AGENDA

Executive Quality Improvement Health Equity Committee (EQIHEC) Meeting

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

Thursday, December 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 September 12, 2024 - APPROVE

CA-4) Behavioral Health Advisory Committee (BHAC) Minutes from October 16, 2024 – APPROVE

CA-5) Health Equity Transformation Steering Committee (HETSC) Minutes from September 12, 2024 – APPROVE

CA-6) Network Advisory Committee (NAC) Minutes from October 18, 2024 – APPROVE

CA-7) Pharmacy Drug Utilization Review (DUR) Minutes from September 30, 2024 – APPROVE

CA-8) Physician Advisory Committee (PAC) Redacted Minutes from August 7, 2024 – APPROVE

CA-9) Physician Advisory Committee (PAC) Redacted Minutes from September 4, 2024 – APPROVE

CA-10) Population Health Management Committee (PHMC) Minutes from September 4, 2024 – APPROVE

CA-11) Utilization Management Committee (UMC) Minutes from September 11, 2024 – APPROVE

CA-12) Quality Improvement Workgroup (QIW) Minutes from September 26, 2024 - APPROVE

13) Behavioral Health Advisory Committee (BHAC) Q3 & Q4 2024 Reports – APPROVE

14) Quality Performance (QP) Q3 2024 Report – APPROVE

15) Quality Improvement Committee (QIW) Q3 2024 Report – APPROVE

16) Grievance Summary & Report – APPROVE

17) Utilization Management (UM) Program Report Q3 2024 – APPROVE

18) Network Adequacy Committee (NAC) Q4 2024 Report – APPROVE

19) Population Health Management (PHM) Q4 2024 Report– APPROVE

20) Health Equity Transformation Steering Committee (HETSC) SOGI Data Collection – APPROVE

21) EQIHEC Report Templates – APPROVE

ADJOURN MEETING TO THURSDAY, March 27, 2025 @ 7:15 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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COMMITTEE: ***EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (EQIHEC)***
DATE OF MEETING: ***SEPTEMBER 12, 2024***
CALL TO ORDER: ***7:15 AM BY TRACO MATTHEWS, CHAIR***

Members Present On-Site:	Jennifer Ansolabehere Satya Arya, MD - ENT. Danielle Colayco, PharmD – Komoto	Todd Jeffries – Bakersfield Community Healthcare Allen Kennedy – Quality Team DME Michael Komin, MD – Komin Medical Group	Chan Park, MD – Vanguard Family Medicine Rukiyah Polk - CAC Chair Traco Matthews – KHS Chief Health Equity Officer
Members Virtual Remote:			
Members Excused=E Absent=A	Debra Cox – Omni Family Health (A) Jasmine Ochoa - Health Equity Manager of Public Health (E) Philipp Melendez, MD – OB/GYN (E)		
Staff Present:	Amy Sanders - 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 Kailey Collier - Director of Quality Performance Yolanda Herrera - Credentialing Manager Flor Del Hoyo Galvan - Manager of W&P Maninder Khalsa – Medical Director Ann StoryGarza, Assistant General Counsel Christine Pence, Senior Director of Health Services	Vanessa Nevarez - Health Equity Coordinator Gregory Panero – Provider Network Analytics Abdolreza Saadabadi, MD – BH Medical Director Isabel Silva - Senior Director of W&P Martha Tasinga, MD – KHS Chief Medical Officer Misty Dominguez, Director of Health Services Special Programs

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Quorum	9 of 12 committee members present; Debra Cox, Jasmine Ochoa, and Philipp Melendez were absent.	Committee quorum requirements met.	N/A
Call to Order	Traco Matthews, Chair, called meeting to order at 7:15 am.	N/A	N/A
Public Presentation	There were no public presentations.	N/A	N/A

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Committee Announcements	Traco Matthews gave the opportunity for member updates. • There were no committee announcements.		
Committee Minutes	**Approval of Minutes** CA-3) The Committee's Chairperson, Traco Matthews, presented the EQIHEC Minutes for approval.	**Action:** • Satya A. first, Todd J. second. All aye's. Motion carried.	9/12/24
Old Business	There was no old business to present.	N/A	N/A
New Business	**Consent Agenda Items** CA-4) Behavioral Health Advisory Committee (BHAC) Q1 Summary of Proceedings CA-5) Behavioral Health Advisory Committee (BHAC) Q2 Summary of Proceedings CA-6) Health Equity Transformation Steering Committee (HETSC) Q2 Summary of Proceedings CA-7) Network Advisory Committee (NAC) Q2 Summary of Proceedings CA-8) Pharmacy Drug Utilization Review (DUR) Q2 Summary of Proceedings CA-9) Physician Advisory Committee (PAC) April 3, 2024, Redacted Summary of Proceedings CA-10) Physician Advisory Committee (PAC) May 1, 2024, Redacted Summary of Proceedings CA-11) Physician Advisory Committee (PAC) June 5, 2024, Redacted Summary of Proceedings CA-12) Population Health Management (PHMC) Q2 Summary of Proceedings CA-13) Utilization Management Committee (UMC) Q2 Summary of Proceedings	**Action:** • Satya A. first, Todd J. second. All aye's. Motion carried.	9/12/24
	14) Behavioral Health Advisory Committee • Melinda S. gave a presentation on the structure, duties, and processes of the Behavioral Health Department. • Melinda S. presented the Behavioral Health Advisory Committee Charter for approval.	**Action:** • Todd J. first, Satya A. second. All aye's. Motion carried.	9/12/24

	15) Quality Performance • Kailey C. presented the Quality Performance Summary Report that covered Q2 2024 data. Kailey C. highlighted a big achievement for the department; W30. Kailey C. concluded by asking the group if they have any recommendations on community partnerships. • Danielle C. asked what services our mobile units are doing. 16) Quality Improvement Committee • Magdee H. presented the QI Workplan Scorecard and the QI Summary Report for Q2 2024. Martha T. added that the term "quality of care" is defined by each members perception. Martha T. concluded that the member can advocate for themselves if the doctor doesn't do what they feel they need. KHS is then required to call the doctor and investigate the quality of care. 60k new members have joined Kern Family Health (KFHC) care so you will see the numbers change. • Michael K. asked if Kern Health Systems (KHS) has seen an increase in complaints about how long it takes to see the doctor.	• Allen K. requested to add redlined documents to the committee meeting packets going forward. • Kailey C. responded that the mobile units are equipped to perform full well visits, screenings, and immunizations; as well as handle anything topical, all measures within children's domains. Kailey C. also commented that staff have inquired about mobile unit services as well. • Michael K. first, Allen K. second. All aye's. Motion carried. • Martha T. responded that yes, we do receive those complaints and still members refuse to leave those doctors even though they know how popular they are. Melinda S.	9/12/24 9/12/24 9/12/24 9/12/24

		added that KHS is trying to track those claims correctly for true representation. In order to address the no-show population KHS has two employees that reengage and talk directly to that population, even offering to attend the appointment with the patient. Pawan G. added that Health Equity is aware of this barrier and has been conducting more outreach to let members know about the resources we have to offer here at KHS such as community health workers (CHW). Martha T. added that while KHS does have health workers, the expectation is for providers to hire their own. Danielle C. commented that Komoto pharmacy has hired their own CHW and have greatly seen the benefits. Satya A. added that surgery no-shows is a real problem for them. Martha T. responded that UM is trying to see what they can do to improve outpatient surgery services.	
	• Michael K. claimed that he lost his social worker to a higher bidder and asked if they need training.	• Melinda S. stated that CHW's don't need to be licensed and anyone can go through the 16-week training at BC. Traco M. commented that we can work offline to assist Michael K. • Satya A. first, Michael K. second. All aye's. Motion carried.	9/12/24 9/12/24

	17) Grievance Summary Report Q2 2024 • Amy S. presented the Grievance Summary Report that covered the Q2 2024 data. 18) Utilization Management Program Report Q2 2024 • Maninder K. presented the UM Program report that covered the Q2 2024 data. • Martha T. commented on the effectiveness of services. She added that the state assumed these services are useful to reduce the cost in care, so they are not requiring as many reports. In appeals, KFHC overturns 40% of denials because records were not received. We would not have to deny if we had the records. Getting us documentation we need is very important to what we do, that way the denial rate can go down. • Satya A. left the meeting at 8:26am. Quorum still met. 19) Network Adequacy Committee Report Q2 2024 • Greg P. presented the Network Adequacy Report that covered the Q2 2024 data. • Jennifer A. asked if KFHC is trying to get Barstow as an option for pregnant women because East Kern moms have nowhere to go. Jennifer A. was told that Omni and Adventist Health no longer have Obstetricians (OB) and it is a big concern.	• Satya A. first, Michael K. second. All aye's. Motion carried. • Informational only. • Greg P. responded that he will find out if Omni and Adventist health are taking those patients or not. • Chan P. first, Allen K. second. All aye's. Motion carried.	9/12/24

	20) Pop Health Management Mid-Report Q1, Q2 2024 • Michelle C. presented the Pop Health Management Mid-Report that covered Q1 and Q2 2024 data. 21) Health Equity Transformation Steering Committee • Pawan G. presented the Strategic Roadmap/Workplan for approval along with the Regional Advisory Committee Summary and Health Equity Presentation that covered Q2 2024 data.	• Allen K. first, Chan P. second. All aye's. Motion carried. • Michael K. first, Chan P. second. All aye's. Motion carried.	

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Open Forum	N/A	Informational only.	N/A
Next Meeting	The next meeting will be held Thursday, November 14, 2024, at 7:15am.	Informational only.	N/A
Adjournment	The Committee adjourned at 9:10am. ***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: **OCTOBER 16, 2024**
CALL TO ORDER: **12:04 PM BY MELINDA SANTIAGO, DIRECTOR OF BEHAVIORAL HEALTH - CHAIR**

Members Present On-Site:	Marisa Garcia-Trebizo, LMFT - Director at CSV Heather Hornibrook, LMFT – Deputy Dir. KBHRS	Mesha Muwanga, LMFT – Rhema Therapy Inc. Melinda Santiago, KHS Director of Behavioral Health	Martha Tasinga MD, KHS Chief Medical Officer
Members Virtual Remote:	Matthew Beare, MD – Clinica Sierra Vista Anuradha Rao, MD - Omni	Franco Song, MD – Psychiatric Wellness Center	
Members Excused=E Absent=A	Cherilyn Haworth, CSUB (A)		
Staff Present:	Amy Daniel, KHS Executive Health Services Coordinator Vanessa Hernandez, KHS Senior Support Clerk Yolanda Herrera, KHS Credentialing Manager	John Miller, MD - KHS QI Medical Director Courtney Morris, KHS Behavioral Health Supervisor Steve Pocasongre, KHS NCQA Accreditation Specialist	Abdolreza Saadabadi, MD PhD Pam Thomsen, KHS NCQA Program Manager Julie Ybarrra, KHS Supervisor BH

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga, CMO and Melinda Santiago, KHS Director of Behavioral Health called the meeting to order at 12:04 PM.		N/A
Committee Minutes	**Approval of Minutes** Approval of Minutes from July 10, 2024 meeting.	☑ **APPROVED**: A motion was made by M. Muwanga, LMFT and seconded by Dr. A. Rao, to approve the minutes of July 10, 2024. Motion carried.	10/16/24
OLD BUSINESS	**Grievance Process** **NCQA ME 7E (BH) Grievance and Appeal – Review qualitative and quantitative analysis**	☑ **PENDING: Held until next meeting.** ☑ **PENDING: Held until next meeting.**	Pending 11

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Eating Disorders Follow-up Follow-up meeting with Dr. Sidhu, Dr. Tasinga and Dr. Rao to work on this suggested algorithm. Dr. Rao suggested including Marlena Tanner, RD in this meeting as she has guidelines for eating disorders.		
NEW BUSINESS	**NCQA Standards QI 4.A-B** Melinda Santiago, Director of Behavioral Health presented qualitative and quantitative analysis report. Reviewed the targeted measures and methodology for data collection on the continuity of care coordination between medical care and behavioral health outcomes. Reviewed all six factors with activities listed that included exchange of information, Appropriate Diagnosis, Treatment, and Referral of Behavioral Health Disorders Commonly Seen in Primary Care, Appropriate Use of Psychotropic Medications, Management of Treatment Access and Follow-Up for Members with Co-Existing Medical and Behavioral Health Disorders, Primary or Secondary Preventive Behavioral Healthcare Program Implementation, and Special Needs of Members with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED). Reviewed the results qualitative analysis, quantitative analysis, reviewed barriers and opportunities, and planned interventions. KHS collaborates with the health plans core system of care with equitable and high-quality integrated care by collecting and analyzing the data to improve those opportunities that found between medical care and behavioral health care. Melinda reviewed with the members that data currently being collected through various targeted measures with data collection through MCAS, HEDIS, Survey results and claims data. Additional barriers identified contributing to low rates or failure to meet goals included lack of coordination between PCPs and Behavioral Health Specialist, especially due to PCPs not aware of the BH Referrals and the BH Providers don't have access to the provider platform to share information with the PCPs.	☑ **ACTION**: Collectively committee agreed with recommendation. Marisa Garcia Trebizo-CSV motioned to approve these targeted areas of focus: AMM, ADD and SSD. Mesha Muwanga seconded, and motion carried.	10/16/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Dr. Saadabadi suggested recommendation of the factors. BH Director selected opportunities where improvements could be made, were thoroughly discussed amongst the members with the following recommendation to target these areas of focus: 1. AMM 2. ADD 3. SSD **<u>NCQA Standards ME 7E1 & 7E2</u>** Melinda presented the Behavioral Health Complaints and Appeals for Year 2023 per 1,000 Members. KHS has an overall behavioral health grievance goal of 10 per 1000 members per year and 2 -per members per year for each grievance category. The following highlights were noted: • 131 BH Complaints were filed – resulting in 0.04 complaints per 1000 members – KHS met our goal of <10 grievances per 1000 • 4 BH Appeals were filed – resulting in less than .01 appeals per 1000 members – KHS met our goal of <1 grievance per 1000 members.	☑ **Action –** Follow-up Agenda Item 1. BH Director will present the NCQA Standards ME 7E1 Grievance and Appeal – Review qualitative and quantitative analysis • Discussion on selected opportunities 2. ME 7E – Annual Assessment of Behavioral Healthcare and Services – Review (BH) Member Experience Surveys • Discussion on selected opportunities	
OPEN FORUM	**<u>Open Forum</u>** APL 24-012 (SB1019)	☑ **CLOSED**: Informational discussion only.	10/16/24
NEXT MEETING	Next meeting will be held January 15, 2025.	☑ **CLOSED**: Informational only.	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
ADJOURNMENT	The Committee adjourned at 1:29 pm. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Behavioral Health Advisory Committee Minutes 10/16/2024

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

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

KERN HEALTH SYSTEMS

COMMITTEE: ***HEALTH EQUITY TRANSFORMATION STEERING COMMITTEE (HETSC)***
DATE OF MEETING: ***September 12, 2024***
CALL TO ORDER: ***2:00pm - 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 • Louie Iturriria, Senior Director of Marketing and Member Engagement • Finster Paul III, Manager of Community Health and Wellness	• Marilu Rodriguez, Senior Health Equity Analyst • Melinda Santiago, Director of Behavioral Health • Adriana Salinas, Director of Community and Social Services • Flor Del Hoyo Galvan, Manager of Member Wellness and Prevention	• Frankie Gonzalez, Employee Relations Manager • Vanessa Nevarez, Health Equity Coordinator • Amy Sanders, Member Services Manager • Maritza Jimenez, Community Engagement Supervisor • Jake Hall, Senior Director of Contracting and Quality Performance
Staff Virtual:	• Kailey Collier, Director of Quality Performance • Gregory Panero, Provider Network Analyst Program Manager	• Russell Hasting, PHM Manager of Case Management • Bianca Zenteno, Health and Wellness Lifestyle Coach	• Stephen Wuertz, Business Intelligence Data Insight and Analyst Manager • Martha Quiroz, Member Services Manager

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
QUORUM	Attendance / Roll Call	N/A – Workshop-style Committee	N/A
CALL TO ORDER	Pawan Gill, Health Equity Manager and Chair called the meeting to order at 2:00pm.	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) 2024 Health Equity Office (HEO) Strategic Roadmap Review – PRESENTATION** • Pawan G. provided an update on the 2024 HEO workplan and asset mapping. **2) Health Equity and Learning (HEAL) Committee – PRESENTATION** • Marilu R. provided a HEAL committee update. **3) Regional Advisory Committee (RAC) – PRESENTATION** • Anastasia L. gave a presentation of the RAC that covered Q3.	• Pawan G. advised that she will be sending the HEO workplan and asset map to the HETSC to update and provide input. • Informational only. • Informational only.	9/12/24 N/A N/A

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
OPEN FORUM	Pawan opened the floor for announcements.	• Lela C. is in the process of creating a member facing department group. • Finn P. promoted the school wellness grant. • Frankie G. announced the mentorship program between HR, JEDI, and HEO.	N/A

NEXT MEETING	Next meeting will be held Thursday, December 12th, 2024, at 2:00pm.		N/A
ADJOURNMENT	The Committee adjourned at 3:00pm ***Respectfully submitted:*** ***Vanessa Nevarez, Health Equity Coordinator***	N/A	N/A

For Signature Only – HETSC Minutes 09/12/24

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: **October 18, 2024**
CALL TO ORDER: **11:08 AM by James Winfrey, KHS - Deputy Director of Provider Network Management, Chair**

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
CALL TO ORDER	- James Winfrey called the meeting to order at 11:08 AM - Quorum/Attendance	- Committee quorum requirements met.	N/A
APPROVAL OF MINUTES	- James Winfrey presented the Q3 2024 Network Adequacy Committee meeting minutes for approval.	☑ **CLOSED**: The committee members in attendance approved Q3 2024 Network Adequacy Minutes.	*10/18/24*
OLD BUSINESS	- No items.	☑ **CLOSED**: Informational only.	*10/18/24*
NEW BUSINESS	Provider Network Management, Q3 2024 Quarterly Network Review - Greg Panero presented the Provider Network Management Q3 2024 Quarterly Network Review. o After Hours Survey Results: Emergency Access at 100% compliant, Urgent Care Access at 99% compliant. Reviewed trending results and discussed Plan follow up action. ▪ During discussion of after-hours survey, Alan Avery inquired about follow up procedures for noncompliant providers.	☑ **CLOSED**: The committee members in attendance approved Provider Network Management, Q3 2024 Quarterly Network Review.	*10/18/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	James Winfrey, Gregory Panero and Melissa McGuire went over noncompliant provider letters and education. Greg Panero also explained noncompliant provider tracking and consequences of continued noncompliance. Deb Murr asked to clarify Carenet Health's role in After Hours surveys. James explained that Carenet Health conducts the initial wave of calls, followed by a second wave from PNM staff to verify the results. Deb Murr also inquired whether all providers are surveyed quarterly, to which James Winfrey confirmed that all PCP offices are surveyed every quarter. ○ Provider Accessibility Monitoring Survey: Plan compliant with all standards (appointment availability, hours of operation, phone answering timeliness, in-office wait times) based on results of Q3 2024 Survey. ▪ During discussion of Provider Accessibility Monitoring, Alan Avery inquired about how surveys are done. Greg Panero, James Winfrey and Melissa McGuire explained survey process as well as tracking and monitoring all responses for trending. No trends identified at this time. Deb Murr asked if provider responses are audited. James Winfrey and Greg Panero explained survey questions and methodology used. ▪ Deb Murr also inquired about Mental Health access availability. James Winfrey explained specialist and NPMH providers are surveyed and at this time meeting compliance with the help of telehealth services. Melissa McGuire also explained random list of specialists selected each quarter may not always include Psychiatry. ▪ Deb Murr noted there is a lot of focus on mental health recently. James Winfrey discussed other mental health report that		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	is still being finalized as part of a different project that can be reported on in the next NAC meeting. Greg Panero also pointed out all non physician mental health providers will be surveyed as part of the DMHC provider appointment availability survey. ▪ Deb Murr inquired if the above-mentioned survey includes ABA services. James Winfrey explained surveying is currently based on regulatory requirements which do not currently include ABA, but if that is a recommendation it could be built into the surveys. Deb Murr and Traco Matthews asked that this be included in future surveying. James Winfrey explained he will meet with Director of Behavioral Health to understand necessary time frames. ▪ Deb Murr noted there was a point in previous minutes about telehealth completion rates and inquired if PNM does any type of auditing on telehealth as far as if there's an issue with compliance and Members being seen. James Winfrey advised PNM does not. o Access Grievance Review: The Plan has 319 access grievances found in favor of the member in Q1 2024, for a total of 36 grievances for every 1,000 members. ▪ During discussion of Access Grievance Review Traco Matthews observed grievances found in favor of the Enrollee are in line with previous quarters despite total access grievance increase. James Winfrey explained Technology/Telephone grievances are considered access grievances, but are not appointment availability concerns. ▪ Traco Matthews inquired if PNM can consider adding average distance to providers in each region to report. James		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Winfrey discussed possibility and will review. ○ 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. ▪ In Q1 2024, the Plan submitted 343 AAS requests to DHCS. In Q3 2024, DHCS informed the Plan that 225 AAS requests approved, 52 were denied, and 66 were no longer needed after the DHCS completed their review. The Plan reviewed the denied AAS and identified inconsistencies with the DHCS's denials and arranged a meeting with the DHCS to review. During the meeting, the DHCS acknowledged that they had denied multiple AAS in error, as the Plan either was within time or distance standards or was contracted with the nearest provider. On September 3, 2024, the Plan resubmitted the remaining denied AAS requests to DHCS for further review. ▪ James Winfrey discussed the regulatory standards for time and distance that the Plan must meet. He raised the question of whether the Plan should consider exploring tighter standards or monitoring additional specialties. Traco Matthews, James Winfrey and Deb Murr discussed reviewing aspirational standards. ○ Network Adequacy & Provider Counts: ▪ FTE PCP ratio at 1:1544 ▪ FTE Physician ratio 1:260 ▪ PCP Accepting new members: 87% ▪ NPMH accepting new members: 95% ▪ NPMH locations accepting new members: 87% ▪ PCP Count: 491 ▪ Specialist Provider Count: 3110 ▪ Mental Health Provider Count: 173		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	▪ Deb Murr and Greg Panero discussed what type of providers are included in the calculations and how they are calculated. ▪ Traco Matthews and James Winfrey discussed provider recruitment efforts. o Significant Network Change: In Q3 2024, the Plan submitted a new significant network change filing on September 20, 2024. ▪ During the Q2 2024 EQIHEC meeting a committee member raised concerns regarding access to OB/GYN services in the eastern part the Plan's Service Area. The Plan is contracted with 11 unique OB/GYN providers across 8 locations in the East Kern area. The Plan conducted an informal appointment availability survey/accessibility discussion and found that for providers that responded, appointments were available within the regulatory access standard. The Plan has directed recruitment and contracting efforts to identify and expand the OB/GYN network within this area, including Antelope Valley Hospital as many providers within this area perform deliveries at this hospital. Historically Antelope Valley Hospital has refused to contract with the Plan. ▪ Greg Panero added that as of December 1st, 2024, Ridgecrest Regional Hospital is reopening its labor and delivery department which will provide some access relief for OBGYN services in the East Kern area. o DHCS Quarterly Monitoring Report/Response Template (QMRT): In Q3 2024, the plan provided a response to DHCS QMRT for Q2 2024 data. The plan did not identify any areas of concern as the Plan's results were in line with statewide results.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	**Open Forum** - No items.	☑ **CLOSED**: Informational only.	*10/18/24*
NEXT MEETING	Next meeting will be held Friday, January 17, 2024.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 12:03 PM. ***Respectfully submitted: James Winfrey; Deputy Director of Provider Network Management***	**N/A**	*N/A*

For Signature Only – AADVOC Minutes 10/18/24

The foregoing minutes were APPROVED AS PRESENTED on: 12/3/2024 (Date) James Winfrey (Name)

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

COMMITTEE: **DRUG UTILIZATION REVIEW (DUR) COMMITTEE**
DATE OF MEETING: **SEPTEMBER 30, 2024**
CALL TO ORDER: **6:36 P.M. BY MARTHA TASINGA, MD - CHAIR**

Members Present On-Site:	Alison Bell, PharmD – Network Provider, Geriatrics Kimberly Hoffmann, Pharm D. - Pharmacist and BOD Member	Sarabjeet Singh, MD - Network Provider, Cardiology Martha Tasinga, MD – KHS Chief Medical Officer Bruce Wearda, RPh – KHS Director of Pharmacy	
Members Virtual Remote:	James "Patrick" Person, RPh – Network Provider Abdolreza Saadabadi, MD – Network Provider, Psy.D.		
Members Excused=E Absent=A	Dilbaugh Gehlawat, MD – Pediatrician - E Vasanthi Srinivas, MD – Network Provider, OB/GYN - E Joseph Tran, MD – Network Provider – A		
Staff Present:	Amy Daniel, KHS Executive Health Svcs Coordinator Christina Kelly, Pharmacy Supervisor	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**: Kimberly Hoffmann moved to approve minutes of June 24, 2024, seconded by Alison Bell. 7 approved, 0 nays.	*09/30/24*
OLD BUSINESS	• Incontinent Supplies Audit	• Dr. Miller and Dr. Sidhu are still developing the verification audits to comply with our current policies. Tabled until next meeting.	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	• Biosimilar Interchangeability Bruce Wearda shared with the committee current positions from the FDA regarding biosimilars, particularly indications approved. • Deprescribing Bruce Wearda stated that the concept of describing is gaining more focus in the Managed Care and Healthcare world. Kim Hoffmann offered that deprescribing is popular in geriatrics, specifically the use of PPI's. Dr. Sarabjeet Singh also noticed potential excess use of PPI's. He suggested that more or better communication between providers may be needed. Dr. Sarabjeet Singh also suggested sending letters to the provider network. • Inflation Reduction Act (IRA) Bruce Wearda informed the committee of the first 10 drugs that will be impacted by the IRA. • Report of Plan Utilization Metrics Bruce Wearda presented the Utilization Metrics of the Plan. • Educational Articles Bruce Wearda commented there were 3 educational articles, 2 were written by DHCS, and 1 by KHS. He indicated the plan sponsored article was due to issues seen by a provider writing a prescription for NSAID's for someone with kidney disease. • DHCS/Executive Order N-01-19: Medi-Cal Bruce Wearda shared the results of the state-wide summary of all the Medicaid Managed Care CMS/DUR Reports. Kim Hoffmann commented on the rampant use of marijuana in the community. She asked about the feasibility of public service announcement warning of the danger.	• Recommended action – Dr. Tasinga stated KHS will take the possibility of the Public Announcements to the Executive Team.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	There were no topics presented during open forum.	☑ **ACTION**: N/A	*09/30/24*
NEXT MEETING	Next meeting will be held Monday, November 25, 2024 at 6:30 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned 7:32 pm.	☑ **ACTION**: Kim Hoffmann moved to adjourn the meeting. Alison Bell seconded it. 7 Ayes, 0 Nays.	*09/30/24*

Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator

For Signature Only – Drug Utilization Review Committee Minutes 09/30/24

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

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer 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) Hasmukh Amin, MD – Network Provider, Pediatrics (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

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 minutes for approval.	☑ **ACTION**: Dr. Parmar moved to approve minutes of June 5, 2024, seconded by Dr. Gevorgyan. Motion carried.	*8/7/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Peer Review Reports **CREDENTIALING REPORT** **Mental Health Pre-Approvals from 6/28/24 & 8/01/24:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on 6/28/2024 and 8/1/2024 Credentialing Report, all files met 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 **8/07/2024.** The clean files were accepted as presented with no additional discussion. There were (5) initial applications presented for comprehensive review. • [redacted]	☑ **ACTION**: Dr. Patel moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated July 28, 2024, August 1, 2024 and August 7, 2024, seconded by Dr. Parmar. Motion carried.	*8/7/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted] **RECREDENTIALING REPORT** **Recredentialing Providers List Dated 8/07/2024.** Recredentialing files 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: [redacted]		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated August 7 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 adverse events or disciplinary monitoring reported for June and July 2024. Current monthly monitoring report that includes licensing disciplinary issues, adverse events or sanctioned/excluded providers did not have any newly added providers to report to the committee.	☑ **ACTION**: Monthly Monitoring accepted as presented. Providers will continue to be monitored monthly with any additional reporting to the committee as it is received.	*8/7/2024*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OLD BUSINESS	**Delegated Credentialing 2024 Audit Summary – Opportunity for Improments and/or Corrective Actions** **ConferMED** (E-Consults Peer to Peer) Last month, Yolanda H. reported the annual oversight and opportunity for improvement submitted by ConferMed. As part of the annual oversight, Yolanda H. inadvertently missed reporting that ConferMed did provide evidence of compliance for their Credentialing System Controls for 2023 and 1st Quarter 2024 all of which was received and reviewed by Credentialing during annual oversight audit. There were no opportunity for improvement and no unauthorized modifications reported.	☑ **ACTION**: Delegation Update for ConferMed was accepted as presented. Committee members had no further discussion or recommendations.	*8/7/24*
	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 Dr. Tasinga informed the members that legal has reviewed the request by KM to utilize Advanced Practice Pharmacist (APP) as a new provider type in their diabetes program, hypertension clinic, HIV, smoking cessation and for ordering retinal exams. As previously reported Dr. Tasinga did not find any other sister plan utilizing APPs. DSR's short answer to KHS' questions, stated that they could not find anything that lists specific CPT codes an APh can bill for. The specific CPT codes Kern Medical ("KM") proposes appear to fall within an APh's scope of practice, but would defer the KHS clinical team for that determination.	☐ **PENDING**: Dr. Tasinga will take DSR Analysis under further review and bring back for discussion at next meeting.	*Pending*
NEW BUSINESS	**UM Prior Authorization (PA) / No Prior Authorization (NPA)** Dr. Tasinga, informed the members that KHS UM Department is currently in process of making significant revisions to the KHS PA/NPA Criteria. Under the purview of the UM responsibilities to review over and under-utilization, the State does not prescribe the criteria to be listed, but rather the health plan is allowed to develop their own criteria. During this review, the KHS Clinical Team have reviewed numerous coding and claims to determine any overage of	☑ **INFORMATIONAL**: Received as information – no action required.	*8/7/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	procedures. After review over 8,000 codes, the clinical team determined the following: • Removed those codes KHS would typically not deny • Added those codes KHS considered high probability of denying, requiring review • Removed those codes not required to be on the list • Adding those codes being used excessively • Adding some codes never used in order to allow the clinical team to review upon receipt and make adjustments accordingly Dr. Tasinga informed the members that a complete overhaul of the PA List has been done and will announce to the provider network once it is completed and available. An additional review will be done after 6-months to determine any necessary adjustments from the State.		
OPEN FORUM	**Grievance Process** Committee member, Dr. Gehar Gevorgyan, requested insight on the KHS Grievance Process to fully understand the grievance numbers reported during recredentialing. Additionally, the process appears to report those grievances (questions/non-formal complaints) by members that do not rise to the provider's level for explanation (previously non-exempt cases). After a few verifications with some of her patients, it was discovered that they did not file a formal complaint but rather called Member Services with follow-up questions. Dr. Tasinga provided further explanation that it is the State's expectation that all complaints, even those submitted as questions or non-formal, must all be reported in the same manner. There is a technical guide and All Plan Letter outlining this process that will be sent to the committee members for review that may help our providers better understand this process and it's requirements.	☑ **CLOSED** – Informational Only	*N/A*
	Behavioral Health Services (Teleremote vs In-Person) Committee member, Dr. Gehar Gevorgyan, requested information on the process for scheduling behavioral health services and if there is a way that the provider can request these services be in-person rather than teleremote. Dr. Gevorgyan reports that there has been several occasions that a	☑ **CLOSED** – Informational Only	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	referral is made to the behavioral health number and the member never receives a return call. Dr. Tasinga, informed the Committee Members that KHS conducts several audits for services conducted via telehealth/teleremote to ensure the appropriate services have been rendered. Some findings have been identified that the telehealth service did not meet the level of a telehealth visit and those affected providers are receiving education. Currently, telehealth is an industry standard that has evolved since COVID and many providers only provide services via teleremote. Members are given the option to have services in-person or via teleremote and KHS Member Services can assist with this process. Dr. Tasinga also reported that our Behavioral Health Department is in its infancy stage; however, it is growing and working diligently to build a successful program for the needs of our members. Dr. Saadabadi, KHS Behavioral Health Medical Director, further informed the committee that telehealth has been successful in some non-verbal members and his department is working to develop tools and resources to help our providers deliver appropriate services.		
NEXT MEETING	Next meeting will be held Wednesday, September 4, 2024	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:23 A< **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: ***SEPTEMBER 4, 2024***
CALL TO ORDER: ***7:06 AM BY MARTHA TASINGA, MD - CHAIR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Hasmukh Amin, MD – Network Provider, Pediatrics Gohar Gevorgyan, MD – Network Provider, FP	Miguel Lascano – Network Provider, OB/GYN Ashok Parmar, MD– Network Provider, Pain Medicine	
Members Virtual Remote:	David Hair, MD - Network Provider, Ophthalmology		
Members Excused=E Absent=A	Atul Aggarwal, MD – Network Provider, Cardiology (E)	Raju Patel, MD - Network Provider, Internal Medicine (E)	
Staff Present:	Alan Avery, Chief Operating Office Michelle Curioso, Director of PHM 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. (REMOTE) 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 7:06 am.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. Tasinga presented the meeting minutes for approval.	☑ **ACTION**: Dr. Parmar moved to approve minutes of September 4, 2024, seconded by Dr. Amin. Motion carried.	*9/4/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Peer Review Reports **CREDENTIALING REPORT** **Mental Health Pre-Approvals from -Report dated 9/4/2024:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on **9/04/2024** Credentialing Report, all files met 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 **9/04/2024.** The clean files were accepted as presented with no additional discussion. There were (5) initial applications presented for comprehensive review. • [redacted]	☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated September 4, 2024, seconded by Dr. Parmar [redacted] Motion carried.	*9/4/24* *Pending PRV001841*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted] **RECREDENTIALING REPORT** **Recredentialing Providers List Dated 9/04/2024.** Recredentialing files meeting clean file review were accepted as presented with no additional questions or alternative actions. [redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated September 4, 2024 were accepted as presented with no additional questions or comments by the committee members.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS: There were no adverse events or disciplinary monitoring reported for August 2024. Current monthly monitoring report that includes licensing disciplinary issues, adverse events or sanctioned/excluded providers did not have any newly added providers to report to the committee.	☑ **ACTION**: Monthly Monitoring accepted as presented. Providers will continue to be monitored monthly with any additional reporting to the committee as it is received.	*n/a*
	Delegated Credentialing 2024 1st & 2nd 2024 - Quarter Oversight Reports Yolanda Herrera KHS Credentialing Manager informed the committee that the 1st and 2nd Quarter Delegated Oversight Reports have all been received and reviewed for CHLA Medical Group, ConferMED, Valley Children's ChildNet, Vision Services Plan, UCLA Medical Group and USC Medical Group. During 1st Quarter and 2nd Quarter 2024, delegates reported Credentialing Committee dates for initial credentialing, recredentialing and terminations. **There were no identified issues.** **Semi-Annual Rosters** were also submitted with no significant changes in network participation.	☑ **ACTION**: Dr. Amin moved to approve 1st and 2nd 2024 Quarter Oversight Reports for delegated credentialing groups. Motion carried.	*9/4/24*
OLD BUSINESS	**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 Dr. Tasinga informed the members that she has reviewed the analysis from legal and although other health plans don't have Advanced Practice Pharmacists, it is reasonable and within their scope of practice to provide services in the diabetes program, hypertension clinic, HIV, smoking cessation and for ordering retinal exams as requested. Having the responsibility of mitigating risk to the organization, Dr. Tasinga recommended a 1-year approval of KM's requested program with a medical record review to determine the program is improving	☑**ACTION**: Dr. Tasinga moved to approve 1-year approval of KM's Advanced Practice Pharmacist to participate in their diabetes program, hypertension clinic, HIV, smoking cessation and for ordering retinal exams as requested with a medical record review after 1-year. Dr. Amin Seconded. Motion carried.	*09/2025*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	MCAS scores and patient compliance with the implementation of this program. Only those pharmacist with the Advanced Practice Pharmacy license will be permitted to render care and services outlined in the KM's hypertension, retinal exam, blood pressure and smoking cessation programs.		
NEW BUSINESS	**Transcranial Magnetic Stimulation** Dr. Tasinga, informed the members that DHCS has approved Transcranial Magnetic Stimulation as a covered benefit; however, there are certain guidelines and criteria that the member must meet prior to being approved for this procedure. Dr. Tasinga informed the members that she will review the extensive criteria with the UM Directors on the requirements for medical necessity.	☑ **INFORMATIONAL**: Received as information – no action required.	*9/4/2024*
	New QP-Credentialing Policy and Procedure Ongoing Monitoring and Sanction Activity Review Yolanda Herrera, KHS Credentialing Manager, presented the New Policy regarding Ongoing Monitoring and Sanction Activity Review. This policy outlines the process to ensure all contracted providers are absent from being identified as ineligible, suspended, sanctioned, debarred, excluded, restricted or opted out of Federal and State Programs. Those providers that appear on any Federal or State list will be subjection to immediate termination in accordance with contractual agreement.	☑ **ACTION**: Dr. Parmar moved to approve the New Policy on Ongoing Monitoring and Sanction Activity Review. Dr. Amin seconded. Motion carried.	*9/4/2024*
	IV Iron Criteria (Pharmacy) Bruce Wearda, Director of Pharmacy presented the KHS IV Iron Criteria when medically necessary following he criteria outlined in the guidelines are met. ommittee member, Dr. Gehar Gevorgyan	☑ **ACTION**: Dr. Gevorgyan moved to approve the New Policy on Ongoing Monitoring and Sanction Activity Review. Dr. Lascano seconded. Motion carried.	*9/4/2024*
OPEN FORUM	No additional items or discussion topics were presented.	☑ **CLOSED** – Informational Only	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, October 2, 2024	Informational only.	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
ADJOURNMENT	The Committee adjourned at 8:03 am **Respectfully submitted: Yolanda Herrera, KHS Credentialing Manager, in the absence of Amy Daniel.**	**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: ***SEPTEMBER 4, 2024***
CALL TO ORDER: ***11:03 AM BY SUKHPREET SIDHU, MD - CHAIR***

Members Present On-Site:	Maria Bermudez, Asst. Director at Dept. of Human Services Babita Datta, MD OB/GYN at Wasco Medical Plaza Paula De La Riva-Barrera, Manager at First 5 Kern	Lito Morillo, Executive Director at KC Human Services Ashok Parmar MD, Pain Mgmt. Cody Rasmussen, Administrator at Height Street SNF	Curt Williams, Director Homeless/Foster at KCSOS
Members Virtual Remote:	Lordes Bucher, Administrator at KCSOS Minty Dillon, Administrator at Premier Valley Medical Grp	Jasmine Ochoa, Manager at KC Public Health Colleen Philley, Program Director at KC Aging & Adult Martin Reynoso, Supervisor at KC Aging & Adult	
Members Excused=E Absent=A	Christopher Boyd, Licensed Clinical Psychologist (E) Brynn Carrigan, Director at KC Public Health (E) Cristina Castro, Recovery Specialist at KCBHRS (E) Valerie Civelli, MD at LTC Premier Valley Med. Group (E) Babita Datta, MD OB/GYN at Wasco Medical Plaza (E) Dixie Denmark-Speer, SS Director at Height Street SNF (E)	Desiree Escobedo, Admissions at Height Street SNF (E) Laura Hasting, NP at Priority Urgent Care (E) Kristine Khuu, Assistant Director at Kern Regional Ctr. (E) Gina Lascon, DON at Delano SNF (E) Alissa Lopez, Administrator at KCBHRS (E)	Celia Pinai, Kern Regional Center (E) Vivek Radhakrishan, MD Primary Care @ Premier (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 Julia Davis, PHM Case Management Social Worker Shellby Dumlao, Special Programs Nurse Consultant Pawan Gill, Health Equity Manager Rubi Gonzalez, Case Management Assistant	Russell Hasting, PHM Manager of CM Magdee Hugais, KHS Director of QI Maninder Khalsa, MD UM Medical Director 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	Christine Pence, Senior Director of Health Services Nate Scott, Senior Director of Member Services Melinda Santiago, Director of Behavioral Health Sukhpreet Sidhu, MD PHM Medical Director Elliott Smith, PHM Outreach Specialist Katelyn Smith, RN PHM Case Manager Ty Williams, PHM Outreach Specialist

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Sukhpreet Sidhu, MD, KHS PHM Medical Director called the meeting to order at 11:03 AM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of June 5, 2024 were presented for review and	☑ **ACTION**: Curt Williams moved to approve minutes of June 5, 2024, seconded by Dr. Babita Datta. Motion carried.	*09/04/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	approval.		
OLD BUSINESS	There was no old business to present	N/A	N/A
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Members and KHS Staff introduced themselves and from the facility/organization they are representing.	☑ **CLOSED**: Informational discussion only.	*09/04/24*
	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.	*09/04/24*
	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	☑ **ACTION**: Lordes Bucher moved to approve the Long-Term Care Quality Assessment Report, seconded by Dr. Ashok Parmar. Motion carried.	*09/04/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	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. 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	☑ **ACTION**: Paula De La Riva-Barrera moved to approve the Palliative Care Report, seconded by Dr. Ashok Parmar. Motion carried.	*09/04/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	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. 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.	*09/04/24*
	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	☑ **CLOSED**: Informational discussion only.	*09/04/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	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 PHM can best provide assistance.		
OPEN FORUM	**Open Forum** No additional items presented for discussion.	☑ **CLOSED**: Informational discussion only.	*09/04/24*
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 09/04/24

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: ***SEPTEMBER 11, 2024***
CALL TO ORDER: ***12:02 PM BY MANINDER KHALSA, MD, UM MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Ashok Parmar, MD –Specialist Pain Medicine	Karan Srivastava MD – Specialist Orthopedics	
Members Virtual Remote:	Maninder Khalsa, MD – KHS UM Medical Director Eural Gordon, FNP, PA-C – Nurse Practitioner	Parikshat Sharma, MD – Outpatient Specialist	
Members Excused=E Absent=A		Philipp Melendez, MD – OB/GYN (E)	
Staff Present:	Linda Corbin, KHS Health Services Consultant (Remote) Kulwant Kaur, UM Outpt Clinical Manager Yolanda Herrera, Credentialing Manager Magdee Hugais, Director of Quality Improvement	Loni Hill-Pirtle, Director of Enhanced Case Mgmt John Miller, MD, QI Medical Director Christine Pence, Sr. Director for Health Services 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 12:02 PM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of June 12, 2024 were presented for review and approval.	☑ **ACTION**: Dr. Sharma moved to approve minutes of June 12, 2024, seconded by Dr. Patel. Motion carried.	N/A
OLD BUSINESS	There was no old business to present	N/A	N/A
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Dr. Khalsa welcomed the members of UM Committee meeting new members Eural Gordon, FNP, PA-C and Karan Srivastava, MD.	☑ **CLOSED**: Informational only.	*9/11/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	PA List Revisions Dr. Khalsa informed the committee that the Prior Authorization List (PA List) has gone through significant revision based on recommendations by KHS CEO Emily Duran as well as internal review by UM Management to reduce the number of services being requested through the PA process. Auto-approvals will still require referral for claims payment and certain services if approved based on medical record review. Members discussed some discrepancies such as knee replacement no authorization required but hip replacement requires authorization. Dr. Khalsa informed the members that is the kind of clean up being done to determine what services truly require review of either medical record review or medical necessity. Most all UM Management are relatively new and don't have the history behind why some services were still on the list. UM Management is working diligently to try and remedy this process and taking advisement from our vendors to have a complete list. The list will be posted in the Provider Portal upon completion.	☑ **ACTION**: No action necessary at this time.	*9/11/24*
	UM Report 2nd Quarter 2024 Dr. Khalsa presented the 2nd Quarter 2024 UM Report. The following highlights were noted: • UM Timeliness of Decisions – there was a slight decrease in timeliness of urgent auths. Dr. Khalsa reported this was due to several staffing issues that are being remedied by utilizing supplemental staff. • Outpatient Referrals – with the addition of 55,000 members the data reflects an increase in referrals and efforts are being made to streamline the staff and process to assist. • Adult Referrals – remain consistent in comparison to past quarters. • CSS Referrals – with the assistance of CSS Support Services there has been as steady increase of referrals linking members to available resources to address various social determinants. • ECM Referrals – also part of the CalAim initiatives focusing on the non-medical issues such as home assistance, food etc.to assist members in these deficiencies.	☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members.	*9/11/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Major Organ Transplant Referrals – most of KHS organ transplants go to USC or UCLA with liver and kidney transplants being the most consistent. Of interest, there was an ischemic bowel transplant. KHS has 2-transplant coordinators that support our transplant members to ensure they have continued support pre and post surgery which has proven to decrease readmissions. • Referral Compliance – KHS remains compliant with the referral process, however, of the noted delays these were attributed to medical record requests and efforts are being made to streamline this effort in increase the turn around times. • Monthly Inpatient LOS – data does not include out of area hospitals such as USC, UCLA or Ridgecrest and UM is working to obtain this data. There was a slight decrease in local inpatient LOS. • Tertiary, SNF and Rehab Monthly Averages – KHS makes every effort to seek services within the community; however, higher level of care is required in some cases where provider type and specialized services are not available locally. • Denial Percentages – KHS remains consistent in comparison with other similar health plans at 3-4% denials.		
	<u>UM Policy and Procedure Review</u> Christine Pence presented the following UM Policy and procedures submitted with revisions due to regulatory updates, accreditation updates as well as current practice updates: • Policy 3.05-P Preventive Medical Care • Policy 3.06-P Dental Services • Policy 3.12 Urgent Care Services • Policy 3.13-P EPDST Supplemental Services and Targeted Case Management • Policy 3.16-P California Children Services • Policy 3.31-P Emergency Services • Policy 3.33-P Admission Discharge Notification and Authorization • Policy 3.36 Asthma Treatment and Management • Policy 3.40-P Continuity of Care for New Members • Policy 3.54 Diabetes Treatment and Management • Policy 3.55-I Coordination of Care for Out of Network • Policy 3.56-P Services for Children with Special Healthcare Needs • Policy 3.91-P Long Term Care Services Program • Policy 3.93-P 2024 MCP Continuity of Care	☑ **ACTION**: Dr. Parmar moved to approve revisions to P&P #3.05, 3.06, 3.12, 3.13, 3.16, 3.31, 3.33, 3.36, 3.40, 3.54, 3.55, 3.56, 3.91 and 3.93, seconded by Dr. Sharma. Motion carried.	*9/11/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	**Open Forum** There were no further open items presented for discussion or comment by the committee members.	☑ **CLOSED**: Informational discussion only.	*9/11/24*
NEXT MEETING	Next meeting will be held Wednesday, December 11, 2024 at 12:00 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 12:32 PM ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Utilization Management Committee Minutes 09/11/24

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

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

KERN HEALTH SYSTEMS

COMMITTEE: ***QUALITY IMPROVEMENT WORKGROUP***
DATE OF MEETING: ***SEPTEMBER 26, 2024***
CALL TO ORDER: ***12:10 PM BY JOHN MILLER, MD, QI MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Dr. John Paul Miller, KHS QI Medical Director, Chair Danielle Colayco, PharmD, Executive Director Komoto		
Members Virtual Remote:	Carmelita Magno, Kern Medical Process Improvement Dir.		
Members Excused=E Absent=A	Irving Ayala-Rodriguez, MD, CMO of CSV (E) Mansukh Ghadiya, MD Family Medicine (E) Joseph Hayes, MD, CMO of Omni Family Health (E)	Michael Komin, MD, Shafter Family Medicine (E)	
Staff Present:	Kailey Collier, RN, Director of Quality Performance Michelle Curioso, Director of PHM Amy Daniel, Executive Health Services Coordinator Dan Diaz, RN, ECM Clinical Manager Mary Jane Dimaano, QI RN I Alma Garcia, NCQA Accreditation Specialist	Pawan Gill, Health Equity Manager Loni Hill-Pirtle, Director of Enhanced Case Mgmt Magdee Hugais, Director of QI Steven Kinnison, NCQA Manager Greg Panero, Provider Network Analytics Program Mgr. Kalpna Patel, RN QI Supervisor	Steve Pocasangre, NCQA Accreditation Specialist Melinda Santiago, Director of Behavioral Health Isabel Silva, Director of Health & Wellness James Winfrey, Deputy Director of Provider Network

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were not met.	N/A
Call to Order	Dr. John Paul Miller, KHS QI Medical Director called the meeting to order at 12:10 PM.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. John Miller, presented the last meeting minutes for approval.	☐ **TABLED**: Due to lack of quorum, the minutes of June 27, 2024 will be presented to the next meeting for approval.	*Pending*
OLD BUSINESS	**Assessment On Mother when Child Established as Patient**	☐ **TABLED**: Due to lack of quorum, we will discuss this at the next meeting.	*Pending*
NEW BUSINESS	**Quality & Safety of Clinical Care** **MCAS** John Miller, MD, QI Medical Director, reviewed with the committee	☑ **CLOSED**: Informational discussion only.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	the importance of the MCAS measures and performance over the last few years. MCAS MY2022 versus MY2023 have shown 16 or 18 measures showing improvement compared to previous year. The future state of these goals is to make a collaborative effort across the health plan, providers and ad hoc groups to further address rates, challenges and barriers. Additionally, Kailey Collier stated more efforts and initiatives will be directed towards provider collaborations, mobile units targeting and partnering with school districts, and adding member engagement efforts through technology campaigns like text messing and robocalls for scheduling appointments.		*9/26/24*
	PIPs Kailey Collier presented the Performance Improvement Projects which currently began August 2023 and will run through 2026. The main focus on Health Equity and non-clinical PIP specific to PUA and FUM measures with reliance on BH and BI support.	☑ **CLOSED**: Informational discussion only.	*9/26/24*
	FSR/PARs/Medical Records Kailey Collier presented the Site Review information completed in Quarter 2 2024: • 4-Initial Site Reviews and 3-Medical Record Reviews • 5-Periodic Site Reviews and 5 -Medical Record Reviews • 100% Passed Site Reviews and 85% YTD MRRs passed • 2-sites failed the initial Review with CAPS completed closed • 5-Physical Accessibility Reviews completed	☑ **CLOSED**: Informational discussion only.	*9/26/24*
	QOC Grievances and PQIs Kailey Collier presented the KHS Grievance Potential Quality Issues for Quarter 2 2024: • 490-Grievances Closed as QOCs • 2543-Grievances Closed as Non-QOCs • 3033-Total Grievances Closed The QI RNs classify grievances received as Potential QOC for further review or send back to Grievance coordinators as non-PQOC. Grievances classified as Potential QOC are reviewed and can be closed in favor of the member and referred to the QI Department for further investigation as a Potential Quality Issue (PQI). Potential QOC grievances resolved in favor of the provider are not referred to QI, as this resolution means there was no QOC concern identified to warrant further investigation.	☑ **CLOSED**: Informational discussion only.	*9/26/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	PQI-Potential Quality Issues Kailey Collier presented the KHS Grievance Potential Quality Issues for Quarter 2 2024: • 162 – PQIs Reviewed • 85-assigned as No Quality Concern • 75-assigned Potential harm • 2-assigned Actual Harm		
	Provider Engagement / Provider Satisfaction Greg Panero presented the KHS Provider Satisfaction 2024 Responses. Many of the satisfaction scores have significantly increased between 2023 and 2024: • Overall Satisfaction 90% • Would Recommend 98.8% (increased from 98.3) • Coordination of Care increased to 53.1%	☑ **CLOSED**: Informational/discussion only.	*9/26/24*
	NCQA Accreditation Steven Kinnison presented the 2024 NCQ Readiness Project Status Report. Some key accomplishments included: • HPA projected points now at 83% overall • All DP & M for HEA scored MET • HEA points increased from 50% to 56% • PHM CCM Mock Review passed For HPA, each Workstream needs to achieve a passing score of 80% in order to attain Accreditation. For HEA, workstreams will need to pass overall with a score of 80%. Continued efforts on evidence reconciliation and progress readiness will be the focus, including bookmarking and annotating final documents for the audit.	☑ **CLOSED**: Informational/discussion only.	*9/26/24*
	QI Policies Review of the QI Policies were tabled due to the lack of quorum and will be presented at the next meeting.	☐ **TABLED**: Due to lack of quorum, we will discuss this at the next meeting.	*Pending*
	QI Workplan Review of the QI Workplan were tabled due to the lack of quorum and will be presented at the next meeting.	☐ **TABLED**: Due to lack of quorum, we will discuss this at the next meeting.	*Pending*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Workplan Scorecard – Q2 Review of the QI Scorecard were tabled due to the lack of quorum and will be presented at the next meeting. **ECM Q2 EQIHEC/Quality Improvement Report** Review of the ECM Q2 report was tabled due to lack of quorum and will be presented by Dan Diaz, RN at the next meeting.	☐ **TABLED**	*Pending* *Pending*
OPEN FORUM	**Open Forum** No additional questions or issues were presented for open forum.	☑ **CLOSED**: Informational only.	*9/26/24*
NEXT MEETING	Next meeting will be held Wednesday, December 12, 2024 at 12:00 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 12:58 PM ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Quality Improvement Committee Minutes 09/26/24

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

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

To: KHS EQIHEC

From: Melinda Santiago, Director of Behavioral Health

Date: December 12, 2024

Re: Behavioral Health Advisory Committee (BHAC)

Background:

KHS has formed a Behavioral Health Advisory Committee to help us enhance the Behavioral Health services for our members. Subcommittee that is comprised of behavioral health practitioners. The committee will support, review, and evaluate interventions to promote collaborative strategic alignment between KHS and the County Behavioral Health Plan (BHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). Kern Behavioral Health and Recovery Services (KBHRS) administers both the BHP and DMC-ODS, treating KHS members with the goal to maintain continuity, reduce barriers to access, linkage to appropriate services, opportunities to integrate care with medical care, and provide resources for members with mental illness and/or substance use disorder. This report reflects activities and outcomes for the third and fourth quarter of 2024.

