Members

Optometry

The Plan currently does not maintain any access standards related to Optometry and has not conducted any Optometry specific analysis within the past 12 months.

As of April 2024, there are 13 unique Optometry providers across 10 locations within the Plans' direct network. The sites are in Bakersfield and Wasco.

Data from vision services provider:

Reported Cases	Members	
Received Eye Exam:	27,332	
Diabetes[1]:	1,766	6.5%
Diabetic Retinopathy:	184	.7%
Glaucoma:	770	2.8%
Hypertension:	713	2.6%
High Cholesterol	313	1.1%
Macular Degeneration:	136	.5%

[1] Patients managing their diabetes can avoid medical costs from $2,000 to over $4,000 annually versus those not managing it.

The vision services provider network doctors are expected to report the conditions they see during the visit.

Qualitative Analysis:

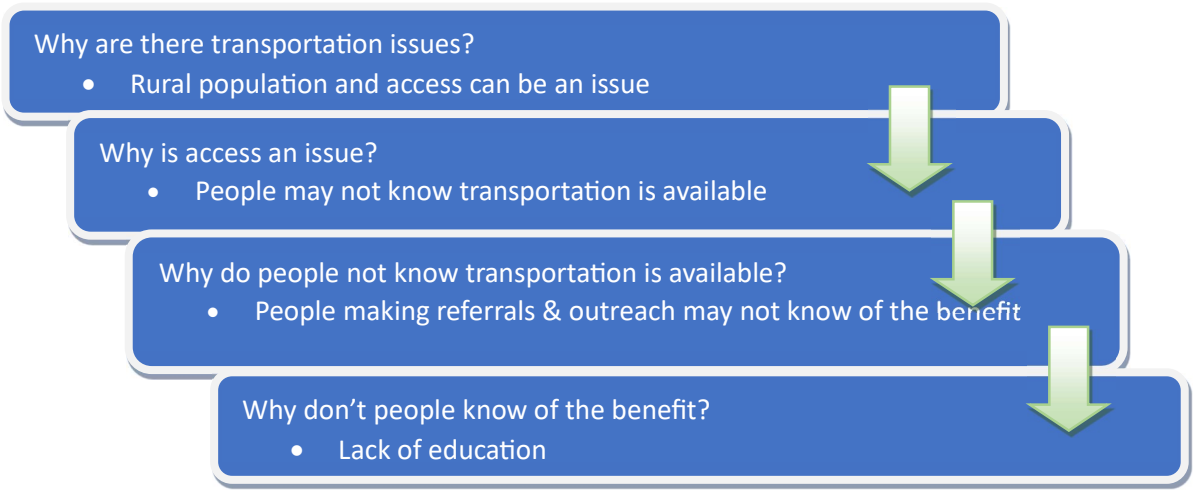
After a review of all the readily available data, a cross-functional group was formed to discuss possible barriers to members getting diabetic eye exams. The findings that 74% of the members who did not get an eye exam are insulin-dependent, and 67% are on medications validates the importance of identifying coordination of care between PCPs and Eye Specialists is improved. that this measure is appropriate to analyze. Members who are insulin-dependent are at higher risk of complications such as hypoglycemia, ketoacidosis, cardiovascular diseases, neuropathy, nephropathy, and retinopathy.

5 Why Analysis was done to brainstorm reasons for root cause of low scores:

Problem: Eye exam rates for diabetics is too low

Why are scores low?

- Known transportation issues



Discussion items and other possible root causes discussed/analyzed:

- Absence of eye exams are not listed as a gap in care for providers. This is an opportunity.
- Configure an alert in E.H.R. systems.
- Educate providers to follow up and check that eye exams have been done and also to go into portal.
- Ethnicity/SDoH:
    - Ethnicity did not appear to be a factor in not getting eye exams. However, of the two groups which comprise 80% of membership, Latino and Caucasian, Latinos had a higher percent (36%) n=4314 than Caucasian (28%) n=762 for getting eye exams.
- Transportation issues:
    - Kern County has several rural areas, including East Kern. There is a known issue with members inability to secure transportation for their medical visits. Geography did not appear to be a primary factor in members not getting their eye exams. However, this does impact some members.
- The absence of a centralized and universally accepted electronic health record (EHR) system is a barrier to achieving interoperability between PCPs and eye care providers. This limitation impedes the exchange and access of patient health information in diabetes (and other eye disease) care management.
- Vision services provider network doctors are independent optometrists and ophthalmologists, and many doctors are not directly contracted with the health plans for the patients they serve.
- Without a referral form, the Specialists staff does not know who to send the information to when they have completed the visual exam. If the member did not

get the appropriate eye exam at this stage, there is still an opportunity for the PCP to make another referral.

- Opthalmologists' and optometrists' office staff do not understand the importance of sharing information with the PCP.
- Staff turnover at Specialists offices can result in a disruption in ongoing processes for continuity and coordination of care.
- Barriers per primary vision service provider:
    - lack of established relationships between vision service providers and PCPs;
    - ~~medical insurance plans that have restricted network;~~
    - patients who have not established care under the supervision of a PCP;
    - absence of E.H.R. platforms to facilitate interoperability.
    - Of NOT doing retinal eye exam: increased use of retinal imaging technology in place of dilation;
    - Health Equity: cultural and language barriers, transportation, food insecurity, housing insecurity, mental health concerns, perceived importance of practitioner concordance associated with a lower likelihood of receiving eye care among adults with diabetes pointing to need to promote health equity.

QI 3A.4

Opportunities for Improvement:

Barrier	Opportunity	Intervention
Access	Improve access in East Kern	Reach out to other groups who are expanding vision services; contract directly with providers within 45 miles of the 3 towns without access; mobile eye exams?
No referral made	Provider Education to PCPs	- Education to PCP - Add eye exam to gap in care
Communication between PCP & Specialists	Consult Report Note getting back to PCP	- Education to specialists - Add PCP to data feed - Add Eye Exam to gap in care report
Lack of established relationships between vision service providers and PCPs	Establish relationship	- Add PCP to data feed - KHS to re-introduce VSP to PCPs

Planned Interventions:

- Facilitate better communication between Specialists & PCPs
- Develop educational materials to send to PCPs & Specialists about referrals & consult notes
- Provider Education: including VSP – they should know to give transportation information

List of Participants involved in discussions:

Name	Department/Title
Magdee Hugais	QI Director
Dr John Miller	QI Medical Director
Dr Sukhpreet Sidhu	PHM Medical Director
James Winfrey	Provider Network Management Director
Steven Kinnison	NCQA Manager
Romeo Astronomo	PHM CHW
Michelle Curioso	PHM Director
Melinda Santiago	BH Director
John Monahan	Business Intelligence

2024 NCQA Steering Committee Meeting

June 18, 2024

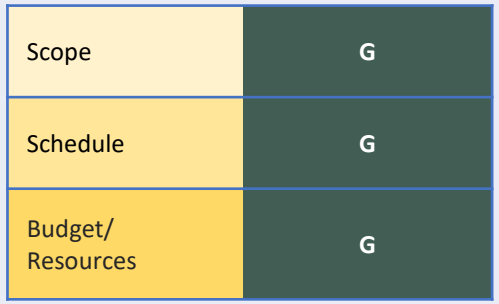
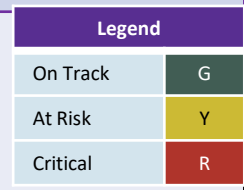
Agenda

NCQA Readiness Project

- Project Status and Performance
- Timeline
- Risks, Issues, Decisions

KERN HEALTH SYSTEMS

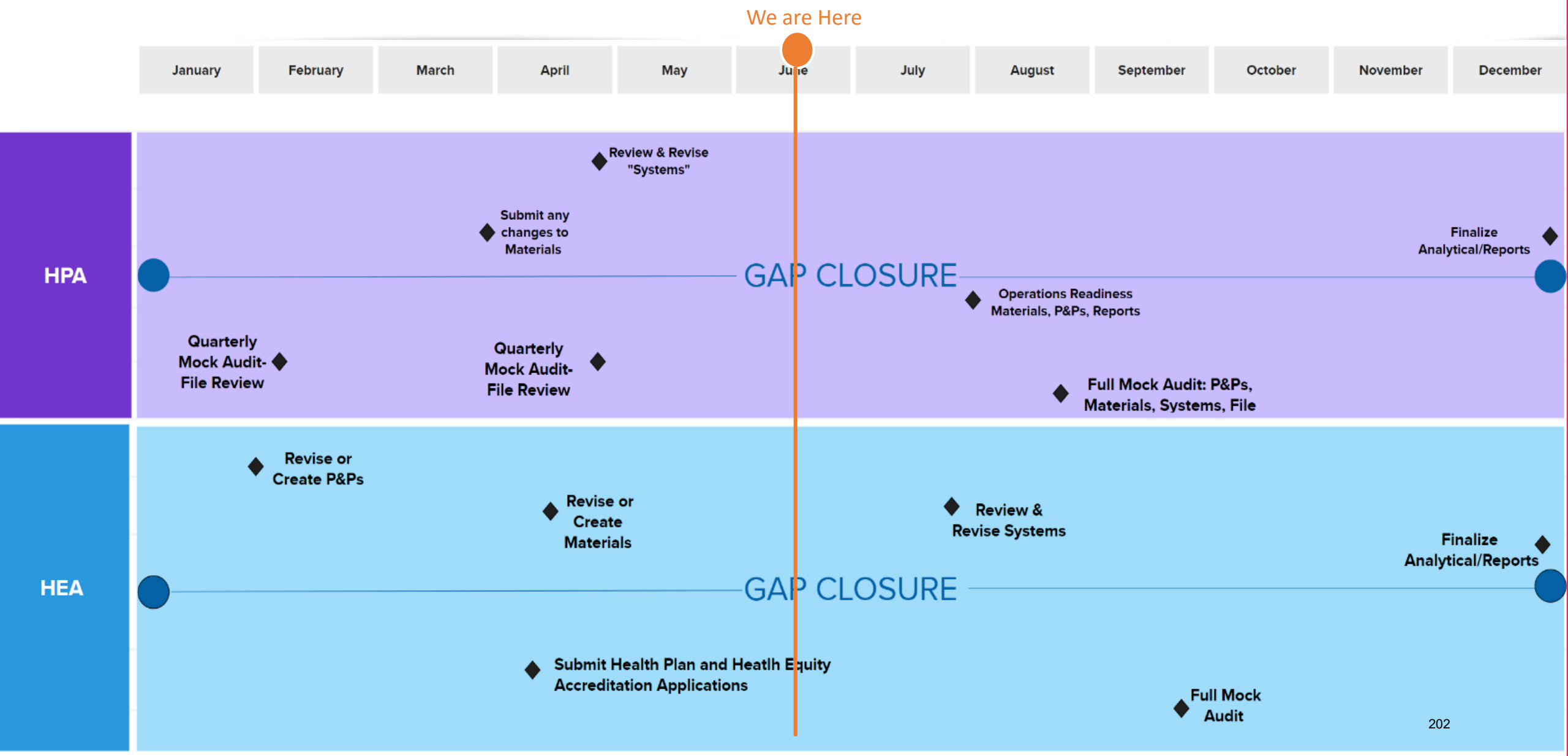
2024 NCQA Readiness Project Status

Project Information	Status
NCQA Accreditation Readiness Health Plan Accreditation (HPA) Workstreams: UM, PHM, QI, NET, CR, ME **Survey Date: April 8, 2025** Health Equity Accreditation (HEA) **Survey Date: June 10, 2025**	 

Key Accomplishments since Last Meeting	Next Steps

• Quality Dept hired 2 Specialists: Alma Garcia & Melinda Caballero
 	
• HEA Points increased from 37% to 43%
 	
• Continue to submit Reports/Drafts of Reports
  ○ UM 1B – Work Plan Evaluation - MET
  ○ All but 1 Report for PHM now MET
 	
• Initial List of DP & M compared to 2024 Contract P&Ps in process
	• Continue HPA & HEA Gap Closure. Focus on Reports
	
	• Quarterly Mock File Reviews scheduled:
	  ▪ UM July: 15-18, 23
	  ▪ Credentialing: July 17
	  ▪ PHM: August 20
	
	• Prep for Operations Readiness completion date July 31

NCQA 2024 Timeline & Milestones



Progress on Remaining Health Equity Accreditation (HEA) DP & M Submissions

Standard/ Element	Task/Element Description	With Business	With TMG	Due Dates
HE 2A	Screen shots for process for receiving, storing and retrieving individual level data on SOGI		X	6/18/2024
HE 3A	Submit copy of Translation vendor agreement addendum	X		6/20/2024
HE 2BCD*E*	Policy to assess and address member language, race/ethnicity and SOGI needs		X	6/18/2024
	TOTALS	**1**	**2**	

*Critical Factors: Score cannot exceed "Partially Met" if one critical factor is scored Not Met (HE2D has 5 factors, HE2E has 2)

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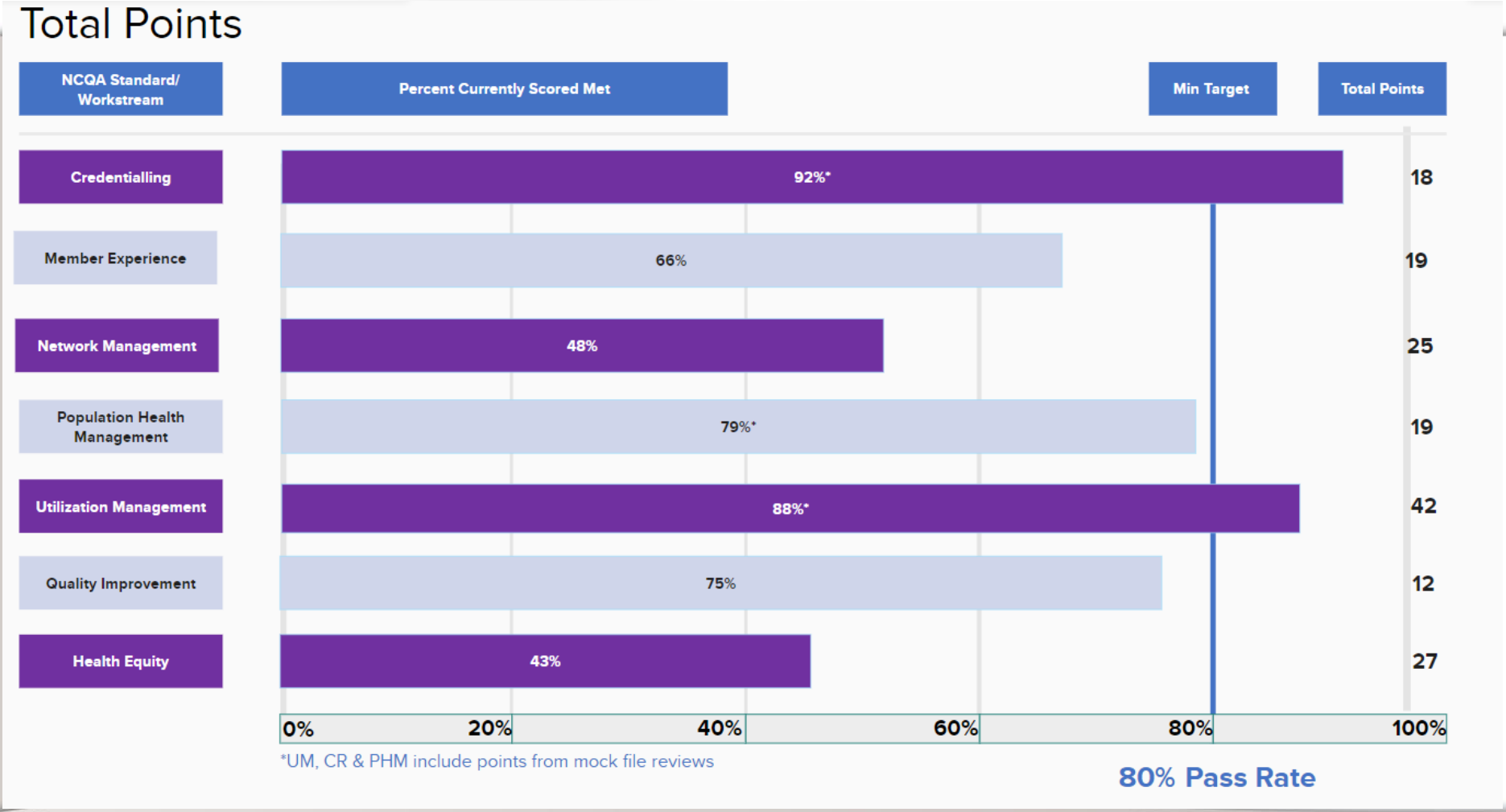
Overall NCQA Accreditation Points Tracking

Goal: 100% by October, 2024



For HPA, each Workstream needs to achieve a passing score of 80% in order to attain Accreditation

For HEA, need to pass overall with a score of 80%

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NCQA **Reports** 2024 Due Dates

Goal: 98% by December, 2024

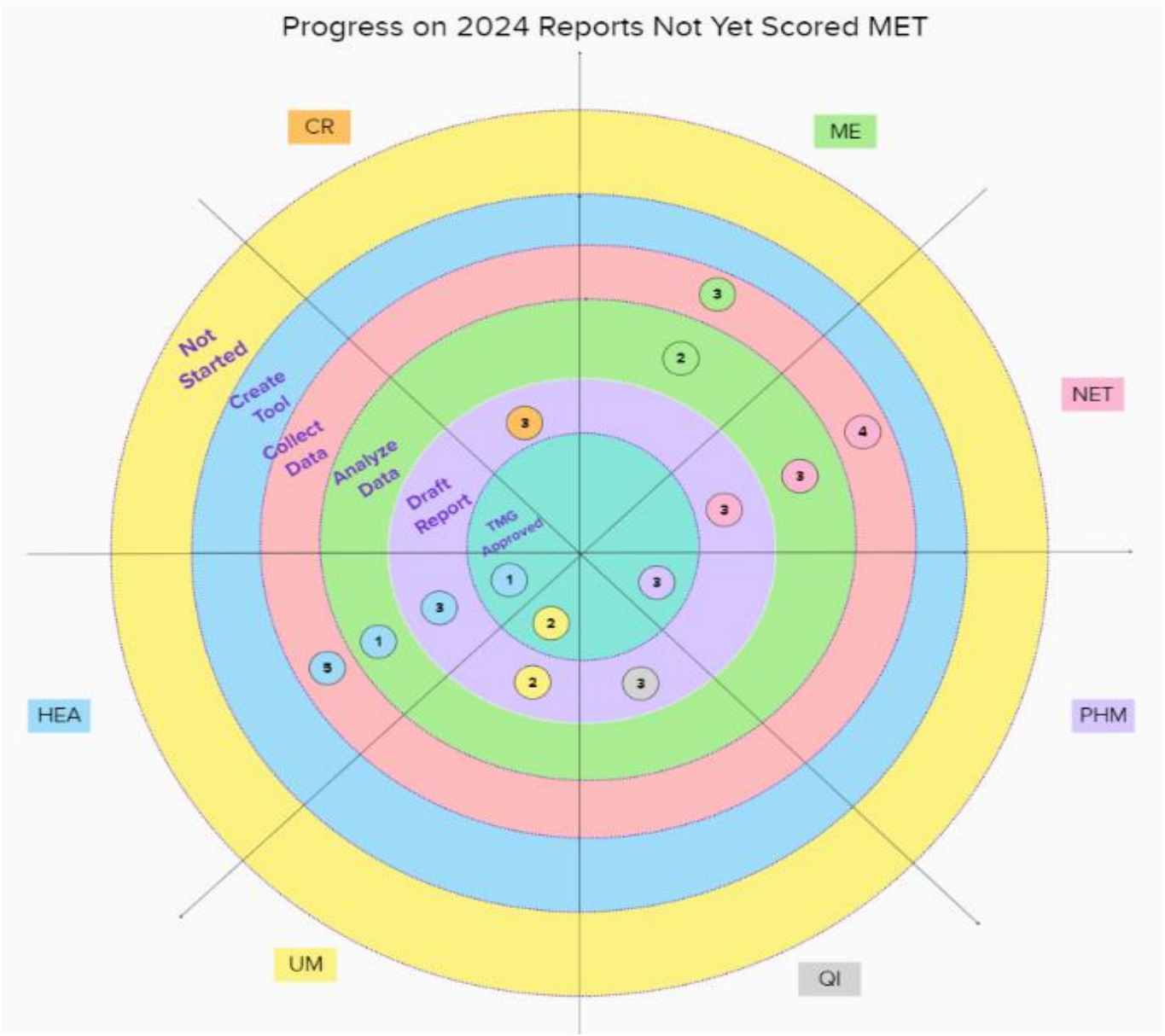
Look Back Period

Most are “at least once in prior year”

Progress on Reports due by end of August

Standard/ Element	Element Description	Due Dates	Status
HE 1B	Promoting Diversity, Equity and Inclusion Among Staff	Jan	MET (LBP)
PHM 6A	Measuring Effectiveness of PHM strategy	April	MET
CR 8C,D	Review of Performance/Opportunities for Improvement	Feb	Partially Met; submitted to TMG 6/14
CR 1D	Credentialing System Controls Oversight	March	MET (LBP)
NET 2B,C	Access to Behavioral Healthcare and Specialty Care	May	Due back from TMG 6/21
HE 5B	Annual Evaluation of the CLAS Program	May	Waiting for final June HEDIS report
ME 7C	Annual Assessment of Nonbehavioral Healthcare Complaints & Appeals	June	In process
NET 1A, 5C,D	Cultural Needs and Preferences - Assessment of Physician Directory Accuracy	June	Due from business this week
UM 1B	Annual UM Program Evaluation	June	MET
ME 6C	Quality and Accuracy of Information Provided to Members – web/phone	July	Survey June 25
NET 1B	Practitioners Providing Primary Care	July	In process
QI 3A, 4AB	Continuity & Coordination of Medical & BH care	July	In process
HE 6A	Reporting Stratified Measures	July	June HEDIS report needed
PHM 1A	PHM Strategy (2024)	July	2023 version MET, working on revising 2024

NCQA **Reports** Progress



Questions/Notes

- Decisions/Actions
- Next Steps

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Appendix

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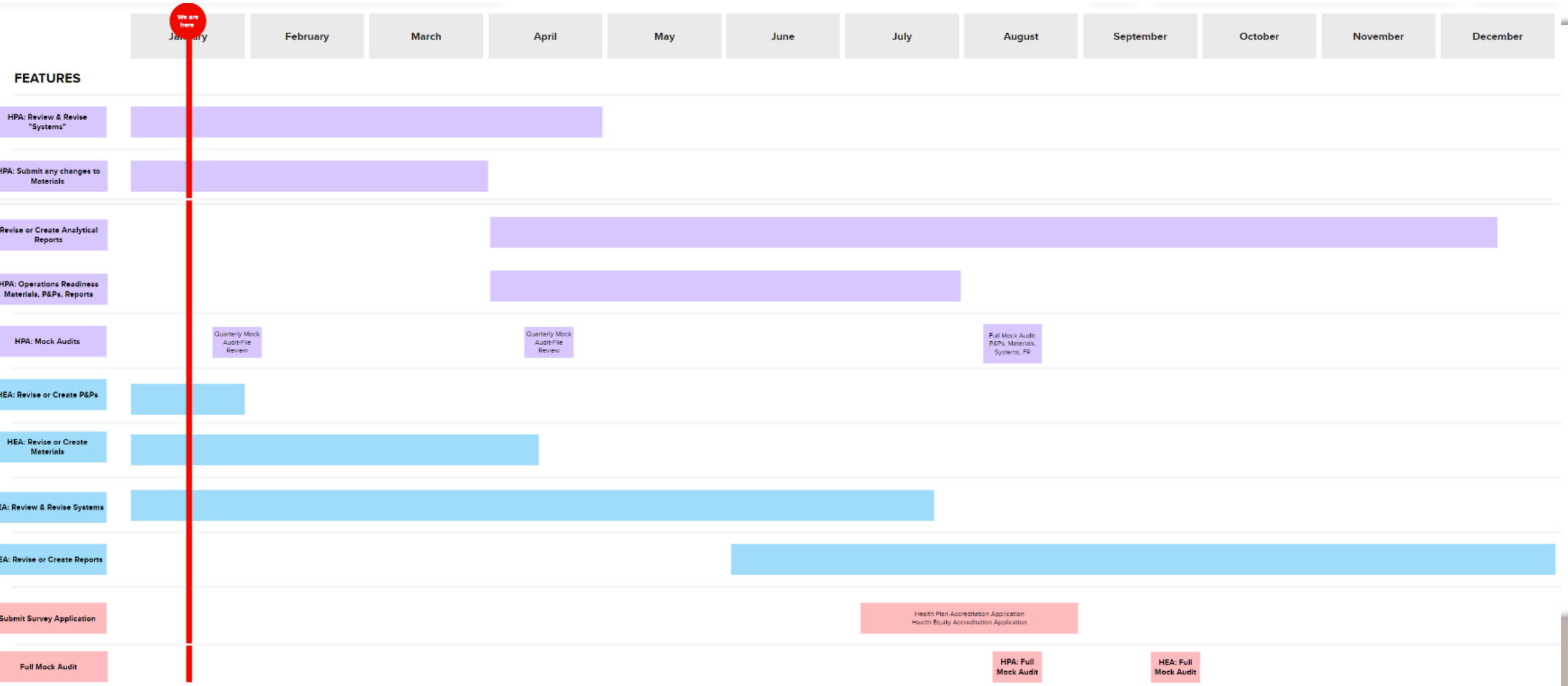
Ops Readiness Initial List

Standard/ Element	Task Description
ME4B & ME6B	After Hours Voice Mail Process
ME6D	Process for monitoring response times to email inquiries.
ME3C & ME6C	Create Mailer for New Member packet and follow up text message survey
UM1B	UM Program applicable Changes [placeholder]
UM2A	Taking UM Criteria to Committee for Approval Annually
NET2B	Provider Survey in support of behavioral health treatments.
NET5C	Provider survey to address accuracy of provider directory information
NET5I	Create usability study evaluating website understandability and usefulness
CR1C	Create automated process to collect information on modifications made in the provider files in the system.
PHM3A	Implement shared decision-making aid for agreed-upon education piece (breast exams)
PHM5D	Add 30d reminder to CM Initial Assessment – (go live Jan 2)
PHM5ABC	In-service training on how to refer to CCM
PHM5E	Training for staff on how to build stronger Case Mgt Plans
QI	QI [placeholder]

NCQA 2024 Timeline & Milestones



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NCQA Project – "Must Pass" Elements

Standard/ Element	Description	Point Value	Met	Not Met
CR-1C	Credentialing System Controls P&P	1	x	
CR-3A	Verification of Credentials	1	x	
CR-3B	File Review	1	x	
CR-3C	File Review	1	x	
UM-4C	File Review: Practitioner Review of Nonbehavioral Healthcare Denials	1	x	
UM-4D	File Review: Practitioner Review of Behavioral Healthcare Denials	1	x	
UM-4E	Practitioner Review of Pharmacy Denials	1	x	
UM-5A	File Review: Notification of Nonbehavioral Healthcare Decisions	1	x	
UM-5B	File Review: Notification of Behavioral Healthcare Decisions	1	x	
UM-5C	File Review: Notification of Pharmacy Decisions	1	x	
UM 7BCEFHI	Denial Notices	6	xxxxxx	
UM-9B	File Review: Timeliness of the Appeal Process	1	x	
UM-9D	File Review: Pre and Post Service Appeals	1		x
UM-12A	UM System controls (P&P specific to UM denial notification dates)	1		
UM-12C	UM Appeal System Controls	1	Conditional	Need edits
	TOTALS	**20**	**19**	**1**

Must Pass Elements and Scoring

1.MUST PASS RULES

The must-pass rules are a bit more complicated than the critical factor rules.

In short, if a plan misses just one must-pass element in either UM or CR, that does not bring the score down for that Standard enough to not pass that Standard or overall Accreditation. The plan would receive an Accredited – Under Corrective Action status and be required to submit a CAP and undergo a CAP Survey.

- If any must-pass elements are not Met, then the plan would have to submit a CAP and undergo a CAP Survey in 6 months.
  - The Accreditation status on the NCQA report card would have the "Under Corrective Action" status modifier next to it.
- If three or more must-pass elements are not Met, the plan receives a Provisional – Under Corrective Action status.
- If the plan has difficulties with a Standard Category (scores above 55% but below 80%) and also does not meet a must-pass element, then it receives a Provisional – Under Corrective Action status, must submit a CAP within 30 days, and undergo a Resurvey in 12 months.
- If three or more UM must-pass timeliness elements are not met (UM 5A-C and UM 9B), the ROC may issue a Denial status.
  - Must-pass elements – the majority of these are file review elements, except the System Controls elements. Scoring is different for file review and for the System Controls elements.

For the System control elements, plans do need to meet every factor to receive a Met score.

Even within the file review elements, scoring can be different. For file review elements that have factors, many do allow one factor to be scored "Medium" and still receive a Met score for the element. See the example below.

The organization's written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information:

1.	**The specific reasons for the denial, in easily understandable language.**
2.	A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based.
3.	A statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, upon request.

