AGENDA

Executive Quality Improvement Health Equity Committee (EQIHEC) Meeting

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

Thursday, May 23, 2024

7:00 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, Jesus Gonzalez

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 February 8, 2024 - APPROVE

CA-4) Physician Advisory Committee (PAC) Q1 2024 Summary of Proceedings– APPROVE

CA-5) Drug Utilization Committee (DUR) Committee Q1 2024 Summary of Proceedings – APPROVE

CA-6) Wellness & Prevention (W&P) Activity Report Q1 2024 – APPROVE

CA-7) Board Approved New and Existing Contracts Report - APPROVE

CA-8) Credentialing and Recredentialing Summary Report Q1 2024 – APPROVE

CA-9) Enhanced Case Management (ECM) Program Report Q1 2024 – APPROVE

CA-10) Quality Improvement Committee (QIC) Program Report Q1 2024

11) Health Equity Transformation Steering Committee (HETSC)
- Updated Workplan – APPROVE
- Preliminary Review of Health Equity Strategic Roadmap - APPROVE
- 2024 Listening Sessions PowerPoint Summary – RECEIVE AND FILE

12) Quality Performance (QP) Summary Report Q1 2024 – APPROVE

13) Grievance Summary Report Q1 2024 – RECEIVE AND FILE

14) Utilization Management (UM) Program Report Q1 2024 – APPROVE

15) Network Adequacy Committee (NAC) Review Q1 2024 – APPROVE

16) Population Health Management (PHM) Report Q1 2024 – APPROVE
    - PHM 2023 Program Highlights
    - PHM Committee Charter

17) Behavioral Health Advisory Committee (BHAC) Summary Report Q1 2024 – APPROVE
    - BHAC Committee Charter

ADJOURN MEETING TO THURSDAY, AUGUST 8, 2024 @ 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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COMMITTEE: ***EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY (EQIHEC) COMMITTEE***
DATE OF MEETING: ***FEBRUARY 8, 2024***
CALL TO ORDER: ***7:03 AM BY MARTHA TASINGA, MD - CHAIR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Jennifer Ansolabehere – PHN Danielle Colayco, PharmD – Komoto	Todd Jeffries – Bakersfield Community Healthcare Allen Kennedy – Quality Team DME Michael Komin, MD – Komin Medical Group	Philipp Melendez, MD – OB/GYN Chan Park, MD – Vanguard Family Medicine
Members Virtual Remote:		Satya Arya, MD - ENT	
Members Excused=E Absent=A	Debra Cox – Omni Family Health (A)		
Staff Present:	Amy Carrillo, KHS Member Services Manager Michelle Curioso, KHS Director of PHM Amy Daniel, KHS Executive Health Svcs Coordinator Dan Diaz, RN – ECM Clinical Manager Pawan Gill – Health Equity Manager	Yolanda Herrera, KHS Credentialing Manager Loni Hill-Pirtle, KHS Director of ECM Magdee Hugais – KHS Director of QI Traco Matthews – Chief Health Equity Officer John Miller, MD – KHS QI Medical Director	Vanessa Nevarez, KHS Health Equity Coordinator Gregory Panero – Provider Network Analytics Abdolreza Saadabadi MD – KHS BH Medical Director Nate Scott, KHS Senior Director of Member Services Isabel Silva, KHS Senior Director of W&P James Winfrey, KHS Deputy Director of PNM

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 and Chair called the meeting to order at 7:03 am.		N/A
Public Presentations	There were no public members present for this meeting.		N/A
Committee Announcements	Danielle Colayco announced Komoto Pharmacy received a Quality Grant from KHS and it will be used to promote their Pediatric Mobile Vaccination Clinic. CMO-CHEO Update:	Informational Only.	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Dr. Tasinga gave a brief overview of the changes to the QI-UM Committee restructure. Committee is now EQIHEC and is responsible for all sub-committees that previously reported to QI-UM Committee, and they will now be reporting to EQIHEC.	Informational Only.	N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Martha Tasinga MD, presented the QI-UM Committee Minutes for approval.	☑ **ACTION**: Dr. Melendez moved to approve minutes of November 30, 2023, seconded by Allen Kennedy. Motion carried.	*2/8/24*
OLD BUSINESS	There was no old business to present	N/A	*N/A*
NEW BUSINESS	**Consent Agenda Items** **CA-5) Physician Advisory Committee (PAC) Q4 2023 Summary of Proceedings – APPROVE** **CA-6) Public Policy – Community Advisory Committee (PP-CAC) Q4 2023 Summary of Proceedings – APPROVE** **CA-7) Drug Utilization Review (DUR) Committee Q4 2023 Summary of Proceedings – APPROVE** **CA-8) Pharmacy TAR Log Statistics – APPROVE** **CA-9) Kaiser Reports (PROPRIETARY AND CONFIDENTIAL)** • **KFHC APL Grievance Report Q4 2023 – RECEIVE AND FILE** • **KFHC Volumes Report for Q4 2023 – RECEIVE AND FILE**	☑ **ACTION**: Dr. Melendez moved to approve the consent agenda items, that included their reports and summaries, seconded by Allen Kennedy. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24*
	10) Health Equity Transformation Steering Committee – Pawan presented the purpose of the HETSC description, function, and composition for the committee's consideration. This report included the following:	☑ **ACTION**: Dr. Saadabadi moved to approve the HETSC Charter, Meeting Schedule, and 2024 Work Plan, seconded by Allen Kennedy. Motion carried.	*2/8/24*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• **2024 Health Equity Strategy PowerPoint Presentation – APPROVE** • **HETSC Charter - APPROVE** • **HETSC Workplan – APPROVE** **11) Credentialing Statistics Q4 2023 – APPROVE** Yolanda presented the 4th Quarter monitoring of credentialing statistics for reporting period October 1, 2023 through December 31, 2023. There were a total of 159 Initially Credentialed Providers and 135 Recredentialed Providers. There were no significant trends identified in credentialing. **12) Board Approved New & Existing Contracts Report – APPROVE** Yolanda summarized the Newly approved contract vendors and there were no significant trends or patterns identified. **13) Credentialing & Recredentialing Summary Report – APPROVE** Yolanda presented the Credentialing & Recredentialing Summary for 4th Quarter revealing an increase in PCP Providers and an increase in Specialty Providers as well. There were no significant trends or patterns identified.	☑ **ACTION**: Dr. Saadabadi moved to approve the Credentialing 4th Quarter Statistics, New Vendor Contracts and Credentialing/Recredentialing Summary Report, seconded by Allen Kennedy. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24*
	14) Network Review Q4 2023 – APPROVE James provided the overview and results for the Plan's 4th Quarter 2023 After-Hours Survey, Provider Accessibility Monitoring Survey, Accessibility Grievance Review, Geographic Accessibility and DHCS Network Certification, Network Adequacy and Provider Counts, and the DHCS Quarterly Monitoring Report Template Review. There were no significant trends or patterns identified.	☑ **ACTION**: Dr. Melendez moved to approve the After-Hours Survey, Provider Accessibility Monitoring Survey, Accessibility Grievance Review, Geographic Accessibility and DHCS Network Certification, Network Adequacy and Provider Counts, and the DHCS Quarterly Monitoring Report Template Review, seconded by Dr. Park. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	15) Enhanced Case Management Program Report Q4 2023 – APPROVE Dan discussed the ECM's progress to date with quantitative/qualitative measures and track and trend relevant ECM demographic data with the committee and presented the following items: • Description of Enhance Care Management • Composition of the Populations of Focus as delineated by the DHCS and relative trends. • Cost/Utilization Savings Measures • Clinical measures • Feedback Measures • 2024 Meeting Schedule	☑ **ACTION**: Dr. Melendez moved to approve the ECM Description, Composition, Cost Savings Measures, Clinical/Feedback Measures and 2024 Meeting Schedule, seconded by Dr. Komin. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24*
	16) Health Education Activity Report Q4 2023 – APPROVE Isabel presented the 4th Quarter 2023 Wellness & Prevention Department report summarizing all health education, cultural and linguistic activities performed during the 4th quarter of 2023. The below highlights were shared with the members on efforts currently being implemented by the WP department: • **New Programs: Diabetes & Empowerment** • **4th Quarter Trainings** • **Community Events** • **Service Monitoring**	☑ **ACTION**: Dr. Melendez moved to approve the Wellness and Prevention 4th Quarter Report, seconded by Dr. Saadabadi. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24*
	17) Grievance Operational Board Update Q4 2023 – APPROVE **18) Grievance Summary Reports Q4 2023 – APPROVE** Amy presented the previous four quarters of 2023. The following trends were identified related to the Grievances and Appeals received during the 4th Quarter, 2023 • There was a slight decrease in Grievances and	☑ **ACTION**: Dr. Komin moved to approve the Wellness and Prevention 4th Quarter Report, seconded by Mr. Jeffries. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Appeals in Quarter 4, 2023 when compared to the previous two quarters in 2023. • Of the 1,667 Standard Grievance and Appeal cases, 915 were closed in favor of the Plan and 626 cases closed in favor of the Enrollee. At the time of reporting, 126 cases were delayed pending a response and/or medical records from providers.		
	19) Quality Improvement Program Reporting Q4 2023 – APPROVE Magdee presented the 2024 Quality Improvement Program Description, 2024 Program Workplan and 2023 Program Evaluation for the committee's consideration. All program documents were presented and approved in the 1 st Quarter 2024 Executive Quality Improvement Health Equity Committee This report included the following: • **2024 QI Program Description – APPROVE** • **2023 QI Work Plan Evaluation – APPROVE** • **2024 QI Work Plan - APPROVE**	☑ **ACTION**: Mr. Jeffries moved to approve the 2024 Quality Improvement Program Description, 2024 Program Workplan and 2023 Program Evaluation, seconded by Dr. Komin. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24*
	20) Utilization Management Program Reporting Q4 2023 – APPROVE Dr. Tasinga presented the 2024 UM Program Description, 2024 UM Program Workplan and 2023 UM Program Evaluation for the committee's consideration. UM is focused on ensuring KHS members receive the right care at the right time in the right setting. This report included the following: • **2024 UM Program Description - APPROVE** • **2023 UM Work Plan Evaluation – APPROVE** • **2024 UM Work Plan**	☑ **ACTION**: Dr. Melendez moved to approve the 2024 UM Improvement Program Description, 2024 UM Program Workplan and 2023 UM Program Evaluation, seconded by Dr. Komin. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24*
	21) Population Health Management (PHM) Reporting - APPROVE Michelle informed the committee of the newly launched Population Health Management (PHM) Department that		*2/8/24*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	became effective January 1, 2023. The DHCS developed a framework that broaden delivery systems, program, and payment reform across the Medi-Cal Program. The purpose of PHM is to engage members with their health care and address social determinants of health and gaps in care while reducing cost. • **PHM 2023 Program Highlights** • **PHM Committee Charter** Mr. Jeffries, Bakersfield Community Healthcare, offered to help develop a program description for KHS's Palliative Care Program.	☑ **ACTION**: Dr. Melendez moved to approve the 2024 UM Improvement Program Description, 2024 UM Program Workplan and 2023 UM Program Evaluation, seconded by Mr. Kennedy. Motion carried.	
OPEN FORUM	There were no issues presented for discussion	**N/A**	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, May 9, 2024 at 7:00 am.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:35 am ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

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For Signature Only – EQIHEC Minutes 02/08/24

The foregoing minutes were APPROVED AS PRESENTED on: ______________________ ______________________________

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: ______________________ ______________________________

Date Name

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COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***FEBRUARY 7, 2024***
CALL TO ORDER: ***7:04 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	Raju Patel, MD - Network Provider, Internal Medicine Ashok Parmar, MD– Network Provider, Pain Medicine
Members Virtual Remote:		David Hair, MD - Network Provider, Ophthalmology	
Members Excused=E Absent=A	(E) Atul Aggarwal, MD - Network Provider, Cardiology		
Staff Present:	John Miller, MD – KHS QI Medical Director Abdolreza Saadabadi MD – KHS BH Medical Director Amy Daniel, KHS Executive Health Svcs Coordinator	Jake Hall, KHS Senior Director of Contracting & QP Yolanda Herrera, KHS Credentialing Manager	Michelle Curioso, KHS Director of PHM Magdee Hugais – KHS Director of QI

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 and Chair called the meeting to order at 7:04 am.		N/A
Committee Minutes	<u>**Approval of Minutes**</u> The Committee's Chairperson, Martha Tasinga MD, presented the meeting minutes for approval.	☑ **ACTION**: Dr. Amin moved to approve minutes of December 6, 2023, seconded by Dr. Parmar. Motion carried.	*2/7/24*

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AND CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Peer Review Reports **CREDENTIALING REPORT** **Mental Health Pre-Approvals from 1/08/24 & 2/01/24:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on the 1/08/2024 and 2/01/2024 Credentialing Report, all meeting clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated 2/07/2024: There were three (3) initial applications presented for comprehensive review. • **PRV004905 -** Reviewed information regarding NPDB Settlement 2013: Pt admitted in labor, MD was on-call provider and assumed care. Delivery of infant via vacuum assist with Apgar's 2/3 at one minute and at five minutes. PH was 6.98 and bandolier cord was not at delivery. *Provider explanation received and accepted with recommendation to add to provider network.* • **PRV092297 -** Reviewed information regarding 2018 and 2022 both Residency Programs in Emergency Medicine were not completed due to personal health reasons and assaulted during 2nd residency resulting in resigning due to effects on the provider. Provider meets General Practice criteria. *Provider explanation received and accepted with recommendation to add to provider network.* • **PRV056978 -** Reviewed information regarding NPDB Settlements from 2017 and 2018 alleged failure to timely deliver the minor pt resulting in alleged lack of oxygen and permanent brain injury; second case alleged delivery was negligent resulting in shoulder dystocia. *Provider explanation received and accepted with recommendation to add to provider network.*	☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated February 7, 2024, seconded by Dr. Parmar. Motion carried.	*2/7/24*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	RECREDENTIALING REPORT **Recredentialing Providers List Dated 2/07/2024:** Recredentialing meeting clean file review were accepted as presented with no additional questions or alternative actions. Recredentialing with comprehensive reviews were conducted for the listed providers below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous three years: • Member Grievances: All Providers with significant Member & Quality Grievances were reviewed. Dr. Tasinga reported there were no quality of service or care issues identified as significant trends or concern requiring further review. There were no additional questions or alternative actions recommended by this committee. • PRV001109 – MBC Public Reprimand 9/29/22: Deviation from standard of care and treatment of five patients; failing to maintain adequate medical records. MD compliant with Compliance of MR Record Course documentation provided 10/11/2. *Provider's compliance with reprimand and monthly monitoring accepted for continued network participation.* • PRV000348 – Self reported NY State lab license voided due to not reporting internal reorganizational changes in direct ownership which has since been resolved and license reissued. *Provider explanation received and accepted with recommendation for continued network participation*. **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated February 15, 2024 (Board of Directors Meeting) were accepted as presented with no additional questions or comments by the committee members.		
OLD BUSINESS	There was no old business to present	N/A	*N/A*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS			
	P&P 4.01-P Credentialing Program – Revised Yolanda Herrera KHS Credentialing Manager, presented the revisions to Policy and Procedure 4.01-P Credentialing Program as follows: • Added non-discriminatory credentialing dates to semi-annual reporting in February and August and monitoring of summary report. • Added Intermediate Care Facility types to additional information for credentialing requirements per APL 23-023 **New Policy & Procedure – Credentialing Assessment of Organizational Providers** • Policy created to outline process for conducting initial assessments of organizational providers confirming they are in good standing with state and federal bodies. **New Policy and Procedure – Physician Advisory Committee (Credentials Committee)** • Policy created designating PAC as the Credentialing Committee outlining the committee responsibilities, oversight, and performance monitoring with final authority to approve or disapprove applicants for initial and recredentialing and recommending corrective or disciplinary actions. • Confidentiality and Non-Discriminatory Practice – as a responsibility of the PAC all members are required to agree to maintain confidentiality of all committee proceedings and agree to conduct all credentialing activities in a manner that is non-discriminatory.	☑ **ACTION**: Dr. Amin moved to approve the revisions to P&P 4.01-P Credentialing Program, New P&P-Credentialing Assessment of Organizational Providers and New P&P – Physician Advisory Committee, seconded by Dr. Gevorgyan. Motion carried. ☑ **ACTION**: All members present at the meeting were asked to sign the KHS Physician Advisory Committee Annual Confidentiality and Non-Discriminatory Statement. Amy D. will collect signed statements from those members not present at today's meeting.	*2/7/24*
	KHS Monthly Monitoring/Adverse Event Reporting Yolanda Herrera KHS Credentialing Manager presented the monthly monitoring and adverse event report for January 2024. The monthly report provides information on providers who have a licensing type of	☑ **ACTION**: Dr. Amin moved to approve the monthly monitoring and adverse event summary report for January 2024, seconded by Dr. Gevorgyan. Motion carried.	

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	monitoring or adverse event that requires on-going monitoring. Previously this was a verbal report out to the committee; however, as part of NCQA requirements will be presented in a summary report listing newly added providers, notes and comments on action items and follow-up recommendations. For the month of January 2024, the following items were noted: • All providers listed #1-11 remain in compliance with licensing probationary requirements or recommendations set forth by PAC. • Newly added PRV006729 – Media Alert KC Investigation by the Kern County Public Integrity Unit opened an investigation on a facility which runs SNF and Clinic for possible violations. Credentialing will update report monthly to review any Grand Jury Reports.		
	KHS Organizational Provider Assessment Report Yolanda Herrera KHS Credentialing Manager presented the Organizational Provider Assessment Report dated 02/05/2024. Ms. Herrera reported that traditionally, KHS has always credentialed their organizational providers and some of the assessments based on the dates of verification fall out-side the 36-month review; however, efforts are being made to implement recredentialing sooner to prevent the current assessment from exceeding the 36-month requirement.	☑ **ACTION**: Dr. Amin moved to approve KHS Organizational Provider Assessment Report dated 2/5/2024 as presented, seconded by Dr. Gevorgyan. Motion carried.	*2/7/24*
	Delegated Credentialing 2023 Tertiary Audit Summary Yolanda Herrera KHS Credentialing Manager presented 2023 Delegated Credentialing Audit Summary for 2023. KHS Credentialing requested permission from each tertiary facility to access the Health Industry Collaboration Effort (HICE) Shared Credentialing Audit Results for Calendar Year 2023. The Tertiary Facilities were audited by other health plans in lieu of conducting individual audits in an effort to reduce duplication. KHS Credentialing Manager conducted desk-top audits for Kaiser Permanente, Vision Service Plan and ConferMED.	☑ **ACTION**: Dr. Amin moved to approve the Delegated Credentialing Tertiary Summary 3rd Quarter 2023 Report dated December 6, 2023, seconded by Dr. Gevorgyan. Motion carried.	*2/7/24*

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	During 2023 there were 3-healthplans that received recommended corrective action plans due to lack of Policy and Procedure for newly created Assembly Bill 2581 requiring all Behavioral Health applications be processed within 60-day turnaround. Children's Hospital of Los Angeles Medical Group, UCLA Medical Group and USC Medical Group were all asked to revise their credentialing Policy and Procedures adding the requirements of AB2581 and submit their revised P&Ps for review. • CHLA and UCLA Medical Groups are pending revisions to their Credentialing Policy and Procedures and have been given 90-days to submit to KHS for review and closure. • USC Medical Group submitted their revised Credentialing Policy and Procedure and CAP has been closed.	☑ **ACTION**: Ms. Herrera will monitor CHLA and UCLA Medical Groups for their pending CAP and will present to the PAC upon receipt.	*Pending*
OPEN FORUM	Dr. Tasinga informed the members that the PAC is no longer under the requirements of the Brown Act, therefore there is no public comment or website posting for the committee agenda. While the meetings will be held on-site at KHS facilities and members are encouraged to attend in person, calling in remote to the meeting is now an option. Dr. Tasinga further informed the members that NCQA preparations and underway as KHS has submitted their application to NCQA for audit in 2025; therefore our "look back period" will begin this year and staff have been working diligently to prepare the required reports and documents to their respective committees.	☑ **CLOSED**: Informational discussion only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, March 6, 2024	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:08 am ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

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For Signature Only – Physician Advisory Committee Minutes 02/07/24

The foregoing minutes were APPROVED AS PRESENTED on: ______________________ ______________________________

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: ______________________ ______________________________

Date Name

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COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***MARCH 6, 2024***
CALL TO ORDER: ***7:10 AM BY JOHN MILLER, MD – CO-CHAIR***

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	In the absence of Dr. Martha Tasinga, MD, KHS Chief Medical Officer, John Miller, MD KHS Medical Director, called the meeting to order at 7:10 am.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, John Miller MD, presented the meeting minutes for approval.	☑ **ACTION**: Dr. Patel moved to approve minutes of February 7, 2024, seconded by Dr. Parmar Motion carried.	*3/6/24*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	<u>**Peer Review Reports**</u> **CREDENTIALING REPORT** **Mental Health Pre-Approvals from 3/01/24:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on 3/01/2024 Credentialing Report, all meeting clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated 3/06/2024: There were five (5) initial applications presented for comprehensive review. • **PRV008806 -** Reviewed information regarding State survey's plan of correction that was accepted by Department of Public Health during recertification. *Provider's POC received and accepted with recommendation to add to provider network.* • **PRV(V.D.) -** Reviewed information regarding 2023 NPDB Settlement alleging neglect against hospital, surgeon and anesthesiologist related to fire in the OR resulting in minor facial and scalp burns. *Provider explanation received and accepted with recommendation to add to provider network as there have been no further incidents of similar nature.* • **PRV056796 -** Reviewed information regarding 1986 program exclusion from OIG for 1-year due to unethical business practices. Provider received 1-year suspension which was completed with MBC Public Reprimand in 1998 and has had no further issues and completed all medical board actions. Provider was previously network provider and is rejoining FQHC Clinic. *Provider explanation received and accepted with recommendation to add to provider network as there have been no further incidents of similar nature.* • **PRV094388 -** Reviewed information regarding 2003 MBC Probation that was completed in 2006 due to failure to maintain adequate medical records following bone density	☑ **ACTION**: Dr. Patel moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated February 7, 2024, seconded by Dr. Lascano. Motion carried.	*3/6/24*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	test entered by tech using female criteria for male pt and showed to be abnormal. *Provider explanation received and accepted with recommendation to add to provider network as there have bee no further incidents of similar nature.* • **PRV066605 -** Reviewed information regarding 2018 Settlement during OB Residency alleging failure to treat fetal distress after induction of Pitocin resulting in emergency c-section. Settlement was paid by Regents of UC and provider indicates she was not involved in the settlement proceedings and has no additional input to provide. *Provider explanation received and accepted with recommendation to add to provider network as there have been no further incidents of similar nature.* **RECREDENTIALING REPORT** **Recredentialing Providers List Dated 3/06/2024:** Recredentialing meeting clean file review were accepted as presented with no additional questions or alternative actions. Recredentialing with comprehensive reviews were conducted for the listed providers below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous three years: • Member Grievances: All Providers with significant Member & Quality Grievances were reviewed. Dr. Miller reported there were no quality of service or care issues identified as significant trends or concern rising to the level of review by PAC. Additionally, Dr. Miller informed the committee that the QI Team is working to standardize the quality-of-care process to identify outliers, benchmark provider types and identify those cases that rise to the level of review by the PAC. There were no additional questions or alternative actions recommended by this committee.		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	NEW VENDOR CONTRACTS New Vendor Contracts List Dated April 2024 (Board of Directors Meeting) were accepted as presented with no additional questions or comments by the committee members.		
OLD BUSINESS	**<u>Delegated Credentialing 2023 Tertiary Audit Summary</u>**	☐ **PENDING**: Ms. Herrera will monitor CHLA and UCLA Medical Groups for their pending CAP and will present to the PAC upon receipt.	*Pending*
NEW BUSINESS			
	<u>P&P 4.01-P Credentialing Program – Revised</u> Yolanda Herrera KHS Credentialing Manager, presented the revisions to Policy and Procedure 4.01-P Credentialing Program as follows: • Additional language was added to Page 3 under "Non-Discriminatory Credentialing of Providers" pursuant to DMHC APL 23-025 Abortion: Provider Protection Codified under H&S Code Section 1375.61 prohibiting discrimination against providers disciplined in other states that interfere with person's right to receive care that is lawful in this state. **<u>New Policy & Procedure – Credentialing System Controls</u>** • P&P was created as required by NCQA Credentialing Standards CR.1-C&D ensuring all credentialing activities related to receiving, verifying, and processing an application for initial and/or recredentialing is received, dated and stored; how modifications are tracked and by whom; titles and roles of staff authorized to review, modify and delete information; the security in place to protect the information from unauthorized modifications; and how the organization monitors its compliance at least annually.	☑ **ACTION**: Dr. Lascano moved to approve the revisions to P&P 4.01-P Credentialing Program, New P&P-Credentialing System Controls, seconded by Dr. Patel. Motion carried.	*3/6/24*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	<u>Annual Report 2023 - Credentialing System Controls</u> Yolanda Herrera, KHS Credentialing Manager, presented the Annual Credentialing System Controls Report for 2023. **Purpose**: to ensure all credentialing activities identified to have modifications are made in compliance with KHS Credentialing System Controls Policy and Procedure. **Audit Results**: A total of 351 Initial Applications were identified with authorized modifications made during final review. Modifications included updates to OIG, Suspended/Ineligible and RPD Reports that were found to have newly posted reports prior to PAC; however, since KHS has NPDB Continuous Query, on all in-network providers, it is no longer our process to update these reports if current report is in compliance with PAC/CMO approval date. During 4th Quarter 2023, as Credentialing P&Ps were updated for NCQA preparation, attestation questions and work history was only date stamped with "received". Credentialing Staff were educated and trained to "review" the attestation questions for completeness per CR.3-Element C including 5-yrs Work History to be reviewed for compliance and stamped "Reviewed". Modifications were made and date stamped "review" during final review prior to the PAC/CMO approval date. There were no unauthorized modifications made. Actions/Interventions/Recommendations: Yolanda reported that this is KHS's first Credentialing System Controls Report. As the Credentialing Manager, she will continue to monitor modifications during final review and will also incorporate the Business Intelligence Report from the Credentialing database Symplr to review system modifications. During this audit, Yolanda identified that the credentialing database did not populate the next credentialing cycle, this caused some providers next recredentialing cycle to be blank; however, those were identified and corrected by the Credentialing Manager immediately. These appear to be one-time errors, manual missed data entries, that will be monitored during the year to confirm completion after each PAC meeting and provider activation.	☑ **ACTION**: Dr. Lascano moved to approve the Annual Report 2023 – Credentialing System Controls, seconded by Dr. Patel. Motion carried.	*3/6/24*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	3rd/4th Year Residents Moonlighting Outside their Residency. Yolanda report recently, KHS has received several requests from currently contracted groups to utilize 3rd Year Residents for primary care and psychiatry services. As researched, this practice is not prohibited by accreditation, licensing agencies nor CMS Medicare/Medicaid Guidelines. Accreditation standards do not require residents to be credentialed/privileged by medical staff organizations unless the resident is acting outside the residency program as an independent contractor and residents must be "authorized" to provide patient care services by their program director. Jake explained any provider practicing outside their residency program at an alternate facility would need to be credentialed if they meet our established criteria. Dr. Saadabadi added that this is a common practice in psychiatry as long as the resident has their program director's permission and abides by the hours permissible as a resident. Yolanda presented the recommended scope of practice and credentialing requirements recommended for 3rd/4th Year Residents who wish to moonlight outside their residency program: **Scope of Practice:** Signed letter of permission to moonlight by Residency Program Director including sufficient details documenting the services the resident may provide without supervision (a Program letter of Agreement (PLA) may be attached to the Residency Program Director's permission letter. 1) ***Services that require supervision are not permitted, including but not limited to invasive and surgical procedures.*** 2) ***Resident's Category is Per Diem and will not be listed in the KHS Provider Network Directory*** 3) ***Approval is only granted until completion of residency completion date at which time the resident must apply for full-time provider network status.***	☑ **ACTION**: Dr. Lascano moved to the Scope of Practice outline and Credentialing requirement for 3rd/4th Year Residents, seconded by Dr. Patel. Motion carried.	3/7/24