Meetings Held:

- July 10, 2024 (Quarter 3)
- October 16, 2024 (Quarter 4)

Discussion Items:

- NCQA Grievance Category Report

- Quality of Clinical Care
  - MCAS/QP Report Q1
  - PIPs
- MOU with MHP

- NCQA deliverables included QI 4AB, ME 7E1, and ME 7E2.
  - The Behavioral Health Advisory Committee (BHAC) convened on October 16, 2024, to review opportunities for QI 4: Continuity and Coordination between medical care and behavioral healthcare. Report completed and submitted to TMG.
  - ME 7E1 - BH Complaints and Appeals Qualitative and Analysis Report completed and submitted to TMG.
  - ME 7E2 - BH Member Experience Survey. SPH ECHO final report delivered and submitted to TMG.

- APL 24-012 Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements. Efforts to improve access to mental health services, to reduce stigma, and increase engagement in telehealth services
    - Community Advisory Committee (CAC) Presentation on 12/10/24
    - Engaged with Tribal Liaison
    - Developing O&E Plan

Fiscal Impact:
None.

Requested Action:
Review and approve.

KERN HEALTH SYSTEMS

Melinda Santiago

Director of Behavioral Health

December 11, 2024

BEHAVIORAL HEATH PROGRAM

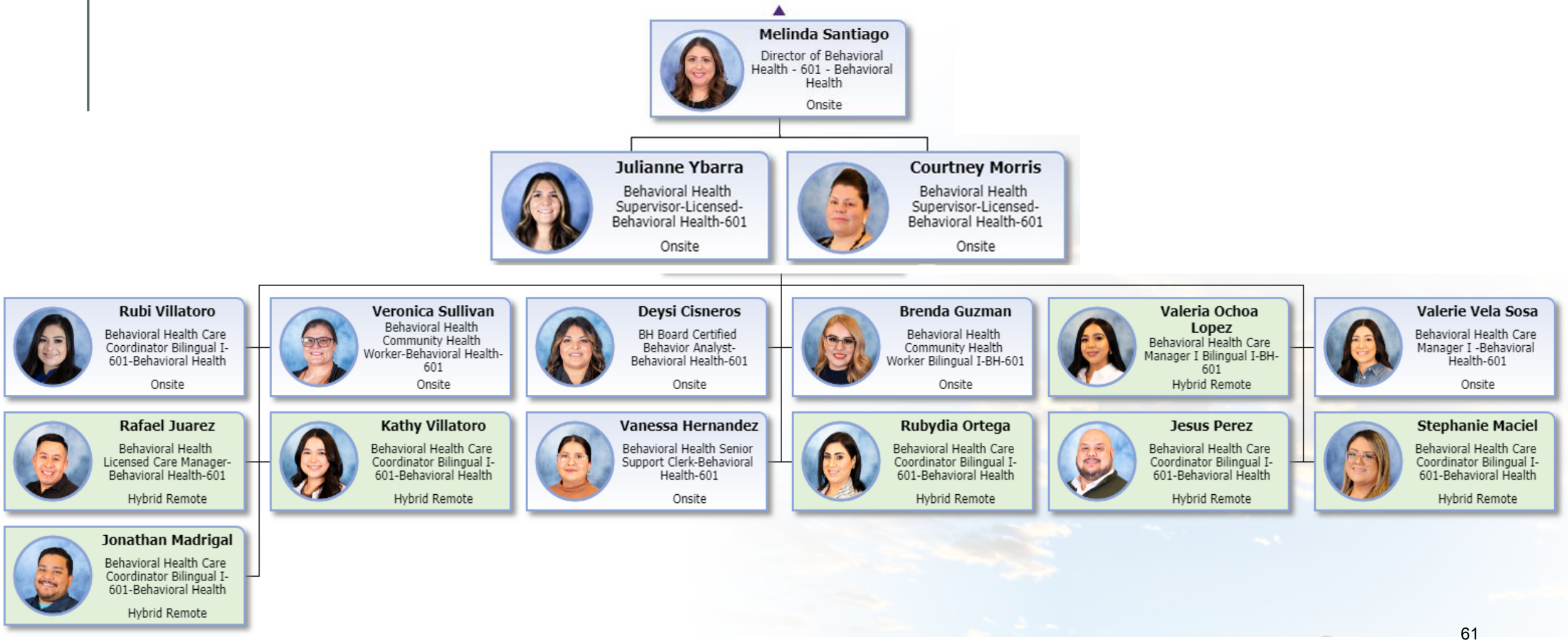
Highlights

- KHS launched the Behavioral Health Project on January 31, 2023, with the goals to improve the integration, coordination and outcomes for members experiencing behavioral and mental health conditions.

- KHS has contracts with 40+ Non-Specialty Mental Health Providers

- KHS has contracts with 40 Applied Behavior Analysis and Qualified Autism Services Providers

BH DEPARTMENT



System of Care
Managed Care Plan (MCP) and Mental Health Plan (MHP)

Kern Health Systems:
- Non-Specialty Mental Health Services

- Beneficiaries 21 years of age and over with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health(MH) disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;
- Beneficiaries under age 21, to the extent eligible for services through the Medicaid EPSDT benefit as described above, regardless of level of distress or impairment or the presence of a diagnosis;
- Beneficiaries of any age with potential mental health disorders not yet diagnosed.
- Services:
  - Mental Health Evaluation
  - Individual/group/family therapy
  - Psychiatric Medication Management

Kern Behavioral Health & Recovery Services:
- Specialty Mental Health Services

- Beneficiaries 21 years of age or older, beneficiaries has significant impairment (distress, disability, or dysfunction in areas of life functioning, or a reasonable probability of significant deterioration in important areas of life functioning.

(The condition is due to either a diagnosed MH disorder or a suspected MH disorder not yet diagnosed.)

- Beneficiaries under age 21, with condition placing them at high risk for a MH due to trauma, involvement in the child welfare system/juvenile justice system or experiencing homelessness.
- Beneficiaries has significant impairment, a reasonable probability of significant deterioration, a reasonable probability of not progressing developmentally, or a need for SMHS that are not included within the MH benefits that an MCP is required to provide.

(The condition is due to either a diagnosed MH disorder or a suspected MH disorder not yet diagnosed.)

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BH ROLES AND RESPONSIBILITIES

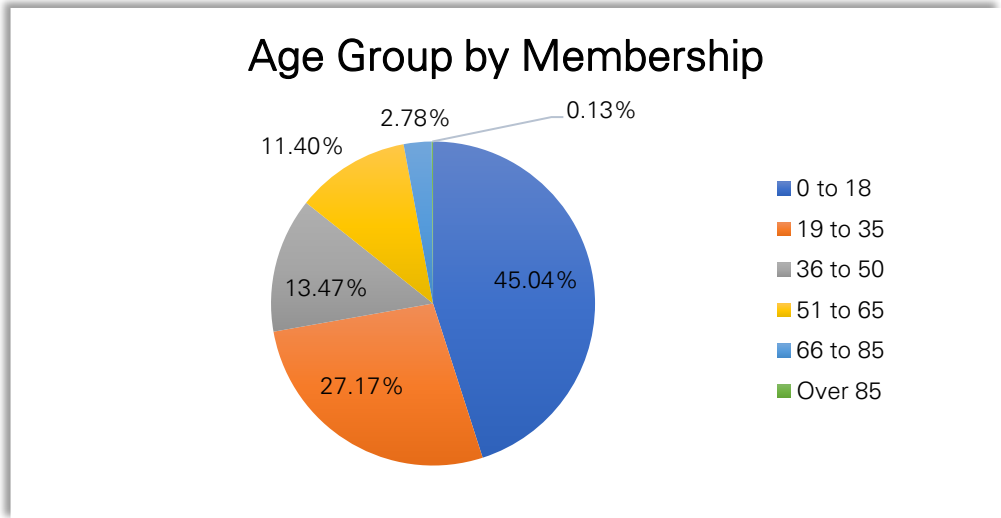
- Care Coordinators: Completes initial screening for any member requesting mental health services and refer members to the appropriate Medi-Cal mental health delivery system, outreach to members and behavioral health outpatient providers to coordinate member care.

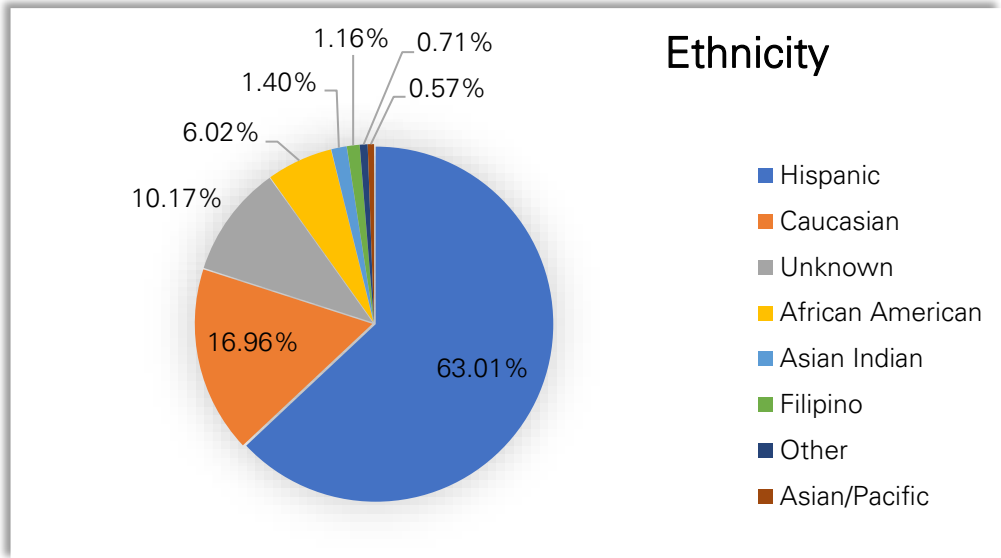
- Care Managers: Provide care management by coordinating with internal and external health partners to support Members' comprehensive care needs, evaluating the needs of complex and high-risk members referred to behavioral health and intervening to support safety.

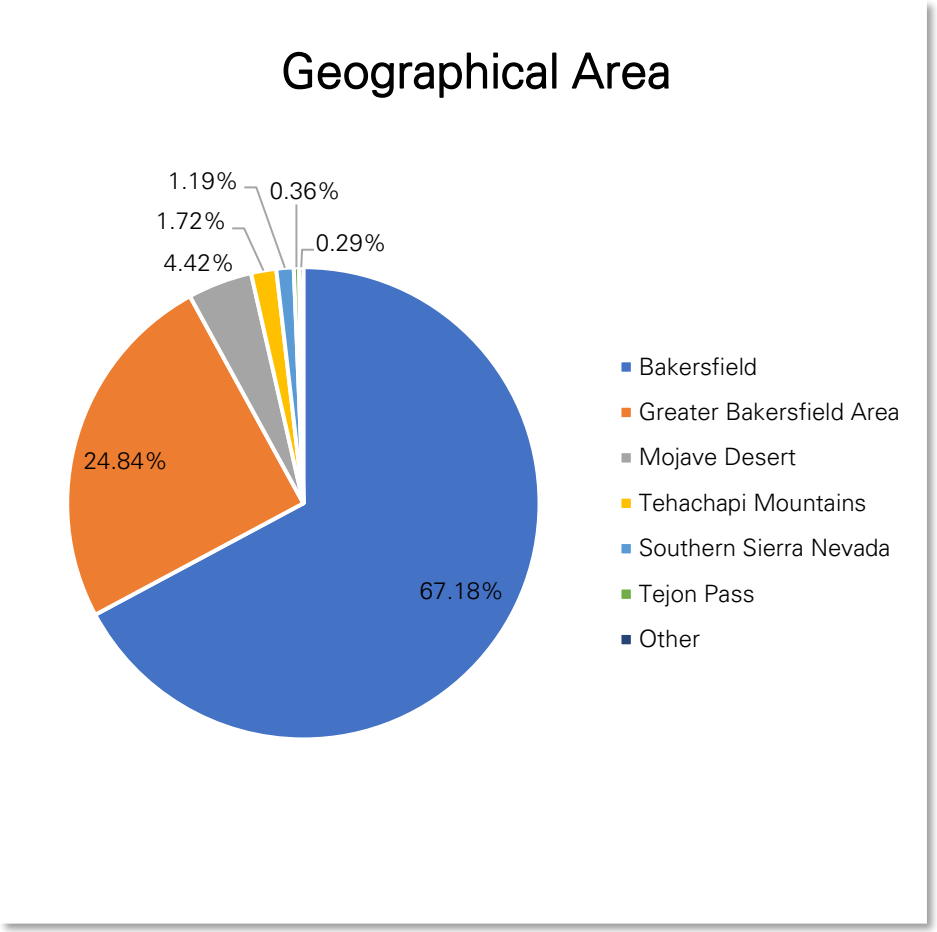
- Community Health Workers: Assisting members in a community-based setting for linkage to preventative services for behavioral health conditions, outreach to unengaged members, assist with overcoming barriers to obtaining needed behavioral health care and social services and attending appointments.

MEMBERSHIP

Serving 400,902 members throughout Kern County







Kern County Population: 913,820

KHS covers about 44% of the Kern County Population

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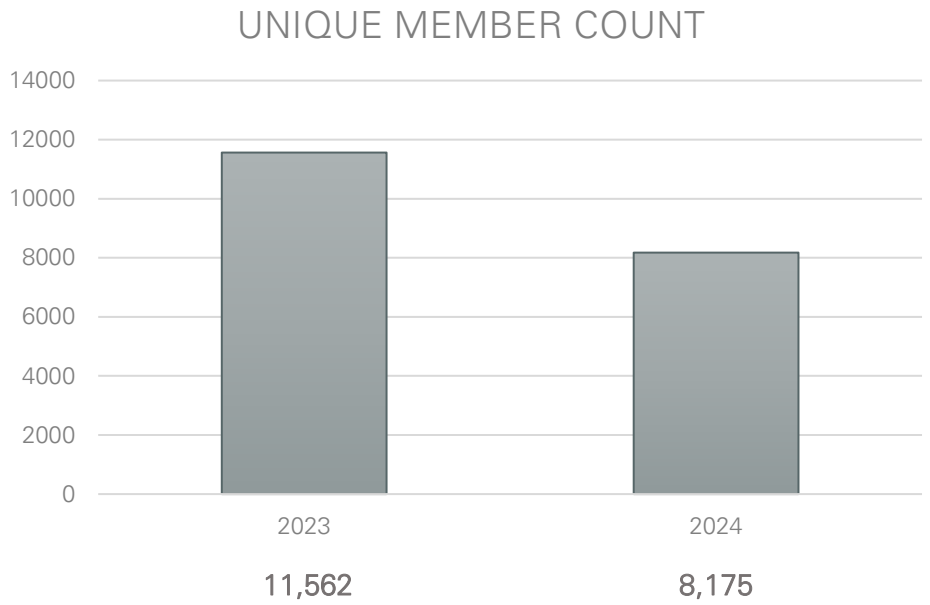
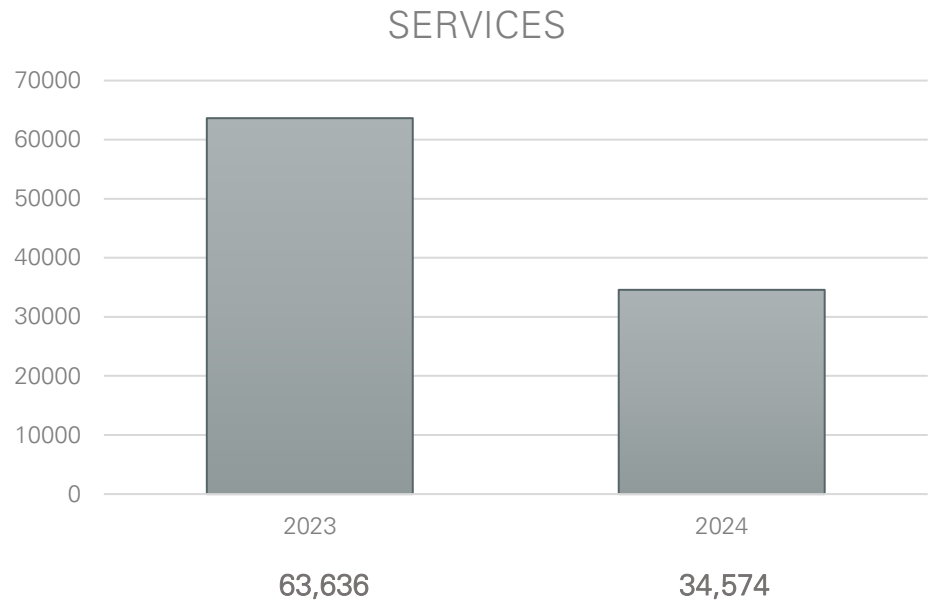
BH MEMBER STRATIFICATION

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
44,113	7,573	24,953	6,859	4,728	6.17	11.52	0.00%	0.92%	0.01%

NON-SPECIATLY MENTAL HEALTH SERVICES





CalAIM Bold Goals

KEY INITIATIVES

APL 21-004 - Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements

Senate Bill (SB) 1019 aims to address historically low utilization of Medi-Cal Non-Specialty Mental Health Services (NSMHS) services by requiring Medi-Cal managed care plans (MCPs) to develop and provide annual outreach and education plan about covered NSMHS to Members and primary care providers (PCPs). SB 1019 highlights the importance of outreach and education to help Members and PCPs better understand how to access these services.

SB 1019 aims to address these gaps in utilization by ensuring Members and primary care providers (PCPs) are aware of all covered NSMHS. SB 1019 provides a framework to address gaps in utilization by focusing on cultural and linguistic appropriateness of outreach and education materials.

The outreach and education (O&E) plan must meet cultural and linguistic appropriateness standards, incorporate best practices in stigma reduction, and provide multiple points of contact for Members to access NSMHS. The O&E plan must be based on the most recently approved population needs assessment, a utilization assessment of provided NSMHS, stratified and analyzed by race, ethnicity, language, age, sexual orientation, gender identity, and disability.

Evidence Based Best Practices

Stigma Reduction in Mental Health

- Promoting National Alliance on Mental Illness (NAMI)
  - "Say it Out Loud" Initiative
  - Peer support groups like "In our Own Voices
- Training healthcare providers
  - Mental Health First Aid (MHFA)
  - Cultural Competence Training
- Linking the platforms for personal testimonies on KHS Website
- Partnering with Kern Behavioral Health and Recovery Services
- Sponsoring community events related to behavioral health and recovery
- Use of Community Health Workers

Open Discussion

Thank You

Follow us on Social Media
Kern Family Health Care

https://www.kernfamilyhealthcare.com/

KERN HEALTH SYSTEMS

BEHAVIORAL HEALTH ADVISORY COMMITTEE (BHAC) MEETING

Wednesday, July 10, 2024
at
8:00 am

2900 Buck Owens Blvd.
Bakersfield, CA 93308
4th Floor – Executive Conference Room

For more information, call (661) 664-5000

KERN HEALTH SYSTEMS

Behavioral Health Advisory Committee (BHAC)
AGENDA – July 10, 2024

AGENDA ITEM	AGENDA TOPIC	PRESENTER	ACTION
CALL TO ORDER	Call meeting order / Attendance-Quorum	Dr. Martha Tasinga, CMO and Melinda Santiago, BH Dir	*N/A*
APPROVAL OF MINUTES	April 2024 Minutes Review, Discussion, Motion to Approve	***All Voting Members***	*Approve*
OLD BUSINESS	1. Update on Survey go live date	Melinda Santiago, BH Dir	*Informational*
NEW BUSINESS	1. NCQA Grievance Category Report 2. Quality of Clinical Care • MCAS/QP Report Q1 • PIPs 3. MOU with MHP	Melinda Santiago, BH Dir	*Informational* *Informational* *Informational*
OPEN FORUM	Open Forum / Committee Members Announcements / Discussion	***Open to all Members***	*Discussion*
NEXT MEETING	Next meeting will be held Wednesday, **October 14, 2024, at TBD**	Informational only	*N/A*
ADJOURNMENT	Meeting Adjournment	Dr. Martha Tasinga, CMO and Melinda Santiago, BH Dir	*N/A*

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

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 Svcs 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 surveys were condensed to 33 questions and Adult surveys condensed to 28 questions. All survey's were cleaned up and sent	☑ **CLOSED**: Informational discussion only	4/8/24

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	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 and 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	☑ **CLOSED**: Informational discussion only.	*3/11/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	(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 (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 8, 2024. Melinda inquired if the set day and time are still good with 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*

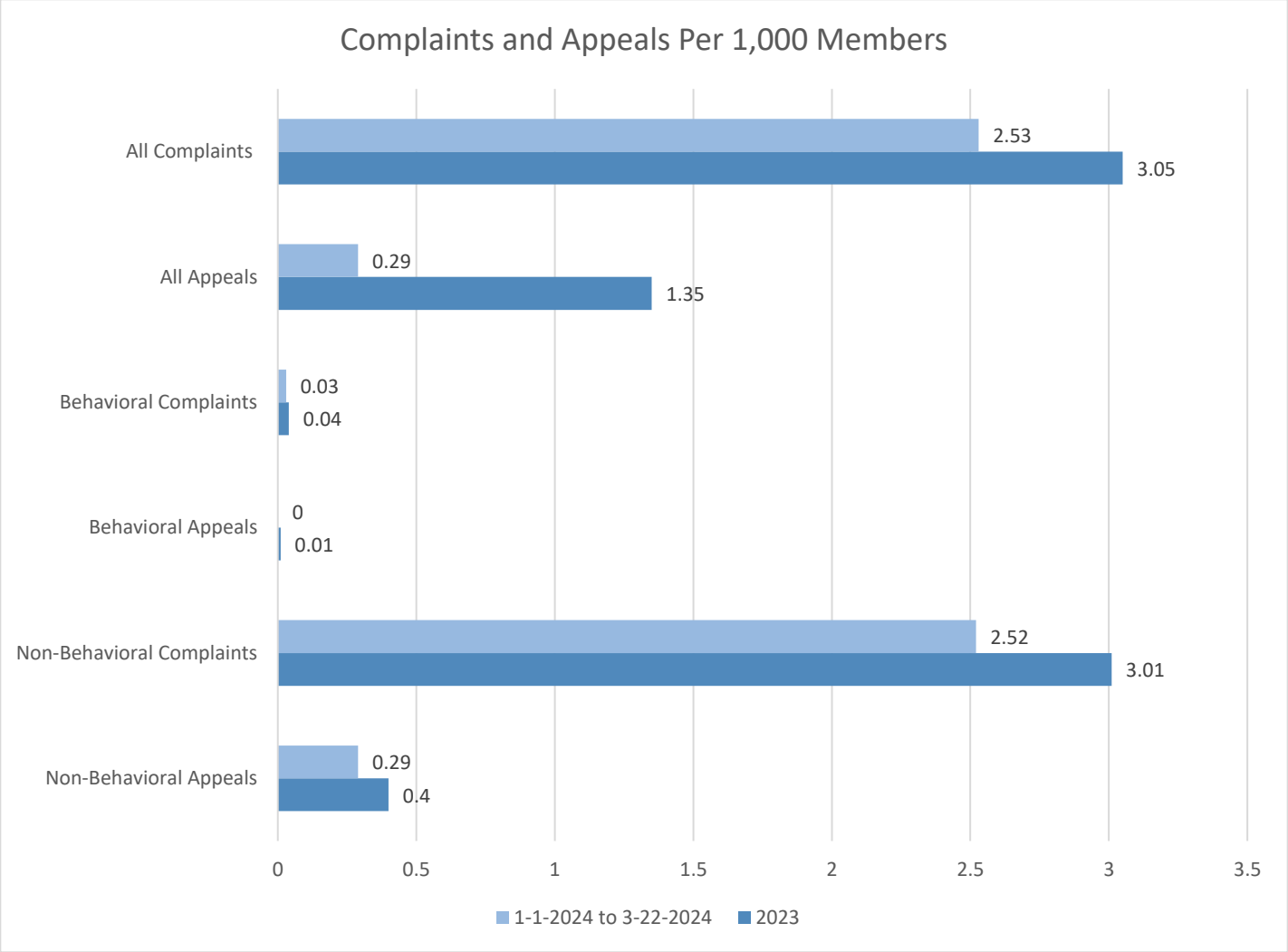
The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

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

NCQA Qualitative Data Analysis Report

Complaints and Appeals

Year 2023 – March 22, 2024



Behavioral Healthcare Complaints

The following tables compares behavioral healthcare complaints filed 2023 through March 22, 2024. Kern Health Systems has overall category goal of 50 per 1000 members and 20 per 1000 members for each category.

Table 1: Complaint Volume Report – Behavioral Healthcare

Category	2023		2024	
	Complaints Total	Complaints per 1,000 members	Complaints Total	Complaints per 1,000 members
Access	49	0.01	8	0.01
Attitude and Service	65	0.02	8	0.01
Billing and Financial Issues	0	0	0	0
Quality of Care	17	<0.01	6	<0.01
Quality of Practitioner Office Site	0	0	0	0
Total	**131**	**0.04**	**22**	**0.03**
Average Per Category	**26.2**	**0.01**	**4.4**	**0.01**

Table 2: Annual Complaint Data – Behavioral Healthcare

Category	2023	2024	Performance Goals	Performance Goals Met?
Access	0.01	0.01	<20	Yes
Attitude and Service	0.02	0.01	<20	Yes
Billing and Financial Issues	0.00	0	<20	Yes
Quality of Care	<0.01	<0.01	<20	Yes
Quality of Practitioner Office Site	0.00	0	<20	Yes
Total	**.04**	**.03**	**<50**	**Yes**

Quantitative Analysis: In 2023, a total of 131 behavioral healthcare complaints were filed, totaling 0.04 complaints per 1000 members. As of March 22, 2024, 22 behavioral healthcare complaints have been filed, totaling .03 per 1000 members; a tentative decrease of .01 from the previous year. As of March 22, 2024, the rate of .03 met the 2024 Kern Health Systems goal of 50 per 1000 members for overall categories. As of March 22, 2024, the average of .01 met the Kern Health Systems goal of 20 complaints per 1000 members for each

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

Behavioral Healthcare Appeals

The following tables compares behavioral healthcare appeals filed 2023 through March 22, 2024. Kern Health Systems has overall category goal of 50 per 1000 members and 20 per 1000 members for each category.

Table 1: Appeal Volume Report – Behavioral Healthcare

Category	2023		2024	
	Appeals Total	Appeals per 1,000 members	Appeals Total	Appeals per 1,000 members
Access	0	0	0	0
Attitude and Service	0	0	0	0
Billing and Financial Issues	0	0	0	0
Quality of Care	4	<.01	0	0
Quality of Practitioner Office Site	0	0	0	0
Total	**4**	**.01**	**0**	**0**
Total Average Per Category	**0.8**	**<.01**	**0**	**0**

Table 2: Annual Appeal Data – Behavioral Healthcare

Category	2023	2024	Performance Goals	Performance Goals Met?
Access	0	0	<20	Yes
Attitude and Service	0	0	<20	Yes
Billing and Financial Issues	0	0	<20	Yes
Quality of Care	<.01	0	<20	Yes
Quality of Practitioner Office Site	0	0	<20	Yes
Total Average Per Category	**.01**	**0**	**<50**	**Yes**

Quantitative Analysis: In 2023, there were 4 behavioral healthcare appeals filed, totaling less than .01 appeals per 1000 members. As of March 22, 2024, there were no behavioral healthcare appeals, totaling 0 per 1000 members; a tentatively decrease of .01 from the previous year. As of March 22, 2024, the rate of 0 met the 2024 Kern Health Systems goal of 50 per 1000 members for overall categories. As of March 22, 2024, the average of 0 met the 2024 Kern Health Systems goal of 20 appeals per 1000 members for each category. Overall, Kern Health Systems maintained the overall category and per category performance goal.

KERN HEALTH SYSTEMS

Quality Performance Department
Executive Summary
1st Quarter 2024

I. 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.

II. 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.

KERN HEALTH SYSTEMS

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

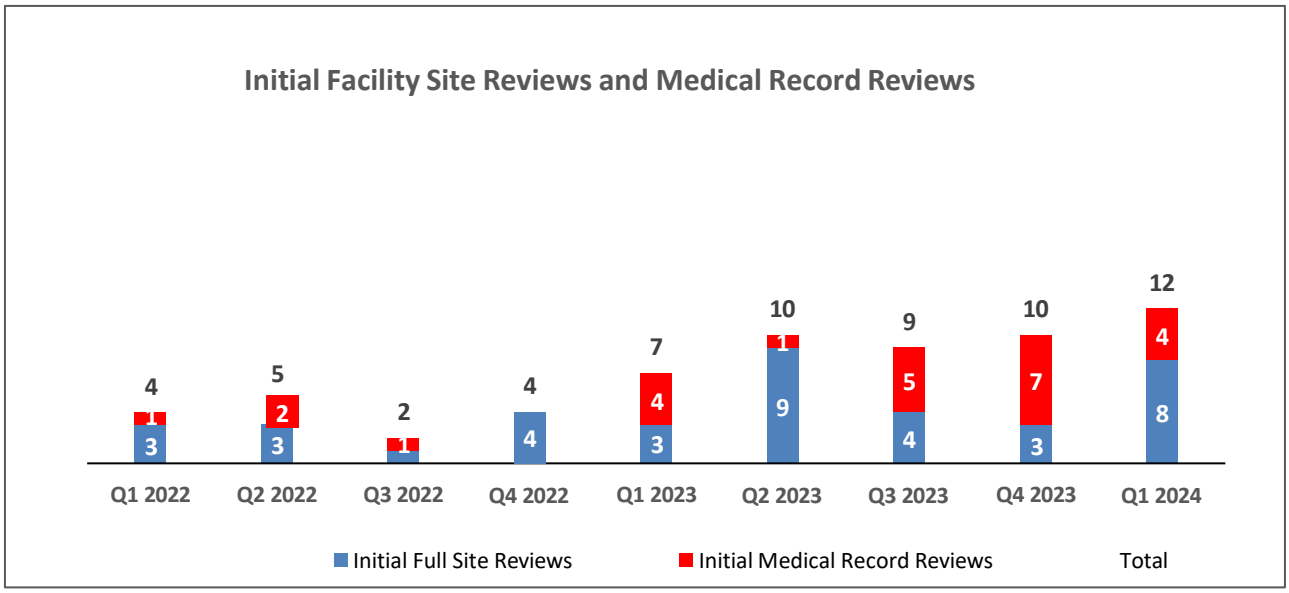
Provider sites that receive an FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are 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.

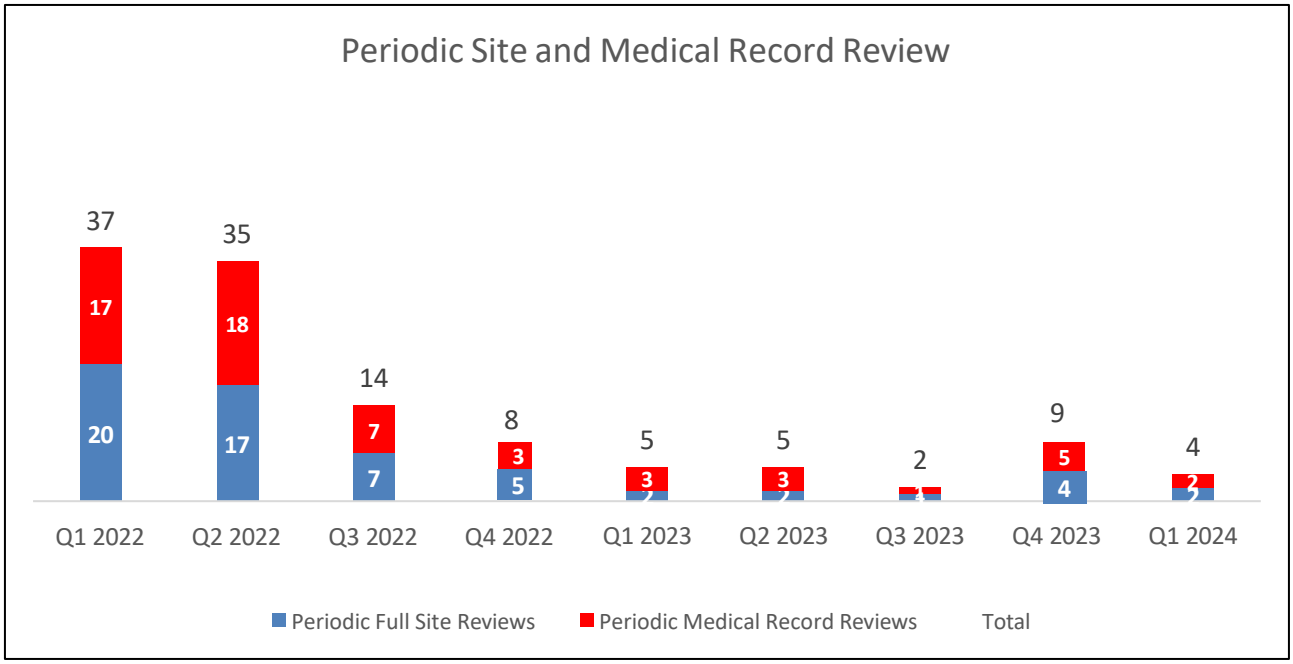
A. Initial Facility Site Review and Medical Record Review Results:



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

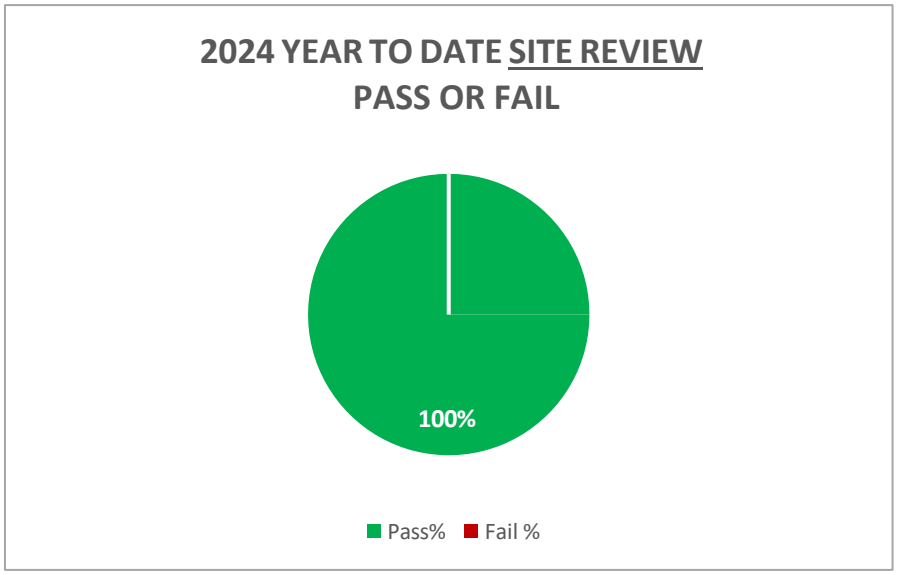
Periodic reviews are required every 3 years. The due date for Periodic FSRs is based on the last Initial or Periodic FSR that was completed. The volume of Periodic Reviews is not controlled by KHS. It is based on the frequency dictated by DHCS.



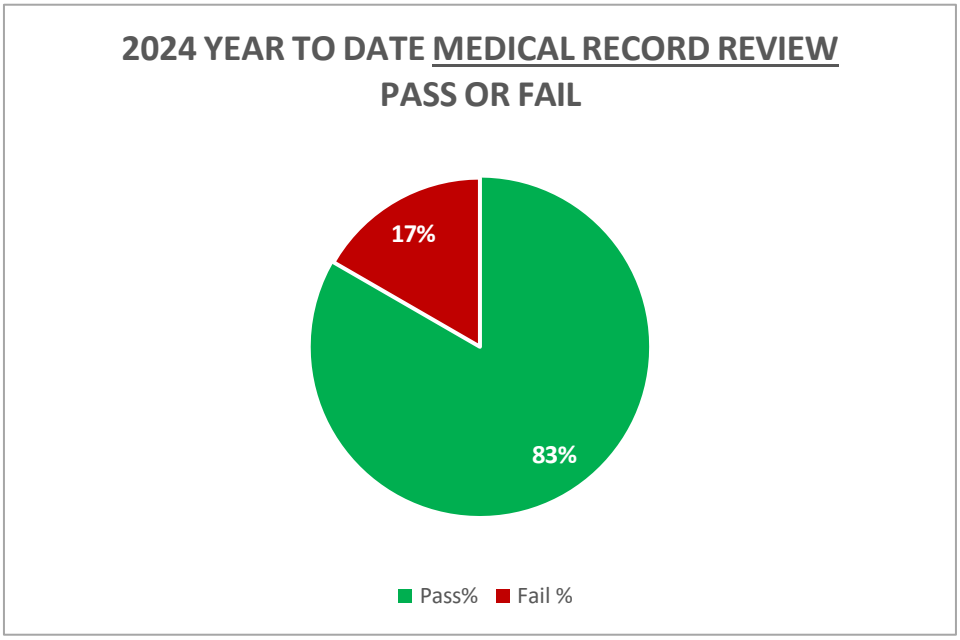
The above chart reflects the number of Periodic Full Site Reviews and Medical Record Reviews that were due and completed for each quarter.

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:

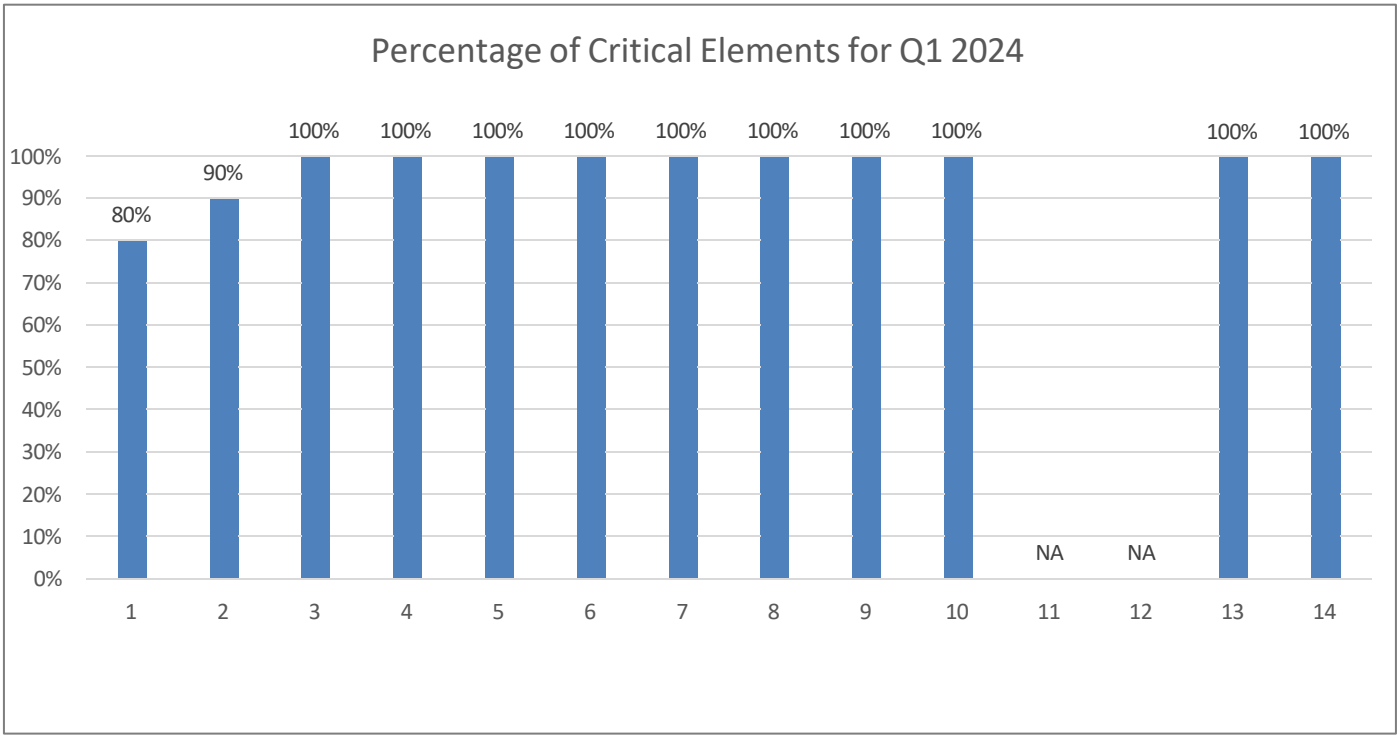
1. Calibration of Equipment not done
2. Clearly diagramed Evacuation Routes are not in visible locations.
3. Site does not utilize California Immunizations Registry (CAIR)

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.

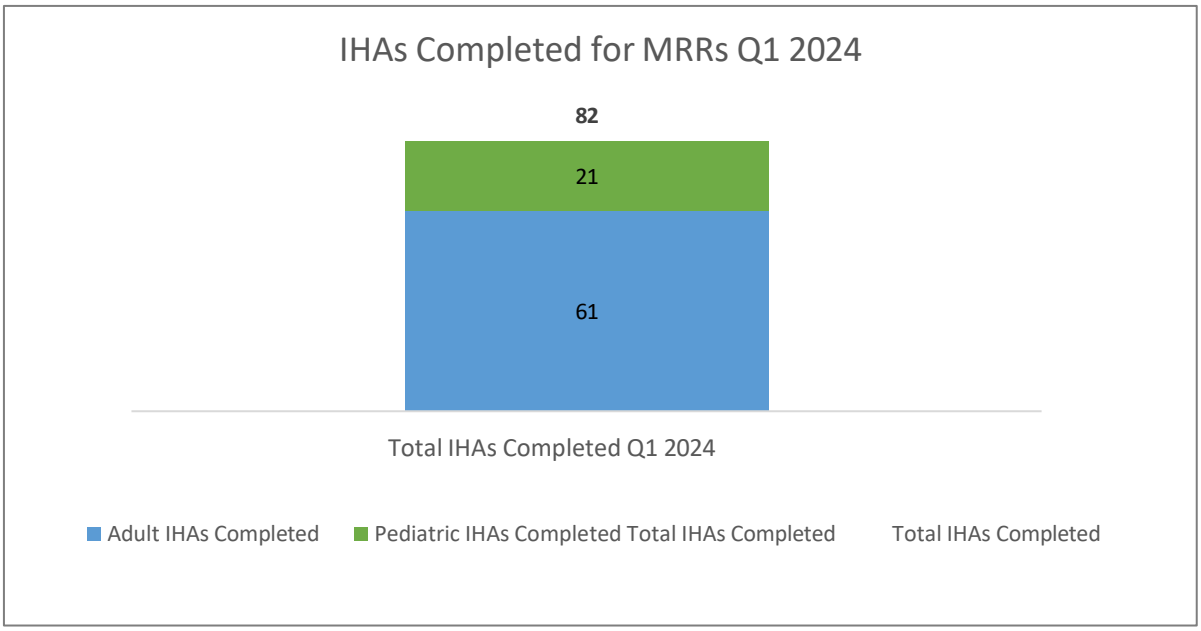
C. Critical Elements (CE) Percentage for Site Reviews:



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**

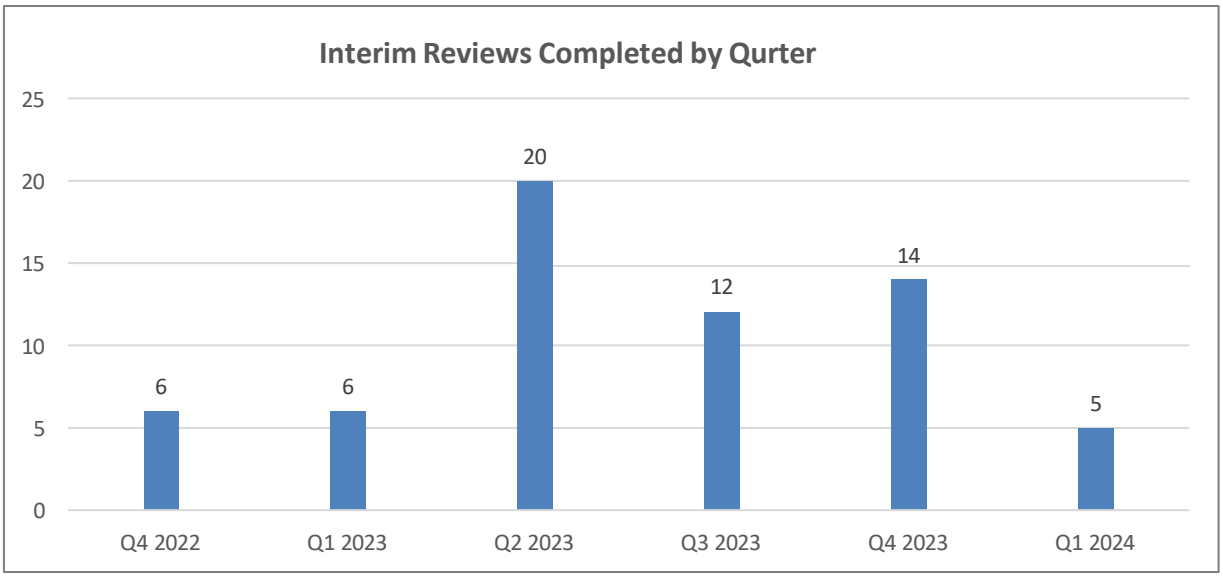
For Q1 2024, based on the medical record reviews, 82 IHA's were completed. 21 total pediatric charts and 61 adult charts. 19 out of the 21 pediatric charts were compliant and 2 were non-compliant. Out of all the 61 Adult charts, 55 adult charts were found to be compliant and 6 were non-compliant. Education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

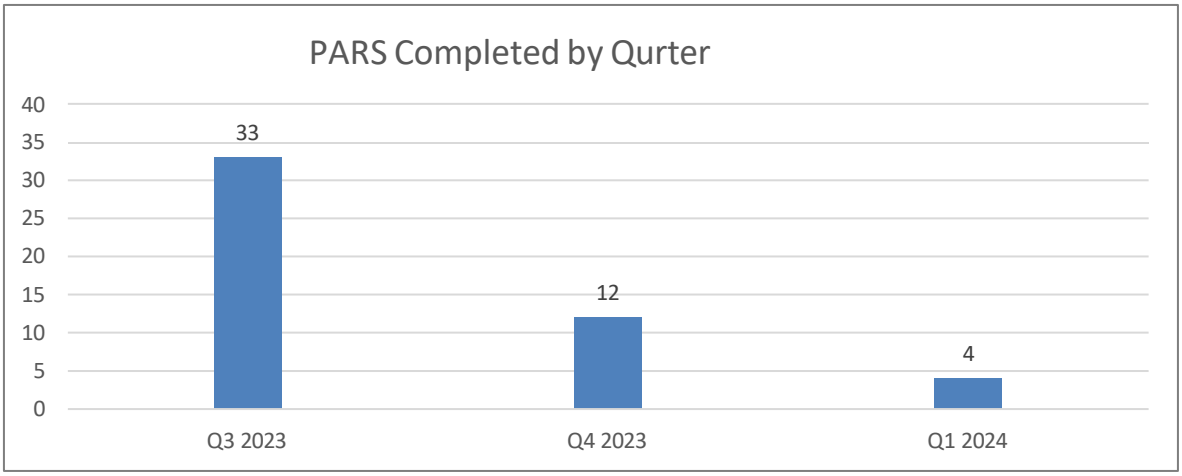


For the Q1 2024, there were 5 Interim reviews completed.