Scoring		
Met	Partially Met	Not Met
High (90-100%) on file review for at least 2 factors and medium (60-89%) on file review for any remaining factor	High (90-100%) or medium (60-89%) on file review for 3 factors	Low (0-59%) on file review for any factor

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Critical Factors and Scoring

1.CRITCAL FACTORS – the score cannot exceed "Partially Met" if one critical factor is scored no.

To illustrate this, let's look at CR 7B.

The organization includes at least the following medical providers in its assessment:

Critical factors: Score cannot exceed Partially Met if one critical factor is scored "no."

In a "normal" element without critical factors, missing any one factor would result in a Met score.

In this element, if a plan misses factor 1 but meets all three of the other factors, they would be capped at "Partially Met."

Element B: Medical Providers
1. Hospitals.*
2. Home health agencies.
3. Skilled nursing facilities.
4. Free-standing surgical centers.

Scoring		
Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

The following elements in the 2024 HP Standards have critical factors:

- CR 7B
- NET 2B
- PHM 1A
- UM 11E
- UM 4F

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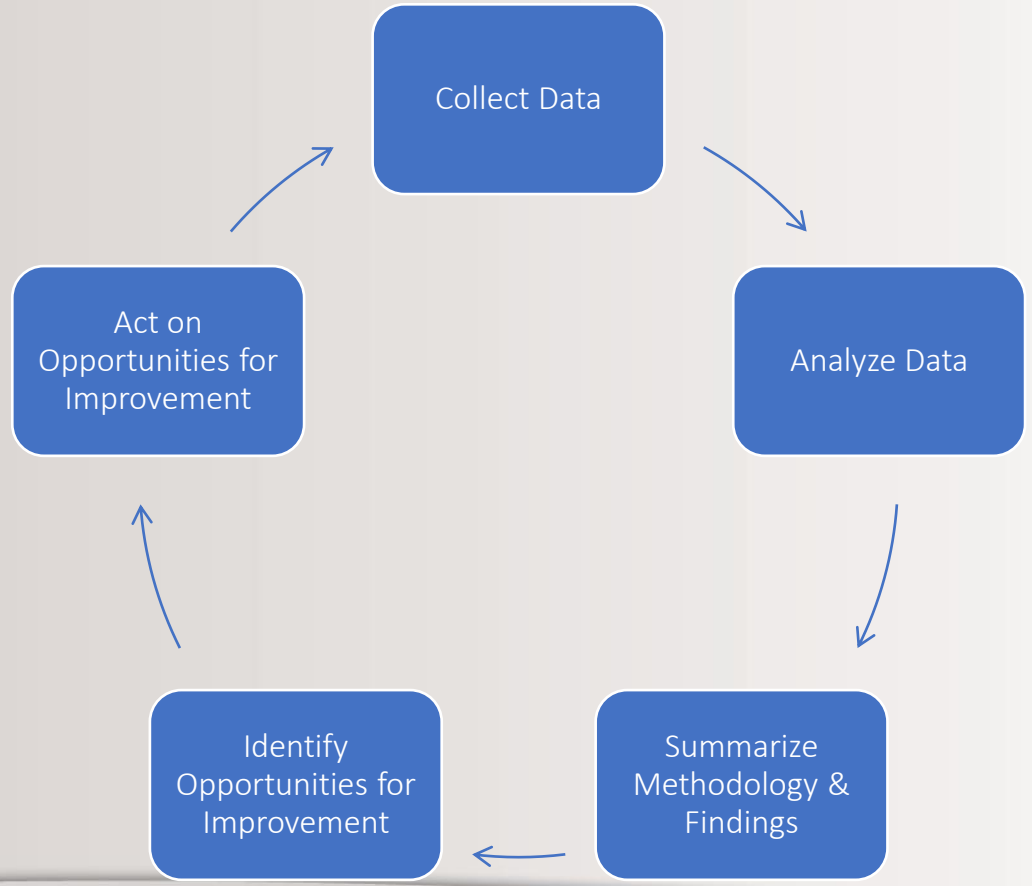
Analysis Elements – Steps in Annual Process



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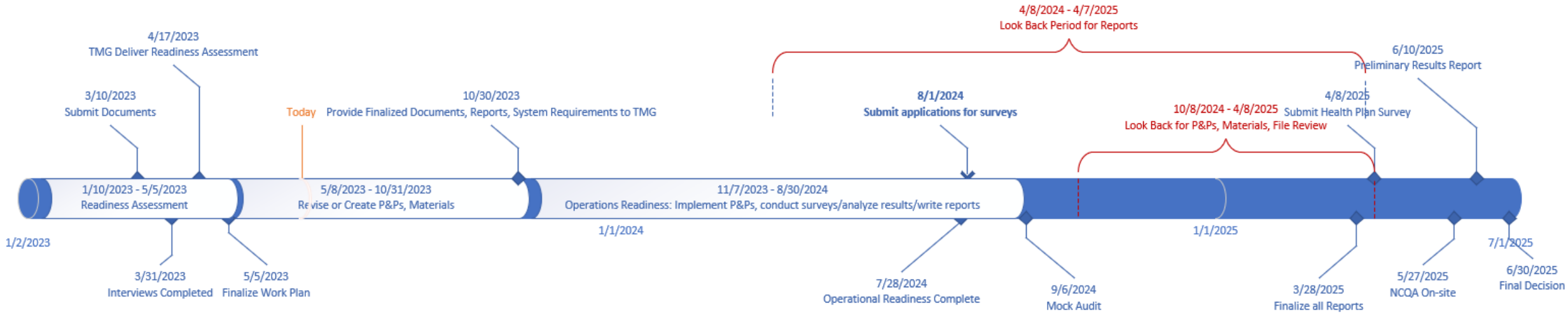
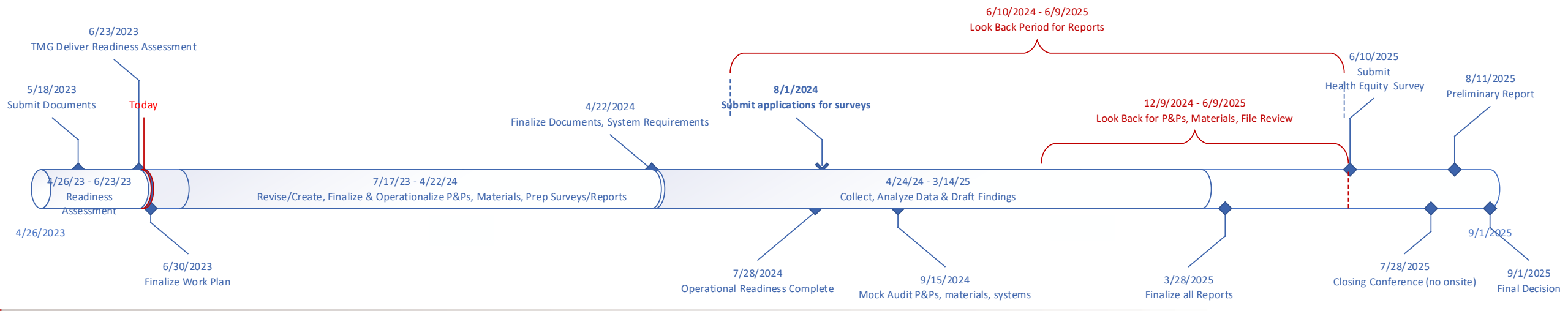
Overall NCQA HPA Project Timeline



Overall NCQA HEA Project Timeline



NCQA Project – Analysis Elements

#	Standard/ Element	Description	TMG Planned Start Date	TMG Planned End Date	Survey ?
1	CR1-D	Analysis of Monitoring of Credentialing System Controls	7/2023	9/2024	
2	NET-2B	Qualitative & Quantitative Analysis of Annual Analysis of Appointment Access to BH	8/2023	7/2024	YES
3	NET5-CD	Qualitative & Quantitative Assessment of Physician Directory Accuracy	9/2023	8/2024	YES
4	UM-12B,D	Analysis of Monitoring of UM System Controls	9/2023	12/2024	
5	ME-6CD	Qualitative & Quantitative Analysis of Quality & Accuracy of information provided to Members	12/2023	10/2024	
6	PHM-6A	Qualitative & Quantitative Assessment of Member Experience on 2 PHM Programs	12/2023	4/2024	
7	ME-3C	Qualitative & Quantitative Analysis of Member Understanding of Policies & Procedures	2/2024	10/2024	
8	ME-7C-E	Qualitative & Quantitative Analysis of member complaints & appeals	3/2024	9/2024	
9	NET-2A	Qualitative & Quantitative Analysis of Appointment Access to Primary Care	3/2024	12/2024	YES
10	NET-2C	Qualitative & Quantitative Analysis of Annual Analysis of Appointment to Specialty Care	3/2024	7/2024	YES
11	NET-3ABC	Qualitative & Quantitative Assessment of Member Experience Accessing Network	5/2024	12/2024	YES(ME)
12	QI-4AB	Qualitative & Quantitative Analysis of Continuity & Coordination of Medical & Behavioral care	7/2024	12/2024	

KHS Enhance Care Management Departmental CAP Flow

Audit Prep

Once a site has completed ECM services for the period of one quarter they will be subject to audit. A site-specific worklist is created with the goal of auditing 10 random assigned members each quarter. Worklists are created with the goal of selecting members enrolled within the past 1-2 quarters to provide insight to recent updates and current processes. Members enrolled longer than this will be added as necessary to complete the list of 10 members.

Audit Process

Assigned ECM audit staff complete an audit of 10 members per site per quarter, from the available audit worklist. Members are audited using the internally approved ECM Audit Tool criteria, derived from the DHCS ECM Criteria. Data regarding member identity and audit findings are recorded on the ECM Summary Sheet. Assigned nurse auditors assign out all quarterly audits with relevant staff management as well as scheduled corrective action plan meetings should they apply.

Audit Scoring

Data collected during the audit process is calculated and scores are determined for each core component of ECM, as well as an overall audit score for the respective quarter for each site. The makeup of the numerator and denominator that constitute the percentage exclude any non-applicable variables.

Audit Pass

Site achieves an overall score of 80% and no CAP needs were identified in any core component section.

Audit Results to Site

Site receives an encrypted email with the scoring and audit findings. Site will be audited again during the next audit quarter.

Incentive Funding

Audit results are reviewed on a bi-annual schedule. Funds are distributed in alignment with IPP funding measurements.

Audit CAP – Low Severity

Site achieves an overall score of 80% but demonstrates a need for improvement in one or more core components.

Audit Results to Site

Site receives an encrypted email with the scoring and audit findings. Site is provided with a CAP for the respective area needing improvement as appropriate.

CAP Implementation

Site progress regarding CAP activities will be re-evaluated within 90 days.

1. Relevant ECM site will produce and return to KHS for review and approval a written action plan based on the findings within 30 days of notification. The written action plan must include an internal audit plan.
2. Within 60 days of notification of CAP findings, the site will produce audit findings as described in the written action plan
3. Within 90 days, KHS will reinstitute a full scale audit as mentioned in the audit process above.

Audit CAP – Medium Severity

Site performs at an overall percentage of 70-80% and demonstrates a need for improvement in one or more core components.

Audit Results to Site

Site receives an encrypted email with the scoring and audit findings. Site is provided with a CAP for the respective areas of improvement.

CAP Implementation

Site will complete CAP activities within 90 days, which includes:

1. Relevant ECM site will produce and return to KHS for review and approval a written action plan based on the findings within 30 days of notification. The written action plan must include an internal audit plan.
2. Within 60 days of notification of CAP findings, the site will produce audit findings as described in the written action plan
3. Within 90 days, KHS will reinstitute a full scale audit as mentioned in the audit process above.

Audit CAP – High Severity

Site performs at an overall score of 70% or less and demonstrates a need for improvement in one or more core components.

Audit Results to Site

Site receives an encrypted email with the scoring and audit findings. Site is provided with a CAP for the respective areas of improvement.

CAP Implementation

Site will complete CAP activities within 90 days, which includes:

1. Relevant ECM site will produce and return to KHS for review and approval a written action plan based on the findings within 30 days of notification. The written action plan must include an internal audit plan.
2. Within 60 days of notification of CAP findings, the site will produce audit findings as described in the written action plan
3. Within 90 days, KHS will reinstitute a full scale audit as mentioned in the audit process above.

Escalation Path

1st Audit CAP

Failure to comply to initial 30-60-90 plan and/ or audit does not pass with the 80% threshold
- Escalation to compliance and executive leadership
- Potential additional funding eligibility suspension
- Site expansion plans withheld

2nd Audit CAP

Failure to improve upon first audit corrective action plan will lead to:

- Escalation to compliance and executive leadership
- Potential additional funding eligibility suspension
- Site expansion plans withheld
- Suspension of program incentives

3rd Audit CAP

Failure to improve upon two consecutive audit corrective action plans will lead to:

- Escalation to compliance and executive leadership
- Potential additional funding eligibility suspension
- Site expansion plans withheld
- Suspension of program incentives
- Suspension of membership eligibility and presumptive authorization

4th Audit CAP

Failure to improve upon three consecutive audit corrective action plans will lead to:

- Escalation to compliance and executive leadership
- Potential additional funding eligibility suspension
- Site expansion plans withheld
- Suspension of program incentives
- Suspension of membership eligibility and presumptive authorization
- Suspension of all ECM reimbursement

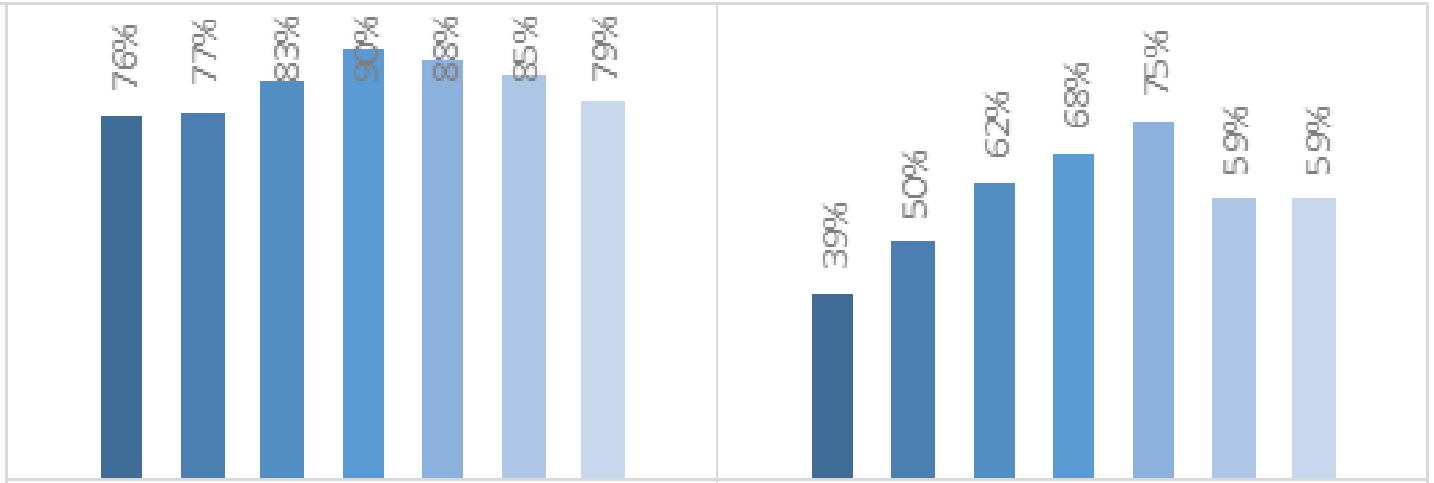
5th Audit CAP

Failure to improve upon four consecutive audit corrective action plans will lead to:

- Potential termination of ECM contract.

ECM AUDIT RESULTS

Below is the site performance of the Kern Medical ECM programs from the range of Quarter 1 2022 – Quarter 3 2023.



Q1 Scores	76%	39%
Q2 Scores	77%	50%
Q3 Scores	83%	62%
Q4 Scores	90%	68%
Q1 Scores	88%	75%
Q2 Score	85%	59%
Q3 Scores	79%	59%

Enhanced Care Management Quarter I QIC Report

Background:

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high cost and/or high-need Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. Members who will be eligible for ECM are expected to be among the most vulnerable and highest-need Medi-Cal Managed Care Members. Members who stratify into the ECM program are broken up into the following DHCS defined Populations of Focus:

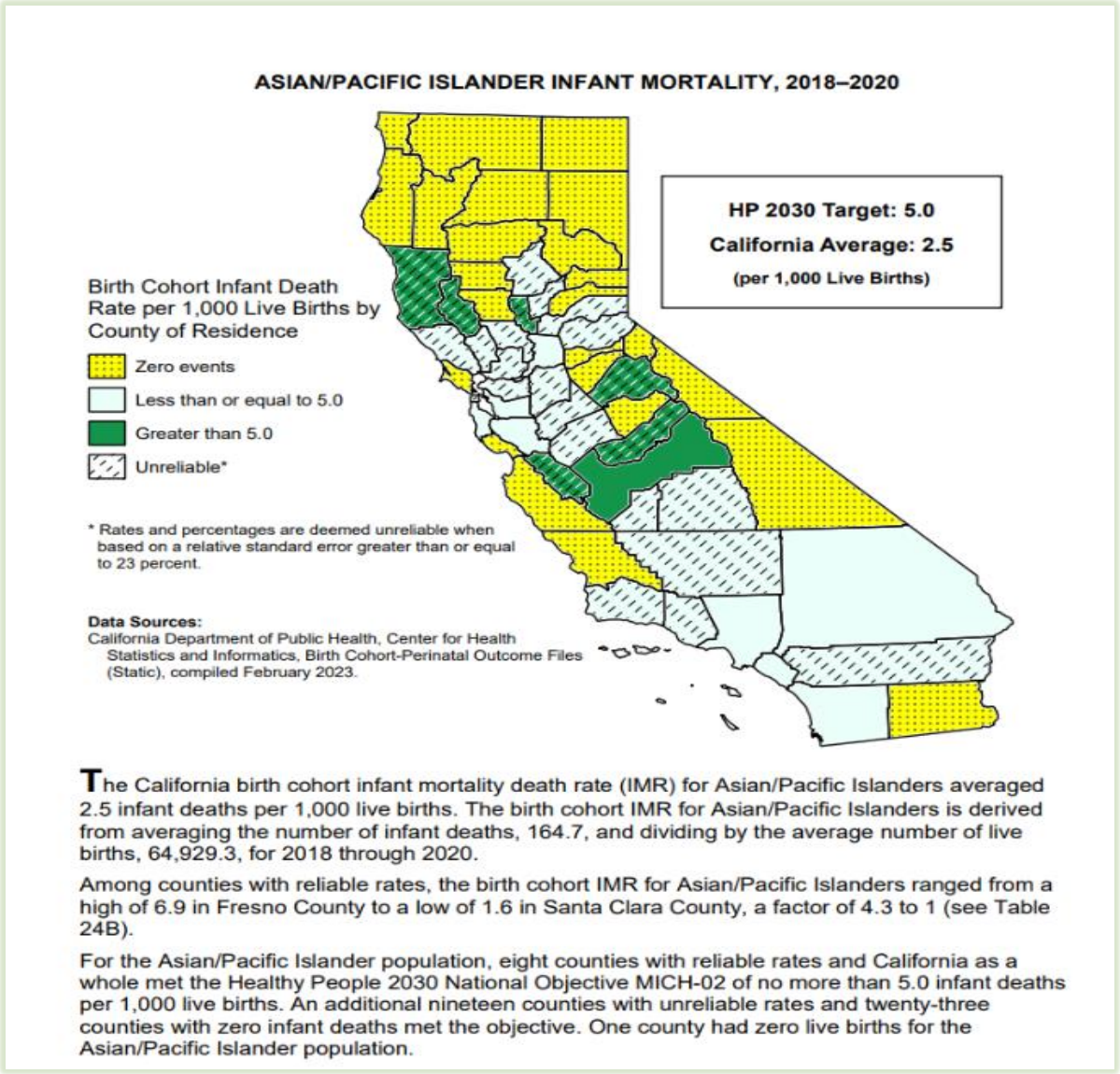
	ECM Populations of Focus	Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	✓	
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✓	✓
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	✓	✓

Populations of Focus live as of January 2024:

Birth Equity PoF:

Adult and Youth who are pregnant or postpartum (for a period of 12 months) that are subject to racial and ethnic disparities as defined by CDPH (California Department of Public Health) data on maternal morbidity and mortality. Currently, CDPH has identified the Black, American Indian, Alaska Native, and Pacific Islander populations but this is subject to change based off CDPH data.

Data that informs this population of focus:

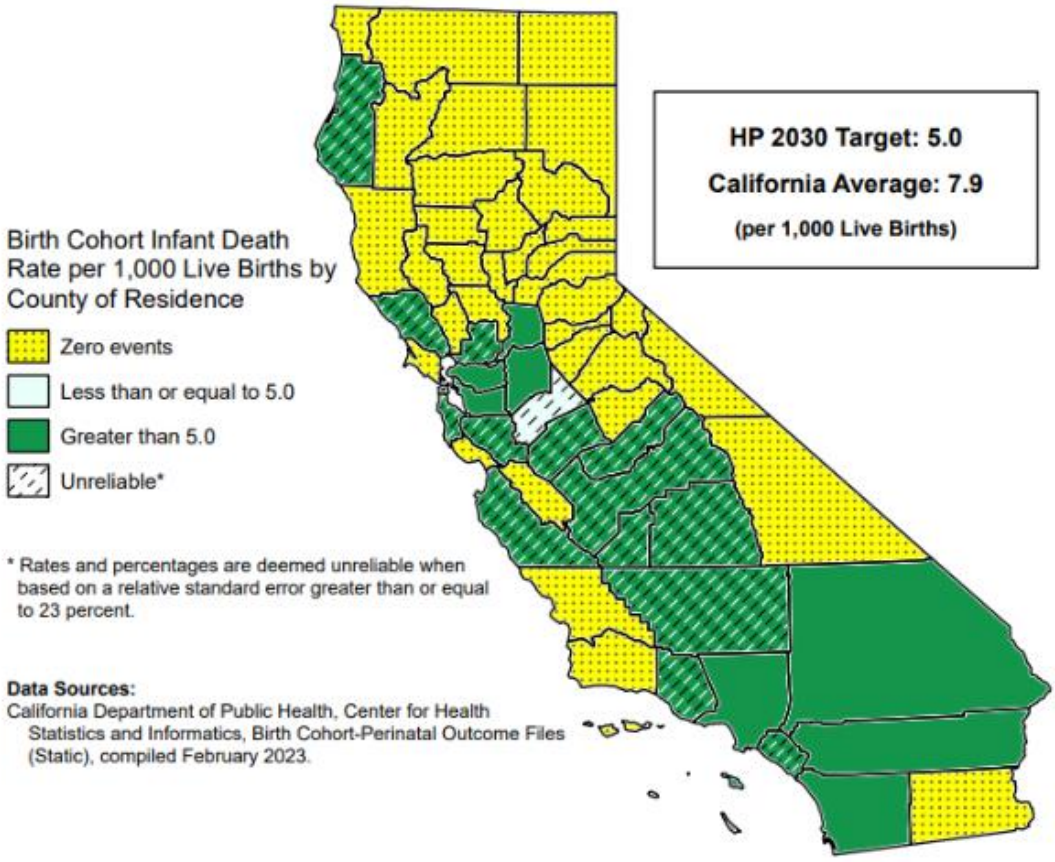


The California birth cohort infant mortality death rate (IMR) for Asian/Pacific Islanders averaged 2.5 infant deaths per 1,000 live births. The birth cohort IMR for Asian/Pacific Islanders is derived from averaging the number of infant deaths, 164.7, and dividing by the average number of live births, 64,929.3, for 2018 through 2020.

Among counties with reliable rates, the birth cohort IMR for Asian/Pacific Islanders ranged from a high of 6.9 in Fresno County to a low of 1.6 in Santa Clara County, a factor of 4.3 to 1 (see Table 24B).

For the Asian/Pacific Islander population, eight counties with reliable rates and California as a whole met the Healthy People 2030 National Objective MICH-02 of no more than 5.0 infant deaths per 1,000 live births. An additional nineteen counties with unreliable rates and twenty-three counties with zero infant deaths met the objective. One county had zero live births for the Asian/Pacific Islander population.

BLACK INFANT MORTALITY, 2018–2020



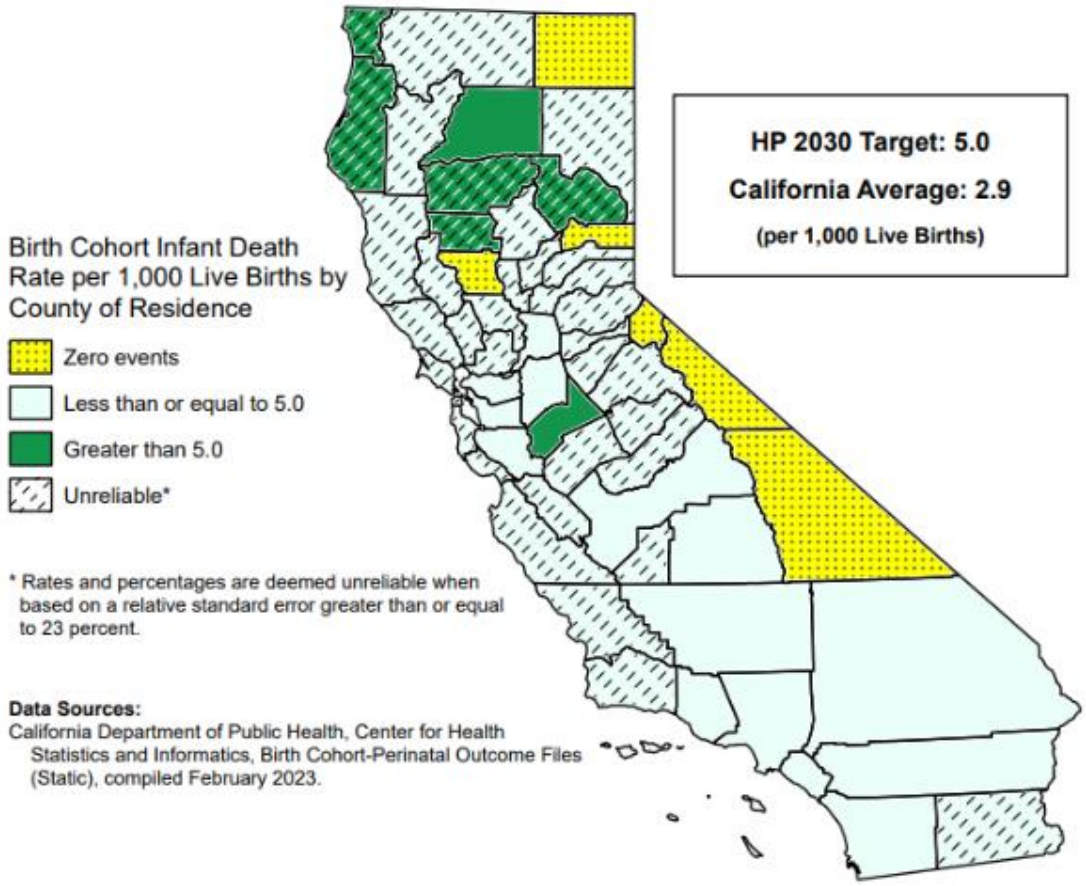
The California birth cohort infant mortality death rate (IMR) for Blacks averaged 7.9 infant deaths per 1,000 live births. The birth cohort IMR for Blacks is derived from averaging the number of infant deaths, 167.3, and dividing by the average number of live births, 21,197.7, for 2018 through 2020.

Among counties with reliable rates, the birth cohort IMR for Blacks ranged from a high of 12.4 in San Joaquin County to a low of 6.9 in Sacramento County and Contra Costa County, a factor of 1.8 to 1 (see Table 24C).

For the Black population, zero counties with reliable rates met the Healthy People 2030 National Objective MICH-02 of no more than 5.0 infant deaths per 1,000 live births. One county with an unreliable rate and thirty-two counties with zero infant deaths met the objective. Two counties had zero live births for the Black population. California as a whole did not meet the national objective for birth cohort IMR for Blacks.

Twenty-eight counties contain suppressed data for the counts, rate, and confidence limits per the Data De-Identification Guidelines (DDG). See Technical Notes for more information regarding DDG.

WHITE INFANT MORTALITY, 2018–2020



The California birth cohort infant mortality death rate (IMR) for Whites averaged 2.9 infant deaths per 1,000 live births. The birth cohort IMR for Whites is derived from averaging the number of infant deaths, 342.7, and dividing by the average number of live births, 116,338.7, for 2018 through 2020.