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Credentialing Requirements: A. Application Form, Supplemental Forms and Supporting Documents-Source: CAQH or CPPA B. Medical School Verification-Sources: AMA Masterfile, AOA Official Osteopathic Masterfile, School Official Transcripts sent directly to KHS. C. Current and valid Post-Graduate California Licensure: Source: CA State licensing or certifying agency via verbal, written or internet/electronic method. *Must apply in advanced for full California Physician & Surgeon's licensure prior to completion of residency otherwise the resident will be terminated upon expiration date of Post-Training License. D. Current and valid DEA-Source: DEA Office of Diversion Control or certifying agency E. Professional liability coverage of at least $1,000,000.00 per occurrence and $3,000,000.00 aggregate *No invasive or surgical procedures that require supervision and resident's name must be listed on the policy certificate or declaration page F. Credentialing only under an existing Contracted Provider Group G. NPI Number – Current Valid with NPPES Registry H. Sanction Information: In good standing with Medicare, Medi-Cal, OIG/LEIE Database, DHCS Restricted Provider List and EPLS/SAM		
	Bariatric Surgery Quality of Care Issues Dr. Miller presented verbal information related to possible quality of care issues with 2-different Bariatric Surgeons who performed Bariatric Sleeve Surgeries that both resulted in gastric leaks. Although this is a rare, but known complication of this surgery, both cases required notification to the State due to being a preventable condition resulting in infection after surgery. Both surgeons are affiliated with Adventist Health and letters requiring the surgeon's responses were submitted to Adventist Health; however, KHS received the standard notification that the letter was received and will be referred to the QI	☑ **ACTION**: Dr. Patel moved to approve tracking and trending of these 2-Quality Cases and a random 10-Case review be conducted as recommended by Dr. Miller, seconded by Dr. Aggarwal. Motion carried.	*10/2/24*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Department for internal review and due to peer review confidentiality, the results would not be shared. Dr. Miller recommended that these cases be tracked and trended for each provider and that a random case review of 10-cases be reviewed over a six-month period be conducted to ensure no further incidents of this type of complication reoccur.		
OPEN FORUM	Dr. Patel opened discussion regarding the increased population to the Kern Family Health Plan and that we are seeing a sicker patient population. Upon patient's discharge from the hospital, the specialists are either not following up with the patient or are not contracted to continue seeing the patient. Jake Hall, Deputy Director of Contracting, provided information on the requirements for continuity of care and the Letter of Agreement process that is utilized when specialist is not contracted with KHS or if there is a need to escalate to a tertiary care provider.	☑ **CLOSED**: Informational discussion only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, April 3, 2024 at 7:00 am.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 7:59 am. ***Respectfully submitted: Amy L. Daniel, Executive Health Services Coordinator***	**N/A**	*N/A*

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For Signature Only – Physician Advisory Committee Minutes 03/06/24

The foregoing minutes were APPROVED AS PRESENTED on: ______________________ ______________________________

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: ______________________ ______________________________

Date Name

PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
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COMMITTEE: ***DRUG UTILIZATION REVIEW (DUR) COMMITTEE***
DATE OF MEETING: ***MARCH 18, 2024***
CALL TO ORDER: ***6:32 P.M. BY MARTHA TASINGA, MD - CHAIR***

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirement met.	*N/A*
APPROVAL OF MINUTES	The Committee's Chairperson, Martha Tasinga MD, presented the meeting minutes for approval.	☑ **ACTION**: Dr. Srinivas moved to approve minutes of November 20, 2023, seconded by Ms. Bell.	*3/18/24*
REPORTS	1. Report of Plan Utilization Metrics A) Dr. Tasinga brought up incontinence supplies are always a subject of audits, and we should verify these particular claims. B) Dr. Gehlawat asked if nebulizers are still covered by Kern Family because some pharmacies were indicated that there were issues. Dr. Tasinga asked if there should be a member newsletter	1A) Dr. Miller and Dr. Sidhu will investigate and develop verification audits. 1B) Dr. Gehlawat would have the pharmacies reach out to KHS for clarification. The education article was addressing prescriber practices, particularly	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	sent. C) Low participation of AB1114 services was observed. Mr. Person requested information on how to become an ORP. The committee at large wondered if the Network is aware of this opportunity. Mr. Person stated participation for providing AB1114 services may be low due to inappropriate reimbursement. Ms. Bell indicated that some low participation may be due to not applicable to practice sites. (ie: Services, Nursing Homes) and therefore she has no desire and/or need to participate. 2. Dr. Gehlawat wanted to know if the Educational Article included restrictions to members under the age of 2 years old. Mr. Person commented that the FDA OTC labeling still applies for age dosing. 3. NCQA	for the elderly. All drugs require a prescription in order to be covered therefore it would not be necessary to inform the members. 1C) Provider Network Management will follow up Mr. Person with ORP enrollment information.	
CLOSED SESSION	N/A	N/A	*N/A*
OLD BUSINESS **4**	No old business.	N/A	*N/A*
NEW BUSINESS **5-6**	**<u>DHCS Update/Executive Order N-01-19: Medi-Cal Rx Update</u>** **1.** The DCHS DUR Board has determined that diphenhydramine is potentially being overutilized, especially in the elderly. They are developing campaigns to educate providers about alternative therapies. **2.** The DHCS DUR Board is looking at removing edits on	**1.** There were no further questions or discussion on this topic from the committee members. **2.** Dr. Saadabadi was concerned by relaxing the edits and/or thresholds could cause an increase in overdose situations.	*3/18/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	opioids regarding Morphine Milligram Equivalents, or at least greatly increasing the threshold. The rationale is that no one is dying/overdosing from prescription opioids, only street versions. No strong consensus among the Board Members on this. **3.** DHCS PBM Magellan was acquired by Prime Therapeutics. **4.** DHCS is forming a workgroup to address Medicare/Dual Eligibility Claims. Ongoing concerns on claims being inappropriately denied by MCRx when Medicare would never cover the service. **5.** DHCS is forming a workgroup to address Physician Administered Drugs (PAD's) billed on Pharmacy claims. The Scope document and operations are not in alignment. Working to develop a list/document that will clearly indicate how a drug/service should be billed, via pharmacy or medical. The goal is to have the allowed drugs to be located on a special list and also on the CDL. **6.** DHCS is forming a workgroup to address DUR alerts. Looking at reducing the messaging and/or focusing on the more important notices. **7.** DHCS is working with WIC to resolve issues of misdirected claims for formula being covered by WIC when should be handled by MCRx.	Ms. Bell shared that we could have increased ER Utilization. Dr. Saadabadi added all providers should be utilizing CURES and this will be even more important if they relax the edits. **3.** There were no further questions or discussion on this topic from the committee members. **4.** There were no further questions or discussion on this topic from the committee members. **5.** Dr. Gehlawat inquired if the nebulizers were a pharmacy or a medical benefit. KHS responded that they are considered a medical benefit but can be billed through the Pharmacy. They are reported to the State as medical. **6.** There were no further questions or discussion on this topic from the committee members. **7.** The committee shared that members were not having problems obtaining WIC products; however, they were instructed to have everything process through WIC. It was suggested to inform and educate the Network on proper billing.	
OPEN FORUM	There were no topics presented during open forum.	☑ **ACTION**: N/A	*3/18/24*
NEXT MEETING	Next meeting will be held Monday, March 18, 2024 at 6:30 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned 7:16 pm.	**N/A**	*3/18/24*

Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator

For Signature Only – Drug Utilization Review Committee Minutes 3/18/24

The foregoing minutes were APPROVED AS PRESENTED on: ______________________ ______________________________

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: ______________________ ______________________________

Date Name

To: KHS Executive Quality Improvement Health Equity Committee

From: Isabel Silva, MPH

Date: 5/23/2024

Re: 1st Quarter Wellness & Prevention Department Reports

Background

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

Discussion

Enclosed are the quarterly Wellness and Prevention Department reports summarizing all activities performed during the 1st quarter:

- Q1 2024 Wellness & Prevention Activities Report
- Q1 2024 Cultural and Linguistic Services Activities Report

Fiscal Impact

None.

Requested Action

Approve and file.

Kern Health Systems
Cultural & Linguistic Services Activities Report
1st Quarter 2024

Executive Summary

Report Date: April 1, 2024

OVERVIEW
Kern Health Systems' Cultural and Linguistic (C&L) Services Program helps ensure that comprehensive, culturally, and linguistically competent services are provided to plan members with the intent of improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care. The Executive Summary below highlights the larger efforts currently being implemented by the C&L Team. Following this summary reflects the statistical measurements for the C&L Services Program detailing the ongoing activity for Q1 2024.

1. Service Monitoring

- Linguistic Performance:
  - ✓ 100% members satisfaction with in-person interpreter
  - ✓ 100% member satisfaction with telephonic interpreter
  - ✓ 96% of KHS calls and 91% of vendor calls reviewed did not have difficulty communicating with members in a non-English language
  - ✓ 98% members satisfaction with bilingual KHS staff communications
  - ✓ 98% KHS staff satisfaction with vendor Over-the-Phone Interpreter (OPI) communications

Respectfully submitted,

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

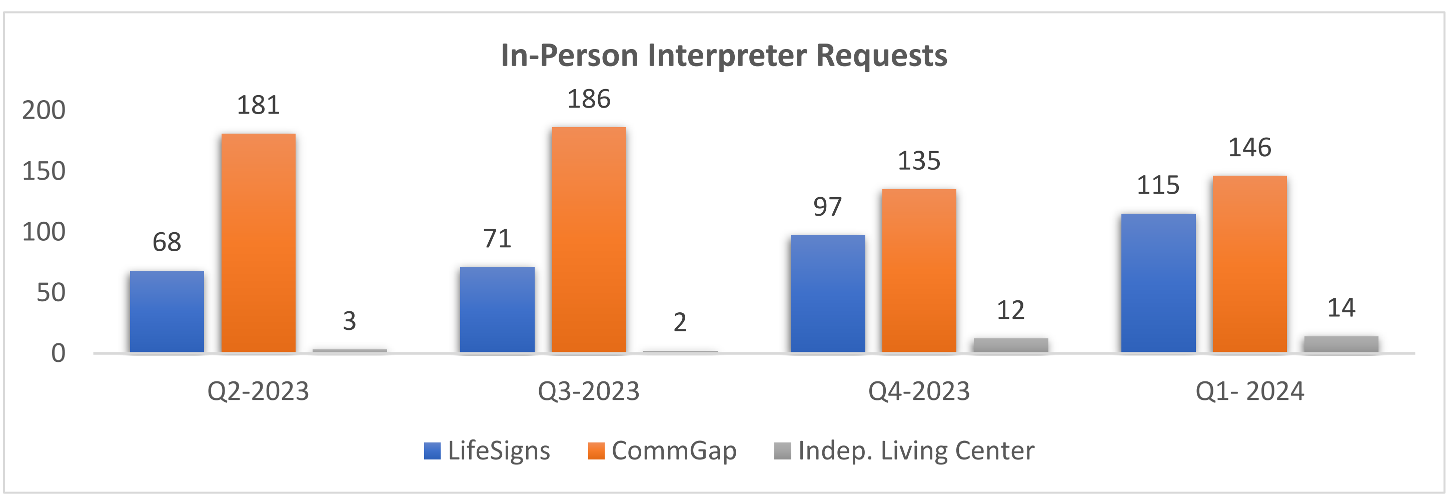
Cultural and Linguistic Services

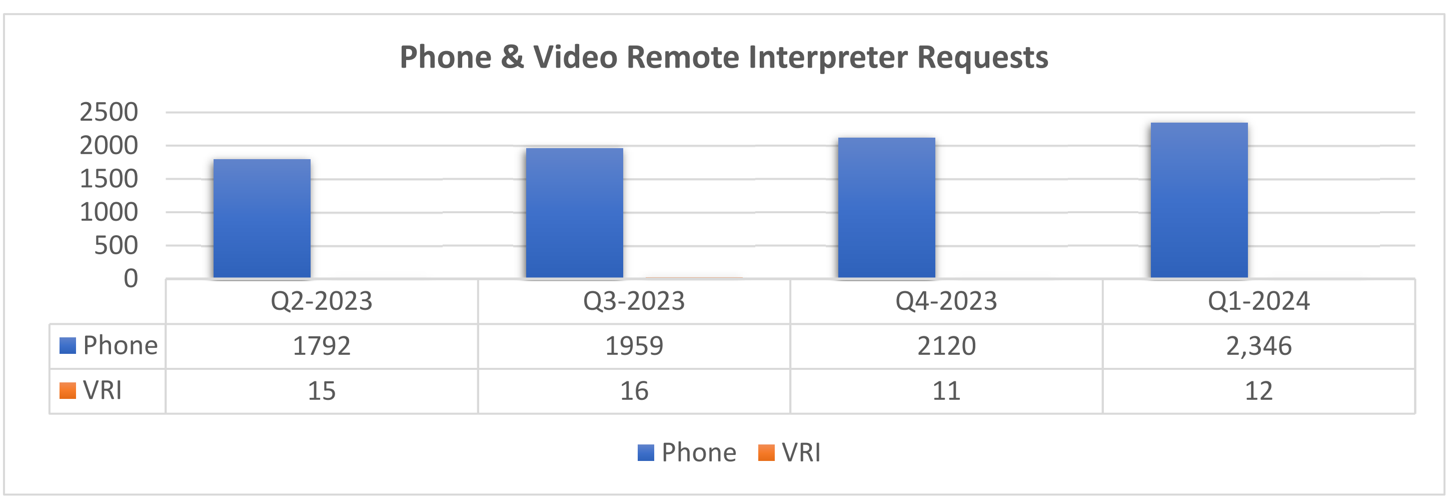
Interpreter Requests

During this quarter, there were 146 requests for Face-to-Face Interpreting, 2,346 requests for Telephonic Interpreting, 12 for Video Remote Interpreting (VRI) and 115 requests for an American Sign Language (ASL) interpreter.

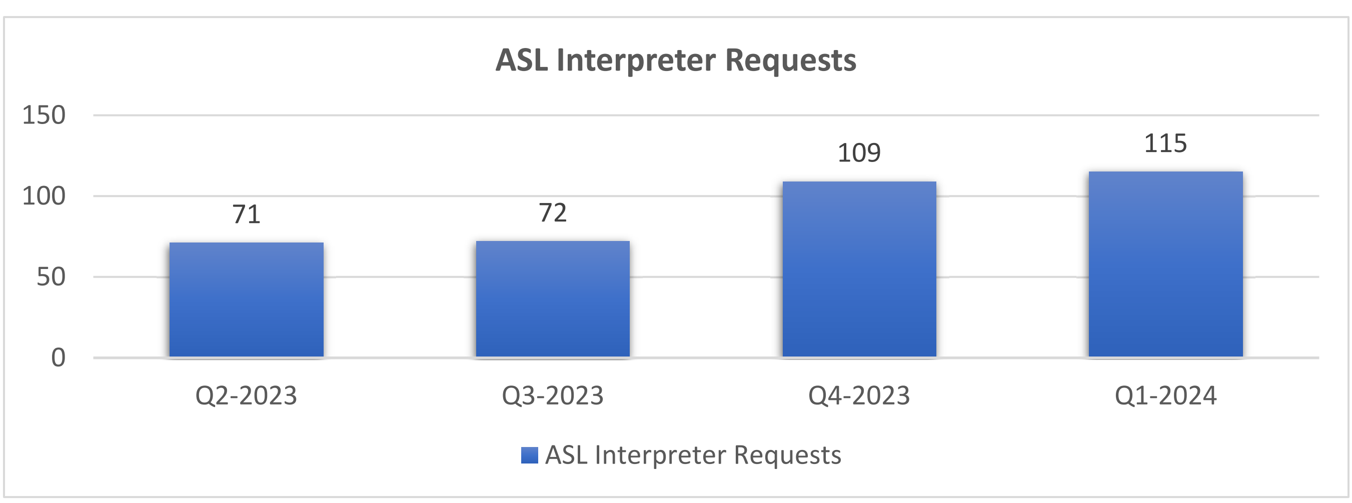
Interpreting Languages Requested
Phone and Video Remote
Spanish
Punjabi
Arabic

Interpreting Languages Requested
In- person
Spanish
Cantonese
Arabic



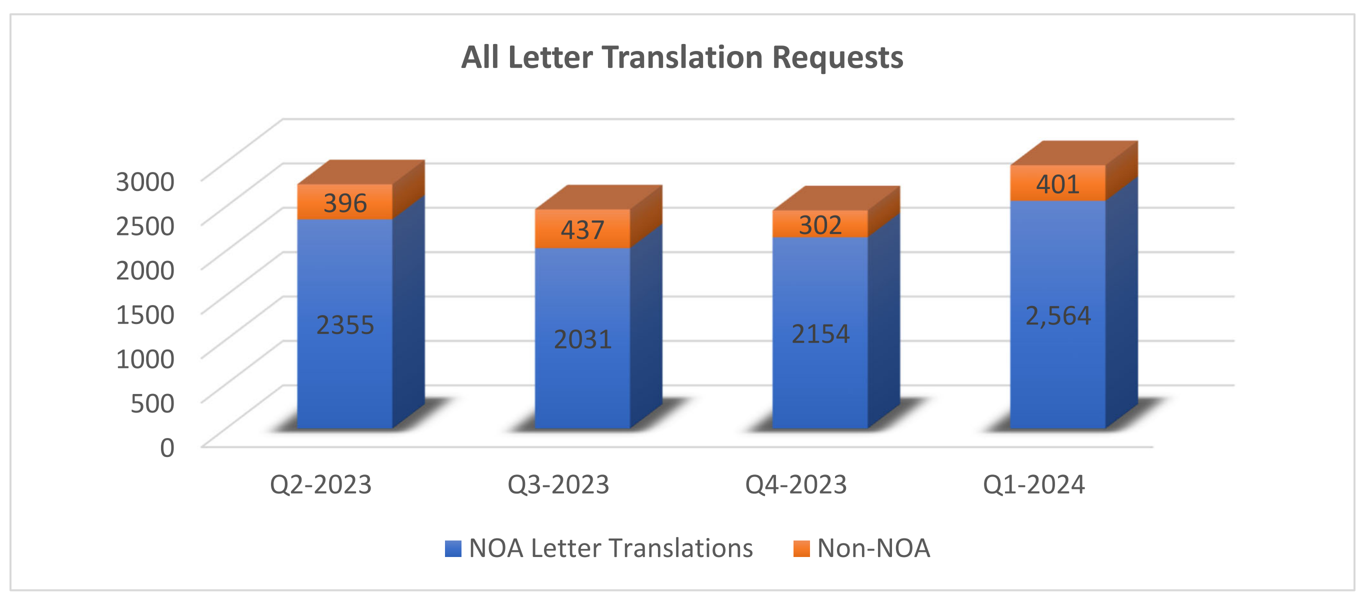


	Q2-2023	Q3-2023	Q4-2023	Q1-2024
Phone	1792	1959	2120	2,346
VRI	15	16	11	12



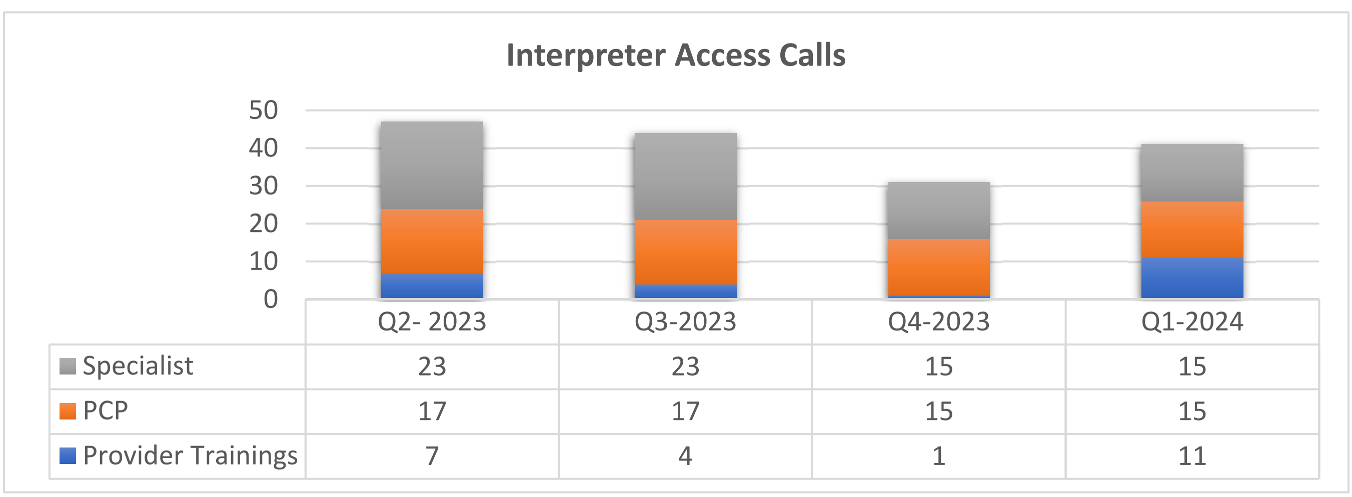
Written Translations

The W&P department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 2,965 requests for written translations were received.



Interpreter Access Survey Calls

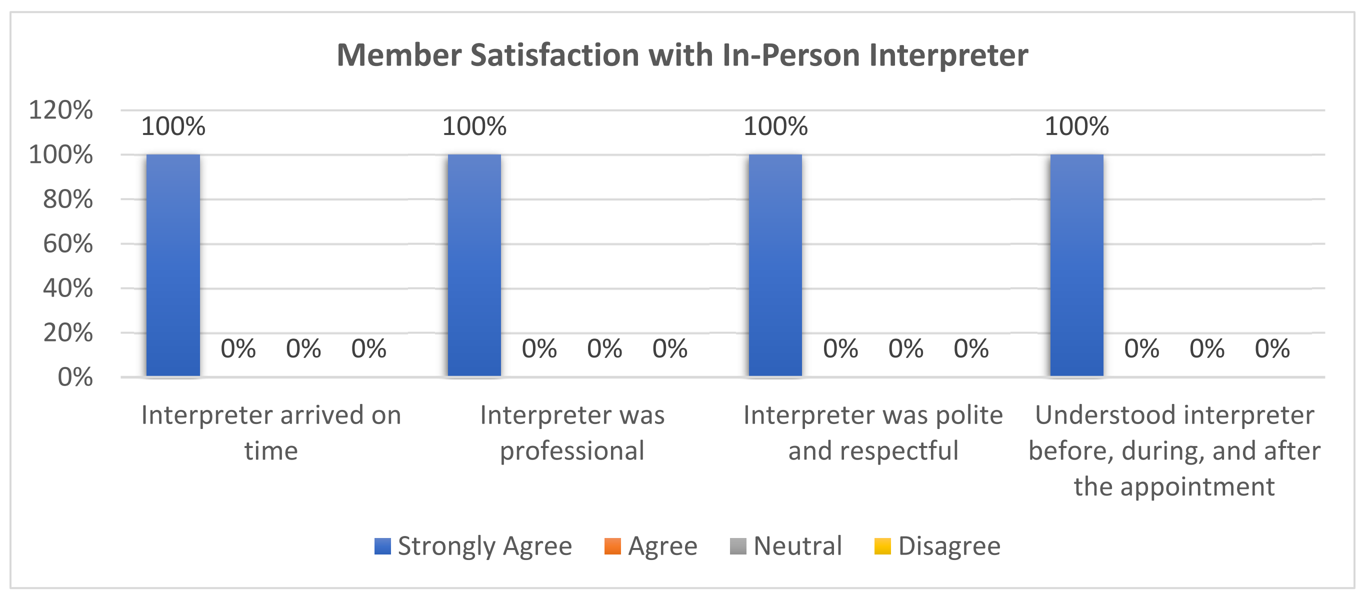
Each quarter, the Provider Network Management (PNM) department conducts an interpreter access survey among KHS providers. During Q1, 15 PCPs and 15 Specialists participated in this survey. Of these providers, 11 needed a refresher training on KHS' C&L services.



	Q2- 2023	Q3-2023	Q4-2023	Q1-2024
Specialist	23	23	15	15
PCP	17	17	15	15
Provider Trainings	7	4	1	11

Member Satisfaction Surveys

During this quarter, a total of 30 satisfaction surveys were collected from members who received in-person interpreting services and more than 100% of members reported they "Strongly Agreed" being satisfied with their interpreter.

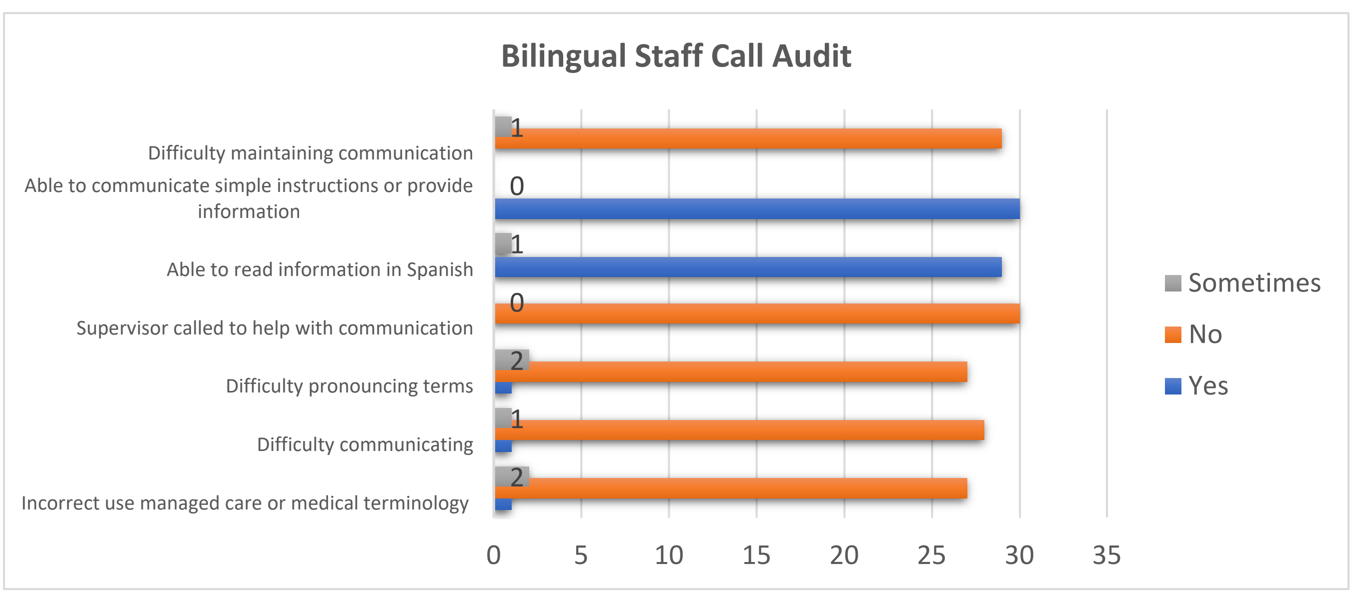


Over-the-Phone (OPI) Interpreter Call Monitoring

During this quarter, an audit was performed on 30 random OPI interpreter services calls. Calls audited were in Arabic, Punjabi, Spanish, Hindi, and Tagalog. Calls were evaluated for the interpreter's Customer Service, Interpretation Skills, and the ability to follow the Code of Ethics and Standards of Practice. Audit findings revealed 100% of calls Met Expectations.