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.

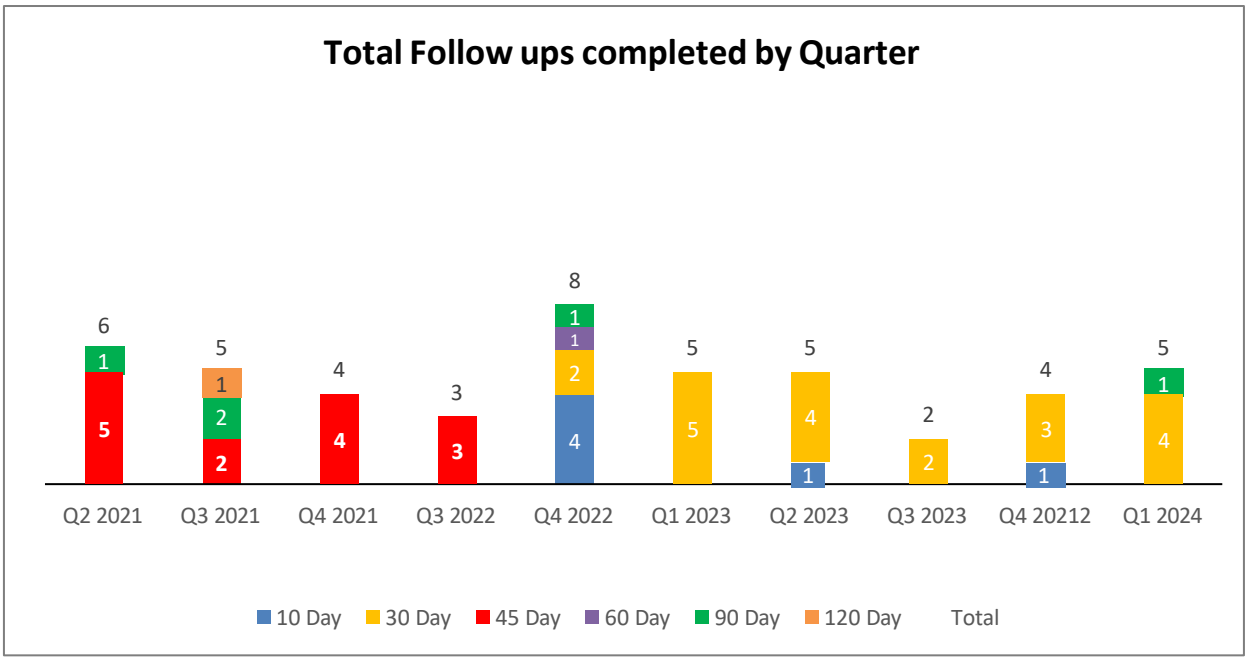
G. Physical Accessibility Review Survey (PARS):

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.

KERN HEALTH SYSTEMS

BEHAVIORAL HEALTH ADVISORY COMMITTEE (BHAC) MEETING

Wednesday, October 16, 2024
at
12:00 pm

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

For more information, call (661) 664-5000

KERN HEALTH SYSTEMS

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

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

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2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

KERN HEALTH SYSTEMS

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

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

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

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

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

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

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

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

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

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

Overview:

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

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

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

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

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

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

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

ii. KHS implemented processes for establishing medical necessity determination, care coordination, creating closed loop referral systems, and exchange of medical information between KHS and the MHP and DMC-ODS.

iii. KHS and Kern BHRS institute policies and procedures to address and document QI activities for services covered under the MOU, including applicable performance measures, such as:
   a. QI initiatives and reports that track cross-system referrals, member engagement and service utilization.
   b. Facilitating member access to medically necessary services and network providers during non-business hours.

iv. KHS is implementing closed loop referral systems referrals.

v. KHS covers medical necessity Non-Specialty Mental Health Services (NSMHS)
   a. For individuals under 21 years of age, a service is medically necessary if the service meets the EPSDT standard set forth in Section 1396d(r)(5) of Title 52 of the United States Code. Services that sustain, support, improve, or make more tolerable a behavioral health condition is considered to ameliorate the condition, and are thus medically necessary and are covered as EPSDT services.
   b. For individuals 21 years old and over, a service is medically necessary when it is reasonable and necessary to protect life, to prevent severe illness or disability, or to alleviate severe pain.

Non-Specialty Mental Health Services:

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

Care Coordination Activities:

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

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

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

Care Management:

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

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

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

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

Coordination of Care Between Medical and Behavioral Health Care:

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

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

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

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

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

Population Assessment:

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

Opportunities for Coordination Between Medical and Behavioral Health Care

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

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

QI 4 Element A Factors 1-6

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

QI 4 Element A Factor 1

Exchange of Information

A. Activity

Provider Satisfaction Survey

B. Description and Relevance:

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

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

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

C. Goal:

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

D. Methodology:

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

There are two attributes related to behavioral health:

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

E. Results

a. Quantitative Analysis:

QI 4 Element B Factor 2

(1) Survey Response:

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

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

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

(2) Criteria:

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

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

QI 4 Element B Factor 2

b. Qualitative Analysis:

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

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

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

F. Barriers and Opportunities

QI 4B Factor 3

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

QI 4 Element B Factor 5

G. Planned Interventions:

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

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

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

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

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

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

QI 4 Element A Factor 2

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

A. Activity

Antidepressant Medication Management (AMM)

B. Description and Relevance

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

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

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

C. Methodology -

KHS uses HEDIS data collection for the methodology:

a. HEDIS Data

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

Two rates are reported:

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

b. Pharmacy Process

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

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

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

D. Goals

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

QI 4 Element B Factor 2

E. Results

Quantitative Analysis:

1. **HEDIS Data:**

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

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

Qualitative Analysis:

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

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

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

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

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

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

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

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

Conclusion Based on Qualitative Analysis

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

F. Barriers and Opportunities

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

G. Planned Interventions

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

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

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

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

QI 4 Element A Factor 3

Appropriate Use of Psychotropic Medications

A. Activity

Follow-Up Care for Children Prescribed with ADHD Medication

B. Description and Relevance

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

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

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

C. Methodology

HEDIS Data:

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

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

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

D. Goal

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

QI 4 Element B Factor 2

E. Results

Quantitative Analysis:

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

continuation and maintenance phase				

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

Qualitative Analysis:

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

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

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

Conclusion Based on Qualitative Analysis

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

F. Barriers and Opportunities:

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

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

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

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

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

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

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

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

G. Planned Interventions:

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

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

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

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

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

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

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

QI 4 Element A Factor 4

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

A. Activity

Multiple Medical Conditions at Risk for Behavioral Health Issues

B. Description and Relevance

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

C. Methodology

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

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

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

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

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

QI 4 Element B Factor 2

D. Goal -

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

E. Results

Quantitative Analysis:

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

Data Analysis:

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

Qualitative Analysis:

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

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

F. Barriers and Opportunities:

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

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

G. Planned Interventions:

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

QI 4 Element A Factor 5

Primary or Secondary Preventive Behavioral Healthcare Program Implementation

A. Activity

Perinatal and Postpartum Depression Screening

B. Description and Relevance

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

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

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

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

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

C. Methodology

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

Tracking PHQ 9 Forms

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

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

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

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

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

D. Goal

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

E. Results

QI 4 Element B Factor 2

Quantitative Analysis:

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

Qualitative Analysis

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

F. Barriers and Opportunities:

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

Understanding of HIPAA Regulations:

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

G. Planned and Ongoing Interventions:

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

QI 4 A Factor 6

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

A. Activity

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

B. Description and Relevance:

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

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

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

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

C. Methodology:

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

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

Denominator:

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

D. Goal:

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

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

E. Results

QI 4 Element B Factor 2

a. Quantitative Analysis:

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

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

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

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

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

QI 4 Element B Factor 2

b. Qualitative Analysis:

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

F. Barriers and Opportunities:

QI 4 Element B Factor 4

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

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

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

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

• Understanding of HIPAA Regulations:

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

• Staffing Challenges:

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

QI 4 Element B Factor 6

G. Planned Intervention:

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

Selected Opportunities

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

Identifying and selecting one opportunity for improvement from Element A.

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

Describe the Barriers

Action Plan:

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

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

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

List of Participants:

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

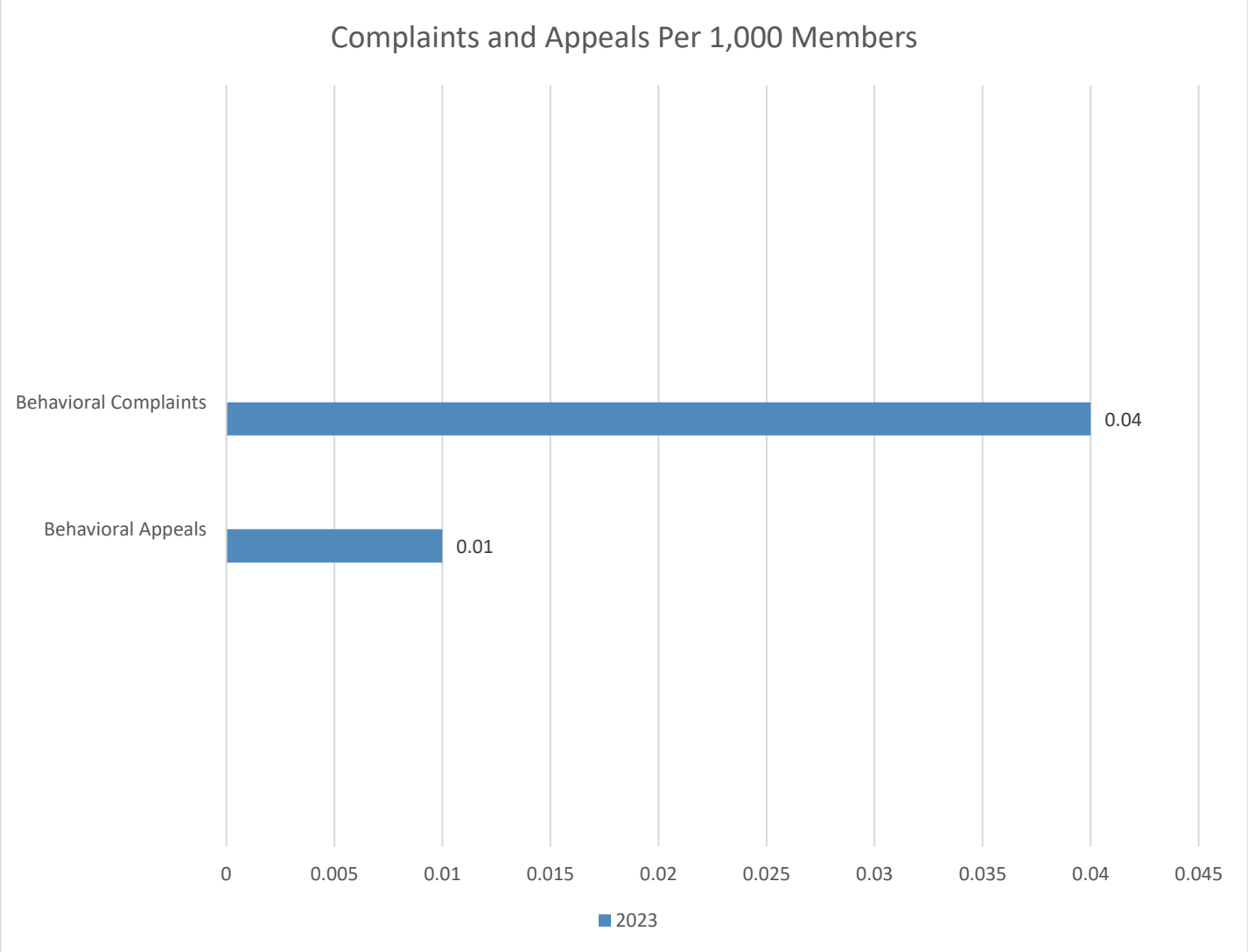
Resources:

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

NCQA Qualitative Data Analysis Report

Behavioral Health Complaints and Appeals

Year 2023



Behavioral Healthcare Complaints

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

Table 1: Complaint Volume Report – Behavioral Healthcare

Category	2023

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

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

Behavioral Healthcare Appeals

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

Table 1: Appeal Volume Report – Behavioral Healthcare

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

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

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

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

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

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

KERN HEALTH SYSTEMS

To: KHS EQIHEC

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

Date: December 12, 2024

Re: Quality Performance Q3 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 third quarter of 2024.

Discussion

See pages 2 of this document.

Fiscal Impact

The fiscal impact of not achieving and maintaining satisfactory MCAS rates may be severe to the health plan. This includes sanctions which may come in the form of monetary fines, reduction in default assignment, reduction in membership, and ultimately revocation of the plan from the Medi-Cal program. Another cost is utilization and increased costs of care associated with the lack of preventive care, that turns preventable conditions into chronic conditions. The ultimate cost is paid by the membership in the form of reduced health status and diminished quality of life. Access to 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 approve.

KERN HEALTH SYSTEMS

Quality Performance Department
Executive Summary
3rd Quarter 2024

I. Facility Site Reviews (FSR) and Medical Record Review (MRR) (pages 3-11)

11 Initial Facility Site Reviews and 2 Initial Medical Record Reviews were completed in Q3 2024. 9 Periodic FSRs and 9 periodic MRRs were also completed. 97% of Facility Site Reviews passed and 75% YTD of Medical Record Reviews passed. 9 of 36 sites failed the first review, however Corrective Action Plans were completed and closed. QP also conducts mid-cycle interim reviews of facilities to monitor facility compliance. The QP department also conducts Physical Accessibility Review Surveys (PARS) and 2 were completed in Q3 2024.

II. Quality Improvement Projects (pages 12-13)

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 in the second phase of the PIP, which focuses on interventions and testing. We have developed a provider notification process for ED visits related to Behavioral Health and Substance Use Disorders. For the W30 PIP, we are leveraging activities from mobile units and the IHI/DHCS collaborative focused on well-care visits for the 0-15 months, African American babies.

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. We have also identified a need for a single page handout for next steps following well care visits in children and adolescents.

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

The QP team continues with MCAS specific initiatives in support of improving all measures for current measurement year with a heavy focus on the Children's domain of care. As of September 2024, 15 of 18 measures have improved compared to last year. According to internal tracking, we are meeting MPL for 5 MCAS measures YTD.

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.

KERN HEALTH SYSTEMS

Quality Performance

Q3 2024

Kailey Collier
Director of Quality Performance

KHS MCAS MY2024 vs. MY2023 Comparison

- 15 measures are trending higher than the previous year at the same point in time.
- 3 measures lower compliance rate than 2023

MY2024 Trending Performance

AMR	BCSE	CBP	CCS	CDEV	CHL Adults and Peds
72.36%	57.32%	46.94%	50.30%	20.78%	55.24%
HITS FOR MPL (105)	HITS FOR MPL (671)	HITS FOR MPL 4,310	HITS FOR MPL 4,147	HITS FOR MPL 1,666	HITS FOR MPL 92
+3.95 % change	+0.40 % change	+3.40 % change	-3.08 % change	+1.61 % change	+0.39 % change
Nov'23 68.41%	Nov'23 56.92%	Nov'23 43.54%	Nov'23 53.39%	Nov'23 19.17%	Nov'23 54.85%

CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	HBD HBA1C >9%	IMA	LSC
19.31%	23.01%	20.39%	59.20%	33.85%	68.82%
HITS FOR MPL 722	HITS FOR MPL 201	HITS FOR MPL 284	HITS FOR MPL 3,881	HITS FOR MPL 31	HITS FOR MPL (375)
-0.09 % change	+10.38 % change	+2.13 % change	-2.77 % change	+3.31 % change	+13.12 % change
Nov'23 19.40%	Nov'23 12.63%	Nov'23 18.26%	Nov'23 56.43%	Nov'23 30.54%	Nov'23 55.70%

PPC Post	PPC Pre	TFLCH	W30 0 - 15 Months	W30 15 - 30 Months	WCV
73.09%	49.48%	37.98%	53.42%	66.54%	45.32%
HITS FOR MPL 285	HITS FOR MPL 1,978	HITS FOR MPL (29,109)	HITS FOR MPL 169	HITS FOR MPL 14	HITS FOR MPL 3,945
+0.51 % change	+7.33 % change	+5.58 % change	+9.42 % change	+3.97 % change	+2.53 % change
Nov'23 72.58%	Nov'23 42.16%	Nov'23 32.40%	Nov'23 44.00%	Nov'23 62.58%	Nov'23 42.78%

KERN HEALTH SYSTEMS

KHS MCAS MY2024 Trending Rates

- Meeting MPL for 5 measures
- 5 measures are within 5% of meeting MPL

MY2024 YTD Performance

AMR	BCSE	CBP	CCS	CDEV	CHL Adults and Peds
72.36%	57.32%	46.94%	50.30%	20.78%	55.24%
HITS FOR MPL (105)	*HITS FOR MPL (671)*	*HITS FOR MPL 4,310*	*HITS FOR MPL 4,147*	*HITS FOR MPL 1,666*	*HITS FOR MPL 92*
MPL: 65.61% Over MPL by 6.75% AMR is not held to MPL.	MPL: 52.60% Over MPL by 4.72%	MPL: 61.31% Under MPL by 14.37%	MPL: 57.11% Under MPL by 6.81%	MPL: 34.70% Under MPL by 13.92%	MPL: 56.04% Under MPL by 0.80%

CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	HBD HBA1C >9%	IMA	LSC
19.31%	23.01%	20.39%	59.20%	33.85%	68.82%
HITS FOR MPL 722	*HITS FOR MPL 201*	*HITS FOR MPL 284*	*HITS FOR MPL 3,881*	*HITS FOR MPL 31*	*HITS FOR MPL (375)*
MPL: 30.90% Under MPL by 11.59%	MPL: 36.34% Under MPL by 13.33%	MPL: 54.87% Under MPL by 34.48%	MPL: 37.96% Under MPL by 21.24% Inverted Measure	MPL: 34.31% Under MPL by 0.46%	MPL: 62.79% Over MPL by 6.03%

PPC Post	PPC Pre	TFLCH	W30 0 - 15 Months	W30 15 - 30 Months	WCV
73.09%	49.48%	37.98%	53.42%	66.54%	45.32%
HITS FOR MPL 285	*HITS FOR MPL 1,978*	*HITS FOR MPL (29,109)*	*HITS FOR MPL 169*	*HITS FOR MPL 14*	*HITS FOR MPL 3,945*
MPL: 78.10% Under MPL by 5.01%	MPL: 84.23% Under MPL by 34.75%	MPL: 19.30% Over MPL by 18.68%	MPL: 58.38% Under MPL by 4.96%	MPL: 66.76% Under MPL by 0.22%	MPL: 48.07% Under MPL by 2.75%

KERN HEALTH SYSTEMS

MCAS Performance Over the Years

KHS MCAS performance for measures held to MPL from the past 7 years to current submission.

- Met MPL for more measures in MY2023 than the previous 4 years.
- Met MPL for 3 measures that had never met MPL or had not met MPL in last few years (CHL, AMR, and CCS).

Measurement Year	MY2017	MY2018	MY2019	MY2020	MY2021	MY2022	MY2023
KHS Membership	242,265	246,564	251,280	277,616	299,864	334,078	346,049
MPL Percentile	25th	25th	50th	50th	50th	50th	50th
Total Held to MPL	21	20	18	19	15	15	18
Met MPL	19	18	3	2	5	5	8
Did Not Meet MPL	1	2	15	17	10	10	10

MCAS MY2022 vs. MY2023

Improvements and Highlights

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

- Met HPL for PPC-Post

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

2024 Goals and Initiatives

Provider Meetings

- Routine meetings with various scheduled and ad hoc provider groups to discuss rates, challenges, barriers and/or accomplishments.
- In progress- establishing an API to allow direct appointment scheduling for Diabetic patients with the Endocrinologist

Provider & Community Collaborations

- Endocrinologist Diabetic program. The goal is to improve members'A1C levels with the appropriate interventions with incentive-based reimbursement structure.
- Local Pediatrician offering weekend and after hours in support of well-care visits
- Mammogram event at local Oncology group in October

Mobile Units

- Pharmacy provider offering routine vaccine events focused on children ages 2 and older.
- Large provider groups are operational and on track with grant milestones.
- Various initiatives partnering with school districts and community organizations
- Development of mobile mammogram event in East Kern in progress

Member Engagement

Member Engagement Reward Program (MERP) Campaigns:

- Text Messages to members encouraging the scheduling of their appointments for gaps in care
- Targeted efforts for CCS, W30, and WCV text messaging
- Robocalls will be sent out to members that do not receive text messages
- Geomapping insights leveraged to drive location of events and targeted population

Site Reviews

- 11 initial Facility Site reviews (FSRs) and 2 initial Medical Record Reviews (MRRs) were completed in Q3 2024
- 9 Periodic FSRs and 9 Periodic MRRs also completed
- 97% of FSRs passed and 75% YTD MRRs passed
  - 29 of the 36 sites failed the initial review, however CAPs completed and closed
- 2 Physical Accessibility Review Surveys (PARS) completed in Q3 2024

Performance Improvement Projects

- DHCS requires MCPs to annually report performance measurement results and conduct ongoing Performance Improvement Projects (PIPs) specific to measures that did not meet MPL.
- Current PIPs began in August 2023 and will run through 2026
  - The clinical PIP is focused on Health Equity, specific to the W30, 0-15 months African American population.
  - The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on BH and BI for support of interventions.
- Two annual check in submissions to HSAG
  - The first submission was approved. The second submission was partially met and requires minor updates. Will re-submit by December 2024.

KERN HEALTH SYSTEMS

FOR ADDITIONAL INFORMATION, PLEASE CONTACT:

Kailey Collier
Director of Quality Performance

QUALITY PERFORMANCE DEPARTMENT

QUATERLY EQIHEC COMMIITTEE REPORT

Q3 2024

KERN HEALTH SYSTEMS
Quality Performance Department Quarterly EQIHEC Committee Report
Q3 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

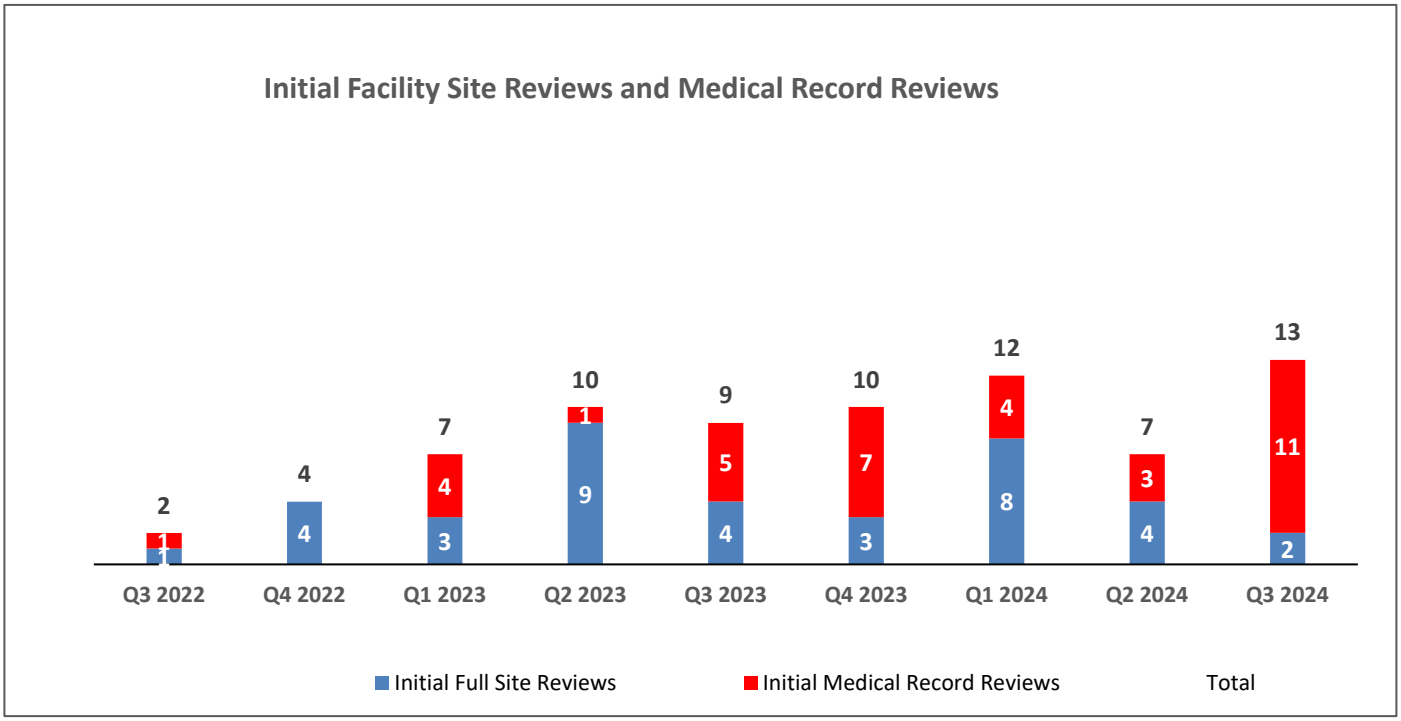
Provider sites that receive an FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are 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 30 days, and if not corrected by the 30 day follow up, at 90 days after a CAP has been issued. Most CAPs issued are corrected and completed within the 30 Day follow up period. Providers are encouraged to speak with us if they have questions or encounter issues with CAP completion. QI nurses provide education and support during the CAP resolution process.

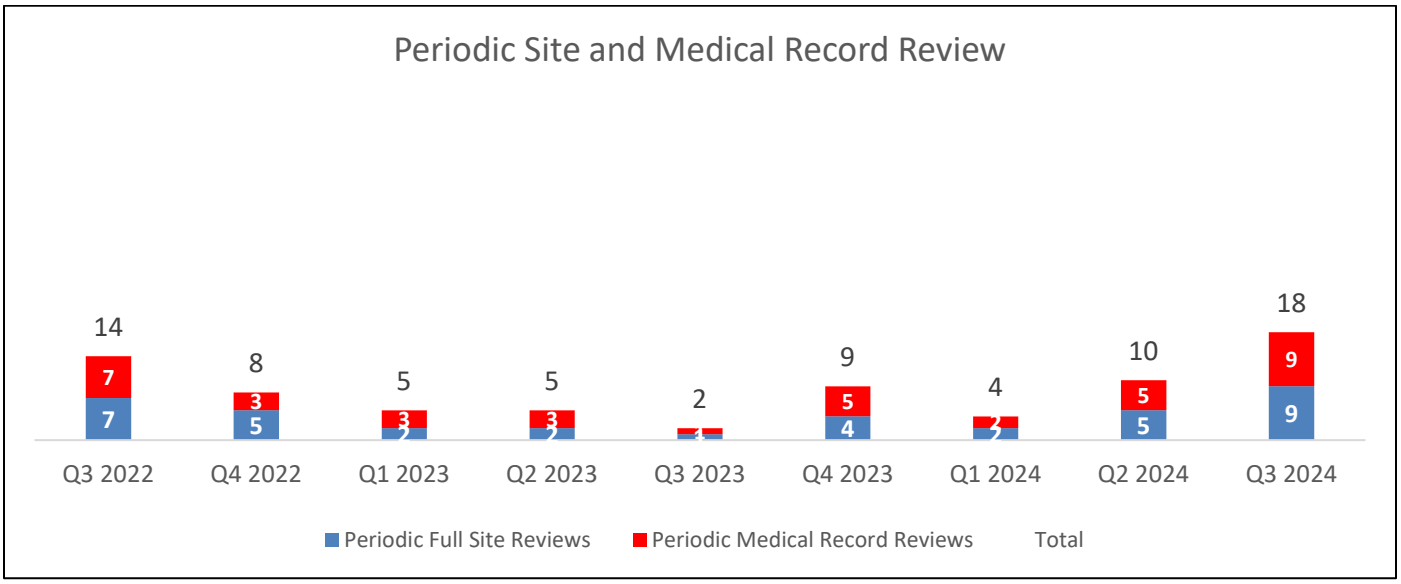
A. Initial Facility Site Review and Medical Record Review Results:



The number of initial site and medical record reviews is determined by the number of new providers requesting to join KHS' provider network. There were 2 IFSRs and 11 IMRRs completed in Q3 of 2024.

B. Periodic Full Site and Medical Record Reviews

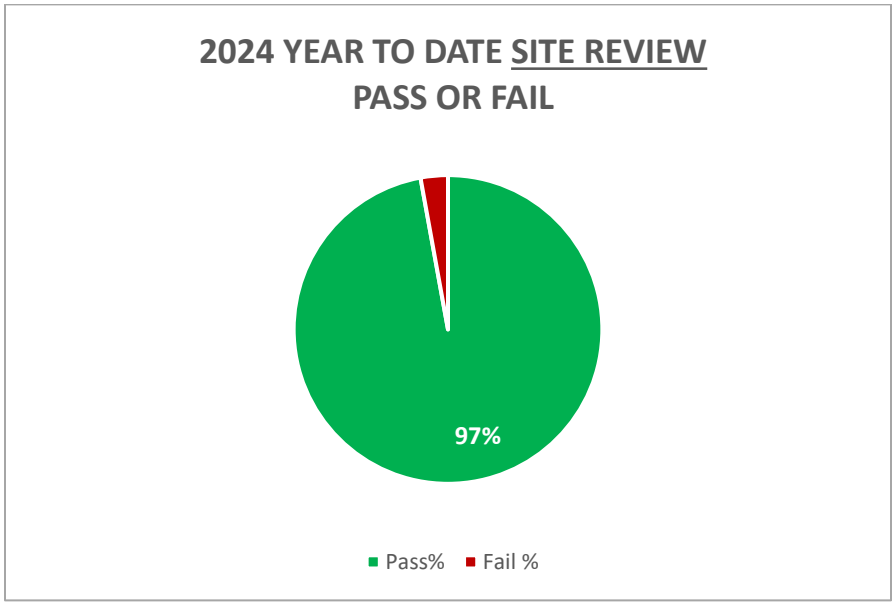
Periodic reviews are required every 3 years. The due date for Periodic FSRs is based on the last Initial or Periodic FSR that was completed. The volume of Periodic Reviews is not controlled by KHS. It is based on the frequency dictated by DHCS.



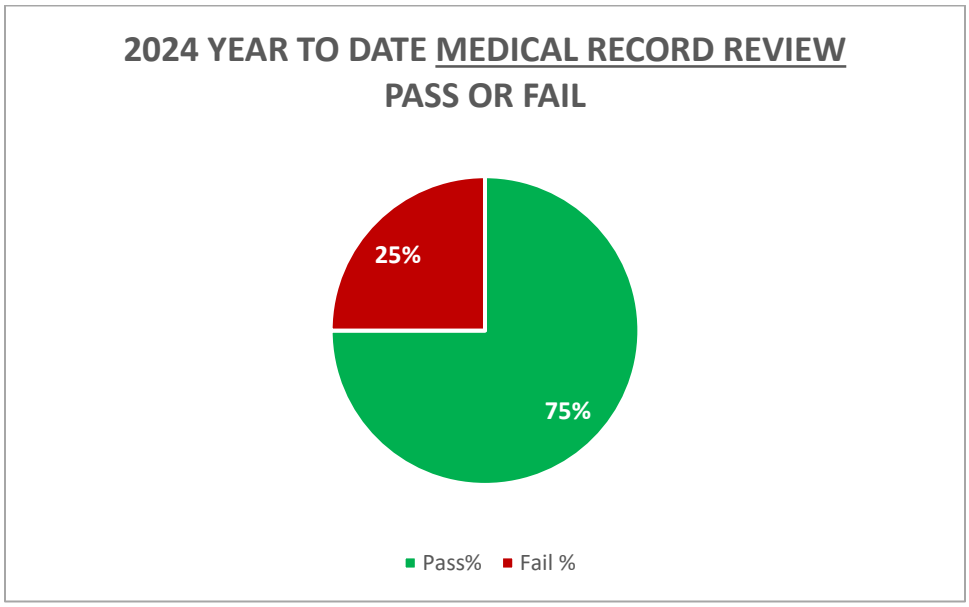
The above chart reflects the number of Periodic Full Site Reviews and Medical Record Reviews that were due and completed for each quarter.

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, 97% of the Initial and Periodic site reviews performed passed. YTD there were 30 site reviews completed by the end of September 2024.



For 2024 YTD, 75% of the Initial and Periodic medical record reviews performed passed. YTD there were 36 medial record reviews completed, 9 of these reviews failed in the first audit. However, following the failed review, additional education was provided, and CAPs were issued to correct deficiencies.

For Q3 2024, top #3 deficiencies identified for Opportunities for improvement in site reviews are:

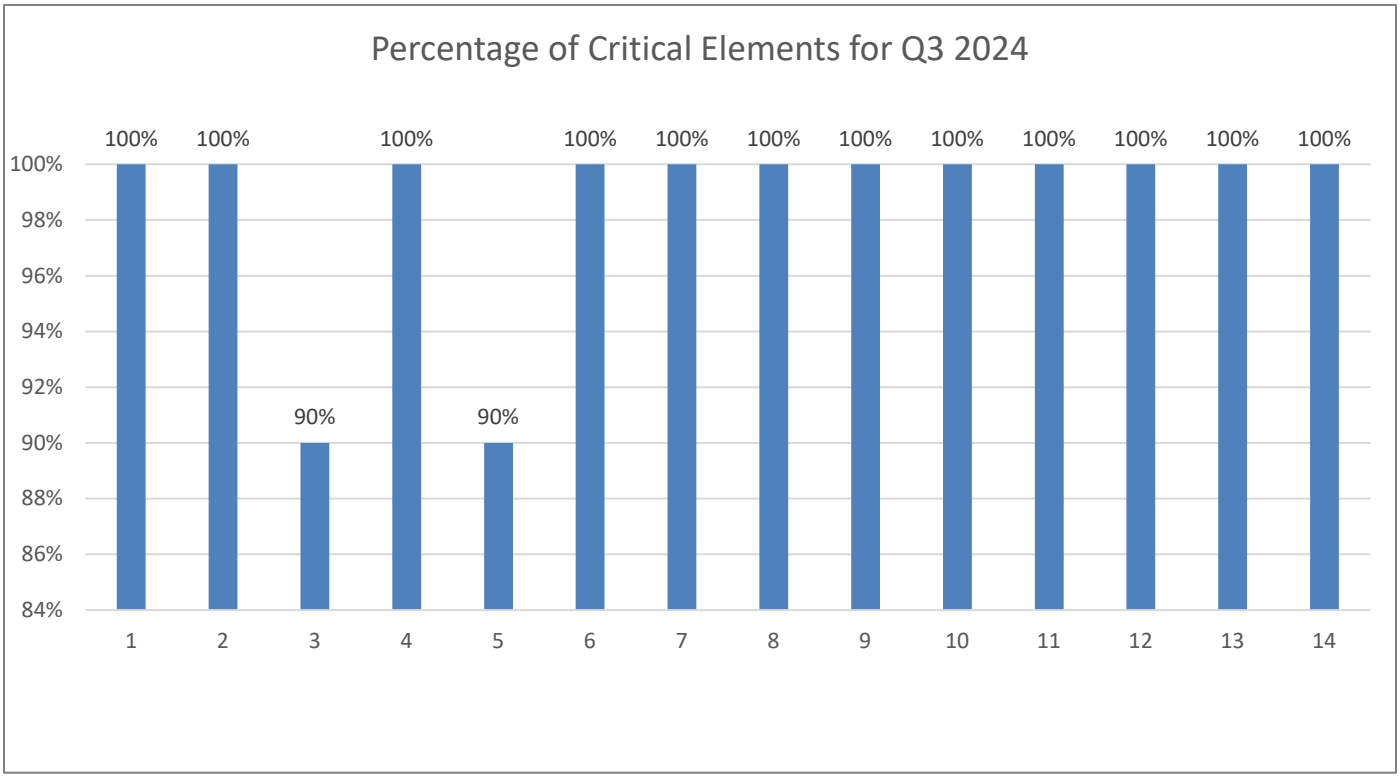
1. No evidence of annual training in Cultural and Linguistics
2. No evidence of training regarding Disability and Provider Obligations
3. Site does not utilize California Immunizations Registry (CAIR).

For Q3 2024, top #3 deficiencies identified for Opportunities for improvement in Medical Record Reviews are:

1. Advanced Healthcare information not being offered.
2. Member Risk Assessments not being assessed for both pediatric and adults.
3. Adult immunization not being given according to ACIP guidelines.

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.

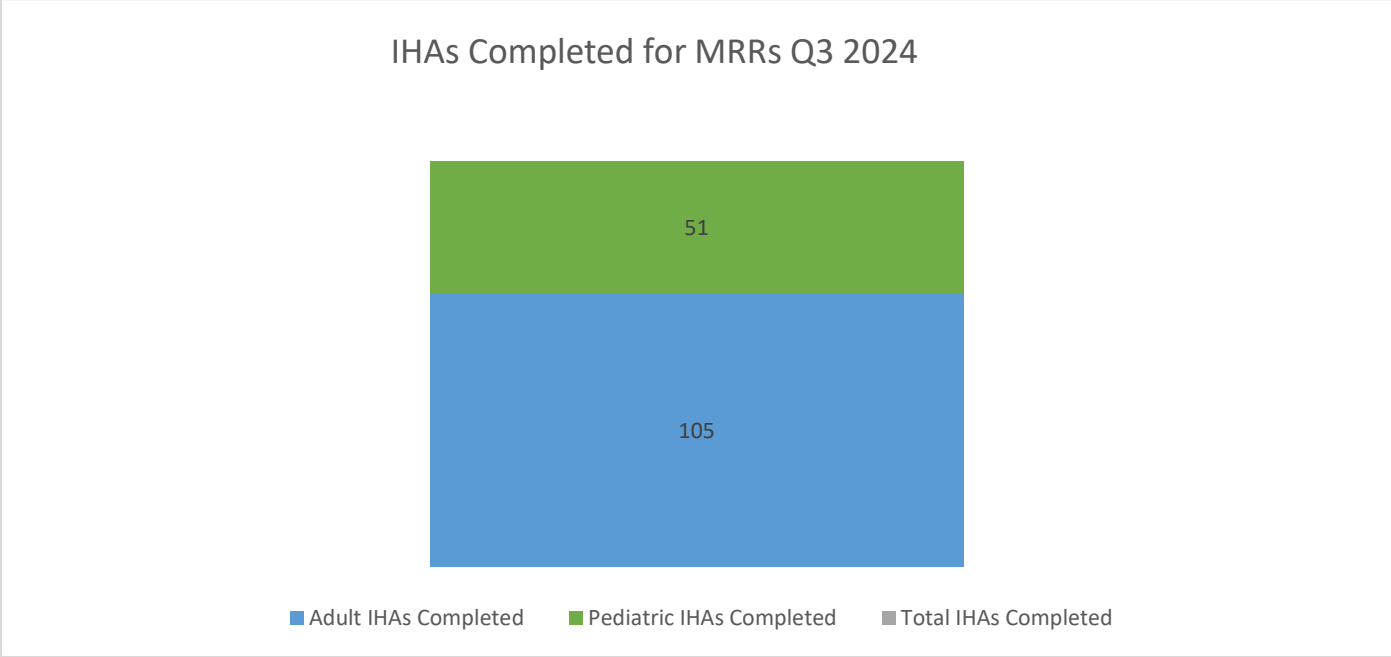
C. Critical Elements (CE) Percentage for Site Reviews:



There were 10 FSRs completed for Q3 2024, and 9 sites have passed the critical elements.

The site review team is working closely with site that failed their Critical Elements by proving ongoing education to ensure compliance. CAPs were issued to correct deficiencies.

D. IHA's percentage for MRRs:



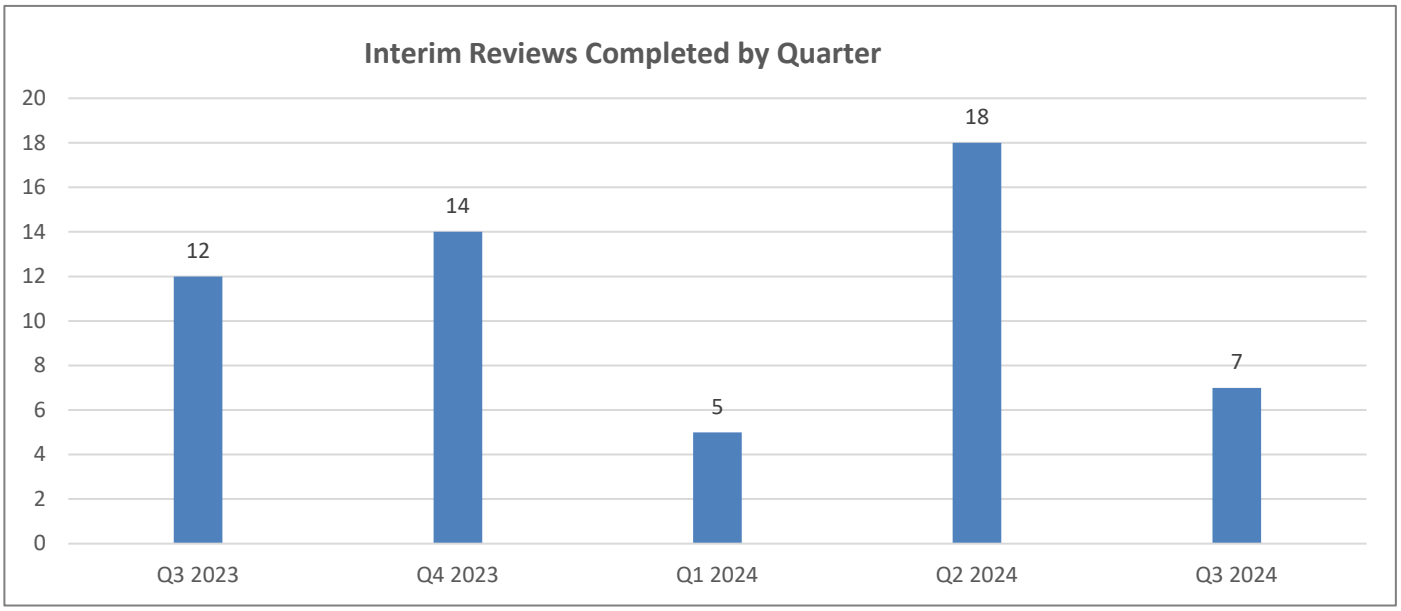
For Q3 2024, based on the medical record reviews, 156 IHA's were completed. 51 total pediatric charts and 105 adult charts. 23 out of the 51 pediatric charts were compliant and 28 were non-compliant. Out of all the 105 Adult charts, 77 adult charts were found to be compliant and 28 were non-compliant. 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.

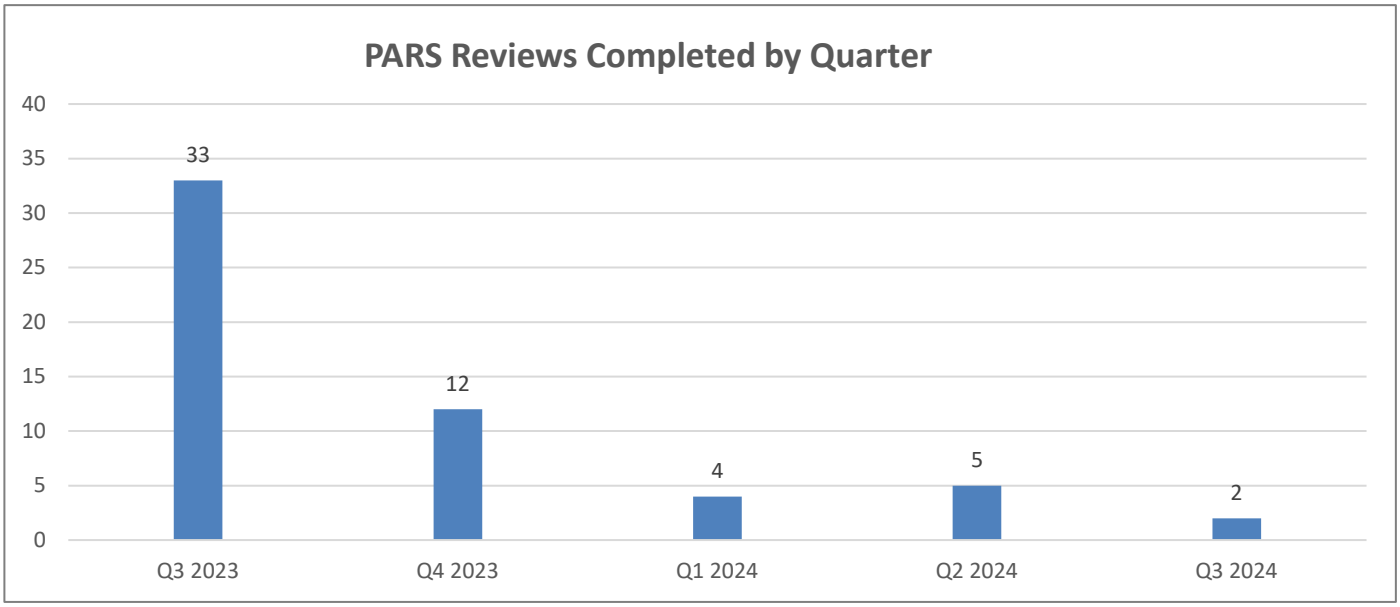


For the Q3 2024, there were 7 Interim reviews completed.

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 Q3 2024, we had 7 Focused MRRs completed.

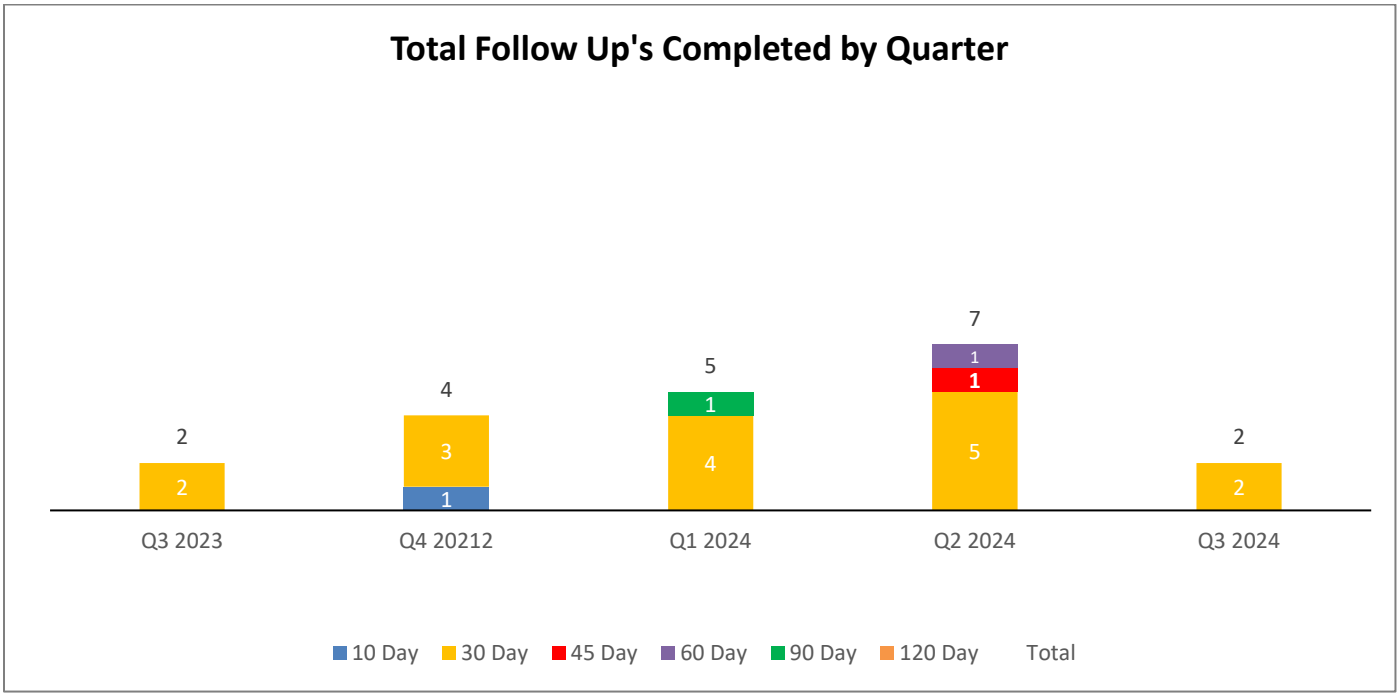
G. Physical Accessibility Review Survey (PARS):

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 Q3 2024, 2 PARS were completed.