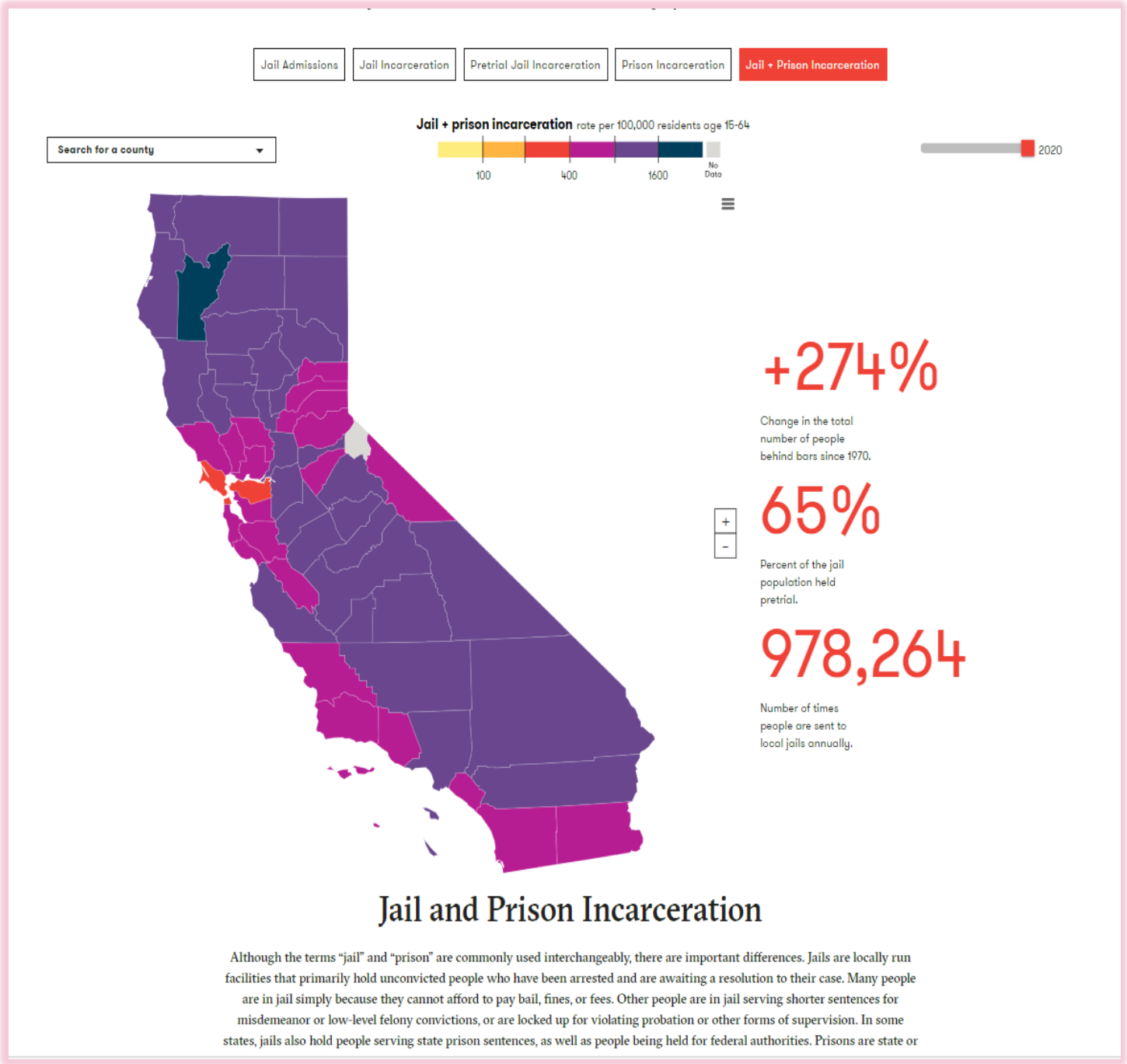
Among counties with reliable rates, the birth cohort IMR for Whites ranged from a high of 6.2 in Shasta County to a low of 2.0 in Orange County, a factor of 3.1 to 1 (see Table 24E).

For the White population, fourteen counties with reliable rates and California as a whole met the Healthy People 2030 National Objective MICH-02 of no more than 5.0 infant deaths per 1,000 live births. An additional thirty-one counties with unreliable rates and six counties with zero infant deaths met the objective.

Justice-Involved PoF:

The ECM team continues to focus on the Justice-Involved Initiative, requiring extensive work and relationship/partnership-building with all correctional facilities throughout the county as the Justice-Involved Initiative goes live throughout the state, as early as 10/1/24 (once DHCS has approved the Readiness Assessment by Correctional Facilities), to be implemented (mandated by DHCS) no later than 9/1/26. The ECM team has worked diligently to contact our local correctional facilities and establish relationships with them in preparation for the Justice-Involved Initiative. We have met with local representatives of the Kern County Sheriff Department, Kern County Probation, and Kern Behavioral Health and Recovery Services, for the county adult and juvenile correctional facilities. We have also continue to meet with the CalAIM representative for the California Department of Corrections and Rehabilitation (CDC-R) for the state adult facilities located in our county.

Data that informs this PoF (from CDPH):

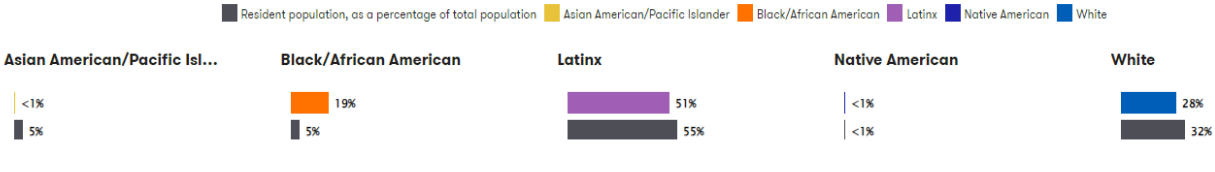


Comparing Jail and Prison Incarceration

Although the terms "jail" and "prison" are commonly used interchangeably, jails are locally run facilities that primarily hold people who are arrested and are awaiting a resolution to their case, while prisons are state or federal institutions where people who have been convicted of crimes are sent to serve sentences of imprisonment. Since almost one in three incarcerated people nationwide are held in jails, incarceration must be measured using numbers that represent people in both jails and prisons. Looking at jail and prison metrics in tandem can illuminate whether incarceration has risen, declined, or shifted between states and counties.

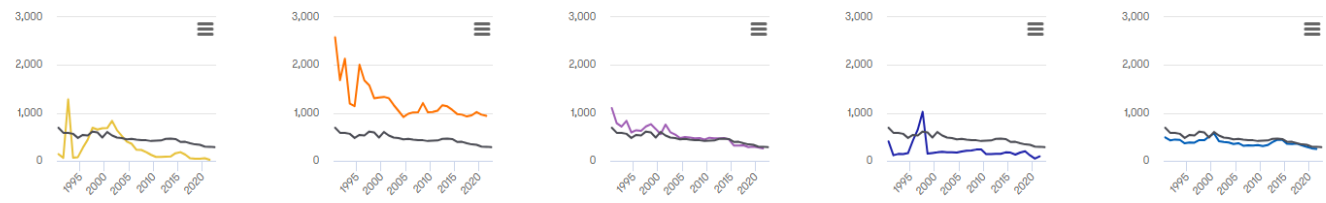
Racial Disparities in Incarceration

Black people are treated more harshly than white people at every stage of the criminal legal process. As a result, people of color—and Black people in particular—are incarcerated at strikingly higher rates than white people in jails and prisons across the country. The bar graphs below show the proportion of people in jail who are from each racial group against that group's share of the general resident population.



Use the charts below to see how racial disparities in jail incarceration have changed over time.

Jail population vs resident population by race Rate per 100K residents ...



Although Latinx people are overrepresented in jails and prisons nationally, common misclassification leads to distorted, lower estimates of Latinx incarceration rates and distorted, higher estimates of white incarceration rates. For more information, see the methodology.

Special word on progress with the homeless population:

Context:

- IPP improvement needed in:
  - Continued enrollment versus eligible population overall for all providers.
  - Need special attention on Homeless Population of Focus and improved enrollment for:

    - ❖ Black/African American population
    - ❖ Hispanic population
    - ❖ Caucasian population

    - We need about 66 more African-American enrollments through the end of June to hit our mark for IPP reporting.
    - For Adult enrollment overall, we need about 600 more cumulative enrollments between now and the end of June.
    - **Adults**

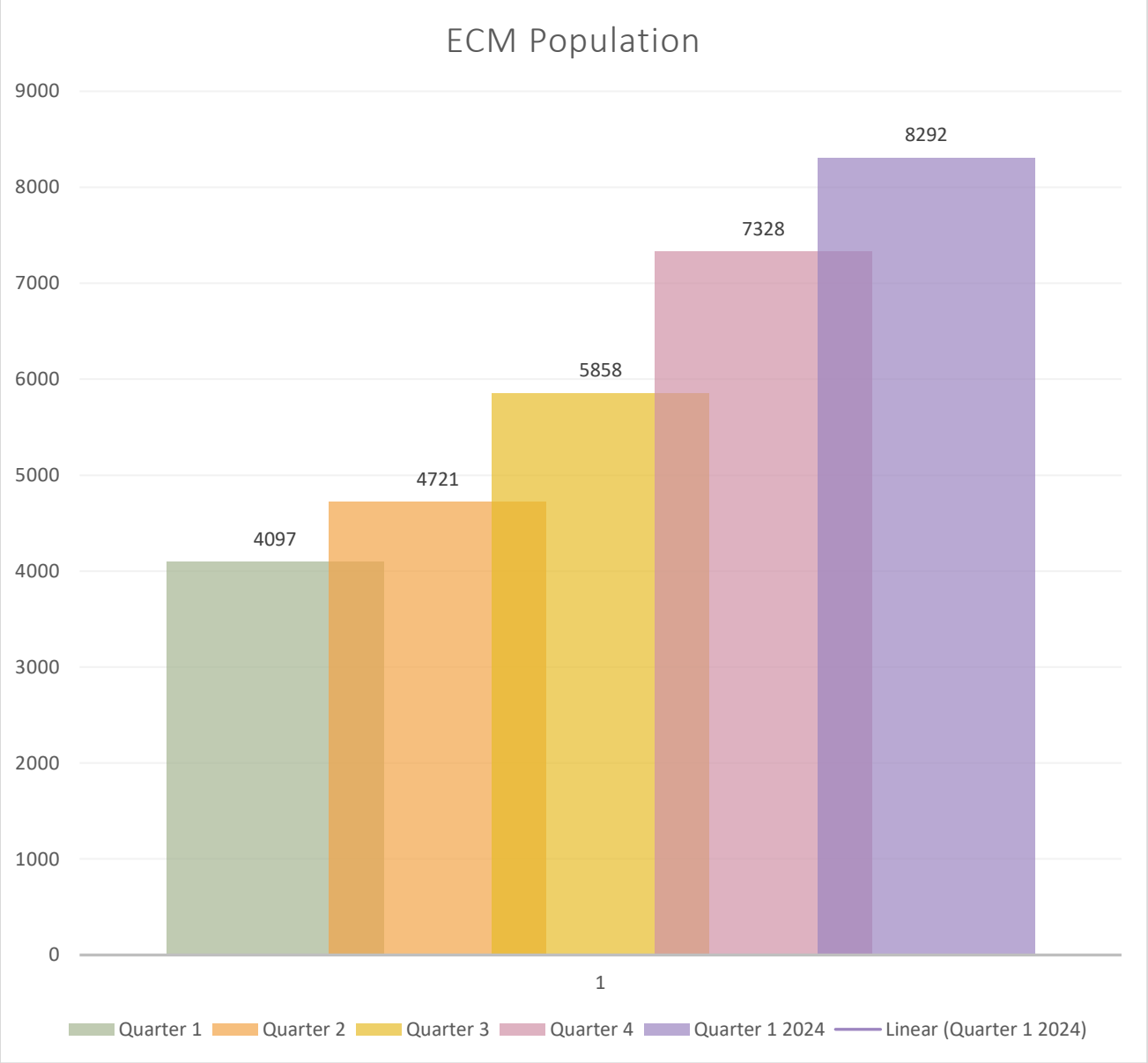
Count of ALT_ID	
ETHNIC_ORIGIN	Total
AFRICAN AMERICAN	358
CAUCASIAN	909
HISPANIC	1392
Grand Total	2659

    - **Youth**

Count of ALT_ID	
ETHNIC_ORIGIN	Total
AFRICAN AMERICAN	25
CAUCASIAN	46
HISPANIC	214
Grand Total	285

ECM Demographic Data

As of April 2024, ECM had a total of members currently enrolled in Enhanced Care Management services. These members are stratified into 32 ECM sites via geographic logic and are assigned into the above distinct populations of focus.



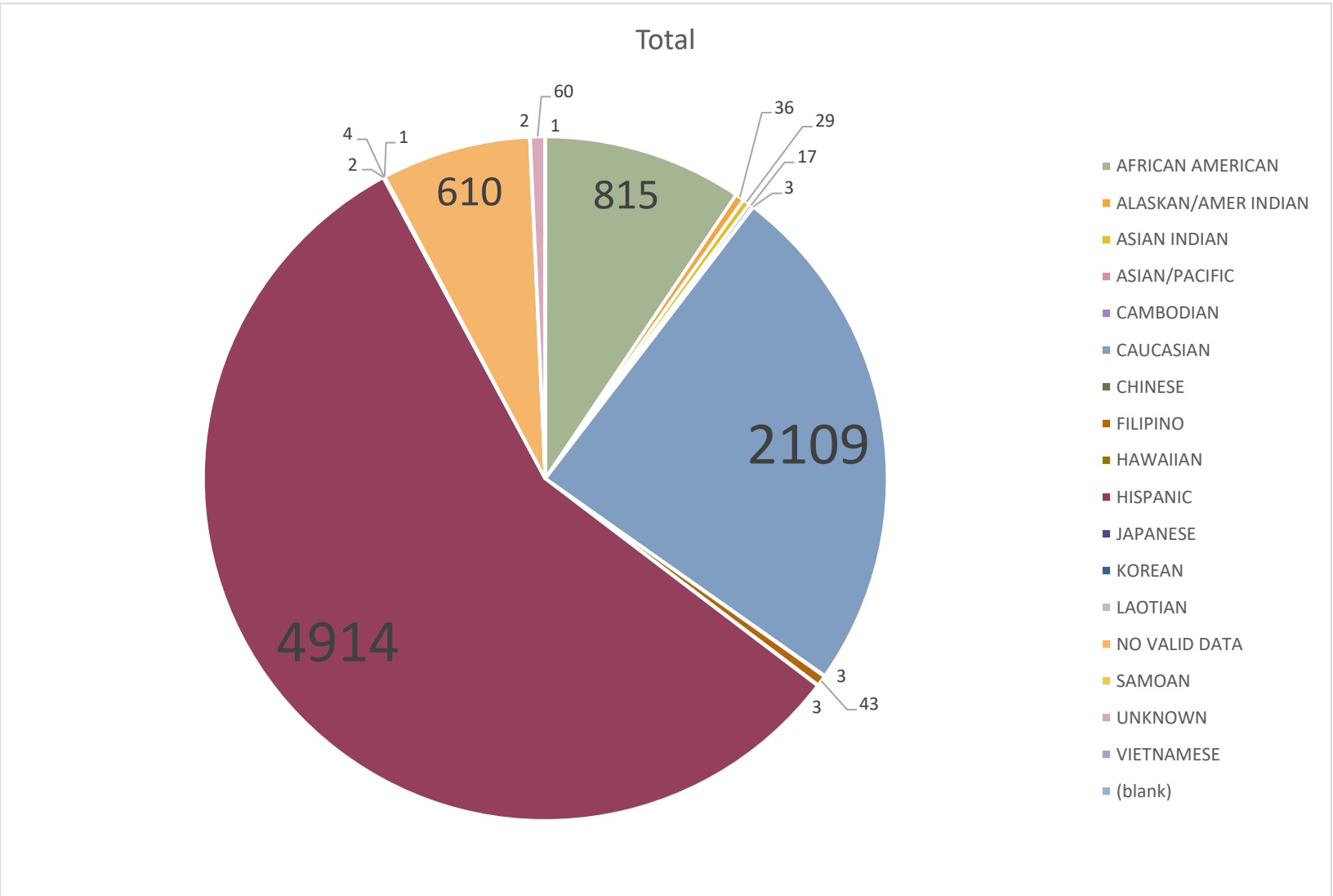
Notes:

- The high points of this (for ECM) are that Kern County is second highest overall in California for ECM penetration rates, second to Contra Costa County.

- KHS is 5th in the state in this report for enrolling adult members overall but is noted to be 3rd in the state in this report for enrolling child/youth members.

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 59.2% of the total ECM population (as of Q1 2024), 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 32 of our locations and continue to look at ways to be more equitable to all our ethnic groups in ECM.



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 of our sites as generated by our internal Business Intelligence team.

In accordance to the most recent DHCS IPP Provider milestone requirements our institutional goals moving forward is to use our this quarterly data as a benchmark to incrementally decrease our overall percentage of utilization. As per the IPP requirements, plans must show a net decrease in the rate of emergency department (ED) visits per 1,000 member months for members ages 21 and older and who are eligible for ECM. MUST have positive improvement in periods 4 and 5. 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.

IPP measures:

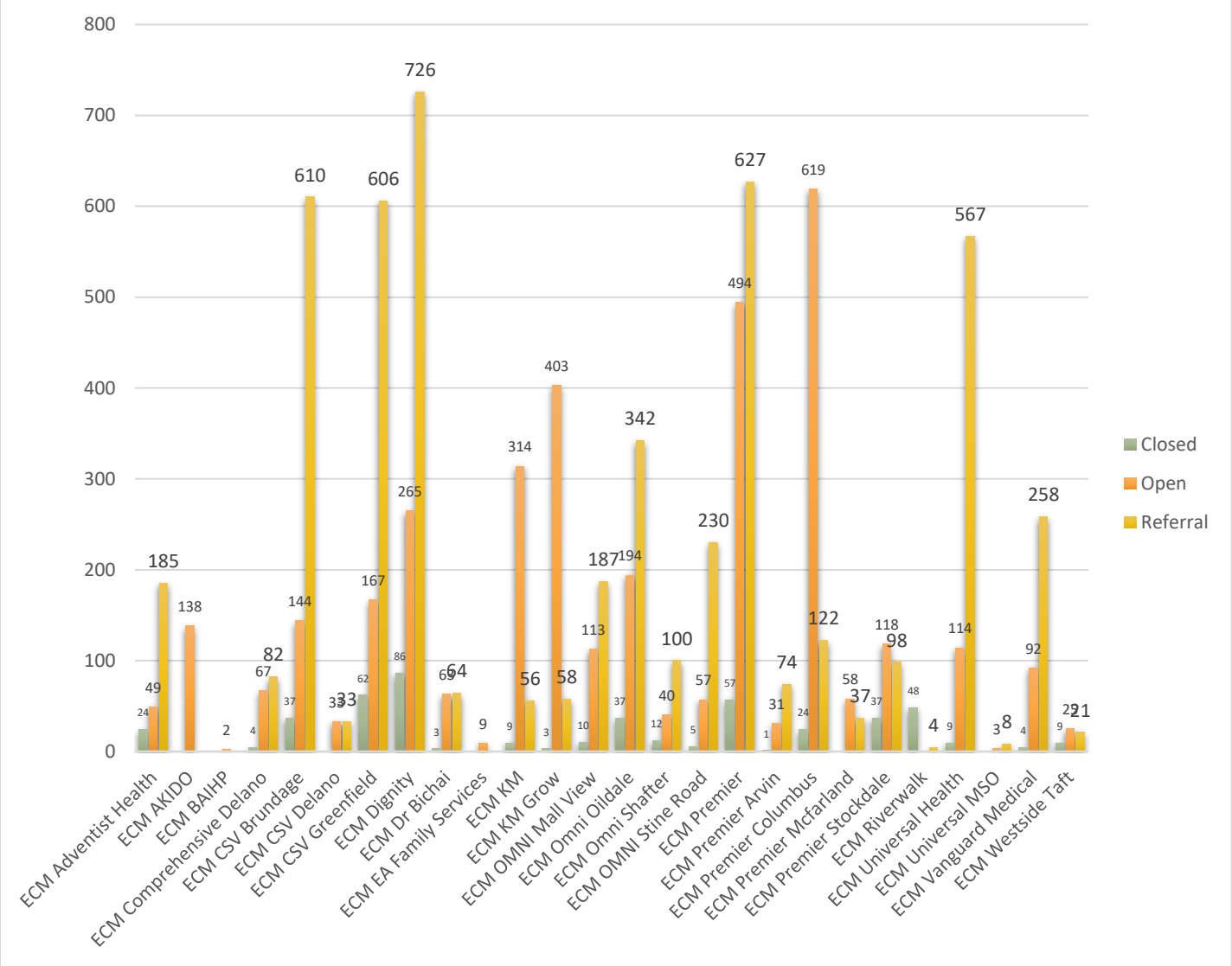
4.4.3 ***Quantitative Response Only*** Percentage of members who had ambulatory visits within 7 days post hospital discharge
4.4.4 **Quantitative Response Only** Rate of emergency department (ED) visits per 1,000 member months for members ages 21 and older and who are eligible for ECM **- Quarter 1 & 2 (P4P) – 168 out of 1000 or 16.8%** **- Quarter 3 % 4 (preliminary) – 138 of 1000 or 13.8%**
4.4.5 ***Quantitative Response Only*** Percentage of emergency department (ED) visits with a discharge diagnosis of mental illness or intentional self-harm for members ages 21 and older and who are eligible for ECM who had a follow-up visit with any practitioner within 30 days of the ED visit (31 total days)
4.4.6 ***Quantitative Response Only*** Percentage of emergency department (ED) visits with a discharge diagnosis of alcohol or other drug (AOD) use or dependence for members ages 21 and older and who are eligible for ECM who had a follow-up visit with any practitioner within 30 days of the ED visit (31 total days)
4.4.7 ***Quantitative Response Only*** Percentage of members ages 21 and older and who are eligible for ECM who had an ambulatory or preventive care visit
4.4.8 ***Quantitative Response Only*** The percentage of members 3-20 years of age and who are eligible for ECM who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner

4.4.9

Quantitative Response Only

Percentage of hospital discharges for members ages 21 and older and who are eligible for ECM who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days after discharge

Quarter I 2024 Total ED Utilization by site:



Total population by site

ECM Adventist Health	109
ECM AKIDO	164
ECM BAIHP	20
ECM CSV 1st	397
ECM CSV Delano	117
ECM CSV Greenfield	460
ECM Dignity	814
ECM Dr Bichai	79
ECM EA Family Services	17
ECM Family Healthcare	201
ECM Kern Psychiatric	16
ECM KM	562
ECM KM Grow	551
ECM OMNI Mall View	209
ECM Omni Oildale	367
ECM Omni Shafter	155
ECM OMNI Stine Road	154
ECM Open Door Network	12
ECM Premier	1469
ECM Premier Arvin	167
ECM Premier Columbus	674
ECM Premier McFarland	135
ECM Premier Stockdale	381
ECM Unity Care Hospitalists	34
ECM Universal Health	690
ECM Universal MSO	295
ECM Vanguard Medical	350
ECM Westside Taft	110

ECM clinical measure:

Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%) measure

With our growing population in ECM we understand that our growing footprint in our organization lends the necessity of a shared commitment to the KHS organizational values to the adherance and wholistic improvement in MCAS measures. With this clinical measure, we want to emphasize our commitment in serving the ECM population in this MCAS measure by reinforce member and provider education regarding MCAS measure with and added emphasis on the Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (> 9%) measure.

Historically with the ECM program we set a benchmark of a minimum of monthly meetings with the sites to discuss all administrative, technical, and clinical needs they may have. As we have evolved and grown in the program we have focused our clinical efforts in these meetings to build a solid focus on MCAS measures and emphasized with the sites the importance of tailoring their coordination/provider workflow to help meet these measures. Below, our internal Business Intelligence team queried the performance ECM member had in this measure as of close of Quarter 1 2024. Our population included members who are in 'Open' status (or engaged) with an ECM site through quarter 1- 4, and met the thresholds of the measure:

2023

Quarter 1 progress:

Measure	Population	Members Compliant	Measure Compliant Rate	MPL Goal	HPL Goal
Hemoglobin A1c Testing & Control for Patients With Diabetes Inverse Measure	1,241	813	**61.5%**	50.95	61.27

Quarter 2 Progress:

Measure	Population	Members Compliant	Measure Compliant Rate	MPL Goal	HPL Goal
Hemoglobin A1c Testing & Control for Patients With Diabetes Inverse Measure	1,327	714	**53.8%**	50.95	61.27

Quarter 3 Progress:

Measure	Population	Members Compliant	Measure Compliant Rate	MPL Goal	HPL Goal
Hemoglobin A1c Testing & Control for Patients With Diabetes Inverse Measure	1,518	548	**36.1%**	50.95	61.27

Quarter 4 Progress:

Measure	Population	Members Compliant	Measure Compliant Rate	MPL Goal	HPL Goal
Hemoglobin A1c Testing & Control for Patients With Diabetes Inverse Measure	1,596	577	**36.15%**	50.95	61.27

2024

Quarter 1 progress:

Measure	Population	Members Compliant	Measure Compliant Rate	MPL Goal	HPL Goal
Hemoglobin A1c Testing & Control for Patients With Diabetes Inverse Measure	2,440	1,384	**56.72%**	50.95	61.27

Site by Site MCAS

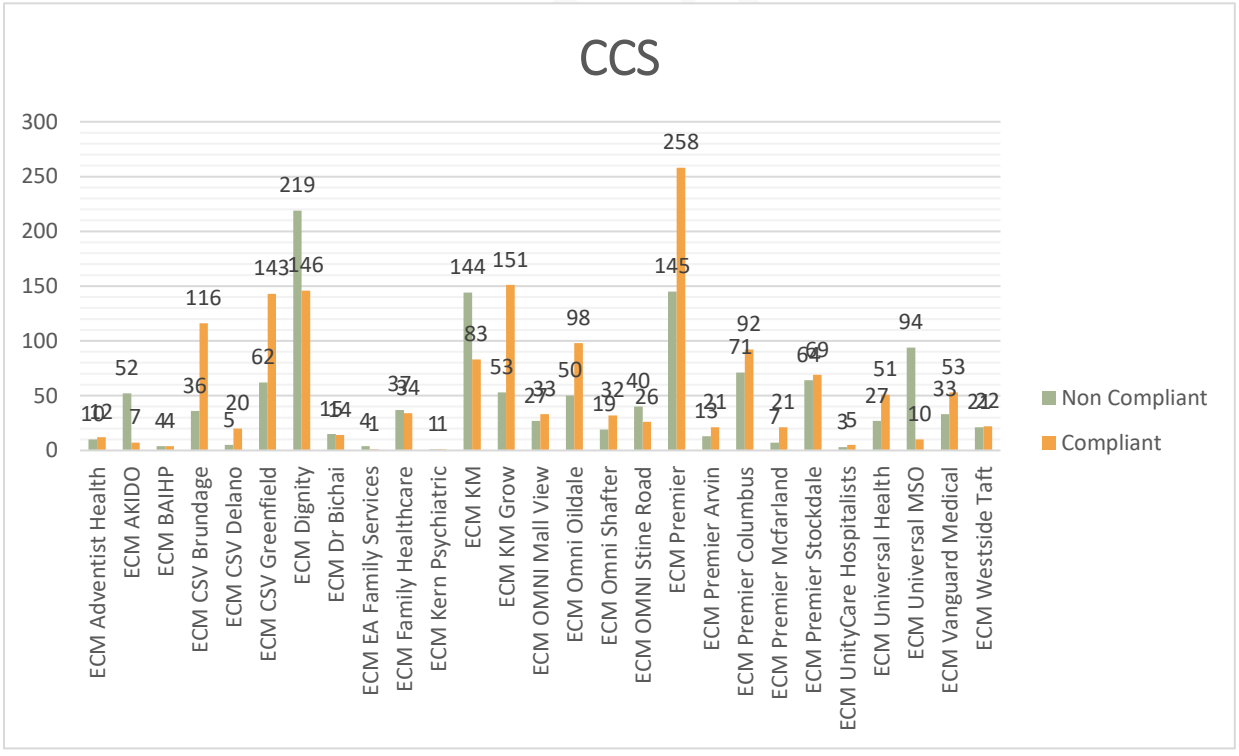
Cervical Cancer Screening

Measure Description: Women who had either the following age-appropriate cervical cancer screenings:

• Women 21 to 64 years of age who had cervical cytology performed within the last 3 years.