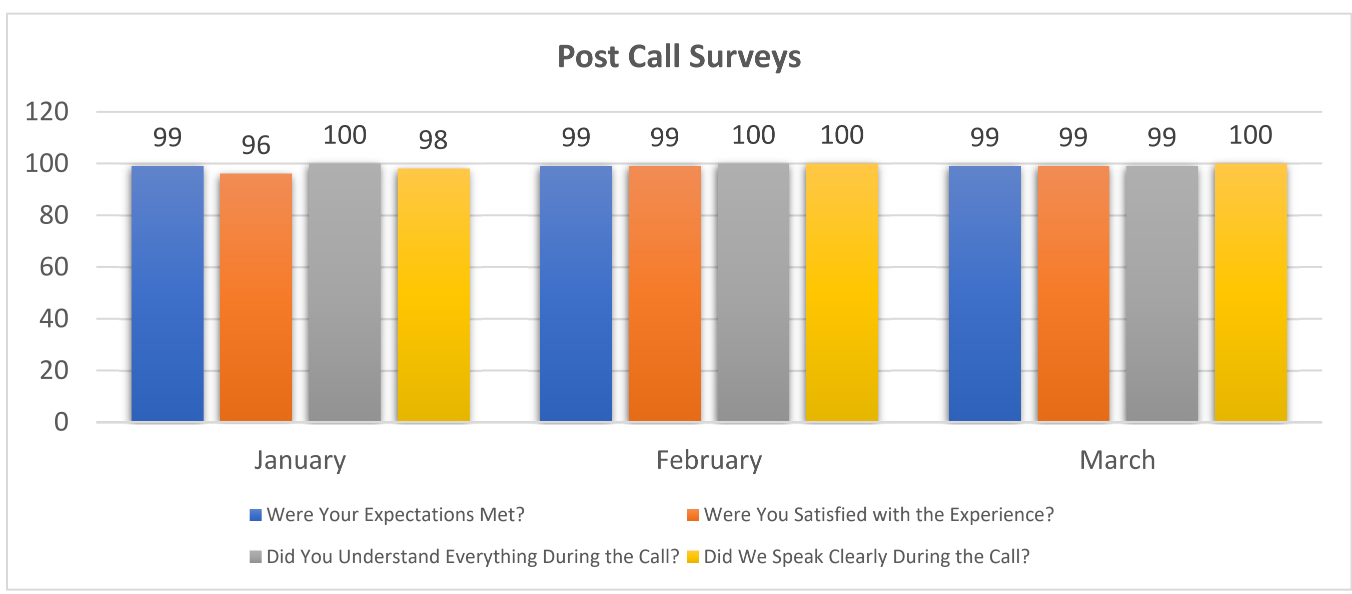
Bilingual Staff Call Audit

During this quarter, a total of 30 Spanish audio calls from KHS member facing departments were reviewed to assess the linguistic performance of the Bilingual Staff. Findings revealed that 96% of Bilingual staff did not have difficulty communicating with members in a non-English language.



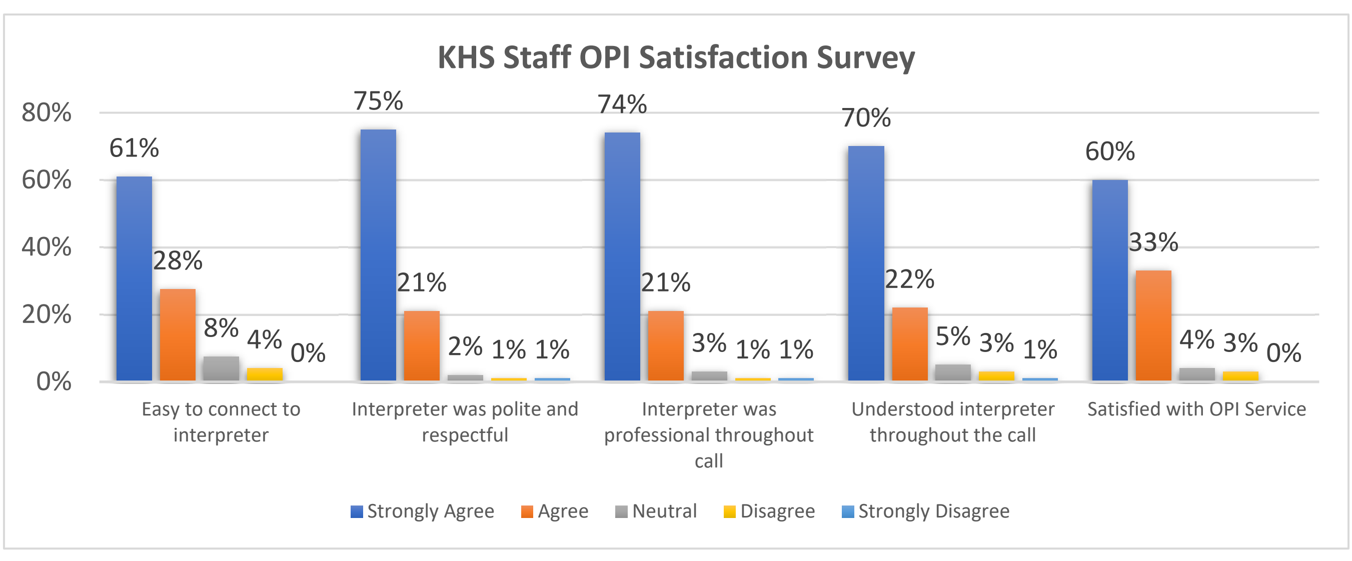
Post Call Surveys

During this quarter, a total of 7,951 Spanish Post Call Surveys were collected from members for all KHS member facing departments to assess the linguistic performance of the Bilingual Staff. KHS' post call survey evaluates member's call experience by language. Findings revealed that 98% of members are satisfied with the linguistic performance of bilingual staff.



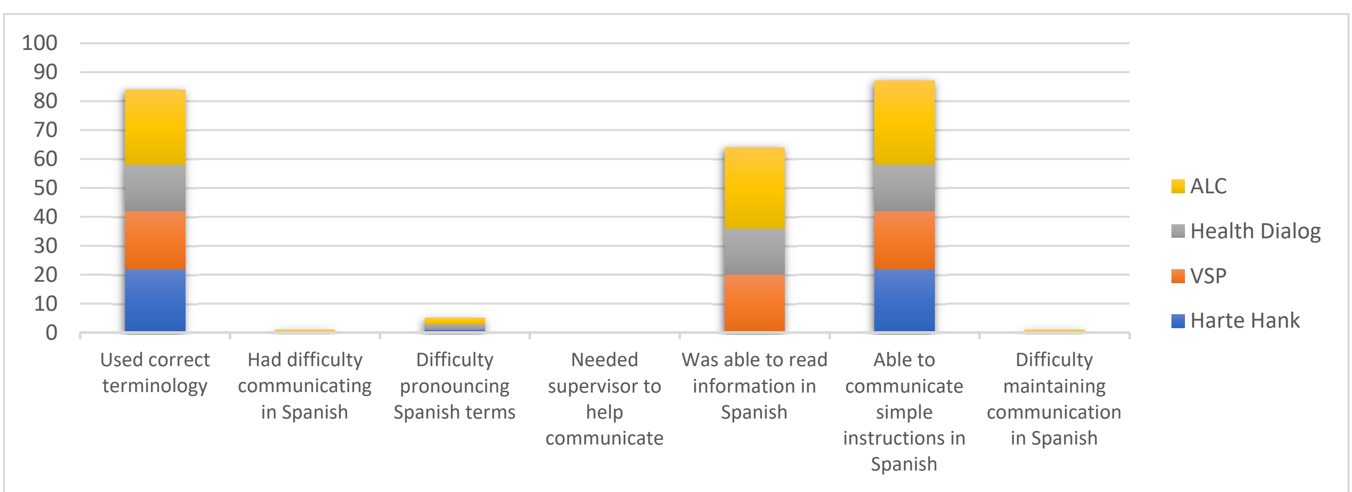
KHS Staff Satisfaction Over-the-Phone (OPI) Survey

During this quarter, a total of 145 surveys were received from KHS member facing department staff regarding their satisfaction with our vendor Language Line Services concerning over-the-phone interpretation. Findings revealed that 98% of KHS staff are satisfied with the linguistic performance of our vendors' interpreters.



Vendor Bilingual Call Audits

During this quarter, a total of 106 Spanish audio calls were received from contracted vendors with KHS. These vendors include: ALC Transportation, Health Dialog, VSP, and Harte Hank. These audio calls were reviewed to assess the linguistic performance of the vendor's Bilingual staff. Findings revealed that 91% of Bilingual staff did not have difficulty communicating with members in a non-English language.



Kern Health Systems
Wellness & Prevention Activities Report
1st Quarter 2024

Executive Summary

Report Date: April 1, 2024

OVERVIEW

Kern Health Systems' Wellness and Prevention (WP) department provides comprehensive, culturally, and linguistically competent services to plan members with the intent of promoting healthy behaviors, improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care. The Executive Summary below highlights the larger efforts currently being implemented by the WP department. Following this summary reflects the statistical measurements for the WP department detailing the ongoing activity for Q1 2024.

1. Community Health and Wellness

- Partnership presentations to California Farmworkers Foundation and the following Family Resource Centers: Greenfield, Kern River Valley, McFarland, Shafter, Lamont, Lost Hills
- Partnering with the Bakersfield American Indian Health Project and The Center for Sexual Identity and Gender Diversity to host a pride seminar concentrating on mental health, cultural competence and medical help for the 2SLGBTQ community for Kern.
- Public Health Internship – Extended agreement with CSUB and Bakersfield College to 3 years. Annual meetings will be arranged with both parties to evaluate and ensure parties goals are being met under the agreement. Working with CSUB to create a community health project that public health students can use towards class credit and experience towards completing their degree.
- Sponsorships – sponsored the OneSight Vision Clinic where 831 students were screened and 94% received prescription eyewear.
- Live Better Program – Program in Taft has been discontinued due to low attendance. Educational classes continue to be offered in Buttonwillow and Delano but fitness sessions are currently on hold while a new trainer is identified. Currently in discussions with Greenfield and Lake Isabella as new sites.

2. Community Events

- 1st Quarter: Casa Loma Career Fair, Black Family Wellness Expo, Lamont Community Resource Fair, Sikh Women's Association, Kiwanis Club of Delano, Delano Kindergarten Blastoff Fair, Albany Park School Carnival

3. Wellness & Prevention Partnerships

- 3rd Party Memorandums of Understanding (MOUs) are required under KHS' contract with DHCS. The MOUs are intended to enhance care coordination and improve the quality of care to members. The WP department is leading this county effort with several agencies, such as Kern Public Health, Aging & Adult Services, Kern Regional Center, Kern County Human Services, Kern County Probation, and Women, Infant and Children (WIC).

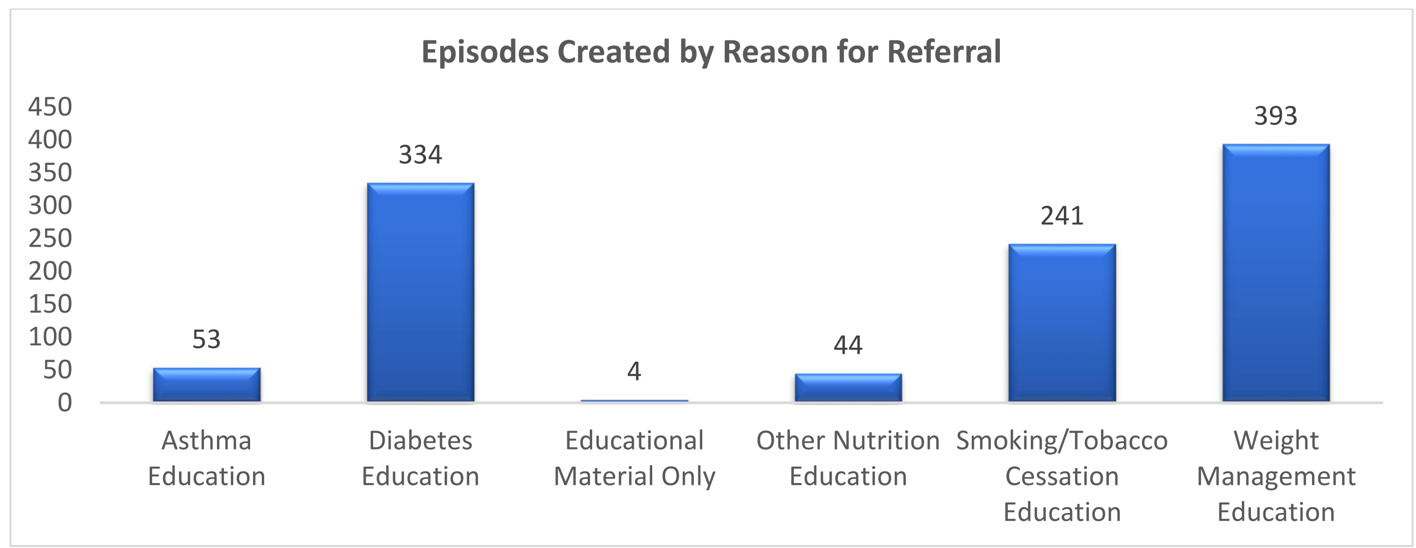
Respectfully submitted,

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

Member Wellness and Prevention

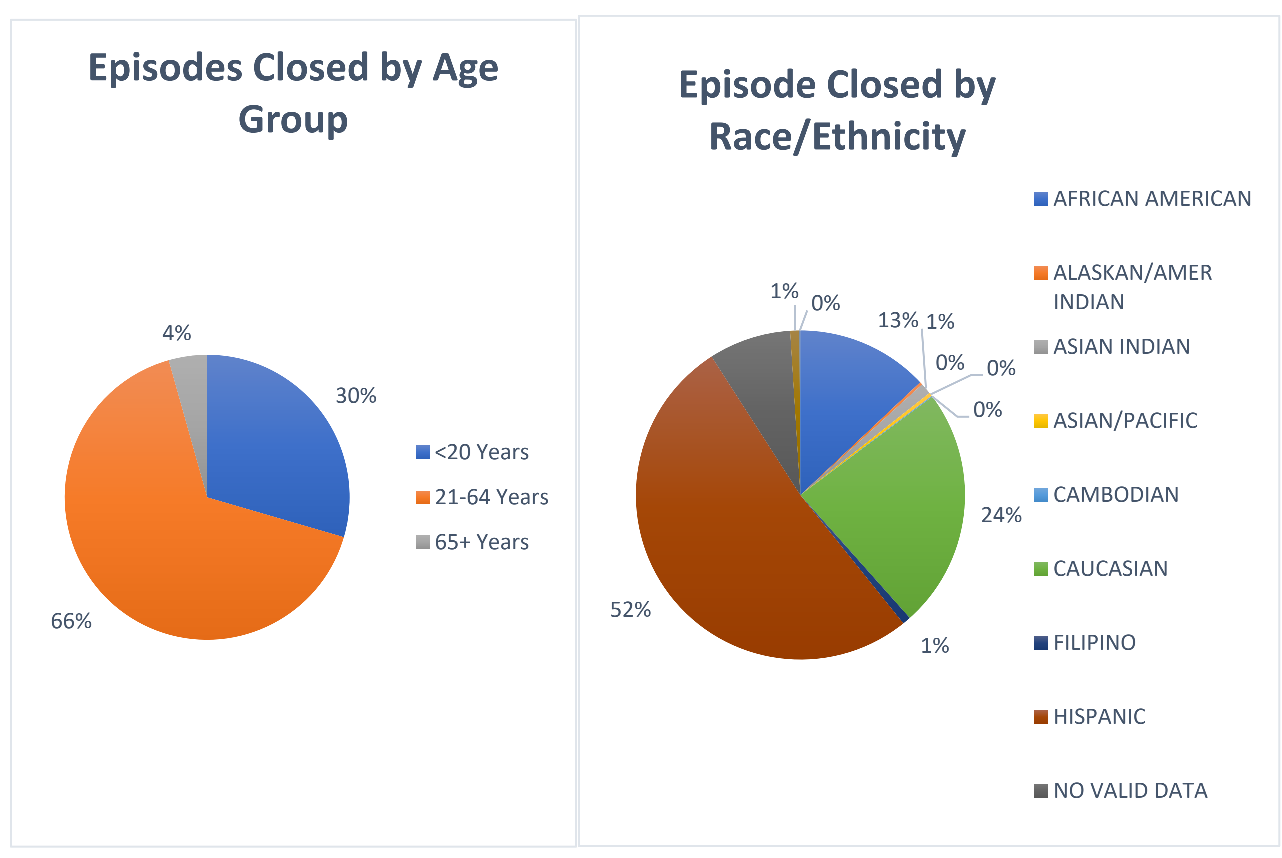
Health Education Referrals

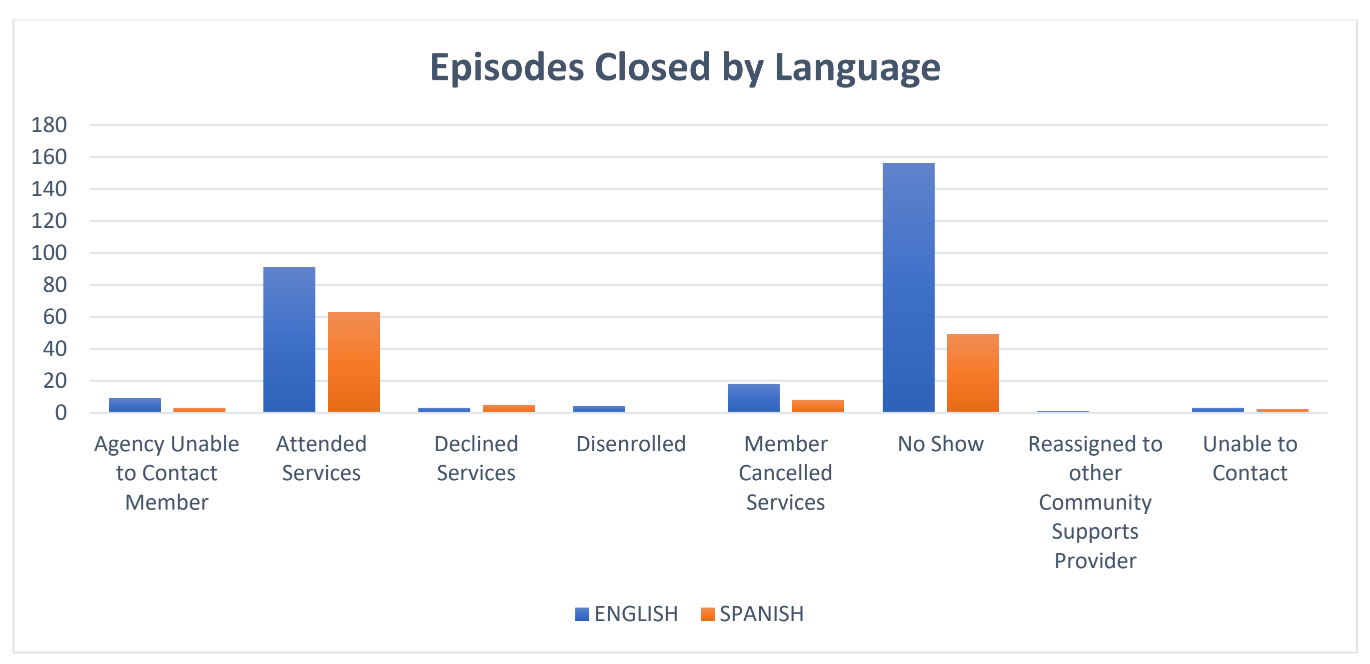
During Q1, there were 1068 referrals for Member Wellness and Prevention (MWP) services which is a 64% increase in comparison to the previous quarter. The increase observed in Q1 is due to the direct outreach to members based on relevant diagnosis: overweight, tobacco use, and diabetes. Changes on outreach strategies has led to a shift in the primary reason for services requested from Weight Management to Smoking/Tobacco Cessation and Diabetes management. Additionally, the health education class service acceptance rate decreased by 1% between Q4 to Q1 whereas the received services rate decreased from 48% in Q4 to 39% in Q1.

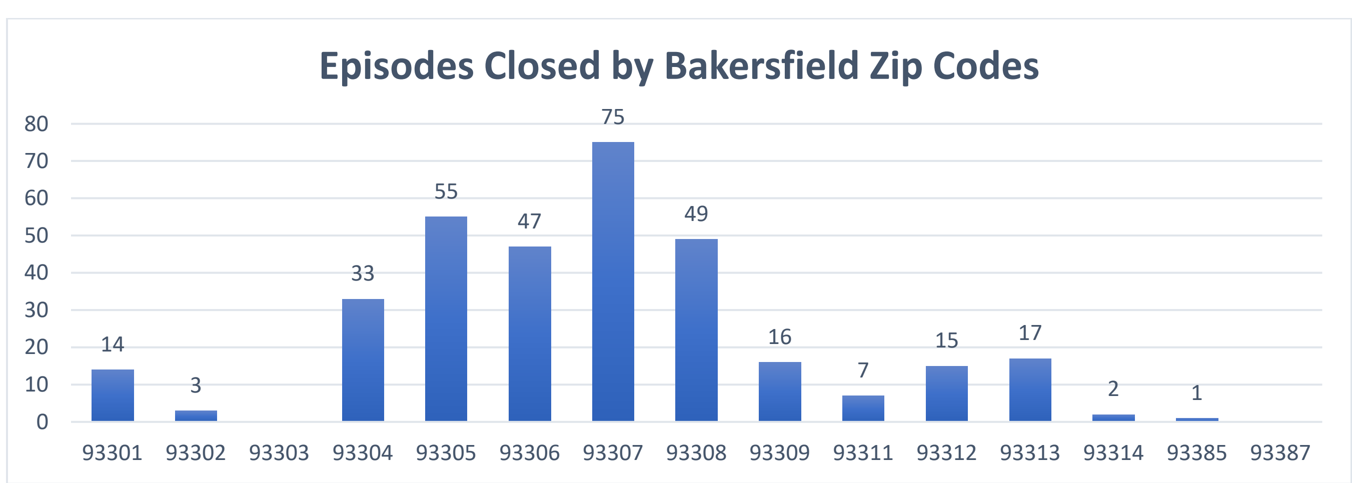


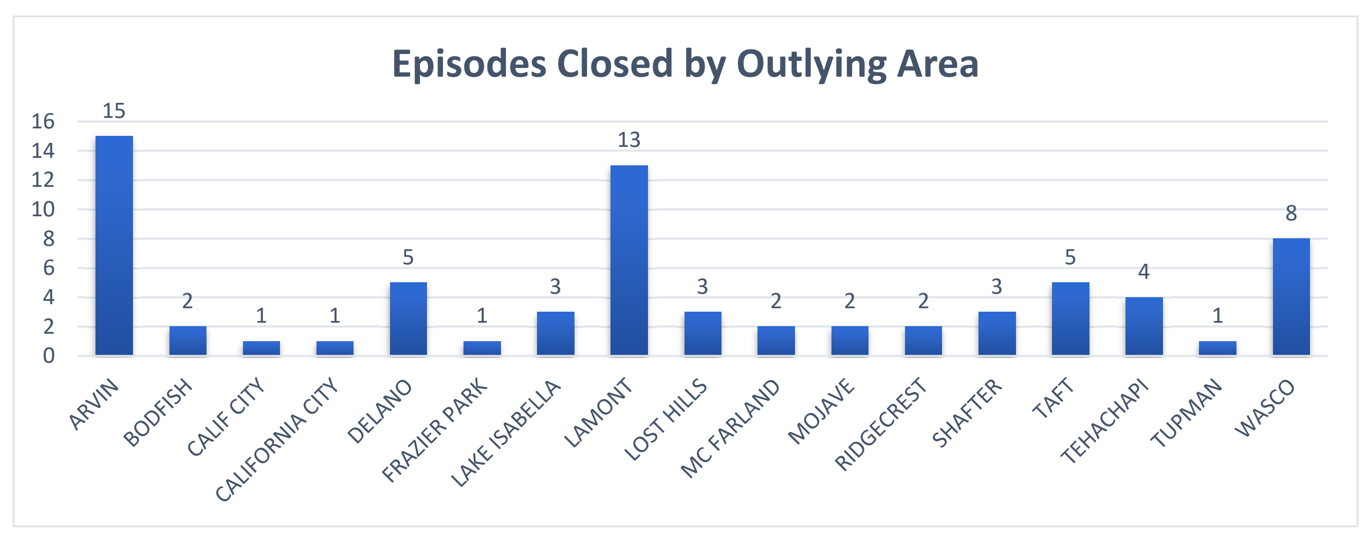
Demographics of Members

KHS provides services to a culturally and linguistically diverse member population in Kern County. Of the members who received services, the largest age groups were 21-64 years followed by <21 years. A breakdown of member classifications by race and language preferences revealed that many members who received services are Hispanic and preferred to receive services in English. The majority of members who received services reside in Bakersfield with the highest concentration in the 93307 area and Delano in the outlying areas of the county.




Episodes Closed by Language
180
160
140
120
100
80
60
40
20
0
Agency Unable to Contact Member
Attended Services
Declined Services
Disenrolled
Member Cancelled Services
No Show
Reassigned to other Community Supports Provider
Unable to Contact
ENGLISH
SPANISH


Episodes Closed by Bakersfield Zip Codes
80
70
60
50
40
30
20
10
0
14
3
33
55
47
75
49
16
7
15
17
2
1
93301
93302
93303
93304
93305
93306
93307
93308
93309
93311
93312
93313
93314
93385
93387


Episodes Closed by Outlying Area
16
14
12
10
8
6
4
2
0
15
2
1
1
5
1
3
13
3
2
2
2
3
5
4
1
8
ARVIN
BODFISH
CALIF CITY
CALIFORNIA CITY
DELANO
FRAZIER PARK
LAKE ISABELLA
LAMONT
LOST HILLS
MC FARLAND
MOJAVE
RIDGECREST
SHAFTER
TAFT
TEHACHAPI
TUPMAN
WASCO

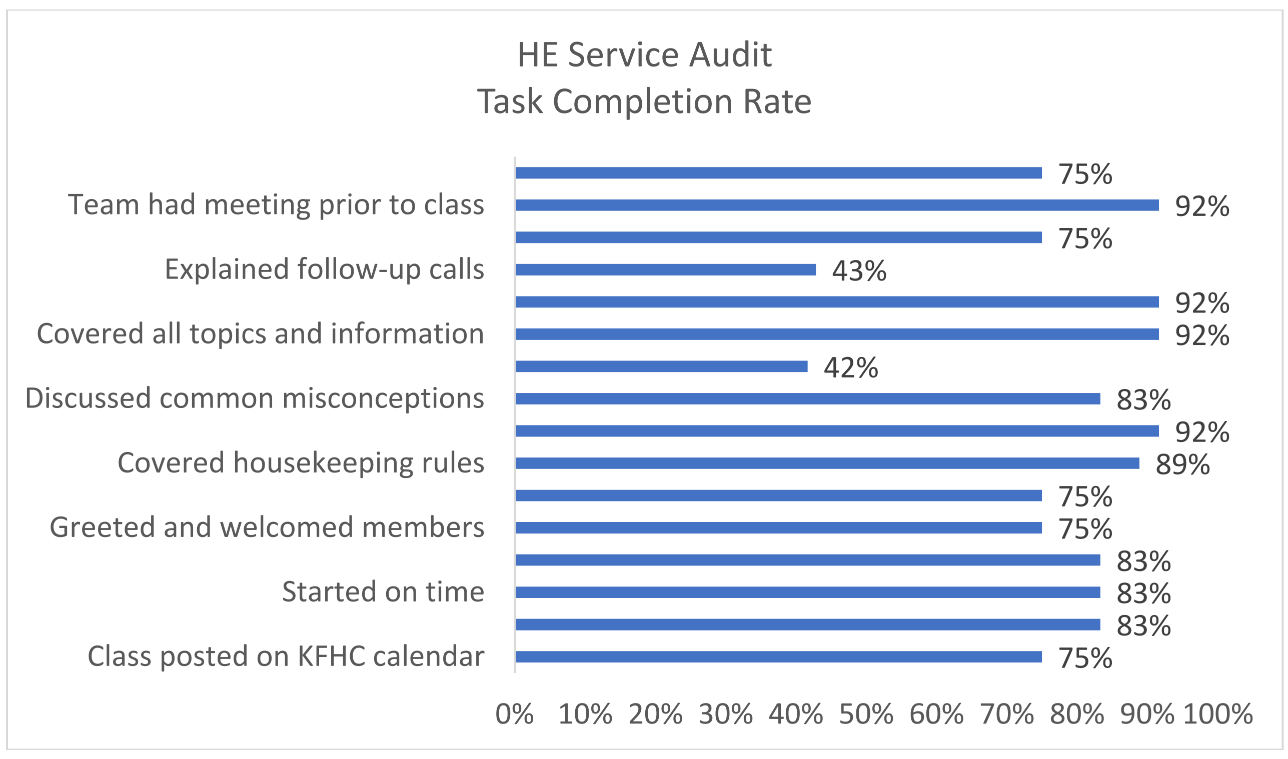
Health Education Class Service Audit

The Health Education Class Service Audit Tool considers a variety of markers to determine the quality of Health Education Class Services being provided to members. It includes observations on planning and preparation, implementation and delivery, and member engagement during health education classes. Service audit results will be reviewed quarterly in 2024.