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



The above chart reflects the total number of follow-ups completed for each quarter. For Q3 2024, there were 2 30-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. All QI Tools completed, including Process Map, with aid from QP department, Member Services, and Member Outreach Marketing. Continued efforts on how to track data (member services outreach on W30, text reminders of WBVs, Mobile unit WBV events). 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, attended Roundtable webinar for advancement of Adolescent Immunizations, which provided many resources and ideas for crossover use on this PIP. Working with BI to get data report. 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, ADT report was previously updated to pull accurate data from ER visits due to SMH/SUD diagnosis report as per the PIP requirement. ADT report is now disseminated to KHS BH, OMNI, and CSV, in addition to Telehealth Docs. ADT report has been added to the 2D Provider Profile and is updated daily. Providers and KHS PNM are being educated on how to find this in the Provider Profile. Ongoing meetings are scheduled to ensure success and to remain on track with deliverables. The PIP team is planning to meet with Kern Medical to discuss strategies for FUA/FUM measures.

Currently working on developing the key driver's diagram and interventions. We will continue PIP efforts, and second submission has been submitted to QP management for review ensure timely submission in 2024.

B. MCAS Initiatives

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

Interventions to improve our performance in MCAS:

- Provider Touchpoint Updates:
    - Met with various scheduled and ad hoc provider groups to discuss rates, focus measures and questions.
        - Full overview of what MCAS is and what DHCS and KHS request from providers team.
        - Resources shared, in-service for fill staff requested and will be arranged with PNM
        - Full set of resources given, including Provider Guide, Coding Card, 2024 MCAS measures list, Member Rewards, and Transportation Benefits.
- 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.
- CSV held a wellness day for child ensuring to captured measure for W30 and WCV.
- KHS is preparing for a Breast Cancer Event for October 5th at CBCC, encouraging member to complete their mammograms, the first 50 member will receive a gift certificate.
- Member Services team is supporting calling applicable members that have a gap in care to schedule their appointment with PCP.
- Extended efforts went out to members to complete BCS
- Member Engagement Reward Program (MERP) Campaigns:
    - IHA
    - BCS
    - CCS
    - CHL
    - GDS (HBD)
    - LSC
    - PPC Pre/ Post
    - W30
    - WCV

- Text Messages to members encouraging to schedule their appointments for gaps in care with a focus on:
  - Breast Cancer Screening
  - Blood Lead Screening
  - Initial Health Appointment
  - Chlamydia Screening
  - Cervical Cancer Screening
  - Hemoglobin A1c
  - 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 September.
- Robocalls will be sent out to members that do not receive text messages.

- Submitted DHCS form to pilot idea for BCS: encourage members to completes their mammograms- Approved

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

For MY2023 MCAS Reporting:

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

- 14 out of 18 measures showed improvement compared to previous year MY2022: CBP, IMA-2, PPS-Post, PPC Pre, LSC, AMR, BCS-E, CHL, DEV, FUA, FUM, TFL, W30 (0-15), W50(15-30) and WCV.
- 4 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%	74.79%	73.99%	▲73.35%			
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%	52.66%	54.29%	▲55.56%			
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%	43.20%	44.26%	▲45.40%			
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%	46.05%	47.50%	▼48.49%			
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%	18.38%	19.15%	▲19.67%			
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%	48.75%	51.25%	▲52.92%			
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%	13.14%	18.61%	▲18.77%			
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%	23.36%	24.71%	▲24.11%			
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%	19.49%	19.38%	▲18.69%			
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%	67.58%	66.51%	▲62.65%			
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%	29.52%	32.00%	▲32.88%			
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%	66.60%	67.25%	▲67.90%			
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%	43.83%	46.35%	▲48.18%			
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%	64.76%	64.28%	▲64.62%			
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%	31.71%	33.47%	▲35.76%			
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	24.72%	29.30%	34.04%	37.92%	41.33%	44.51%	47.26%	49.52%	▲51.70%			
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	51.49%	54.30%	56.86%	59.32%	61.71%	63.56%	64.36%	65.26%	▲66.12%			
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%	29.14%	34.53%	▲38.73%			

GSD* is an inverse measure, where a lower rate indicates better performance.

Please note the above rates are based on admin and supplemental data, they do not include medical record review.

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

As of September 2024, **16 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
- CIS-10- Childhood Immunization Status- Combo 10
- FUA- Follow-Up After Emergency Department Visit for Substance Abuse
- FUM- Follow-Up After Emergency Department Visit for Mental Illness
- IMA-2- Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)
- LSC- Lead Screening in Children
- TFL-CH- Topical Fluoride for Children
- PPV- Pre- Prenatal & Postpartum Care –Prenatal Care
- 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

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

- CCS - Cervical Cancer Screening
- GSD- Glycemic Status Assessment for Patients with Diabetes

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: There were no policy updates in September 2024.

KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: John Miller, M.D.

Date: December 12, 2024

Re: Quality Improvement Workgroup (QIW)

Background

The 3rd Quarter meeting of the KHS Quality Improvement Workgroup (QIW) took place on September 26, 2024. This committee operates within the new reporting structure, which reports to the Executive Quality Improvement Health Equity Committee (EQIHEC). Committee members include providers and representatives from the community. The committee's goal 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 NOT met, and items requiring a vote were tabled.

The present members discussed the importance of MCAS measures and performance trends over the past few years. A comparison of MCAS MY2022 and MY2023 revealed that 16 of the 18 measures showed improvement. Moving forward, the goals include fostering collaboration across the health plan, providers, and ad hoc groups to address rates, challenges, and barriers. Additionally, planned initiatives include:

- Strengthening provider collaborations.
- Utilizing mobile units to partner with school districts.
- Enhancing member engagement through technology-driven campaigns, such as text messaging and robocalls for scheduling appointments.

Performance Improvement Projects (PIPs), initiated in August 2023 and scheduled to run through 2026, will focus on health equity and non-clinical measures. Special attention is being given to PUA and FUM measures, with reliance on Behavioral Health (BH) and Business Intelligence (BI) support.

The following site review activities were completed during Q2 2024:

- 4 Initial Site Reviews and 3 Medical Record Reviews.
- 5 Periodic Site Reviews and 5 Medical Record Reviews.
- 100% of site reviews passed, and 85% of year-to-date medical record reviews passed.
- 2 sites failed their initial review, but corrective action plans (CAPs) were completed and closed.
- 5 Physical Accessibility Reviews were completed.

Quality of Care (QOC) Grievances for Q2 2024 was presented:

- 490 grievances were classified as Quality of Care (QOC) concerns and closed.
- 2,543 grievances were classified as non-QOCs and closed.
- 3,033 total grievances were closed.

Grievances received by the QI RNs are classified as Potential QOCs for further review or sent back to grievance coordinators as non-PQOCs. Grievances classified as Potential QOCs are further reviewed and may be resolved in favor of the member or referred to the QI Department as a Potential Quality Issue (PQI). Grievances resolved in favor of the provider are not referred to QI, as this resolution indicates no QOC concern was identified requiring further investigation.

A summary of PQI activity for Q2 2024 was presented:

- 162 PQIs were reviewed.
- 85 were classified as "No Quality Concern."
- 75 were classified as "Potential Harm."
- 2 were classified as "Actual Harm."

The results of the 2024 KHS Provider Satisfaction Survey showed significant improvements compared to 2023:

- Overall Satisfaction: 90%.
- Would Recommend: 98.8% (up from 98.3% in 2023).
- Coordination of Care: increased to 53.1%.

Fiscal Impact

None.

Requested Action

Approval of committee proceedings.

KERN HEALTH SYSTEMS

QUALITY IMPROVEMENT WORKGROUP (QIW) MEETING

Thursday, September 26, 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 Workgroup Subcommittee (QIW)
AGENDA – September 26, 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	June 2024 Minutes	***All Voting Members***	*2 min*	*Approve*
OLD BUSINESS	1. Follow-up: Assessment on mother when child is established patient	Michelle Curioso, PHM Dir	*3 min*	*Discussion*
NEW BUSINESS	1. Quality & Safety of Clinical Care a. MCAS b. PIPs c. FSR/PARs/Medical Records d. QOC Grievances & PQIs 2. Provider Engagement a. Provider Satisfaction 3. NCQA Accreditation 4. QI Policies 5. Workplan Scorecard – Q2	Kailey Collier, QP Dir Magdee Hugais, QI Dir Greg Panero, Provider Network Analytics Program Manager Steven Kinnison, NCQA Mgr Dr. Miller MD, KHS Med Dir Magdee Hugais, QI Dir	*10 min* *5 min* *10 min* *10 min* *5 min* *5 min*	*Informational* *Informational* *Discussion* *Informational* *Approval* *Approval*
OPEN FORUM	Open Forum / Committee Members Announcements / Discussion	***Open to all Members***	*10 min*	*Discussion*
NEXT MEETING	Next meeting will be held Thursday, **December 12, 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: ***JUNE 27, 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, KHS Executive Health Services Coordinator	Dan Diaz, RN, KHS ECM Clinical Manager Pawan Gill, KHS Health Equity Manager Loni Hill-Pirtle, KHS Director of Enhanced Case Mgmt Magdee Hugais, KHS Director of QI	Steven Kinnison, KHS NCQA Manager Courtney Morris, KHS Behavioral Health Supervisor Isabel Silva, KHS 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 Director called the meeting to order at 12:01 PM.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. John Miller, presented the last meeting minutes for approval.	☑ **ACTION**: Dr. Joseph Hayes moved to approve minutes of March 29, 2024, seconded by Dr. Mansukh Ghadiya. Motion carried.	*6/27/24*
OLD BUSINESS	**Committee Survey & Discussion** At the March meeting, Magdee Hugais, posed a committee survey question "What do you see as the top priority to improve the overall quality of healthcare in our community?" A QR Code was given to the members to complete. Magdee reported the results are not yet completed and will be presented at the September 26th meeting.	☑ **CLOSED**: Informational discussion only.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	**<u>Quality of Clinical Care</u>** **MCAS / QP Report 1st Quarter 2024** Magdee Hugais, QI Director, reported the Quality Performance 1st Quarter 2024 summarizing the following: • Facility Site Reviews: Of the 8 initial FSR reviews completed in Q1 2024 all passed with 100% and 83% Medical Record Reviews. One site failed first review however, corrected action plan was implemented and closed upon compliance. • Performance Improvement Projects (PIPs): The first PIP was W30 MCAS measure, specific to Health Equity of the 0-15 months African American Population in Kern County. The second PIP is non-clinical Behavioral Health, specific to the FUA and FUM measures. • MCAS Update: The QP Team continues with MCAS specific initiatives in support of improving all measures for current year with a focus on Children's domain of care.	☑ **CLOSED**: Informational discussion only.	. *6/27/24*
	<u>QOC Grievances and PQIs</u> Magdee Hugais presented the 1st Quarter QOC Grievances and PQIs (Potential Quality Improvements). The following highlights were noted: • 3905 Grievances were closed by QI of which 610(15.62%) were classified as QOC Grievances. • 37% increase in total grievance volume was noted in Q1 2024. • No other significant trends or issues of concern were identified, and QI will continue to monitor. Dr. Michael Komin asked if KHS is still requiring physician explanations to the QOC Grievances. April Dutton responded that yes, every physician/provider is required to submit explanation. Dr. Komin requested whether there was training available to assist with appropriate documentation for responding to these types of requests.	☑ **CLOSED**: Informational discussion only. QI will take Dr. Komin's request for training on documentation as a follow-up.	*6/27/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Standard Q13: Across Settings As part of the QI Plan, Magdee Hugais presented the annual Qualitative and Quantitative Analysis for Continuity and Coordination of Medical Care. This is an NCQA requirement (QI-3A). Magdee then shared the requirements of QI-3A from the 2024 Standards, as well as the measures selected for improvement, and the quantitative analysis. He then opened the floor for discussion of barriers and potential interventions. **Summary of Discussion:** Measures analyzed are 7 day follow up post discharge, and diabetic retinal eye exam (EED) information shared with PCP. Barriers identified and discussed: • Health literacy • Provider availability • Providers unaware • Discharge Plan not getting sent to PCP office. • Accurate contact info • Staffing including CHWs. Possible interventions discussed: • Member/Patient education before they are discharged. • Add CHWs to staff at clinics and on street. • Opening another clinic in East Kern for high-risk, homeless patients • Improvements to provider portal to include discharge records, provider education.	☑ **CLOSED**: Informational/discussion only.	*6/27/24*
	Standard Q13: Across Practitioners In 2023, only 39% of members had office visits within 7 days of inpatient discharge. Committee was asked to discuss barriers in the community that are preventing the follow up visit from happening, and what we can do to improve it. Lela Criswell, Manager of Member Engagement, suggested 2 barriers: 1. Members are not educated to call their doctor to schedule the follow up visit. 2. Provider availability	☑ **CLOSED**: Informational/discussion only.	*6/27/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Michelle Curioso, Director of KHS PHM, offered that one way this can be improved is through implementation of the DHCS mandate that every member transitioning from one setting or care level to another will have a Care Coordinator. This will be accomplished through the KHS Population Health Management transitional care team. Part of the requirement is to ensure that the medical records from the hospital are shared with the PCPs. She also shared that an analysis of members who were seen by PCP within 7 days of discharge had a lower rate of readmission. She shared that a barrier raised at Provider Advisory Committee is that PCPs are not often aware that their patients have been to the hospital. Melinda Santiago, Director of Behavioral Health suggested doing a better job with using the provider portal to facilitate the transfer of medical records to the PCPs. Dr. John Miller suggested that PCP awareness of patient in hospital is an age-old problem, and that it is necessary to hand hold everyone at the hospital, because other interventions have not worked. Another barrier brought up by Melinda Santiago is accurate contact information. Dr. Mansukh Ghadiya agreed this is an issue, especially with the large homeless population, so that in-person modality and making sure we have feet on the street is important. Melinda Santiago stated she has added two CHWs going out into the community. Dr. Mansukh Ghadiya MD will be opening another office in East Kern, Lake Isabella, and Basin area. Isabel Silva asked if Golden & Premier would consider adding CHWs to staffing model, as there is a lot of data showing they make a significant difference in outcomes of patients being discharged from hospital. Dan Diaz, ECM Clinical Manager, said both Golden & Premier were starting ECM programs, and both have CHWs. Those high-risk patients who are transferring out of hospital are part of ECM. Carmelita Magno, Kern Medical Process Improvement Director, discussed no contact information or incorrect information being a barrier they see. They do have nurses follow patients after discharge		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	from hospital. What they have done, is to reiterate while patient is still in hospital that someone will be calling them, so that when they see the number 326-6000, they recognize and pick up.		
	Safety of Clinical Care 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.	☑ **CLOSED**: Informational/discussion only.	*6/27/24*
	NCQA Accreditation Stephen Kinnison, KHS NCQA Manager presented the 2024 NCQA Readiness Project Status noting the following key accomplishments: • Quality Dept has hired 2-specialists. • HEA points have increased from 37% to 43%. • Reports continue to be submitted for UM Evaluation and PHM are now considered "Standard Met." • Next steps include continuing mock audits for UM, Credentialing and PHM as well as preparation for operation readiness to be completed by July 31st. • Accreditation Dates has been scheduled for April 8, 2025	☑ **CLOSED**: Informational/discussion only.	*6/27/24*
	ECM CAP Process The Corrective Action Plan process was presented to the Quality Improvement Committee to explain the updated new escalation path specific to contracted Enhanced Care Management sites. Dan Diaz, ECM Clinical Manager asked Committee for approval prior to publishing this as policy to the public.	☑ **ACTION**: Dr. Joseph Hayes, moved to approve ECM CAP Process, seconded by Dr. Michael Komin. Motion carried.	
	Workplan Scorecard – 1st Quarter 2024 Magdee Hugais, QI Director, presented the QI Program Workplan Q1 2024 Scorecard that identified the key measures that are on track, in jeopardy, barrier or completed and the actions and/or	☑ **CLOSED**: Informational/discussion only.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	improvement being taken. Most key measures are either completed or on track; there appear to be no barriers at this time, and MCAS Measures and Telephone access to Member Services continue to be analyzed for improvements.		
OPEN FORUM	**<u>Open Forum</u>** Dr. Michael Komin requested clarification if doing as assessment on a mother when their child is an established patient, but they are not. KHS will check with Member Services department to follow up on this question.	☑ **PENDING**	*6/27/24*
NEXT MEETING	Next meeting will be held Wednesday, September 26, 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 06/27/24

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

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

KERN HEALTH SYSTEMS

Quality Performance

MCAS

Kailey Collier
Director of Quality Performance

MCAS Performance Over the Years

KHS MCAS performance for measures held to MPL from the past 7 years to current submission.

- Met MPL for more measures in MY2023 than the previous 4 years.
- Met MPL for 3 measures that had never met MPL or had not met MPL in last few years (CHL, AMR, and CCS).

Measurement Year	MY2017	MY2018	MY2019	MY2020	MY2021	MY2022	MY2023
KHS Membership	242,265	246,564	251,280	277,616	299,864	334,078	346,049
MPL Percentile	25th	25th	50th	50th	50th	50th	50th
Total Held to MPL	21	20	18	19	15	15	18
Met MPL	19	18	3	2	5	5	8
Did Not Meet MPL	1	2	15	17	10	10	10

MCAS MY2022 vs. MY2023

Improvements and Highlights

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

- Met HPL for PPC-Post

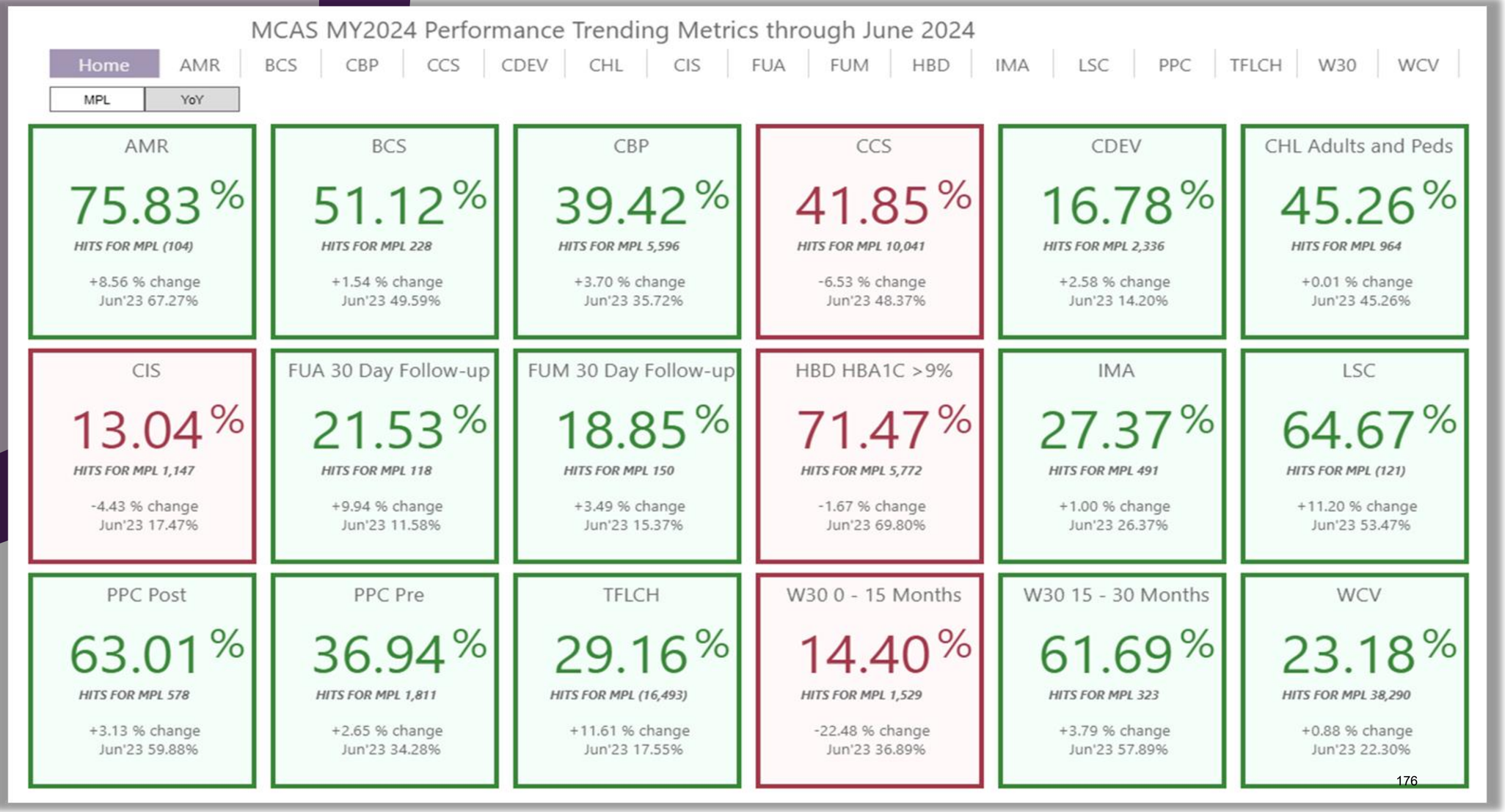
- 16 out of 18 measures showed improvement compared to previous year:
  - CCS, HBD, CBP, IMA-2, PPC-Post, LSC, AMR, BCS-E, CHL, DEV, FUA, FUM, TFL, W30 (0-15), W30(15-30), and WCV.

MY2024 Trending Performance

KHS MCAS MY2024 vs. MY2023 Comparison

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

**W30 0-15m does not display an accurate rate, issue is being reviewed.*



KERN HEALTH SYSTEMS

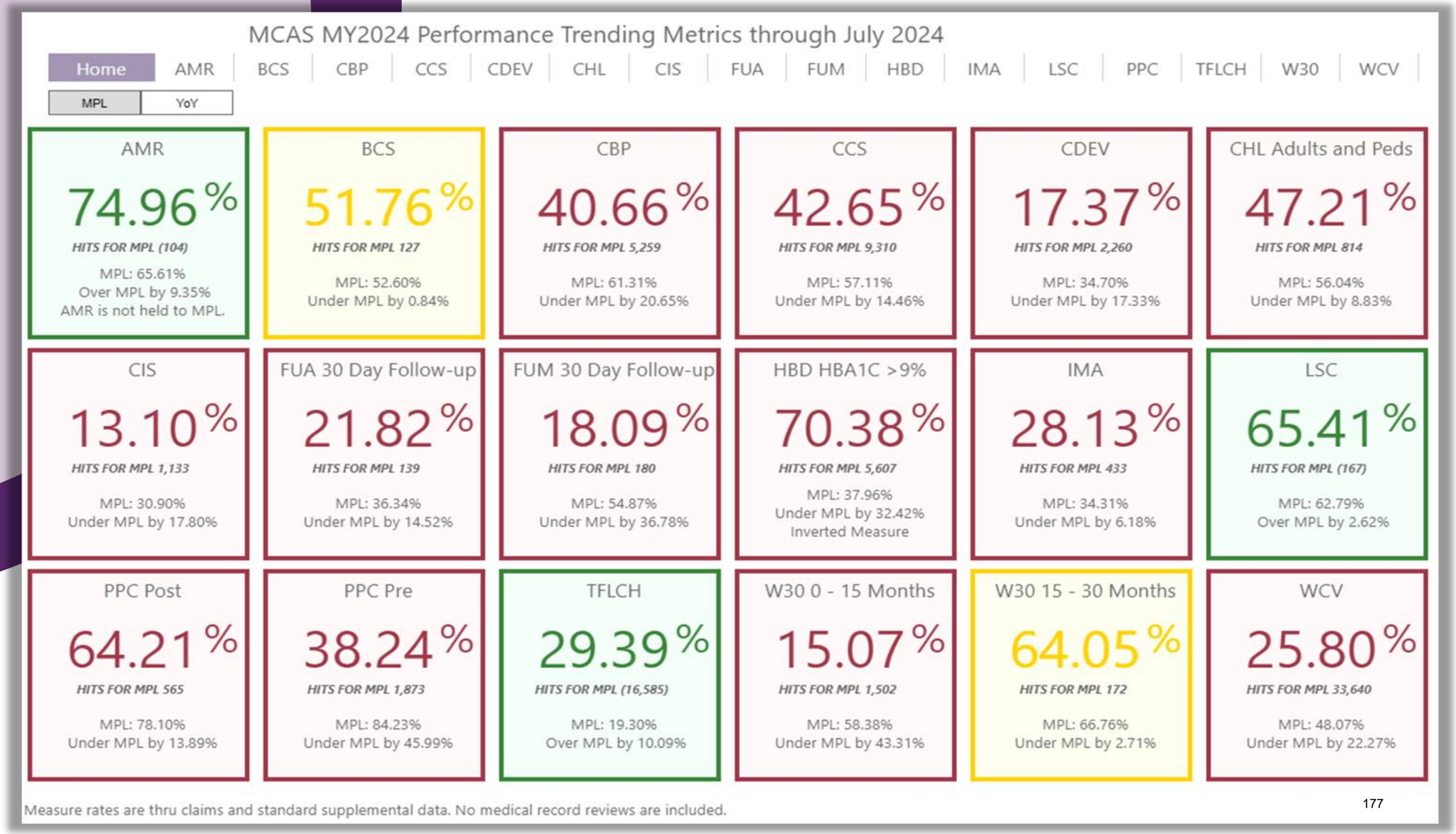
KHS MCAS MY2024
Trending Rates

- Meeting MPL for 3 measures
- 2 measures are within 5% of meeting MPL

**W30 0-15m does not display an accurate rate, issue is being reviewed.*

KERN HEALTH SYSTEMS

MY2024 YTD Performance



2024 Goals and Initiatives

Provider Meetings

The QP team has initiated monthly and quarterly meetings with assigned providers. Met with various scheduled and ad hoc provider groups to discuss rates, challenges, barriers and/or accomplishments.

Provider Collaborations

Endocrinologist maintaining program for Diabetic members, 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 l

·The QP leadership team is in the process of establishing an API to allow appointment scheduling for this population directly with the Endocrinologist's office.

Mobile Units

Pharmacy provider establishing routine vaccine events focused on children ages 2 and older. Large provider groups are operational and on track with grant milestones. Various initiatives partnering with school districts and community organizations focused on children's domain of care. KHS supporting various efforts with targeted call campaigns and geomapping insights for prime event locations.

Member Engagement

Member Engagement Reward Program (MERP) Campaigns:

- Text Messages to members encouraging the scheduling of their appointments for gaps in care with a focus on various MCAS measures.
- 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.

Site Reviews

- 4 initial Facility Site reviews (FSRs) and 3 initial Medical Record Reviews (MRRs) were completed in Q2 2024
- 5 Periodic FSRs and 5 Periodic MRRs also completed
- 100% of FSRs passed and 85% YTD MRRs passed
- 2 sites failed the initial review, however CAPs completed and closed
- 5 Physical Accessibility Review Surveys (PARS) completed in Q2 2024

Performance Improvement Projects

- DHCS requires MCPs to annually report performance measurement results and conduct ongoing Performance Improvement Projects (PIPs) specific to measures that did not meet MPL.
- Current PIPs began in August 2023 and will run through 2026
  - The clinical PIP is focused on Health Equity, specific to the W30, 0-15 months African American population.
  - The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on BH and BI for support of interventions.

KERN HEALTH SYSTEMS

FOR ADDITIONAL INFORMATION, PLEASE CONTACT:

Kailey Collier
Director of Quality Performance

KHS Quality Improvement Department

Q3: September 26, 2024

KERN HEALTH SYSTEMS

Quality Improvement Department

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

Contents

Quality Improvement Department

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

Quarter	Grievances Closed as QOCs	Closed as Non-QOCs	Total Grievances Closed
Q2 2023	560	2383	2943
Q3 2023	346	2224	2570
Q4 2023	463	2382	2845
Q1 2024	610	3295	3905
Q2 2024	490	2543	3033

Quality Improvement Department

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

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

Severity Level	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024
Level 0 - No Quality Concern	299	265	162	129	129	85
Level 1 - Potential for Harm	145	172	138	127	108	75
Level 2 - Actual Harm	2	4	2	2	0	2
Level 3 - Actual Morbidity	0	0	0	0	0	0
Total	446	441	302	258	237	162

Quality Improvement Department

What is next for QI?

1. Grievances move to JIVA system
2. PQI rate for each provider
3. PQI by Ethnicity, ESL, Age, SOGI
4. Clinical Network Oversight Results
5. Delegation oversight
6. Appeals, clinical claims and disputes

Provider Satisfaction Report

2024 Results

Prepared for: Kern Health Care

July 2024

Methodology

The Provider Satisfaction survey was administered via mail, telephone and internet. Qualified respondents were providers contracted with the plan. A synopsis of the data collection methodology is outlined below:

2024 RESPONSE RATES

Provider type	Sample size	Completed surveys				2024 Response rates	2023 Response rates
		Mail	Phone	Internet	Total		
PCP	450	25	9	22	56	12.4%	7.9%
Specialist	714	34	15	35	84	11.8%	14.1%
Behavioral Health	285	4	2	15	21	7.4%	9.5%
Other	51	10	2	2	14	27.5%	20.3%
Total	**1,500**	**73**	**28**	**74**	**175**	**11.7%**	**12.1%**

$$\textbf{Response Rate} = \frac{\text{Completed surveys}}{\text{Sample size}}$$

Statistical references and notes:

- All statistical testing is performed at the 95% confidence level.
- Percentages less than 10.0% are not shown in graphs where space does not permit.
- Totals reported in graphs and tables may not be equal to the sum of the individual components due to the rounding of all figures.
- A caret (^) indicates a base size smaller than 20. Interpret with caution.

Dashboard – Key Findings

Changes from last year

TRENDING UP

Measures that increased significantly from 2023

None of the measures increased significantly

TRENDING DOWN

Measures that decreased significantly from 2023

None of the measures decreased significantly

Measure Name	2024 Summary Rate Score	2023 PG Medicaid BoB %tile
Would Recommend *(%Yes)*	**98.8%**	**98th**
All Other Plans (Comparative Rating) *(%Well or Somewhat above average)*	**68.4%**	**98th**
Overall Satisfaction *(%Completely or Somewhat Satisfied)*	**90.0%**	**97th**
Finance Issues *(%Well or Somewhat above average)*	**59.1%**	**98th**
Utilization and Quality Management *(%Well or Somewhat above average)*	**61.4%**	**97th**
Network/Coordination of Care *(%Well or Somewhat above average)*	**53.1%**	**98th**
Health Plan Call Center Service Staff *(%Well or Somewhat above average)*	**61.4%**	**97th**
Provider Relations *(%Well or Somewhat above average)*	**65.3%**	**98th**

Net Satisfaction Score: 86.5%

Net Loyalty Score: 89.8%

SatisAction™ KEY DRIVER STATISTICAL MODEL
Key Drivers of Overall Satisfaction with Health Plan

POWER

(Top 6)

Promote and Leverage Strengths

4E	Quality of BH providers in this health plan's provider network
4D	Number of BH providers in the health plan's provider network
4F	Timeliness of feedback/reports from BH providers in this health plan's provider network
4C	Timeliness of feedback/reports from specialists in this health plan's provider network
4B	Quality of specialists in this health plan's provider network
4A	Number of specialists in this health plan's provider network

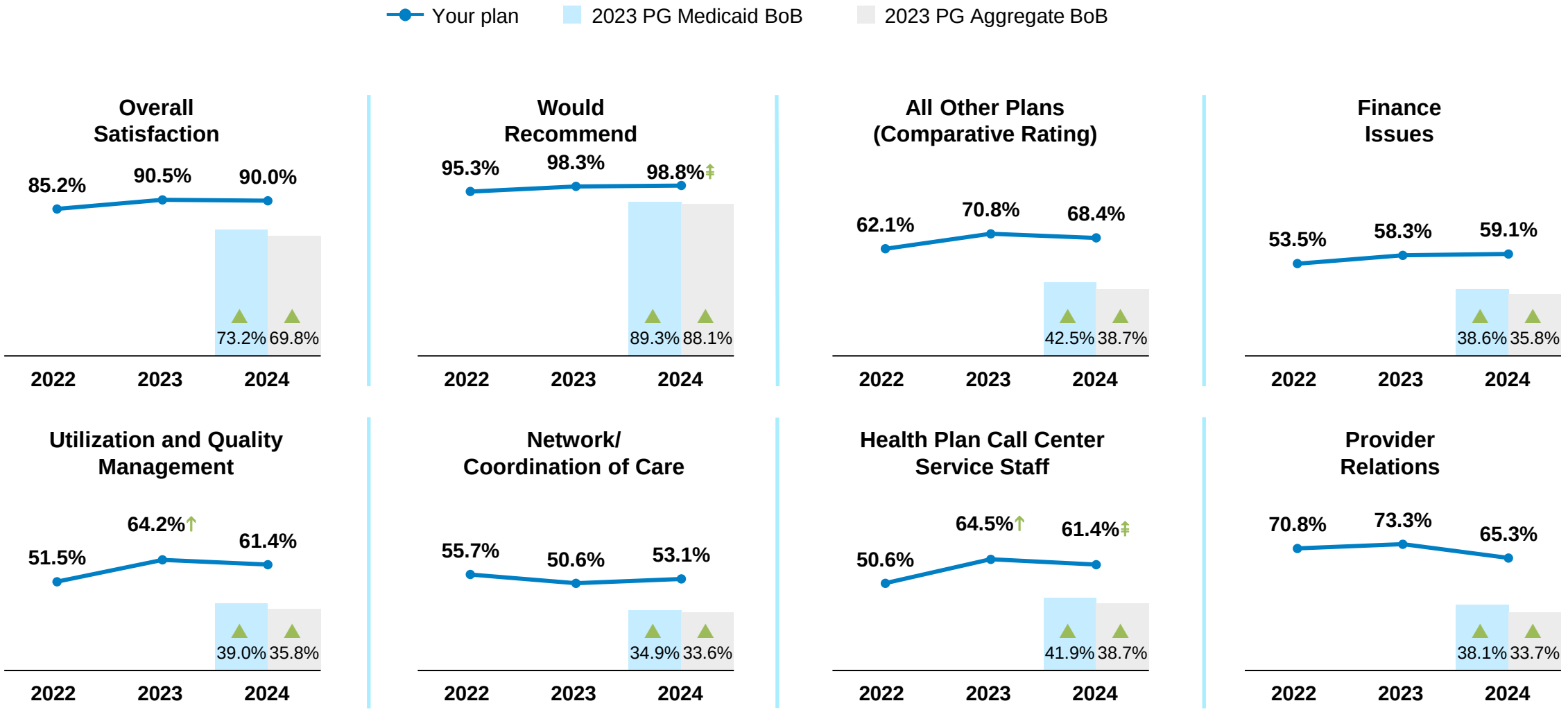
OPPORTUNITIES

Focus Resources on Improving Processes That Underlie These Items

None of the measures are considered to be areas of opportunity

Please refer to slide 8 for details.

Composite Summary Rate Scores



Significance Testing

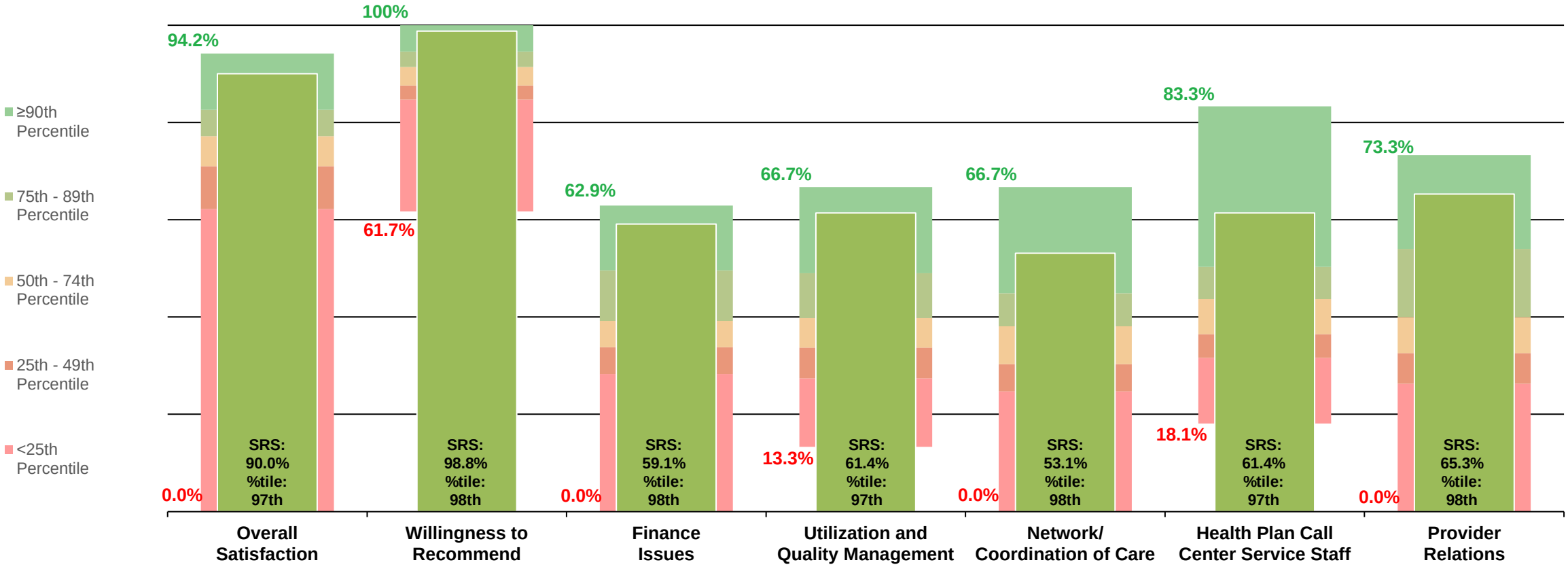
↑↓ Score is significantly higher or lower than the previous year's score. ▲▼ 2024 score is significantly higher or lower than the respective benchmark score.

‡‡ 2024 score is significantly higher or lower than the 2022 score.

Composite and Key Question Summary

COMPARISON RELATIVE TO PG Medicaid BOOK OF BUSINESS

The graph below shows how Kern Health Care scores compare to the distribution of scores in the 2023 PG Medicaid Book of Business. Kern Health Care is performing above the 75th percentile for all measures.

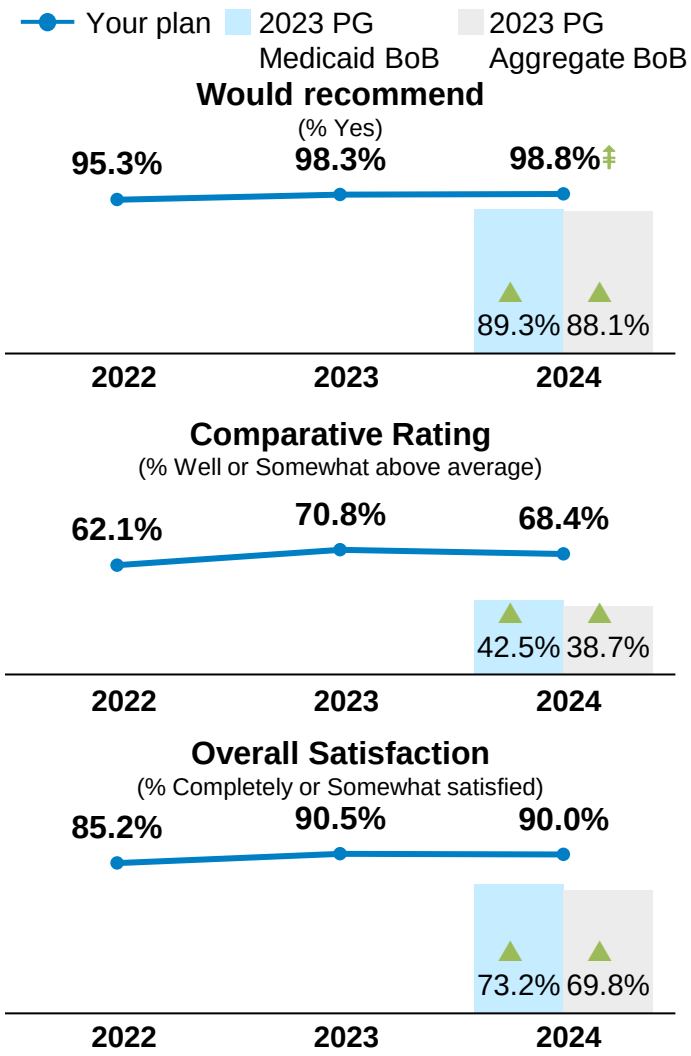


Green bar = Kern Health Care performing at or above the 75th percentile

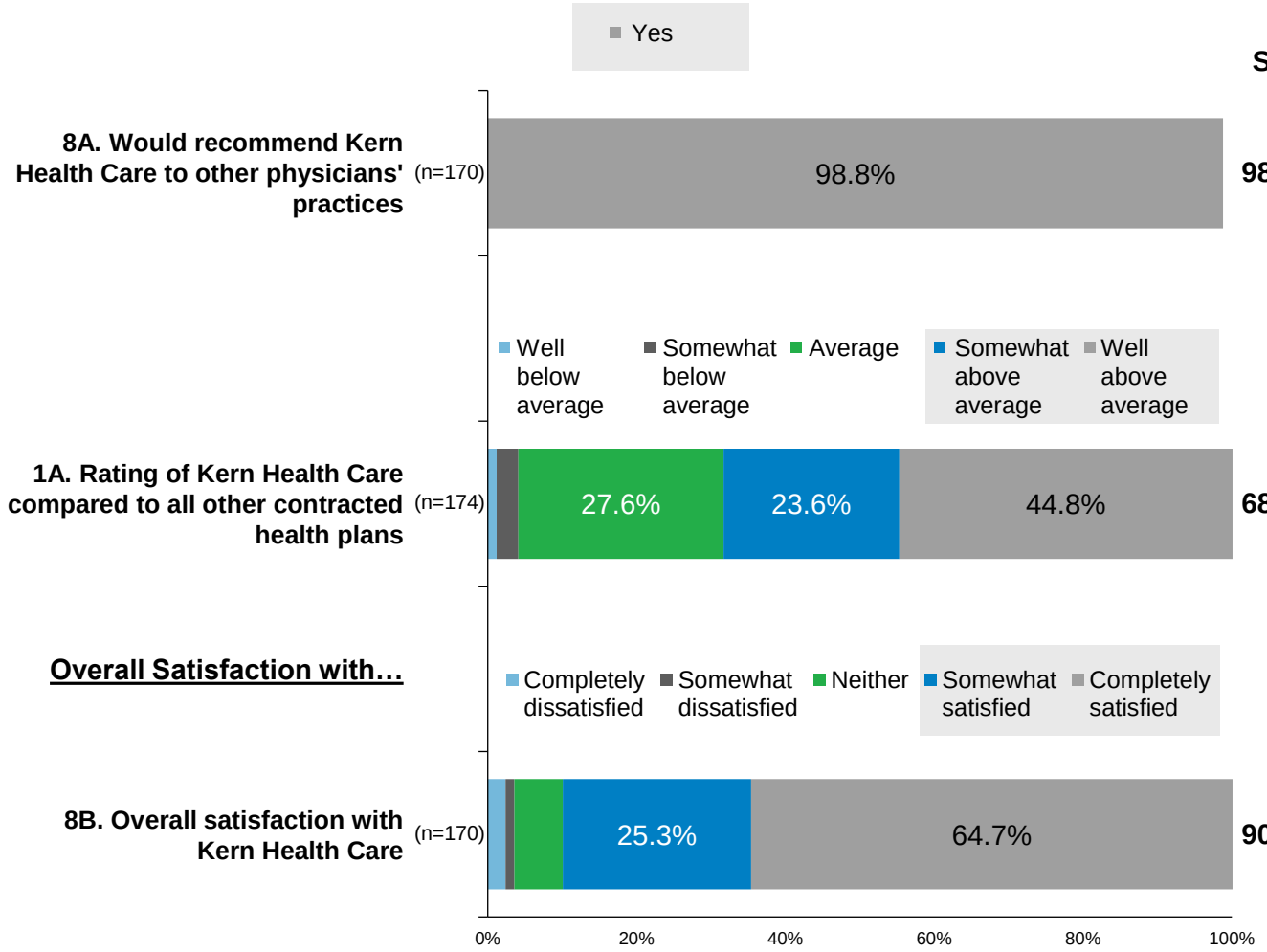
Red bar = Kern Health Care performing below the 25th percentile

Overall Measures

Overall Measure Summary Rate Scores



2024 Attribute Response Distributions



2023 PG BoB

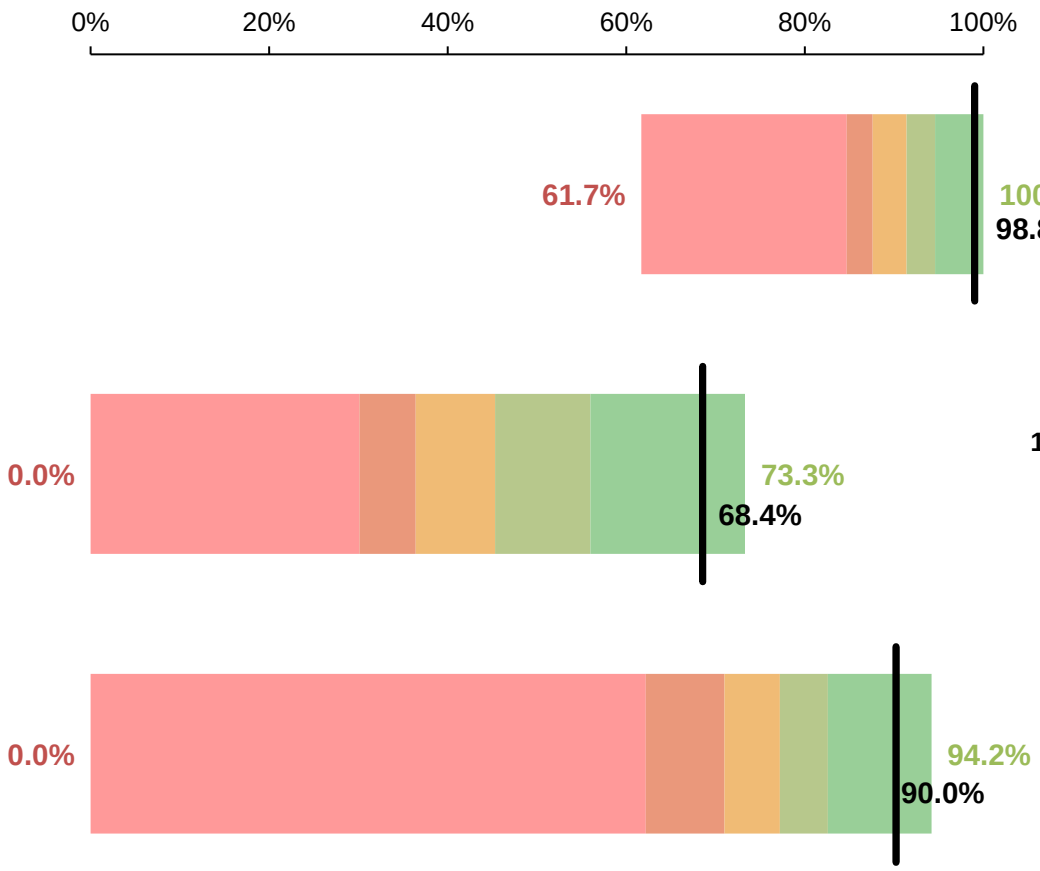
Significance Testing

↑↓ Score is significantly higher or lower than the previous year's score. ▲▼ 2024 score is significantly higher or lower than the respective benchmark score.
‡ 2024 score is significantly higher or lower than the 2022 score.

Overall Measures

2024 SRS Relative Performance

Percentiles represent the distribution of the PG Medicaid BoB. Figures in **red** represent the lowest score in the BoB; figures in **green** represent the highest score in the BoB.



The black marker indicates your plan's percentile ranking within the PG Medicaid BoB. The percentiles represented within each color are defined below.

<25th	25th – 49th	50th – 74th	75th – 89th	>90th

Attributes

(%Completely or Somewhat satisfied)

8A. Would recommend Kern Health Care to other physicians' practices
(% Yes)

1A. Rating of Kern Health Care compared to all other contracted health plans
(%Well or Somewhat above average)

8B. Overall satisfaction with Kern Health Care

SRS Trending Performance

	2022	2023	2024
8A. Would recommend Kern Health Care to other physicians' practices	95.3%	98.3%	98.8%
1A. Rating of Kern Health Care compared to all other contracted health plans	62.1%	70.8%	68.4%
8B. Overall satisfaction with Kern Health Care	85.2%	90.5%	90.0%

2023 PG BoB

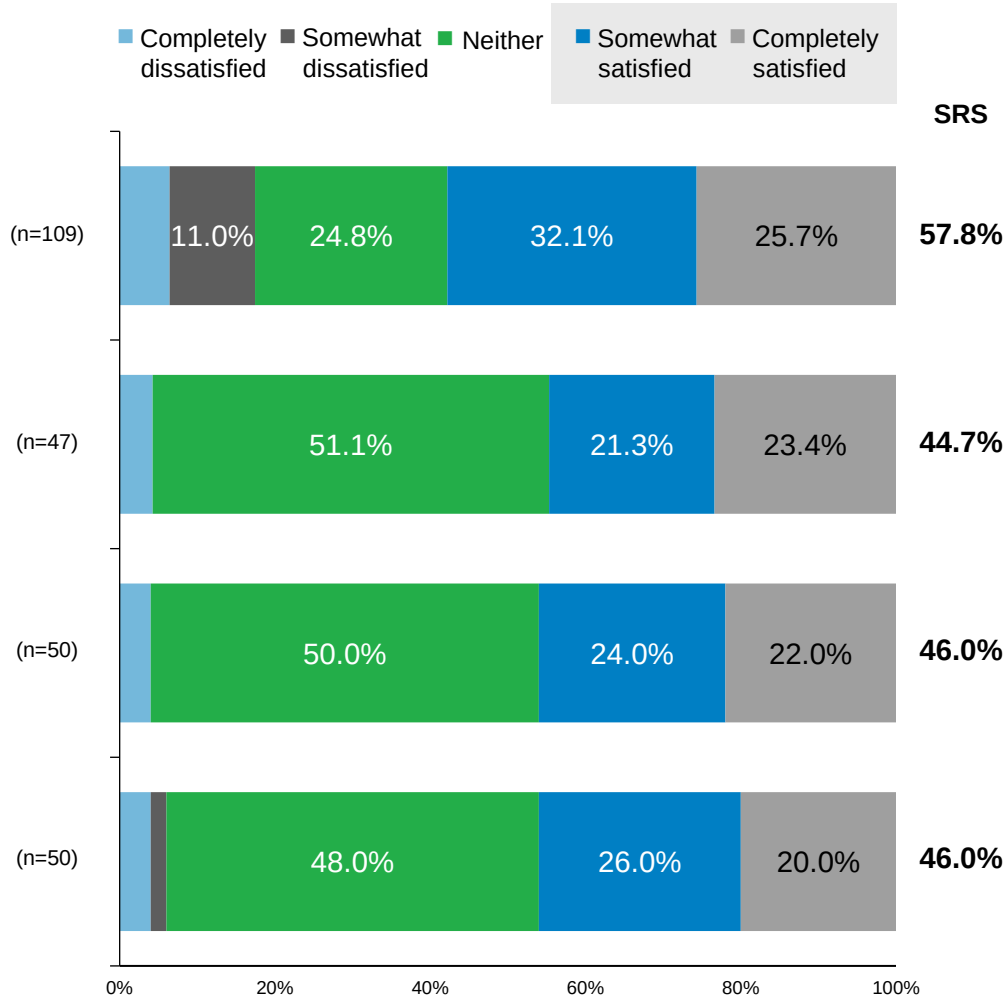
	%tile	Medicaid	Aggregate
8A. Would recommend Kern Health Care to other physicians' practices	98th	89.3%	88.1%
1A. Rating of Kern Health Care compared to all other contracted health plans	98th	42.5%	38.7%
8B. Overall satisfaction with Kern Health Care	97th	73.2%	69.8%

Significance Testing

↑↓ Score is significantly higher or lower than the previous year's score. ▲▼ 2024 score is significantly higher or lower than the respective benchmark score.
‡‡ 2024 score is significantly higher or lower than the 2022 score.