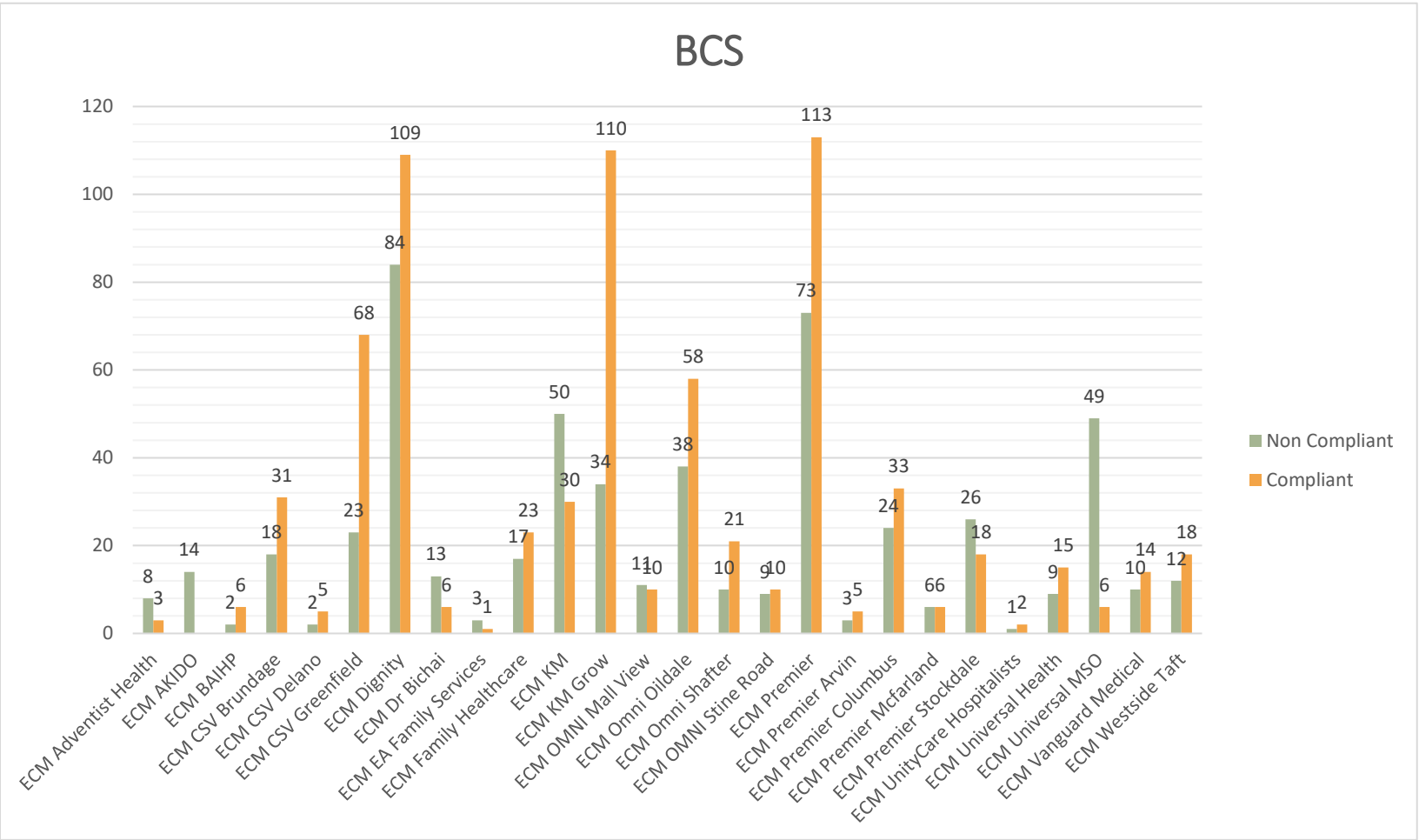
OR

• 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.



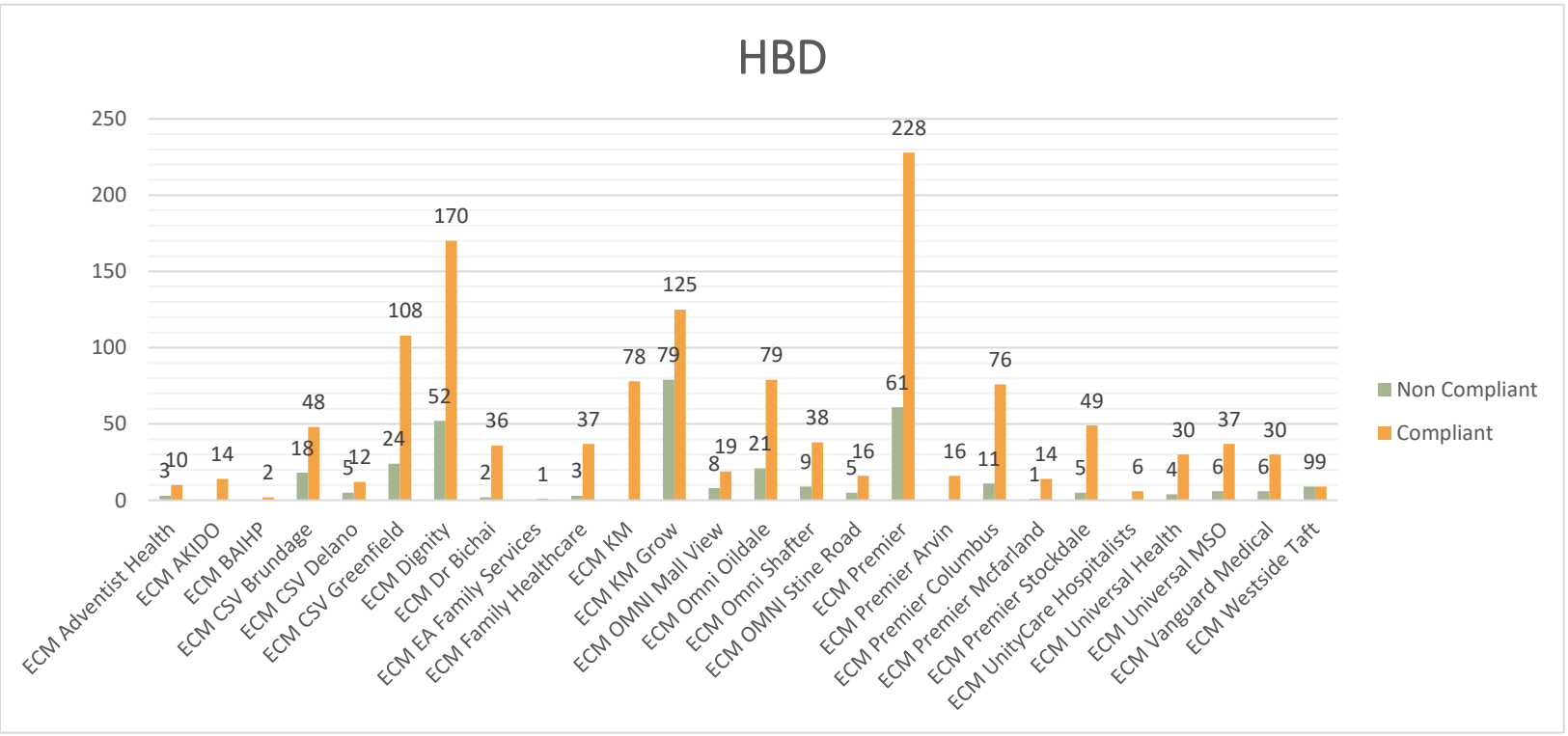
Breast Cancer Screening

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.



Comprehensive Diabetes Care

Measure Description: Members 18 to 75 years of age with diabetes (type 1 or 2) whose hemoglobin A1c (HbA1c) level was >9.0% during the measurement year.



Patient Satisfaction:

Survey Data

The Enhanced Care Management team has historically sent an experience satisfaction survey out to it's members for resubmission to the plan. As of date of submission to the QIC, we have worked internally with our delegated parties to distribute the surveys out to our membership and will begin receiving response data April 2024.

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:

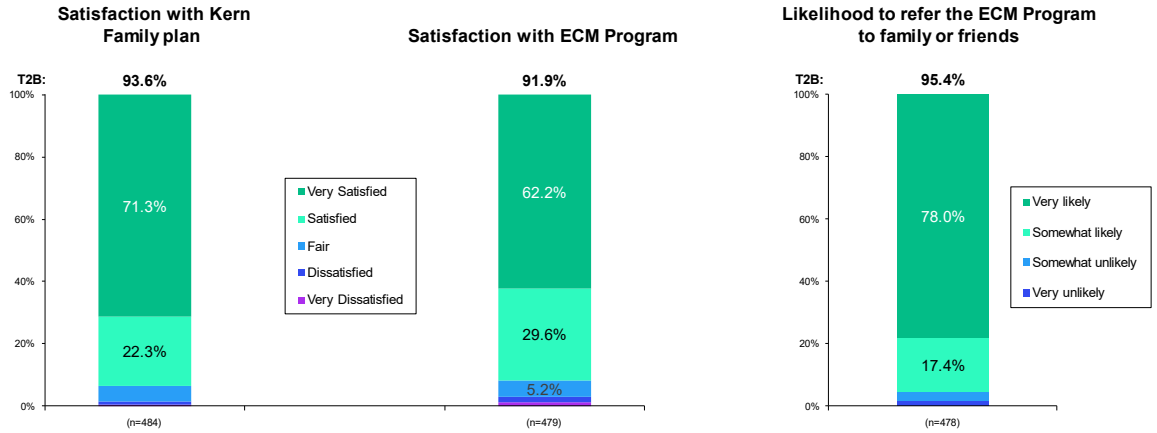
- **Sample size and response rate.**

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%

2023 Results:

Overall satisfaction

More than nine in 10 are satisfied with Kern Family as their insurance plan and with their overall experience with the ECM Pr ogram and are likely to refer the program to family or friends.

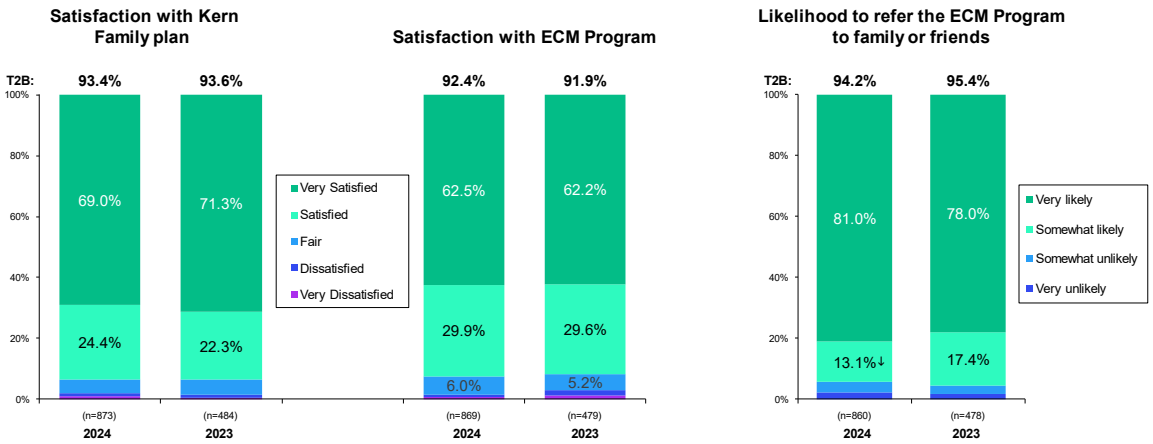


Q13. How satisfied are you with Kern Family as your health insurance plan? Q14. How satisfied are you with your overall exper ience with your Kern Health ECM Program? Q15. How likely are you to refer Kern Health's ECM Program to family or friends?

2024 Results:

Overall satisfaction

The vast majority are satisfied with Kern Family as their insurance plan as well as with their overall experience with the EC M Program and are likely to refer the program to family or friends.

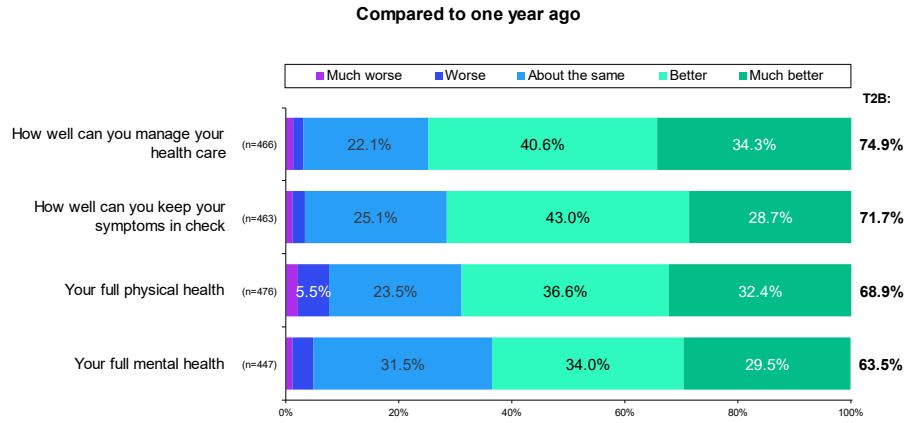


Q9. How satisfied are you with Kern Family as your health insurance plan? Q10. How satisfied are you with your overall experi ence with your Kern Health ECM Program? Q11. How likely are you to refer Kern Health's ECM Program to family or friends? An arrow (↑↓) indicates a significantly different result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

2023 Results:

Outcomes

Three in four indicated that they are better able to manage their health care now, compared to 12 months ago. Roughly seven i n 10 indicated that they are better able to keep their symptoms in check and that their physical health is better. Nearly two -thirds indicated that their mental health is better.

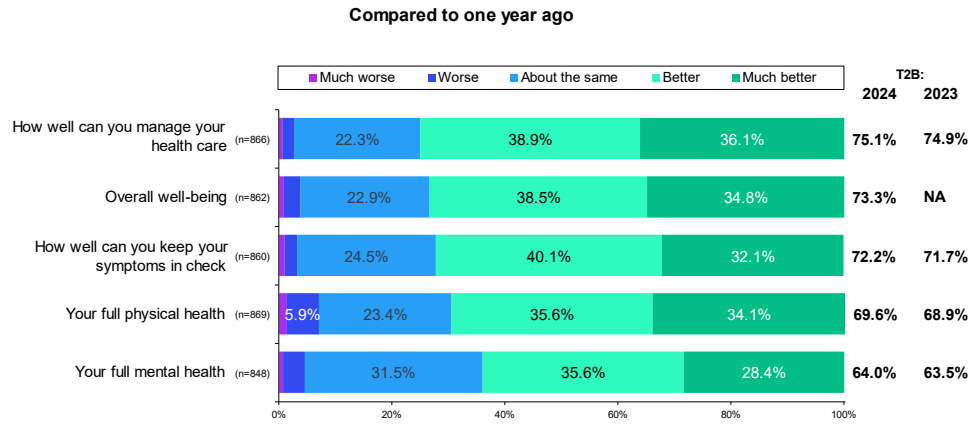


Q16. Compared to 12 months ago, how would you rate…?

2024 Results:

Outcomes

More than seven in 10 indicated that their overall well -being is better compared to one year ago. Scores for the remaining measu res are consistent with 2023.



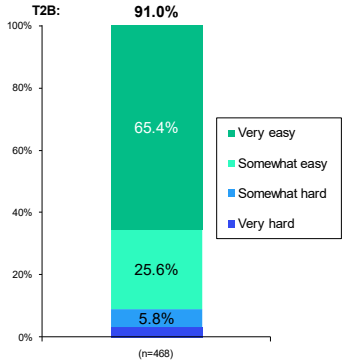
Q12. Compared to 12 months ago, how would you rate…? An arrow (↑↓) indicates a significantly different result from the previous year.

2023 Results:

Experience with ECM Program

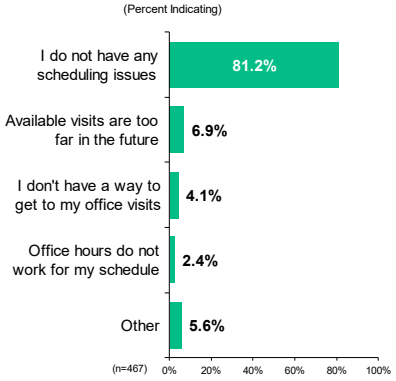
Nine in 10 indicated that it was easy for them to schedule their visits with the ECM Program, and four in five indicated that they do not have any scheduling issues. Among those who do have difficulties, a lack of timely appointments is the most common problem

Ease of scheduling visits with the Kern Family ECM Program



Reasons for difficulties with scheduling ongoing visits

(Percent Indicating)



Q1. When did you first become involved with the Kern Family ECM Program? Q2. How easy is it for you to schedule visits with t he Kern Family ECM Program?? Q3. Do you have a hard time scheduling ongoing visits for any of the following reasons?

Enhanced Care Management Participant Survey | Kern Health Systems | Results 9

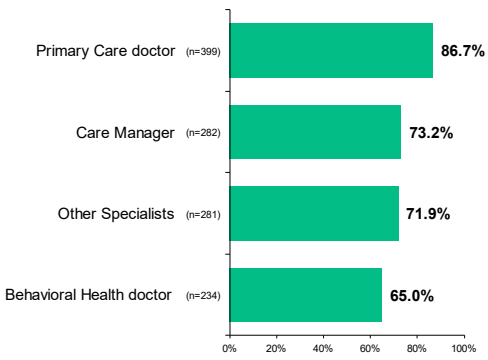
2024 Results:

Experience with ECM staff

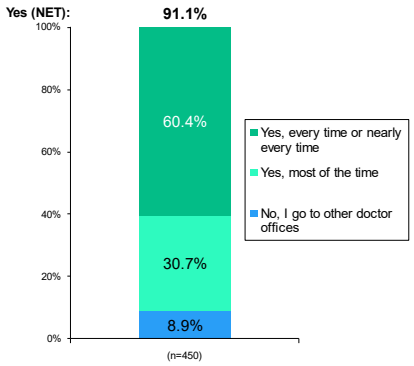
The majority have seen or talked with the same provider regularly for the past year. Nine in 10 typically visit their assigne d ECM physician each time they need care.

Have seen or talked with the same person regularly

(% Yes)



Visit assigned Kern Family ECM Program physician each time care is needed



Q4. For each of the following, please check if you have seen or talked with the same person regularly for the past 12 months. Q5. Do you visit your assigned Kern Family ECM Program physician each time you need care?

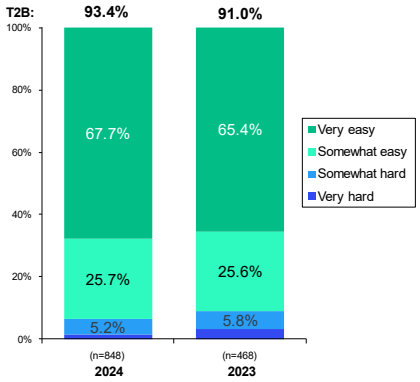
Enhanced Care Management Participant Survey | Kern Health Systems | Results 10

2023 Results:

Experience with ECM Program

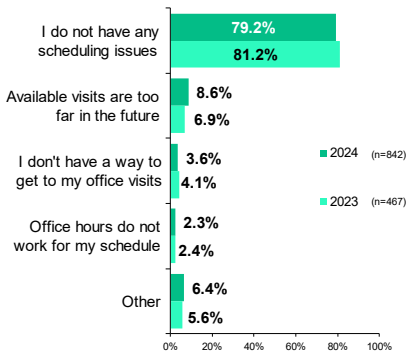
Nine in 10 indicated that it was easy to schedule their visits with the ECM Program, and roughly four in five indicated that they do not have any difficulties with scheduling ongoing visits. Among those who do have difficulties, a lack of timely appointments is the most common problem.

Ease of scheduling visits with the Kern Family ECM Program



Reasons for difficulties with scheduling ongoing visits

(Percent Indicating)



Q2. How easy is it for you to schedule visits with the Kern Family ECM Program?? Q3. Do you have a hard time scheduling ongoi ng visits for any of the following reasons? An arrow (↑↓) indicates a significantly different result from the previous year.

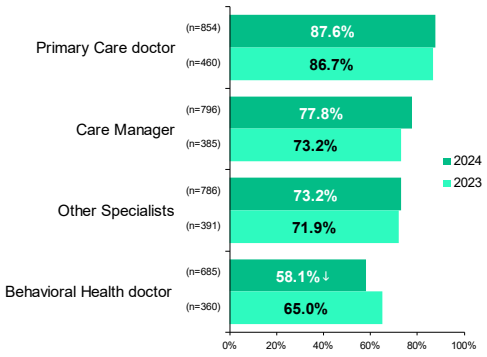
2024 Results:

Experience with ECM staff

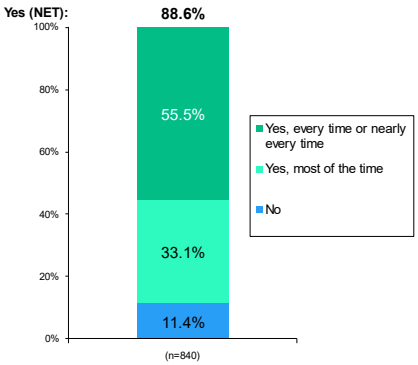
A significantly lower percentage indicated speaking with the same Behavioral Health Doctor, while a slightly higher percentag e spoke to the same Care Manager. Nearly nine in 10 typically saw or spoke to their Lead Care Manager when needed.

Have seen or talked with the same person regularly

(% Yes)



Saw or spoke to Lead Care Manager when needed*



Q4. For each of the following, please check if you have seen or talked with the same person regularly for the past 12 months. An asterisk (*) indicates a new question in 2024. Q5. Do you get to see or talk to your Lead Care Manager when you need to? An arrow (↑↓) indicates a significantly different result from the previous year.

Kern Health Systems
2024 Quality Improvement Program Work plan
Last Updated: 6/27/2024

	On Track
	In Jeopardy
	Barrier
	Complete

Source	Key Performance Measure	Metrics	Measurable Goals	Actions/Improvement Activities	Status	Q1 Comments
QUALITY PROGRAM STRUCTURE						
NCQA 1A	QI Program Description	QI Program description of committee accountability, functional areas and responsibilities, reporting relationship, resources and analytical support	Annual approval by the QIC and the BOD	Presentation of the QI Program to BOD and QIC for review and approval.	Complete	2024 Program Description presented to QIC and EQIHEC
NCQA 1B	Annual QI Work Plan	Yearly planned objectives and activities	Annual approval by the QIC and the BOD	Presentation of the QI Work Plan to BOD and QIC for review and approval.	Complete	2024 Workplan presented to QIC and EQIHEC
NCQA 1C	Annual QI Evaluation	Summary of completed and ongoing QI activities, trending of results and overall evaluation of effectiveness	Annual approval by the QIC and the BOD	Presentation of the QI Evaluation to BOD and QIC for review and approval	Complete	2023 Evaluation presented to EQIHEC
NCQA; DHCS	Policies and Procedures	Review of organization's policies and procedures	Annual approval by the QIC	Presentation of the QI Evaluation to QIC for review and approval		Need to complete by end of year
NCQA 1A	Quality Improvement Health Equity Committee (QIHEC)	Quarterly meetings and maintenance of minutes	Conduct quarterly meetings, as required by the QM Program	Meet quorum of voting members +at every meeting		Meeting invites sent out for rest of year
Quality of Clinical Care						
DHCS	MCAS Measures	18 MCAS measures mandated by DHCS to meet minimum performance levels (MPLs)	All DHCS- mandated MCAS measures must meet the MPL at the 50th percentile 1. Timely Submission of all 18 measures. 2. Meet MPL for all 18 measures we are held accountable.	Based on the Fishbone diagram submitted to DHCS (RED Tier) a) Data management b) Training and resources c) Collaboration and communication		2023 MCAS submission completed timely. 8 of 18 measures met MPL. 2024 MCAS, as of March 2024, 14 of 18 measures have improved compared to last year.
DHCS	Performance Improvement Projects (PIPs)					
	Clinical PIP: The clinical PIP will be focused 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.	Use MY2023 W30 (0-15months) baseline data to develop PIP interventions and get Annual Approval by HSAG.	Interventions to be established in 2024		Leveraging activities from mobile units and the IHI/DHCS collaborative focused on well-care visits for the 0-15 months, African American babies.
	Non-Clinical PIP: The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health department and interventions.	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 visist.	Use MY2023 baseline data to develop interventions that includes a process for notifying PCPs of ED visits for eligible population. Annual Approval by HSAG	Interventions to be established in 2024		Developing a provider notification process for ED visits related to Behavioral Health and Substance Use Disorders.
DHCS	Potential Quality of care Issue (PQI)	Monitoring of PQI volume month over month.	Monitor if the volume is below the median value of last 12 months.	Monitor Trending Reports		
		PQI Volume by Provider and by Severity	Monitor Total PQI volume with severity level 2 and 3 is below 30 for rolling 12month period.	Monitor Trending Reports		
		PQI Volume by Ethnicity and by Severity	Monitor Total PQI volume with severity level 2 and 3 is below 30 for rolling 12month period.	Monitor Trending Reports		
NCQA QI 3	Continuity and Coordination of Medical Care - Transitions of Care:	*Collecting data, identifying improvement opportunities and measuring effectiveness*	Will establish baseline for NCQA requirements	Interventions to be established in 2024		
	a) Movement of Members Between Practitioners	example – consult report received by PCPs	Will establish baseline for NCQA requirements	Interventions to be established in 2024		Eye exam for diabetics (EED) measure selected. Quantitative & Qualitative analysis completed. Results need to be presented to QIC.

	b) Movement of Members Across Settings	example – post partum rate	Will establish baseline for NCQA requirements	Interventions to be established in 2024		Plan all cause readmissions (PCR) measure selected.
NCQA QI 4	Continuity and Coordination Between Medical Care and Behavioral Healthcare –	*Collecting data, identifying improvement opportunities and evaluation of effectiveness that improve coordination of behavioral and general medical care:*	Will establish baseline for NCQA requirements	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		In-progress
	a) Exchange of information	*Ambulatory Medical Record Review* : Example - Presence of consult reports Example – PCP survey regarding satisfaction with coordination of care with BH practitioners	Will establish baseline for NCQA requirements	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		
	b) Appropriate diagnosis, treatment and referral of BH disorders seen in primary care	Example – Antidepressant Medication Management (AMM) Example – Follow-up Care or Children Prescribed ADHD medications (ADD)	Increase MCAS result by 2 percentage points from previous year	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		
	c) Appropriate use of psychotropic medications	Examples: AMM ; ADD Analysis of pharmaceutical data for appropriateness of a psychopharmacological medication	Increase MCAS result by 2 percentage points from previous year	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		
	d) Management of coexisting medical and behavioral disorders	Example: FUH	Will establish baseline for NCQA requirements	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		
	a) Primary or secondary preventive behavioral healthcare implementation	Examples: Data on need for stress management program for adults Data on need for prevention of substance abuse program Data on the need for developmental screening of children in primary care settings Data on the need for ADHD screening of children in primary care settings Data on the need for postpartum depression screening	Will establish baseline for NCQA requirements	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		
	b) Special needs of members with serious mental illness or serious emotional disturbance	Example: HEDIS measure Diabetes Monitoring for People with Diabetes and Schizophrenia	Will establish baseline for NCQA requirements	New NCQA requiremnet. Will develop initiatives to meet NCQA standards.		
Safety of Clinical Care						
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*	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	CSR will schedule and complete reviews timely.		8 initial and 2 periodic FSR completed. 100% pass rate
DHCS	Physical Accessibility Review Survey (PARS)	Conduct PARS audit with FSR	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	QP Senior coorninator will schedule and complete all PARS due 2024		4 completed in Q1
DHCS	Medical Record Review	Conduct medical record review of practitioners due for facility site reviews	Achieve medical record review score of 85% for each practitioner	CSR will schedule and complete reviews timely.		4 initial and 2 periodic medical record reviews. 83% pass rate
Kern	Drug Utilization Review	TAR PAD	Turnaround Time Timeliness - reviewed and returned in 1 business day TAR=24hrs PAD=5 days routine 3days=urgent	None		
NCQA	Credentialing/Recredentialing	Credential/recredential practitioners timely	100% timely credentialing/recredentialing of practitioners	Review of trends for Grievances and PQIs, QOC look back review Q3 years		All credentialing/recredentialing for Q1 completed on time
Quality of Service						
NCQA; DHCS	Grievance and Appeals	a) Timeliness of acknowledgment letters	Within 5 calendar days			
		b) Timeliness of resolution	Within 30 calendar days			
DHCS; NCQA	Potential Quality of Care Issues (PQI)	a) Timeliness of acknowledgment letters	Within 5 calendar days			
		b) Timeliness of resolution	Within 30 calendar days			
NCQA; DHCS	Access to Care - PCP	*PCP access for preventive, routine care, urgent care, and after-hours access* Urgent care – w/in 48 hrs Routine care – 10 business days		Provider Accessibility Monitoring Survey		

			80%			
	Access to Care - SCP	*Access to specialty care* Urgent care – w/in 48 hrs a) Routine care – 15 business days	80%	Provider Accessibility Monitoring Survey		
DHCS; NCQA	Telephone access to Member Services	a) Speed of answer	≤ 30 seconds	Perform quarterly telephone access audit		2:22
		b) Call abandonment rate	5%			10%
Members' Experience						
Kern	CAHPS survey	Adult and Child Medicaid Survey	Monitor CAHPS Resutls and establish basline for Getting Care needed measure	Trending report on CAHPS results by survey questions		Satisfaction surveys underway
	Member Engagement / Rewards	Establish year-round, member outreach program focused on members with gaps in care. Redesign MCAS member rewards program to increase motivation for compliance with obtaining preventive health services and follow through with chronic condition self-care.	Increase the included MCAS Measure Rates by 2% points by end of the year.	a) Text Messages to members encouraging the scheduling of 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 oRobocalls will be sent out to members that do not receive text messages FUM Got Approved for incentives for MY2024. FUA is Pending Approval		
Provider Engagement						
Kern	Provider Satisfaction Survey			Trend PSS results by survey questions		Satisfaction surveys underway
	Provider Incentive Program	Improve HBD Measure rate	Improve HBD A1C level	Dr. Duggal began a pilot for members with Diabetes. With this pilot, Dr. Duggal is provided a group of members with uncontrolled Diabetes and help get their A1C controlled with the appropriate interventions. This will be an incentive-based reimbursement structure.		
	Provider education	Improve MCAS Measure Rates	Meet Providers Quarterly	QI cordinator meet Providers to update them on the MCAS Measure Rate performance		

KERN HEALTH SYSTEMS

To: KHS Executive Quality Improvement Health Equity Committee

From: Nate Scott

Date: August 8, 2024

Re: Executive Summary for 2nd Quarter 2024 Grievance Summary Report

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Background

Executive Summary for the 2nd Quarter Grievance Summary Report:
The Grievance Summary Report supports the high-level information provided on the Operational Report and provides more detail as to the type of grievances KHS receives on behalf of our members.