In Q1, class facilitators reached 100% in the following areas: tracking class participants, covering all class material, explaining new topics or concepts, providing participants opportunities to engage by asking questions and doing hands on activities, and conducting administrative tasks.

During Q1, only 2 items were observed to fall below the 50% mark, highlighting the importance of ongoing training and development. To ensure our team is equipped with the best practices, we will be implementing training sessions on the teach back method. The teach back method is one way to check for member understanding on concepts related to their health or the topics discussed during the class.

In addition, in Q2, follow-up call information will be provided on facilitator manuals or class materials. This will serve as reminders to facilitators to mention the follow-up calls, including frequency, when conducting classes. Follow-up calls are an important piece in our evaluation process.



Health Education Class Evaluations

Health Education classes include an evaluation questionnaire for participants. The questionnaire is provided at the end of the class. Below is an analysis of the findings from open-ended questions in previous quarters.

What did you like most about the class?

More than half of participants who responded expressed great satisfaction in the workshops and suggested no change, and that everything was fine.
The remaining half of members responded:

- Appreciated learning about nutrition, healthy habits, smoking cessation, and managing allergies. Expressed that the classes were interactive and engaging through discussions and hands-on activities. They appreciated the content clarity. Participants felt supported and part of a community.
- Felt that facilitators were effective and that the information was relevant to their needs and the content applied practical strategies to improve their health by helping lower blood-pressure, eat healthier, and setting SMART goals.
- Expressed they enjoyed the flexibility of virtual classes, while others appreciated the transportation services provided by KHS.

In addition, members provided the following suggestions:

- Adding more visual aids, physical activities, and cooking demos for added practicality and classroom engagement.
- Longer classes and follow-up sessions for an extended learning experience.
- Community resources that are relevant to the topic.

How could we improve the class?

Members responded:

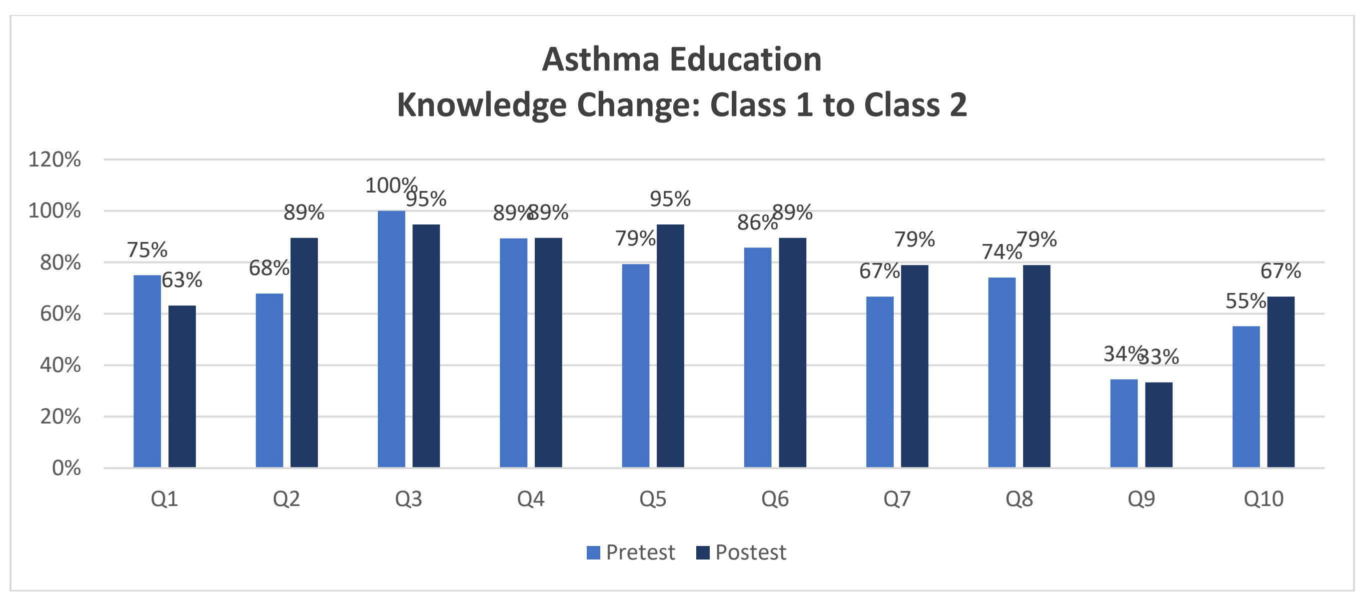
- More videos and interactive questions and visual diagrams to enhance participant engagement.
- Schedule flexibility – offer more or other times, including weekends, if possible.
- Longer sessions to allow for more questions and answers with the facilitators and group discussions.

In addition, members referred to the Kick it California (KIC) Quitline are surveyed to gauge satisfaction with this service. Two members were referred to KIC in Q1. Attempts were made to conduct the satisfaction survey, and one members was unable to contact while the other member declined to take the survey.

Health Education Class Effectiveness

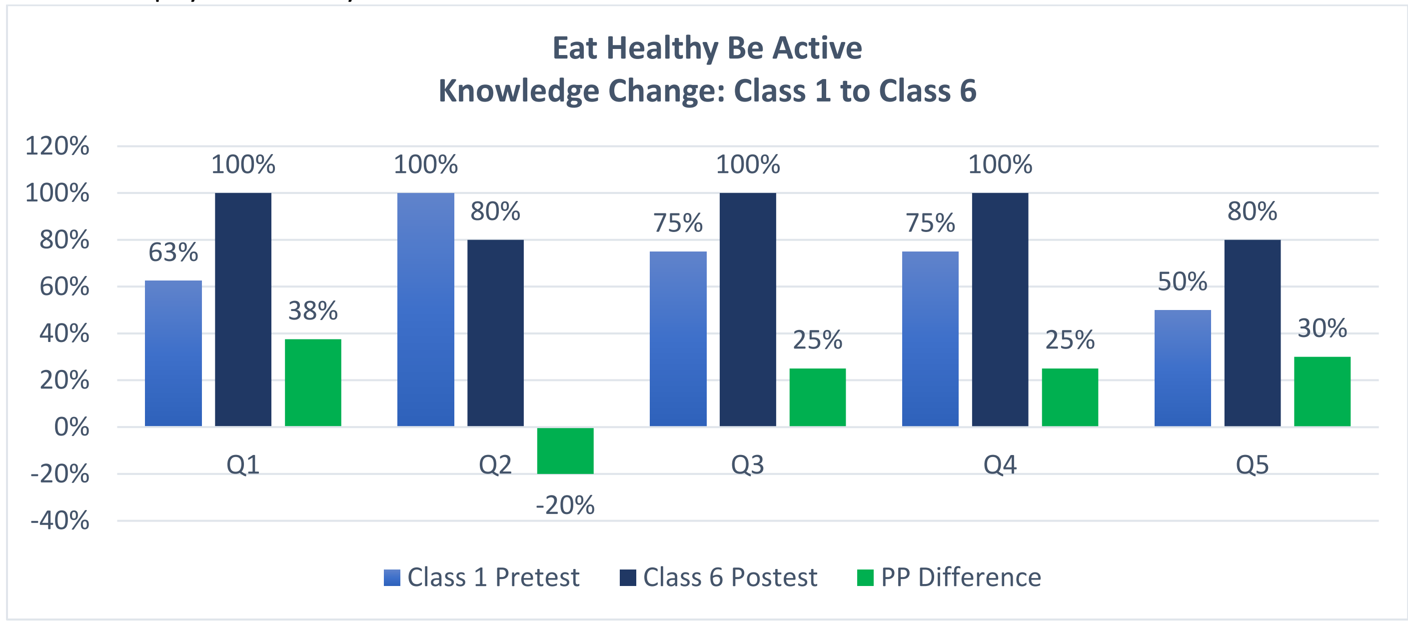
Asthma

The asthma education program consists of 2 classes and at least 2 follow-up calls. A pre and posttest questionnaire is distributed per series. During Q1, findings revealed there was an average 5 percentage point increase in knowledge gained after completing the series. The largest increase in understanding was in understanding common triggers, long-term controller medicines, strong emotions can cause asthma symptoms, and in reducing environmental asthma triggers.



Nutrition: Eat Healthy, Be Active

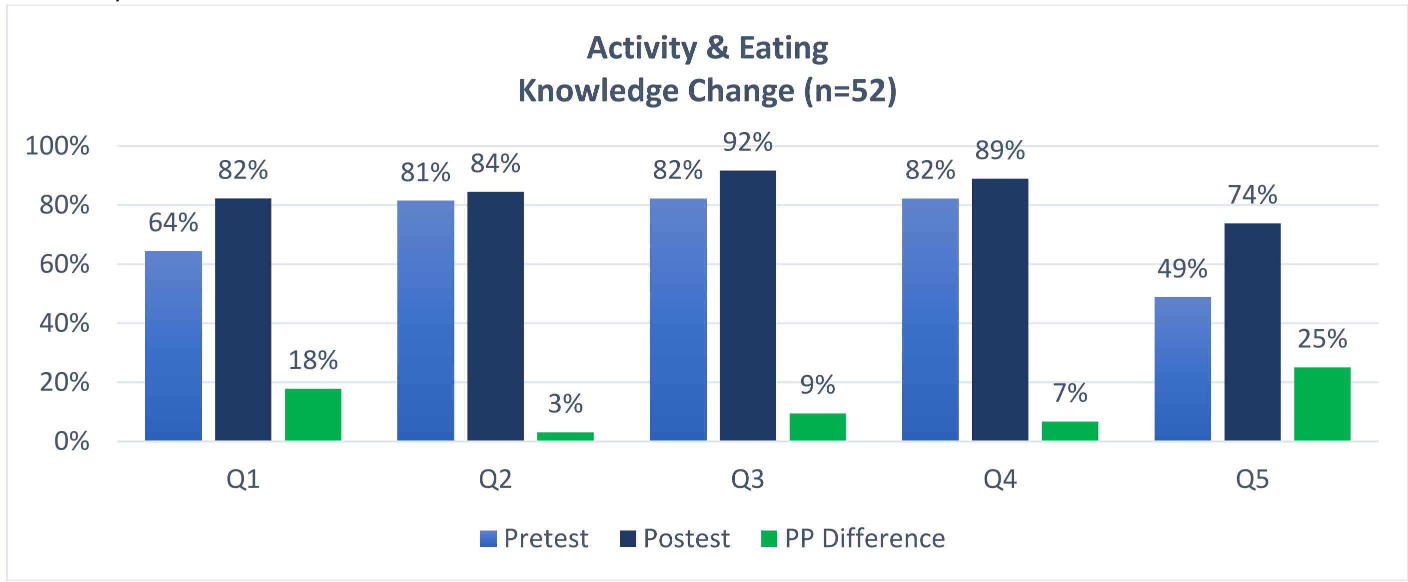
The Eat Healthy, Be Active curriculum was launched in September 2023. This is a 6-class series, each class lasts about 90 minutes. A pre and posttest questionnaire is distributed per class. During Q1, findings revealed that among those members who completed the pre and posttest, there was an average 20 percentage point increase in knowledge gained after completing classes. The largest increase in understanding minutes of physical activity but there was a decrease in understanding in benefits of physical activity.



Nutrition: Activity + Eating

The Activity + Eating curriculum was launched in September 2023. This is a 1-time class that lasts about 90 minutes. The evidence shows that it can impact behavior around physical activity. A pre and posttest questionnaire is distributed at each class. During Q1, findings revealed a 12-

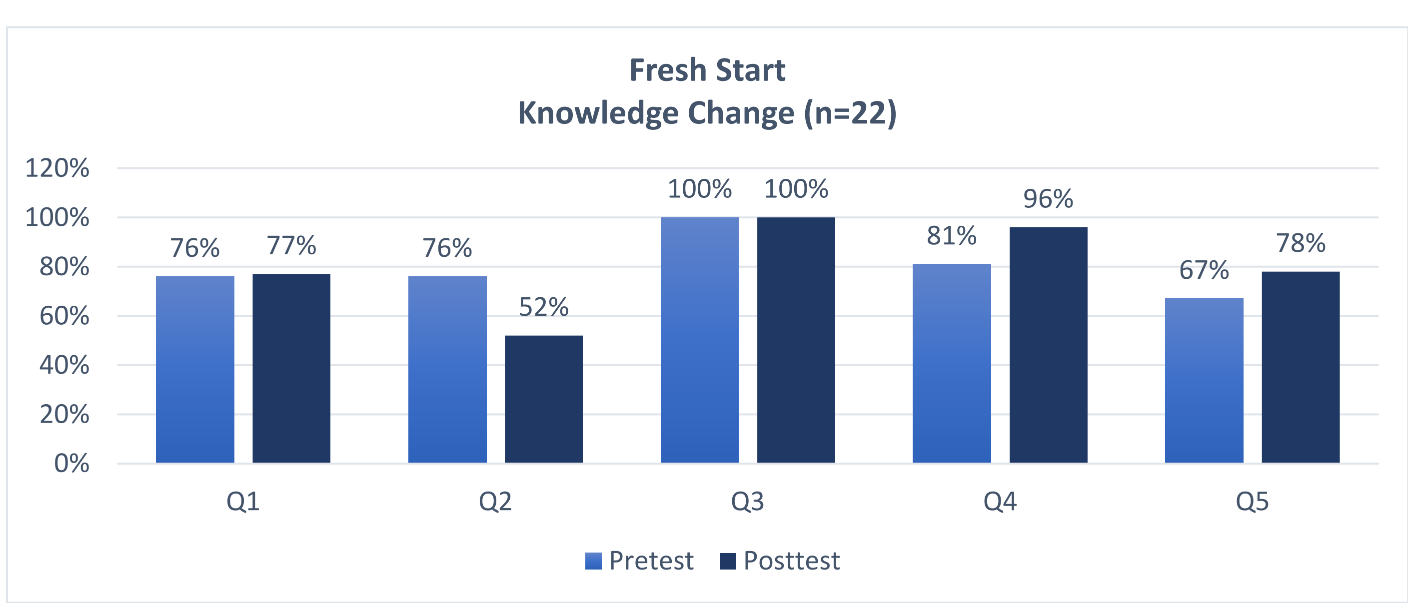
percentage point increase in knowledge when comparing members who completed a pretest (average 72% correct answers) to members who completed a posttest (average 84% correct answers).



Members who participated and completed the tests seem to have increased awareness on the relationship of calorie intake and physical activity and weight management. However, there was a decrease in understanding in benefits of physical activity overall.

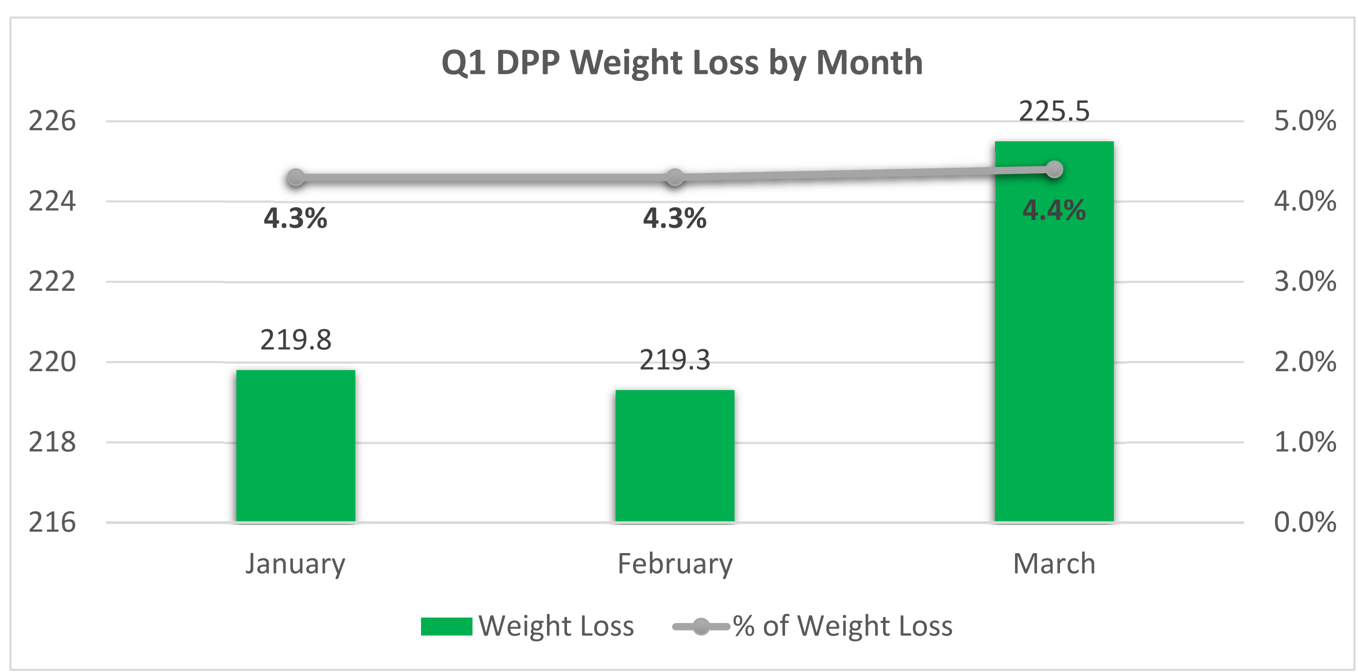
Smoking/Tobacco Cessation: Fresh Start

The Fresh Start program has the goal of reducing harm from tobacco products. Knowledge tests are implemented at each series. In Q1, 22 members completed a pre- and posttest, with a total of 86 tests completed during this period. Members appear to gain or maintain knowledge on withdrawal symptoms, triggers, committing to a quit date, and Nicotine Replacement Therapy. More emphasis is needed in learning about and having a quit plan.



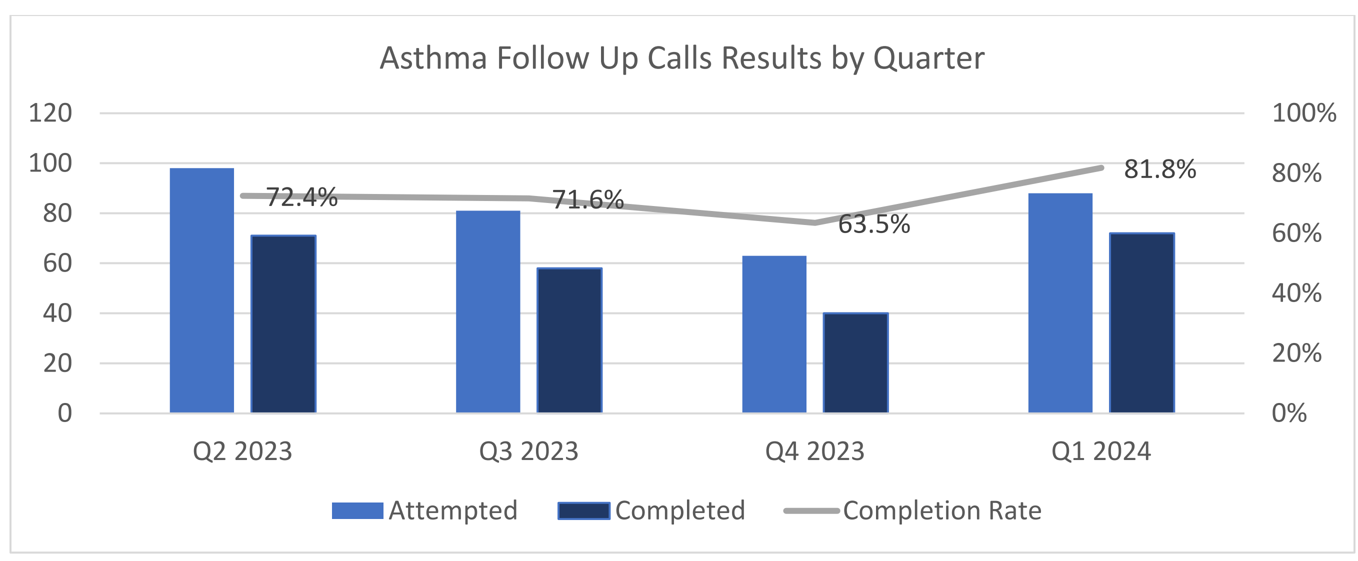
Chronic Disease Prevention and Management: Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program designed to prevent or delay the onset of type 2 diabetes among at risk members. Weight loss totals and percentages that compare initial combined cohort weight with combined weight at the end of each month in Q1 2024 are shown in the chart below. By the end of Q1 2024, 29 members were enrolled in the Spanish DPP cohort with an average weight loss of 4.4%. There was no English DPP series being offered in Q1 2024.



Chronic Disease Prevention and Management: Asthma Education Effectiveness

Members who have attended the KFHC Breathe Better Asthma Classes are offered asthma follow up calls. These calls occur at 1 month, 3 months, and 6 months (optional or only if needed) after attending the classes. During the follow up call, members are screened to determine if asthma symptoms are well controlled using the Asthma Control Test (ACT) screening tool. An ACT score of 20 or higher is an indicator of well controlled asthma. During Q1 2024, 81.8% of members completed an asthma follow up call. This was an improvement compared to 63.5% during the previous quarter. The average ACT score improved slightly for both members under 12 years old and those 12 years and older when comparing the initial assessment to the 1 and 3 month follow ups.



Q1 2024 Average ACT Scores During Asthma Follow Up Calls		
Call Month	<12 years of age	12+ years of age
Initial	17.6	15.8
1	18.1	17.6
3	19.3	19.3
6	No data	Only 1 score

To: KHS EQIHEC Committee

From: Yolanda Herrera, CPMSM, CPCS
Credentialing Manager

Date: May 1, 2024

Re: Credentialing Statistics 1st Quarter 2024

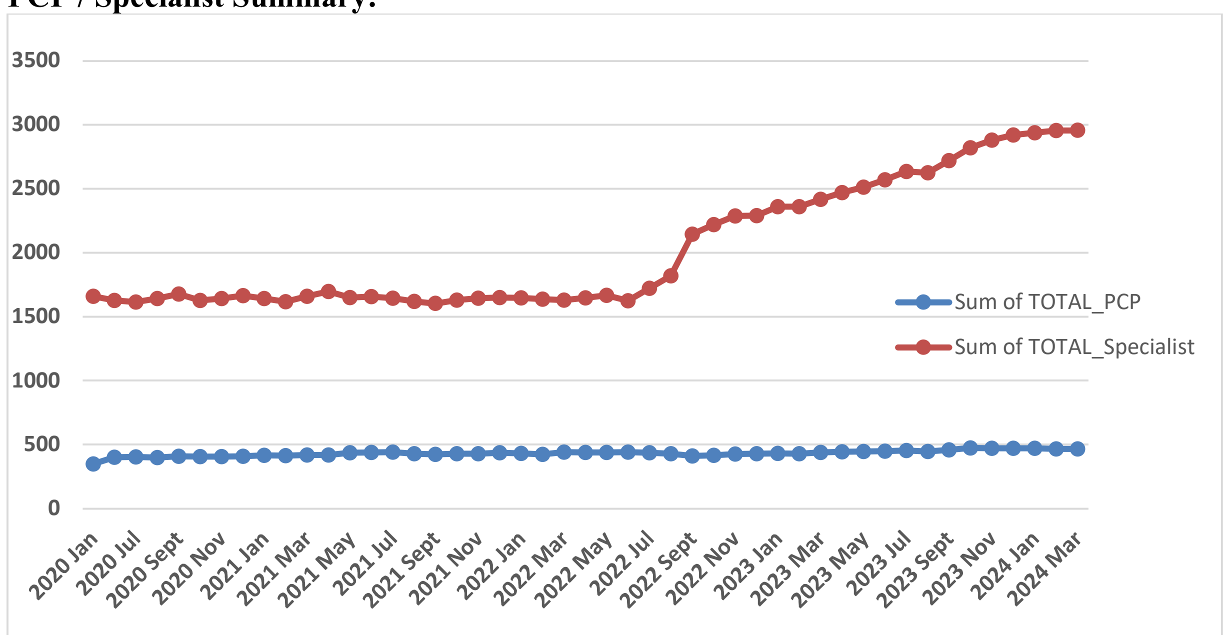
Background
During 1st Quarter monitoring/reporting period January 1, 2024 through March 31, 2024 there were a total of 139 Initially Credentialed Providers and 65 Recredentialed Providers.

31 New Contracts were processed and approved:

1	Ambulatory Surgery Center	3	ABA Specialist
1	CHW	6	Comm Support Svcs/ECM/CBO
2	Home Health	6	Mental Health Groups
2	ICF/DD	2	Primary Care Group
2	Skilled Nursing Facility/CHLF	4	Transportation
		2	SPECIALTY CONTRACTS:
			Specialties: Infectious Disease, IM-Hyperbaric Tx,

Discussion

- All credentialing and recredentialing files were approved as presented.
  - PCPs slightly decreased from 489 to 484 (As of March 2024 - Excluding out of area telehealth)
    20-PCP additions included 8-Physicians and 11-NP/PA
    25-PCP Terminations from the network
  - Specialists increased from 3,106 to 3142
    154-Specialists added to the network
    (Includes non-licensed BH Technicians and Delegated Tertiary Specialists)
    118-Specialist terminations
  - No significant trends identified for termed PCP or Specialist Providers
- All New Contracts listed above were approved.
  - There were 12-contract terminated voluntarily, change of ownership, sites closed and/or business dissolved.
  - There were 4-contracts withdrawn due to not meeting credentialing requirements.
    - 1-ABA non-response to missing items; 1-Transporation City license & insurance not met; 1-Hospice non-response missing items and 1-Hospice not FFS Enrolled at new location.