Overall Measures

2024 Attribute Response Distributions



Attributes

Summary rate: % Completely or Somewhat satisfied

8C. Overall Satisfaction with Health Net Kern County*

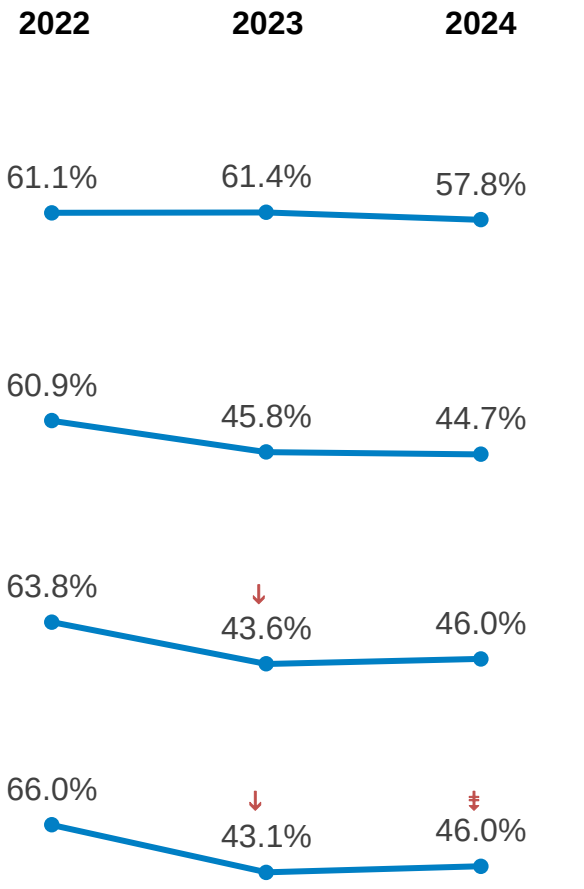
8D. Overall Satisfaction with Gold Coast*

8E. Overall Satisfaction with Health Plan of San Joaguin*

8F. Overall Satisfaction with Cal-Viva*

*Measure not included in composite calculation.

SRS Trending Performance



Significance Testing

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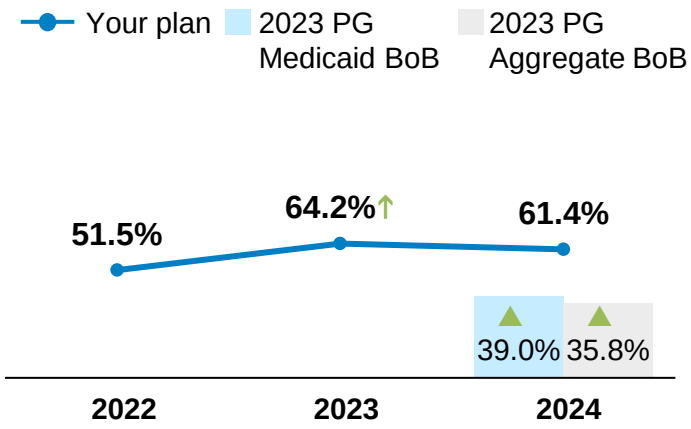
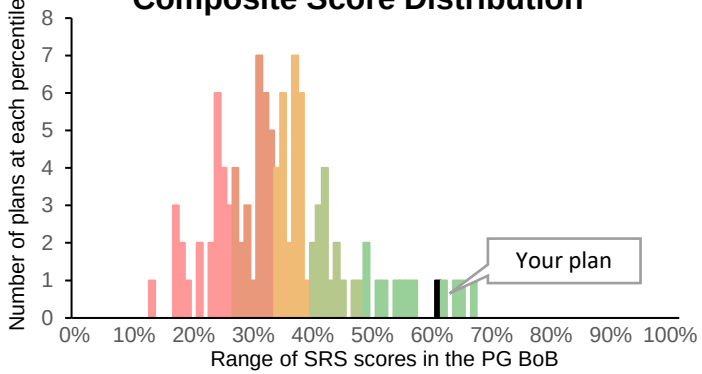
Utilization and Quality Management

Composite Summary Rate Score



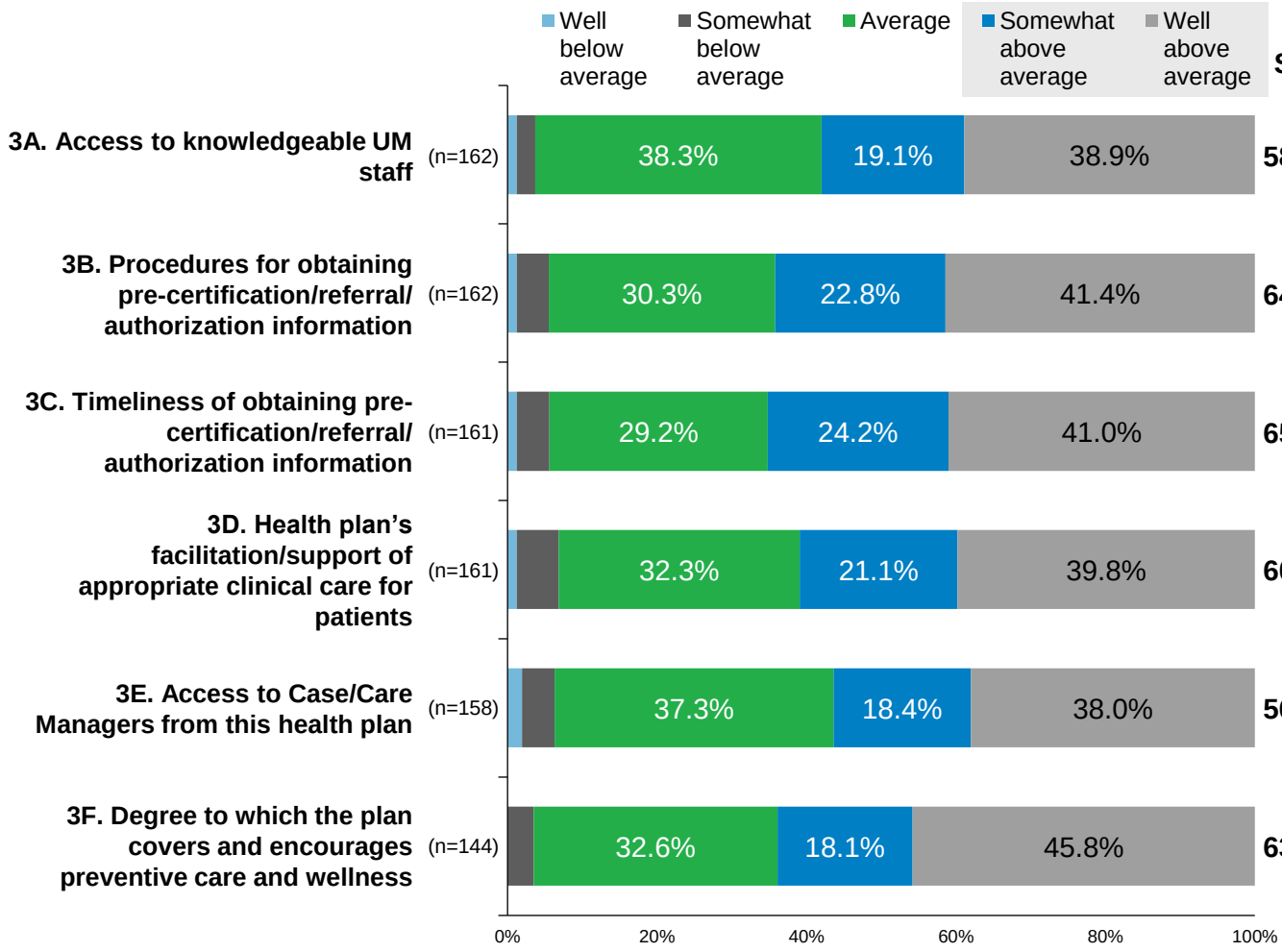
2023 Medicaid BoB Composite Score Distribution



The black marker indicates your plan's percentile ranking within the PG Medicaid BoB. The percentile range represented by each color are defined below.

<25th	25th – 49th	50th – 74th	75th – 89th	>90th

2024 Attribute Response Distributions



SRS	%tile	2023 PG BoB Medicaid	2023 PG BoB Aggregate
58.0%	96th	36.6%	33.3%
64.2%	96th	38.5%	35.4%
65.2%	97th	39.4%	36.4%
60.9%	97th	38.9%	35.8%
56.3%	96th	36.4%	33.2%
63.9%	96th	43.9%	41.0%

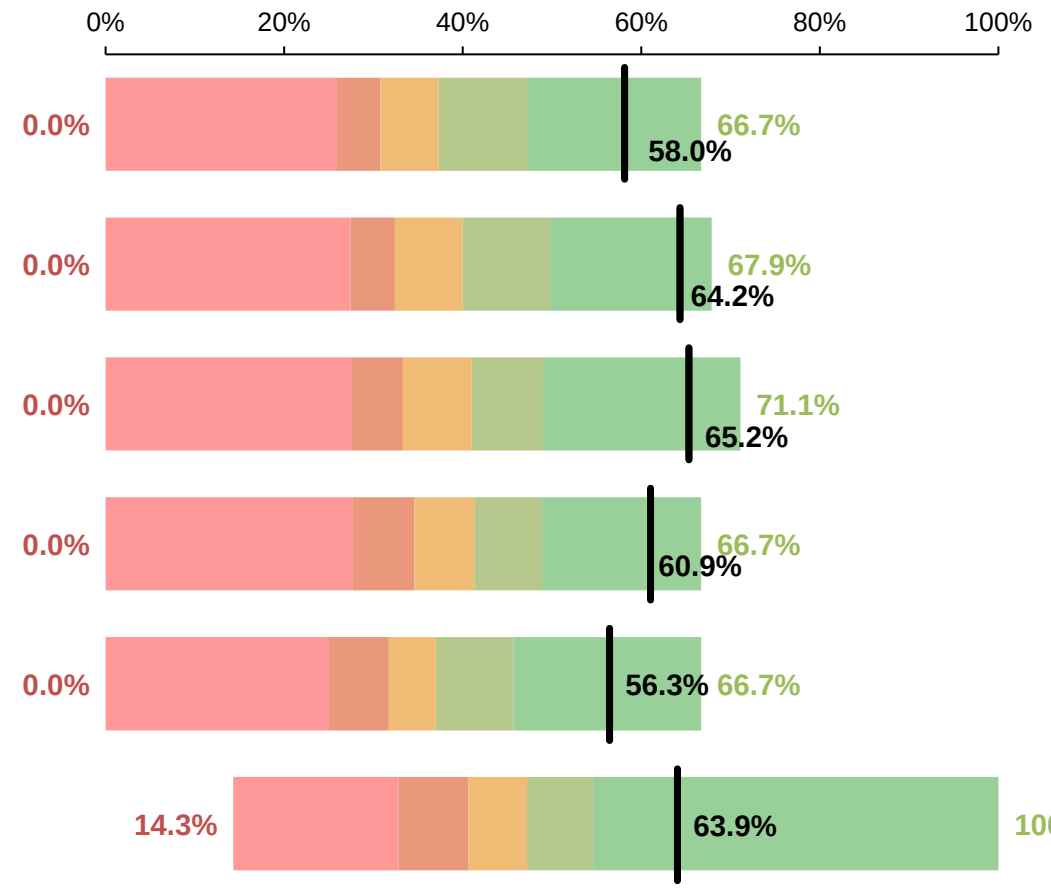
Significance Testing

↑↓ Score is significantly higher or lower than the previous year's score. ▲▼ 2024 score is significantly higher or lower than the respective benchmark score.
⇕ 2024 score is significantly higher or lower than the 2022 score.

Utilization and Quality Management

2024 SRS Relative Performance

Percentiles represent the distribution of the PG Medicaid BoB. Figures in **red** represent the lowest score in the BoB; figures in **green** represent the highest score in the BoB.



The black marker indicates your plan's percentile ranking within the PG Medicaid BoB. The percentiles represented within each color are defined below.

<25th	25th – 49th	50th – 74th	75th – 89th	>90th

Attributes

(%Well or Somewhat above average)

SRS Trending Performance

Attributes	2022	2023	2024	%tile	2023 PG BoB Medicaid	2023 PG BoB Aggregate
3A. Access to knowledgeable UM staff	49.8%	63.9% ↑	58.0%	96th	36.6%	33.3%
3B. Procedures for obtaining pre-certification/referral/ authorization information	51.0%	66.7% ↑	64.2% ‡	96th	38.5%	35.4%
3C. Timeliness of obtaining pre-certification/referral/ authorization information	52.3%	67.7% ↑	65.2% ‡	97th	39.4%	36.4%
3D. Health plan's facilitation/support of appropriate clinical care for patients	51.8%	61.0%	60.9%	97th	38.9%	35.8%
3E. Access to Case/Care Managers from this health plan	50.0%	61.5% ↑	56.3%	96th	36.4%	33.2%
3F. Degree to which the plan covers and encourages preventive care and wellness	53.9%	64.3%	63.9%	96th	43.9%	41.0%

Significance Testing

↑↓ Score is significantly higher or lower than the previous year's score. ▲▼ 2024 score is significantly higher or lower than the respective benchmark score.
‡ 2024 score is significantly higher or lower than the 2022 score.

2024 NCQA Steering Committee Meeting

Sept 17, 2024

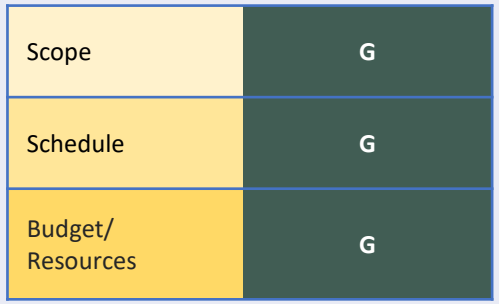
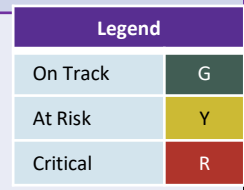
Agenda

NCQA Readiness Project

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

KERN HEALTH SYSTEMS

2024 NCQA Readiness Project Status

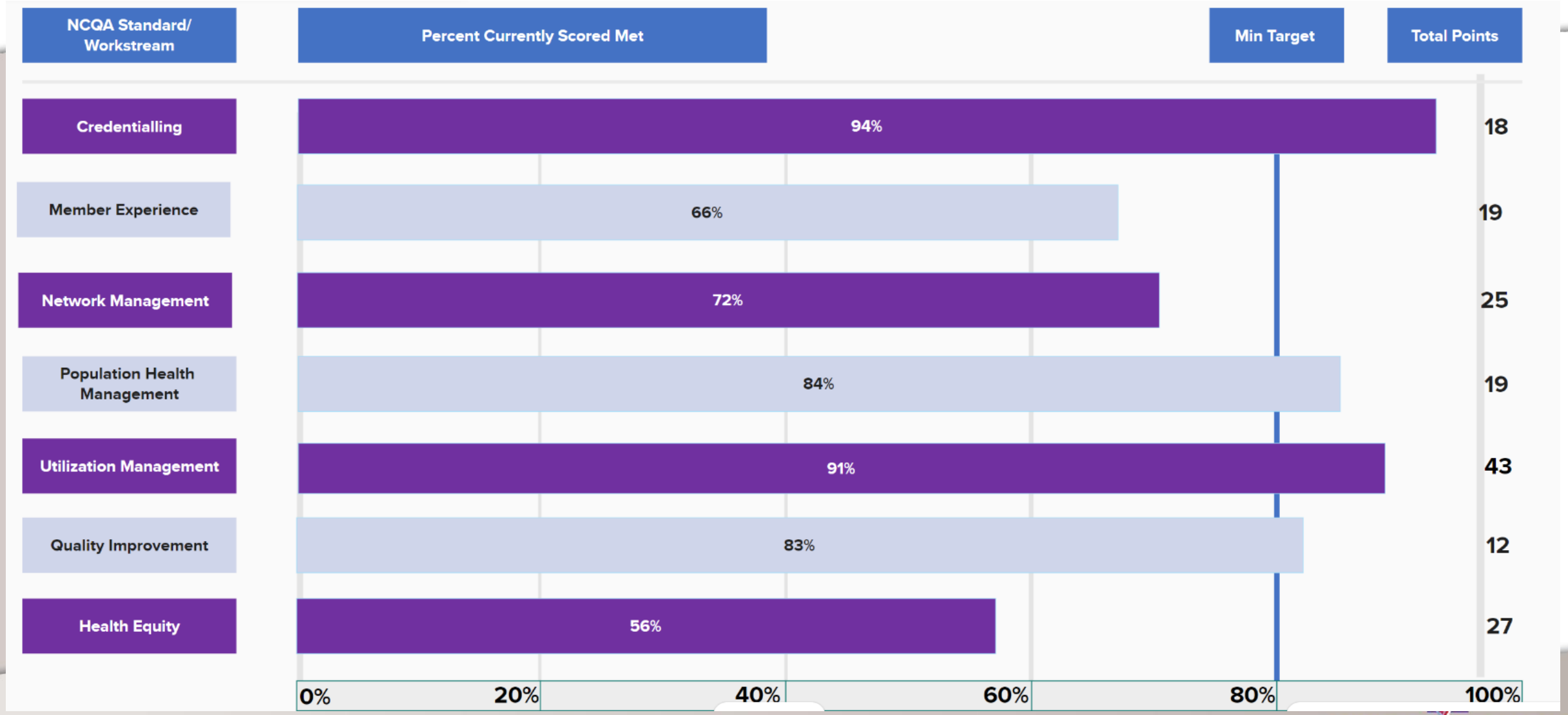
Project Information	Status
NCQA Accreditation Readiness Health Plan Accreditation (HPA) Workstreams: UM, PHM, QI, NET, CR, ME **Survey Date: April 8, 2025** Health Equity Accreditation (HEA) **Survey Date: June 10, 2025**	 

Key Accomplishments since Last Meeting	Next Steps
• HPA projected points now at 83% overall • All DP & M for HEA scored MET • HEA points increased from 50% to 56% • PHM CCM Mock Review passed	• Evidence reconciliation and Ops Readiness in progress • Continue HPA & HEA gap closure. Focus on Reports • PDF, annotate & bookmark all final documents

Issues & Risks	Mitigation

Overall NCQA Accreditation Points Tracking

Goal: 98% by December, 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

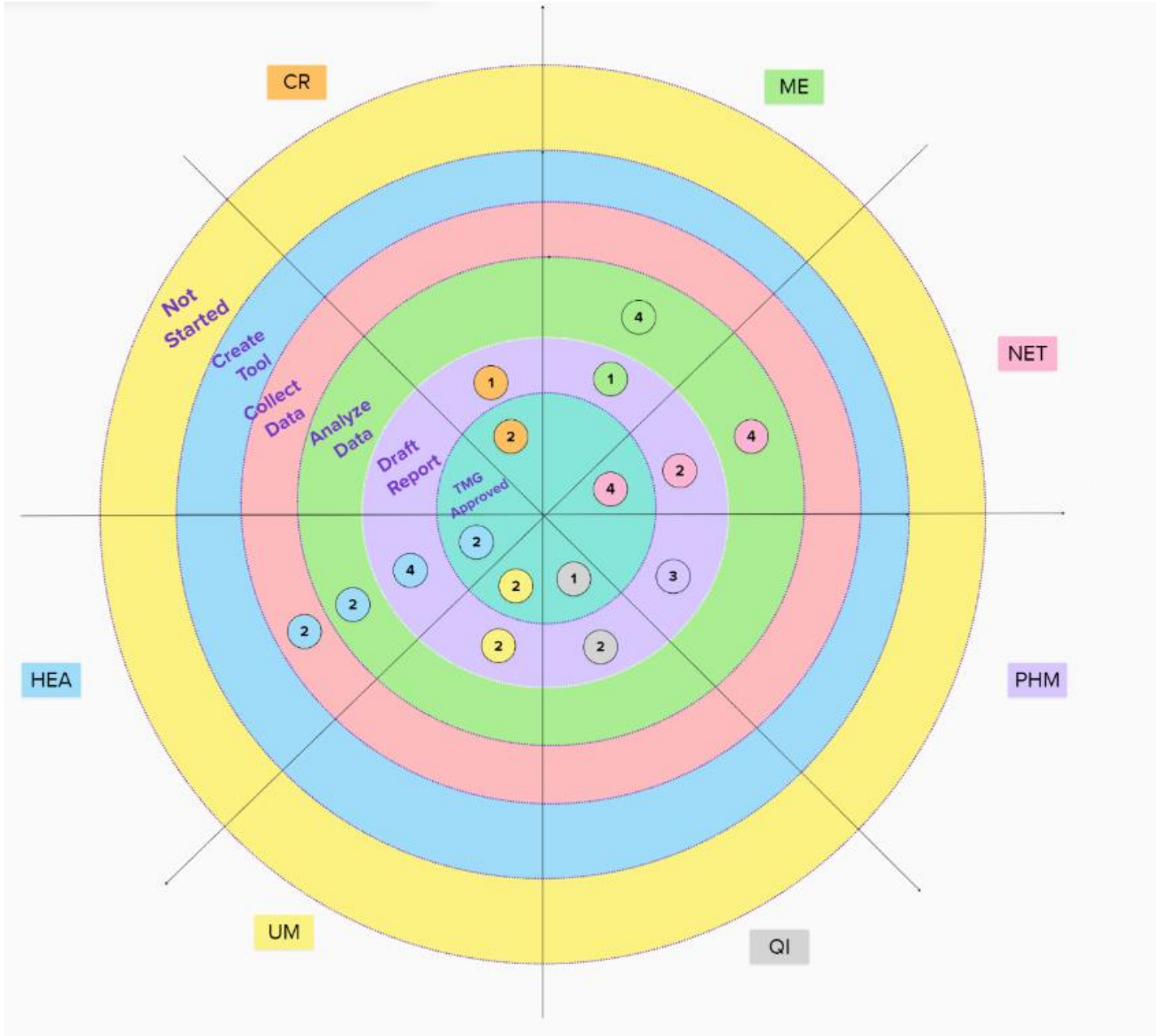
Look Back Period

Most are “at least once in prior year”

Progress on Reports

Standard/ Element	Element Description	Due Dates	Status
CR 8C	Review of Delegates Performance	Feb	Finalizing submission
PHM 1A	PHM Strategy (2024)	July	Revising 2024 version
ME 7E	Annual Assessment of Behavioral Healthcare and Services	Sept	In Process
UM 12B	Medical Denials System Controls Monitoring	Oct	In Process
UM 12D	Appeals System Controls Monitoring	Oct	In Process
NET 3A,B,C	Assessment of Member Experience Accessing the Network	Oct	In Process
ME 6D	Email Response Evaluation	Nov	Submitted to TMG
HE 4B	Enhancing Network Responsiveness	Nov	Revisions due to TMG
HE 1A	Building a Diverse Staff	Dec	Revisions due to TMG
HE 6B, D	Use of Data to Assess Disparities and Measure CLAS and Disparities	Nov	In Process
HE 6C	Use of Data to Monitor and Assess Services	Sept	Revisions due to TMG
HE 2C	Collection of Data on Language	Dec	4 of 5 factors Met; awaiting final IDSS report Sept/Oct
ME 7C	Annual Assessment of Nonbehavioral Healthcare Complaints & Appeals	Dec	In Process
NET 1A	Cultural Needs and Preferences	Dec	In Process
QI 4AB	Continuity & Coordination of Medical & BH care	Dec	Finalizing
HE 5B	Annual Evaluation of the CLAS Program	Dec	Waiting on final HEDIS
HE 6A	Reporting Stratified Measures	Dec	Waiting for IDSS approval rates from DHCS (Sept/Oct)

NCQA Reports Progress



2025 Standards - Changes

- QI 3 & 4 combined
- System Controls changed to System Integrity, eliminated monitoring factor

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Questions/Notes

- Decisions/Actions
- Next Steps

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Appendix

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Look Back Period - 2025 Survey

Survey	Survey Date	LBP	2025 Survey Look Back Dates
Health Plan Accreditation	April 8, 2025	6 months	Oct 8, 2024 to April 8, 2025
		At least once in prior year	At least once between April 8, 2024 to April 8, 2025
		12 months	Evidence meets requirement the entire 12 months April 8, 2024 to April 8, 2025
Health Equity Accreditation	June 10, 2025	6 months	Dec 10, 2025 to June 10, 2025
		At least once in prior year	At least once between June 10, 2024 to June 10, 2025
		12 months	Evidence meets requirement the entire 12 months June 10, 2024 to June 10, 2025

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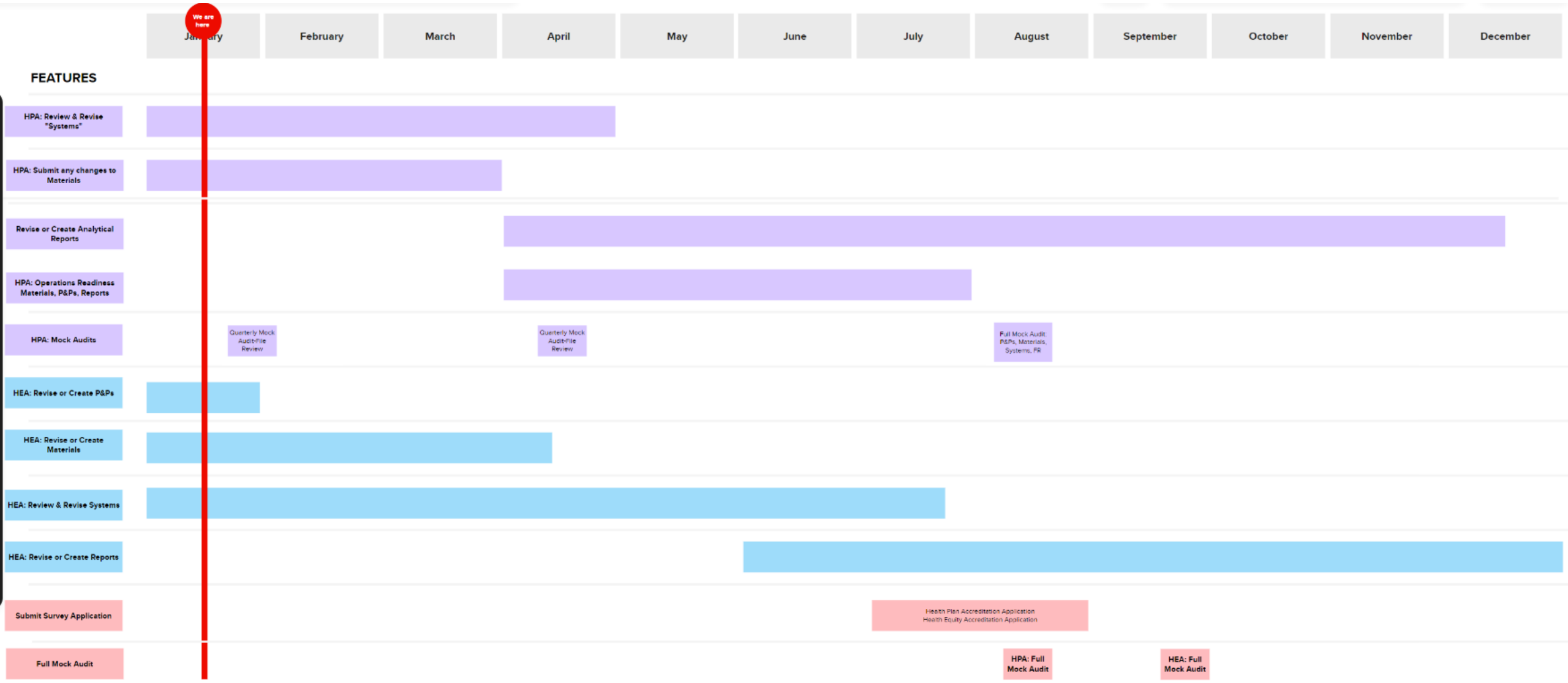
Ops Readiness Initial List

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	x	
UM-12C	UM Appeal System Controls	1	x	
	TOTALS	**20**	**20**	

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

KERN HEALTH SYSTEMS

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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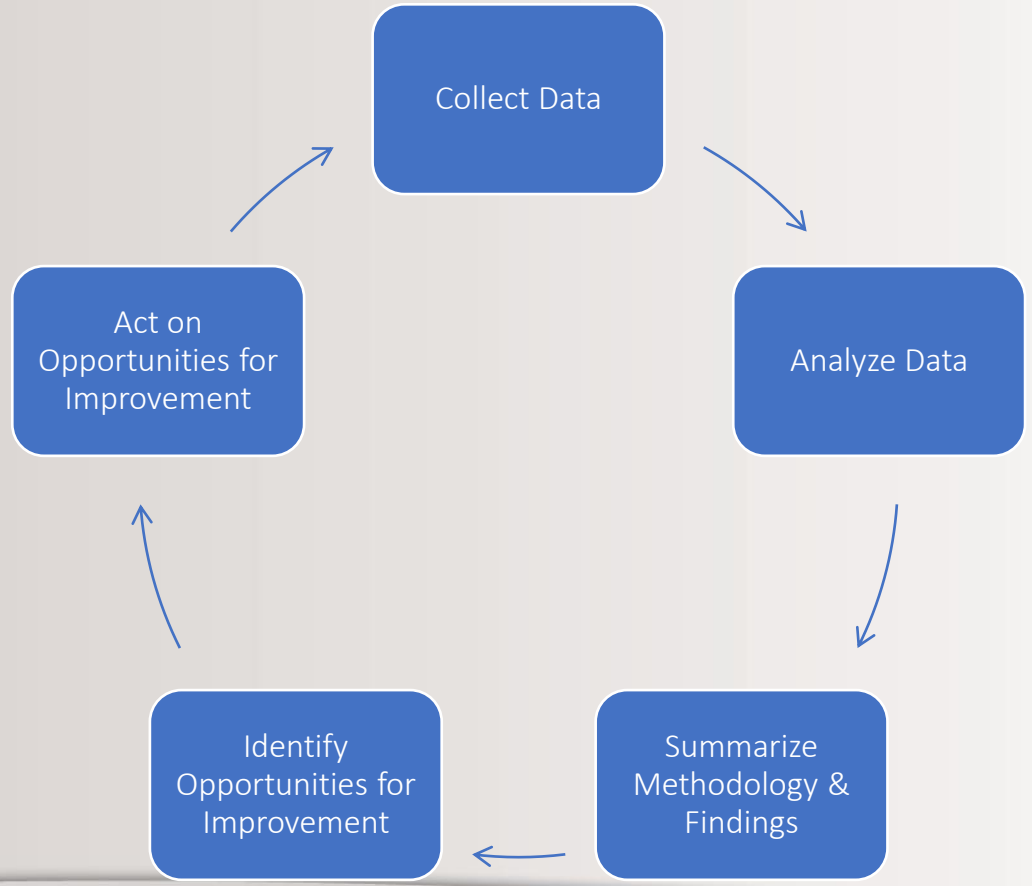
Analysis Elements – Steps in Annual Process



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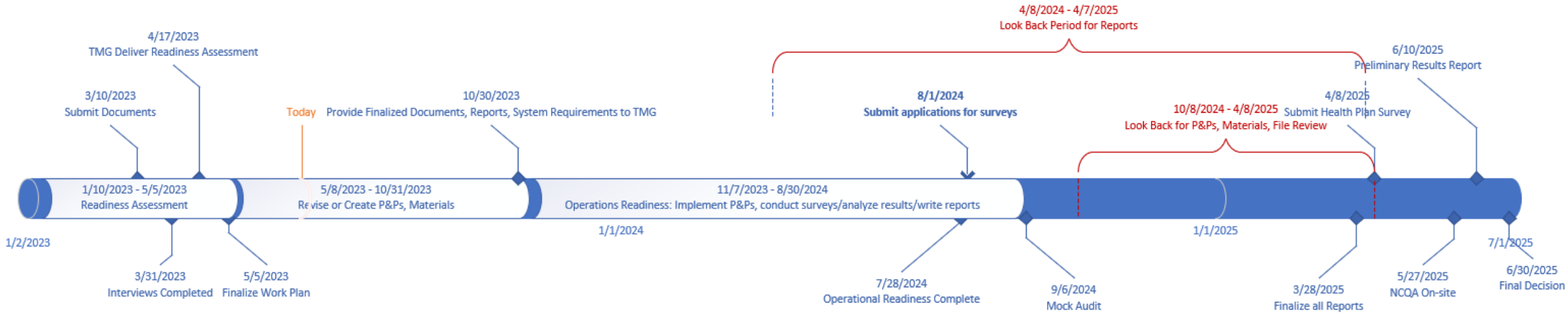
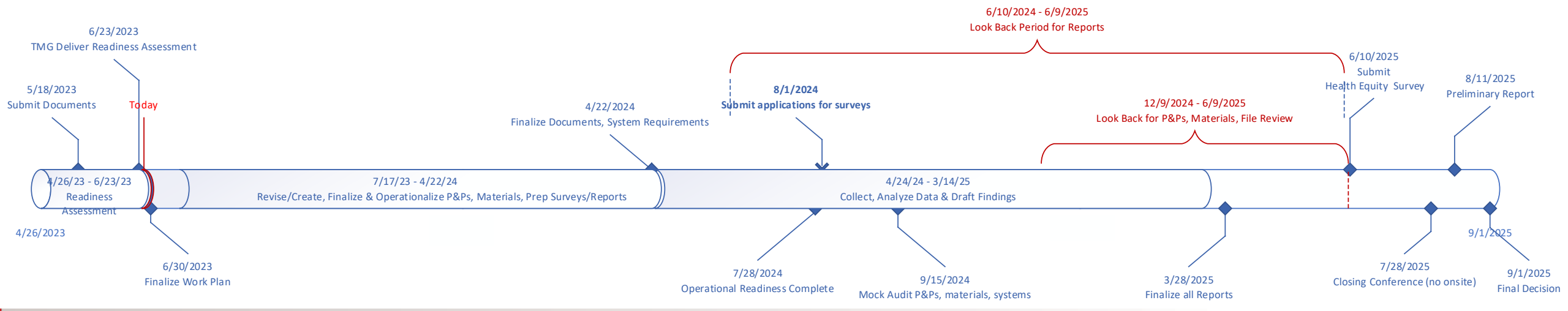
Overall NCQA HPA Project Timeline



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	

Stakeholders - updated 7.19.24

Workstream	Stakeholder	Workstream Lead	Title
Utilization Management (UM)	Christine Pence	✓	Director, UM
	Dr. Khalsa		Medical Director
	Bruce Wearda		Director, Pharmacy
Population Health Management (PHM)	Michelle Curioso	✓	Director, PHM
	Dr. Sidhu		Medical Director
	Isabel Silva		Sr. Director, Wellness & Prevention
Quality Improvement (QI)	Magdee Hugais	✓	Director, QI
	Dr. Miller		Medical Director
	Steven Kinnison		NCQA Manager
Network Management (NET)	Amisha? James Winfrey		Director, Provider Network
Member Experience (ME)	Nate Scott	✓	Sr. Director, Member Services
Credentialing (CR)	Jake Hall	✓	Sr. Director Contracting & Quality Performance
	Yolanda Herrera		Credentialing Manager
Health Equity	Traco Matthews		Chief Health Equity Officer
	Pawan Gill	✓	Health Equity Manager

KHS Quality Improvement Policies

Q3: September 26, 2024

KERN HEALTH SYSTEMS

Quality Improvement Department

No.	Type	Subject	Last Revision Date	Review status
2.51	I	Disease Management Staffing	2014	Retiring; Disease Management no longer program at KHS
2.53	I	Disease Management Outcomes Reporting	2014	Retiring; Disease Management no longer program at KHS
2.54	I	Disease Management Program - Financial Outcomes Reporting	2014	Retiring; Disease Management no longer program at KHS
2.56	I	Communication with Treating Providers	2014	Retiring; Disease Management no longer program at KHS
2.40	I	Enhanced Medical Home for Seniors and Persons with Disabilities (SPDs)	2015	Retiring; No longer a program at KHS
2.52	I	Ethics Training for Disease Management Staff	2015	Retiring; Disease Management no longer program at KHS
2.60	I	Case Management Case Closure Criteria	2015	PHM owned; retiring QI version
2.61	I	Case Management Documentation	2015	PHM owned; retiring QI version
2.62	I	Case Management Ethics Policy	2015	PHM owned; retiring QI version
2.63	I	Case Management Provider Communication	2015	PHM owned; retiring QI version
2.64	I	Case Manger Qualifications	2015	PHM owned; retiring QI version
2.65	I	Case Management Assessment	2015	PHM owned; retiring QI version

Kern Health Systems
2024 Quality Improvement Program Work plan
Last Updated: 9/24/2024

	On Track
	In Jeopardy
	Barrier
	Complete

Source	Key Performance Measure	Metrics	Measurable Goals	Actions/Improvement Activities	Status	Q2 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.		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.		2025 Workplan to be ready for December.
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		2024 Workplan to be ready for December.
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 Sept 2024, 16 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		2 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		2 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. Report completed and approved by consultant. Ready for NCQA submission.
	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 presented to QIW
	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 BH Committee
	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 BH Committee
	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 BH Committee
	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 BH Committee
	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 BH Committee
	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 BH Committee
	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 BH Committee
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.		4 initial and 5 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		5 completed in Q2
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.		3 initial and 5 periodic medical record reviews. 85% YTD 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 Q2 completed on time
Quality of Service						
NCQA; DHCS	Grievance and Appeals	a) Timeliness of acknowledgment letters	Within 5 calendar days			Goal met for Q2
		b) Timeliness of resolution	Within 30 calendar days			Goal met for Q2
DHCS; NCQA	Potential Quality of Care Issues (PQI)	a) Timeliness of acknowledgment letters	Within 5 calendar days			Goal met for Q2
		b) Timeliness of resolution	Within 30 calendar days			Goal met for Q2
		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. 98%.
	Access to Care - SCP	*Access to specialty care* Urgent care – w/in 96 hrs a) Routine care – 15 business days	80%	Provider Accessibility Monitoring Survey		Goal met. 89%
DHCS; NCQA	Telephone access to Member Services	a) Speed of answer	≤ 30 seconds	Perform quarterly telephone access audit		0:15
		b) Call abandonment rate	5%			1%
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; Results in December
	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		Results presented at Q3 QI Workgroup Subcommittee
	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		Q2 meetings completed with top 20 providers.

KERN HEALTH SYSTEMS

To: EQIHEC

From: Nate Scott

Date: December 2024

Re: Executive Summary 2023 Grievance Analysis

Background

Executive Summary 2023 Grievance Analysis:
This report was created to send to the National Committee of Quality Assurance (NCQA) for KHS to become NCQA accredited. NCQA holds health plans, like KHS, to higher standards to make sure better health care is available to all members. NCQA has specific criteria for grievance reporting that KHS must follow. This is to identify deficiencies and improve overall care and services provided to our members.

NCQA requires KHS to set goals regarding grievances received by plan members. Our goals are as follows:

- No more than ten (10) grievances per one thousand (1,000) members, per year.
- No more than two (2) grievances per grievance category, per one thousand (1,000) members, per year.

NCQA has five (5) grievance categories:

- Access
- Attitude and Service
- Billing and Financial Issues
- Quality of Care
- Quality of Practitioner Office Site.

The Department of Health Care (DHCS) has more than forty (40) grievance categories that KHS must report on. To ensure compliance with requirements from both regulators, KHS mapped all the DHCS grievance categories to the five NCQA categories.

NCQA also requires KHS to perform Qualitative and Quantitative analysis of plan grievances. This is to provide statistical data and trend characteristics of our member grievances. In addition

of the Plan review of individual member grievances, KHS used feedback from our members received through our Regional Advisory Committee (RAC) meetings and our Member Satisfaction Survey to help with our analysis. We found that while we were meeting our goals listed above, there is room for improvement in certain areas of access and care provided to our members.

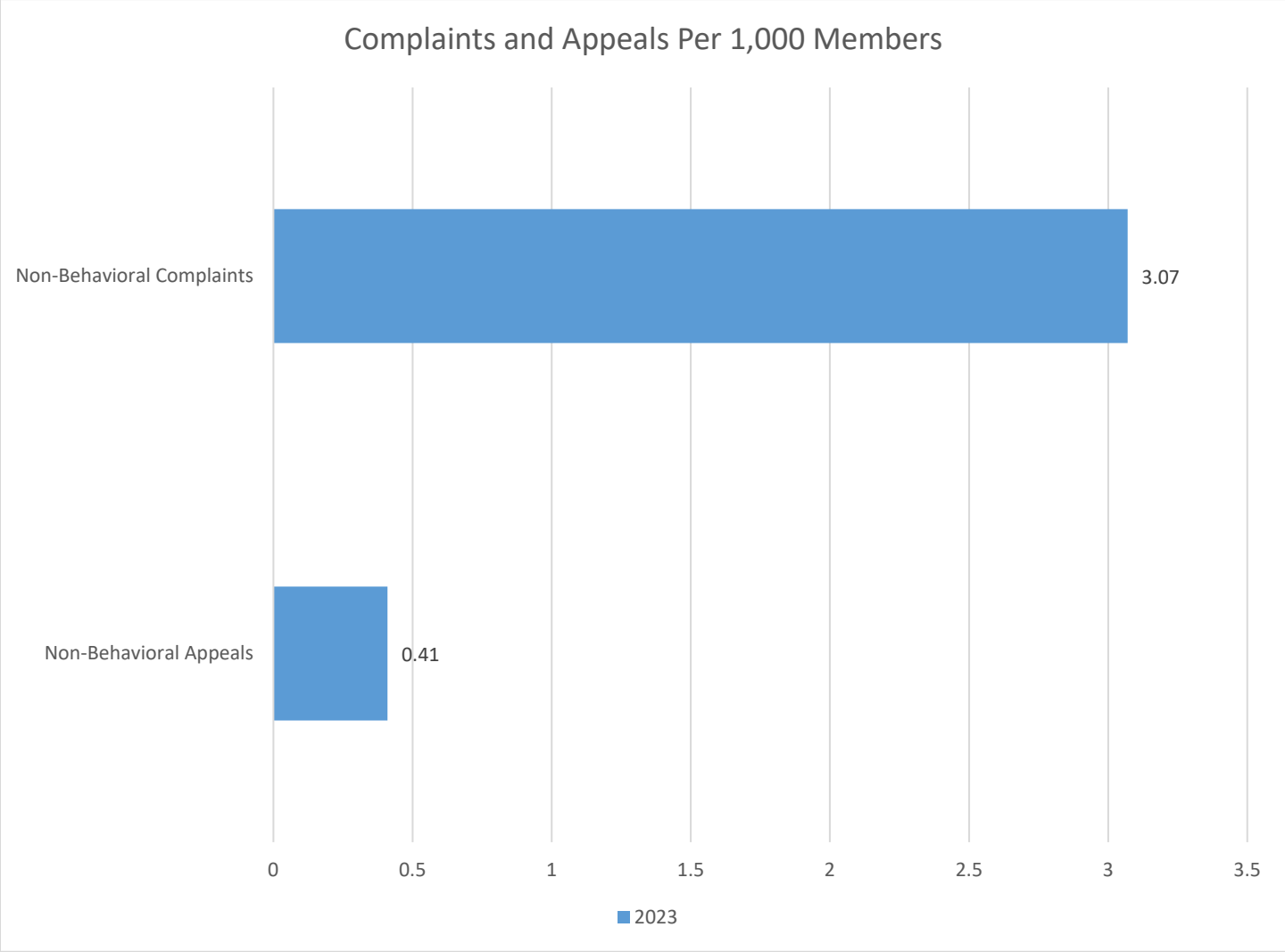
Conclusion: While the Plan met the goals of fewer than ten (10) grievances per one thousand (1,000) members per year and fewer than two (2) grievances per grievance category per one thousand (1,000) members per year, the Plan will focus on continued improvement in the areas of Quality of Care, Access to Care and Quality of Service.

Action: Receive and Approve

NCQA Qualitative Data Analysis Report

Non-Behavioral Health Complaints and Appeals

January 1, 2023-December 31, 2023



Non-Behavioral Healthcare Complaints

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

Table 1: Complaint Volume Report – Non-Behavioral Health

Category	2023			
	Complaints Total	**Complaints per 1,000 members**	**Performance Goals**	**Performance Goals Met?**
Access	4231	1.03	<2	Yes
Attitude and Service	5044	1.23	<2	Yes
Billing and Financial Issues	61	0.01	<2	Yes
Quality of Care	3256	0.80	<2	Yes
Quality of Practitioner Office Site	0	0	<2	Yes
Total	**12592**	**3.07**	**<10**	**Yes**

Quantitative Analysis: In 2023, a total of 12,592 non-behavioral healthcare complaints were filed, totaling 3.07 complaints per 1000 members. KHS met our goals of <10 grievances per 1000 members per year and <2 grievances per grievance category per 1000 members for the year.

Non-Behavioral Healthcare Appeals

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

Table 1: Appeal Volume Report – Non-Behavioral Healthcare

Category	2023			
	Complaints Total	**Complaints per 1,000 members**	**Performance Goals**	**Performance Goals Met?**
Access	1	<0.01	<2	Yes
Attitude and Service	0	0	<2	Yes
Billing and Financial Issues	0	0	<2	Yes
Quality of Care	1674	0.41	<2	Yes
Quality of Practitioner Office Site	0	0	<2	Yes
Total	**1675**	**0.41**	**<10**	**Yes**

Quantitative Analysis: In 2023, a total of 1,675 non-behavioral healthcare appeals were filed, totaling 0.41 complaints per 1000 members per year, with <1 grievance per 1000 members per grievance category per year. Overall, Kern Health Systems maintained the overall grievance and per category performance goal.

Methodology: All complaints are processed by a Grievance Coordinator and assigned a specific grievance classification. Grievances are discussed during a weekly Grievance Workgroup meeting to ensure there is a clear and concise resolution to each member's grievance. Grievance information is then presented quarterly at the Plan's Board of Directors, Community Advisory Committee (CAC) and Executive Quality Improvement Health Equity Committee (EQIHEC) meetings. All reports are prepared by pulling data from logs, the Plan's core information systems, and reviewing individual case files as necessary. Grievance reporting is prepared and/or reviewed by Member Services Management to ensure accurate information is presented.

Qualitative Analysis: In 2023, the top three categories for grievances and appeals were Access, Attitude and Service and Quality of Care. When reviewed against the 2023 CAHP Member Satisfaction Survey, we found common deficiencies in these categories. For Access, KHS was able to incorporate street medicine and telehealth to alleviate access to care challenges. KHS is now contracted with 2 street medicine providers and 128 telehealth provider groups with 707 providers. Attitude and Service was addressed by implementing the following improvement strategies based on the CAHP Member Satisfaction Survey results

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

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

Conclusion: While the Plan met the goals of fewer than ten (10) grievances per one thousand (1,000) members per year and fewer than two (2) grievances per classification, per one thousand (1,000) members, per year, the Plan will focus on continued improvement in the areas of Quality of Care, Access to Care and Quality of Service.

Report prepared and reviewed by
Gilma Arias, Member Services Supervisor
Danesha Makes, Member Services Supervisor
Marleny Martinez, Member Services Supervisor
Amy Sanders, Member Services Manager
November 1, 2024

KERN HEALTH SYSTEMS

To: EQIHEC

From: Nate Scott

Date: December 2024

Re: Executive Summary for 3rd Quarter 2024 Operational Board Update - Grievance Report

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Background

Executive Summary for 3rd Quarter 2024 Operational Board Update - Grievance Report: When compared to the previous four quarters, the following trends were identified related to Grievances received during the 3rd Quarter, 2024.

- There was a decrease in the Plan's grievance volume for the 3rd quarter, 2024, compared to the previous four quarters. The overall volume of Grievances and Appeals dropped 8% from the 2nd quarter to 3rd quarter, 2024. Access to Care, Quality of Care, and Quality of Service grievances remained the three largest grievance categories. The volume of Exempt grievances continued to fall, dropping 27% from the previous quarter. No other significant trends were identified.

KHS Grievance and Appeals per 1,000 members = 2.47 per month.

Requested Action

Receive and approve.