For the 2nd quarter, 2024, we had three thousand, two hundred, twenty-eight (3,228) Grievances and Appeals (G&A) received. Here are the top three grievance categories:

- Access to Care/Difficulty Accessing Specialists at 33.6% of grievances received.
- Quality of Service at 29.8% of grievances received.
- Quality of Care at 16.7% of grievances received.

Of the 3,228 G&A received:

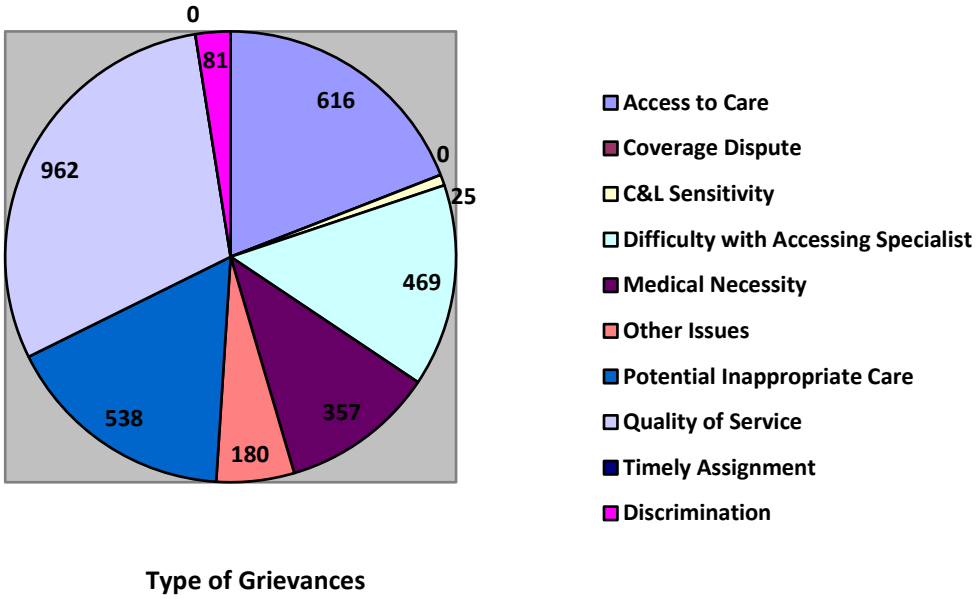
- 2,053 (63.6%) G&A were Standard Grievances and took up to 30 days to investigate and resolve.
- 1,175 (36.4%) G&A were Exempt Grievances and were resolved within one business day.
- 1,724 (53.4%) closed in Favor of the Enrollee
- 1,392 (43.1%) closed in Favor of the Plan/Provider
- 112 (.3.5%) are still open for review.

Requested Action

Receive and Approve

2ND Quarter 2024 Grievance Summary

Issue	Number	In Favor of Health Plan	In favor of Enrollee	Still under review
Access to care	616	134	473	9
Coverage dispute	0	0	0	0
Cultural and Linguistic Sensitivity	25	12	13	0
Difficulty with accessing specialists	469	141	313	15
Medical necessity	357	224	116	17
Other issues	180	84	83	13
Potential Inappropriate care	538	410	100	28
Quality of service	962	314	623	25
Timely assignment to provider	0	0	0	0
Discrimination	81	73	3	5



Type of Grievances

KHS Grievances and Appeals per 1,000 members = 2.67/month

During the second quarter of 2024, there were three thousand two hundred and twenty-eight grievances and appeals received. Two thousand fifty-three cases were standard, and one thousand one hundred seventy-five cases were exempt and closed within one business day. One thousand three hundred and ninety-two cases were closed in favor of the Plan. One thousand seven hundred and twenty-four cases were closed in favor of the Enrollee. There are one hundred and twelve cases still under review. Of the three thousand two hundred and twenty-eight, three thousand fifty-seven cases closed within thirty days; one hundred and seventy-one cases were pended and closed after thirty days.

2ND Quarter 2024 Grievance Summary

Access to Care

There were six hundred and sixteen grievances pertaining to access to care. Two hundred and fifty-four cases were standard, and three hundred sixty-two were exempt cases that closed within one business day. One hundred and thirty-four closed in favor of the Plan. Four hundred and seventy-three cases closed in favor of the Enrollee. There are nine cases pending review. The following is a summary of these issues:

Three hundred and fourteen members complained about the lack of available appointments with their Primary Care Provider (PCP). Fifty-one 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. Two hundred and sixty-one cases closed in favor of the Enrollee after the responses indicated the offices may not have provided appropriate access to care based on Access to Care standards. There are two cases pending review.

Forty members complained about the wait time to be seen by a Primary Care Provider (PCP) appointment. Fourteen 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-six 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.

One hundred and fifty-five members complained about the telephone access availability with their Primary Care Provider (PCP). Thirty-nine cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate telephone access availability. One hundred and fourteen 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 two cases pending review.

One hundred and six members complained about a provider not submitting a referral authorization request in a timely manner. Twenty-nine cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Seventy-two 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 five cases pending review.

One member complained about out-of-network access to a provider. The case closed in favor of the Plan after it was determined the out-of-network access provided was appropriate.

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

There were twenty-five members that complained about the lack of available interpreting services to assist during their appointments. Fourteen were standard cases and eleven were exempt cases that closed within one business day. Twelve 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. Thirteen 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.

Difficulty with Accessing a Specialist

There were four hundred and sixty-nine grievances pertaining to Difficulty Accessing a Specialist. Two hundred and seventy-four were standard cases and one hundred and ninety-five were exempt cases that closed within one business day. One hundred and forty-one cases closed in favor of the Plan. Three hundred and thirteen cases closed in favor of the Enrollee. There are fifteen cases still under review. The following is a summary of these issues:

Sixty-three members complained about a provider not submitting a referral authorization request in a timely manner. Twenty-three cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Thirty-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 six cases under review.

Ninety-one members complained about experiencing difficulties in arranging, scheduling, or accessing transportation services. Thirty-three cases closed in favor of the Plan after the responses indicated the members were provided the appropriate services. Fifty-six cases closed in favor of the Enrollee after the responses indicated the members were provided the appropriate services. There are two cases still under review.

Forty-one members complained about the driver showing up outside of the scheduled pick-up time to transport the member to their appointment. Twelve cases closed in favor of the Plan after the response indicated the member was provided with the appropriate wait time for a scheduled appointment. Twenty-eight 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 is one case under review.

One hundred and seventy-eight members complained about the lack of available appointments with a specialist. Fifty-three cases closed in favor of the Plan after the responses indicated the members were provided 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 are four cases still under review.

Eighty members complained about the telephone access availability with a specialist office. Fifteen cases closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access availability. Sixty-three 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 two cases under review.

Sixteen members complained about the wait time to be seen for a specialist appointment. Five 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. Eleven 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.

Medical Necessity

There were three hundred and fifty-seven appeals pertaining to Medical Necessity. Two hundred and twenty-four 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, three were partially overturned. One hundred and sixteen were closed in favor of the Enrollee. There are seventeen cases under review.

Other Issues

There were one hundred and eighty grievances pertaining to Other Issues that are not otherwise classified in the other categories. One hundred and eighteen were standard cases and sixty-two were exempt cases that closed within one business day. Eighty-four cases closed in favor of the Plan after the responses indicated the appropriate service was provided. Eighty-three cases closed in favor of the Enrollee after the responses indicated the appropriate service may not have been provided. Thirteen cases are still open pending investigation and resolution.

Potential Inappropriate Care

There were five hundred and thirty-eight 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 ten cases were closed in favor of the Plan, as it was determined a quality-of-care issue could not be identified. One hundred 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 twenty-eight cases still pending further review with QI.

Quality of Service

There were nine hundred and sixty-two grievances involving Quality of Service issues. Four hundred and seventeen were standard cases and five hundred and forty-five were exempt cases that closed within one business day. Three hundred and fourteen cases closed in favor of the Plan after the responses determined the members received the appropriate service from their providers. Six hundred and twenty-three cases closed in favor of the Enrollee after the responses determined the members may not have received the appropriate services. There are twenty-five cases still under review.

Timely Assignment to Provider

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

2ND Quarter 2024 Grievance Summary

Discrimination

There were eighty-one standard grievances pertaining to Discrimination. Seventy-three cases closed in favor of the Plan as there was no discrimination found. Three cases closed in favor of the Enrollee. There are five cases still under review. All grievances related to Discrimination, are forwarded to the DHCS Office of Civil Rights upon closure.

KERN HEALTH SYSTEMS

To: KHS Executive Quality Improvement Health Equity Committee

From: Nate Scott

Date: August 8, 2024

Re: Executive Summary for 2nd Quarter 2024 Operational Board Update - Grievance Report

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Background

Executive Summary for 2nd Quarter 2024 Operational Board Update - Grievance Report: When compared to the previous four quarters, the following trends were identified related to the Grievances and Appeals received during the 2nd Quarter, 2024.

- There was a significant increase in volume for three categories in the 2nd quarter compared to the 1st quarter of 2024. The overall volume of Grievances and Appeals dropped 12% but Access to Care, Other Issues, and Quality of Service standard grievances all had a significant increase. The volume of Exempt grievances dropped by 37%; meaning more member complaints could not be resolved in one day and took longer to resolve. The drop in Exempt grievances is a factor in the increase in volume for Access to Care, Other Issues, and Quality of Service standard grievances as those are typically the highest type of Exempt grievances received.

KHS Grievance and Appeals per 1,000 members = 2.66 per month.

Requested Action

Receive and Approve

2nd Quarter 2024 Operational Report

Alan Avery
Chief Operating Officer

2nd Quarter 2024 Grievance Report

Category	2nd Quarter 2024	Status	Issue	Q1 2024	Q4 2023	Q3 2023	Q2 2023
Access to Care	541		Appointment Availability	384	347	303	233
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	357		Questioning denial of service	385	423	478	420
Other Issues	118		Miscellaneous	64	39	65	55
Potential Inappropriate Care	538		Questioning services provided. All cases forwarded to Quality Dept.	572	522	644	703
Quality of Service	417		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	338	296	326	282
Discrimination (New Category)	81		Alleging discrimination based on the protected characteristics	60	40	45	64
Total Formal Grievances	2052			1803	1667	1861	17547
Exempt	1177		Exempt Grievances	1881	1620	2026	1873
Total Grievances (Formal & Exempt)	3229			3684	3287	3887	3630

*Report with data collected as of 07/19/2024

KHS Grievances and Appeals per 1,000 members = 2.66/month

Additional Insights-Formal Grievance Detail

Issue	2024 2nd Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	262	127	0	98	37
Coverage Dispute	0	0	0	0	0
Specialist Access	279	126	0	108	45
Medical Necessity	357	224	0	116	17
Other Issues	118	77	0	17	24
Potential Inappropriate Care	538	359	85	94	0
Quality of Service	417	279	0	69	69
Discrimination	81	68	0	3	10
Total	2052	1260	85	505	202

KERN HEALTH SYSTEMS

To: EQIHEC

From: Christine Pence, Senior Director of Health Services

Date: 7/1/2024

Re: Utilization Management Department Reporting Q2 2024

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 directives.

Discussion

This report contains a synopsis of analytics that reflect the performance of the Utilization Management Department's in the 2nd quarter of 2024.

- Utilization Management Metrics
- Internal Audit Results

Fiscal Impact: N/A

Requested Action: No action needed.

Utilization Management Executive Summary

The Utilization Management Department continues to focus on ensuring all requests for services are processed within regulatory turnaround time standards and determinations are provided both accurately and efficiently.

This year the department has undertaken a dedicated effort to improve communication with providers and members. Of particular focus is ensuring notifications are clear, concise and at an appropriate readability level. This work will continue next quarter as we look to implement notice of action templates within our JIVA system.

The Utilization Management (UM) Department continues work focused on the adoption of processes and policies that coincides with regulatory requirements and prepare for NCQA initial accreditation survey. The Utilization Department is on track to meet accreditation standards and is incorporating the requirements into workflow processes.

The Utilization Management Team continues to audit performance to ensure industry standards are met or exceeded as well as analyze available data using a Health Equity lens and identifying areas where additional effort will benefit the population we serve.

The following report reflects Utilization Management performance through 2nd quarter 2024.

Respectfully submitted,

Christine Pence

Christine Pence, MPH, RN, RD
Senior Director of Health Services
Kern Health Systems

Timeliness of Decision Trending

Summary:

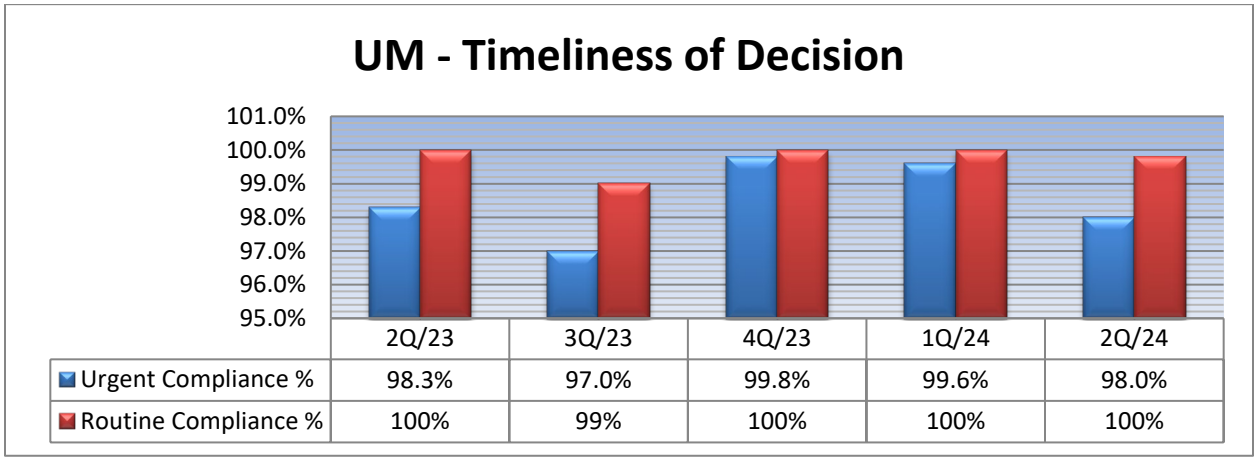
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

Providers may indicate 'Urgent' on the referrals indicating a decision needs to be made within 3 business days. Routine/non-emergent referrals must be processed within 5 business days. Once an urgent referral has been reviewed it may be downgraded for medical necessity at which time the provider will be notified via letter that the referral has been re-classified as a routine and nurse will clearly document on the referral "re-classified as routine". Random referrals are reviewed every quarter to observe timeliness. 10% of referrals received are reviewed monthly.

For those referrals that are found to be out of compliance with turn-around-timelines, the case manager and support staff are notified, and importance of timeframes discussed to help ensure future compliance.

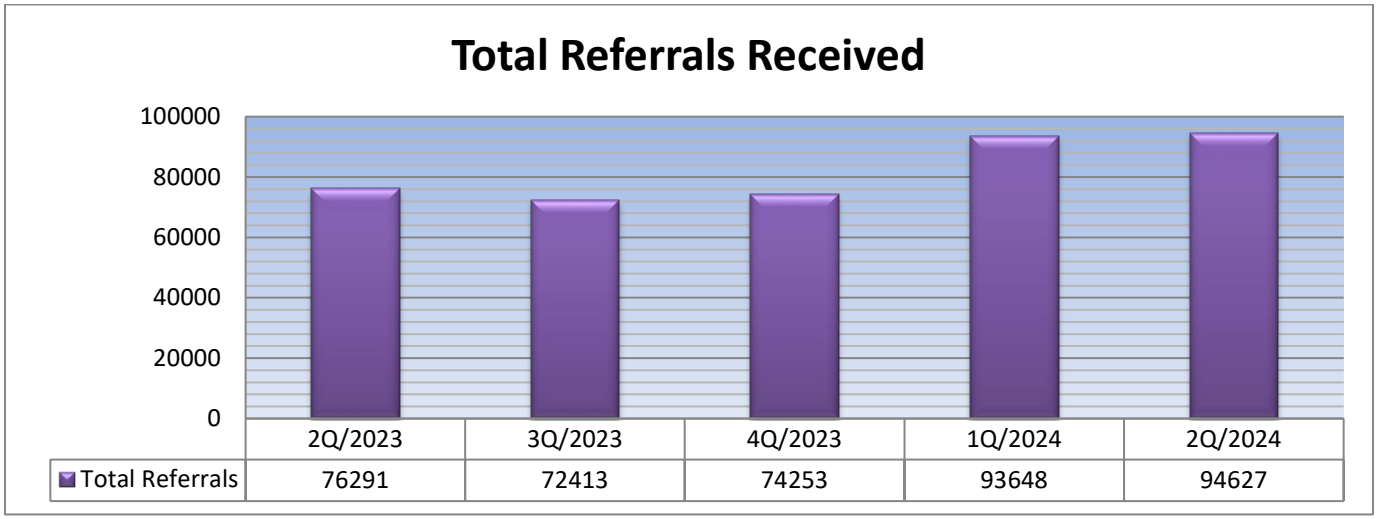
Urgent: Response back to Provider in 3 business days
Routine: Response back to Provider in 5 business day

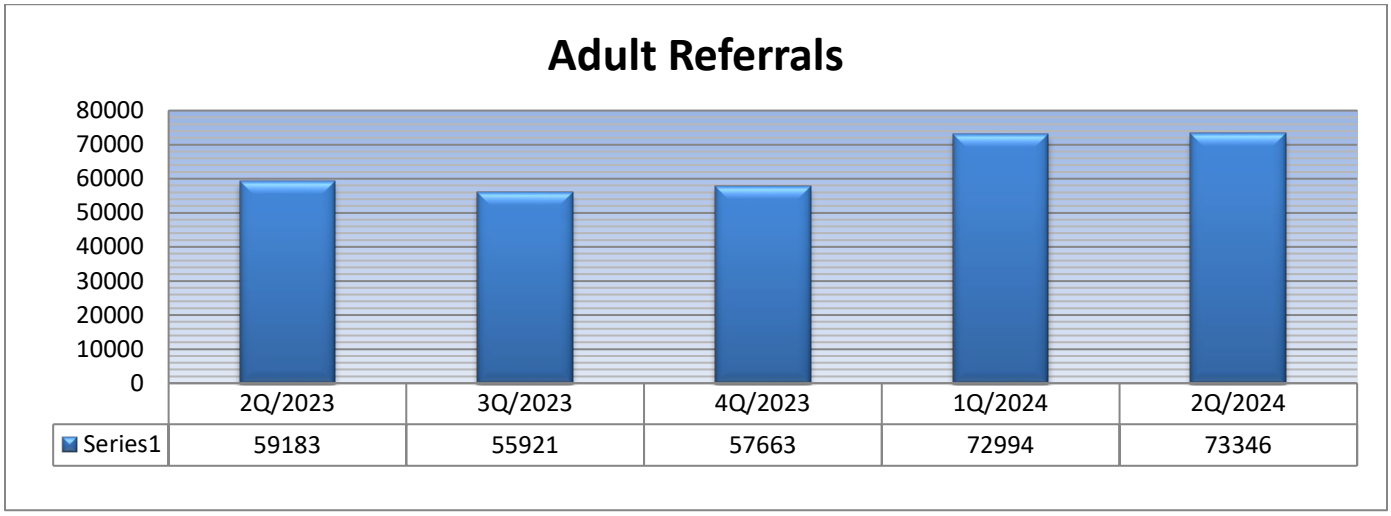
There were 95,459 referrals processed in the 2nd quarter 2024 of which 8,893 referrals were reviewed for timeliness of decision. In comparison to the 1st quarter's processing time, routine referrals decreased from the 1st quarter which was 100% and urgent referrals decreased from the 1st quarter which was 99.6% to 98.0%.



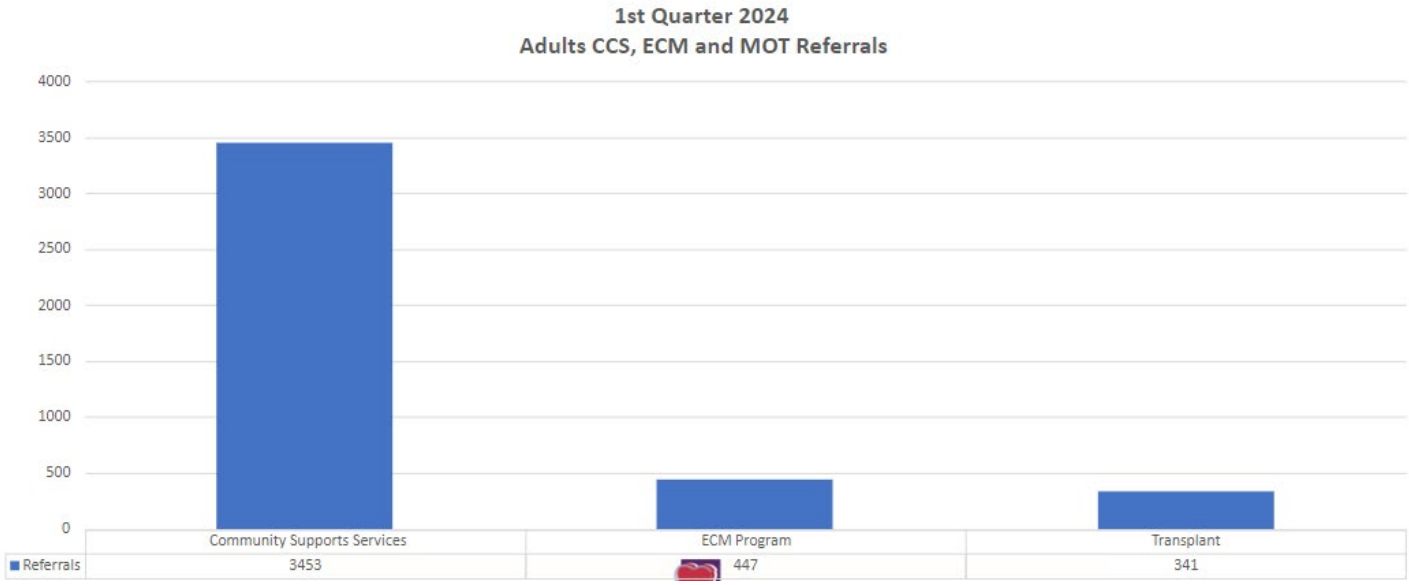
	2Q/23	3Q/23	4Q/23	1Q/24	2Q/24
Urgent Compliance %	98.3%	97.0%	99.8%	99.6%	98.0%
Routine Compliance %	100%	99%	100%	100%	100%

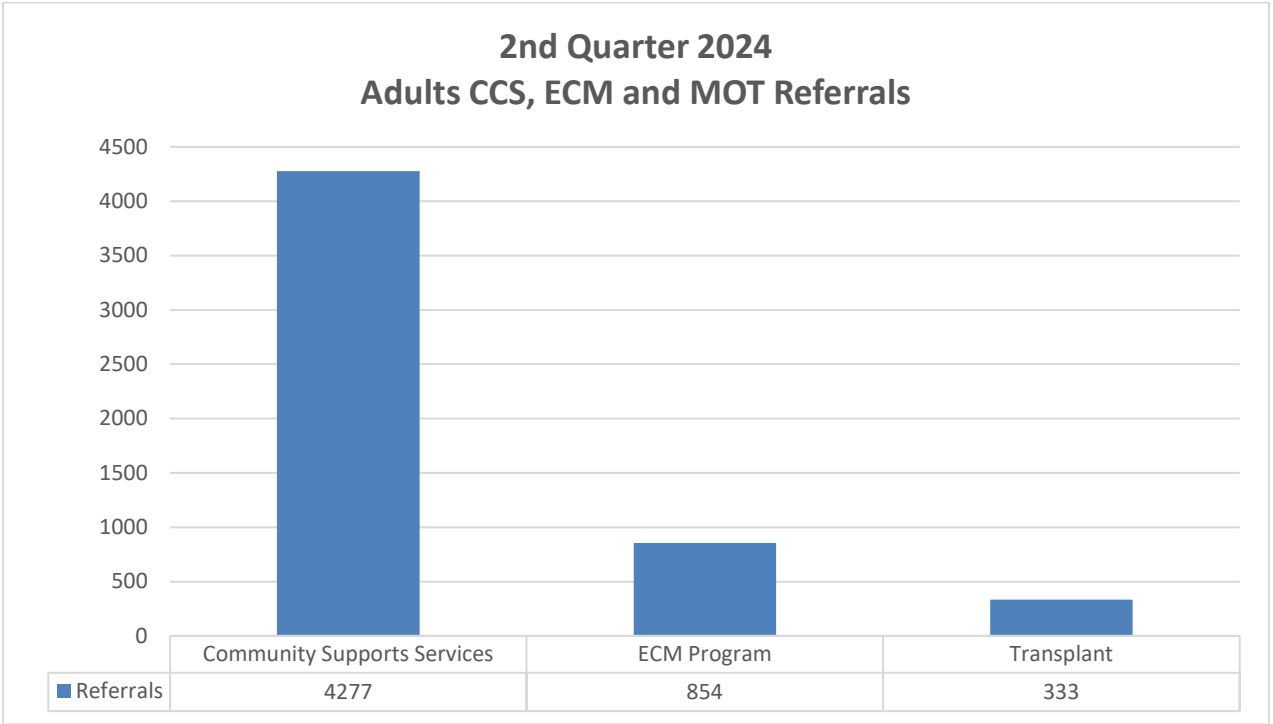
Outpatient Referral Statistics





Specialty Referral Management

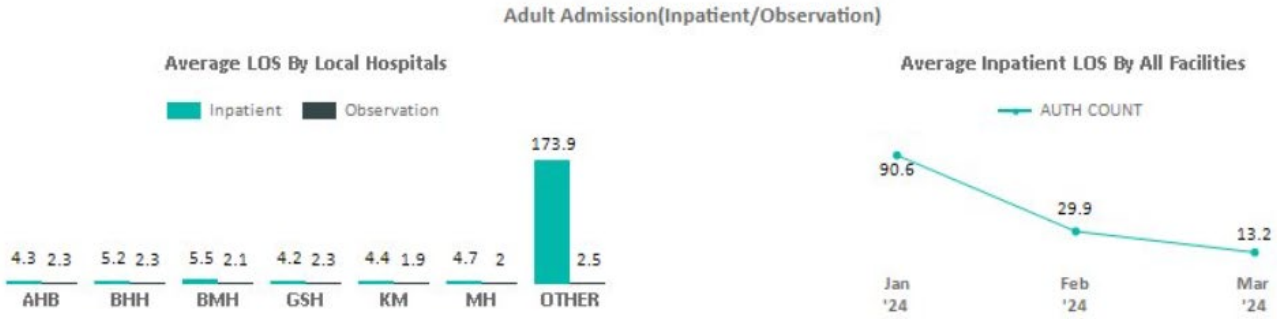




KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(Inpatient/Observation)

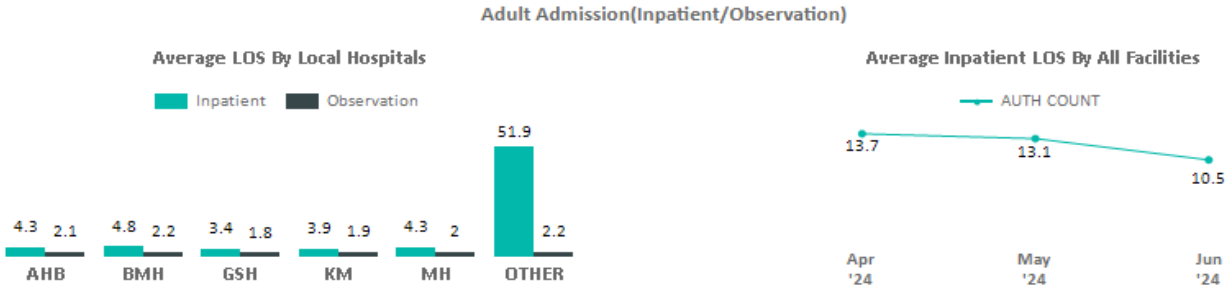
Dates of Discharge Between : 1/1/2024-3/31/2024



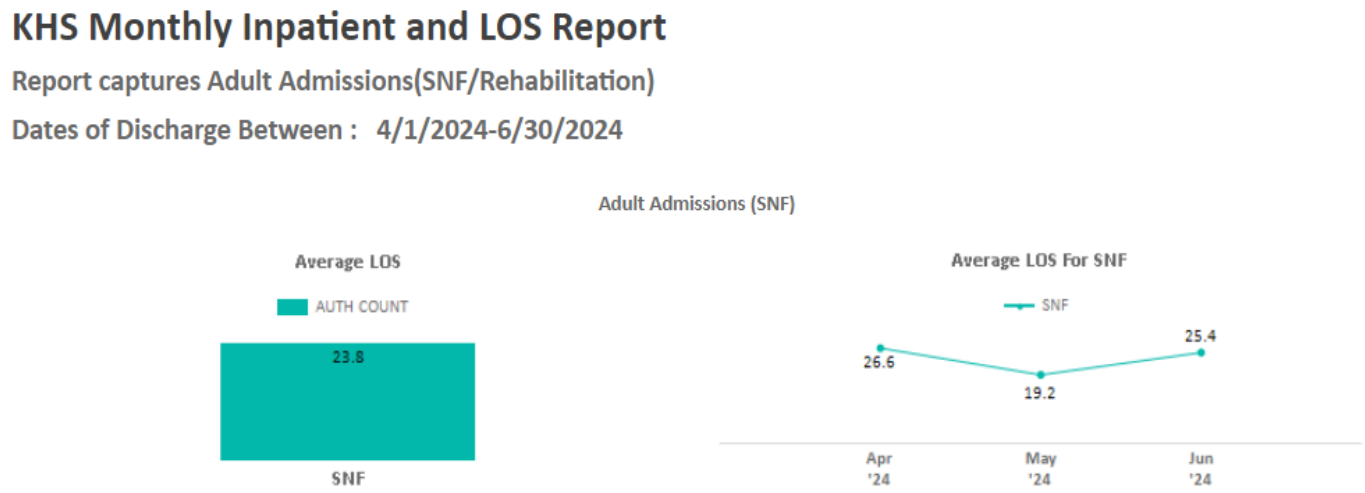
KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(Inpatient/Observation)

Dates of Discharge Between : 4/1/2024-6/30/2024



Post-Acute Statistics:



Internal Auditing Results

Delayed Referrals - Quarter 1, 2024

Audit Period:
January 1, 2024 – March 31, 2024

Audit Sample Size:
The greater of 10% of the total number of referrals delayed or 10 referrals per month.