Fiscal Impact: N/A

Requested Action: Informational Only

KERN HEALTH SYSTEMS
3rd Quarter 2023
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: March 11, 2024

Department: Quality Performance

Monitoring Period: January 1, 2024 through March 31, 2024

Population:

Providers	Credentialed	Recredentialed
MD's	40	26
DO's	3	2
AC's	1	0
PA's	5	5
NP's	30	9
CRNA's	1	1
DPM's	0	1
OD's	1	0
RD's	3	0
BCBA's	19	2
Mental Health	17	2
Ancillary	13	17
Comm Supp Svcs	2	0
Enhanced Care/Case Mgmt	4	0
TOTAL	**139**	**65**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	1	0	1	0
Anesthesiology / CRNA	1	1	2	0
Autism / Behavioral Analyst	19	2	21	0
Cardiology	0	3	3	0
Emergency Medicine	1	1	2	0
Endocrinology	1	0	1	0
Family Practice	14	9	23	0
Gastroenterology	1	1	2	0
General Practice	3	1	4	0
General Surgery	4	2	6	0
Hematology/Oncology	3	0	3	0
Hospitalist	0	1	1	0
Infectious Disease	1	0	1	0
Internal Medicine	7	8	15	0
Mental Health	17	2	19	0
Neurological Surgery	1	0	1	0
Neurology	1	2	3	0
Obstetrics & Gynecology	7	0	7	0
Ophthalmology	5	4	9	0
Optometry	1	0	1	0

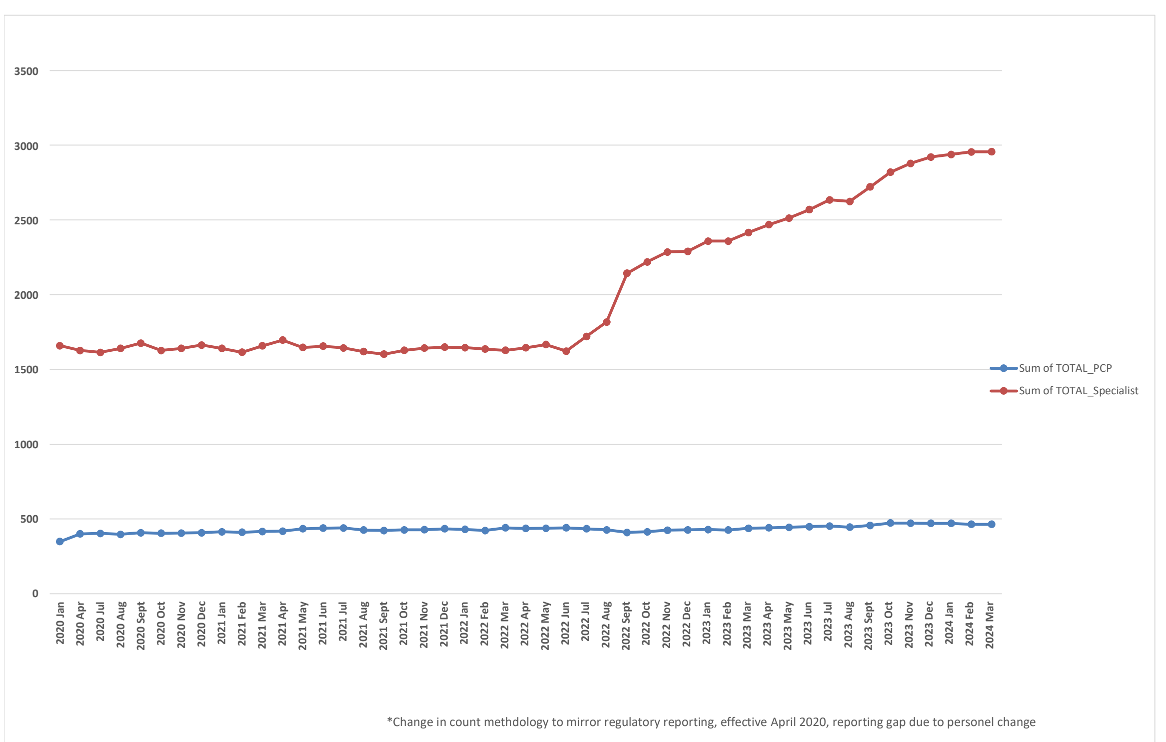
KERN HEALTH SYSTEMS
3rd Quarter 2023
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Pain Management	1	1	2	0
Pathology	1	0	1	0
Pediatrics	4	3	7	0
Plastic Sugery	0	1	1	0
Podiatry	0	1	1	0
Psychiatry	15	4	19	0
Pulmonary	1	1	2	0
Radiology	7	1	8	0
Registered Dieticians	3	0	3	0
Urology	0	2	2	0
TOTAL	**120**	**51**	**171**	**0**

ANCILLARY	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Comm. Based Adult Services	0	1	1	0
DME	0	2	2	0
Home Health	2	0	2	0
Hospice	1	1	2	0
Hospital / Tertiary Hospital	2	2	4	0
Laboratory	0	1	1	0
Pharmacy	1	4	5	0
SNF /Congregate Living	1	1	2	0
Surgery Center	2	1	3	0
Transportation	4	1	5	0
Urgent Care	0	3	3	0
Community Support Services	2	0	2	0
Enhanced Care/Case Mgmt	4	0	4	0
TOTAL	**19**	**17**	**36**	**0**

Defer = 0 **Denied = 0**

PCP/Specialist Summary



PROVIDER NAME	LEGAL NAME/DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROV PRV	VENDOR PRV	NOTES	PAC APPROVED - EFFECTIVE DATE
Black, Danell LPCC	Grow Healthcare Group PC 4900 California Ave, Tower B, 2nd Floor Bakersfield CA	Professional Clinical Counselor	New Contract	PRV095608	**PRV095380**	**Notes**: On-Site & Telehealth	Yes Eff 12/1/23
Edwards, Clint LCSW	Grow Healthcare Group PC 4900 California Ave, Tower B, 2nd Floor Bakersfield CA	Clinical Social Worker	New Contract	PRV095609	**PRV095380**	**Notes**: On-Site & Telehealth	Yes Eff 12/1/23
Rivera, Christine PsyD	Jigsaw Diagnostics a Professional Psychology Corporation 2131 Ashton Ave Menlo Park CA	Psychology (Qualified Autism Provider - AB Evals Only)	New Contract	PRV095620	**PRV095199**	**Notes**: Telehealth Only / AB Evaluations Only / No Mental Health Referrals	Yes Eff 12/1/23
Wray, Lindsay PsyD	Jigsaw Diagnostics a Professional Psychology Corporation 2131 Ashton Ave Menlo Park CA	Psychology (Qualified Autism Provider - AB Evals Only)	New Contract	PRV095621	**PRV095199**	**Notes**: Telehealth Only / AB Evaluations Only / No Mental Health Referrals	Yes Eff 12/1/23
Abernathy-Cornelius, Jordan LCSW	Adventist Health Reedley 1025 North Douty St Hanford CA	Clinical Social Worker	Existing	PRV095862	**PRV040784**	**Notes**: Telehealth Only	Yes Eff 12/1/23
Babarinde, Ololade NP-C	Clinica Sierra Vista 625 34th Street, Suite 100 & 200 Bakersfield CA	Psychiatry Nurse	Existing	PRV094885	**PRV000002**	**Notes**: On-Site & Telehealth	Yes Eff 12/1/23
Gail, Landon BCBA	Achieve Behavioral Change 1200 21st St Ste. A Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV095864	**PRV031922**	**Notes**: On-Site & Telehealth	Yes Eff 12/1/23
Hernandez, Ernesto NP-C	Infusion & Clinical Services dba: Premier Valley Medical Group *All Locations 5401 White Lane Bakersfield CA Good Samaritan Wasco RHC 1217 7th St Wasco CA	Psychiatry Nurse	Existing	PRV095476	**ALL SITES**	**Supervising MD**: J. Sosa MD **Notes**: On-Site & Telehealth	Yes Eff 12/1/23
Lopez Azpeitia, Liliana LMFT	Clinica Sierra Vista 625 34th Street, Suite 100 & 200 Bakersfield CA	Marriage/Family Therapy	Existing	PRV095475	PRV000002	None	Yes Eff 12/1/23
McPherson, Sharda LCSW	Clinica Sierra Vista 1611 1st Street Bakersfield CA	Clinical Social Worker	Existing	PRV094091	**PRV000002**	**Notes**: On-Site & Telehealth	Yes Eff 12/1/23
Nettimi, Balaji PsyD	Telehealthdocs Medical Group 2215 Truxtun Ave Ste. 100 *All Locations Bakersfield CA	Psychology	Existing	PRV095865	**ALL SITES**	**Notes**: Telehealth Only	Yes Eff 12/1/23
Porter, Alada BCBA	Shih Applied Behavior Analysis 8723 Winlock St. Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV095866	**PRV052861**	**Notes**: On-Site & Telehealth	Yes Eff 12/1/23
Sabalza, Maritza BCBA	Prism Behavioral Solutions 4900 California Ave 210B #1009 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV095867	**PRV069746**	**Notes**: Telehealth Only	Yes Eff 12/1/23
Sosa, Juan MD	Infusion & Clinical Services dba: Premier Valley Medical Group *All Locations 5401 White Lane Bakersfield CA Good Samaritan Wasco RHC 1217 7th St Wasco CA	Psychiatry	Existing	PRV071001	**ALL SITES**	**Notes**: On-Site & Telehealth	Yes Eff 12/1/23
Sphar, Stacy NP-C	Bright Heart Health Medical Group 2960 Camino Diablo, Ste. 105 Walnut Creek CA	Psychiatry Nurse	Existing	PRV095868	**PRV061628**	**Notes**: Telehealth Only **Supervising MD**: B. Aladag MD	Yes Eff 12/1/23
Vazquez, Jenny BCBA	Pantogran LLC dba: Center for Autism & Related Disorders 8302 Espresso Dr Ste 100 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV095869	**PRV091753**	**Notes**: On-Site & Telehealth	Yes Eff 12/1/23
NEW CONTRACTS							
Antelope Valley Orthotics & Prosthetics (AVOP)	Toby D. Janowitz dba: Antelope Valley Orthotics & Prosthetics (AVOP) 525 Commerce Ave Suite B Palmdale CA	Prosthetics & Orthotics	New Contract	PRV042341	PRV042341	**NPI: 1720076912** **TIN: 330604336** **Type: DME** **Limitations: None**	**Yes** **Eff 1/1/24**
Banafshe, Paymon MD	Manchester Medical Group PC 6222 W Manchester Ave Ste. A Los Angeles CA	IM/Hospitalist SNF	New Contract	PRV078964	PRV073985	**Prov NPI: 1346341575** **TIN: 830682658** **Type: Specialist** **Ages: 18+** **Limitations: Hospitalist / Non-Assignable**	**Yes** **Eff 1/1/24**
CityServe Network	CityServe Network 3201 F St. Bakersfield CA	CSS / Housing Services	New Contract	PRV095136	PRV095136	**NPI: 1639871528** **TIN: 824490879** **Type: CSS - Housing Deposits, Housing Tenancy & Housing Transition Navigation** **Limitations: None**	**Yes** **Eff 1/1/24**
CityServe Network at The Mission of Kern County	CityServe Network dba: The Mission of Kern County 816 East 21st Street Bakersfield CA	CSS / Sobering Center	New Contract	PRV095136	PRV095136	**NPI: 1639871528** **TIN: 824490879** **Type: Sobering Center** **Limitations: Men's Only**	**Yes** **Eff 1/1/24**

PROVIDER NAME	LEGAL NAME/DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROV PRV	VENDOR PRV	NOTES	PAC APPROVED - EFFECTIVE DATE
CityServe Network at Keepers of the Cross	CityServe Network dba: Keepers of the Cross 125 N. Chester Ave. Bakersfield CA	CSS / Sobering Center	New Contract	PRV095136	PRV095136	NPI: 1639871528 TIN: 824490879 Type: Sobering Center Limitations: Women's Only	Yes Eff 1/1/24
Gomez Knupp, Joanne	Joanne Gomez Knupp dba: Peaceful Passages Birthing Support Center 2573 E. Perrin Ave Ste.103 Fresno CA	Doula	New Contract	PRV095902	PRV095902	Prov NPI: 1285393975 TIN: 163526200 Type: Doula Limitations: None	Yes Eff 1/1/24
Novocure Inc	Novocure Inc 195 Commerce Way Portsmouth NH	DME	New Contract	PRV035258	PRV035258	Note: Tumor Treating Fields/Optune wearable, portable, FDA-approved glioblastoma (GBM) treatment NPI: 1255617569 TIN: 205063536 Type: DME Limitations: None	Yes Eff 1/1/24
Redwood Senior Living Bakersfield	Redwood Bakersfield LLC dba: Redwood Senior Living Bakersfield 810 S Union Ave Bakersfield CA	Congregate Living Facility	New Contract	PRV095872	PRV095872	NPI: 1740873694 TIN: 861364154 Type: SNF/CHLF Limitations: None	Yes Eff 1/1/24
Roots Food Group Management	Roots Food Group Management LLC 1105 E Levee Street Dallas Tx	CSS / Medical Tailored Meals-Supportive Foods	New Contract	PRV095135	PRV095135	NPI: 1164122826 TIN: 873713998 Type: CSS-Medical Tailored Meals Limitations: None	Yes Eff 1/1/24
St. Vincent Preventative Family Care	St. Vincent Preventative Family Care 1221 W 3rd Street Los Angeles CA	CSS / Housing Services	New Contract	PRV095134	PRV095134	NPI: 1629707526 TIN: 812053094 Type: CSS - Housing Deposits, Housing Tenancy & Housing Transition Navigation Limitations: None	Yes Eff 1/1/24
Stephens, Amelda	Amelda Stephens dba: New Beginnings Doula 2825 Lady Fern Lane Bakersfield CA	Doula	New Contract	PRV095871	PRV095871	Prov NPI: 1518645605 TIN: 932189886 Type: Doula Limitations: None	Yes Eff 1/1/24
Tanner, Marlena RD	Marlena Tanner RD dba: The Yellow House Project 2598 Main Street Morro Bay CA	Registered Dietician	New Contract	PRV095435	PRV095435	Prov NPI: 1952472961 TIN: 770579627 Type: Dietician Limitations: None	Yes Eff 1/1/24
T&J Unlimited Transportation Inc	T&J UB23:G31ransportation Inc 840 West Avenue J Lancaster CA	Transportation	New Contract	PRV075201	PRV075201	NPI: 1306395165 TIN: 874496244 Type: Transportation Limitations: None	Yes Eff 1/1/24
COMPREHENSIVE REVIEWS							
Cadden, Joseph MD	Bartz-Altadonna Community Health Ctr 9300 N Loop Blvd Ste California City CA	Infectious Disease	Existing	PRV001901	**PRV029961**	Prov NPI: 1881640399 TIN: 273261289 Type: Dual PCP & Specialist Ages: 12+ Limitations: None	Yes Eff 1/1/24
EXISTING - CLEAN FILES							
Araim, Leheb MD	Adventist Health Physicians Network 2701 Chester Ave 102 Bakersfield CA	Cardiothoracic Surgery	Existing	PRV010399	**PRV053701**	Prov NPI: 1083623540 TIN: 680357690 Type: Specialist Ages: 18+ Limitations: None	Yes Eff 1/1/24
Bramham, Amanda MD	Ridgecrest Regional Hospital 105 E Sydnor Avenue Ste 100 Ridgecrest CA	Family Practice	Existing	PRV094518	**PRV057082**	Prov NPI: 1689994014 TIN: 952082686 Type: PCP Ages: All Limitations: None	Yes Eff 1/1/24
Caldwell, Kira NP-C	Onyinye Okezie MD Inc 500 Old River Road #110 Bakersfield CA	Pediatrics	Existing	PRV094884	**PRV029412**	Prov NPI: 1740067941 TIN: 452395120 Type: PCP Ages: 0-5 Limitations: None	Yes Eff 1/1/24
Campbell, Megan NP-C	Accelerated Urgent Care *All locations 212 Coffee Rd Ste 100 Bakersfield CA	Family Practice / UC	Existing	PRV095477	**ALL SITES**	Supervising MD: J. Chu MD Prov NPI: 1215604392 TIN: 274590874 Type: Specialist / UC Non-Assignable Ages: All Limitations: OnSite & Telehealth	Yes Eff 1/1/24

PROVIDER NAME	LEGAL NAME/DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROV PRV	VENDOR PRV	NOTES	PAC APPROVED - EFFECTIVE DATE
Chandrasekaran, Arjun MD	Ridgecrest Regional Hospital 1011 N China Lake Blvd Ridgecrest CA	General Surgery	Existing	PRV076939	**ALL SITES**	**Prov NPI: 1811351513** **TIN: 952082686** **Type: Specialist** **Ages: All** **Limitations: None**	**Yes** **Eff 1/1/24**
Gautam, Gayatri NP-C	Accelerated Urgent Care *All locations 212 Coffee Rd Ste 100 Bakersfield CA Kern County Hospital Authority 9330 Stockdale Hwy Ste 400 Bakersfield	Family Practice / UC Neurology	Existing	PRV094135	**ALL SITES**	**Supervising MD:** O. Imo MD (AUC) Prov NPI: 1184409716 TIN: 274590874 Type: Specialist / UC Non-Assignable Ages: All Limitations: OnSite & Telehealth **Supervising MD:** H. Kunhi Veedu (KM) Prov NPI: 1184409716 TIN: 475618278 Type: Specialist Ages: All	**Yes** **Eff 1/1/24**
Gill, Tessa NP	Planned Parenthood Mar Monte Inc 2633 16th St Bakersfield CA	OB/GYN	Existing	PRV081650	**PRV000476**	**Prov NPI:** **TIN: 941583439** **Type: Specialist** **Ages: All** **Limitations: Gender Affirming/Hormone Therapy**	**Yes** **Eff 1/1/24**
Greene, David MD	LA Laser Center PC *All Locations 5600 California Ave Ste 101 Bakersfield CA	Radiation Oncology	Existing	PRV082006	**PRV013922**	**Prov NPI: 1235284225** **TIN:** **Type: Specialist** **Ages: All** **Limitations: None**	**Yes** **Eff 1/1/24**
Hansen, Stephanie CNM	OBHG California PC 420 34th Street Bakersfield CA	OBG / Hospitalist	Existing	PRV095901	**PRV000384**	**Supervising MD:** U. Hernandez MD **Prov NPI:** **TIN:** **Type: PCP** **Ages: All** **Limitations: On-Site and Telehealth**	**Yes** **Eff 1/1/24**
Hunt, Raselette MD	Bartz-Altadonna Community Health Ctr 9300 N Loop Blvd Ste California City CA	Family Practice	Existing	PRV086812	**PRV029961**	**Prov NPI: 1649445800** **TIN: 273261289** **Type: PCP** **Ages: 12+** **Limitations: None**	**Yes** **Eff 1/1/24**
Kaur, Navdeep NP-C	Omni Family Health 1110 W. Visalia Rd. Suite 102 Exeter 860 Sequioa Ave Lindsey CA	Family Practice	Existing	PRV052711	**PRV000002**	**Prov NPI: 1922578426** **TIN: 953218000** **Type: PCP / Non-Assignable** **Ages: All** **Limitations: Telehealth Only**	**Yes** **Eff 1/1/24**
Mervin, Addias MD	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	OB/GYN	Existing	PRV084011	**PRV000002**	**Prov NPI: 1316392756** **TIN: 952707101** **Type: Specialist** **Ages: 12+** **Limitations: None**	**Yes** **Eff 1/1/24**
Nayyar, Samir MD	Ridgecrest Regional Hospital 1041 N China Lake Blvd Ridgecrest CA	Orthopedic Surgery	Existing	PRV095900	**ALL SITES**	**Prov NPI: 1063703270** **TIN: 952082686** **Type: Specialist** **Ages: All** **Limitations: None**	**Yes** **Eff 1/1/24**
Patil, Sadanand MD	Ravi Patel, MD Inc dba: Compreh. Blood & Cancer Ctr 6501 Truxtun Ave Bakersfield CA	Hematology / Oncology	Existing	PRV093860	**PRV013881**	**Prov NPI: 1497713267** **TIN: 770356364** **Type: Specialist** **Ages: All** **Limitations: None**	**Yes** **Eff 1/1/24**
Redon, Kenneth NP-C	Carlos Alvarez MD Inc 8929 Panama Road Ste. A Lamont CA	Internal Medicine	Existing	PRV057104	**PRV055424**	**Prov NPI: 1528531274** **TIN: 800730752** **Type: PCP** **Ages: 12+** **Limitations: None**	**Yes** **Eff 1/1/24**
Royle, Kenneth MD	Ridgecrest Regional Hospital 1011 N China Lake Blvd Ridgecrest CA	OB/GYN	Existing	PRVV046837	**ALL SITES**	**Prov NPI: 1891873378** **TIN: 952082686** **Type: Specialist** **Ages: 12+** **Limitations: None**	**Yes** **Eff 1/1/24**

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Sands, Stacie NP-C	Dignity Health Medical Group 3838 San Dimas St Ste B201 Bakersfield CA	Cardiovascular Disease	Existing	PRV095874	**PRV012886**	**Prov NPI: 1629720958** **TIN: 352441895** **Type: Specialist** **Ages: 18+** **Limitations: None**	**Yes** **Eff 1/1/24**
Shete, Mona MD	Dignity Health Medical Group 3838 San Dimas St Ste B231 Bakersfield CA	Otolaryngology	Existing	PRV094679	**PRV051775**	**Prov NPI: 1265736607** **TIN: 352441895** **Type: Specialist** **Ages: 18+** **Limitations: None**	**Yes** **Eff 1/1/24**
Stark, Sara NP-C	Accelerated Urgent Care *All locations 212 Coffee Rd Ste 100 Bakersfield CA	Family Practice / UC	Existing	PRV074320	**ALL SITES**	**Supervising MD:** A. Alvarez MD **Prov NPI: 1992317390** **TIN: 274590874** **Type: Specialist / UC Non-Assignable** **Ages: All** **Limitations: OnSite & Telehealth**	**Yes** **Eff 1/1/24**
Tammela, Jonathan MD	Pacific Central Coast Health Centers dba: Dignity Health Women's Center 500 Old River Rd Ste. 200 Bakersfield CA	Gyn Oncology	Existing	PRV048152	**PRV073607**	**Prov NPI: 1265451058** **TIN: 301277816** **Type: Specialist** **Ages: 18+** **Limitations: None**	**Yes** **Eff 1/1/24**
Thomas, Debi MD	Adventist Health Physicians Network 8311 Brimhall Rd Bldg 1900 Ste 1903 Adventist Health - Delano 1201 Jefferson St Delano CA	General Surgery	Existing	PRV095873	PRV092665 PRV060593	**Prov NPI: 1245611995** **TIN: 680357690** **Type: Specialist** **Ages: 18+** **Limitations: None**	**Yes** **Eff 1/1/24**
Zentner, Cheryl MD	Ridgecrest Regional Hospital 1111 N China Lake Blvd Ridgecrest CA	Pediatrics	Existing	PRV094704	**ALL SITES**	**Prov NPI: 1023128824** **TIN: 952082686** **Type: PCP** **Ages: 0-18** **Limitations: None**	**Yes** **Eff 1/1/24**

VENDOR PRV	VENDOR NAME	Specialty	Address	Comments	Contract Effective Date
PRV042341	Toby D. Janowitz dba: Antelope Valley Orthotics & Prosthetics (AVOP)	Orthotics & Prosthetics	525 Commerce Ave Suite B Palmdale CA	**NPI: 1720076912 TIN: 330604336 Type: DME Limitations: None**	1/1/2024
PRV073985	Manchester Medical Group PC	Hospitalist/IM	6222 W Manchester Ave Ste. A Los Angeles CA	**Banafshe, Paymon MD GROUP NPI: 1164918892 TIN: 830682658 Type: Hospitalist / Specialist Limitations: None**	1/1/2024
PRV095136	CityServe Network	CSS / Housing Services	3201 F Street Bakersfield CA	**NPI: 1639871528 TIN: 824490879 Type: CSS - Housing Deposits, Housing Tenancy & Housing Transition Navigation Limitations: None**	1/1/2024
PRV095136	CityServe Network dba: CityServe Network at The Mission of Kern County	CSS / Sobering Center (Men)	816 East 21st Street Bakersfield CA	**NPI: 1639871528 TIN: 824490879 Type: Sobering Center Limitations: Men's Only**	1/1/2024
PRV095136	CityServe Network at Keepers of the Cross	CSS / Sobering Center (Women)	125 N. Chester Ave. Bakersfield CA	**NPI: 1639871528 TIN: 824490879 Type: Sobering Center Limitations: Women's Only**	1/1/2024
PRV005603	Dignity Health dba: Mercy Hospital Bakersfield	CSS / Asthma Remediation	Mercy Hospital Bakersfield - Community Wellness Program 2215 Truxtun Avenue Bakersfield CA Phone -661-632-5062 Fax - 661-632-5988	**NPI: 1104981661 TIN: 870692237 Type: Asthma Remediation Limitations: None**	1/1/2024
PRV095902	Gomez Knupp, Joanne dba: Peaceful Passages Birthing Support Center	Doula	2573 E. Perrin Ave Ste.103 Fresno CA	**Prov NPI: 1285393975 TIN: 163526200 Type: Doula Limitations: None**	1/1/2024
PRV095380	Grow Healthcare Group PC	Mental Health	4900 California Ave, Ste. B Bakersfield CA	**NPI: 1154994846 TIN: 871702628 Type: Specialist Limitations: None**	**Retro Approval 12/1/2023**
PRV095199	Jigsaw Diagnostics, a Professional Psychology Corporation	ABA Evaluations Only	2131 Ashton Ave Menlo Park CA	**NPI: 1699342436 TIN: 870932797 Type: Specialist Limitations: ABA Evaluations Only**	**Retro Approval 12/1/2023**
PRV092319	Jonathan Rizo dba: Rizo Psychological & Behavioral Health Services	ABA	930 Truxtun Ave Ste 206 Bakersfield CA	**NPI: 1821778770 *NEW TIN: 933717064 Type: Specialist Limitations: None**	1/1/2024
PRV095435	Marlena Tanner RDN LLC dba: The Yellow House Project	Registered Dietician	2598 Main Street Morro Bay CA	**NPI: 1942716626 TIN: 823400554 Type: Dietician Limitations: None**	1/1/2024
PRV035258	Novocure Inc	DME / Cancer Treatment Assisted device	195 Commerce Way Portsmouth NH	**NPI: 1255617569 TIN: 205063536 Type: DME Limitations: None**	1/1/2024
PRV095872	Redwood Bakersfield LLC dba: Redwood Senior Living Bakersfield	SNF/Congregate Living Facility	810 S Union Avenue Bakersfield CA	**NPI: 1740873694 TIN: 861364154 Type: SNF/CHLF Limitations: None**	1/1/2024
PRV095135	Roots Food Group Management	CSS / MedicallyTailored Meals	1105 E Levee Street Dallas TX	**NPI: 1164122826 TIN: 873713998 Type: CSS-Medical Tailored Meals Limitations: None**	1/1/2024
PRV095134	St. Vincent Preventative Family Care	CSS / Housing Services	1221 W 3rd Street Los Angeles CA	**NPI: 1629707526 TIN: 812053094 Type: CSS - Housing Deposits, Housing Tenancy & Housing Transition Navigation Limitations: None**	1/1/2024
PRV095871	Stephens, Amelda dba: New Beginnings Doula	Doula	2825 Lady Fern Lane Bakersfield CA	**Prov NPI: 1518645605 TIN: 932189886 Type: Doula Limitations: None**	1/1/2024
PRV075201	T&J Unlimited Transportation Inc	Transportation	840 West Avenue J Lancaster CA	**NPI: 1306395165 TIN: 874496244 Type: Transportation Limitations: None**	1/1/2024