3rd Quarter 2024 Operational Report

Alan Avery
Chief Operating Officer

3rd Quarter 2024 Grievance Report

Category	3rd Quarter 2024	Status	Issue	Q2 2024	Q1 2024	Q4 2023	Q3 2023
Access to Care	601		Appointment Availability	541	384	347	303
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	290		Questioning denial of service	357	385	423	478
Other Issues	106		Miscellaneous	118	64	39	65
Potential Inappropriate Care	532		Questioning services provided. All cases forwarded to Quality Dept.	538	572	522	644
Quality of Service	525		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	417	338	296	326
Discrimination (New Category)	62		Alleging discrimination based on the protected characteristics	81	60	40	45
Total Formal Grievances	2116			2052	1803	1667	1861
Exempt	858		Exempt Grievances	1177	1881	1620	2026
Total Grievances (Formal & Exempt)	2974			3229	3684	3287	3887

KERN HEALTH SYSTEMS
kernhealthsystems.com

*Report with data collected as of 11/01/2024
KHS Grievances and Appeals per 1,000 members = 2.47/month

Additional Insights-Formal Grievance Detail

Issue	2024 3rd Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	275	149	0	104	22
Coverage Dispute	0	0	0	0	0
Specialist Access	326	179	0	121	26
Medical Necessity	290	185	0	103	2
Other Issues	106	72	0	18	16
Potential Inappropriate Care	532	383	0	65	84
Quality of Service	525	389	0	91	45
Discrimination	62	55	0	1	6
Total	2116	1412	0	503	201

KERN HEALTH SYSTEMS

To: EQIHEC

From: Nate Scott

Date: December 2024

Re: Executive Summary for 3rd Quarter 2024 Grievance Summary Report

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Background

Executive Summary for the 3rd 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 3rd quarter, 2024, we had two thousand, nine hundred, seventy-four (2,974) Grievances and Appeals (G&A) received. Here are the top three grievance categories:

- Access to Care/Difficulty Accessing Specialists at 33% of grievances received.
- Quality of Service at 31.5% of grievances received.
- Quality of Care at 17.9% of grievances received.

Of the 3,228 G&A received:

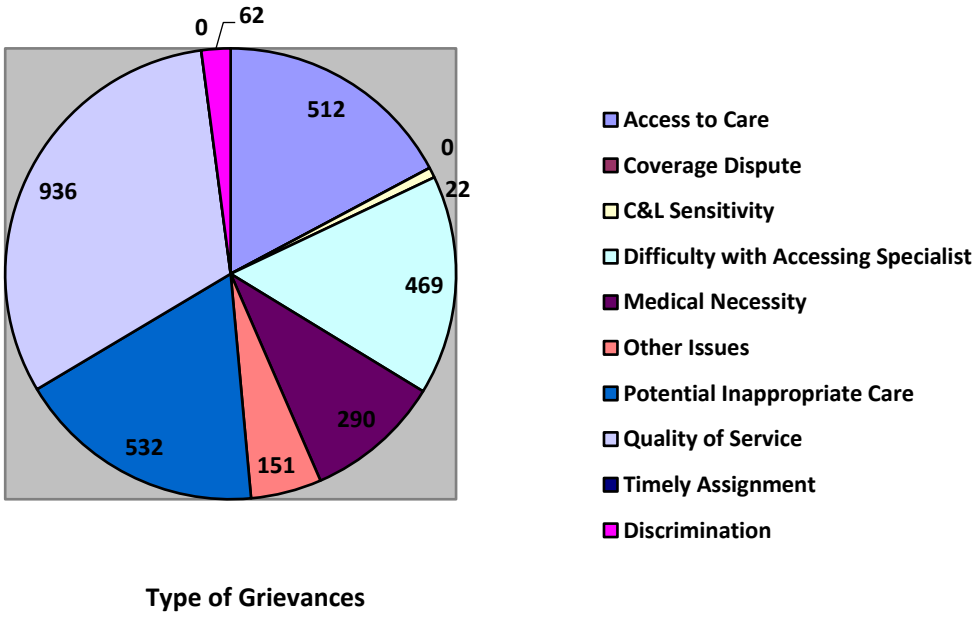
- 2,116 (71.1%) G&A were Standard Grievances and took up to 30 days to investigate and resolve.
- 858 (28.9%) G&A were Exempt Grievances and were resolved within one business day.
- 503 (23.8%) closed in Favor of the Enrollee
- 1,412 (66.7%) closed in Favor of the Plan/Provider
- 201 (9.5%) are still open for review.

Requested Action

Receive and approve.

3rd Quarter 2024 Grievance Summary

Issue	Number	In Favor of Health Plan	In favor of Enrollee	Still under review
Access to care	512	143	348	21
Coverage dispute	0	0	0	0
Cultural and Linguistic Sensitivity	22	10	10	2
Difficulty with accessing specialists	469	175	269	25
Medical necessity	290	185	103	2
Other issues	151	72	63	16
Potential Inappropriate care	532	383	65	84
Quality of service	936	390	501	45
Timely assignment to provider	0	0	0	0
Discrimination	62	55	1	6



KHS Grievances and Appeals per 1,000 members = 2.47/month

During the third quarter of 2024, there were two thousand nine hundred and seventy-four grievances and appeals received. Two thousand one hundred and sixteen cases were standard, and eight hundred fifty-eight cases were exempt and closed within one business day. One thousand four hundred and thirteen cases were closed in favor of the Plan. One thousand three hundred and sixty cases were closed in favor of the Enrollee. There are two hundred and one cases still under review. Of the two thousand nine hundred and seventy-four, two thousand eight hundred and forty-one cases closed within thirty days; one hundred and thirty-three cases were pended and closed after thirty days.

3rd Quarter 2024 Grievance Summary

Access to Care

There were five hundred and twelve grievances pertaining to access to care. Two hundred and sixty-seven cases were standard, and two hundred and forty-five were exempt cases that closed within one business day. One hundred and forty-three closed in favor of the Plan. Three hundred and forty-eight cases closed in favor of the Enrollee. There are twenty-one cases pending review. The following is a summary of these issues:

Two hundred and thirty-seven members complained about the lack of available appointments with their Primary Care Provider (PCP). Forty-nine cases closed in favor of the Plan after the responses indicated the offices provided the appropriate access to care based on the Access to Care standards. One hundred and eighty-one cases closed in favor of the Enrollee after the responses indicated the offices may not have provided appropriate access to care based on the Access to Care standards. There are seven cases pending review.

Fifty-one members complained about the wait time to be seen by a Primary Care Provider (PCP) appointment. Fifteen 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. Thirty-five cases closed in favor of the Enrollee after the response indicated the member was not seen within the appropriate wait time for a scheduled appointment. There is one case pending review.

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

Ninety-three members complained about a provider not submitting a referral authorization request in a timely manner. Forty-five cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Forty 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 eight cases pending review.

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

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

There were twenty-two members that complained about the lack of available interpreting services to assist during their appointments. Fourteen were standard cases and eight were exempt

cases that closed within one business day. Ten 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. Ten cases closed in favor of the Enrollee after the responses from the providers indicated the members may not have been provided with the appropriate access to interpreting services. There are two cases still under review.

Difficulty with Accessing a Specialist

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

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

One hundred members complained about experiencing difficulties in arranging, scheduling, or accessing transportation services. Forty-four cases closed in favor of the Plan after the responses indicated the members were provided the appropriate services. Fifty cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate services. There are six cases still under review.

Fifty-three members complained about the driver showing up outside of the scheduled pick-up time to transport the member to their appointment. Twenty cases closed in favor of the Plan after the response indicated the member was provided with the appropriate wait time for a scheduled appointment. Thirty-two 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 forty-seven members complained about the lack of available appointments with a specialist. Thirty-nine 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. Ninety-eight 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 ten cases still under review.

Eighty-six members complained about the telephone access availability with a specialist office. Thirty-four cases closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access availability. Forty-eight 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 four cases under review.

Thirty members complained about the wait time to be seen for a specialist appointment. Sixteen 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. Thirteen cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate wait time for a scheduled appointment based on the Access to Care Standards. There is one case still under review.

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

One member complained about access to labor and delivery doula services. The case closed in favor of the Plan after it was determined the access to doula services was appropriate.

Medical Necessity

There were two hundred and ninety appeals pertaining to Medical Necessity. One hundred and eighty-five 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, nine were partially overturned. One hundred and three were closed in favor of the Enrollee. There are two cases under review.

Other Issues

There were one hundred and fifty-one grievances pertaining to Other Issues that are not otherwise classified in the other categories. One hundred and six were standard cases and forty-five were exempt cases that closed within one business day. Seventy-two cases closed in favor of the Plan after the responses indicated the appropriate service was provided. Sixty-three cases closed in favor of the Enrollee after the responses indicated the appropriate service may not have been provided. Sixteen cases are still open pending investigation and resolution.

Potential Inappropriate Care

There were five hundred and thirty-two standard grievances involving Potential Inappropriate Care issues. These cases were forwarded to the Quality Improvement (QI) Department for their due process. Upon review, three hundred and eighty-three cases were closed in favor of the Plan, as it was determined a quality-of-care issue could not be identified. Sixty-five 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 eighty-four cases still pending further review with QI.

Quality of Service

There were nine hundred and thirty-six grievances involving Quality of Service issues. Five hundred and twenty-six were standard cases and four hundred and ten were exempt cases that closed within one business day. Three hundred and ninety cases closed in favor of the Plan after the responses determined the members received the appropriate service from their providers. Five hundred and one cases closed in favor of the Enrollee after the responses determined the

members may not have received the appropriate services. There are forty-five cases still under review.

Timely Assignment to Provider

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

Discrimination

There were sixty-two standard grievances pertaining to Discrimination. Fifty-five cases closed in favor of the Plan as there was no discrimination found. One case closed in favor of the Enrollee. There are six cases still under review. All grievances related to Discrimination are forwarded to the DHCS Office of Civil Rights upon closure.

KERN HEALTH SYSTEMS

To: EQIHEC

From: Christine Pence, Senior Director of Health Services

Date: 12/12/2024

Re: Utilization Management Department Reporting Q3 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 3rd quarter of 2024.

- Utilization Management Metrics
- Internal Audit Results

Fiscal Impact:

None.

Requested Action:

Review and approve.

Utilization Management Executive Summary

The Utilization Management (UM) Department continues to focus on ensuring all requests for services are reviewed with high standards for accuracy and efficiency to meet regulatory turnaround time and quality standards.

On October 1, 2024, KHS revised the codes required for Prior Authorization. Although a small number of codes were added, a significantly larger number of codes were removed to result in an overall reduction in authorizations throughout the Provider Network. The UM team is monitoring the impact of these changes and addressing Provider questions and concerns.

The Utilization Management Team audits performance to ensure regulatory and industry standards are met or exceeded. In addition, available data is analyzed 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 3nd quarter 2024.

The following policies will be reviewed by the UM Committee on December 11th for discussion and approval.

- Policy 3.07-P Vision Care
- Policy 3.25-P Prior Authorization Services and Procedures
- Policy 3.27-P Radiology Services
- Policy 3.35-P online Authorization Tool
- Policy 3.50-P Medical Transportation
- NEW – Appropriate UM Staffing
- NEW – Inter-Rater Reliability
- NEW – Referral Systems Control
- NEW – Specialty Referral and Use of Board-Certified Consultants
- NEW – UM Staff Access Availability Regarding UM Issues

Respectfully submitted,

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

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.

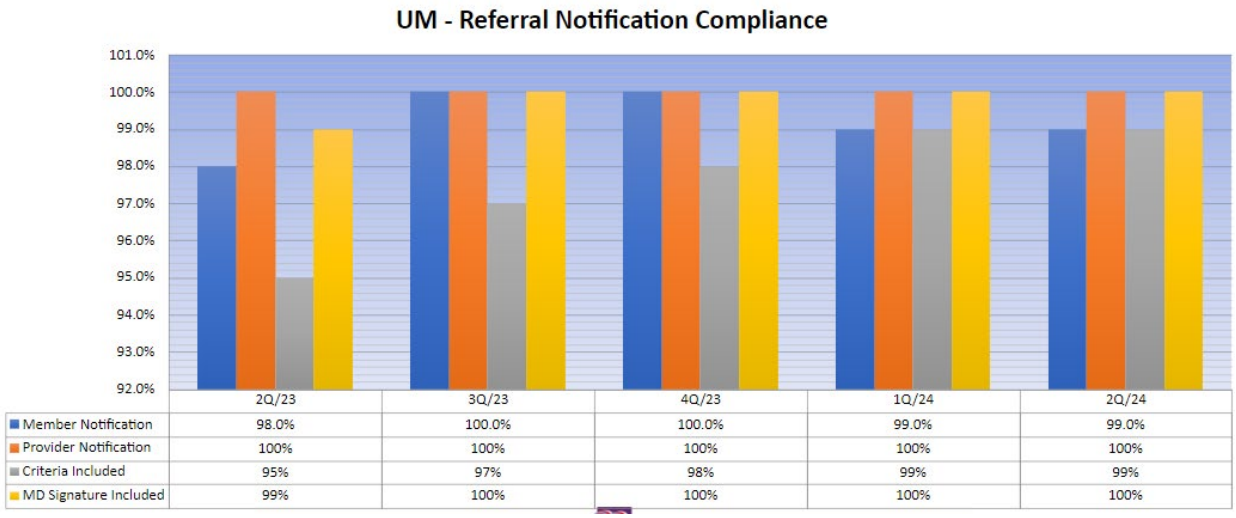
Providers may indicate 'Urgent' on the referrals indicating a decision needs to be made within 3 business days. Routine/non-emergent referrals must be processed within 5 business days. Once an urgent referral has been reviewed it may be downgraded for medical necessity at which time the provider will 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

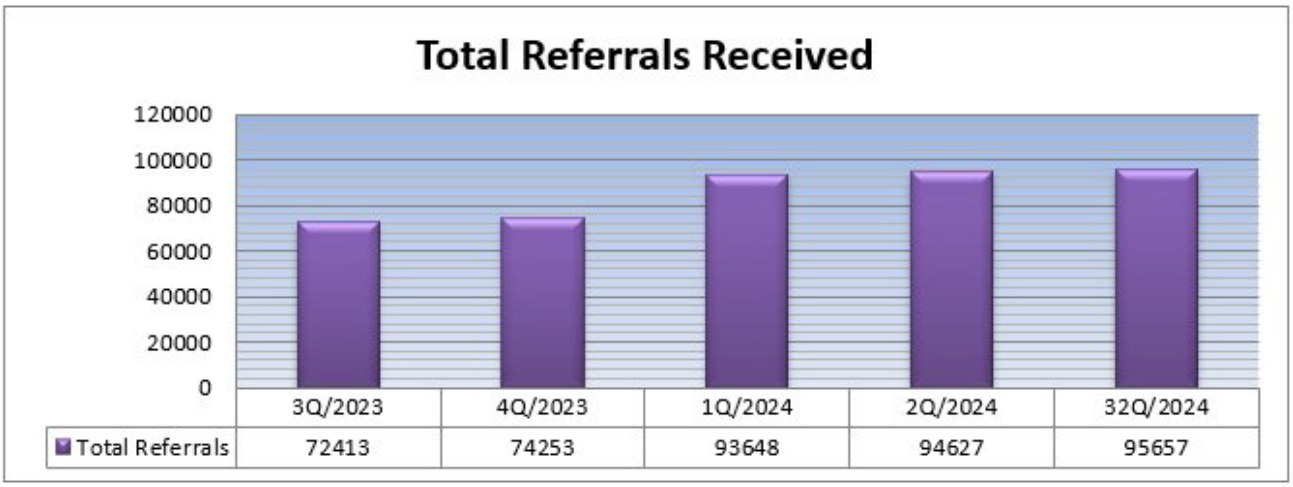
There were 95,657 referrals processed in the 3rd quarter 2024. In comparison to the 2nd quarter's processing time, routine referrals decreased from the 2nd quarter which was 100% and urgent referrals increased from the 2nd quarter which was 98.0% to 99.0%.

	3Q/23	4Q/23	1Q/24	2Q/24	3Q/24
Urgent Compliance %	97.0%	99.8%	99.6%	98.0%	99.9%
Routine Compliance %	99%	100%	100%	100%	99%

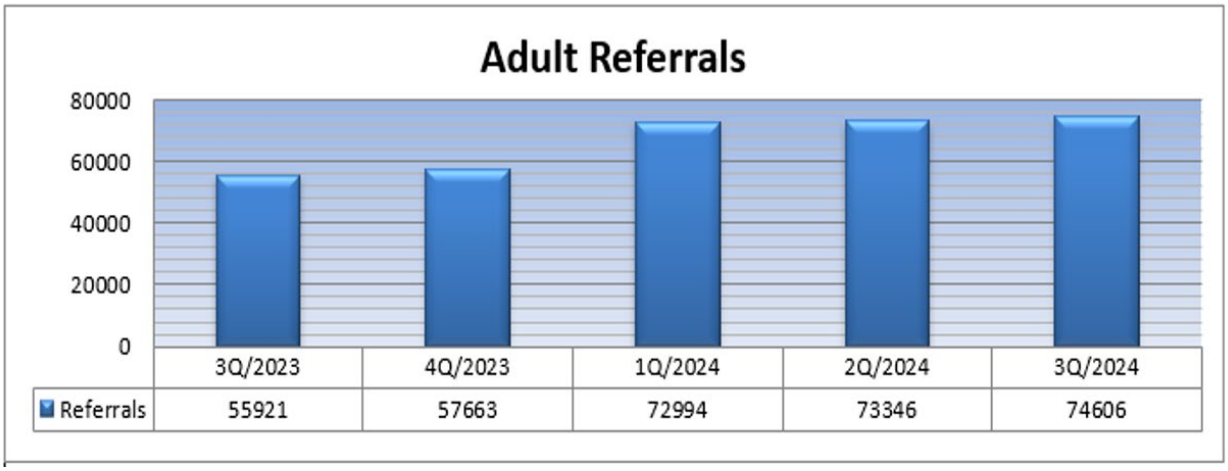


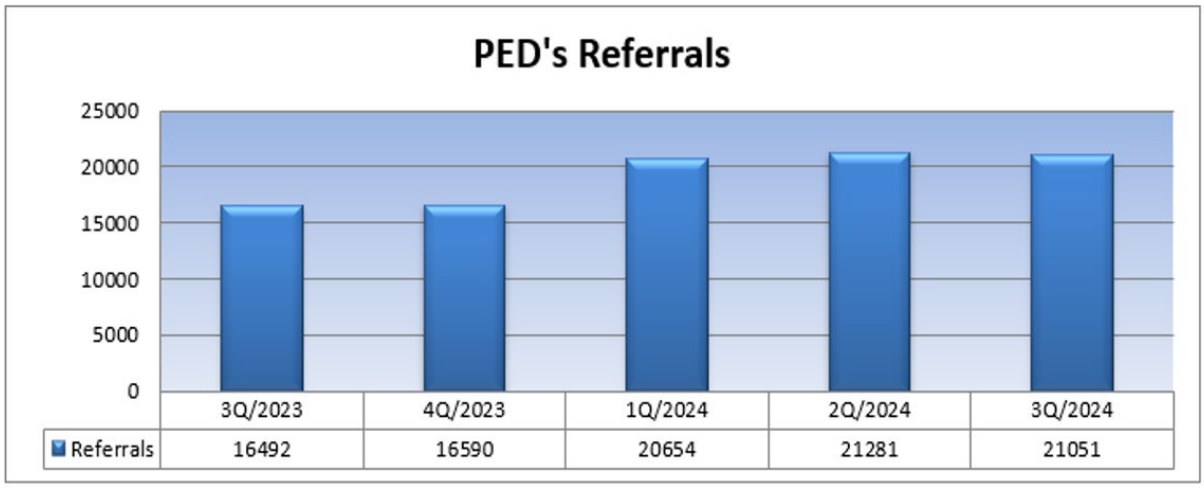
	2Q/23	3Q/23	4Q/23	1Q/24	2Q/24
Member Notification	98.0%	100.0%	100.0%	99.0%	99.0%
Provider Notification	100%	100%	100%	100%	100%
Criteria Included	95%	97%	98%	99%	99%
MD Signature Included	99%	100%	100%	100%	100%

Outpatient Referral Statistics



	3Q/2023	4Q/2023	1Q/2024	2Q/2024	32Q/2024
Total Referrals	72413	74253	93648	94627	95657



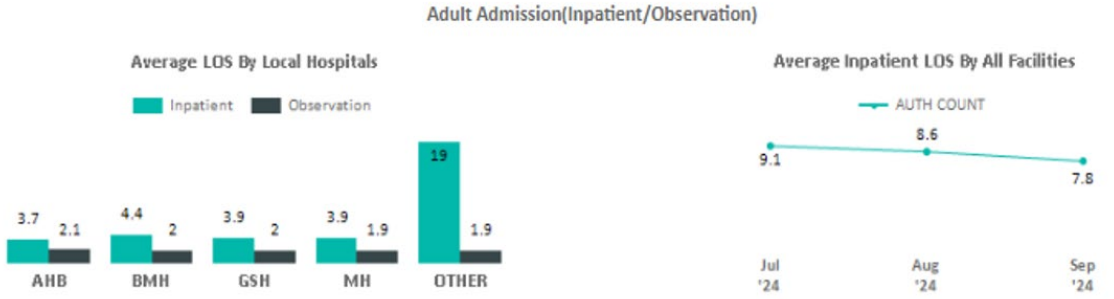


Inpatient and Post-Acute

KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(Inpatient/Observation)

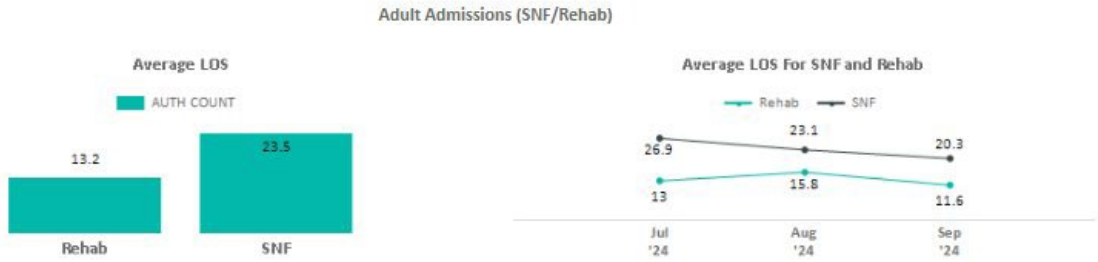
Dates of Discharge Between : 7/1/2024-9/30/2024

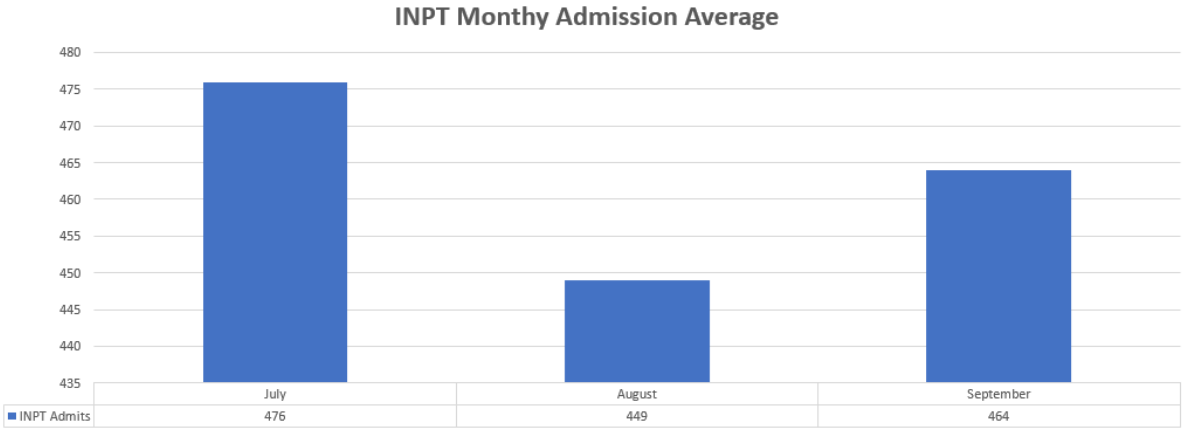


KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(SNF/Rehabilitation)

Dates of Discharge Between : 7/1/2024-9/30/2024

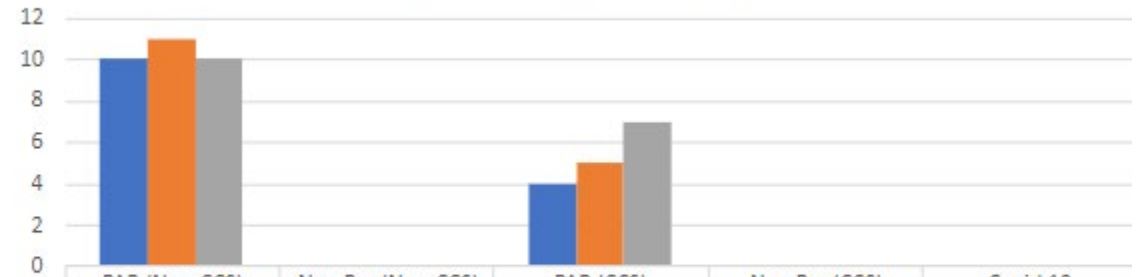




Acute Monthly Average

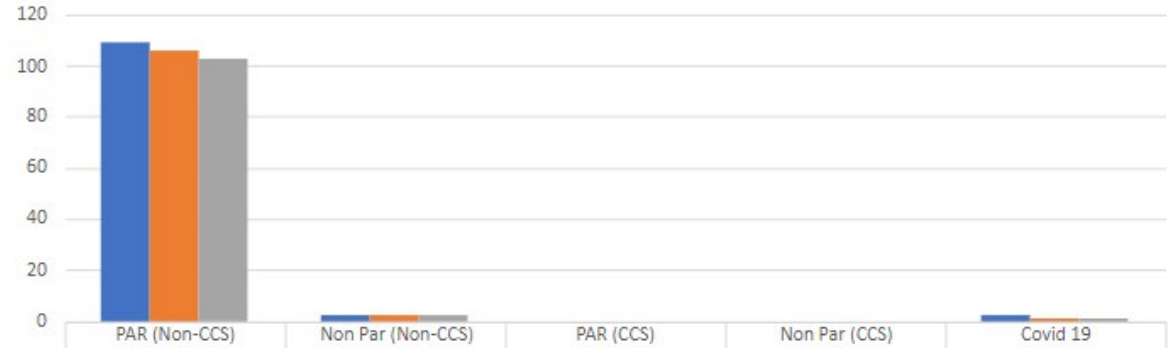
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	269	26	14	2	1
August	238	25	19	2	3
September	251	24	22	2	3

Tertiary Monthly Average



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	10	0	4	0	0
August	11	0	5	0	0
September	10	0	7	0	0

SNF Monthly Average



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	109	2	0	0	2
August	106	2	0	0	1
September	103	2	0	0	1

KHS - 2024 IRR Q3 Results

All Non-Clinical Staff in UM must successfully pass Quarterly IRR testing to demonstrate competency and understanding of the review process.

Results:
All staff were able to complete 2nd Quarter IRR case studies. Staff were given a case study with a total of 10 questions for NCIC review process to meet our passing standards of 95 percent or better.

All non-clinical staff members participated in the case study and has completed the required IRR testing in Learning Management System (LMS) with a passing score of 100 percent at first attempt.

	Number of Staff	Percentage
Number of Total Staff	30	
Number of Staff Passed on First Attempt	29	99%
Number of Staff Needing to re-take	1	1%
Number of staff passed on Second Attempt	1	1% (% of number who re-took)

Refresher training conducted on demand as needed and upon hiring via LMS.

Internal Audits

Utilization Management Department Internal Audit:

Delayed Referrals - Quarter 3, 2024

Audit Period:

July 1, 2024 – September 30, 2024

Completion Date:

November 8, 2024

Audit Sample Size:

10 Referrals per month

	July	August	September
Total referrals for the month	33,078	33,431	31,109
Total referrals that were delayed	52	53	63
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 Utilization Management (UM) Department to ensure that the procedures followed are 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 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. Notices to Provider and Member after referral delayed.
    - 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

2. 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.

3. 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

4. Processing of Referral
    - Appropriately delayed for additional medical records.
    - Delay completed on a routine authorization (not on urgent request).
    - Delay completed on the fifth working day of receipt.
    - Service line(s) appropriately chosen.

5. 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.

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

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

July Audit Findings:

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

- Notices to Provider and Member after Referral Delayed
    - One (1) authorization did not provide notice to the member within 2 business days of the date of decision: 202407190001079.

- Notice of Action Letter
    - One (1) NOA letter used abbreviations and had misspelled words: 202407300000544

- Signatures and Credentials
    - All authorizations had signatures and credentials.

- Processing of Referral

- There were zero (0) errors withing processing of the referral.

- Final decision Turnaround time (TAT)
  - All authorizations had a final decision made within TAT.

- Criteria used, cited, and attached for final decision.
  - One (1) authorization cited Medi-Cal criteria.
  - One (1) authorization cited MCG criteria.
  - Eight (8) authorizations cited KHS policies.

- NOA Language at or below 6th grade reading level
  - Two (2) authorizations were found to have NOA language that was above the 6th grade reading level: 202407100000022, 202407100000075.

August Audit Findings:

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

- Notices to Provider and Member after Referral Delayed
  - One (1) NOA letter was not mailed timely: 202408210001081

- Notice of Action Letter
  - One (1) NOA letter was not completed: 202408210001081
  - One (1) NOA letter had capitalization errors found: 202408091017779

- Signatures and Credentials
  - All authorizations had signatures and credentials.

- Processing of Referral
  - One (1) referral was found errors in processing: 202408210001081.

- Final decision Turnaround time (TAT)
  - All authorizations had a final decision made within TAT.

- Criteria used, cited, and attached for final decision.
  - Three (3) authorizations cited Medi-Cal criteria.
  - One (1) authorization cited MCG criteria.
  - Five (5) authorizations cited KHS policies.
  - One (1) authorization cited recuperative care

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

September Audit Findings:

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

- Notices to Provider and Member after Referral Delayed
  - One (1) NOA letter was not mailed timely due to not being completed and set to print: 202409270001164
- Notice of Action Letter
  - One (1) NOA letter was not completed: 202409270001164.
- Signatures and Credentials
  - All authorizations had the signatures and credentials.
- Processing of Referral
  - Zero (0) errors found withing processing of the referral.
- Final decision Turnaround time (TAT)
  - All authorizations had a final decision made within TAT.
- Criteria used, cited, and attached for final decision.
  - One (1) authorization cited Medi-Cal criteria.
  - Two (2) authorization cited MCG criteria.
  - Seven (7) authorizations cited KHS policies.
- NOA Language at or below 6th grade reading level
  - All NOA delay letters were at or below 6th grade readability.

Corrective Action Plan (CAP):

1. Email sent to staff to remember to set letters added manually in Jiva correspondence to print.

Utilization Management Department Internal Audit:

Denied Referrals - Quarter 3, 2024

Audit Period:

July 1, 2024 – September 30, 2024

Report Completion Date:

November 8, 2024

Audit Sample Size:

30 referrals total for each month.

Current denied audit exclusions:

-Pharmacy denials
-CCS denials
-Kern County Mental Health denials
-Search and Serve denials
-VSP denials
-Denti-Cal denials
-Retro denials
-Kern Regional denials
-Duplication of Services

	July	August	September
Total referrals processed for the entire month: (total number of referrals approved, modified, denied etc. during the month)	33,078	33,431	31,109
Total referrals denied for medical necessity: (total of all referrals in the green + red rows on workbook)	938	982	772
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)	<3%	<3%	<3%
Number of referrals in audit (this is 10% of the total from row 2 above)	30	30	30

Purpose:

Quarterly audits are done on referrals that have been denied by the Utilization Management (UM) Department 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

July Audit Findings:

The following is a breakdown of the findings of the thirty (30) referrals that were denied:

- Zero (0) referrals were outside of the turnaround times.
- Zero (0) referrals had criteria that was not attached. Two (2) referrals had UTD guidelines cited that were not most current versions: 202407190001173, 202407230001619. One (1) referral had MCG cited, but Medi-Cal criteria was available to use (hierarchy), and one (1) referral had Medi-Cal criteria that was attached but differed from what was cited by the Medical Director: 202407260000423.
- One (1) referral had grammatical errors found on the NOA: 202407250000974.
- Zero (0) referrals had errors within the signatures of the NOA letter.
- Zero (0) referrals were found with processing errors.
- Six (6) referrals were found to have NOA language above 6th grade reading level: 202407120001431, 202407290001567, 202407230001822, 202407260001349, 202407080000398, 202407160000997.
- Guidelines cited and attached:
    - Nine (9) referrals cited Medi-Cal guidelines.
    - Two (2) referrals cited UpToDate guidelines.
    - Twenty-one (21) referrals cited MCG guidelines.
    - Two (2) referrals cited KHS Policies.

**Some referrals may have cited more than one criterion.

August Audit Findings:

The following is a breakdown of the findings of the thirty (30) referrals that were denied:

- Zero (0) referrals were outside of the turnaround times.
- Zero (0) referrals had criteria that was not attached.
- One (1) referral was found within grammatical errors within the NOA letter.
- Zero (0) referrals had errors within the signatures of the NOA letter.
- Zero (0) referrals were found with processing errors.
- One (1) referral was found to have NOA language above 6th grade reading level.
- Guidelines cited and attached:
    - Ten (10) referrals were denied using Medi-Cal guidelines.
    - Eighteen (18) referrals were denied using MCG guidelines.
    - Six (6) referrals were denied using KHS Policies.

**Some referrals may have cited more than one criterion.

September Audit Findings:

The following is a breakdown of the findings of the thirty (30) referrals that were denied:

- Zero (0) referrals were outside of the mailing and notices turnaround times, one (1) referral had a decision made outside of TAT: 202409190000263
- One (1) referral cited criteria that was not attached: 20240906000064 0
- Zero (0) referrals were found with errors within the NOA letter.
- Zero (0) referrals were found with errors within the signatures of the NOA letter.
- Zero (0) referrals were found with processing errors.
- Seven (7) referrals were found to have NOA language above 6th grade reading level.
- Guidelines cited and attached:
    - Six (6) referrals cited Medi-Cal guidelines.
    - One (1) referral cited UpToDate guidelines.
    - Seventeen (17) referrals cited MCG guidelines.
    - Seven (7) referrals cited KHS Policies.

**Some referrals may have cited more than one criterion.

Corrective Action Plan (CAP):

1. Email sent to UM Management with audit findings.

Utilization Management Department Internal Audit:

Modified Referrals - Quarter 3, 2024

Audit Period:

July 1, 2024 – September 30, 2024

Report Completion Date:

November 8, 2024

Audit Sample Size:

10 referrals per month

	July	August	September
Total referrals processed for the entire month: (total number of referrals approved, modified, denied etc. during the month)	33,078		
Total referrals that were modified	519		
Percent of referrals that were modified	<2%		
Number of referrals in audit	10	10	10

Purpose:

Quarterly audits of referrals that were modified by the Utilization Management (UM) Department are performed 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 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

July Audit Findings:

The following is a breakdown of the findings of the **10** referrals audited:

- One (1) referral was found to be mailed outside of the referral turnaround time indicator: 202407010000454.
- Zero (0) referrals were found with errors in the Notice of Action letter.
- Zero (0) errors were found within the and signatures indicator.
- Four (4) errors were found within the processing of the referral:
  - 202407010000062 – modified to routine in error and set to modified, but this was a partial approval, and no approval letter was generated.
  - 202407080000888 – modified to routine in error.
  - 202407010000454 – NOA letter was not set to print
  - 202407080000399 – was modified from tertiary to non-tertiary level of care without MD review.
- Zero (0) referrals were found with NOA language that was above 6th grade readability.

August Audit Findings:

The following is a breakdown of the findings of the **10** referrals audited:

- One (1) referral was found to be mailed outside of the referral turnaround time indicator: 202408090000762 – not set to print and no translation done, or final document generated.
- One (1) referral was found with errors in the Notice of Action letter: 202408090000762 was not completed.
- Zero (0) errors were found within the and signatures indicator.
- Two (2) errors were found within the processing of the referral:
  - 202408090000762 – as mentioned above, this was not sent to translation, not set to print, and no final docs were generated.
  - 202408050001687– modified to routine in error.
- Zero (0) referrals were found with NOA language that was above 6th grade readability.

September Audit Findings:

The following is a breakdown of the findings of the **10** referrals audited:

- Zero (0) referrals were found to be mailed outside of the referral turnaround time indicator.
- Two (2) referrals were found with errors in the Notice of Action letter:

    - 202409160000305 – NOA language for modification reasoning is confusing in stating that request was modified to an "expert in town" as original requested treating provider, SCOI, is in town.
    - 202409230001457 – spacing on phone number and of the MD name.
- Zero (0) errors were found within the and signatures indicator.
- One (1) error was found within the processing of the referral:
    - 202409040001819 – codes were only set to denied-modified and no approved-modified codes entered.
- Zero (0) referrals were found with NOA language that was above 6th grade readability.

Corrective Action Plan (CAP):

1. Email with findings to UM Management with findings.

KERN HEALTH SYSTEMS

To: KHS Executive Quality Improvement Health Equity Committee Meeting

From: James Winfrey, Deputy Director of Provider Network Management

Date: 12/12/2024

Re: Network Adequacy Committee, Q4 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 4th Quarter Network Adequacy Committee meeting, including minutes.

Fiscal Impact:
None.

Requested Action:
Review and approve.

Network Adequacy Committee, Q4 2024

Executive Quality Improvement Health Equity Committee

December 12, 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

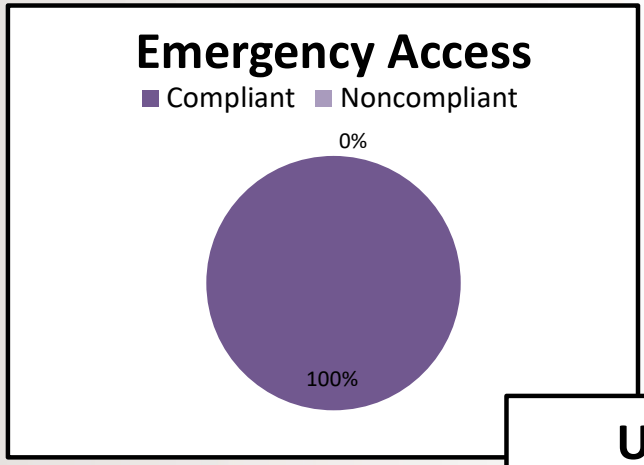
Q4 Committee Meeting

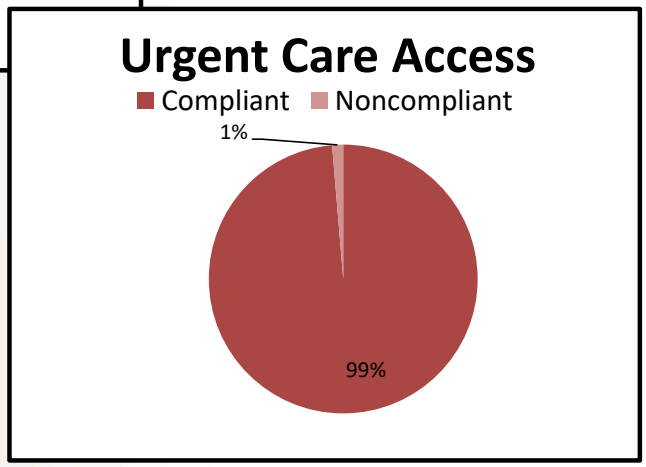
Quarter 4, 2024 Meeting – 10/18/2024

- Reviewed Quarter 3, 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 Q3 2024 **149** provider offices were contacted.
- **149** were compliant with the **Emergency Access Standards**
- **147** 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

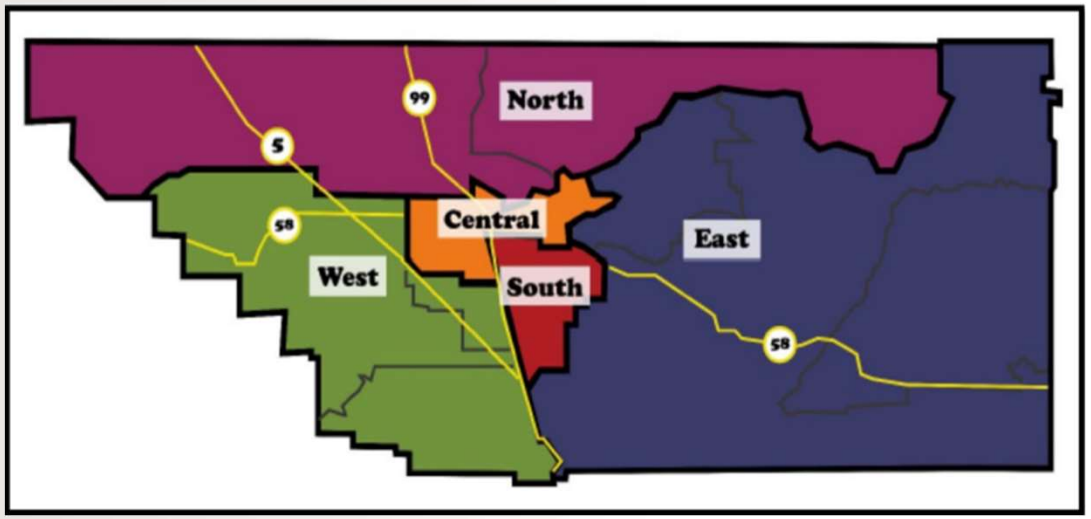
- A random sample of 25 primary care provider offices, 25 specialist offices, 5 non-physician mental health (NPMH) offices, 5 ancillary offices, and 5 OBGYN offices were surveyed during Q3 2024.
- Results are averaged to review appointment availability at the network level
- **KHS network was compliant with all standards**
- Non-compliant offices are educated, resurveyed, and tracked to identify trends.

Average urgent wait time	Q3 2024
Primary Care (48 Hours)	21.8 Hours
Specialist (96 Hours)	32.5 Hours

Average non-urgent wait time	Q3 2024
Primary Care (10 Days)	2.5 Days
Specialist (15 Days)	4.6 Days
NPMH (10 Days)	2.8 Days
Ancillary (15 Days)	3.6 Days
OB/GYN (Two Weeks)	1.2 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.
- No trends identified amongst Specialty compliance rates.
- The Plan was at **80% or higher** for all compliance rates.

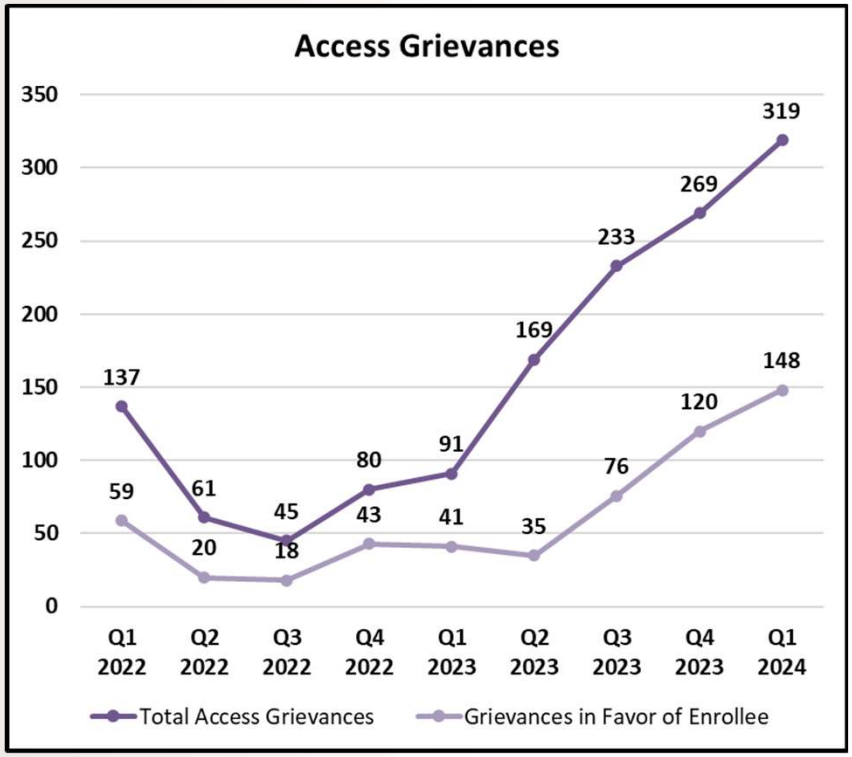


Access Grievance Review

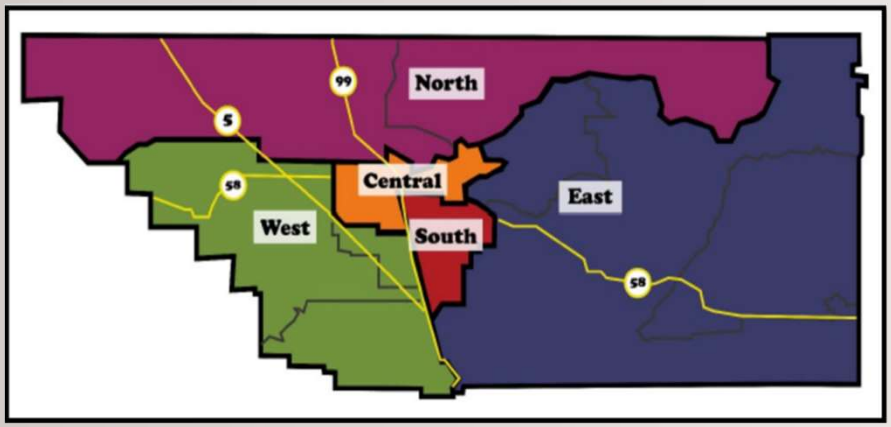
- Quarterly, the Provider Network Management Department retroactively reviews Access Grievances found in favor of the enrollee to identify potential access trends amongst provider types, provider groups, etc.

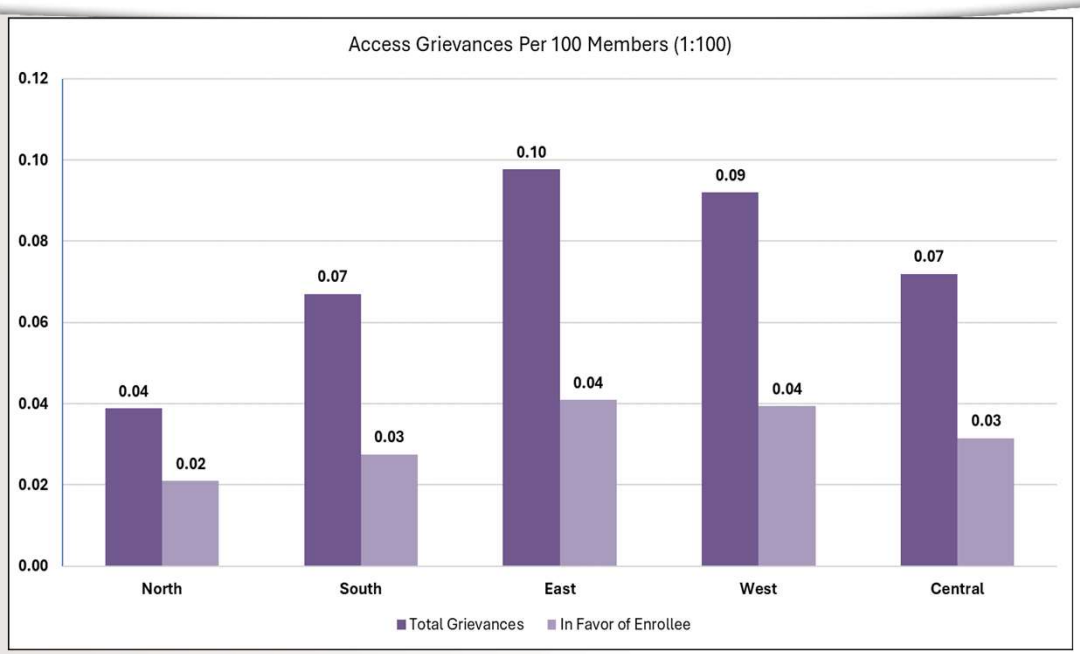
- The Plan identified an increase in access grievances found in favor of the enrollee when compared to prior quarters.

- Potential Causes:
  - Membership increase of approximately 50,000 members on 1/1/24.
  - Omni had systems down for approximately 2 weeks.



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.