	January	February	March
Total referrals for the month	30,961	28,663	31,474
Total referrals that were delayed	71	89	94
Percent of referrals delayed	<1%	<1%	<1%
Audit sample size	10 referrals	10 referrals	10 referrals

Purpose:
This is a quarterly audit performed to monitor the process of referrals that have been delayed by the UM Department to ensure that the procedures followed compliant with the Kern Health Systems' Policy and Procedure 3.22-P Referral and Authorization Process, Sections 4.2.1 and 4.2.1.1.

KHS Policy and Procedures 3.22-P, section 4.2.1 Deferrals states, "Authorization requests needing additional medical records may be deferred, not denied, until the requested information is obtained. If deferred, the UM Clinical Intake Coordinator UM Clinical Intake Coordinator follows-up with the referring provider within 14 calendar days from the receipt of the request if additional information is not received. Every effort is made at that time to obtain the information. Providers are allowed 14 calendar days to provide additional information. On the 14th calendar day from receipt of the original authorization request, the request is approved or denied as appropriate."

Section 4.2.1.1 Extended Deferral states, "The time limit may be extended an additional 14 calendar days if the member or the Member's provider requests an extension, or KHS UM Department can provide justification for the need for additional information and how it is in the Member's interest. In cases of extension, the request is approved or denied as appropriate no later than the 28th calendar day from receipt of the original authorization request.

Audit Indicators:

1. Processing of Referral
    - Appropriately delayed for additional medical records.
    - Delay completed on a routine authorization.
    - Delay completed on the fifth working day of receipt.
    - Service line(s) appropriately chosen.

2. Notices to Provider and Member after referral delayed.
    - Referring Provider Notice:
        i. Copy of Notice of Adverse Determination Letter and the Referral/Prior Authorization Form within 24 hours of the date of decision.
    - Member Notice:
        i. Notice of Adverse Determination documents within 2 business days of the decision.

1. Notice of Adverse Determination – Delay letter
2. Your Rights Under Medi-Cal Managed Care
3. Form to File a State Hearing

3. Notice of Action Letter
    - NOA Delay letter attached with correct language and font size selected.
    - Accurate spelling, grammar, verbiage, and format.
    - The reason for delaying the authorization is clear and concise.
    - An anticipated decision due date is provided.

4. NOA language is at or below 6th grade readability per Flesch-Kincaid scale.

5. Signatures
    - Case Manager information on the delayed authorization:
        i. NOA Letters and OP Notifications as applicable:
            1. Signatures
            2. Name
            3. Title
            4. Phone

    - Medical Director information on the extended delay and final decision documents if send for MD review.
        i. NOA Letters and OP Notifications as applicable:
            1. Signature
            2. Title
            3. Specialty

6. Final decision Turnaround time (TAT)
    - A final decision to approve or deny a delayed referral was made within fourteen (14) calendar days from the original receipt of the request.
    - A final decision to approve or deny a referral that the delay was extended by the medical director was made within 28 calendar days from the original authorization request.

7. Criteria used, cited, and attached for final decision.

<u>January Audit Findings:</u>

Out of the ten (10) delayed referrals that were audited, the following is a breakdown of the findings:

- Processing of Referral
    - One (1) authorization was incorrectly delayed for reasons other than obtaining additional medical records: 202401050000817.

- All delayed authorizations were correctly done on routine requests only.
- One (1) authorization had the service line chose as previously delayed in error by the CIC when it was not delayed: 202401180000291.
- Three (3) authorizations were incorrectly delayed by the CIC before the 5th working day: 202401080001297, 202401170001550, 202401220001264.

- Notices to Provider and Member after Referral Delayed
  - All OP notification forms to the referring provider were within 24 hours of the delay.
  - Two (2) authorizations did not provide notices to the member within 2 business days: 202401080001297, 202401020000842.
  - All authorizations contained the "Your Rights Under Medi-Cal Managed Care" and "Form to File a State Hearing" information.

- Notice of Action Letter
  - One (1) NOA was not sent to the NOA Team to be completed: 202401080001297.

- NOA Language at or below 6th grade reading level
  - Seven (7) authorizations were found to be above the 6th grade reading level: 202401050000817, 202401150000648, 202401170001550, 202401220001264, 202401310001027, 202401020000842, 202401050000840.

- Signatures and Credentials
  - All authorizations had the appropriate signatures, names, titles, and specialties listed as applicable.

- Final decision Turnaround time (TAT)
  - All authorizations had a final decision made prior to the 14-day timeframe.
  - There were zero (0) authorizations that had an extended delay.

- Criteria used, cited, and attached for final decision.
  - Two (2) authorizations cited Medi-Cal criteria.
  - Two (2) authorizations cited MCG criteria.
  - Four (4) authorizations cited KHS policies.

February Audit Findings:

Out of the ten (10) delayed referrals that were audited, the following is a breakdown of the findings:

- Processing of Referral
  - One (1) authorization was incorrectly delayed for reasons other than obtaining additional medical records: 202402230000793.
  - All delayed authorizations were correctly done on routine requests only.

- Two (2) authorizations were incorrectly delayed by the CIC before the 5th working day: 202402150001139, 202402230000793.

- Notices to Provider and Member after Referral Delayed
  - All OP notification forms to the referring provider were within 24 hours of the delay.
  - One (1) authorization did not provide notices to the member within 2 business days because it was not set to print: 202402150001139.
  - All authorizations contained the "Your Rights Under Medi-Cal Managed Care" and "Form to File a State Hearing" information.

- Notice of Action Letter
  - All NOA letters were clear and concise for the reason of delay and had the due dates listed.

- NOA Language at or below 6th grade reading level
  - Four (4) NOA delay letters were above 6th grade readability: 202402060001478, 202402080001177, 202402150001139, 202402210001023.

- Signatures and Credentials
  - All authorizations had the appropriate signatures, names, titles, and specialties listed as applicable.

- Final decision Turnaround time (TAT)
  - All authorizations had a final decision made prior to the 14-day timeframe.
  - There were zero (0) authorizations that had an extended delay.

- Criteria used, cited, and attached for final decision.
  - Zero (0) authorizations cited Medi-Cal criteria.
  - Two (2) authorizations cited MCG criteria.
  - Seven (7) authorizations cited KHS policies.

March Audit Findings:

Out of the ten (10) delayed referrals that were audited, the following is a breakdown of the findings.

- Processing of Referral
  - One (1) authorization was inappropriately delayed for records, but there were medical records attached: 202403200000880.
  - All delayed authorizations were correctly done on routine requests only.
  - Two (2) authorizations were incorrectly delayed by the CIC before the 5th working day: 202403050000057, 202403180000086.

- Notices to Provider and Member after Referral Delayed

- One (1) OP notification form was not added or sent to the referring provider within 24 hours of the delay.
- All authorizations provided notices to the member within 2 business days.
- All authorizations contained the "Your Rights Under Medi-Cal Managed Care" and "Form to File a State Hearing" information.

- Notice of Action Letter
  - All NOA letters were clear and concise for the reason of delay and had the due dates listed.

- NOA Language at or below 6th grade reading level
  - All NOA letters were at or below 6th grade readability.

- Signatures and Credentials
  - All authorizations had the appropriate signatures, names, titles, and specialties listed as applicable.

- Final decision Turnaround time (TAT)
  - All authorizations had a final decision made prior to the 14-day timeframe.
  - There were zero (0) authorizations that had an extended delay.

- Criteria used, cited, and attached for final decision.
  - Zero (0) authorizations cited Medi-Cal criteria.
  - Two (2) authorizations cited MCG criteria.
  - Six (6) authorizations cited KHS policies.

Denied Referrals - Quarter 1, 2024

Audit Period:
January 1, 2024 – March 31, 2024

Audit Sample Size:
10% of the total number of referrals denied based on medical necessity.

Current denied audit exclusions:
-Pharmacy denials
-CCS denials
-Kern County Mental Health denials
-Search and Serve denials

	January	February	March
Total referrals processed for the entire month: (total number of referrals approved, modified, denied etc. during the month)	30,961	28,663	31,474
Total referrals denied for medical necessity: (total of all referrals in the green + red rows)	1,267	1,153	1,287
Percent of referrals denied: (this is the total referrals denied for medical necessity in the green + red rows divided by the total referrals processed for the entire month)	4%	4%	4%
Percent of audit: (audit sample size is always 10% of total referrals denied for medical necessity)	10%	10%	10%
Number of referrals in audit (this is 10% of the total from row 2 above)	127	115	129

Purpose:

Quarterly audits of referrals that have been denied by the UM Department is done to monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process, Section 4.2.3 Denials.

Policy and Procedures 3.22, Section 4.2.3 Denials states, if initial review determines that an authorization request does not meet established utilization criteria, denial is recommended. Only the Associate Medical Director may deny an authorization request. Reasons for possible denial include:

A. Not a covered benefit
B. Not medically necessary
C. Member not eligible
D. Continue conservative management.
E. Services should be provided by a PCP
F. Experimental or investigational treatment (See KHS Policy #3.44)
G. Member made unauthorized self-referral to practitioner/provider
H. Services covered by CCS
I. Inappropriate setting
J. Covered by hospice

Audit Indicators:

8. Referral Turnaround Time
    - Decision rendered within 72 hours for urgent referrals and 5 working days for routine referrals.
    - Provider notification within 24 hours of decision and member notification within 48 hours of decision.
9. Notice of Action Letter

- Spelling/Grammar, Verbiage, and Format
- 6th grade reading level
- Criteria indicated and attached.
- Recommendations indicated.

10. Medical Director / Case Manager Name and Signatures on NOA and OP Notification
11. Processing of Referral

January Audit Findings:

Out of the **127** denied referrals reviewed, the following is a breakdown of the findings:

- Three (3) referrals were found to be mailed outside of the referral turnaround time indicator due to not being set to print our being outside of TAT when completed.
- One (1) referral was cited with MCG guidelines, but they were not attached.
- One (1) referral cited with MCG guidelines, but only 1 of the 3 cited were attached.
- Seven (7) referrals were found to have been denied with KHS policy, but the attached policy was outdated.
- Five (5) referrals were found to have UpToDate cited, but the criteria attached was not the most current.
- Zero (0) referrals were found within the signatures of the NOA letter.
- Three (3) referrals were found with errors in the NOA letter verbiage.
    - Misspelling and repeat words found. MD description of cervical spine MRI stated as part of the "back" rather than "neck" to describe the area.
- One (1) referral was found with the incorrect member's notes attached.
- Eighteen (18) referrals were found to have above 6th grade readability on the NOA.
- Guidelines cited and attached:
    - Seven (7) ECM referrals denied for medical necessity had DHCS criteria attached.
    - Fourteen (14) referrals were denied using Medi-Cal guidelines.
    - Five (5) referrals were denied using UpToDate guidelines.
    - Sixty-four (64) referrals were denied using MCG guidelines.
    - Fifteen (15) referrals were denied using KHS Policies.

**Some referrals may have applied more than one criterion per MD review.

February Audit Findings:

Out of the **115** denied referrals reviewed, the following is a breakdown of the findings:

- Five (5) referrals were found to be mailed outside of the referral turnaround time indicator due to not being set to print our being outside of TAT when completed.
- One (1) referral cited KHS policy for denial, but the policy was not attached.

- Two (2) referrals cited KHS policy for denial, but the attached policy was outdated.
- Zero (0) referrals were found within the signatures of the NOA letter.
- Two (2) referrals were found with errors in the NOA letter verbiage.
    - Citations not separated and abbreviations/errors within the letter.
- Four (4) referrals were found with processing errors.
- Eight (8) referrals were found to have above 6th grade readability on the NOA.
- Guidelines cited and attached:
    - Three (3) ECM referrals denied for medical necessity had DHCS criteria attached.
    - Nine (9) referrals were denied using Medi-Cal guidelines.
    - Two (2) referrals were denied using UpToDate guidelines.
    - Forty-nine (49) referrals were denied using MCG guidelines.
    - Five (5) referrals were denied using KHS Policies.

**Some referrals may have applied more than one criterion per MD review.

March Audit Findings:
Out of the **129** denied referrals reviewed, the following is a breakdown of the findings:

- Five (5) referrals were found to be mailed outside of the referral turnaround time indicator due to not being set to print our being outside of TAT when completed.
- Three (3) referral cited criteria, but the criteria was not attached.
- Seven (7) referrals cited KHS policy or UTD criteria for denial, but the attached policy or guidelines was outdated/not most current.
- Zero (0) referrals were found within the signatures of the NOA letter.
- Three (3) referrals were found with errors in the NOA letter.
    - NOA not completed, grammatical errors, missing information.
- Three (3) referrals were found with processing errors.
- Nine (9) referrals were found to have above 6th grade readability on the NOA.
- Guidelines cited and attached:
    - Six (6) ECM referrals denied for medical necessity had DHCS criteria attached.
    - Twelve (12) referrals were denied using Medi-Cal guidelines.
    - Four (4) referrals were denied using UpToDate guidelines.
    - Seventy-eight (78) referrals were denied using MCG guidelines.
    - Fourteen (14) referrals were denied using KHS Policies.

**Some referrals may have applied more than one criterion per MD review.

Corrective Action Plan (CAP):

1. Email reminder sent to NOA/NCIC/CIC teams:

a. Ensure to check body of the NOA letter for 6th grade readability using the HLA Tool.
    i. Many letters were found with above 6th grade reading level.
b. Check for any spelling or grammatical errors.
    i. Some letters had grammar errors, missing information, or had repeat words/sentences.
c. Ensure that each criterion or policy that is cited is attached and most current.
    i. KHS policy updated 11/2023
    ii. UTD guidelines are reviewed periodically and will show the date that the guideline is current through.
d. Always verify that the correct member's notes are attached.
e. NOA letters must be mailed to the member within 48 hours of the decision.

Modified Referrals - Quarter 1, 2024

Audit Period:
January 1, 2024 – March 31, 2024

Report Completion Date:
May 8, 2024

Audit Sample Size:
10% or 10 per month (whichever is greater)

	January	February	March
Total referrals processed for the entire month: (total number of referrals approved, modified, denied etc. during the month)	30,961	28,663	31,474
Total referrals that were modified	534	573	
Percent of referrals that were modified	2%	2%	
Percent of audit (10% or 10 referrals whichever is larger)	10%	10%	10%
Number of referrals in audit	54	58	

Purpose:
Quarterly audits of referrals that have been modified by the UM Department is done to monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process, Section 4.2.2 Modifications

Policy and Procedures 3.22, Section 4.2.2 Modifications states – There may be occasions when recommendations are made to modify an authorization request in order to provide members with

the most appropriate care. Recommendations to modify a request are first reviewed by the KHS Chief Medical Officer, or their designee(s).

The referrals that qualify for a modification are:

A. Change in place of service
B. Change of specialty
C. Change of provider or
D. Reduction of service

Under KHS's Knox Keene license and Health and Safety Code §1300.67.2.2 , KHS, as a plan operating in a service area that has a shortage of one or more types of providers is required to ensure timely access to covered health care services, including applicable time-elapsed standards, by referring enrollees to, or, ***in the case of a preferred provider network***, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. KHS will arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition.

KHS's Knox Keene license permits KHS to arrange for the provision of specialty services, which implies that the clause "if either the member or requesting provider disagrees, KHS does not require approval to authorize the modified services.

Audit Indicators:

12. Referral Turnaround Time
    - Decision rendered within 72 hours for urgent referrals and 5 working days for routine referrals.
    - Provider notification within 24 hours and member notification within 48 hours of decision.
13. Notice of Action Letter
    - Spelling/Grammar, Verbiage, and Format
    - 6th grade reading level
    - Approved provider information (name/phone)
14. Medical Director / Case Manager Name and Signatures
15. Processing of Referral

January Audit Findings:

Out of the **54** modified referrals that were audited, the following is a breakdown of the findings:

- Three (3) referrals were found to be mailed outside of the referral turnaround time indicator.
- Four (4) referrals were found with errors in the Notice of Action letter: Typos, abbreviated verbiage, and commentary errors.
- One (1) referral was found with NOA language that was above 6th grade readability.

- Ten (10) errors found within the processing of referral: With five (5) urgent auths that were modified to routine in error.
- Zero (0) errors were found within the Medical Director / Case Manager name and signatures indicator.

February Audit Findings:

Out of the **58** modified referrals that were audited, the following is a breakdown of the findings:

- Four (4) referrals were found to be mailed outside of the referral turnaround time indicator.
- Two (2) referrals were found to not have final documents generated.
- Two (2) referrals were found to have the incorrect NOA template attached (denied instead of modified)
- Four (4) referrals were found with errors in the NOA letters: Typos, grammatical errors, abbreviated verbiage, guidelines running together etc.
- Zero (0) referrals were found to have NOA language that was above 6th grade readability.
- Eight (8) errors found within the processing of the referrals: Six (6) of these referrals were found to have been received as urgent requests but were all or in part modified to routine in error. One (1) referral was found to not have commentary for a code that was voided for MCRx. One (1) referral was inpatient, but partly modified to outpatient in error. One (1) referral was from a local ortho requesting 2nd opinion with pediatric orthopedic surgeon at VCH but was modified back to local ortho.
- Zero (0) errors were found within the Medical Director / Case Manager name and signatures indicator.

March Audit Findings:

Out of the **57** modified referrals that were audited, the following is a breakdown of the findings:

- Three (3) referrals were found to be mailed outside of the referral turnaround time indicator: one (1) was not set to print, one (1) was sent to the wrong person's queue and was not closed out appropriately and NOA was not completed or set to print, and one (1) other was mailed outside of the TAT.
- Two (2) referrals had the incorrect NOA template used (denial template used instead of modified template).
- Nine (9) referrals were found to have errors in the NOA letters: five (5) referrals had typos and spacing errors and four (4) referrals had periods added inappropriately and this is due to Jiva system template errors.
- Zero (0) referrals were found to have NOA language that was above 6th grade readability.
- Two (2) errors found within the processing of the referrals: one (1) was reviewed as 12 items and modified to 1 item, but this should have been reviewed as a 12-month rental. One (1) was an urgent referral that was modified to routine by the NOA team in error when processing the modification.

- Zero (0) errors were found within the Medical Director / Case Manager name and signatures indicator.

Corrective Action Plan (CAP):

1. Refresher email to be sent out to ensure choosing the correct NOA letter template, to review for correct grammar and verbiage, and for any typos or system errors.
2. NOA Team email reminder that when modifying an urgent authorization, the status of the authorization should remain as urgent and NOT be changed to routine.
3. System errors brought to management's attention to discuss and rectify.
4. Emails will be sent to appropriate CIC/NCIC/NOA team members regarding specific errors such as CCS review, web notes being missed, ensuring correct assignment of referrals etc.

NAR/ Appeal Audit

Audit Period:
January 1, 2024 – March 31, 2024

Report Completion Date:
May 17, 2024

Audit Sample Size:
Thirty (30) total NAR/Appeal audits for the quarter. This includes ten (10) randomly selected NAR/Appeal audits from each month in the audit period.

Purpose:
Quarterly audits of appeals that have been processed for a previously denied or modified referral to ensure appropriate processes were used to review and monitor compliance with the Kern Health Systems' Policy and Procedure 3.23 Appeals Regarding Authorizations.

Audit Indicators:

- NAR spelling, grammar, verbiage, and format
- 6th grade readability level
- Criteria indicated and attached
- Recommendations indicated
- Medical Director / Case Manager name and signatures
- Overall process
- Criteria used

January Audit Findings:

Out of the **10** NARs audited, the following is a breakdown of the findings:

- **NAR spelling, grammar, verbiage, and format:** One (1) cert 202401090000960 with minor grammatical error on the NOA.

- **6th grade readability:** Zero (0) errors found within the 6th grade readability.

- **Criteria indicated and attached:** Zero (0) errors found.

- **Recommendations indicated:** Zero (0) errors found.

- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.

- **Overall Process:** Zero (0) errors found.

- **Criteria Used:**
  - One (1) referral with Medi-Cal guidelines used.
  - Three (3) referrals with MCG guidelines used.
  - Two (2) referrals with UTD guidelines used.
  - Four (4) referrals with KHS policy used.

February Audit Findings
Out of the **10** NARs audited, the following is a breakdown of the findings:

- **NAR spelling, grammar, verbiage, and format:** One (1) cert 202402170000066 with minor grammatical error found on the NOA.

- **6th grade readability:** Zero (0) errors found within the 6th grade readability.

- **Criteria indicated and attached:** Zero (0) errors found.

- **Recommendations indicated:** Zero (0) errors found.

- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.

- **Overall Process:** One (1) cert 202401230001447 with error found within the process indicator where a final document was not generated.

- **Criteria Used:**
  - One (1) referral with Medi-Cal guidelines used.
  - Five (5) referrals with MCG guidelines used.
  - Three (3) referrals with UTD guidelines used.
  - One (1) referral with KHS policy used.

March Audit Findings:
Out of the **10** NARs audited, the following is a breakdown of the findings:

- **NAR spelling, grammar, verbiage, and format:** Zero (0) errors found.

- **6th grade readability:** Zero (0) errors found.

- **Criteria indicated and attached:** Zero (0) errors found.

- **Recommendations indicated:** Zero (0) errors found.

- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.

- **Overall Process:** Zero (0) errors found.

- **Criteria Used:**
  - Two (2) referrals with Medi-Cal guidelines used.
  - Three (3) referrals with MCG guidelines used.
  - Zero (0) referrals with UTD guidelines used.
  - Five (5) referrals with KHS policy used.

Corrective Action Plan (CAP):
1. Physician was emailed regarding minor error on NOA template (KSH instead of KHS)
2. Staff member emailed regarding KHS Policy 3.22 revision 11/2023 and will use most current policy when attaching in Jiva.
   a. KHS website Policy 3.22 has also been updated to reflect the most current policy.

NOA Audit:

Audit Period:

January 1, 2024 – March 31, 2024

Report Completion Date:
May 20, 2024

Audit Sample Size:
Thirty (30) total for the quarter. This includes ten (10) randomly selected referrals from each month in the audit period.

Purpose:
Quarterly audits of the Notice of Action (NOA) Team to ensure appropriate processing of referrals that were previously denied or modified and to monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process.

Audit Indicators:

- NOA spelling, grammar, verbiage, and format
- 6tth grade readability level
- Criteria indicated and attached.
- Recommendations indicated.
- Medical Director / Case Manager name and signatures

January Audit Findings:

Out of the **10** NOAs audited, the following is a breakdown of the findings:

- **NOA spelling, grammar, verbiage, and format:** One (1) cert 202401100000674 with minor grammatical error on the NOA which is an error from within the template regarding incorrect period placement after the treating provider.

- **6th grade readability:** Zero (0) errors found.

Criteria indicated and attached: Zero (0) errors found.

Recommendations indicated: Zero (0) errors found.

Medical Director / Case Manager name and signatures: Zero (0) errors found.

February Audit Findings:
Out of the 10 NOAs audited, the following is a breakdown of the findings:

NOA spelling, grammar, verbiage, and format: One (1) cert 202402020001061 with minor grammatical error on the NOA which is an error from within the template regarding incorrect period placement after the treating provider.

6th grade readability: Zero (0) errors found.

Criteria indicated and attached: Zero (0) errors found.

Recommendations indicated: Zero (0) errors found.

Medical Director / Case Manager name and signatures: Zero (0) errors found.

March Audit Findings:
Out of the 10 NOAs audited, the following is a breakdown of the findings:

NOA spelling, grammar, verbiage, and format: One (1) cert 202403160000126 with minor grammatical error on the NOA which is an error from within the template regarding incorrect period placement after the treating provider. One (1) cert 202402270000345 with minor grammatical errors found with a word missing. One (1) cert 202402240000042 with the Medi-Cal and MCG criteria not separated appropriately on the NOA.

6th grade readability: Zero (0) errors found within the 6th grade readability.

Criteria indicated and attached: Zero (0) errors found.

Recommendations indicated: Zero (0) errors found.

Medical Director / Case Manager name and signatures: Zero (0) errors found.

Corrective Action Plan (CAP):
Email was sent to supervisor regarding the findings and for any follow-up refresher training of the NOA Team that may be needed.

To: KHS EQIHEC Committee

From: James Winfrey, Deputy Directory of Provider Network Management

Date: August 8, 2024

Re: Network Adequacy Committee, Q3 2024

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 meetings, including minutes for both sessions.

Fiscal Impact

None

Requested Action

Approve and File.

Network Adequacy Committee, Q3 2024

Executive Quality Improvement Health Equity Committee

August 8, 2024

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

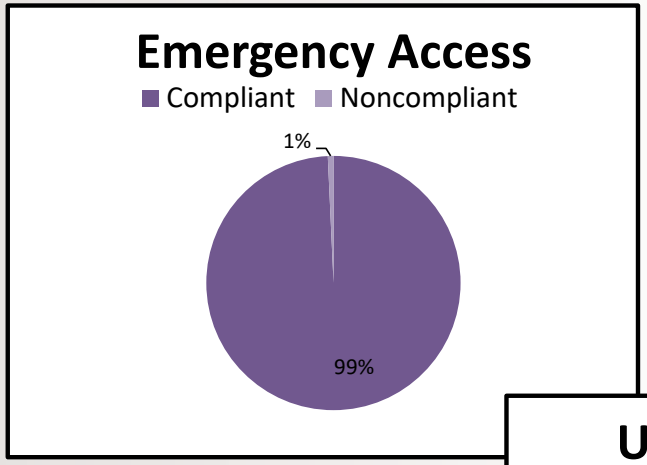
Q3 Committee Meeting

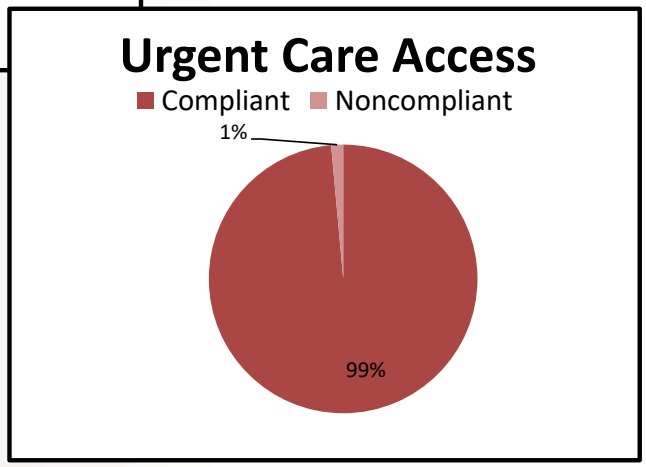
Quarter 3, 2024 Meeting – 7/19/2024

- Reviewed Quarter 2, 2024 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

- During Q2 2024 **142** provider offices were contacted.
- **141** were compliant with the **Emergency Access Standards**
- **140** were compliant with the **Urgent Care Access Standards**.
- High compliance results are in line with prior quarters.
- Non-compliant providers are educated and tracked to identify trends.