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Alcantar-Gomez, Alejandra LCSW	Clinica Sierra Vista 217 Kern Ave McFarland CA	Clinical Social Worker	Existing	PRV096059	PRV000002	**Yes Eff 1/8/24**
Ballesteros, Judy BCBA	Learning Arts 1800 Westwind Dr. Ste 403 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV087930	PRV052185	**Yes Eff 1/8/24**
Camacho, Ana BCBA	Adelante Behavioral Health ABA LLC 2005 Eye St Ste. 8 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV096607	PRV067923	**Yes Eff 1/8/24**
Carraway, Raquel LCSW	Adventist Health Reedley 1041 Rose Avenue Selma CA	Clinical Social Worker	Existing	PRV096608	PRV042227	**Yes Eff 1/8/24**
Cortez, Paulette BCBA	Pantagon LLC dba: CARD 8302 Espresso Drive Ste. 100 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV095798	PRV091753	**Yes Eff 1/8/24**
Cruz, Herbert MD	Omni Family Health 2505 Merced Street Fresno CA	Psychiatry	Existing	PRV096601	PRV000019	**Yes Eff 1/8/24**
Guerrero, Diana BCBA	Adelante Behavioral Health ABA LLC 2005 Eye St Ste. 8 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV096609	PRV067923	**Yes Eff 1/8/24**
Lyons, Denise LCSW	Omni Family Health 2811 H Street Bakersfield CA	Clinical Social Worker	Existing	PRV095478	PRV000019	**Yes Eff 1/8/24**
Rivera, Anastasia LCSW	Omni Family Health 1701 Stine Road Bakersfield CA	Clinical Social Worker	Existing	PRV096052	PRV000019	**Yes Eff 1/8/24**
Saha, Sujata PhD	Jigsaw Diagnostics a Professional Psychology Corporation 2131 Ashton Ave Menlo Park CA	Psychology (Qualified Autism Provider - AB Evals Only)	Existing	PRV096610	PRV095199	**Yes Eff 1/8/24**
Aldaz, Edward LCSW	Esteem Health 5850 El Camino Real Atascadero CA	Clinical Social Worker	**New Contract**	PRV097472	PRV097479	**Yes Eff 2/1/24**
Dudley, Chanell LCSW	Esteem Health 5850 El Camino Real Atascadero CA	Clinical Social Worker	**New Contract**	PRV097478	PRV097479	**Yes Eff 2/1/24**
Esguerra, Chris MD	Esteem Health 5850 El Camino Real Atascadero CA	Psychiatry	**New Contract**	PRV097469	PRV097479	**Yes Eff 2/1/24**
Espinoza, Raquel LCSW	Esteem Health 5850 El Camino Real Atascadero CA	Clinical Social Worker	**New Contract**	PRV097480	PRV097479	**Yes Eff 2/1/24**
Figueroa, Vivian LCSW	Esteem Health 5850 El Camino Real Atascadero CA	Clinical Social Worker	**New Contract**	PRV097481	PRV097479	**Yes Eff 2/1/24**
Juarez, Jose LCSW	Esteem Health 5850 El Camino Real Atascadero CA	Clinical Social Worker	**New Contract**	PRV097482	PRV097479	**Yes Eff 2/1/24**
Leon, Patricia LMFT	Esteem Health 5850 El Camino Real Atascadero CA	Marriage Family Therapy	**New Contract**	PRV097483	PRV097479	**Yes Eff 2/1/24**
Lipscomb-Hammond, Cecelia NP	Esteem Health 5850 El Camino Real Atascadero CA	Nurse Practitioner - Psychiatry	**New Contract**	PRV097484	PRV097479	**Yes Eff 2/1/24**
Swetland, Kaleigh LCSW	Esteem Health 5850 El Camino Real Atascadero CA	Clinical Social Worker	**New Contract**	PRV097485	PRV097479	**Yes Retro-Eff 2/1/24**
Verma, Kristy LPCC	Esteem Health 5850 El Camino Real Atascadero CA	Professional Clinical Counselor	**New Contract**	PRV097486	PRV097479	**Yes Retro-Eff 2/1/24**
Bhurgri, Ashhar MD	Kern Psychiatric Health & Wellness Ctr 8329 Brimhall Rd Ste. 804 Bakersfield CA	Psychiatry	**New Contract**	PRV056779	PRV046499	**Yes Eff 2/1/24**
Fernando, Gerard MD	Kern Psychiatric Health & Wellness Ctr 8329 Brimhall Rd Ste. 804 Bakersfield CA	Psychiatry & Substance-Addiction Medicine	**New Contract**	PRV041952	PRV046499	**Yes Retro-Eff 2/1/24**
Malini, Iyengar MD	Kern Psychiatric Health & Wellness Ctr 8329 Brimhall Rd Ste. 804 Bakersfield CA	Psychiatry	**New Contract**	PRV006707	PRV046499	**Yes Retro-Eff 2/1/24**

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Song Seo, Franco MD	Kern Psychiatric Health & Wellness Ctr 8329 Brimhall Rd Ste. 804 Bakersfield CA	Psychiatry	**New Contract**	PRV003980	PRV046499	**Yes Retro-Eff 2/1/24**
Rios, Rachel LCSW	Rachel Iris Rios 10316 Riata Lane Bakersfield CA	Clinical Social Worker	**New Contract**	PRV080651	PRV080651	**Yes Retro-Eff 2/1/24**
Schwartz, Suzanne BCBA	Suzanne Schwartz dba: Social Behavioral Solutions 6705 Topaz Lane Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	**New Contract**	PRV055642	PRV097471	**Yes Retro-Eff 2/1/24**
Aguirre, Angelica BCBA-D	Achieve Behavior Change 1200 21st St Ste A Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV097473	PRV031922	**Yes Retro-Eff 2/1/24**
Lowery, Stephanie BCBA	Prism Behavioral Solutions 4900 California Ave 210B #1009 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV097474	PRV069746	**Yes Retro-Eff 2/1/24**
Nease, Shaina BCBA	Prism Behavioral Solutions 4900 California Ave 210B #1009 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV097475	PRV069746	**Yes Retro-Eff 2/1/24**
Price, Lauren BCBA	Autism Behavior Services, Inc 3616 Coffee Rd Ste A Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV097476	PRV062872	**Yes Retro-Eff 2/1/24**
Rajalakshmi, Shruthi BCBA	Positive Behavior Supports Corporation 3815 Ming Avenue #352 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV097477	PRV092347	**Yes Retro-Eff 2/1/24**
De Jesus, Hector MD	Hector De Jesus, MD Inc 2121 17th Street Ste A Bakersfield CA	Internal Medicine	**New Contract**	PRV000596	PRV013614	**YES 3/1/24**
J&B Transport	Brittany Ruch dba: J&B Transport 316 East Woodrow St Taft CA	Transportation	**New Contract**	PRV088729	PRV088729	**YES 3/1/24**
Kern Psychiatric Health and Wellness Center Inc	Kern Psychiatric Health & Wellness Center Inc 2204 Q Street Ste. B Bakersfield CA	ECM (Case Management)	**New Contract**	PRV046499	PRV046499	**YES 3/1/24**
Loyd's Liberty Homes Inc	Loyd's Liberty Homes Inc 9166 Anaheim Place Ste. 200 Rancho Cucamonga CA 91730	Intermediate Care Facility for Developmentally Disabled	**New Contract**	PRV095304	PRV095304	**Yes Retro-Eff 2/1/2024**
Mangat, Geeteshwar MD	Synchrony Medical Group & Mind Body Wellness 9500 Stockdale Hwy Ste 100 Bakersfield CA	Internal Medicine	**New Contract**	PRV012241	PRV097838	**YES 3/1/24**
Parikshat Alka PC	Parikshat Alka PC 3008 Sillect Ave Ste. 205 Bakersfield CA	ECM (Case Management)	**New Contract**	PRV096611	PRV096611	**YES 3/1/24**
Sunrise MedTransport Services LLC	Sunrise MedTransport Services LLC 860 E. Ave K, Suite A Lancaster CA	Transportation	**New Contract**	PRV097839	PRV097839	**YES 3/1/24**
The Open Door Network	The Open Door Network 1600 E Truxtun Ave Bakersfield CA	ECM (Case Management)	**New Contract**	PRV086956	PRV086956	**YES 3/1/24**
WeCare Medical Transport LLC	WeCare Medical Transport LLC 4700 Easton Drive Ste. 7 Bakersfield CA	Transportation	**New Contract**	PRV097850	PRV097850	**YES 3/1/24**
Del Mundo, Noel MD	Adventist Health Physicians Network 8339 Brimhall Rd Ste 1304 Bakersfield CA	OB/GYN	Existing	PRV004905	PRV039909	**YES 3/1/24**

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Rader, Collin DO	Accelerated Urgent Care 212 Coffee Road Suite 100 *All Locations Bakersfield CA	General Practice	Existing	PRV092297	ALL SITES	**YES 3/1/24**
Swanson, Gary MD	Bartz-Altadonna Comm. Health Center 9300 N Loop Blvd Ste C Cal City CA 12560 Boron Ave Boron CA	OB/GYN	Existing	PRV056798	PRV029961	**YES 3/1/24**
Ahmadi, Adam MD	Kern County Hospital Authority 2920 F St Ste B-1 Bakersfield CA	Ophthalmology	Existing	PRV096883	ALL SITES	**YES 3/1/24**
Arigo, Richard MD	Kern Radiology Medical Group Inc 2301 Bahamas Dr *All Locations Bakersfield CA	Diagnostic Radiology	Existing	PRV004947	ALL SITES	**YES 3/1/24**
Artymowicz, Anna MD	West Coast Eye Institute 215 China Grade Loop 11901 Bolthouse Dr Ste 300-400 Bakersfield CA	Ophthalmology	Existing	PRV091430	PRV064010	**YES 3/1/24**
Avila, Angelica NP-C	Vanguard Medical Corporation 565 Kern St Shafter CA	Internal Medicine	Existing	PRV094107	ALL SITES	**YES 3/1/24**
Babaidorabad, Nasim MD	Yosemite Pathology Medical Group, Inc 3000 Sillect Ave Bakersfield	Pathology	Existing	PRV072671	PRV013993	**YES 3/1/24**
Bath, Mandeep MD	Kern County Hospital Authority 1111 Columbus St 9330 Stockdale Hwy Ste 400 Bakersfield	Family Practice	Existing	PRV095474	ALL SITES	**YES 3/1/24**
Bracewell, Gregory MD	Kern County Hospital Authority 1111 Columbus St Bakersfield CA	OB/GYN	Existing	PRV096604	ALL SITES	**YES 3/1/24**
Bristol Hospice - Lancaster	Optimal Hospice, Inc. 44151 15th Street West, Ste 201 Lancaster CA	Hopice	Existing	PRV069292	PRV069292	**YES 3/1/24**
Cabasag, Witchell NP-C	Hany Aziz, MD Inc 3805 San Dimas St Ste B Bakersfield CA	Pulmonary Disease	Existing	PRV094706	PRV013766	**YES 3/1/24**
Carmack, Maria PA-C	Comprehensive Blood & Cancer Ctr 6501 Truxtun Ave Bakersfield CA	Hematology & Oncology	Existing	PRV097841	PRV013881	**YES 3/1/24**
Carranza, Claudia MD	Premier Valley Medical Group & ECM 5401 White Ln *All Loc- Bakersfield CA **Addtitional Affiliations** Good Sam Hospital Wasco RHC	Family Practice	Existing	PRV096053	ALL SITES	**YES 3/1/24**
Casparro, Elizabeth RD	The Yellow House Project 2598 Main St Morro Bay CA	Registered Dietician	Existing	PRV097842	PRV095435	**YES 3/1/24**
Cha, Peter MD	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA	Trauma/Surgical Critical Care	Existing	PRV094136	ALL SITES	**YES 3/1/24**
Dhillon, Balwinder NP-C	Omni Family Health 3800 Mall View Rd. Bakersfield CA 525 Roberts Lane Bakersfield CA	Family Practice	Existing	PRV096054	PRV000019	**YES 3/1/24**
Farrukh, Omar DO	Antelope Valley Nueroscience Med Grp 42135 10th Street West Ste 301 Lancaster CA	Neuromusculo- skeletal Medicine	Existing	PRV092083	PRV030410	**YES 3/1/24**
Foulad, Sharon PA-C	Kern Gastroenterology Medical Group 5959 Truxtun Ave Ste 200 Bakersfield CA	Gastroenterology	Existing	PRV097843	PRV000338	**YES 3/1/24**
Franco-Garcia MD	Telehealthdocs Medical Group 2215 Truxtun Ave Ste 100 *All Locations Bakersfield CA	Infectious Disease	Existing	PRV041039	PRV036952	**YES 3/1/24**
Gilani, Safia NP-C	Bartz-Altadonna Comm. Health Center 9300 N Loop Blvd Ste C Cal City CA 43322 Gingham Ave Lancaster CA	Internal Medicine	Existing	PRV097844	PRV029961	**YES 3/1/24**

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Han, Sang-Hun MD	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	Endocrinology	Existing	PRV096290	PRV000002	**YES 3/1/24**
Keenan, Robert MD	Adventist Health Tehachapi Valley 105 W E St Tehachapi CA	General Surgery	Existing	PRV038313	ALL SITES	**YES 3/1/24**
Kim, Huisoon AC	Omni Family Health 4131 Ming Ave Bakersfield CA	Acupuncture	Existing	PRV040073	PRV000019	**YES 3/1/24**
Kinas, Erica NP-C	Kern County Hospital Authority 1111 Columbus St Bakersfield CA	Oncology	Existing	PRV096603	ALL SITES	**YES 3/1/24**
Lopez, Nilda MD	Bartz- Altadonna Community Health Ctr 9300 N Loop Blvd Ste C Cal City CA 12560 Boron Ave Boron CA	Family Practice	Existing	PRV097638	PRV029961	**YES 3/1/24**
Loudermilk, Briana RD	The Yellow House Project 2598 Main St Morro Bay CA	Registered Dietician	Existing	PRV097845	PRV095435	**YES 3/1/24**
MacDonald, Christopher MD	Kern Radiology Medical Group Inc 2301 Bahamas Dr *All Locations Bakersfield CA	Diagnostic Radiology	Existing	PRV094767	ALL SITES	**YES 3/1/24**
Mardiat, John MD	Kern Radiology Medical Group Inc 2301 Bahamas Dr *All Locations Bakersfield CA	Diagnostic Radiology	Existing	PRV033167	ALL SITES	**YES 3/1/24**
McDaniel, Brock MD	Kern Radiology Medical Group Inc 2301 Bahamas Dr *All Locations Bakersfield CA	Diagnostic Radiology	Existing	PRV077008	ALL SITES	**YES 3/1/24**
Niles Family Health Pharmacy	Omni Family Health dba: Niles Family Health Pharmacy 6700 Niles St Ste 155 Bakersfield CA	Pharmacy	Existing	PRV097846	PRV000019	**YES 3/1/24**
Nunez, Katie NP-C	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	OB/GYN	Existing	PRV087547	PRV000002	**YES 3/1/24**
Ochoa-Frongia, Laura MD	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA	Trauma/Surgical Critical Care	Existing	PRV096055	ALL SITES	**YES 3/1/24**
Okeke, Stella NP-C	Universal Healthcare Services *All Loc 8325 Brimhall Rd Ste 100A **Additional Affiliation:** Universal Urgent Care *All Loc 8325 Brimhall Rd Ste 100	Family Practice & Urgent Care	Existing	PRV075898	ALL SITES	**YES 3/1/24**
Ortiz, Lucia NP-C	Carlos A. Alvarez MD Inc 6001-D Truxtun Ave. #220 Bakersfield 8929 Panama Road #A Lamont CA	Internal Medicine	Existing	PRV097847	ALL SITES	**YES 3/1/24**
Osborne, Jacob NP-C	Pain Institute of Central California 9802 Stockdale Hwy Ste 105 Bakersfield CA	Pain Management	Existing	PRV097848	PRV000510	**YES 3/1/24**
Pietrangelo, Mariah NP-C	Ridgecrest Regional Hospital 1011 N China Lake Blvd Ste A Bakersfield CA	OB/GYN	Existing	PRV097640	PRV038718	**YES 3/1/24**
Rivera, Andres PA-C	Adventist Health Reedley 1040 7th Street Wasco CA	Family Practice	Existing	PRV096570	PRV036302	**YES 3/1/24**
Rivera, Thalia NP-C	Omni Family Health 860 Sequoia Ave Lindsay CA 1110 W Visalia Rd Ste. 102 Exeter CA	Family Practice	Existing	PRV094883	PRV000019	**YES 3/1/24**
San Joaquin Valley Surgery Center	San Joaquin Valley Surgery Center LLC 2620 Chester Ave Ste. 400 Bakersfield CA	Ambulatory Surgery Center	Existing	PRV093946	PRV093946	**YES 3/1/24**

KERN HEALTH SYSTEMS
Board Approved Effective 03/01/2024

Tan, Michelle PA-C	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA	Neurosurgery	Existing	PRV096057	ALL SITES	**YES** **3/1/24**
Umansky, Kelsey RD	The Yellow House Project 2598 Main St Morro Bay CA	Registered Dietician	Existing	PRV097849	PRV095435	**YES** **3/1/24**

KERN HEALTH SYSTEMS
Board Approved Effective 03/01/2024

Legal Name/ DBA	Specialty	Address	VENDOR PRV	Contract Effective Date
Andrea Stocker dba: Seasons of Change Therapeutic Services	Mental Health	20288 W Valley Blvd Tehachapi CA	PRV058691	Retro-Eff 2/1/2024
Chris E. Esguerra MD PC dba: Esteem Health PSC	Pediatric Mental Health	5850 El Camino Real Atascadero CA	PRV097479	Retro-Eff 2/1/2024
Millicent Pitts-Licensed Marriage & Family Therapist, Inc	Mental Health	1430 Truxtun Ave, Suite 700 Bakersfield CA	PRV097470	Retro-Eff 2/1/2024
Rachel Iris Rios	Mental Health	10316 Riata Lane Bakersfield CA	PRV080651	Retro-Eff 2/1/2024
Suzanne Schwartz dba: Social Behavior Solutions LLC	ABA	6705 Topaz Lane Bakersfield CA	PRV097471	Retro-Eff 2/1/2024
Kern Psychiatric Health and Wellness Center Inc	Mental Health-PCP	8329 Brimhall Road Ste. 804 Bakersfield CA	PRV046499	Retro-Eff 2/1/2024
Kern Psychiatric Health and Wellness Center Inc	ECM / Case Management	Psychiatric Wellness Center 2204 Q Street Ste. B Bakersfield CA	PRV097851	3/1/2024
Hector De Jesus, MD Inc	Internal Medicine	2121 17th Street Ste A Bakersfield CA	PRV013614	3/1/2024
Brittany Ruch dba: J&B Transport	Transportation	316 East Woodrow St Taft CA	PRV088729	3/1/2024
Loyd's Liberty Homes Inc	ICF/DD	9166 Anaheim Place Ste. 200 Rancho Cucamonga CA 91730	PRV095304	Retro-Eff 2/1/2024
Parikshat Alka PC	ECM / Case Management	3008 Sillect Ave Ste. 205 Bakersfield CA	PRV096611	3/1/2024
Pear Suite Inc.	3012024	3951 Higuera Street Culver City CA	PRV097840	3/1/2024
Randolph Senining Corp	Specialist	7702 Meany Ave Suite 101 Bakersfield CA	PRV084817	3/1/2024
St. Vincent Preventative Family Care	ECM / Case Management	1221 W 3rd Street Los Angeles CA	PRV095134	3/1/2024
Synchrony Medical Group dba: Synchrony Medical Group & Mind Body Wellness	PCP	9500 Stockdale Hwy Ste. 100 Bakersfield CA	PRV097838	3/1/2024
Sunrise MedTransport Services LLC	Transportation	860 E. Ave K, Suite A Lancaster CA	PRV097839	3/1/2024
The Open Door Network	ECM / Case Management	1600 E Truxtun Ave Bakersfield CA	PRV086956	3/1/2024
WeCare Medical Transport LLC	Transportation	4700 Easton Drive Ste. 7 Bakersfield CA	PRV097850	3/1/2024

KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: Enhanced Case Management Department (ECM)

Date: 05/23/24

Re: 1st Quarter ECM Program Report

Background

Reporting ECM to the Health Equity team provides an opportunity to highlight its role in advancing health equity objectives within our healthcare organization. By prioritizing patient-centered care, interdisciplinary collaboration, health literacy, data-driven decision-making, and community engagement, ECM contributes to reducing disparities, improving outcomes, and fostering health equity for all individuals, regardless of race, ethnicity, socioeconomic status, or other social determinants of health.

Discussion

Enhanced Care Management (ECM) is a proactive healthcare approach aimed at improving health outcomes for individuals with complex medical needs. As part of our commitment to advancing health equity, it is essential to provide the Health Equity team with a thorough understanding of how ECM aligns with and supports our overarching goals in this critical area. Through this discussion, we hope to give better line of sight to the committee key performance measures and our initiatives approach that demonstrate our alignment with the KHS vision for health equity for our members.

Fiscal Impact

None.

Requested Action

Review and approval of the report as presented by the Enhanced Case Management leadership team.

Enhanced Care Management Quarter I EQIHEC Report

Background:

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

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

Populations of Focus live as of January 2024:

Birth Equity PoF:

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

Data that informs this population of focus:

ASIAN/PACIFIC ISLANDER INFANT MORTALITY, 2018–2020

HP 2030 Target: 5.0
California Average: 2.5
(per 1,000 Live Births)

Birth Cohort Infant Death Rate per 1,000 Live Births by County of Residence

- Zero events
- Less than or equal to 5.0
- Greater than 5.0
- Unreliable*

* Rates and percentages are deemed unreliable when based on a relative standard error greater than or equal to 23 percent.

Data Sources:
California Department of Public Health, Center for Health Statistics and Informatics, Birth Cohort-Perinatal Outcome Files (Static), compiled February 2023.

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

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

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

BLACK INFANT MORTALITY, 2018–2020

HP 2030 Target: 5.0

California Average: 7.9

(per 1,000 Live Births)

Birth Cohort Infant Death Rate per 1,000 Live Births by County of Residence

- Zero events
- Less than or equal to 5.0
- Greater than 5.0
- Unreliable*

* Rates and percentages are deemed unreliable when based on a relative standard error greater than or equal to 23 percent.

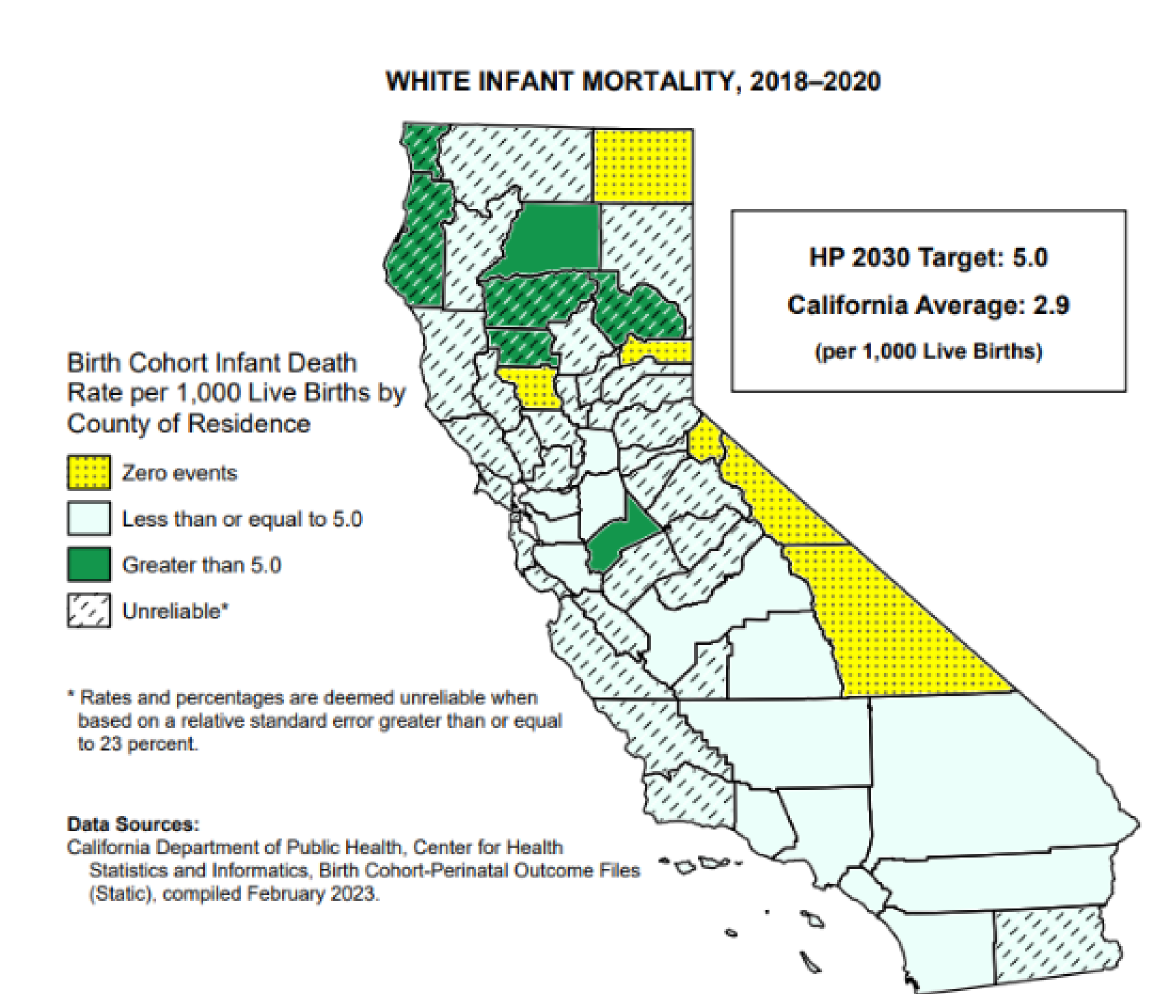
Data Sources:
California Department of Public Health, Center for Health Statistics and Informatics, Birth Cohort-Perinatal Outcome Files (Static), compiled February 2023.

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

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

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

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



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

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

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

Justice-Involved PoF:

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

ECM

Data that informs this PoF (from CDPH):

Jail Admissions | Jail Incarceration | Pretrial Jail Incarceration | Prison Incarceration | Jail + Prison Incarceration

Search for a county

Jail + prison incarceration rate per 100,000 residents age 15-64

100 400 1600 No Data

2020

+274%

Change in the total number of people behind bars since 1970.

65%

Percent of the jail population held pretrial.

978,264

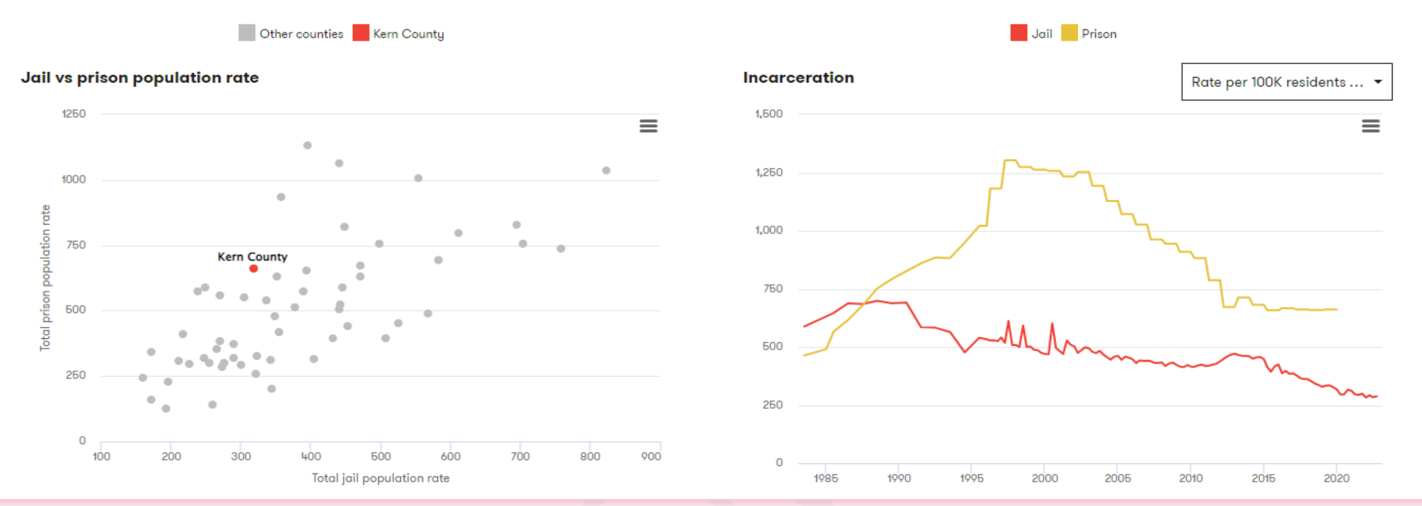
Number of times people are sent to local jails annually.