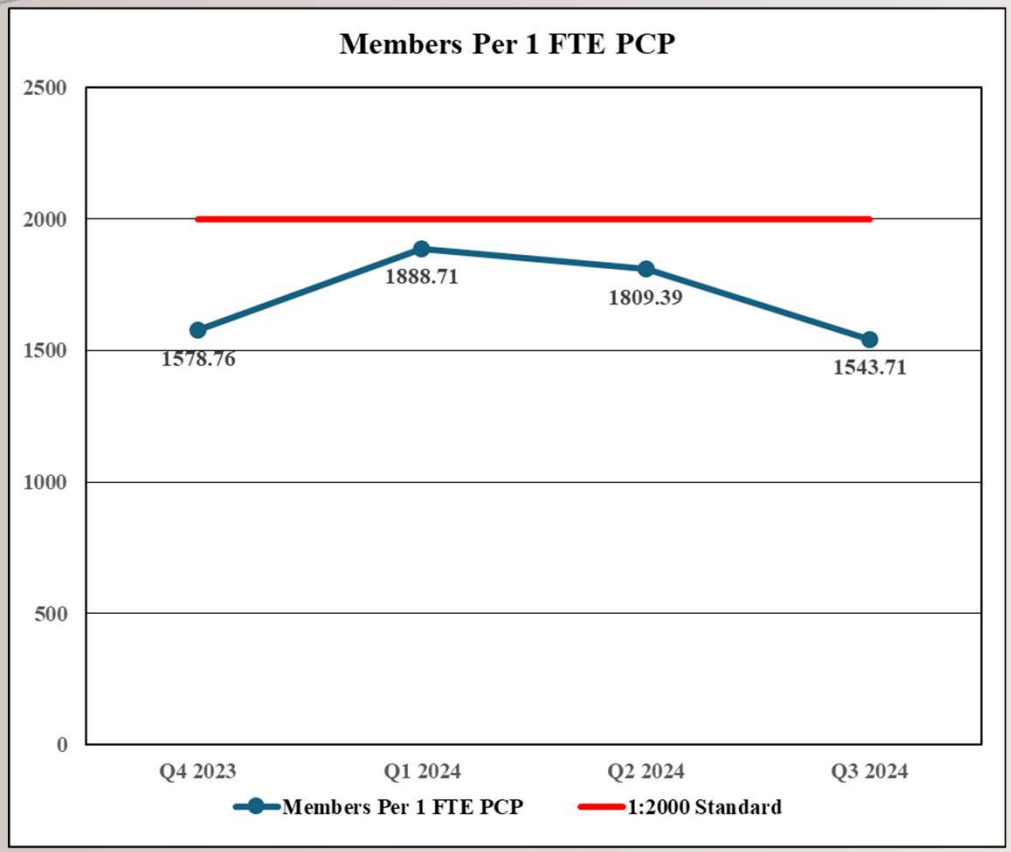
Geographic Accessibility

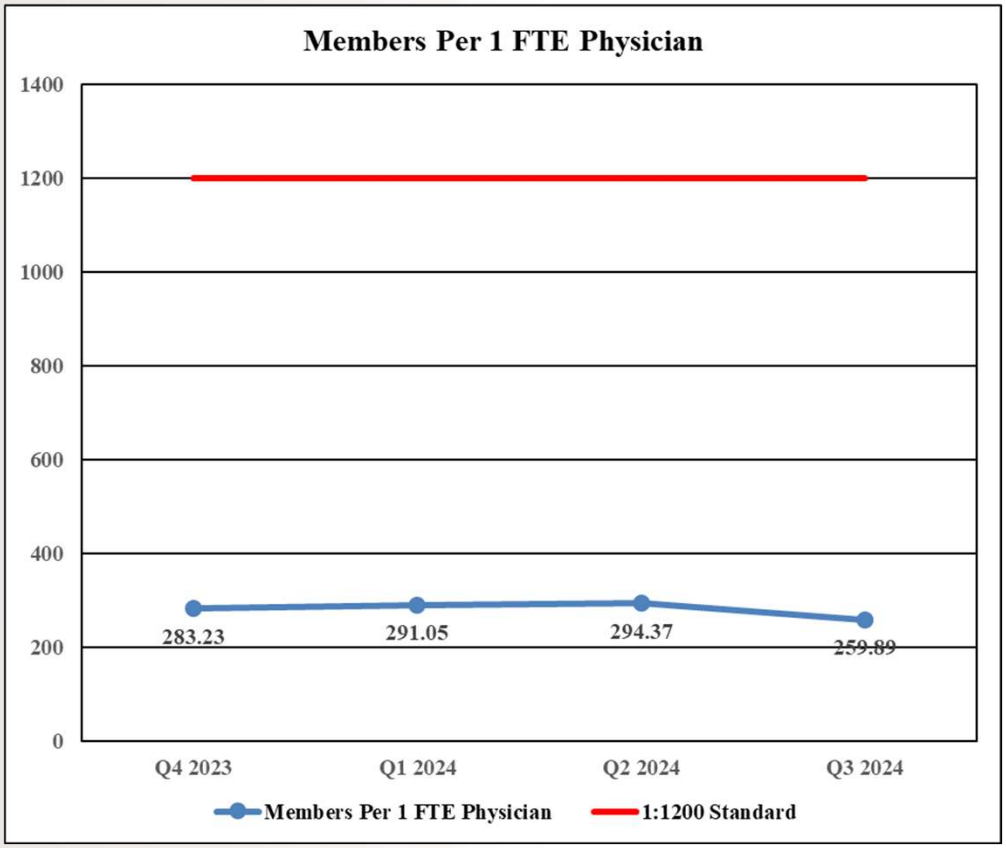
- The Provider Network Management department conducts ongoing review of our network to measure member geographic accessibility to our providers

- As of Q3 2024, **the Plan was compliant with all geographic accessibility standards**, or maintained a regulatory-approved alternative access standard

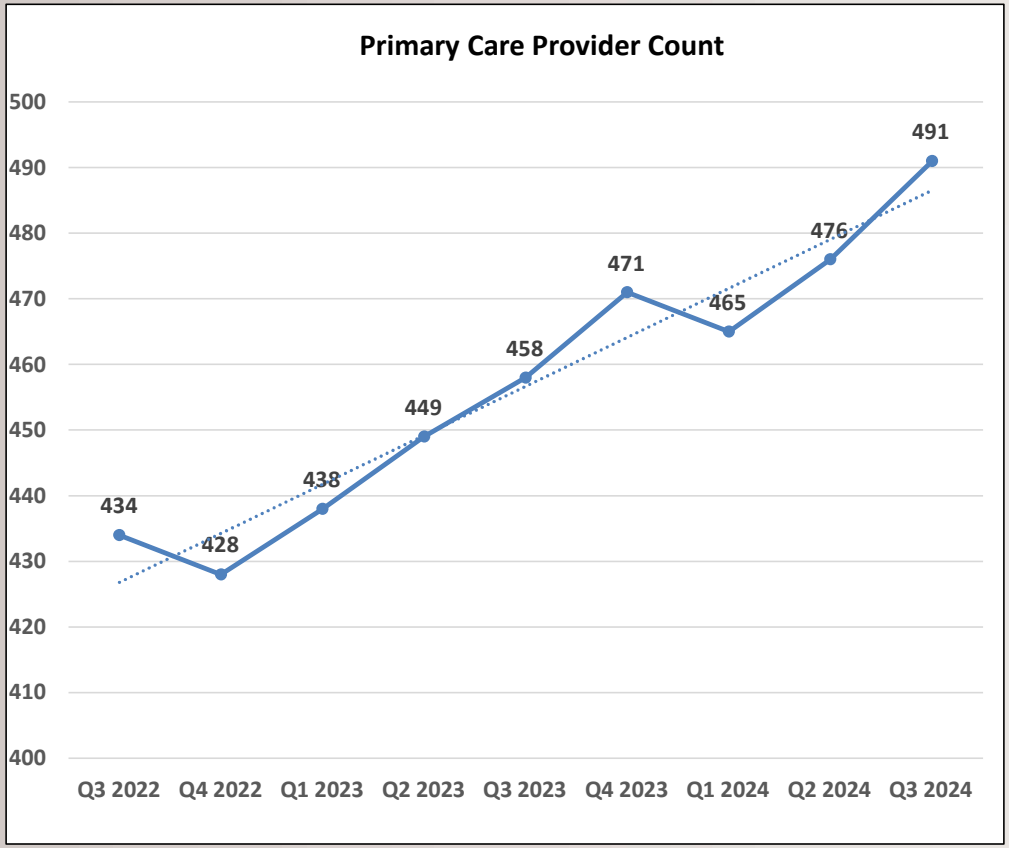
Geographic Accessibility Standards	
Primary Care (Adult and Pediatric)	10 miles or 30 minutes
Specialty Care (Adult and Pediatric)	45 miles or 75 minutes
OB/GYN Primary Care	10 miles or 30 minutes
OB/GYN Specialty Care	45 miles or 75 minutes
Hospitals	15 miles or 30 minutes
Non-Specialty Mental Health (Adult and Pediatric)	45 miles or 75 minutes

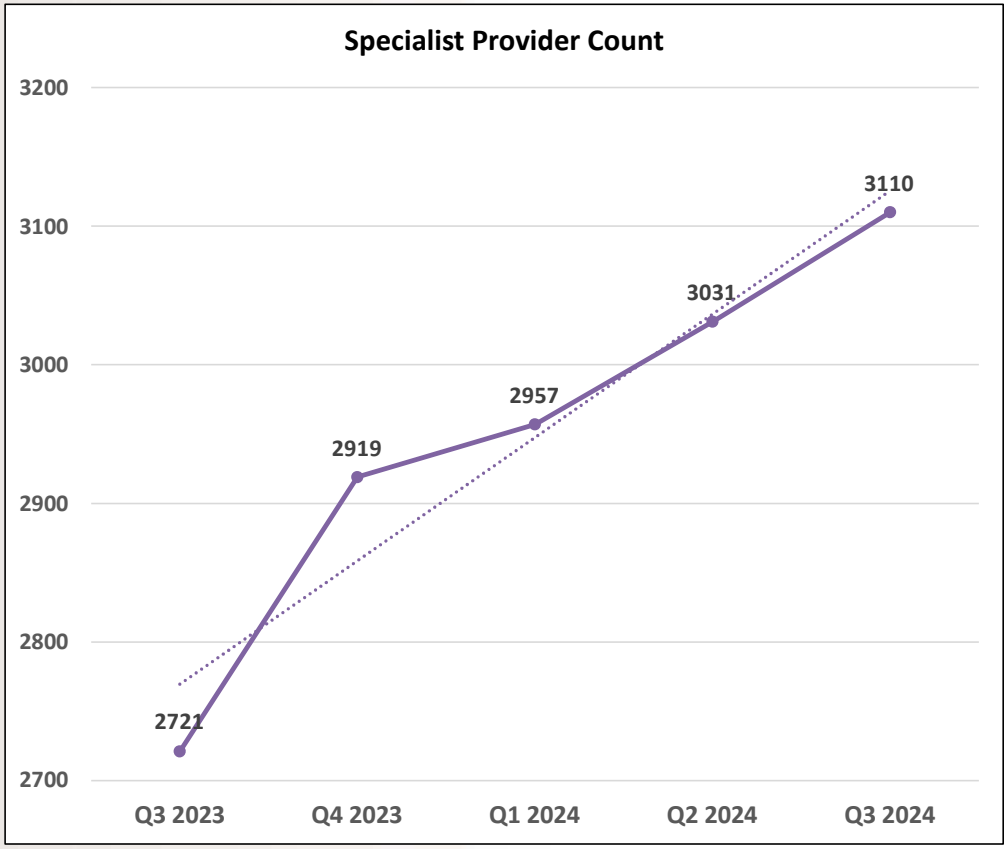
Network Adequacy





Network Adequacy & Provider Counts





KERN HEALTH SYSTEMS

Network Adequacy Committee (NAC)

Agenda – October 18, 2024

AGENDA ITEM	AGENDA TOPIC	PRESENTER	TIME	ACTION
CALL TO ORDER	Call meeting order / Attendance-Quorum	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*3 min*	*N/A*
APPROVAL OF MINUTES	Review, Discussion, Motion to Approve	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*1 min*	*Approve*
OLD BUSINESS	N/A – There is no old business from prior committee meeting to discuss.	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*1 min*	*N/A*
NEW BUSINESS	1. Provider Network Management, Q3 2024 Quarterly Network Review	***Greg Panero, KHS, Provider Network Analyst Program Manager***	*20 min*	*Approve*
OPEN FORUM	Open Forum / Committee Members Announcements / Discussion	***Open to all Members***	*10 min*	*Discussion*
NEXT MEETING	Next meeting will be held Friday January 17th, time to be determined.	***Informational only***	*N/A*	*N/A*
ADJOURNMENT	Meeting Adjournment	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*N/A*	*N/A*

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

KERN HEALTH SYSTEMS

COMMITTEE: **Network Adequacy Committee**
DATE OF MEETING: **October 18, 2024**
CALL TO ORDER: **11:08 AM by James Winfrey, KHS - Deputy Director of Provider Network Management, Chair**

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
CALL TO ORDER	- James Winfrey called the meeting to order at 11:08 AM - Quorum/Attendance	- Committee quorum requirements met.	N/A
APPROVAL OF MINUTES	- James Winfrey presented the Q3 2024 Network Adequacy Committee meeting minutes for approval.	☑ **CLOSED**: The committee members in attendance approved Q3 2024 Network Adequacy Minutes.	*10/18/24*
OLD BUSINESS	- No items.	☑ **CLOSED**: Informational only.	*10/18/24*
NEW BUSINESS	Provider Network Management, Q3 2024 Quarterly Network Review - Greg Panero presented the Provider Network Management Q3 2024 Quarterly Network Review. o After Hours Survey Results: Emergency Access at 100% compliant, Urgent Care Access at 99% compliant. Reviewed trending results and discussed Plan follow up action. ▪ During discussion of after-hours survey, Alan Avery inquired about follow up procedures for noncompliant providers.	☑ **CLOSED**: The committee members in attendance approved Provider Network Management, Q3 2024 Quarterly Network Review.	*10/18/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	James Winfrey, Gregory Panero and Melissa McGuire went over noncompliant provider letters and education. Greg Panero also explained noncompliant provider tracking and consequences of continued noncompliance. Deb Murr asked to clarify Carenet Health's role in After Hours surveys. James explained that Carenet Health conducts the initial wave of calls, followed by a second wave from PNM staff to verify the results. Deb Murr also inquired whether all providers are surveyed quarterly, to which James Winfrey confirmed that all PCP offices are surveyed every quarter. ○ Provider Accessibility Monitoring Survey: Plan compliant with all standards (appointment availability, hours of operation, phone answering timeliness, in-office wait times) based on results of Q3 2024 Survey. ▪ During discussion of Provider Accessibility Monitoring, Alan Avery inquired about how surveys are done. Greg Panero, James Winfrey and Melissa McGuire explained survey process as well as tracking and monitoring all responses for trending. No trends identified at this time. Deb Murr asked if provider responses are audited. James Winfrey and Greg Panero explained survey questions and methodology used. ▪ Deb Murr also inquired about Mental Health access availability. James Winfrey explained specialist and NPMH providers are surveyed and at this time meeting compliance with the help of telehealth services. Melissa McGuire also explained random list of specialists selected each quarter may not always include Psychiatry. ▪ Deb Murr noted there is a lot of focus on mental health recently. James Winfrey discussed other mental health report that		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	is still being finalized as part of a different project that can be reported on in the next NAC meeting. Greg Panero also pointed out all non physician mental health providers will be surveyed as part of the DMHC provider appointment availability survey. ▪ Deb Murr inquired if the above-mentioned survey includes ABA services. James Winfrey explained surveying is currently based on regulatory requirements which do not currently include ABA, but if that is a recommendation it could be built into the surveys. Deb Murr and Traco Matthews asked that this be included in future surveying. James Winfrey explained he will meet with Director of Behavioral Health to understand necessary time frames. ▪ Deb Murr noted there was a point in previous minutes about telehealth completion rates and inquired if PNM does any type of auditing on telehealth as far as if there's an issue with compliance and Members being seen. James Winfrey advised PNM does not. ○ Access Grievance Review: The Plan has 319 access grievances found in favor of the member in Q1 2024, for a total of 36 grievances for every 1,000 members. ▪ During discussion of Access Grievance Review Traco Matthews observed grievances found in favor of the Enrollee are in line with previous quarters despite total access grievance increase. James Winfrey explained Technology/Telephone grievances are considered access grievances, but are not appointment availability concerns. ▪ Traco Matthews inquired if PNM can consider adding average distance to providers in each region to report. James		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Winfrey discussed possibility and will review. ○ 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. ▪ In Q1 2024, the Plan submitted 343 AAS requests to DHCS. In Q3 2024, DHCS informed the Plan that 225 AAS requests approved, 52 were denied, and 66 were no longer needed after the DHCS completed their review. The Plan reviewed the denied AAS and identified inconsistencies with the DHCS's denials and arranged a meeting with the DHCS to review. During the meeting, the DHCS acknowledged that they had denied multiple AAS in error, as the Plan either was within time or distance standards or was contracted with the nearest provider. On September 3, 2024, the Plan resubmitted the remaining denied AAS requests to DHCS for further review. ▪ James Winfrey discussed the regulatory standards for time and distance that the Plan must meet. He raised the question of whether the Plan should consider exploring tighter standards or monitoring additional specialties. Traco Matthews, James Winfrey and Deb Murr discussed reviewing aspirational standards. ○ Network Adequacy & Provider Counts: ▪ FTE PCP ratio at 1:1544 ▪ FTE Physician ratio 1:260 ▪ PCP Accepting new members: 87% ▪ NPMH accepting new members: 95% ▪ NPMH locations accepting new members: 87% ▪ PCP Count: 491 ▪ Specialist Provider Count: 3110 ▪ Mental Health Provider Count: 173		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	▪ Deb Murr and Greg Panero discussed what type of providers are included in the calculations and how they are calculated. ▪ Traco Matthews and James Winfrey discussed provider recruitment efforts. o Significant Network Change: In Q3 2024, the Plan submitted a new significant network change filing on September 20, 2024. ▪ During the Q2 2024 EQIHEC meeting a committee member raised concerns regarding access to OB/GYN services in the eastern part the Plan's Service Area. The Plan is contracted with 11 unique OB/GYN providers across 8 locations in the East Kern area. The Plan conducted an informal appointment availability survey/accessibility discussion and found that for providers that responded, appointments were available within the regulatory access standard. The Plan has directed recruitment and contracting efforts to identify and expand the OB/GYN network within this area, including Antelope Valley Hospital as many providers within this area perform deliveries at this hospital. Historically Antelope Valley Hospital has refused to contract with the Plan. ▪ Greg Panero added that as of December 1st, 2024, Ridgecrest Regional Hospital is reopening its labor and delivery department which will provide some access relief for OBGYN services in the East Kern area. o DHCS Quarterly Monitoring Report/Response Template (QMRT): In Q3 2024, the plan provided a response to DHCS QMRT for Q2 2024 data. The plan did not identify any areas of concern as the Plan's results were in line with statewide results.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	**<u>Open Forum</u>** - No items.	☑ **CLOSED**: Informational only.	*10/18/24*
NEXT MEETING	Next meeting will be held Friday, January 17, 2024.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 12:03 PM. ***Respectfully submitted: James Winfrey; Deputy Director of Provider Network Management***	**N/A**	*N/A*

For Signature Only – AADVOC Minutes 10/18/24

The foregoing minutes were APPROVED AS PRESENTED on: 12/3/2024 (Date) James Winfrey (Name)

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

KERN HEALTH SYSTEMS

To: EQIHEC

From: Michelle Curioso, Director of Population Health Management

Date: 12/12/2024

Re: Population Health Management: Addressing Lack of Access to Care for Pregnant Women in East Kern Area

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Background:

Improving maternal health is a key objective for the Department of Health Care Services (DHCS) Comprehensive Quality Services (CQS), with an emphasis on improving maternity outcomes and promoting birth equity. The Kern Health System (KHS) Population Health Management (PHM) Department is vital in enhancing care quality and reducing disparities in maternity services. During the most recent EQIHEC meeting, it was highlighted that there is insufficient access to care for pregnant women, including during delivery. Addressing the lack of access to care for pregnant women is crucial for several reasons:

1. Access to prenatal care is essential for monitoring the health of both the mother and the developing baby. Early detection of complications can reduce risks, ensuring better health outcomes for both.
2. Regular prenatal visits can prevent complications such as gestational diabetes, preeclampsia, and preterm labor. Lack of access to care increases the risk of these and other serious conditions.
3. Inequities in healthcare access can contribute to disparities in maternal and infant mortality rates. By addressing gaps in care, we can help ensure that all pregnant women, regardless of their background or location, have the support and resources they need.
4. Ensuring all women, especially those in underserved communities, have access to timely and quality maternity care is critical for promoting birth equity—giving every woman the same opportunity for a healthy pregnancy and safe delivery.

Discussion:

The purpose of this report is to assess the population of childbearing and pregnant women in East Kern and evaluate the current healthcare infrastructure. The aim is to address the challenges these residents face in accessing care and propose strategies to improve access, ensuring they receive the necessary support for a healthy pregnancy and safe delivery.

Fiscal Impact:

None.

Requested Action:

Review for approve.

Population Health Management Quarter 4

Michelle Curioso, MPA, PHN, RN
Director of Population Health Management

KERN HEALTH SYSTEMS

Improving Maternal Health Care

Problem: Pregnant women living in the East Kern area face limited access to healthcare services.

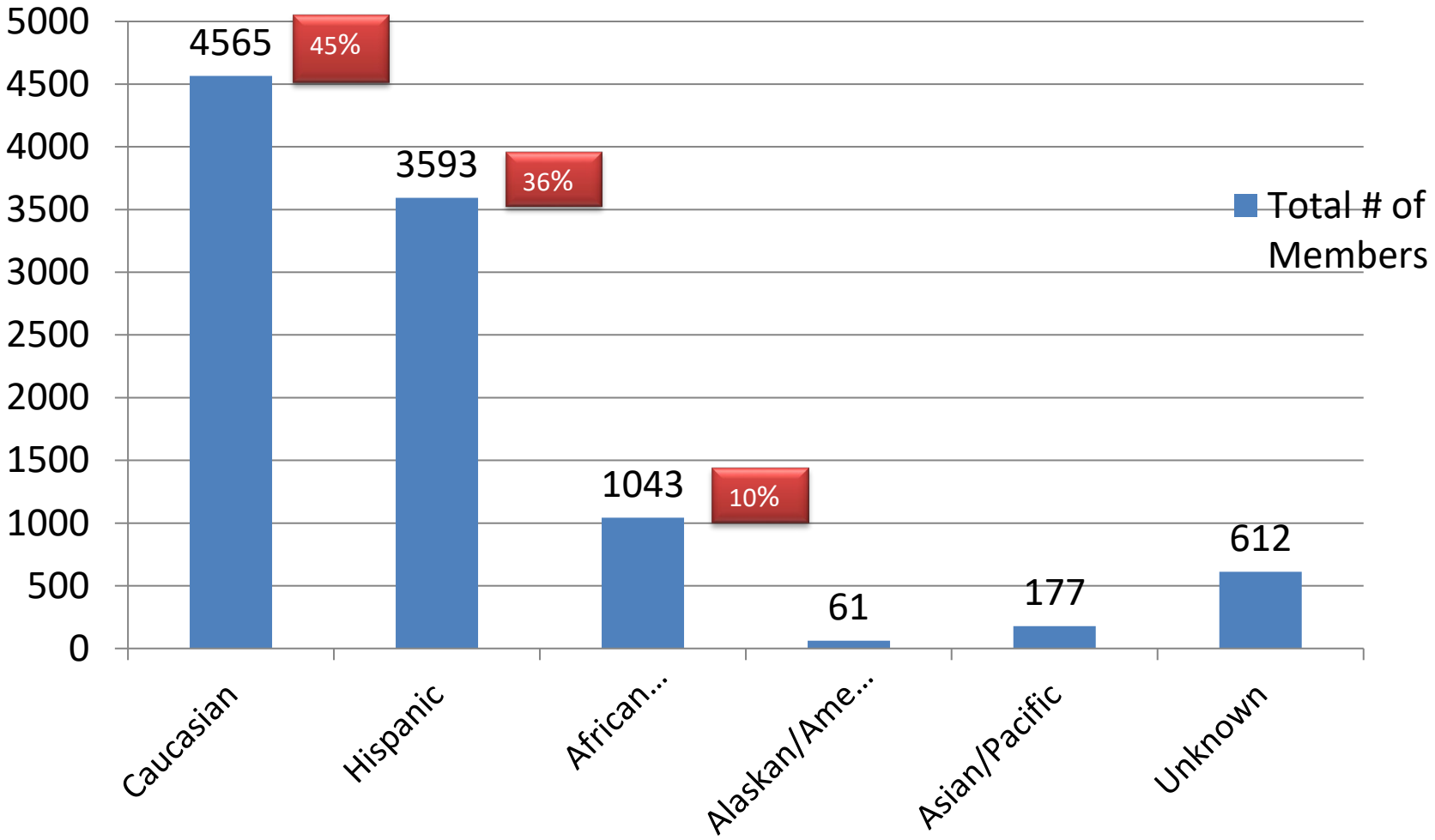
Goal: To improve access to healthcare for pregnant women in the East Kern area, ensuring that they receive the care they need for a healthy pregnancy and a safe delivery.

Objective: To assess the population of childbearing women, ages 12-51 residing in East Kern and analyze the existing healthcare infrastructure.

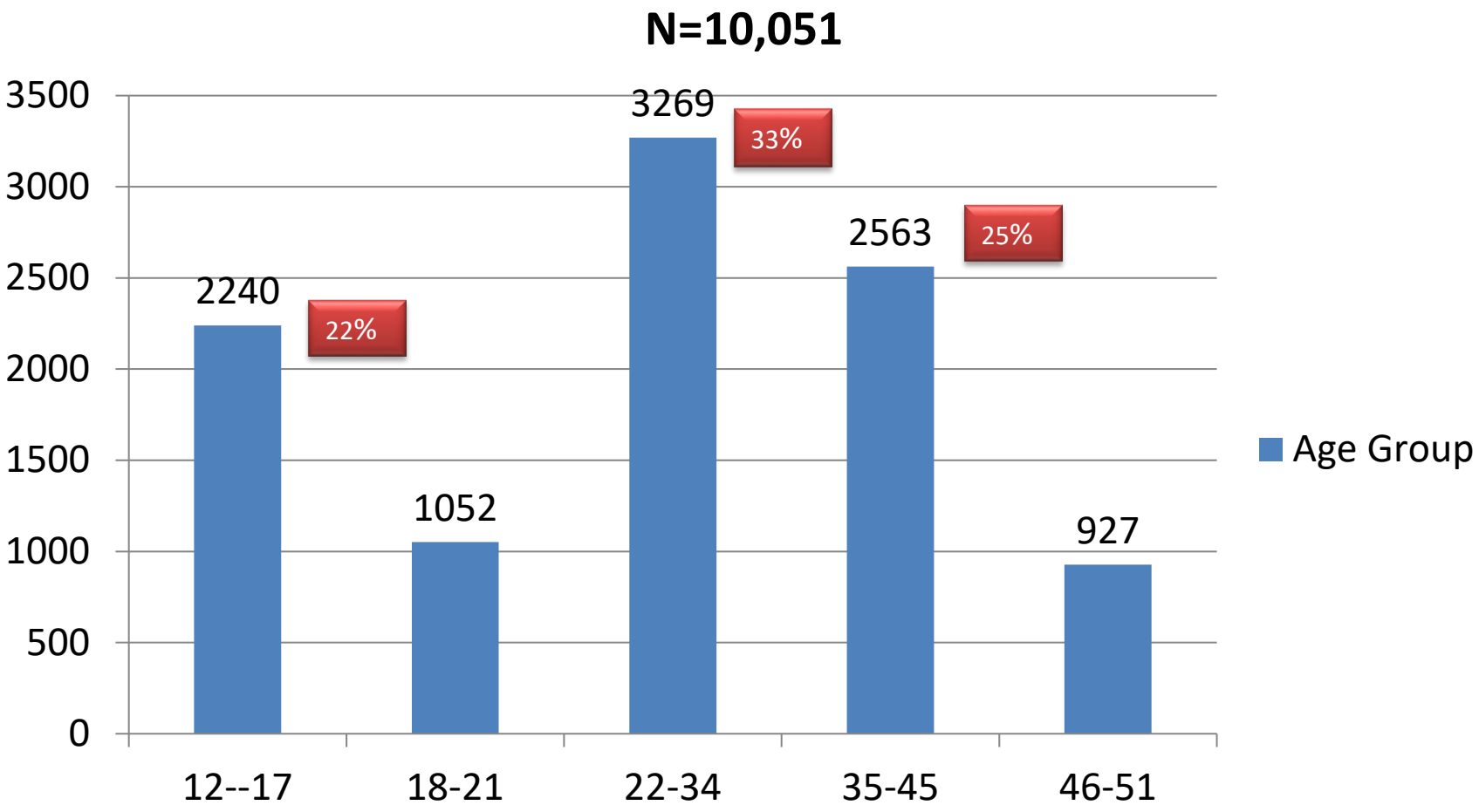
East Kern Zip Codes	City	Total # of female members 12-51 y/o residing in East Kern
93205	Bodfish	221
93226	Glenville	16
93238	Kernville	74
93240	Lake Isabella	576
93255	Onyx	74
93285	Wofford Heights	205
93501	Mojave	618
93502	Mojave	24
93504	California City	38
93505	California City	1,541
93516	Boron	244
93518	Caliente	68
93519	Cantil	1
93523	Edwards	114
93527	Inyokern	243
93528	Johannesburg	12
93531	Keene	30
93554	Randsburg	2
93555	Ridgecrest	2,618
93556	Ridgecrest	55
93558	Red Mountain	1
93560	Rosamond	1,375
93561	Tehachapi	1,806
93581	Tehachapi	95
Grand Total		**10,051**

Ethnicities

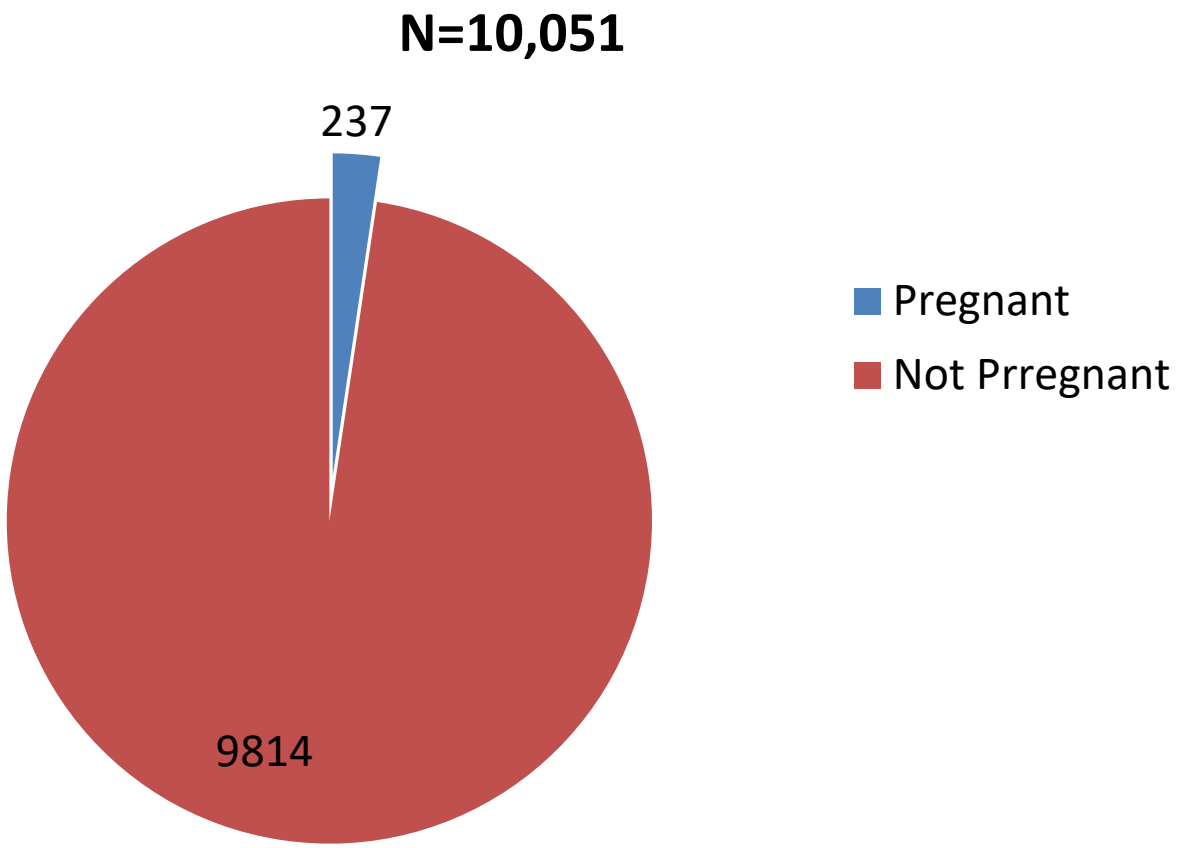
N=10,051



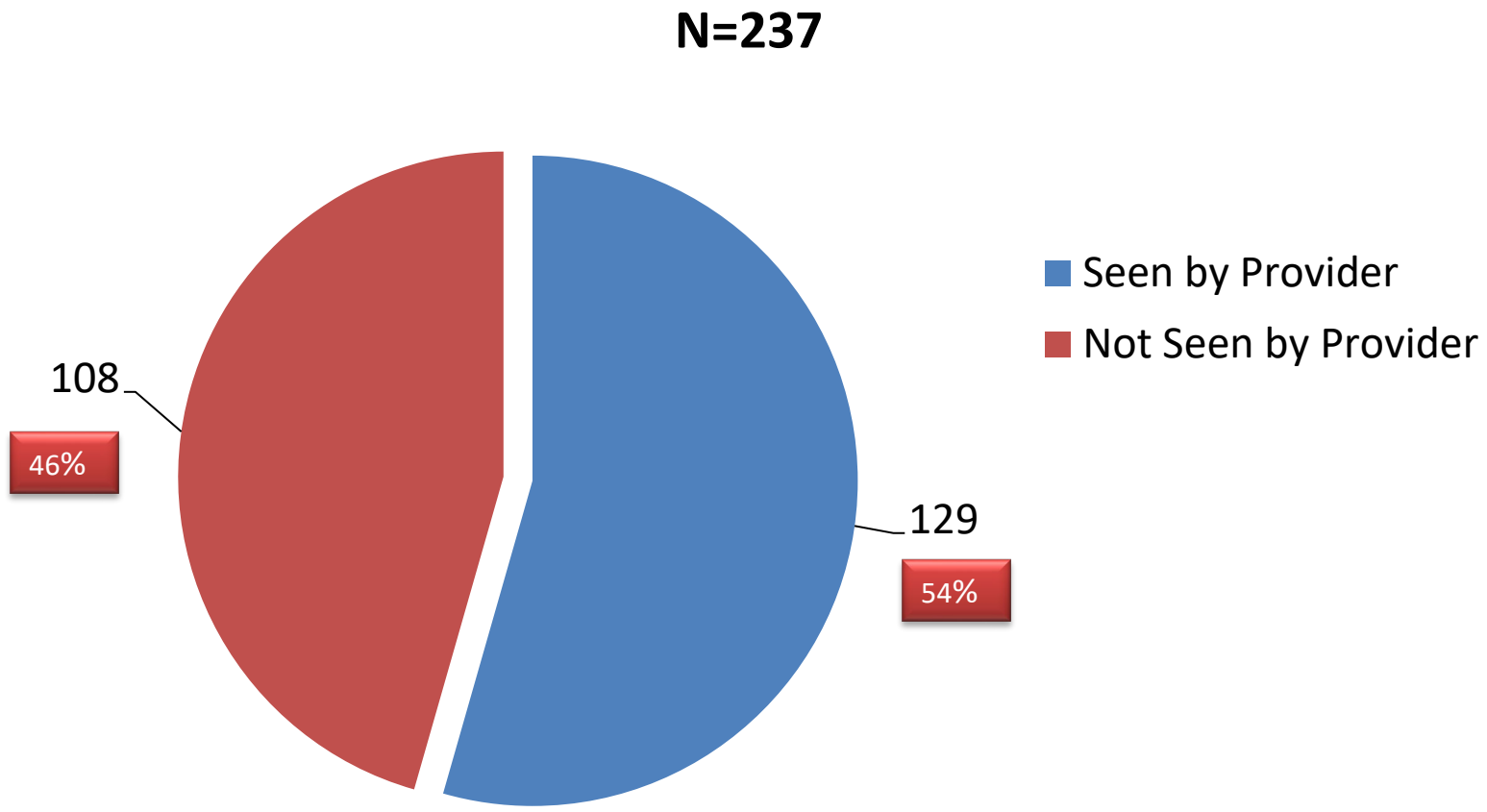
Age Group


N=10,051
3500
3000
2500
2000
1500
1000
500
0
2240
22%
1052
3269
33%
2563
25%
927
12--17
18-21
22-34
35-45
46-51
Age Group

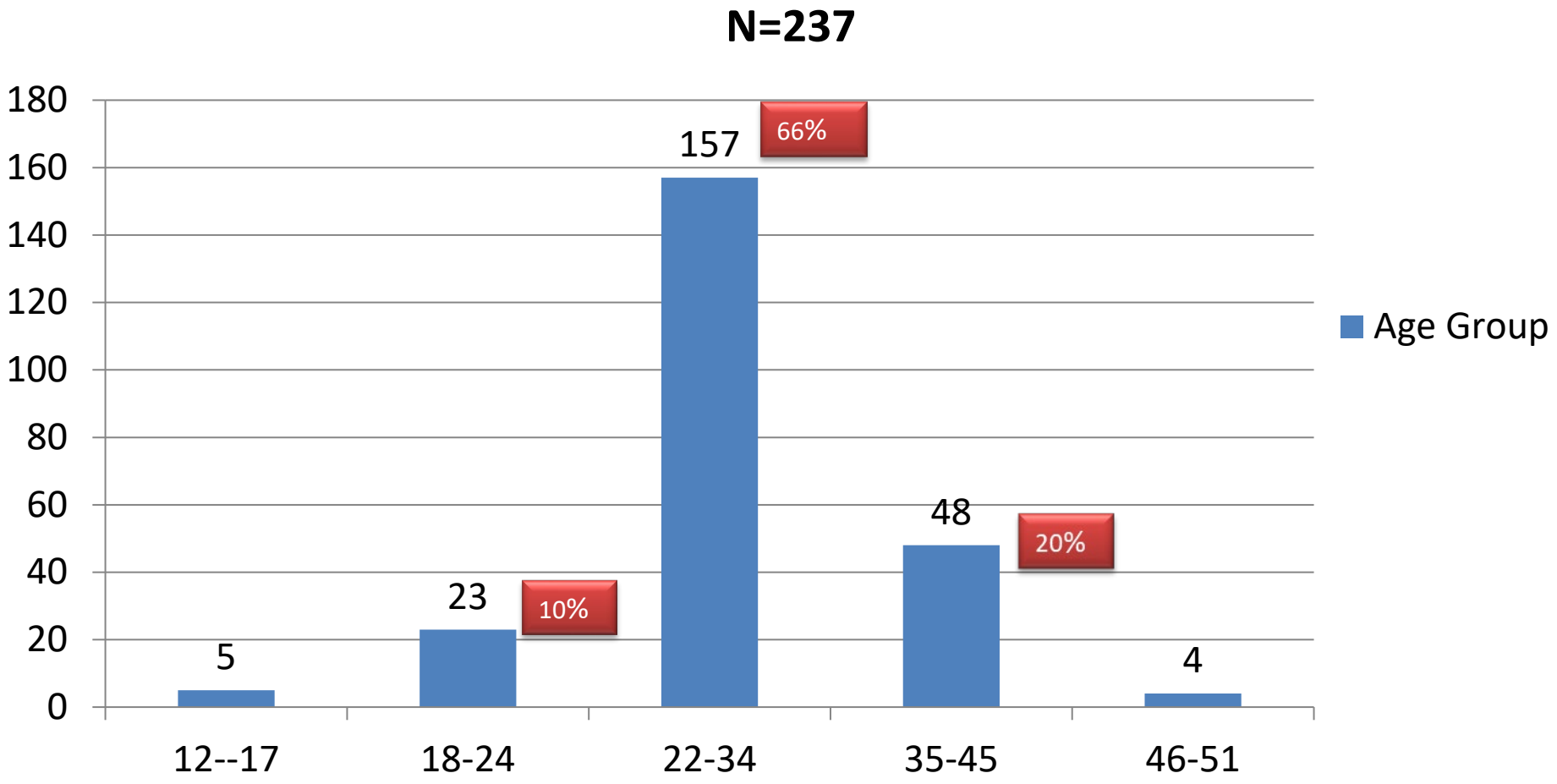
Pregnant vs. Not Pregnant



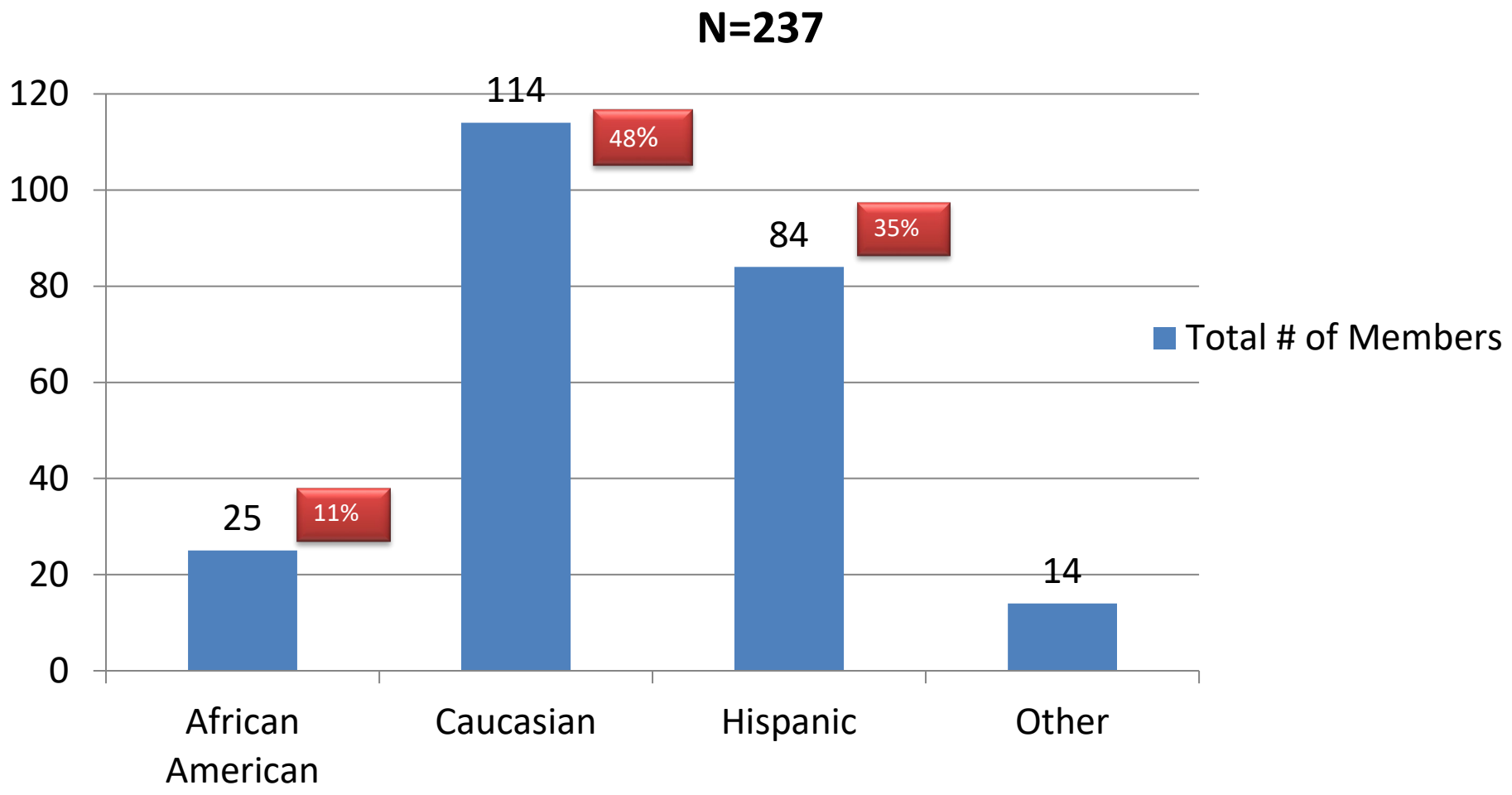
Seen by Provider



Pregnant Members by Age



Pregnant Members by Ethnicity



18.6 ▲

pregnancy-related deaths per 100,000 live births in 2020

3.1–3.6x

HIGHER

rate of pregnancy-related deaths for Black birthing people

2.7x

HIGHER

rate of pregnancy-related deaths with Medi-Cal health coverage

2.1x

HIGHER

rate of pregnancy-related deaths when living in the least healthy community conditions

Cardiovascular Disease

current leading cause of pregnancy-related deaths

45% ▼

decrease in pregnancy-related deaths from hypertensive disorders

#	Providers Full Name	Provider Specialties Description	City	County	State	Zip Code
1	Sayeed Iqbal, MD	Obstetrics & Gynecology	California City	Kern	CA	93505
2	Gary Swanson, MD	Obstetrics & Gynecology	California City	Kern	CA	93505
	Gary Swanson, MD	Obstetrics & Gynecology	Lancaster	Los Angeles	CA	93535
3	Simona Myers, MD	Obstetrics & Gynecology	Lancaster	Los Angeles	CA	93535
4	Wanda Wilburn, MD	Obstetrics & Gynecology	Barstow	San Bernardino	CA	92311
5	Diego Mendez, MD	Obstetrics & Gynecology	Tehachapi	Kern	CA	93561
6	Luis Lopez, MD	Obstetrics & Gynecology	Tehachapi	Kern	CA	93561
7	Joseph Edwards, MD	Obstetrics & Gynecology	Ridgecrest	Kern	CA	93555
	Joseph Edwards, MD	Obstetrics & Gynecology	Ridgecrest	Kern	CA	93555
	Joseph Edwards, MD	Obstetrics & Gynecology	Ridgecrest	Kern	CA	93555
8	Carl Hayes, MD	Obstetrics & Gynecology	Lancaster	Los Angeles	CA	93535
	Carl Hayes, MD	Obstetrics & Gynecology	California City	Kern	CA	93505
9	Billie Guerra, DO	Obstetrics & Gynecology	Ridgecrest	Kern	CA	93555
	Billie Guerra, DO	Obstetrics & Gynecology	Ridgecrest	Kern	CA	93555
10	Kalamani Dharma, MD	Obstetrics & Gynecology	Ridgecrest	Kern	CA	93555
12	Mariah Pietrangelo, NP-C	Obstetrics & Gynecology	Ridgecrest	Kern	CA	93555
13	Alessa Siler, NP-C	Obstetrics & Gynecology	Ridgecrest	Kern	CA	93555

Delivery Hospital

Bakersfield

1. Kern Medical
2. Memorial Hospital
3. Mercy Southwest
4. Adventist Health

Out of Kern County

1. Antelope Valley Medical Center
2. Palmdale Regional Medical Center

Call to Action

To tackle the issue of limited access to healthcare services for pregnant women in the East Kern area, the following actions are proposed:

1. Present the problem to the PHM Committee for initial discussion.
2. Form a workgroup to develop strategies for addressing the issue.
3. Share the proposed strategies with the EQIHEC Committee for additional feedback and support.

THANK YOU!

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: Pawan Gill, Health Equity

Date: December 12, 2024

Re: Sexual Orientation & Gender Identity Policy & Procedure

Background

This agenda item is being presented to create a policy and procedure for expanding our demographic data collection efforts to include Sexual Orientation and Gender Identify (SOGI) data for members. Collection of SOGI data is critical in understanding and addressing the diverse health needs of our members. This policy is a requirement for NCQA accreditation and requires review and approval by the Health Equity Transformation Steering Committee (HETSC) and the Executive Quality Improvement Health Equity Committee (EQIHEC).

Discussion

The attached SOGI policy and corresponding training materials outline:

- Procedures for the collection
- Staff training requirements for staff collecting data
- Adds SOGI questions to the Health Risk Assessment (HRA)

Fiscal Impact

None - SOGI questionnaire was integrated into the HRA.

Requested Action

Review & approve.

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Collection of Sexual Orientation and Gender Identity (SOGI) Data	**Policy #**	22.08-I
Policy Owner	Health Equity Office	**Original Effective Date**	9/2024
Revision Effective Date		**Approval Date**	
Line of Business	☒ Medi-Cal ☐ Medicare		

I. PURPOSE

Kern Health Systems (KHS) and its subcontracted Plan Partners, if applicable, shall collect the sexual orientation and gender identity (SOGI) information demographic data including member pronouns, sex assigned at birth as well as gender identity and sexual orientation, in accordance with applicable regulations and regulatory agency requirements. Collection of this information from members is voluntary.

II. POLICY

A. KHS is committed to ensuring a safe and welcoming environment for all members. All KHS employees are expected to engage in affirmative interactions with all our members. To do this, KHS employees will use names and pronouns in accordance with member choice and will not assume gender. Member chosen name is to be used throughout our interactions. KHS staff will note the member's chosen name and pronouns in the configuration parameters list of the Member database. Chosen name should also be used in all other forms of communication related to the member, except in situations where a legal name is required (i.e., insurance notification of admission, legal documents). KHS uses SOGI screening questions to collect chosen name, sex assigned at birth pronoun, gender identity and sexual orientation data from members 18 years and older in a safe and welcoming environment using the following data sources.

1. Health Risk Assessment (HRA)
2. Member facing Health Services departments; Population Health Management, Wellness and Prevention, Behavioral Health when members call in.
3. Medical Record data received from providers.

Using these data sources ensures that KHS collects SOGI data from as many members as possible because any gaps in the HRA data can be closed during member interactions with

Member facing Health Services Departments, Population Health Management, Wellness and Prevention, Behavioral Health. To ensure that our staff are equipped to collect and use SOGI data, all current staff will be trained (Attachment B: Collecting SOGI information from Members PowerPoint; training will also be part of new employees onboarding process.

B. KHS and its Delegated Subcontractors, if applicable, shall have an electronic information data system which is capable of receiving, storing, and retrieving such demographic data as separate fields at the individual Member level.

C. KHS staff will follow the script below when collecting member data in the system of record and share KHS's privacy protect policy with the member.

D. KHS staff collecting the SOGI information will receive training on the collection of data related to sexual orientation and gender identity to ensure staff members are equipped to collect the data and ensure our members do not feel stigmatized during the collection process. Training will be conducted upon onset of SOGI data collection for all member services representatives and with all subsequent new hires in that role or any role which is charged with collecting the data.

E. KHS staff will select "Information unavailable" when soliciting information from individuals if a response was requested but not provided.

F. KHS staff will select "Decline to answer" when a member chooses not to disclose SOGI information, including member pronouns, sex assigned at birth, as well as gender identity and sexual orientation.

G. KHS shall have a process to show member pronouns to member-facing departments in the Member Home >Summary screen of the Member database screen in QNXT. Member facing health services staff will use the Member home screen in the record system to address members in the correct pronouns.

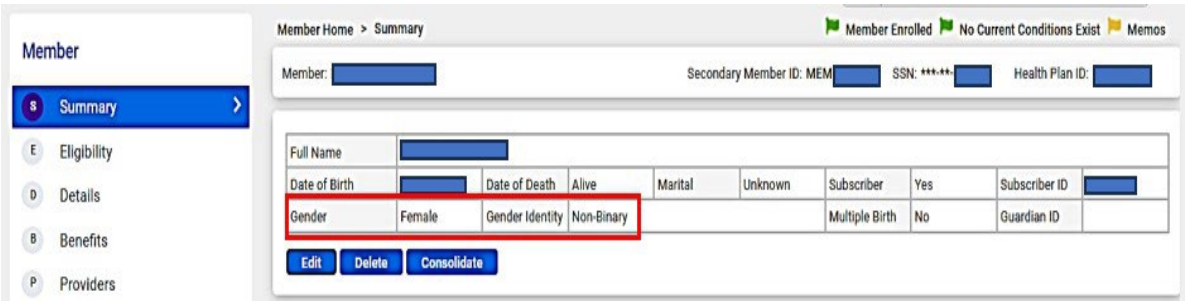
H. KHS staff data collection will be utilized to complement HRA SOGI question responses in cases where information is absent or requires updating.