Provider Accessibility Monitoring Survey

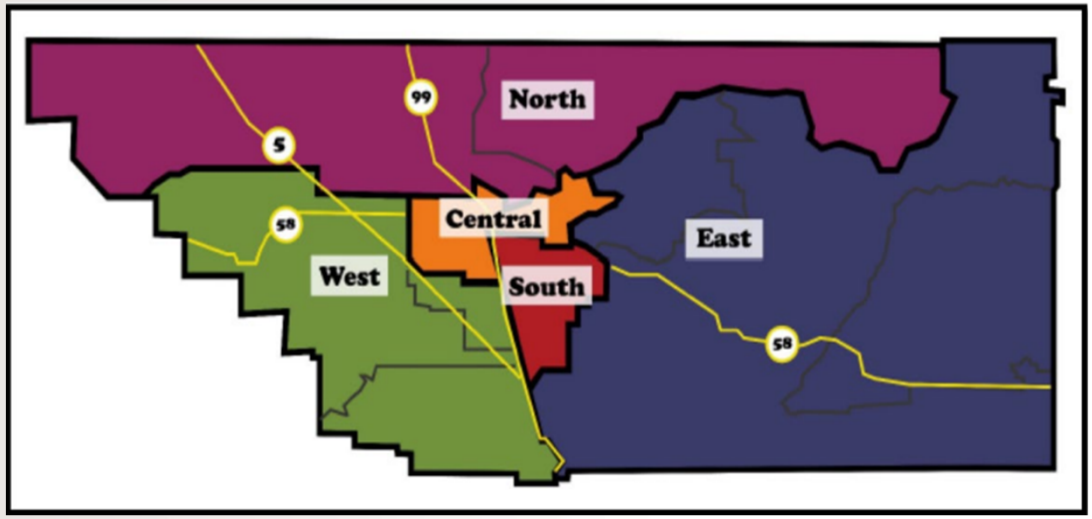
- A random sample of 25 primary care provider offices, 23 specialist offices, 5 non-physician mental health (NPMH) offices, 5 ancillary offices, and 5 OBGYN offices were surveyed during Q2 2024.
- Results are averaged to review appointment availability at the network level
- **KHS network was compliant with all standards**
- Non-compliant offices are educated, resurveyed, and tracked to identify trends.

Average urgent wait time	Q1 2024
Primary Care (48 Hours)	11.9 Hours
Specialist (96 Hours)	75 Hours

Average non-urgent wait time	Q1 2024
Primary Care (10 Days)	3.2 Days
Specialist (15 Days)	6.8 Days
NPMH (10 Days)	4.2 Days
Ancillary (15 Days)	7.8 Days
OB/GYN (Two Weeks)	4.6 Days

Provider Accessibility Monitoring Survey

- The Plan's survey methodology selected an equal sample of PCP and Specialty providers from each Kern County geographic region.
- No trends identified amongst PCP compliance rates.
- Accessibility compliance rates amongst specialty providers **trended lower in the South and Central Regions.**
- Potential Causes:
  - Provider shortage in Southern Region
  - Members traveling to Central Region from rural areas, increasing appointment wait times.

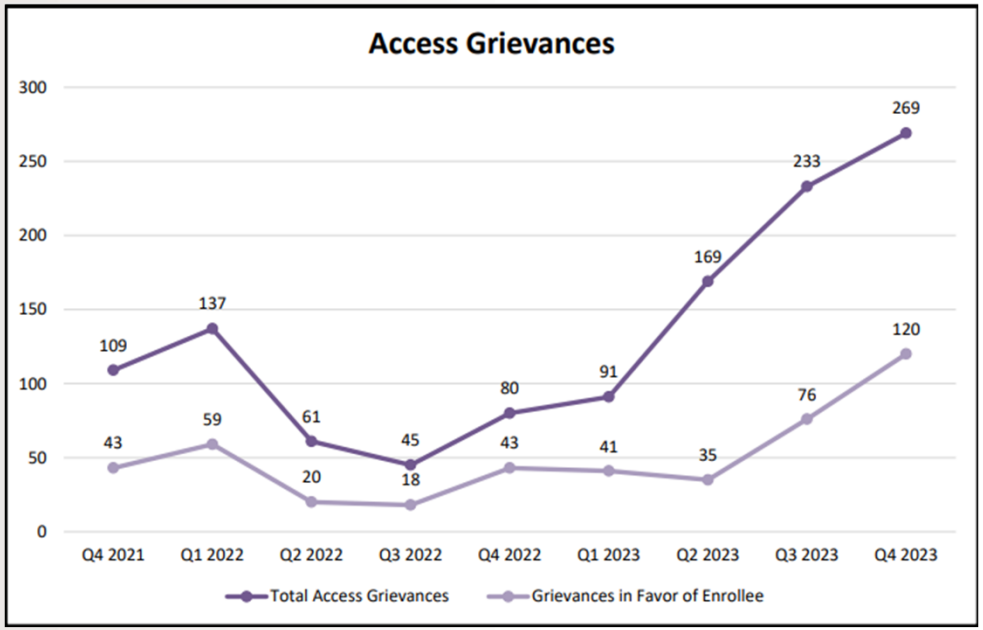


Access Grievance Review

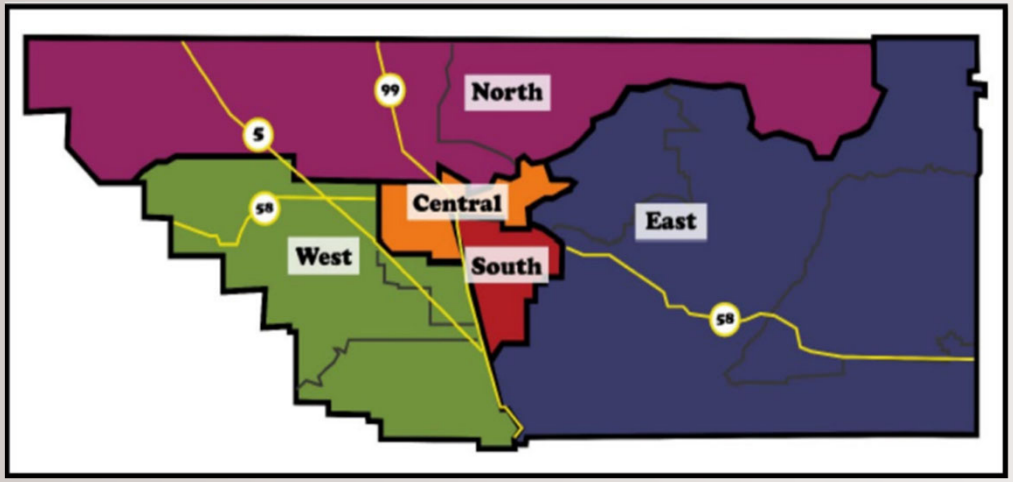
- Quarterly, the Provider Network Management Department retroactively reviews Access Grievances found in favor of the enrollee to identify potential access trends amongst provider types, provider groups, etc.

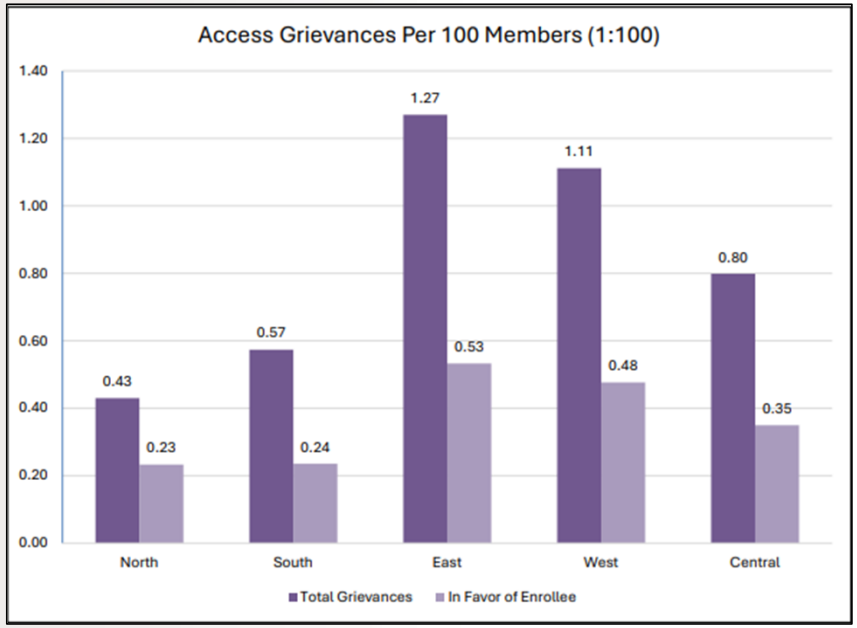
- The Plan identified an increase in access grievances found in favor of the enrollee when compared to prior quarters.

- Potential Causes:
  - Flu season - increase in requested appointments
  - Office closures due to Thanksgiving/Winter Holidays



Access Grievance Review





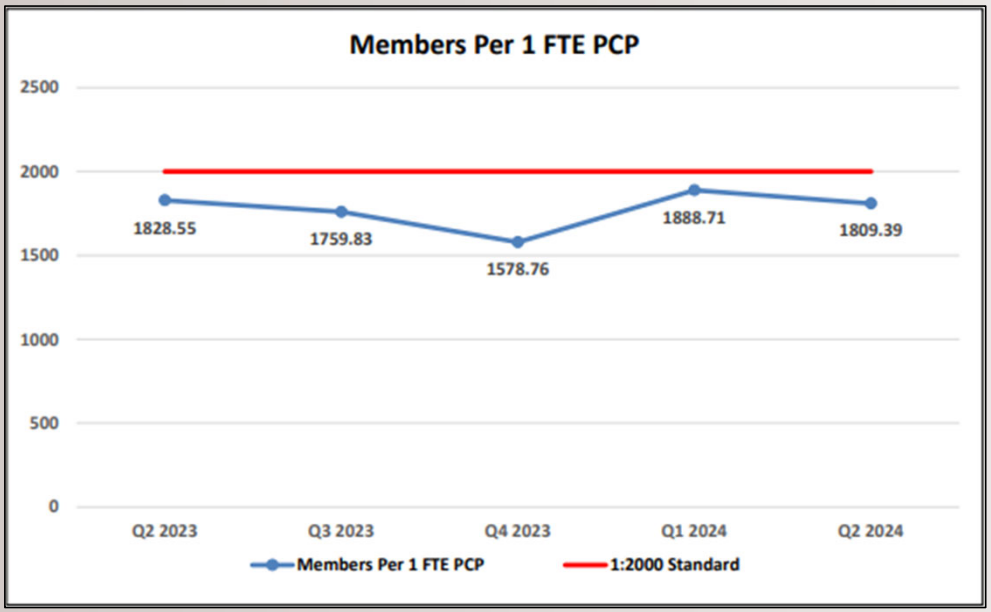
- Normalized per 100 members, members in the east region had more total grievances and more grievances found in favor of the enrollee.
- The Plan will continue to monitor access grievance data by geographic region to identify potential trends and health equity concerns.

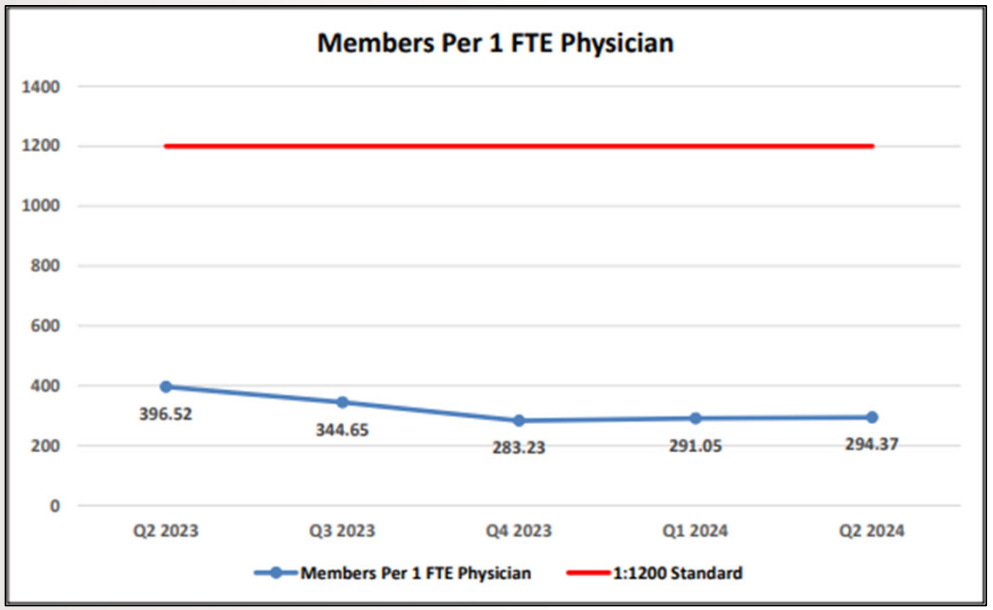
Geographic Accessibility

- The Provider Network Management department conducts ongoing review of our network to measure member geographic accessibility to our providers
- As of Q2 2024, **the Plan was compliant with all geographic accessibility standards**, or maintained a regulatory-approved alternative access standard

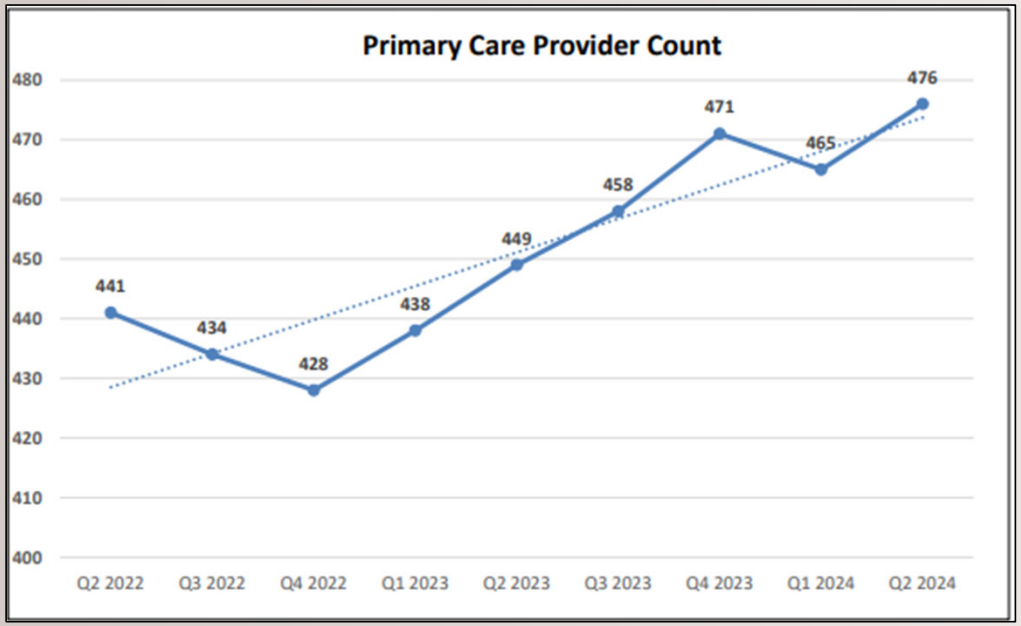
Geographic Accessibility Standards	
Primary Care (Adult and Pediatric)	10 miles or 30 minutes
Specialty Care (Adult and Pediatric)	45 miles or 75 minutes
OB/GYN Primary Care	10 miles or 30 minutes
OB/GYN Specialty Care	45 miles or 75 minutes
Hospitals	15 miles or 30 minutes
Non-Specialty Mental Health (Adult and Pediatric)	45 miles or 75 minutes

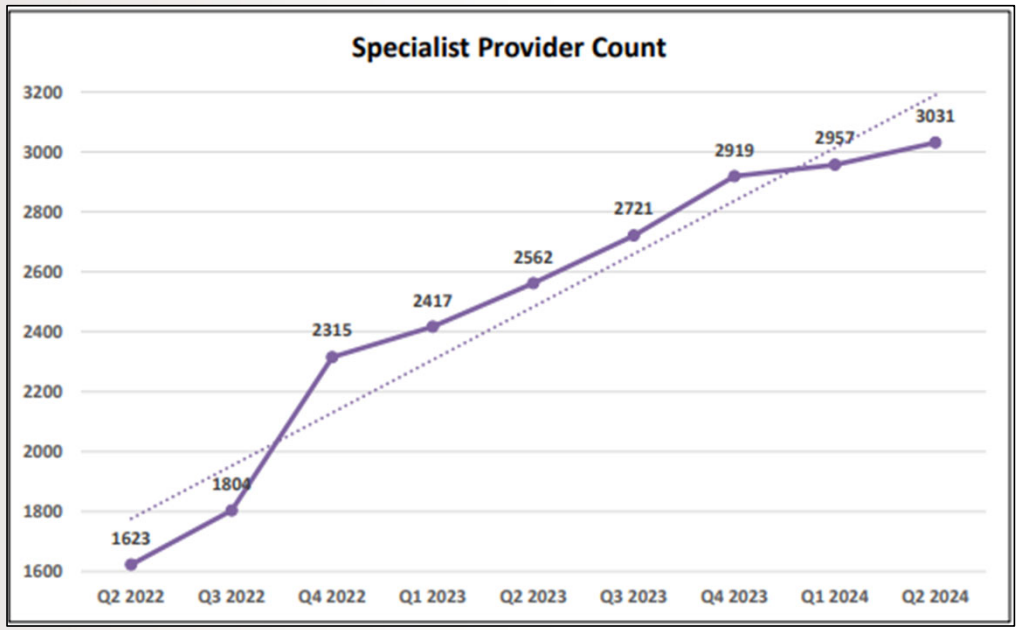
Network Adequacy





Network Adequacy & Provider Counts





KERN HEALTH SYSTEMS

To: EQIHEC

From: Michelle Curioso, Director of Population Health Management

Date: 8/8/2024

Re: Population Health Management: Maternal Child Adolescent Services

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Background:
Improving maternal health is a primary goal for Department of Health Care Services (DHCS) Comprehensive Quality Service (CQS), focusing on better maternity outcomes and birth equity. Kern Health System (KHS) Population Health Management (PHM) Department plays a crucial role by enhancing quality and reducing disparities in maternity care.

For children under 21, KHS PHM must ensure children have access to necessary physical, behavioral, developmental, dental services at intervals consistent with the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule. We must also ensure that children receive initial health appointments promptly and provide preventive care and immunizations according to Advisory Committee on Immunization Practices (ACIP). Additionally, KHS PHM offer necessary Medicaid-covered services and coordinate care across different settings and systems.

Discussion:
The purpose of the report is to provide information about the services offered to mothers, children, and adolescent through the following programs:

- Baby Steps
- Baby Steps Plus (High Risk Pregnancy)
- Children with Special Health Care Needs (CSHCN)

Fiscal Impact: None.

Requested Action: Review for approval.

Population Health Management
Time Period: January – June 2024

Michelle Curioso, MPA, PHN, RN

August 8, 2024

KERN HEALTH SYSTEMS

Mothers

- Baby Steps
- Baby Steps Plus

Children

- Children with Special Health Care Needs (CSHCN)

Young Adults

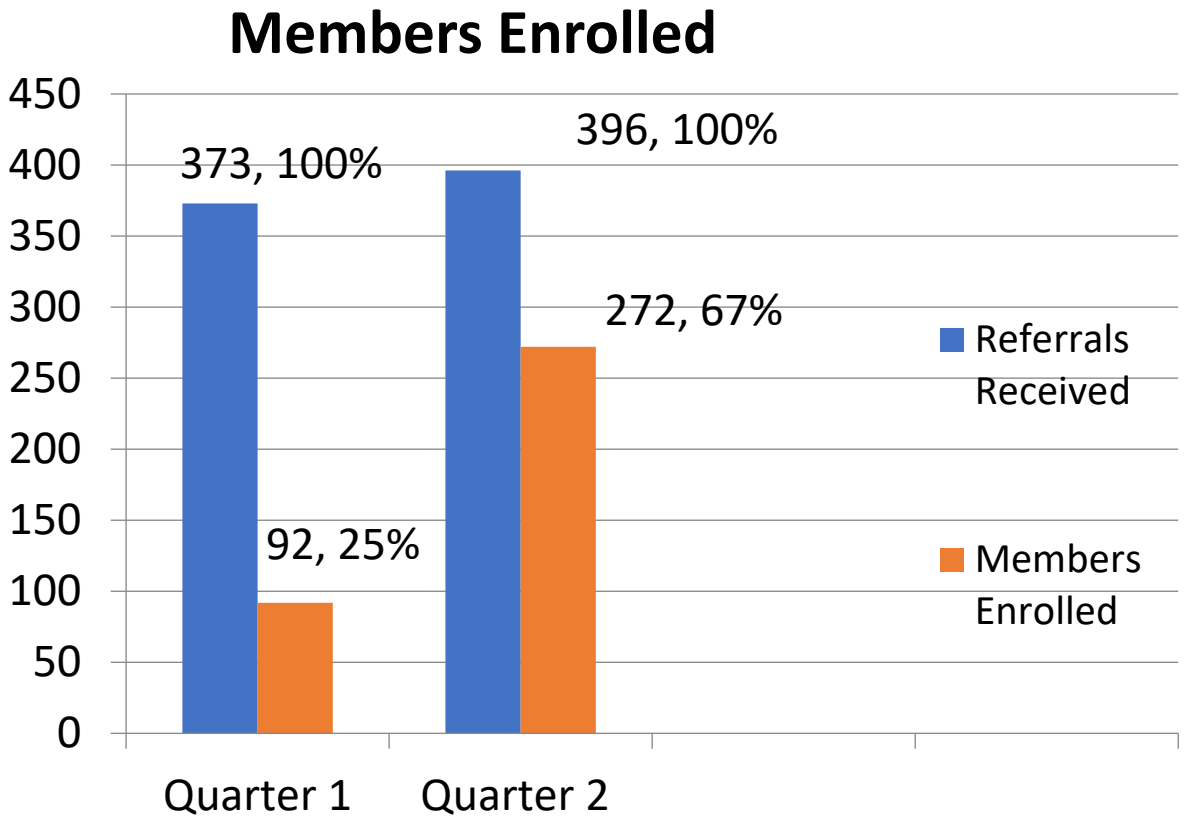
- Kids & Youth Transition (KAY-T)

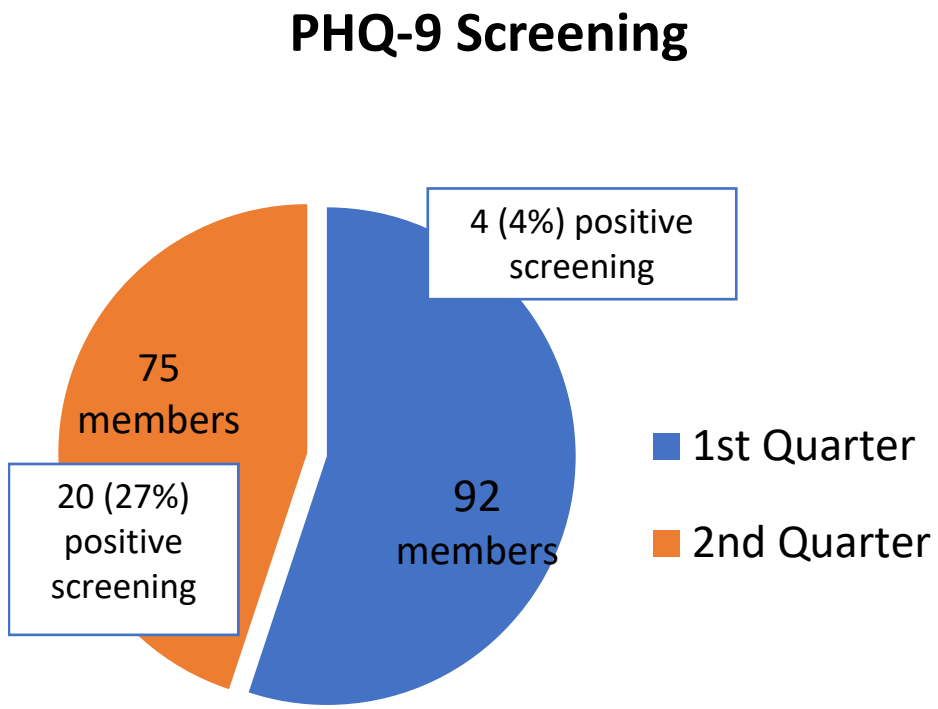
Baby Steps & Baby Steps Plus Services

Dedicated team to support mothers.
Provide care coordination before, during and after pregnancy.

Connecting	Advocating	Screening	Educating
• Resources • Providers	• Address barriers • Empower with Resources • Advocate for Quality • Encourage feedback	• Psychosocial Assessments • PHQ-9, GAD-7, Audit C, SDOH, & IPV.	• S/S preterm birth, fetal kick counts, healthy eating, breastfeeding immunizations, newborn check up, etc.

Baby Steps Program

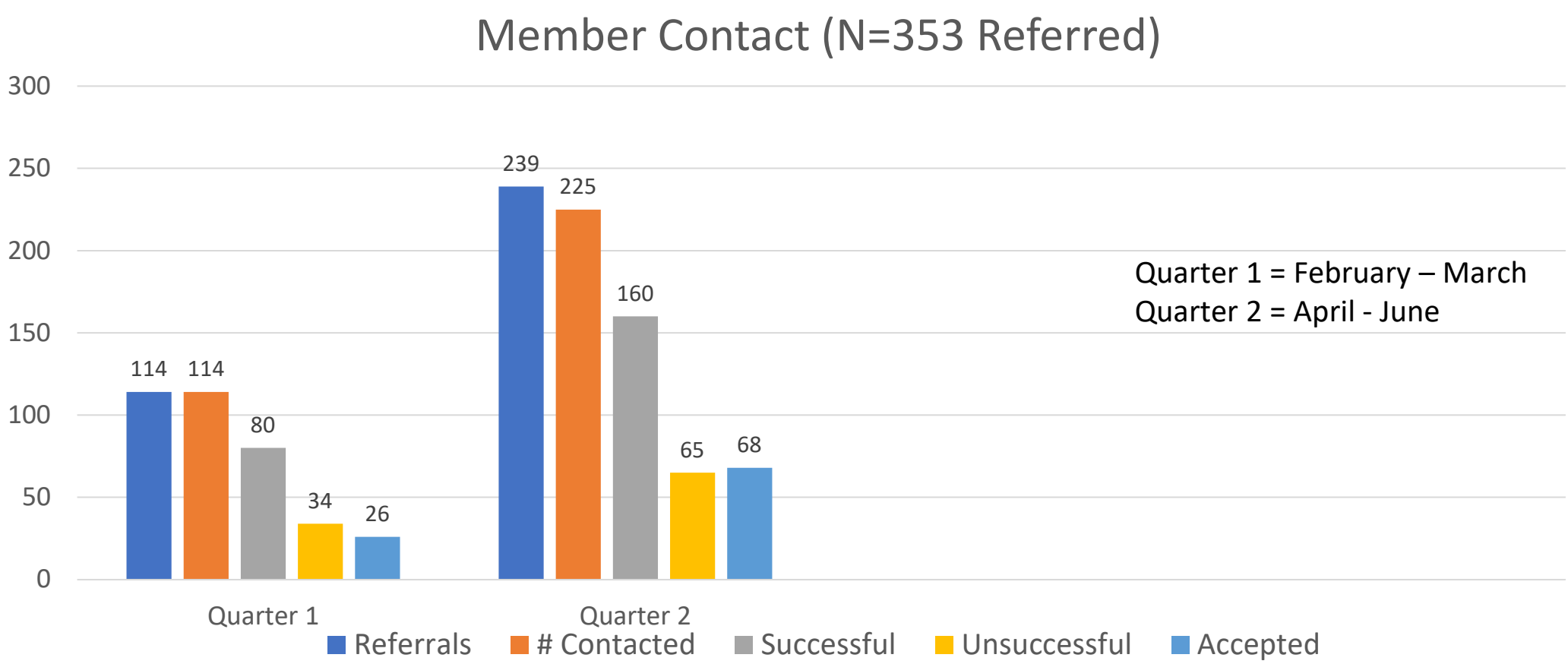




Provides care coordination to all **low-risk** pregnant and postpartum women.
Provides education about prenatal and postpartum care, and newborn care.
Identifies those who are at risk for depression and refer for further evaluation.

KERN HEALTH SYSTEMS

Baby Steps Plus (High Risk Pregnancy)



Childrens with Special Health Care Needs

Implementation: February 2024

	January	February	March	April	May	June	Total
Referred		34	129	149	302	217	831
Total # Contacted		34	129	138	245	195	741
Successful Contacts		23	98	73	203	152	549
Unsuccessful Contacts		11	31	50	50	55	197
Total Newly Enrolled ***(not counting existing members)***		**8**	**32**	**20**	**30**	**10**	100

Examples of education provided: diabetes management, ADHD, autism, immunizations, car seat safety, well child visits, wellness and preventative care, etc.

- Ensure members have assigned PCPs and engaged with PCPs.
- Complete screenings and assessments.
- Link members to community resources and KHS benefits.
- Ensure members are seen for well child visits and immunizations.