Jail and Prison Incarceration

Although the terms "jail" and "prison" are commonly used interchangeably, there are important differences. Jails are locally run facilities that primarily hold unconvicted people who have been arrested and are awaiting a resolution to their case. Many people are in jail simply because they cannot afford to pay bail, fines, or fees. Other people are in jail serving shorter sentences for misdemeanor or low-level felony convictions, or are locked up for violating probation or other forms of supervision. In some states, jails also hold people serving state prison sentences, as well as people being held for federal authorities. Prisons are state or

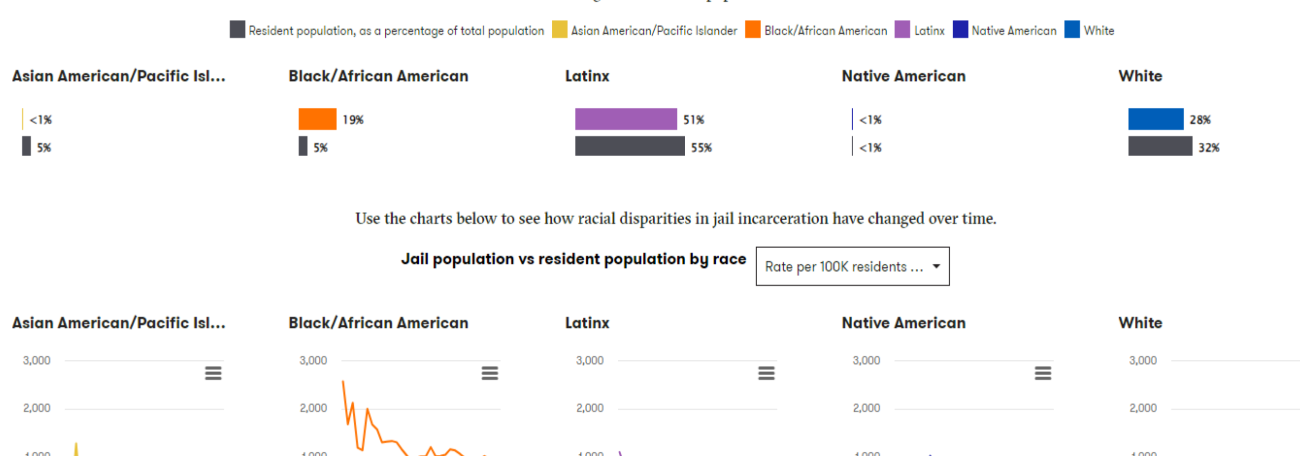
Comparing Jail and Prison Incarceration

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



Racial Disparities in Incarceration

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



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

Special word on progress with the homeless population:

Context:

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

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

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

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

  - **Youth**

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

ECM

ECM Demographic Data

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

ECM Population

9000
8000
7000
6000
5000
4000
3000
2000
1000
0

4097
4721
5858
7328
8292

1

Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Quarter 1 2024 | Linear (Quarter 1 2024)

Notes:

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

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

ECM

Ethnicity

In the Enhanced Care Management program we pride ourselves on maintaining the alignment in values shared throughout Kern Family Health Care in serving a diverse population. As denoted in the below graph (Ethnicity table), the largest ethnic group served by our ECM providers is the Hispanic population which constitutes 59.2% of the total ECM population (as of Q1 2024), while a smaller population identify as other ethnic groups such as African American, Caucasian, Alaskan/American Indian, etc. We proudly boast a robust bilingual staff serving our membership throughout all 32 of our locations and continue to look at ways to be more equitable to all our ethnic groups in ECM.

Total

815
36
29
17
3
2109
3
43
3
4914
2
4
1
610
2
60
1

AFRICAN AMERICAN
ALASKAN/AMER INDIAN
ASIAN INDIAN
ASIAN/PACIFIC
CAMBODIAN
CAUCASIAN
CHINESE
FILIPINO
HAWAIIAN
HISPANIC
JAPANESE
KOREAN
LAOTIAN
NO VALID DATA
SAMOAN
UNKNOWN
VIETNAMESE
(blank)

ECM cost saving measure:

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

In accordance to the most recent DHCS IPP Provider milestone requirements our institutional goals moving forward is to use our this quarterly data as a benchmark to incrementally decrease our overall percentage of utilization. As per the IPP requirements, plans must show a net decrease in the rate of emergency department (ED) visits per 1,000 member months for members ages 21 and older and who are eligible for ECM. MUST have positive improvement in periods 4 and 5. We leverage our monthly site meetings and auditing periods to present emergency room utilization trends and totals to the providers and continue to work synergistically to find innovative ways to engage these members in the post discharge event and strategize on ways to prevent the over-utilization of emergency department services.

IPP measures:

4.4.3
Quantitative Response Only
Percentage of members who had ambulatory visits within 7 days post hospital discharge

4.4.4
Quantitative Response Only

Rate of emergency department (ED) visits per 1,000 member months for members ages 21 and older and who are eligible for ECM

- Quarter 1 & 2 (P4P) – 168 out of 1000 or 16.8%

- Quarter 3 % 4 (preliminary) – 138 of 1000 or 13.8%

4.4.5
Quantitative Response Only
Percentage of emergency department (ED) visits with a discharge diagnosis of mental illness or intentional self-harm for members ages 21 and older and who are eligible for ECM who had a follow-up visit with any practitioner within 30 days of the ED visit (31 total days)

4.4.6
Quantitative Response Only
Percentage of emergency department (ED) visits with a discharge diagnosis of alcohol or other drug (AOD) use or dependence for members ages 21 and older and who are eligible for ECM who had a follow-up visit with any practitioner within 30 days of the ED visit (31 total days)

4.4.7
Quantitative Response Only
Percentage of members ages 21 and older and who are eligible for ECM who had an ambulatory or preventive care visit

4.4.8
Quantitative Response Only
The percentage of members 3-20 years of age and who are eligible for ECM who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner

ECM

4.4.9
Quantitative Response Only
Percentage of hospital discharges for members ages 21 and older and who are eligible for ECM who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days after discharge

ECM

Quarter I 2024 Total ED Utilization by site:

Site	Closed	Open	Referral
ECM Adventist Health	24	49	185
ECM AKIDO		138	
ECM BAIHP		2	
ECM Comprehensive Delano	4	67	82
ECM CSV Brundage	37	144	610
ECM CSV Delano		33	33
ECM CSV Greenfield	62	167	606
ECM Dignity	86	265	726
ECM Dr Bichai	3	63	64
ECM EA Family Services		9	
ECM KM	9	314	56
ECM KM Grow	3	403	58
ECM OMNI Mall View	10	113	187
ECM Omni Oildale	37	194	342
ECM Omni Shafter	12	40	100
ECM OMNI Stine Road	5	57	230
ECM Premier	57	494	627
ECM Premier Arvin	1	31	74
ECM Premier Columbus	24	619	122
ECM Premier Mcfarland		58	37
ECM Premier Stockdale	37	118	98
ECM Riverwalk	48	4	
ECM Universal Health	9	114	567
ECM Universal MSO		3	8
ECM Vanguard Medical	4	92	258
ECM Westside Taft	9	25	21

Total population by site

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

ECM

ECM clinical measure:

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

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

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

ECM

2023

Quarter 1 progress:

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

Quarter 2 Progress:

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

Quarter 3 Progress:

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

Quarter 4 Progress:

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

2024

Quarter 1 progress:

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

ECM

Site by Site MCAS

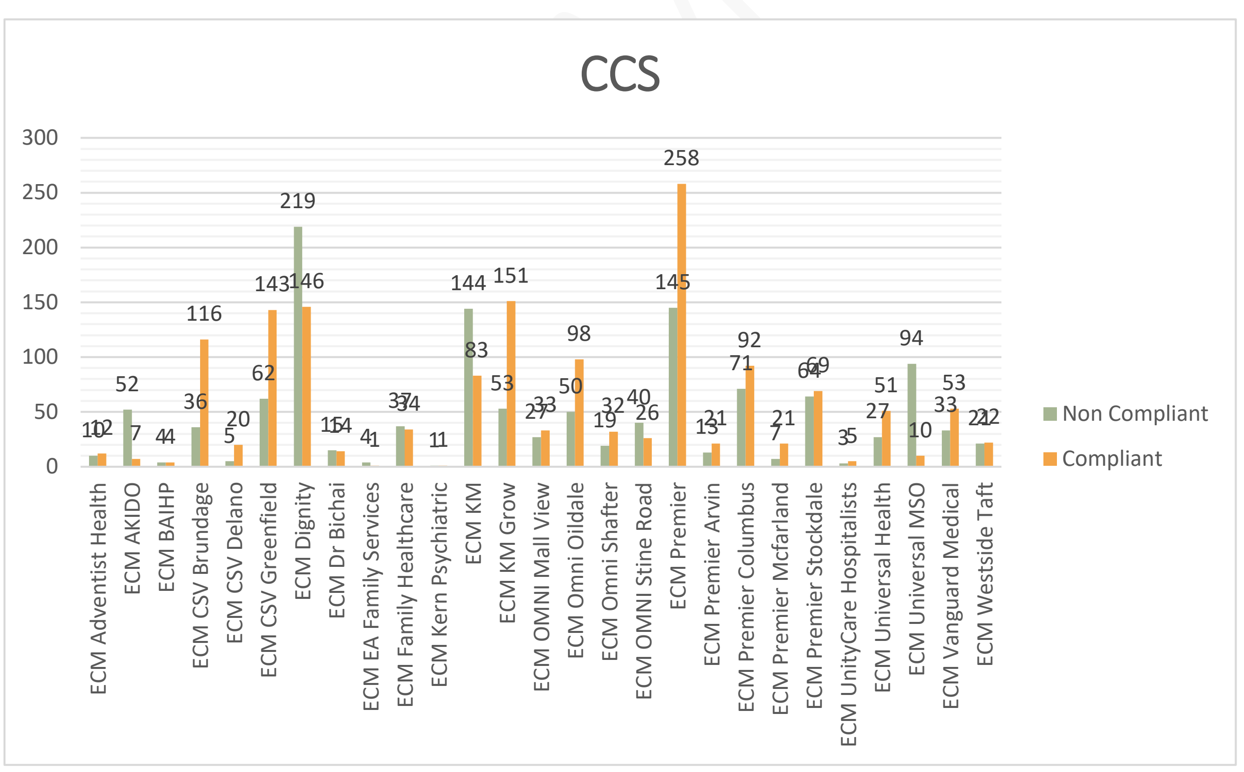
Cervical Cancer Screening

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

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

OR

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



Breast Cancer Screening

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

BCS

	Non Compliant	Compliant
ECM Adventist Health	8	3
ECM AKIDO	14	
ECM BAIHP	2	6
ECM CSV Brundage	18	31
ECM CSV Delano	2	5
ECM CSV Greenfield	23	68
ECM Dignity	84	109
ECM Dr Bichai	13	6
ECM EA Family Services	3	1
ECM Family Healthcare	17	23
ECM KM	50	30
ECM KM Grow	34	110
ECM OMNI Mall View	11	10
ECM Omni Oildale	38	58
ECM Omni Shafter	10	21
ECM OMNI Stine Road	9	10
ECM Premier	73	113
ECM Premier Arvin	3	5
ECM Premier Columbus	24	33
ECM Premier Mcfarland	6	6
ECM Premier Stockdale	26	18
ECM UnityCare Hospitalists	1	2
ECM Universal Health	9	15
ECM Universal MSO	49	6
ECM Vanguard Medical	10	14
ECM Westside Taft	12	18

Comprehensive Diabetes Care

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

HBD

Provider	Non Compliant	Compliant
ECM Adventist Health	3	10
ECM AKIDO		14
ECM BAIHP		2
ECM CSV Brundage	18	48
ECM CSV Delano	5	12
ECM CSV Greenfield	24	108
ECM Dignity	52	170
ECM Dr Bichai	2	36
ECM EA Family Services		1
ECM Family Healthcare	3	37
ECM KM		78
ECM KM Grow	79	125
ECM OMNI Mall View	8	19
ECM Omni Oildale	21	79
ECM Omni Shafter	9	38
ECM OMNI Stine Road	5	16
ECM Premier	61	228
ECM Premier Arvin		16
ECM Premier Columbus	11	76
ECM Premier Mcfarland	1	14
ECM Premier Stockdale	5	49
ECM UnityCare Hospitalists		6
ECM Universal Health	4	30
ECM Universal MSO	6	37
ECM Vanguard Medical	6	30
ECM Westside Taft	9	9

Patient Satisfaction:

Survey Data

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

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

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

Sample design.

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

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

Note:

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

ECM

2023 Survey Response Rate:

- **Sample size and response rate.**

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

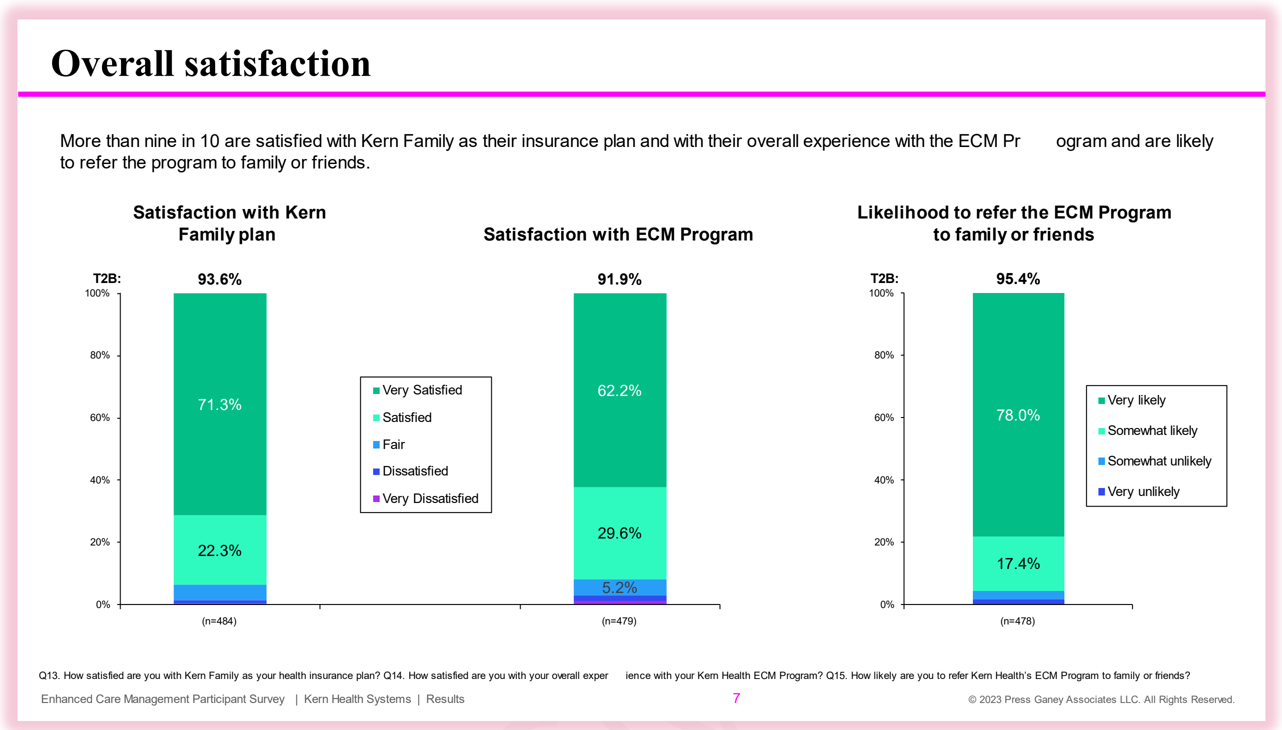
ECM

2024 Survey Response Rate:

- **Sample size and response rate.**

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

2023 Results:



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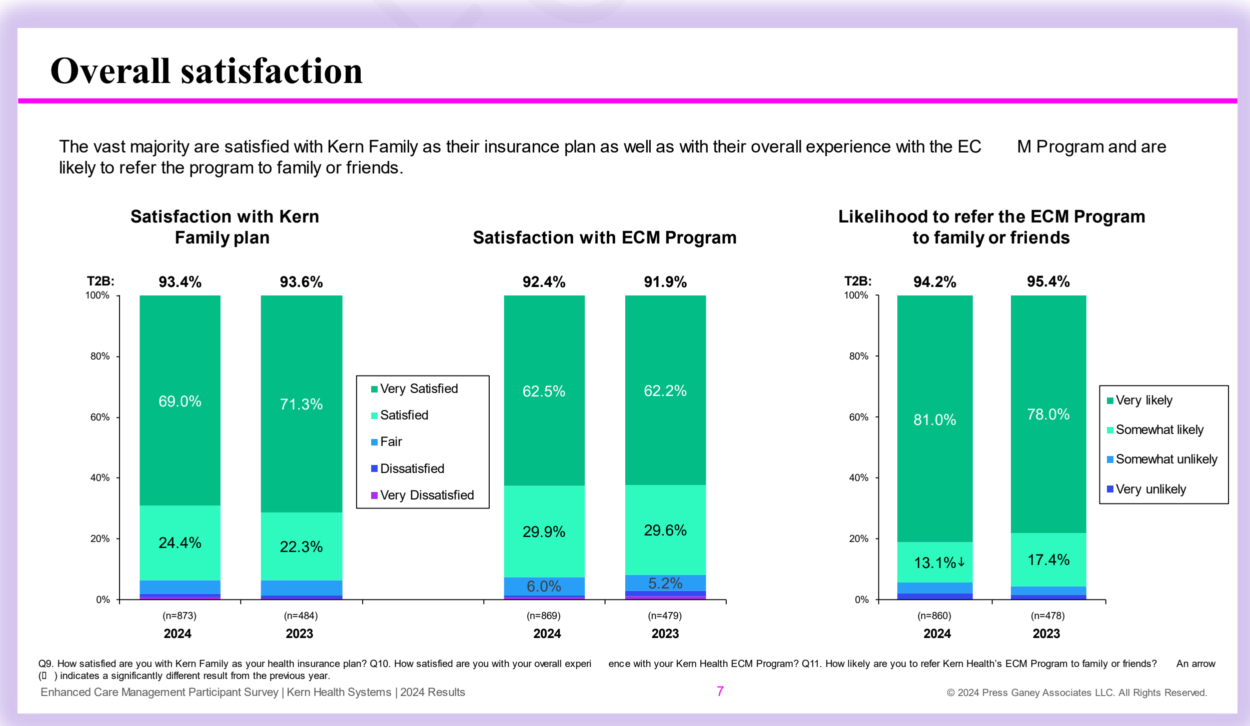

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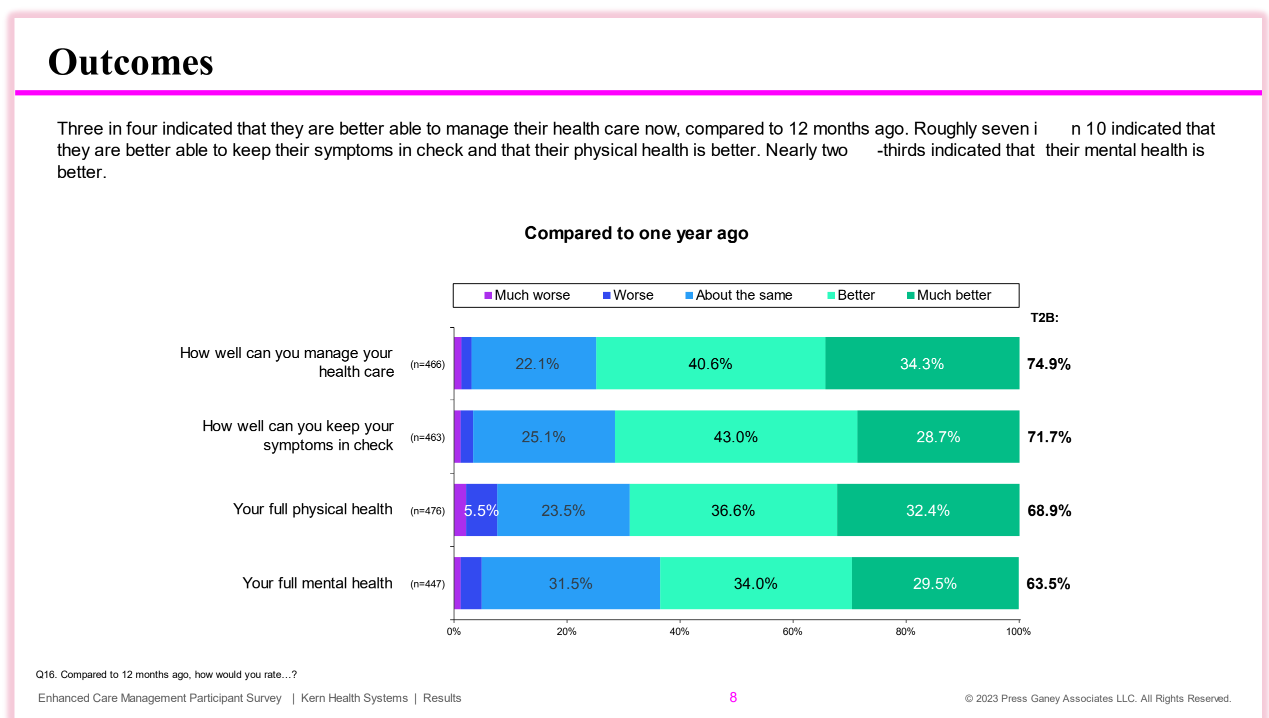

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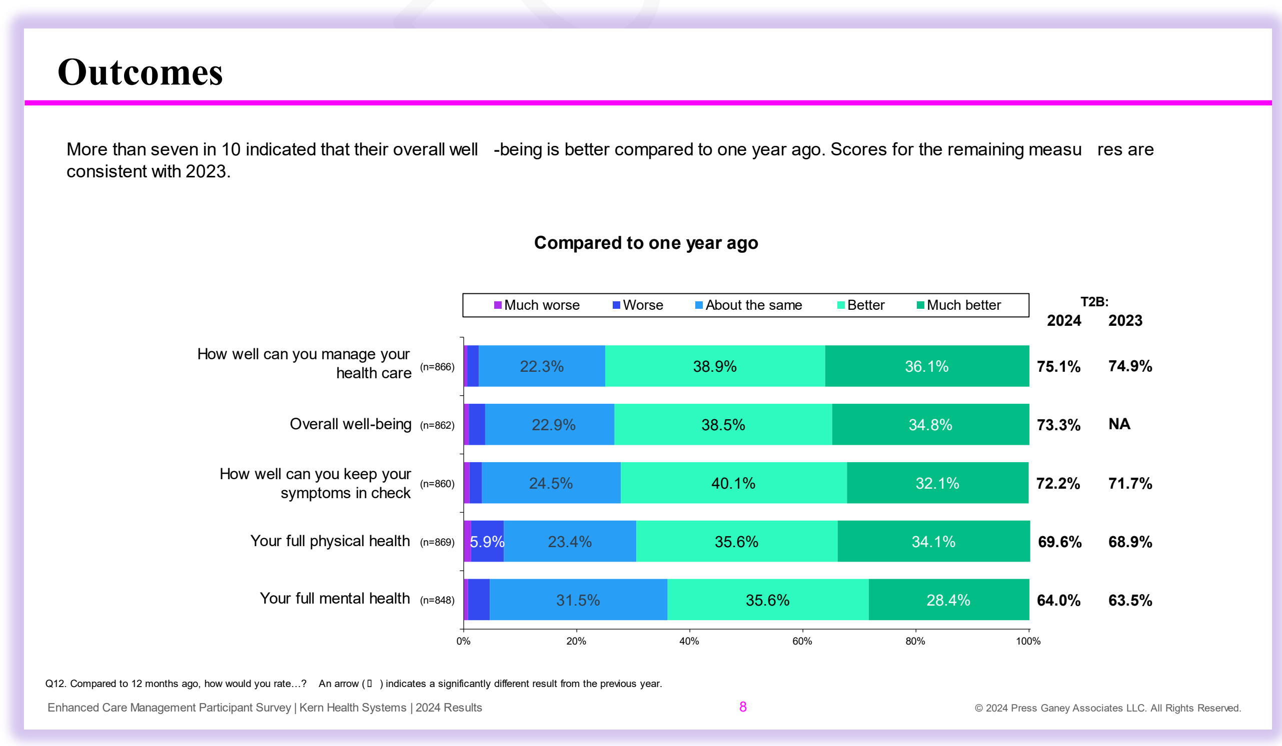

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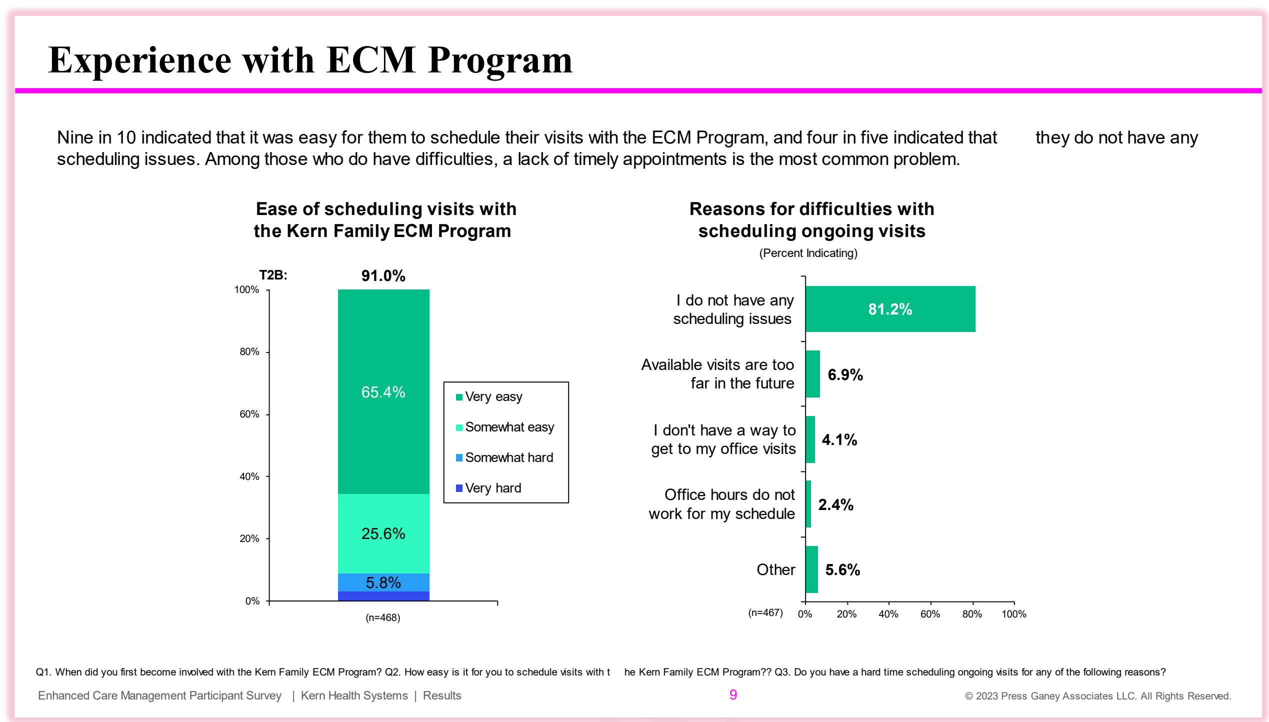