III. DEFINITIONS

TERMS	DEFINITIONS
Pronouns	Gendered and gender-neutral identifiers (He/him, She/her, They/them, etc.)
Sex Assigned at Birth	The sex (male or female) assigned to a child at birth, most often based on the child's external anatomy and also referred to as birth sex, natal sex, biological sex, or sex.
Gender Identity	A person's innermost concept of self as male/female, a blend of both, or neither; how a person perceives themselves and what they identify as.
Sexual Orientation	How a person characterizes their emotional and sexual attraction to others

IV. PROCEDURES

A. KHS designated staff will attempt to collect Member SOGI data, including member chosen name, pronouns, sex assigned at birth, gender identity, and sexual orientation when members call into KHS. SOGI information may also be solicited in outbound calls. The information is collected and stored in the Member Home >Summary screen of the Member database and CRM in accordance with the applicable technical procedures.



KHS health services or designated staff will follow the following script.

Inbound calls:
"Thank you for calling, Kern Family Health Care, this is [your name]. How can I help you?" Help the member then follow the following steps and script to update their profile.

During any over the phone contact with the member, if the member profile is missing SOGI information, state the following to advise the member of the identified mission SOGI information: "I see that we are missing information on your (state the missing data only) pronouns, gender identity and sexual orientation. May I ask you some questions on these topics? If Member declines, confirm that they want to decline all SOGI questions including preferred name and pronouns; thank the member and document "Prefer not to answer." If member says yes, follow the script below.

"At Kern Family Health Care, we value and respect all our members and want to make sure we are addressing you by the correct name and pronouns. Any answers you provide will be kept confidential. Your personal information (PI) includes your race, ethnicity, language, gender identity, pronouns, and sexual orientation. Kern Family Health Care (KFHC) protects your PI by restricting access to your PI so that only those who are approved and allowed use it will see it. KFHC also protects your information securely. You can access our privacy protection policy on our website at www.kernfamilyhealthcare.com/privacy-policy/ or request us to mail you a printed copy. Is it ok if I ask you a few questions about your sex assigned at birth, gender identity, pronouns, and sexual orientation? This information helps us to provide services and resources around the unique needs of each member we serve. Providing this information will not negatively affect your access to services in any way. Any answers you provide will be kept confidential."

B. If member says "yes," KHS staff will thank the member and then proceed in asking the SOGI questions below as depicted in the attached Sexual Orientation and Gender Identity

Categories, as applicable.

1. What is your name as you would like it to appear on your health record?
    a. If asked what this means explain as follows: "A chosen name is different from your legal name. Our records show your name as… First Name/Last Name"

2. What are your pronouns?
   If asked what this means, give them the following options listed in the drop-down field:
    a. He/Him
    b. She/Her
    c. They/Them
    d. Other (please specify): If the member identifies pronouns that are not in the drop-down option (ex. Zi, Zir, Xe), MSRs should indicate this in a contact note.
    e. Decline to answer.
    f. Information Unavailable

3. Sexual Orientation: Do you think of yourself as:
   Give them the following options listed in the drop-down field:
    a. Straight or heterosexual
    b. Lesbian or gay
    c. Bisexual
    d. Queer, pansexual, and/or questioning
    e. Something else, please describe:
    f. Don't know.
    g. Decline to answer.
    h. Information Unavailable

4. Gender Identity: Do you think of yourself as:
   Give them the following options listed in the drop-down field:
    a. Male
    b. Female
    c. Transgender man/trans man/female-to-male (FTM)
    d. Transgender woman/trans woman/male-to-female (MTF)
    e. Genderqueer, neither exclusively male nor female
    f. Additional gender category (or other); please describe:
    g. Decline to answer.
    h. Information Unavailable

5. Sex Assigned at Birth: What sex was originally listed in your birth certificate?
   Give them the following options listed in the drop-down field:
    a. Male
    b. Female
    c. Unknown
    d. Decline to answer.
    e. Information Unavailable

C. KHS's Health Equity Department will use internal reporting mechanisms generated Business

Intelligence (BI) reports from QNXT to monitor the collection of the sexual orientation and gender identity (SOGI) information demographic data, including member pronouns, sex assigned at birth as well as gender identity and sexual orientation, in accordance with applicable regulations and regulatory agency requirements on an annual basis. Summaries and identified trends are presented for recommendation at the Executive Quality Improvement Health Equity Committee (EQIHEC) meeting.

D. KHS's Health Equity Department will report the collection of SOGI data to National Committee on Quality Assurance (NCQA) for Health Equity Accreditation and other regulatory agencies. Our Health Equity Department also runs internal audit reports on SOGI data. It will report to the EQIHEC meeting annually to monitor the collection of SOGI data for our members.

V. ATTACHMENTS

Attachment A: Health Risk Assessment (HRA) Survey
Attachment B: Collecting SOGI information from Members Training
Attachment C: SOGI Questionnaire Intake Process Technical

VI. REFERENCES

Reference Type	Specific Reference
Choose an item.	

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Created	2024-09	Created for NCQA Health Equity Accreditation	M.R. Health Equity Office
Revised			
Retired			

VIII. APPROVALS

Committees | Board (if applicable)	Date Reviewed	Date Approved
Executive Quality Improvement Health Equity Committee (EQIHEC)		
HETSC		
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		
Choose an item.		

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Operating Officer		
Chief Health Equity Officer		
Chief Medical Officer		
Choose an item.		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 22.08-I Collection of Sexual Orientation and Gender Identity (SOGI) Data

Reason for revision: The policy was created for NCQA Health Equity Accreditation.

Director Approval		
Title	**Signature**	**Date Approved**
Jake Hall Senior Director of Quality Performance and Contracting		
Kailey Collier Director of Quality Performance		

Date posted to public drive: _____

Date posted to website ("P" policies only): _____

Collecting SOGI information from Members

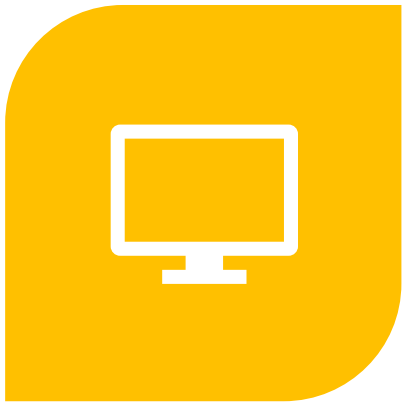
Presented by: Health Equity Office – Kern Health Systems

December 3, 2024

Key Objectives

WHAT IS SOGI DATA?

WHY WILL BE COLLECTING SOGI DATA?



HOW WILL WE USE IT?

What is SOGI data?

SOGI is the acronym for **Sexual Orientation Gender Identity**

At KHS, SOGI data collection includes 5 pieces of information, including:

1.) **Sexual Orientation**: How a person characterizes their emotional and sexual attraction to others

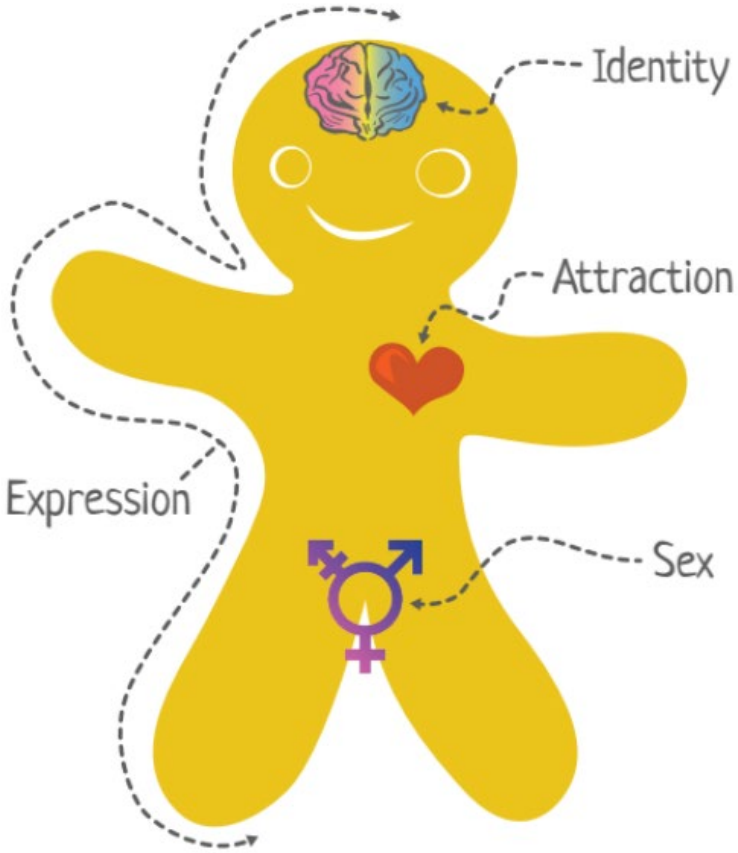
2.) **Gender Identity**: A person's innermost concept of self as male/female, a blend of both or neither; how a person perceives themselves and what they call themselves

3.) **Pronouns**: Gendered and gender-neutral identifiers (he/him, she/her, they/them)

4.) **Sex Assigned at Birth**: The sex (male or female) assigned to a child at birth, most often based on the child's external anatomy. Also referred to as birth sex, natal sex, biological sex, or sex

5.) **Preferred Name**: Provides option for member to provide their preferred name which may differ from their legal name and may also correspond with their gender identity

SOGI Simplified



Sexual Orientation

Gender identity

Sex

Sexual Orientation

- “Do you think of yourself as”:

- Options
  - Straight or heterosexual
  - Lesbian or gay
  - Bisexual
  - Queer, pansexual and/or questioning
  - Something else, please describe:
  - Don’t know
  - Decline to Answer
  - Information unavailable

Sexual Orientation

Definitions

– ***Lesbian or gay***: A person who is emotionally, romantically or sexually attracted to members of the same gender. Men, women and non-binary people may use this term to describe themselves.

– ***Bisexual*** : people are attracted to more than one gender

– ***Queer:*** A term people use to express a spectrum of identities and orientations that are counter to the mainstream. Someone who isn't exclusively heterosexual or cisgender.

– ***pansexual and/or questioning*** : people who has the potential for emotional, romantic or sexual attraction to people of any gender though not necessarily simultaneously, in the same way or to the same degree. Exploring their sexuality or gender

https://www.cdss.ca.gov/inforesources/cdss-programs/sogie/resources

Gender Identity

- "Do you think of yourself as":
- Options:
  - Male
  - Female
  - Transgender man/trans man/female-to-male (FTM)
  - Transgender woman/trans woman/male-to-female (MTF)
  - Genderqueer, neither exclusively male nor female
  - Additional gender category (or other); please describe:
  - Decline to answer
  - Information unavailable

Other gender identities that could be used for other include but are not limited to:

Bigender: A person who fluctuates between traditionally "male" and "female" gender-based behaviors and identities

Cisgender: This gender refers to when someone's gender identity coincides with the sex that they were assigned at birth, such as male or female.

Genderfluid: A person does not identify as male or female but rather as one or the other depending on the day.

Agender: If you identify as agender, you might not identify as either female or male.

Sex assigned at Birth:

- “What sex was originally listed on your birth certificate”:

- Options:
  - Male
  - Female
  - Unknown
  - Decline to answer
  - Information unavailable

Name and Pronouns

- What is your name as you would like it to appear on your health record?

Fill in option: _____

- What are your pronouns:
  - He/Him
  - She/Her
  - They/Them
  - Other please specify:

  If the member identifies pronouns that are not in the drop- down option (ex. Zi, Zir, Xe), MSRs should indicate this in the contact note.
  - Decline to answer
  - Information unavailable

Who are we collecting SOGI information on?

SOGI related questions are **only** applicable to Members 18 years and older. If a member is under the age of 18, these questions SHOULD NOT be asked.

Why collect this information?

- It's simple- **BETTER CARE FOR OUR MEMBERS!**

- Understanding LGBTQIA+ identities and healthcare needs enables our staff and clinicians to provide the most inclusive and appropriate care leading to better outcomes and better member satisfaction

Why collect SOGI Data?

Reduce Health Disparities:

- LGBTQIA+ members face alarming health disparities including mortality, pysch, substance abuse, HIV
- History of invisibility has left the healthcare industry behind in offering appropriate interventions
- Lack of data for researching improved care

Doing the Right Thing:

- LGBTQIA+ members deserve patient-centered care & quality of life – which requires them to feel safe & respected in healthcare settings
  - Patients have walked out, sued, not returned for care due to mistreatment – not because
  - they do not need healthcare
- Business need – this is a growing member population that we need to prepare for now
  - LGBTQ-identified population has doubled since previous generation (GLAAD, Accelerating Acceptance)
  - Trans/nonbinary population will increase 4x in next generation (.5% -> 2%, More Inclusive EHRs, Healthcare IT News)

Member/Patient Satisfaction:

- Goal: provide seamless use of preferred name, preferred pronouns, and gender identity in all patient-facing interactions. LGBTQIA+ members deserve patient-centered care & quality of life – which requires them to feel safe & respected in healthcare settings
- Collect SOGI data for all patients to provide best care with inclusive respectful language & knowledgeable clinicians
  - No longer consider LGBTQ-related healthcare to be a “specialty,” but rather standard knowledge for all providers & essential part of taking a patient’s medical/social history

LGBTQIA+ Health Disparities – by the Numbers

Anti LGBTQIA+ discrimination and high rates of abuse and trauma result in the following health disparities, which can be made worse when people are also subject to racism

LGBTQ Health Disparities – by the Numbers

Anti LGBTQ discrimination and high rates of abuse and trauma result in the following health disparities, which can be made worse when people are also subject to racism

Transgender / Nonbinary

(gender minority)

- 50% higher mortality for transgender women – due to higher rates of substance abuse, HIV, suicide
- 44% - clinical depression
- 41% - suicide attempted
- 33% - anxiety
- 30% - currently smoking
- 26% - current or former alcohol or drug use to cope with mistreatment
- 20% - HIV prevalence (trans women)

Lesbian, gay, bisexual, pansexual, queer

(sexual minority)

- 35% - youth suicide attempt
- 27% - adults using excessive alcohol
- 27% - adults currently smoking
- 24% - adults receiving healthcare in emergency rooms
- 20% - adults experiencing psychological distress in past year
- 19% - youth threatened or injured with weapon at school

Krehely, Jack. "How to Close the LGBT Health Disparities Gap." *Center for American Progress*. December 2009. https://www.americanprogress.org/issues/lgbt/reports/2009/12/21/7048/how-to-close-the-lgbt-health-disparities-gap/

Safe, Joshua D., et al. "Barriers to Health Care for Transgender Individuals." *Current Opinion in Endocrinology & Diabetes and Obesity*. April 2016. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4802845/#R1

Staff & Member Comfort with SOGI

"Most healthcare organizations have yet to implement systematic data collection due to concerns about making staff and patients uncomfortable […] Most LGBTQ and non-LGBTQ patients understand the importance of discussing SOGI with providers and are willing to answer SOGI questions."

— Chis Grasso, et. al, "Planning and implementing sexual orientation and gender identity data collection in electronic health records" (2018)

Question 1: What can stop SOGI data collection before it even begins?

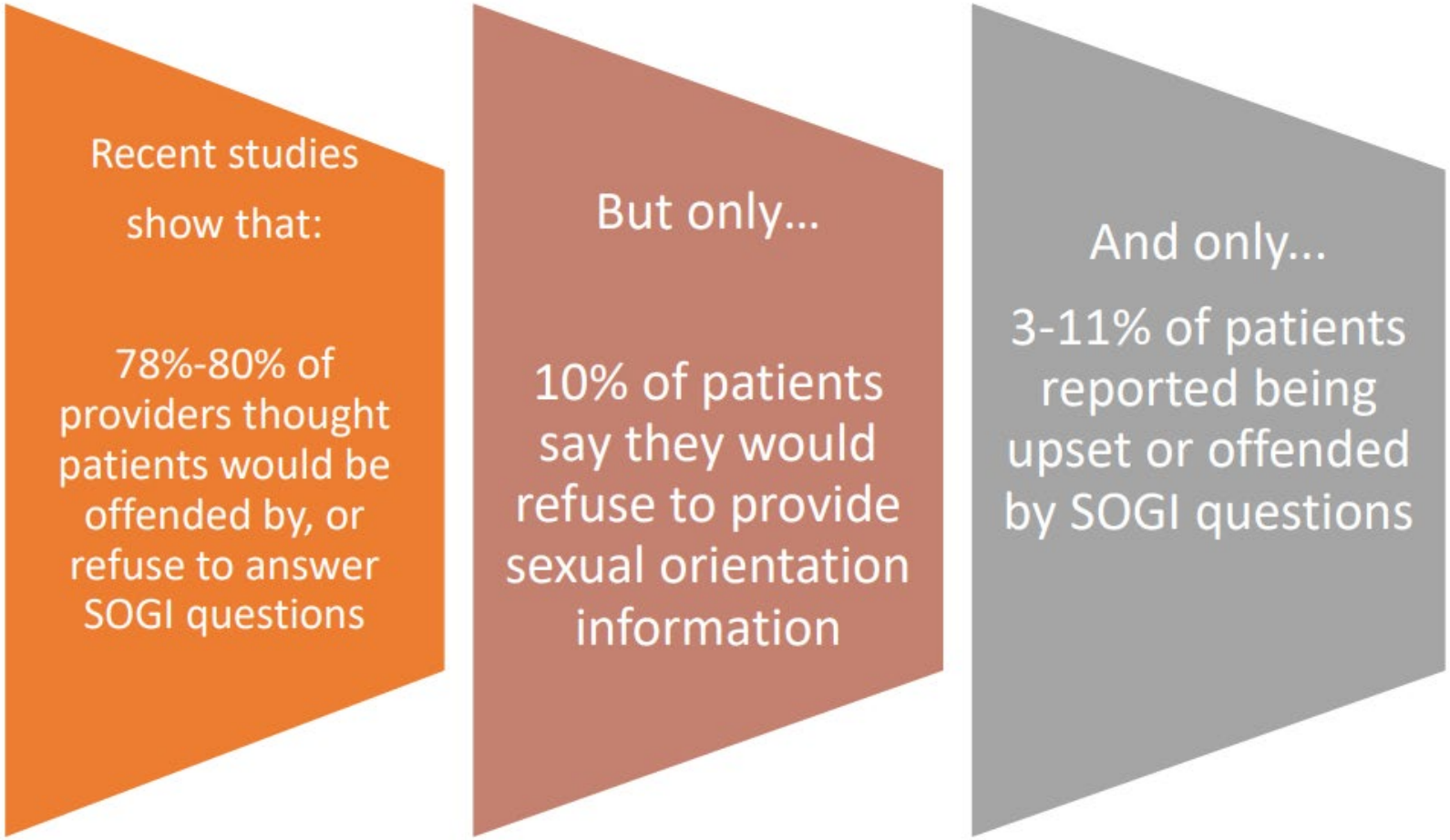
- **Concerns about staff and patient comfort.**

Question 2: Whose comfort issue is the main stumbling block?

- It's not usually the patient's!

Staff & Member comfort with SOGI contd.

You may think our members will not be okay answering these questions. However…



Chis Grasso, et. al, "Planning and implementing sexual orientation and gender identity data collection in electronic health records" (2018)

Staff & Member comfort with SOGI contd.

Most members will answer SOGI questions (or decline without pushback) when they understand *why* the information is collected, *who* uses it for *what* reasons, and that it will remain *private*.

Have you considered? SOGI information – like Race, Ethnicity, Language and Disability – is unique in that it is both a personal, social identity and also very clinically relevant. Approach collecting all this information the same

Scripting: What NOT to say

- When collecting SOGI data, we should not:
  - Apologize
  - Express discomfort
  - Avoid asking
  - Guess the member's responses
  - Assume how a patient will react to being asked
  - Phrase questions differently based on who they perceive the

    member to be - E.g. male/female, gay/straight, etc

SOGI – How to begin

• For SOGI, before beginning to ask questions, state: We are missing information on your pronouns, gender identity and sexual orientation. May we ask you some questions on this topic?

• If Member declines, confirm that they want to decline all SOGI questions including preferred name and pronouns; thank the member and document “Prefer not to answer.” If member says yes, follow the script below.

“At Kern Family Health Care, we value and respect all our members and want to make sure we are addressing you by the correct name and pronouns. Any answers you provide will be kept confidential. Your personal information (PI) includes your race, ethnicity, language, gender identity, pronouns and sexual orientation. Kern Family Health Care (KFHC) protects your PI by restricting access to your PI so that only those who are approved and allowed use it will see it. KFHC also protects your information securely. You can access our privacy protection policy on our website at www.kernfailymhealthcare.com/privacy-policy/ or request us to mail you a printed copy. Is it ok if I ask you a few questions about your sex assigned at birth, gender identity, pronouns and sexual orientation? This information helps us to provide services and resources around the unique needs of each member we serve. Providing this information will not negatively affect your access to services in any way. Any answers you provide will be kept confidential.”

Then Proceed in asking the SOGI questions.

Responding to Challenging Responses or Questions to SOGI collection

• Example Question #1: “I don’t understand. What is the difference between gender identity and sex on my birth certificate?”

– Suggested Response: “We ask both questions because gender identity may be different than what is on your birth certificate. Gender identity is how you understand yourself and what you call yourself – it can be male, female, or something else. One's gender identity can be the same or different from their sex at birth.”

• Example Question #2: “Why are you asking me this? What does this have to do with my health?”

– Suggested Response: “People of different sexual orientations and gender identities may have different health care needs. By collecting this information, we can make sure to provide you with the best care. We can also identify patterns and work to reduce health risks by making sure that everyone gets high quality health care”

Responding to Challenging Responses or Questions to SOGI collection

- Example Question #3: “Why do you care about my sexual orientation?”

– Suggested Response: “By collecting this information, you are helping us to provide better services and programs to our Members. The information can help us identify patterns, and work to reduce risks by making sure that everyone gets high quality health care. Regardless of whether you answer these questions, we will provide you with quality care.”

- Example Question #4: “Why are you asking me this? Do you think I’m gay?”

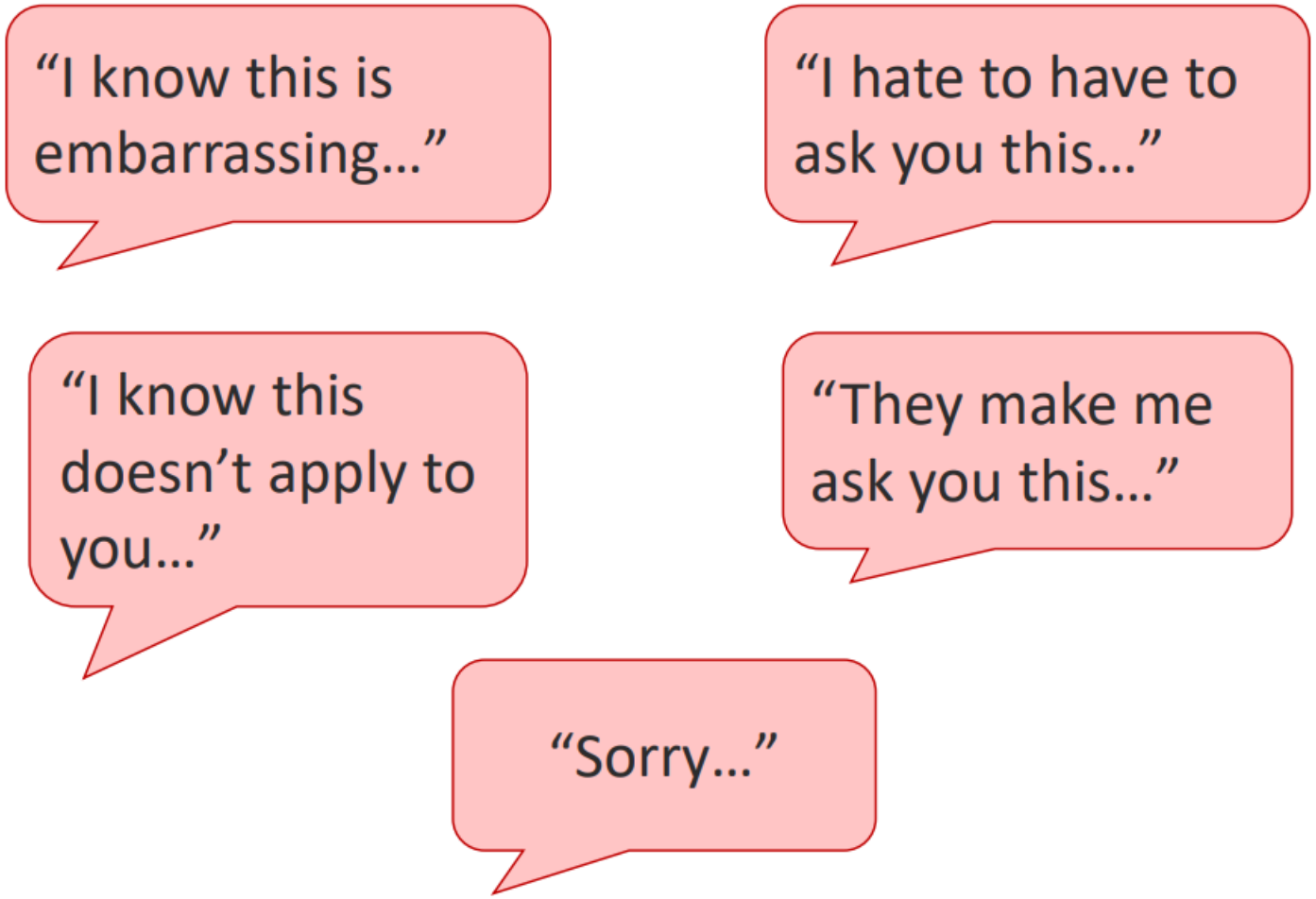
– Suggested Response: “We ask all members to self-identify because we want our records to capture you as accurately as possible. People of different sexual orientations and gender identities may have different health care needs. By collecting this information, we can make sure to provide you with the best care. ”

Scenario

- You are a Health Services Department representative who notices that the member you are currently assisting has not completed the SOGI questionnaire. You offer and the member indicates they do not want to complete the survey.

- How might you handle this call?

Phrases to Avoid



SOGI – Responding to Challenging Questions

Member: I am offended by these questions. This is none of your business.”

I understand, and it is not my intention to offend you. We ask all of our Members, however, these questions are optional and you can most definitely opt out. Regardless of whether you answer these questions, we will provide you with quality care. This information does help our health plan to provide better care. Anything you do share with us is private and will not be shared with any unauthorized individuals.

Possible Responses contd.

Most members will answer (or decline without pushback) when they understand **<u>why</u>**

Member seems to hesitate…..

This information is confidential and not shared with anyone outside of Kern Family Health Care.

"No problem. You do no have to answer any questions you do not wish to answer." [Record "Decline to answer" in system]

"I don't want to tell you that"

What does KHS do with this information?

Pronoun information will be shared with KHS internal departments in order to address members in their preferred pronouns.

KHS Health Equity & Quality Improvement data teams will use this information, similar to that of race, ethnicity and language data, to identify health disparities within these populations.

Health Equity, Quality Improvement and Health Services teams will work together to address health disparities, which may include targeted interventions to improve health outcomes based on the data.

At this time, data will not yet be shared with vendors or other agencies

Friendly Reminders…

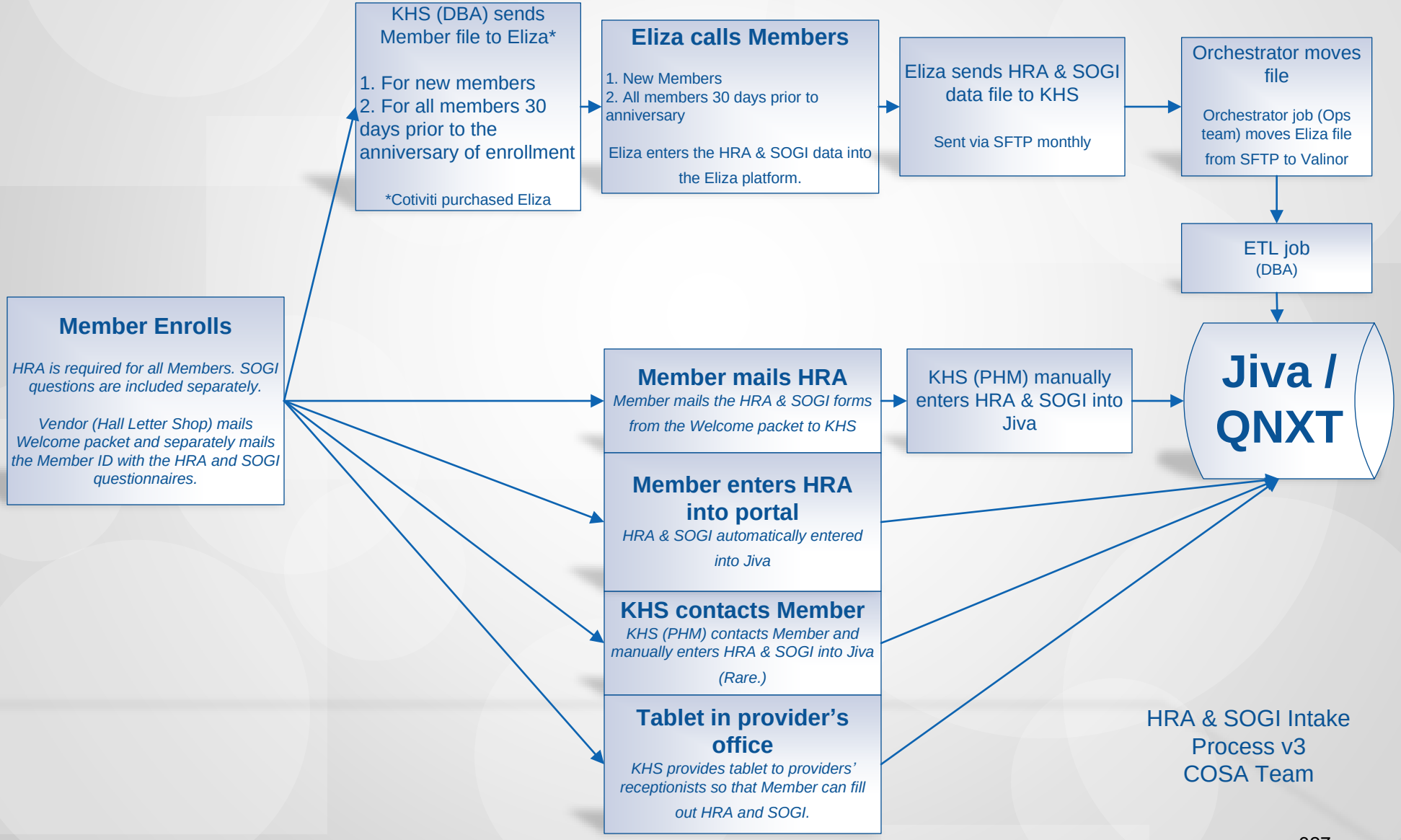
- Mistakes happen! You may accidentally use the wrong pronoun
    - Always apologize – even if the error did not originate with you, even if avoidable. This communicates to our member that we care.
    - Make a quick, sincere apology (do not express discomfort or draw extra attention from others)
    - Be sincere!

Questions?

Please contact your KHS Health Equity Team for any additional support

HEO@khs-net.com

HRA & SOGI Questionnaire Intake Process



HRA & SOGI Intake Process v3
COSA Team

Member Name:
Member ID:

Please take a few minutes to complete this Health Risk Assessment (HRA). Please send it back to us as soon as possible in the enclosed postage paid envelope. Completing this HRA will help us to manage your health care needs. We want to work with you to make a plan to improve or maintain your health. Any answers you provide will be kept confidential. Your personal information (PI) includes your race, ethnicity, language, gender identity, pronouns and sexual orientation. Kern Family Health Care (KFHC) protects your PI by restricting access to your PI so that only those who are approved and allowed use it will see it. KFHC also protects your information securely. You can access our privacy protection policy on our website at www.kernfamilyhealthcare.com/privacy-policy/ or request us to mail you a printed copy. This HRA is optional. If you choose to provide your PI, or you choose not to complete it, it will not affect your health care coverage, Medi-Cal benefits, or services. You can choose to not complete the HRA by checking the "no" box of the last question under MEMBER DEMOGRAPHICS. **Para español, llame al 1-800-391-2000.** Please call Member Services at 1-800-391-2000 (TTY 711) Monday through Friday, 8:00 am to 5:00 pm if you have questions.

MEMBER DEMOGRAPHICS

Please provide the following information.

Address City Zip

Telephone Number (Home/Work/Cell/other)

Birthdate

Medi-Cal Identification Number
Preferred Language

What is your race?
☐Black/African American ☐White/Caucasian ☐Chinese ☐Filipino ☐Vietnamese
☐Asian Indian ☐Korean ☐Alaskan Native or American Indian ☐Japanese
☐Cambodian ☐Samoan ☐Laotian ☐Hawaiian ☐Guamanian ☐Amerasian
☐Some other race (please describe) _____ ☐Decline to answer

What is your ethnicity?
☐Hispanic or Latino ☐Not Hispanic or Latino
☐Other Ethnicity (please describe) _____ ☐Decline to answer

Do you need California Relay Services to complete this survey? ☐ Yes ☐ No
Do you need an interpreter to complete this survey? ☐ Yes ☐ No
Do you want to participate in this survey? ☐ Yes ☐ No

Do you think of yourself as:
☐ Straight or heterosexual ☐ Lesbian or gay
☐ Bisexual ☐ Queer, pansexual, and/or questioning
☐ Don't know ☐ Decline to answer ☐ Information unavailable
☐ Something else; please describe: _____

Do you think of yourself as:

☐ Male ☐ Female ☐ Transgender man/trans man/female-to-male (FTM)
☐ Transgender woman/trans woman/male-to-female (MTF)
☐ Genderqueer, neither exclusively male nor female
☐ Decline to answer ☐ Information unavailable
☐ Additional gender category (or other); please describe: _____

What sex was originally listed on your birth certificate?

☐ Male ☐ Female ☐ Unknown ☐ Decline to answer ☐ Information unavailable

What is your name as you would like it to appear on your health records? _____

What are your pronouns?

☐ He/him ☐ She/her ☐ They/them ☐ Decline to answer ☐ Information unavailable
☐ Other: _

HEALTH INFORMATION FORM (HIF)/ MEMBER EVALUATION TOOL (MET)

1. a. Do you need someone to help you with your routine activities of daily living?
   ☐ Yes ☐ No
   b. If yes, do you have someone to help you?
   ☐ Yes ☐ No

2. a. Do you have any physical, sensory, or learning problems that prevent you from getting what you need for your health?
   ☐ Yes ☐ No
   b. If yes, what types of problems have you had?

3. a. Do you need any medical equipment or supplies right now?
   ☐ Yes ☐ No
   b. If yes, what do you need?

4. a. Do you have any of the following health conditions? Check all that apply.

☐ Asthma	☐ Kidney Failure	☐ Behavioral or mental health condition	
☐ Digestive problems	☐ Multiple Sclerosis	☐ Breathing problems	☐ Seizures
☐ Quadriplegia	☐ Cancer	☐ Heart disease	☐ Schizophrenia
☐ Congestive Heart Failure	☐ Hepatitis	☐ HIV/AIDS	☐ COPD, Emphysema
☐ Diabetes	☐ Stroke	☐ Dementia	☐ Depression
☐ High Blood Pressure	☐ Other		

   b. If other, please describe:

5. How many medications are you currently taking?
   ☐ 1-3 ☐ 4-6 ☐ 7-14 ☐ 15 or more

6. How many times have you been seen in the emergency room in the past year?
   ☐ 1 ☐ 2 ☐ 3 or more

7. Do you have any appointments scheduled with your primary care provider or other doctors within the next 3 months?
☐ Yes ☐ No

8. a. Are you pregnant right now?
☐ Yes ☐ No
b. If yes, are you seeing a doctor on a regular basis for this pregnancy?
☐ Yes ☐ No

LONG-TERM SERVICES AND SUPPORTS (LTSS)

9. a. Do you have someone such as a caregiver or others willing and able to help you when you need it?

☐ Yes ☐ No
b. If yes, check all that apply.
☐ Family ☐ Neighbor ☐ Church or community group
☐ Significant other ☐ Legal services ☐ Other
c. If other, please describe:

10. Do you ever think your caregiver has a hard time giving you all the help you need?
☐ Yes ☐ No

11. a. Which of the following functions do you need help with? Check all that apply.
☐ Does not apply ☐ Bathing ☐ Dressing ☐ Using the phone ☐ Utilities
☐ Eating ☐ Walking ☐ Climbing stairs ☐ Getting a ride to the doctor/see friends
☐ Obtaining food ☐ House chores ☐ Shaving ☐ Washing Dishes/Clothes
☐ Brushing teeth ☐ Brushing hair ☐ Shopping ☐ Managing money/writing checks
☐ Doing yard work ☐ Preparing meals ☐ Transportation ☐ Going out to visit family/friends
☐ Getting out of bed ☐ Using the bathroom/toilet ☐ Keeping track of appointments ☐ Other
b. If other, please describe
c. If you selected any answers in the question above, are you getting all the help you need with these functions?

12. a. Can you live safely and move easily around in your home?
☐ Yes ☐ No
b. If no, does the place where you live have:
☐ Good lighting ☐ Good heating ☐ Good cooling ☐ Rails for any stairs or ramps
☐ Hot water ☐ Indoor toilet ☐ Elevator ☐ A door to the outside that locks
☐ Space to use a wheelchair ☐ Clear ways to exit your home
☐ Stairs to get into your home or stairs inside your home

13. Do you sometimes run out of money to pay for food, rent, bills, and medicine?
☐ Yes ☐ No

14. a. Have you fallen in the last month?
☐ Yes ☐ No
b. Are you afraid of falling?
☐ Yes ☐ No

15. Have you had any changes in thinking, remembering, or making decisions?
☐ Yes ☐ No

16. a. In general, do you feel confident in being able to manage your medical conditions?
☐ Yes ☐ No
b. If no, what would help you better manage your medical conditions?

17. Do you need help taking your medicines?
☐ Yes ☐ No

18. Do you need help answering questions during a doctor's visit?
☐ Yes ☐ No

19. Over the past month (30 days), how many days have you felt lonely?
☐ None - I never feel lonely ☐ Less than 5 days ☐ More than half the days (more than 15)
☐ Most days - I always feel lonely

20. Are you afraid of anyone or is anyone hurting you?
☐ Yes ☐ No

21. Is anyone using your money without your okay?
☐ Yes ☐ No

22. Do you need help filling out health forms?
☐ Yes ☐ No

RISK STRATIFICATION AND SEGMENTATION (RSS)

23. Are you homeless right now or do you have problems with your current living arrangement?
☐ Yes ☐ No

24. a. Do you need assistance with receiving any of the following community resources?
Check all that apply.
☐ Government sponsored programs ☐ Maternal and child services
☐ Disability ☐ Communicable disease services ☐ Living assistance ☐ Other
b. If other, please describe:

25. a. Do you use or need any assistive or medical equipment?
☐ Yes ☐ No
b. If yes, check all that apply:
☐ Wheelchair ☐ Walker ☐ Cane ☐ Scooter ☐ CPAP ☐ Oxygen tank
☐ Nebulizer ☐ Catheters ☐ Supplies (other than diabetic) ☐ Hospital Bed
☐ Toileting device/bedside commode ☐ Other
c. If other, please describe:

26. Have you used an oxygen tank in the past 3 months for more than 30 days?
☐ Yes ☐ No

27. Have you had, been approved for, or are you waiting for any type of transplant?
☐ Yes ☐ No

28. Have you been prescribed antipsychotic medication within the past 90 days?
☐ Yes ☐ No

29. How many times have you been admitted to the hospital or an inpatient behavioral or mental health facility in the past 3 months?
☐ 1 ☐ 2 ☐ 3 or more

30. When was the last time you saw your primary care provider? _/ /
month day year

31. Do you see more than one doctor to manage your medical conditions?
☐ Yes ☐ No

32. Do you have more than 4 drinks of alcohol (3 for women) in one day more than once a week?
☐ Yes ☐ No

33. a. Do you need or receive treatment for any kind of mental health, substance abuse, or emotional problems?
☐ Yes ☐ No
b. If yes, please describe:

34. Have you been depressed or down most of the day or nearly every day for the last two weeks?
☐ Yes ☐ No

35. a. Do you have concerns about your safety?
☐ Yes ☐ No
b. If yes, what concerns do you have?

36. a. Is there anything else you want us to know about you or your medical needs?
☐ Yes ☐ No
b. If yes, please describe:

Date Completed:_____/_____/_____

Readability Results:

Checked on: 10/03/2024, 10:41 am

To create health literate documents aim for Grade 6 or lower

Flesch-Kincaid Grade: 5.50 

Trouble Spots Details:

Number of:

- Paragraphs with 1 words or more: 147
- Long Sentences: 54 (29%)
- Multi-syllable words: 289 (22%)

REDA Tool

KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: Traco Matthews, CHEO

Date: December 12, 2024

Re: EQIHEC Report Templates

Background

The Department of Health Care Services (DHCS) would like to provide an update on artifact D.0021 Quality Improvement and Health Equity Committee (QIHEC) written summary.

2.2.3 Quality Improvement and Health Equity Committee

1. Contractor must ensure that the QIHEC meets at least quarterly, and more frequently if needed. A written summary of QIHEC activities, as well as QIHEC activities of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, findings, recommendations, and actions must be prepared after each meeting and submitted to Contractor's Governing Board. Contractor must also submit the written summary to DHCS upon request.

2. Contractor must make the written summary of the QIHEC activities publicly available on Contractor's website at least on a quarterly basis.

3. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain a QIHEC that meets the requirements set forth in this Section. Contractor must also ensure that they report to Contractor's QIHEC quarterly, at a minimum.

Discussion

Addition of the following items: activities, initiative, projects, and updates on to all committee agendas and minutes.

Fiscal Impact

None.

Requested Action

Review & approve.

KERN HEALTH SYSTEMS

Committee Title (Committee Acronym)

Agenda – Date [Month, Day, Year]

AGENDA ITEM	AGENDA TOPIC	PRESENTER	ACTION
CALL TO ORDER	Call meeting order / Attendance	***Name, Agency, Department, Title or Open to All or Information Only***	*N/A,*
REVIEW OF MINUTES	Review of Minutes	***Name, Agency, Department, Title or Open to All or Information Only***	*N/A, or Discussion*
OLD BUSINESS	List items from the previous meeting	***Name, Agency, Department, Title or Open to All or Information Only***	*N/A, Approve, or Discussion*
NEW BUSINESS	1. Topic 2. Topic a. Sub - Topic b. Sub-Topic 3. Topic	***Name, Agency, Department, Title or Open to All or Information Only*** ***Name, Agency, Department, Title or Open to All or Information Only*** ***Name, Agency, Department, Title or Open to All or Information Only***	*N/A, Approve, or Discussion* *N/A, Approve, or Discussion* *N/A, Approve, or Discussion*
OPEN FORUM	Open Forum / Committee Members Announcements / Discussion	***Name, Agency, Department, Title or Open to All or Information Only***	*N/A, Approve, or Discussion*
NEXT MEETING	Next meeting will be held [Date and Time]	***Name, Agency, Department, Title or Open to All or Information Only***	*N/A, Approve, or Discussion*
EQIHEC ITEMS for DISCUSSION	Items to bring to the EQIHEC meeting: - Activities - Initiatives - Projects - Updates	***Name, Agency, Department, Title or Open to All or Information Only***	*N/A, Approve, or Discussion*
ADJOURNMENT	Meeting Adjournment	***Name, Agency, Department, Title or Open to All or Information Only***	*N/A*

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Committee Title (Committee Acronym)

Agenda – Date [Month, Day, Year]

AGENDA ITEM	AGENDA TOPIC	PRESENTER	TIME	ACTION
CALL TO ORDER	Call meeting order / Attendance	***Name, Agency, Department, Title or Open to All or Information Only***	*_ min*	*N/A,*
REVIEW OF MINUTES	Review of Minutes	***Name, Agency, Department, Title or Open to All or Information Only***	*_ min*	*N/A, or Discussion*
OLD BUSINESS	List items from the previous meeting	***Name, Agency, Department, Title or Open to All or Information Only***	*_ min*	*N/A, Approve, or Discussion*
NEW BUSINESS	1. Topic 2. Topic a. Sub - Topic b. Sub-Topic 3. Topic	***Name, Agency, Department, Title or Open to All or Information Only*** ***Name, Agency, Department, Title or Open to All or Information Only*** ***Name, Agency, Department, Title or Open to All or Information Only***	*_ min* *_min* *_min*	*N/A, Approve, or Discussion* *N/A, Approve, or Discussion* *N/A, Approve, or Discussion*
OPEN FORUM	Open Forum / Committee Members Announcements / Discussion	***Name, Agency, Department, Title or Open to All or Information Only***	*_ min*	*N/A, Approve, or Discussion*
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ADJOURNMENT	Meeting Adjournment	***Name, Agency, Department, Title or Open to All or Information Only***	*_ min*	*N/A*

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COMMITTEE: **Full Name of Committee**

DATE OF MEETING: **Month, Day, Year**

Members On-Site:	List of Members attending at the location of meeting Name, Agency, Department – Job Title
Members Virtual:	List of Members attending the meeting virtually Name, Agency, Department – Job Title
Members Excused:	List of Members not in attendance but excused (provided notification of absence prior to meeting) Name, Agency, Department – Job Title
Members Absent:	List of Members not in attendance (did not provide notification of absence prior to meeting) Name, Agency, Department – Job Title
KHS Staff Present:	List of KHS Staff attending the meeting – Notate if virtual (V) Name, Agency, Department – Job Title

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
CALL TO ORDER	- [Chair of meeting Name] called the meeting to order at [time]. - Attendance	- State time meeting was called to order	Date [0/00/00]
REVIEW OF MINUTES	- [Chair of meeting Name] led - Write down any discussion or modifications of minutes	- Provide outcome of the discussion and if there were any edits to the minutes	Date [0/00/00]
OLD BUSINESS	- List Old Business Items Individually - Provide the information of the agenda item [Presentation/Discussion by whom] - Provide anecdotal discussion/questions [from whom and answered by whom]	Provide Actions: N/A, Information only, Informational discussion only, or write out the next steps (if action was not completed)	N/A, Pending, or Date [0/00/00]
NEW BUSINESS	**1st Agenda Item [In Bold]** - Provide the information of the agenda item [Presentation/Discussion by whom] - Provide anecdotal discussion/questions [from whom and answered by whom]	Provide Actions: N/A, Information only, Informational discussion only, or write out the next steps (if action was not completed)	N/A, Pending, or Date [0/00/00]
	2nd Agenda Item [In Bold] - Provide the information of the agenda item [Presentation/Discussion by whom] - Provide anecdotal discussion/questions [from whom and answered by whom] **Note: continue to create a cell set for each Agenda Item	Provide Actions: N/A, Information only, Informational discussion only, or write out the next steps (if action was not completed)	N/A, Pending, or Date [0/00/00]

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	**Open Forum** - List each individual committee member's report-out item and provide anecdotal discussion/questions [from whom and answered by whom]	Provide Actions: N/A, Information only, Informational discussion only, or write out the next steps (if action was not completed)	N/A, Pending, or Date [0/00/00]
NEXT MEETING	Next meeting will be held [Date – Weekday, Month, Day, Year]	Provide Actions: N/A, Information only, Informational discussion only, or write out the next steps (if action was not completed)	*N/A, Pending, or Date [0/00/00]*
EQIHEC ITEMS for DISCUSSION	List up to three items that the committee would like to bring to the Executive Quality Improvement Health Equity Committee. 1. . 2. . 3. . List each DHCS D.0021 Summary Requirements (Bullet Items) • Activities • Initiatives • Projects • Updates	Provide Actions: N/A, Information only, Informational discussion only, or write out the next steps (if action was not completed)	*N/A, Pending, or Date [0/00/00]*
ADJOURNMENT	The Committee adjourned at [Time] ***Respectfully submitted: Name and Title of Committee Chair***	Provide Actions: N/A, Information only, Informational discussion only, or write out the next steps (if action was not completed)	*Date [0/00/00]*

For Signature Only - [Name of Committee] Minutes [Date – 00/00/00}

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

DATE **NAME**

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

DATE NAME

KERN HEALTH SYSTEMS

Committee Title (Committee Acronym)

Agenda – Date [Month, Day, Year]

AGENDA ITEM	AGENDA TOPIC	PRESENTER	ACTION
CALL TO ORDER	Call meeting order / Quorum	***Name, Agency, Department, Title or Open to All or Information Only***	*N/A, Approve, or Discussion*
REVIEW OF MINUTES	Approval of Minutes	***Name, Agency, Department, Title or Open to All or Information Only***	*N/A, or Discussion*
OLD BUSINESS	List items from the previous meeting	***Name, Agency, Department, Title or Open to All or Information Only***	*N/A, Approve, or Discussion*
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ADJOURNMENT	Meeting Adjournment [State time and request vote]	***Name, Agency, Department, Title or Open to All or Information Only***	*Approve*

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Committee Title (Committee Acronym)

Agenda – Date [Month, Day, Year]

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COMMITTEE: **Full Name of Committee**

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ADJOURNMENT	The Committee adjourned at [Time] ***Respectfully submitted: Name and Title of Committee Chair***	Provide Actions: Write down the 1st, 2nd, if motion carries and the ratio of Ayes	*Date* *[0/00/00]*

For Signature Only - [Name of Committee] Minutes [Date – 00/00/00}

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
DATE **NAME**

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
DATE **NAME**