KERN HEALTH SYSTEMS

Kids and Youth (KAY) Transition (aka CCS Transition)

The team assists CCS eligible members that are aging out or transitioning out of CCS Services. These members are the sickest kids (e.g., cerebral palsy, cystic fibrosis, cancer, heart disease, traumatic injuries, hemophilia, etc.) in our plan, and need to be seen by multiple specialists.

Education was geared toward the needs of members. Top 3 identified needs for members:
"I know when and how to get emergency care."
"I have a way to get to my doctor's office."
"I know what I need to do to keep my health insurance."

These members were turning 21 y/o within 6 months are prioritized and then extended out to all 20-year-olds are completed.

	January – March 2024	April – June 2024
Total # of Members Contacted	85 (100%)	123 (100%)
Accepted	55 (65%)	37 (30%)
Did Not Accept	30 (35%)	18 (15%)
Unable to Contact	5 (5%)	68 (55%)
Care Notebooks	85	28

KERN HEALTH SYSTEMS

A Certified Medical Assistant (CMA) assisted a 26-year-old pregnant member, who was 32 weeks pregnant and had missed several prenatal appointments due to a lack of childcare for her two young children, ages 3 and 1.

The member had been discharged from her previous OB provider due to these missed appointments. The CMA successfully helped her find a new OB doctor and arranged for transportation services to her appointments.

Additionally, the CMA connected her to community resources, including childcare and safe sleep support.

The member expressed interest in behavioral services from a Clinic and requested a referral to Kern Health Systems (KHS) Behavioral Health Department. The CMA was particularly pleased with this development, as the member had previously declined behavioral health services despite scoring high on her PHQ-9 depression screening.

Now actively engaged in counseling for depression alongside her prenatal care, she uses transportation services provided to attend both OB and behavioral health appointments. During subsequent screenings, the CMA noted improvement in her PHQ-9 scores, indicating positive progress in managing her depression.

THANK YOU!

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: Pawan Gill, Health Equity Manager

Date: 8/8/24

Re: Health Equity Transformation Steering Committee (HETSC)

Background

The Health Equity Office (HEO) was officially launched on January 3, 2023 in response to the 2024 DHCS contractual requirements and the pursuit of NCQA Accreditation. The mission of the Health Equity Office is to improve the health and well-being of our members and the communities through the delivery of trusted, high quality, cost effective and accessible healthcare to all, regardless of their zip code, race, ethnicity, preferred language, cultural preference or personal history. The HEO is responsible for developing an annual workplan which is informed by both quantitative and qualitative analysis that includes clinical and non-clinical interventions in support of equitable service delivery for our members. The work is being coordinated through the HETSC which is structured to receive valuable input from employees, members, providers and the community through the development of multiple feedback mechanisms, including but not limited to: five Regional Access Committees (RACs), a Provider Health Equity and Learning Committee (HEAL), an internal Justice, Equity, Diversity & Inclusion (JEDI) committee and a Community Advisory Committee (CAC).

Discussion

- Updated Strategic Roadmap: In May of 2024, the HEO presented the 2024 strategic roadmap of the Health Equity Office that reflects the work being undertaken in the 4 HE domains: Employees, Providers, Members and Community. This roadmap has been further developed and expanded upon to include
- Updated 2024 Workplan & Review of Organizational-wide HE related Programs & Activities
- Q2 RAC Summary: The HEO held 5 RAC meetings this quarter in Arvin, Buttonwillow, Shafter, Oildale and Ridgecrest, to gather qualitative feedback from members and community regarding their experience accessing heal. The primary goals were to establish trust, enhance visibility, and understand the unique needs and concerns of the members in these areas. These meetings are held quarterly in each of the 5 designated regions of Kern County and build upon the listening sessions. Each session included facilitators and translators to ensure all members could participate fully. The purpose of this presentation is to summarize our findings. This feedback, along with other

qualitative data that is being solicited through various channels including KHEP, will be addressed and incorporated into the workplan.

Fiscal Impact
None.

Requested Action
Workplan/Roadmap – Approve.
Summary – Receive and File.

2024 Strategic Roadmap
Health Equity Office

	MEMBERS - 45%	PROVIDERS - 15%	COMMUNITIES - 25%	EMPLOYEES - 15%
FUTURE	Create and maintain a comprehensive report of all organizational wide, health equity related programs and interventions to better inform development key programs and initiatives R,V	Practice/Service Expansion: Identify & explore areas of opportunities for providers to expand access and/or services that align with and support health equity initiatives and/or expand network to ensure equitable care for underserved populations V	Develop and implement robust Community Engagement Framework & Strategy that includes Educational Partnership Strategy (co creating strategic plan for health initiatives) V, R	Co- design & implement a formalized organizational culture and development strategy with Human Resources V
	Enhance organizational workflows to improve the effectiveness of designed interventions in service of members (particularly from a member/community engagement lens) R,V	Create streamlined, robust and engaging training & development program for Providers with regular course offerings (May be 2025 before this is possible) V	Develop and implement robust Member Engagement Framework & Strategy V, R	Partner with HR Talent Acquisition team to develop and implement a robust recruitment & retention program V, M
	Develop a formal approach of identifying and prioritizing the development of health equity related interventions R,V	Network expansion: Identify, explore and discuss areas of opportunities for KHS to expand existing network to ensure equitable care for underserved populations V	Develop and implement Community Investment Framework & Strategy V, R	Partner with HR Learning & Development team to create robust training & development opportunities for internal KHS staff to promote organizational excellence V
		Create resource hub for Provider Network with trainings, guides, templates, best practices V	Conduct organizational wide review of CBO contracts to ensure equitable and effective use of funds V, R	Partner with HR to standardize JD language, format & education & experience requirements (NCQA HE) V, M
IN PROGRESS	Launched RAC's to solicit regular and actionable feedback from members and communities to better understand member experience from a geographic perspective and understand barriers to care to help inform the development of KHS's programs. initiatives and training R, V, M	Launch HEAL committee to solicit feedback from providers to share challenges faced in the field related to health equity to inform the development of KHS's training offerings, programs and support for providers R, V M	Launch RAC's to solicit regular and actionable feedback from members and communities to better understand lived experience from a geographic perspective and understand barriers to care to help inform the development of KHS's programs. initiatives and training R, V M	DEIB/JEDI Committee Launch (NCQA HE) R, V M
	SOGI Training & Data Collection (NCQA HE) R, V M	Identify, develop and promote opportunities for training and professional development to enhance providers' knowledge and skills in delivering equitable healthcare R, M V	Kern Health Equity Partnership (KHEP) - APL 24-004 V, M	Change Management Trainings R, V
	CRM - Enhancing member experience by implementing a CRM; ensuring HE related critical info such as preferred names, pronouns and other necessary information are available on initial screens so members are properly addressed V. R	Design, develop and launch robust Health Equity & DEIB training for all KFHC contracted healthcare providers V, M	Develop surrogates by supporting regional equity related initiaves throughout the County to build capacity, share expertise, forge stronger partnerships in community V	Recruitment & Selection Policy and Procedures (NCQA HE) P, M
				Design, develop and launch robust Health Equity & DEIB training for all KHS employees (APL 23-025) V, M
COMPLETED	Expanded internal demographic collection capability to include Sexual Orientation and Gender Identitiy (SOGI) information in QNXT and member portal V, M R	Establish Health Equity & Learning (HEAL) Committee - a collaborative forum for highly engaged healthcare providers in KFHC network dedicated to advancing health equity R, V M	Successfully restructured and rejuevenated CAC to bring into compliance, meet new regulations and improve quality of feedback V, R, M	Design, develop, launch and analzyze DEIB survey (NCQA HE) V, M
	Launched innaugural Health Equity Office (HEO) listening sessions in 5 regions of Kern County to introduce HEO and connect with members, community memebers, providers and partner agencies V, M R	Hosted first provider & community cultural competency training - Intimate Partner Violence in South Asian Community V	Work with PNM and Grants team to develop 2024 Grants Program (participated in program development and marketing, created scoring rubric and helped select recipients V	Employee engagement survey redesign, launch and analysis V, M
			Marketing community grants program V	Partner with HR to develop report to assess workforce demographics (NCQA HE) V. M
			Completed innaugural Health Equity Office (HEO) listening sessions in 5 regions of Kern County to introduce HEO and connect with members, community memebers, providers and partner agencies V, M R	Goal Setting Process V, R

R - Process, V - KHS Values, P = Policy , M - Mandate

2024 Health Equity Office - Strategic Roadmap

GOAL	OBJECTIVE	RESPONSIBLE PERSON(S)	ACTIVITIES/INTERVENTIONS	MEASURE(S)	TIMEFRAME	PREVIOUSLY IDENTIFIED ISSUE
MEMBER DOMAIN (45%)						
Focus on member wellness, prevention, reducing health disparity and quality improvement/performance						
Create and maintain a comprehensive report of all organizational wide health equity related programs and interventions to better inform development of key programs and initiatives	Identify, track & report organizational wide, HE related targeted interventions/programs and develop effective tracking mechanism to capture and report health equity related programming	HEO Manager	Create tracking sheet of all targeted interventions including lead dept, focus population, etc.	HETSC reviews organization-wide targeted intervention and discuss engagement strategy for existing pro	Q3-Q4	No process measure
Enhance organizational workflows to improve the effectiveness of designed interventions in service of members	Create organization process flow that formalizes HEO engagement in initial design phase of developing targeted interventions or programs	HEO Manager in partnership with COSA & BI	Create template and process for launch of new health equity related intiatives	Completion of template; review at HETSC & EQIHEC	Q3-Q4	
Member Needs Assessment	Conduct an annual member needs assessment. Identified gaps in the provider network will be addressed through the recommendations of the Network Adequacy Committee.	Director of Provider Network Management	Run report to assess needs of members. Review with stakeholders. Adjust provider network as necessary.	Percentage increase of providers; # of findings taken to NAC	Q1-Q2	No
Collection of Providers' Race/Ethnicity Demographic Data	Expand and increase data integrity and reportability related to the the Collection of Provider's Demographic data to enable more effective decision making	Director of Provider Network Management & HEO Manager	Run current report, identify areas of opportunity to validate & update existing data and expand data collection	# of providers with updated demographic collection categories, data sharing capabilities etc	Q2-Q3	No
Share CLAS Progress with Stakeholders	Share CLAS progress with stakeholders, including obtaining MHC distinction	Sr Director of Wellness & Prevention	Share with Stakeholders		Q2-Q3	No
Annual evaluation of the CLAS program	Conduct annual evaluation of the CLAS program	Sr Director of Wellness & Prevention	Share with Stakeholders Identify and address areas for improvement	# of actionable items taken to committee; # of actions taken to address gaps	Q2-Q3	No
Improve tracking mechanism of grievances	Enhance current tracking mechanism to capture and easily report types of grievances (particularly discrimination related) and monitor regularly to identify trends	Complaints and Grievances Manager & HEO	Assess current report, add necessary columns and include in HESTC report	Create tracking mechanism with a minmum 2 year look back to establish initial tracking mechanism for grievances with a focus on HE	Q1	No
Reduce language disparities among Asian speaking members	Reduce language disparities among Asian speaking members getting screening for breast cancer by 5 % in comparison to other groups.	Director of Quality & HEO Manager	Run quarterly report to assess IET measures. Review reports with stakeholders. Take corrective actions as necessary.	Listed in goal	Q1-Q4	No
Reduce disparities among Hispanic Members	Improve manamgent of Diabetes by reducing A1c levels in Hispanic members by 2024. Improve the good control rate by 5 % by 2024.	Director of Quality & HEO Manager	Run quarterly report to assess IET measures. Review reports with stakeholders. Take corrective actions as necessary.	Listed in goal	Q1-Q4	No
Assessment of member experience with Language Resources	Assess baseline of member experience with language resources	Director of Member Services	Run Annual Report Share with Stakeholders Identify and address areas for improvement	# of actionable items taken to committee; # of actions taken to address gaps	Q1 & Q3	No
PROVIDER DOMAIN (15%)						
Provide training, programmatic support and incentives ato provider network to ensure the delivery of quality care to all members						
Multicultural Practices Provider Survey	Assesss provider cultural responsiveness. Additional goals and objectives with a timetable for implementation are documented in the C&L	Director of Provider Network Management	Conduct Survey Review results Adjust provider network and/ or address gaps	# of actionable items taken to committee; # of actions taken to address gaps	Q1-Q2	No
Assess KHS Provider Network Language Capabilities	Assesss provider language capabilities to that of the KHS member language needs.	Director, Member Services	needs of members. Review with stakeholders. Add to Provider Directory	By December 31, 2024, KHS will increase language access through translation and/or interpreter services to at least 20 events where specific language needs are determined.	Q3-Q4	No
Provider Training on Language Resources	Offer KHS contracted providers access and availability of language assistance resources	Director Member Services	Run report to assess needs of members. Review with stakeholders.	HEO to review current provider resources available to providers re: language assistance resources - expand current offerings	Q3-Q4	No
Collection of Providers' Race/Ethnicity Demographic Data	Assess provider's race/ethnicity demographic profile to that of the member race/ethnicity profile	Director of Provider Network Management	Assess race/ethnicity profiles of providers to members Review reports with stakeholders. Take corrective actions	Initial measurement: Meet with at least 2 districts; Once launched measures will be performance based on specific intervention	Q2-Q3	No
COMMUNITY DOMAIN (25%)						
Build relationships and invest in communities & community based orgnzations (CBOs)						
HEO Regional Listening Sessions	Gather qualitative data directly from members and the community regarding their experience	Health Equity Office	Assess baseline of member experience for medical access, quality and trust	On an annual basis, conduct Regional Listening sessions in each of the 5 designated regions of Kern.	Q1	No
Regional Access Committees's	Gather qualitative data directly from members and the community regarding their experience	Health Equity Office	Assess baseline of member experience for medical access, quality and trust	By December 31, 2024, a process will be implemented to track the organizational diversity of community partners outreached for each RAC.	Q3-Q4	No
Develop Comprehnsive Community Investment Strategy	Assess KHS community investments to ensure equitable and effective use of organizational resources	Health Equity Office	Track, analyze and report community investments by activity (sponsorships, contracts, community grants programs), identify areas of improvement & address gap	By December 31, 2024, a process will be implemented to effectively track organizational investments in the community across departments.	Q3-Q4	No
Develop Comprehensive School Partnership Strategy	Assess KHS school partnership strategy to ensure equitable and effective use of organizational resources and maximize impact	Health Equity Office	Streamline and formalize educational partnerships with schools; co-create a strategy with district and multiple KHS depts on health initiatives	Initial measurement: Meet with at least 2 districts; Once launched measures will be performance based on specific intervention	Q3-Q4	No
Assess KHS Provider Network Language Capabilities	Assesss provider language capabilities to that of the KHS member language needs.	Director, Member Services & PNM Director	needs of members. Review with stakeholders. Add to Provider Directory		Q3-Q4	No
EMPLOYEE DOMAIN (15%)						

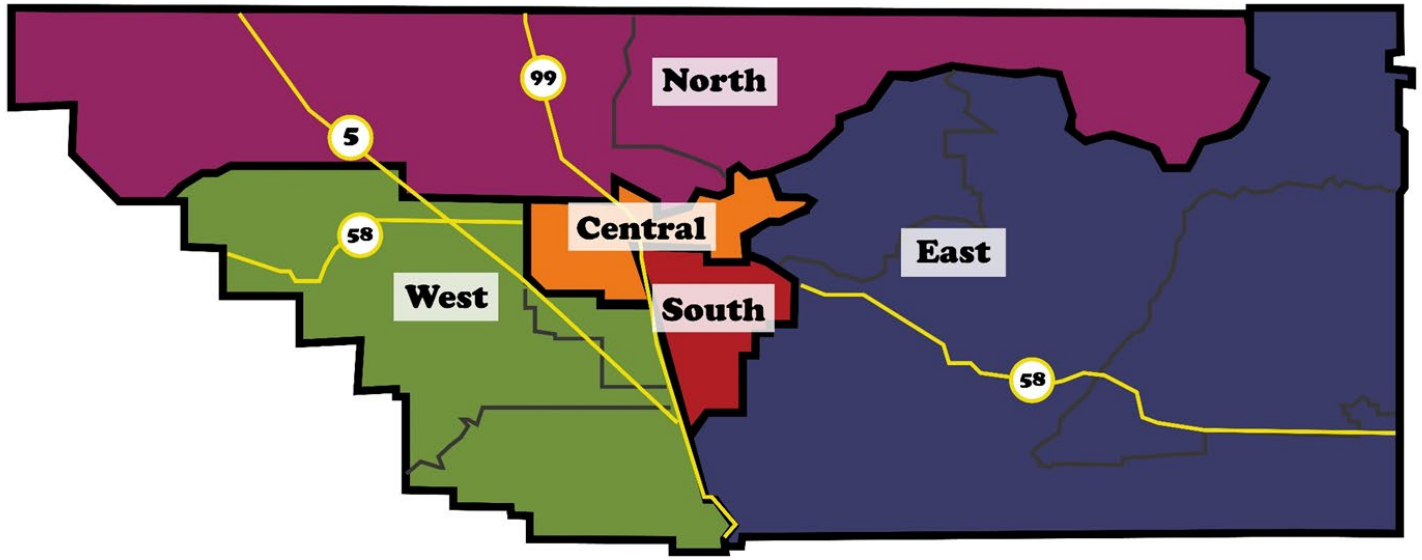
Engage and develop employees with training, culture inititiaves, and state-mandated DEIB programs. Ensure employments practices are fair & equitable.						
Assessment of KHS Workforce Demographics	Analyze KHS workforce demographics	Health Equity Manager & HR	workforce activities. Review with stakeholders. Monitor workforce demographics for hiring		Q1	No
Diversity, Equity and Inclusion (DEI) Task Force Development	Development of the KHS DEI Task Force will serve as the stepping stone to mobilize efforts around implementation of DEI practices, policies, engagement, climate pulse checks, and training opportunities.	Health Equity Manager & HR	Solicit workforce participation for task force development Establish task force with regular occuring meeting schedule		Q2-Q3	No
Organizational Climate Assessment	Conduct Annual Organizational Climate Assessment	Health Equity Manager & HR	Develop KHS Organizational Climate Assessment Tool in conjunction with HR Facilitate Organizational response to results	Launch of survey; survey participation	Q1	No
Diversity, Equity and Inclusion (DEI) Training	Develop organization- wide divesity, equity and inclusion training curriculum	Health Equity Officer	Assess organizational training needs Create DEI Training Curriculum		Q1-Q3	No
Ensure Bilingual KHS Workforce	Maintain a bilingual Member Services Department workforce that is representative of 5% of the population	Director of Human Resources Director of Member Services	Maintain Member Service Staffing Share with Stakeholders Add to Qualified	Stated in goal	Q1	No
Bi-Lingual Staff Competency Assessment	Conduct Language Proficiency Test for all new bilingual applicants	Director of Human Resources Director of Member Services	Facilitate LPT Assessment Provide LPT assessment scores	% complete	Q1-Q4	No
Staff Experience with Language Assistance Resources	Assess baseline of staff experience with language resources	Director of Member Services/HR	Run Annual Report Share with Stakeholders Identify and address		Q1 & Q3	No

QUARTER 2 RACS - ACCESS

Presented by Health Equity

FIVE REGIONS

- South – Arvin - 04/24/24
- West – Buttonwillow - 05/08/24
- North – Shafter - 05/09/24
- Central – Oildale – 05/14/24
- East – Ridgecrest - 05/22/24



THE TEAM

Community Engagement

Cultural and Linguistics

Health Equity

Member Engagement

Member Services

FRCs/Collaboratives

Community Partners

ARVIN - SOUTH REGION

- Attendees:16
  - 12 KFHC Members
- Predominate Culture: Hispanic
- Families: 4
- Sandwich Generation: 2

- Takeaways specific to this region:
  - Local allergist retired - must go to Bakersfield/Tehachapi
  - Transportation does not go to all parts of region and will cancel at the last minute, and rescheduling is months out
  - Immunization/Physicals - hard to get appointments (2-5 months out), mobile clinics not in Arvin
  - Not Educated on the KFHC Plan - transportation, referral, authorizations
  - Urologist retired

BUTTONWILLOW - WEST REGION

- Attendees:12
  - 8 KFHC Members
- Predominate Culture: Hispanic
- Families: 10
- Sandwich Generation: 8

- Takeaways specific to this region:
  - Only have OMNI clinic – open 2 days per week
  - Closet Urgent Care is Shafter - 5 hour wait
  - Only have 1 dentist - open on Wednesdays
  - No pharmacy and no deliveries from outside communities (Bakersfield, Shafter, Taft)
  - Healthy Food - No Farmer's Market in region, commodities 1x/month, 1 grocery store with limited supply

SHAFTER - NORTH REGION

- Attendees: 26
  - 14 KFHC Members
- Predominate Culture: Hispanic
- Families: 12
- Sandwich Generation: 9

- Takeaways specific to this region:
  - Urgent Care closes at 8pm
  - No specialty providers in Shafter and few in the region
  - Members travel to Delano for dentist for children
  - Dentist and Ophthalmologist - 1-2 month wait
  - If community receives a mobile clinic, they leave before 5pm

OILDALE - CENTRAL REGION

- Attendees: 6
  - 1 KFHC Member
- Predominate Culture: White
- Families: 2
- Sandwich Generation: 0

- Takeaways specific to this region:
  - Need for sober/detox facilities
  - Support/ services for the unhoused population
  - Long wait times after scheduled appointment (1pm appointment - seen at 5pm, so didn't need to miss as much work)
  - Need for a behavioral health services
  - Only one dentist, who only pulls teeth and refers out other services

RIDGECREST - EAST REGION

- Attendees:15
  - 5 KFHC Members
- Predominate Culture: None
- Families: 5
- Sandwich Generation: 5
- *Note: additional 8 discussed family/sandwich

- Takeaways specific to this region:
  - No pregnancy services - must deliver at the ER
  - Special needs services/therapies
  - Veteran services
  - Vision/Dental services
  - Appointments not upheld if 2 minutes late

REGIONAL OVERVIEW - COMMON ACCESS THEMES FOR ALL RAC MEETINGS

- Education
  - Translation/Interpreter Services
  - Telehealth
  - Access the KFHC Plan
  - Text messages

- Medical Facilities
  - Clinics
  - Extended Hours
  - Hospitals

- Providers
  - Language
  - Specialists
  - Hours
  - Appointment Scheduling
  - Telehealth options
  - Behavioral Health

REGIONAL OVERVIEW CONT.

- Transportation
  - Access
  - Curb-to-curb vs Door-to-door
  - Not all locations are given services
- Healthy Food
  - Fruits/vegetables accessible at local market
  - Limited Farmer's Markets – even though they take SNAP
- Special Needs Services
  - Wrap-around services not in local communities
  - Providers (especially for youth) out of county
  - Delays in assessments for children

RECOMMENDATIONS

- Education - text message service
- Transportation - Increase capacity to outlying areas
- Healthy Food - Partner with Farmer's Markets
- Providers
  - Telehealth Services
  - Behavioral Health Services
  - Appointment Scheduling
  - Hours of Operation

Q3 RACS - QUALITY

South - Greenfield - 07/16/24

Central - Boys and Girls Club - 08/29/24

West - Frazier Park - 09/03/24

North - McFarland - 09/11/24

East - Mojave - TBD

QUESTIONS

Health Equity

Pawan Gill,
Health Equity Manager

KERN HEALTH SYSTEMS

Challenges of our Four Domains

- Members
- Providers
- Community
- Employees

Barriers for Members and Community

- Access
  - Availability of providers/services for an appt (timeliness as well as service hours)
    availability of alternative options (telehealth)
- Transportation
  - Door to door vs curbside – no knowledge of benefit
- Trust
  - Often associated with two complaints above, people feel disconnected from system

Breaking the Barrier

KHS established the Kern Health Equity Partnership with the County, aligning our strategic goals with social determinants of health. Our HEO leads subcommittees on Healthcare Access and Health Education and Outreach. Additionally, we participate in the IHI/DHCS Child Health Equity Collaborative, working with two providers on pilot programs to improve children's health outcomes.

Challenges for Providers

- Patient Related
  - Patient no-shows
- Resources
  - Lack of resources (seeking funding opportunities, building capacity for small-medium size practices – data, bigger picture)

Meeting the Challenge

KHS has implemented the EPT Program which now includes 12 practices eligible to earn up to $7,619,527. We also offered cultural competency training focused on the South Asian community and the LGBTQIA++ population.

Challenges for Employees

- *The employee engagement survey revealed...*
  - Employees struggle to navigate hurdles creating access issues for members
  - Overall employees reluctant to share feedback that could be "tracked" back to them
  - Underrepresented employees are less likely to recommend KHS (perceived inequities in projects, pay and promotions reduce employees' discretionary effort)

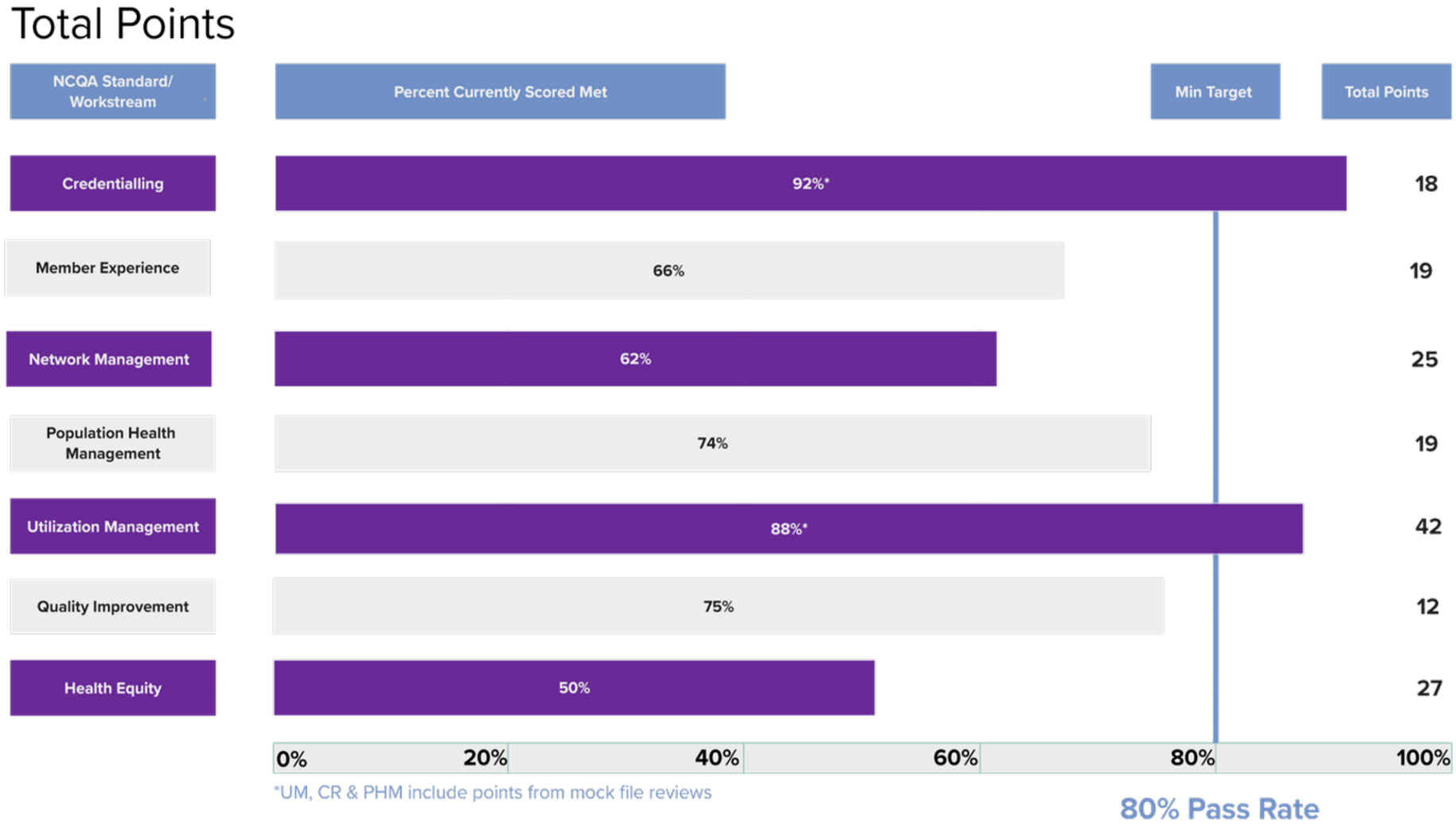
Meeting the Challenge

The health equity office will partner with HR on DEIB and employee engagement initiatives, launch the JEDI Committee, set new performance goals, review recruitment and retention programs, and develop comprehensive health equity and DEIB training for all employees.

Inaugural Sexuality and Gender Identity Forum

- June 14, 2024, Bakersfield College
  - The event featured sessions on diverse topics, including affirming healthcare, trans healthcare, and 2sLGBTQIA+ intersections, aiming to equip providers with essential skills to serve the community effectively.

Journey to NCQA Health Equity Accreditation



THANK YOU!

Questions?

KERN HEALTH SYSTEMS