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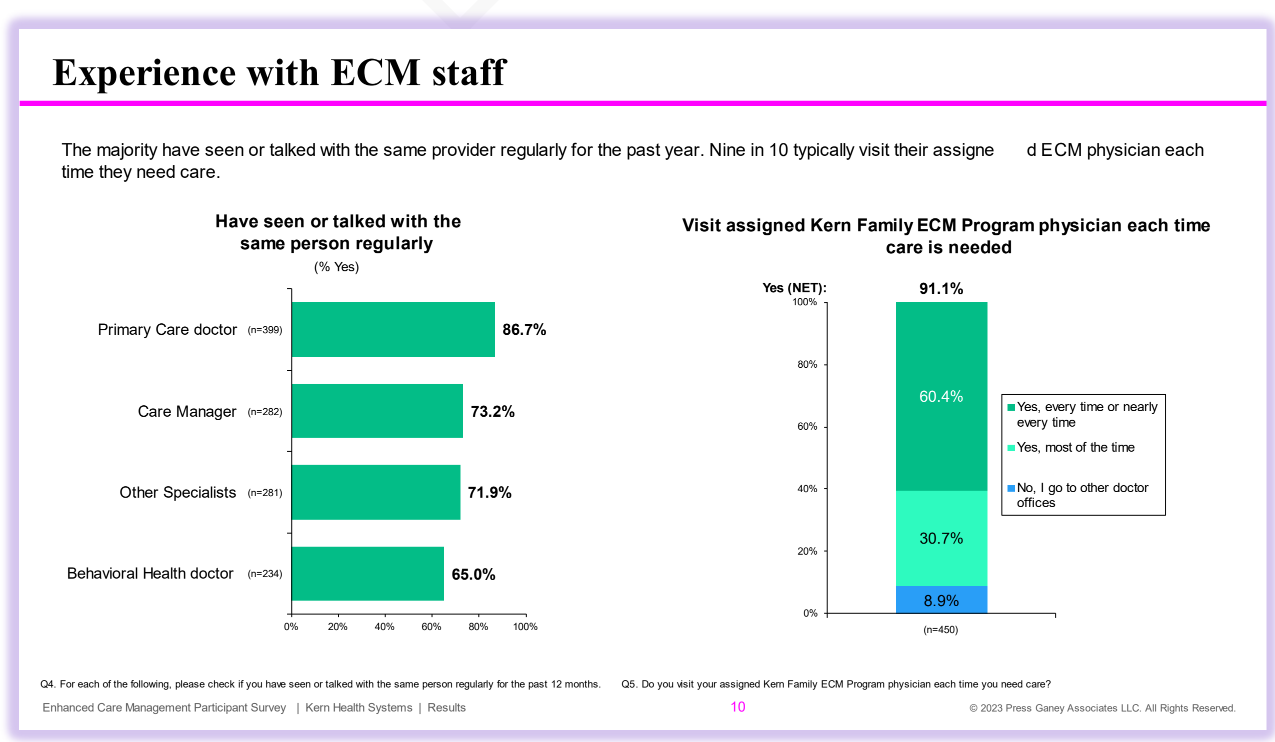

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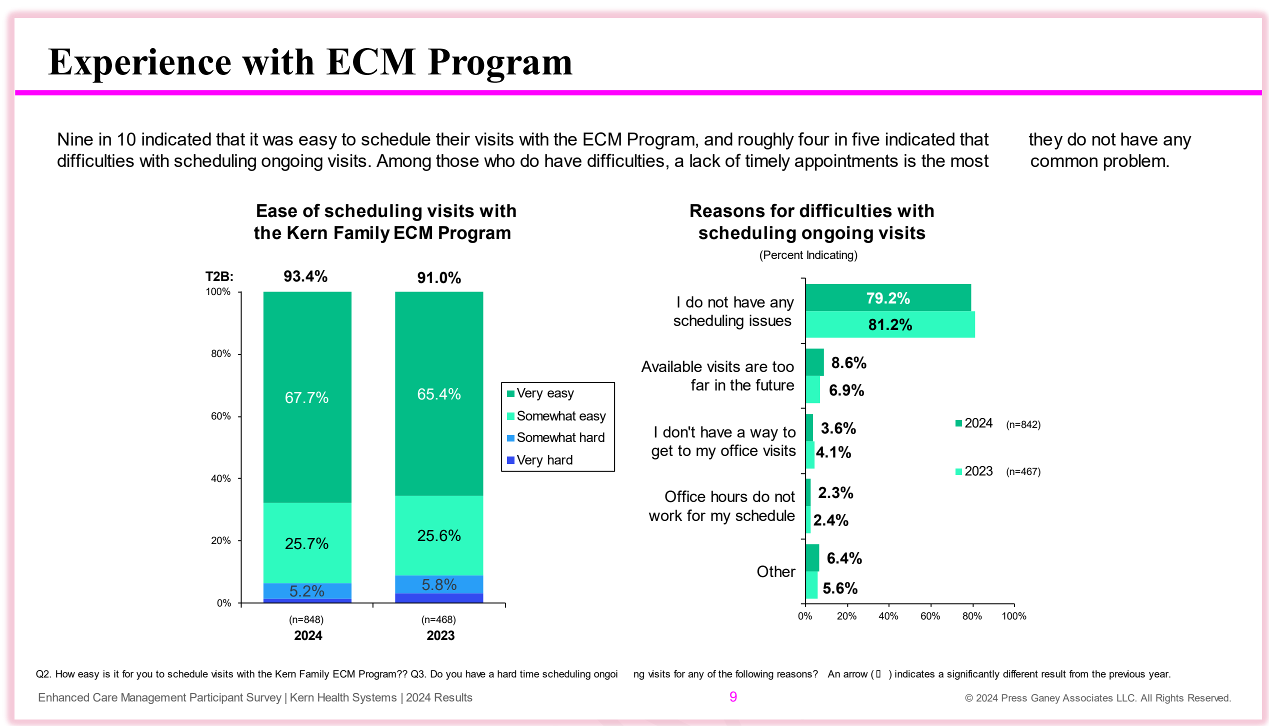

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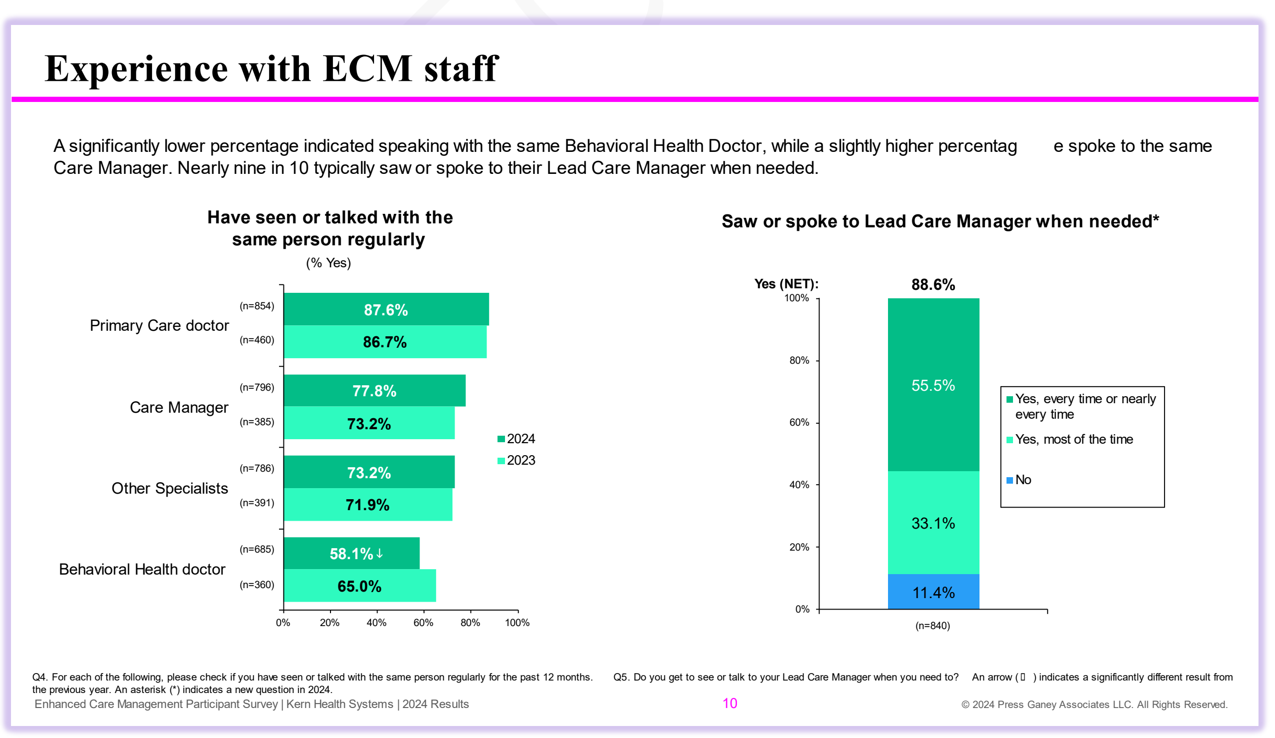

To: KHS EQIHEC

From: John Miller, M.D.

Date: May 23, 2024

Re: Quality Improvement Committee (QIC)

Background

The inaugural meeting of the KHS Quality Improvement Committee (QIC) took place on March 29, 2024. This committee is part of the new reporting structure that flows up to the Executive Quality Improvement Health Equity Committee. Committee members include representatives from the community. The goal of the committee is to monitor the KHS QI workplan throughout the year and provide input on the direction and future of the Quality Program and workplans.

Discussion

During this session quorum was met and the committee reviewed the QIC Charter, the current QI Program Description and the Workplan. The role of the committee members was discussed including:

- Review and approve Quality Program, Plan, and Related P&Ps.
- Monitor KHS Quality Plan throughout the year.
- Review and provide feedback on new APL's.
- Provide feedback on trends, priorities, community health, equity, and disparities.
- Identify and address gaps in care.
- Provide recommendations for improvement opportunities.
- Serve as the voice of your organization and the community.

The progress to NCQA accreditation during this cycle will also be monitored and into the re-accreditation cycle years.

Fiscal Impact

None.

Requested Action

Approval of committee proceedings.

COMMITTEE: ***QUALITY IMPROVEMENT COMMITTEE***
DATE OF MEETING: ***MARCH 29, 2024***
CALL TO ORDER: ***12:03 PM BY MARTHA TASINGA, MD, CHIEF MEDICAL OFFICER - CHAIR***

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

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

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

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

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

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

The foregoing minutes were APPROVED AS PRESENTED on: __________________________ __________________________________

Date | Name

The foregoing minutes were APPROVED WITH MODIFICATION on: __________________________ __________________________________

Date | Name

QUALITY IMPROVEMENT COMMITTEE (QIC) MEETING

Friday, March 29, 2024
at
12:00 pm

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

For more information, call (661) 664-5000

Quality Improvement Committee (QIC)
AGENDA – MARCH 29, 2024

AGENDA ITEM	AGENDA TOPIC	PRESENTER	TIME	ACTION
CALL TO ORDER	Call meeting order / Attendance-Quorum	***Dr. Miller MD, KHS Medical Director, Chair***	*2 min*	*N/A*
APPROVAL OF MINUTES	None	***All Voting Members***	*0 min*	*Approve*
OLD BUSINESS	1. None		*N/A*	*Pending*
NEW BUSINESS	1. Welcome & Agenda 2. Introductions 3. Charter 4. QI Program and Plan 5. NCQA Accreditation 6. Your Role	John Miller, MD All John Miller, MD Magdee Hugais, QI Dir Steven Kinnison, NCQA Mgr John Miller, MD	*3 min* *5 min* *10 min* *20 min* *5 min* *5 min*	*Discussion*
OPEN FORUM	Open Forum / Committee Members Announcements / Discussion	***Open to all Members***	*10 min*	*Discussion*
NEXT MEETING	Next meeting will be held Thursday, **June 27, 2024 at 12:00 pm**	Informational only		*N/A*
ADJOURNMENT	Meeting Adjournment	***Dr. Miller MD, KHS Medical Director, Chair***		*N/A*

KHS PROPRIETARY PROPERTY – NOT FOR PUBLIC DISCLOSURE

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

KHS Quality Improvement Committee (QIC)

Agenda

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

Introductions

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

Everyone Cares About Quality

Congress/ FDA

United States Department of Health and Human Services

National Trade Organizations

State Legislature/ DMHC/HHS

Centers for Medicare & Medicaid Services (CMS)

Health Resources Services Administration (HRSA)

Indian Health Service (IHS)

State Advocates and Trade Organizations

County Government and Public Health

State Medicaid Agencies (DHCS)

D-SNP and other Medicare Advantage Plans

NACHC/CPCA

NIHB/CRIHB/CCUIH

Community Based Organizations

Medicaid Managed Care

SNF/ Long-Term Care

Acute Care Hospitals

Public/ District Hospital

Private Practice Docs

IPA

Medical Groups

Rural Health Centers

FQHCs

Tribal Health Centers

Lab

Pharmacy

← Patients

Credit: Rudie Strummer/Shutterstock

16

Survey

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

- Link to Survey

QIC Charter

Quality Improvement Committee (QIC)

Charter

The QIC is a subcommittee of the EQIHEC. The committee will be chaired by the Chief Medical Officer or designee. The Committee is responsible for ensuring the development, implementation, and monitoring of the KHS QI Program.

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

Activities:

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

QIC Charter

Composition

The QIC is a collaborative group that engages business units from multiple KHS departments and across the organization that are involved in the development, execution and monitoring and evaluation of the QI Program.

- 2 participating contracted providers
- 2 representatives from Federally Qualified Health Centers (FQHCs)
- 1 representative from a pharmacy
- 1 representative from Kern Medical.

Other KHS attendees:

- Quality Medical Director
- Director of Quality Improvement
- Senior Director of Contracting and Quality Performance
- Director of Quality Performance
- Director of Behavioral Health
- Director of Enhanced Care Management
- Director of Utilization Management
- NCQA Manager
- Director of Wellness and Prevention
- Director of Pharmacy
- Director of PHM
- Chief Health Equity Officer or Representative
- Senior Director of Member Engagement or Representative
- Director of Member Services

Meetings

The QIC meets four times annually with additional meetings as necessary.

QI Program & Plan

- QI Program
  - Reporting structure and Responsibilities
  - Personnel
  - Key Functional Areas
  - QI Work Plan & Activities
  - QI Process
  - QI Strategies
  - Evaluation of KHS Program
  - KHS Providers
  - Confidentiality, Information Security, FWA, External Audits, Delegation

QI Program & Plan

- Reporting Structure

KHS Board of Directors

Executive Quality Improvement Health Equity

- Utilization Management
- Physician Advisory
- Population Health Management
- Grievance & Appeals Review
- Health Equity Steering Transformation
- Behavioral Health Advisory
- Drug Utilization Review
- Access & Availability & Delegation Vendor Oversight
- Quality Improvement

QI Program & Plan

- Personnel

CEO
- CMO
  - Health Services Departments
  - QI Medical Director
    - QI Director
      - QI Staff
- COO
  - Director of Contracting and QP
    - QP Director
      - QP Staff
  - Support Departments

QI Program & Plan

Key Functional Areas

Member Grievances and Appeals	Behavioral Health	Health Education	Member Services	Pharmacy Safety Monitoring	Provider Network	Utilization Management	Business Intelligence	Management & Information System

QI Program & Plan

- QI Plan

1. Quality Program Structure
    - Program Description, Annual Work Plan, Evaluation, P&Ps

2. Quality of Clinical Care
    - MCAS, PIPs, PQIs, Continuity and Coordination of Care

3. Safety of Clinical Care
    - Site Reviews, Record Reviews, Drug Utilization, Credentialing/Recredentialing

QI Program & Plan

- QI Plan

4. Quality of Service
    - Grievances & Appeals, Access to Care

5. Members' Experience
    - CAHPS, Member Engagement/Rewards

6. Provider Engagement
    - Provider Satisfaction, Provider Incentives, Education

QI Program & Plan

- QI Improvement Process & Strategies
  - Prioritization of identified issues
  - Corrective Action Plans (CAP)
  - Quality Indicators
  - Data Accuracy, completeness, & timeliness
  - Training & resources
  - Collaboration & communication
  - Integration of outcomes with KHS operational P&Ps

QI Program & Plan

- Annual Evaluation of the KHS QI Program
  - Evaluate effectiveness of Program and Plan
  - Update as needed
  - Multi-disciplinary input
  - Will be brought to QIC for input, recommendations, and initial approval
  - Presented to EQIHEC and Board of Directors

QI Program & Plan

- KHS Providers
  - Provider Network
  - Provider Information - newsletters
  - Provider Cooperation
  - Provider and Hospital Contracts

QI Program & Plan

- Confidentiality, Information Security, External Audits
  - All members, participating staff and guests of the EQIHEC Committee and subcommittees are required to sign the Committee Attendance Record, including a statement regarding confidentiality and conflict of interest.
  - Information Security and FWA
    - QI evaluates and refers concerns to KHS Compliance, provides clinical review if necessary, and participates in the FWA committee.
  - QI is responsible for monitoring and oversight of the QI Program.
  - QI aid compliance in medical reviews and audits by regulatory agencies. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI Program.

QI Program & Plan

- Delegation

KHS delegates quality improvement activities as follows:

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

MCAS Overview

Managed Care Accountability Set (MCAS) is a set of performance measures that DHCS selects for annual reporting by Medi-Cal managed care plans (MCPs).

Measures are from different stewards such as NCQA HEDIS measures, CMS, and DQA.

Each measure is represented with an Acronym and have a corresponding definition (AMR = Asthma Medication Ratio).

Measures utilize different methodology for data collection, such as administrative, hybrid or EDCS.

The MCP has many measures it must report on, but only selected measures are held to Minimum Performance Level (MPL).

Measurement year (MY) reflects services/events that occurred during the measurement year. Reporting Year (RY) reflects the prior calendar or measurement years' data.

MY2024 MCAS Measures

Behavioral Health Domain

- **FUM** - Follow-Up After ED Visit for Mental Illness – 30 days
- **FUA** - Follow-Up After ED Visit for Substance Abuse – 30 days

Children's Health Domain

- **WCV** - Child and Adolescent Well – Care Visits
- **CIS-10** - Childhood Immunization Status – Combination 10
- **DEV** - Developmental Screening in the First Three Years of Life
- **IMA-2** - Immunizations for Adolescents – Combination 2
- **LSC** - Lead Screening in Children
- **TFL-CH** - Topical Fluoride for Children
- **W30-6+** - Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well – Child Visits
- **W30-2+** - Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits

Chronic Disease Management Domain Measures

- **AMR -** Asthma Medication Ratio
- **CBP** - Controlling High Blood Pressure
- **GSD (previously HBD)**- Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9%)

Reproductive Health Domain Measures

- **CHL** - Chlamydia Screening in Women
- **PPC-Pre** - Prenatal and Postpartum Care: Timeliness of Prenatal Care
- **PPC-Pst** - Prenatal and Postpartum Care: Postpartum Care

Cancer Prevention Domain Measures

- **BCS-E** - Breast Cancer Screening
- **CCS** - Cervical Cancer Screening

2024 Goals and Initiatives

Member Outreach Team

- Continue member outreach efforts from 2023

Mobile Units

- KHS has secured commitment from three (3) provider partners to utilize Mobile Units in rural areas & focused on Street Medicine
- Approval from Homeless centers for medical mobile unit on-site services

Quality Grant Programs

- Develop innovative partnerships with network providers to elevate the quality of care delivered to our members.

Data Exchange & EMR Access

- Increase EMR, Rx, and Lab data exchange from providers
- Increase provider EMR access
- Use Admission, Discharge, and Transfer (ADT) data
- Leverage CSV appointment data

Pediatric Focus

- Increase focus around the various pediatric measures in the Children’s domain.
- Increase accessibility to services on school campuses

Address Verification

- Utilize GIS to target specific populations and and help locate based on zip codes.
- Increase member mailings

Direct Appointment Access

- Partnering with providers to access their appointment scheduler and book appointments directly for members

National Committee of Quality Assurance (NCQA):

Health Plan Accreditation (HPA)
&
Health Equity Accreditation (HEA)

Description

- DHCS requires that all Medi-Cal Managed Care Plans (MCPs) achieve the NCQA Health Plan Accreditation and Health Equity Accreditation by January 1, 2026.

- National Committee of Quality Assurance (NCQA)
  - Points the way to health **care that science says works**.
  - Studies how well health plans and doctors provide scientifically recommended care.
  - Identifies organizations that are run in ways that **make care better**. (ncqa.org)

Accreditations

- Health Plan Accreditation (HPA) – Survey Date: 4/8/2025
  - Credentialing and Recredentialing (CR)
  - Quality Management and Improvement (QI)
  - Member Experience (ME)
  - Network Management (NET)
  - Population Health Management (PHM)
  - Utilization Management (UM)
- Health Equity Accreditation (HEA) – Survey Date: 6/10/2025
  - Internal culture to support external health equity work, address cultural and linguistic needs, and reduce health inequities for improved care (ncqa.org).

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

KERN HEALTH SYSTEMS

Your Role

- Review and approve Quality Program, Plan and related P&Ps
- Monitor KHS Quality Plan throughout the year
- Review and provide feedback on new APLs
- Provide feedback on trends, priorities, community health, equity and disparities
- Identify and address gaps in care
- Provide recommendations for Improvement opportunities
- Serve as the voice of your organization and the community

Open Discussion

- Thoughts?
- Feedback?
- Questions?

You + Us = a better day!

KERN HEALTH SYSTEMS

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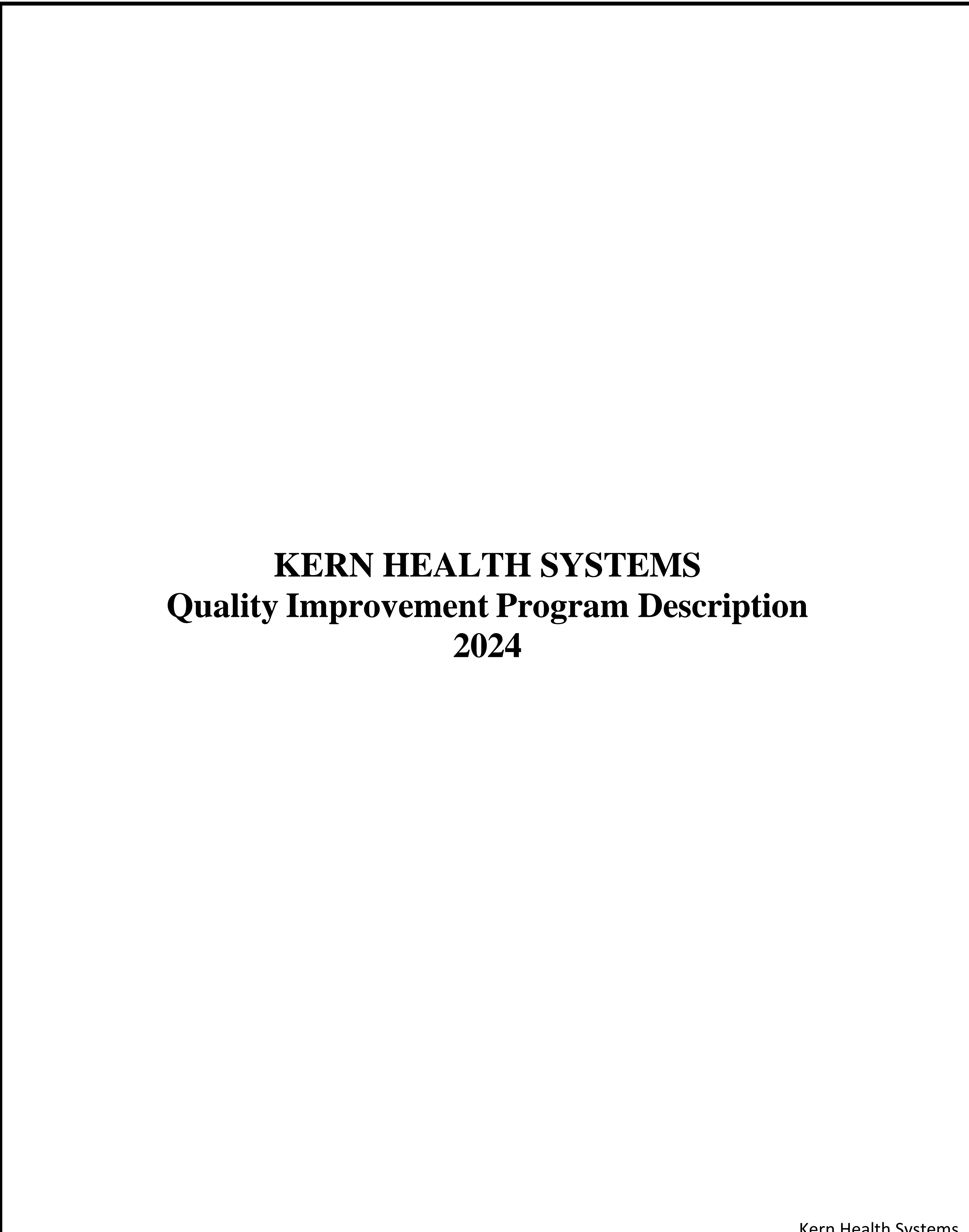

KERN HEALTH SYSTEMS
Quality Improvement Program Description
2024

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Mission, Purpose, Goals and Objectives

I. Mission

In a commitment to the community of Kern County and the members of Kern Health Systems (KHS), the Quality Improvement (QI) Program is designed to objectively monitor, systematically evaluate, and effectively improve the health and care of those being served. The KHS Quality Improvement Department manages the Program and oversees activities undertaken by KHS to achieve improved health of the covered population. All contracting providers of KHS participate in the Quality Improvement (QI) program.

II. Purpose

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

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

The KHS Quality Improvement Program is composed of several systematic processes that monitor and evaluate the quality of clinical care and health care service delivery to KHS members. This structure is designed to:

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

This is accomplished through the development and maintenance of an interactive health care

system that includes the following elements:

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

III. Goals and Objectives:

KHS has developed and implemented a plan of activities to encompass a progressive health care delivery system working in cooperation with contracting providers, members, community partners and regulatory agencies. An evaluation of program objectives and progress is performed by the QI Department on an annual basis with modifications as directed by the KHS Board of Directors. The results of the evaluation are considered in the subsequent year's program description. Specific objectives of the QI Program include:

1. Improving the health status of members by identifying potential areas for improvement in the health care delivery system.
2. Developing, distributing, and promoting guidelines for care including preventive health care and disease management through education of members and contracting providers.
3. Developing and promoting health care practice guidelines through maintenance of standards of practice, credentialing, and recredentialing. This applies to services rendered by medical, behavioral health and pharmacy providers.
4. Establishing and promoting open communication between KHS and contracting providers in matters of quality improvement. This includes maintaining communication avenues between KHS, members, and contracting providers to seek solutions to problems that will lead to improved health care delivery systems.
5. Monitoring and oversight of delegated activities.
6. Performing tracking and trending on a wide variety of information including:
   - Over and underutilization data
   - Grievances
   - Potential and actual quality of care issues
   - Accessibility of health care services
   - Compliance with Managed Care Accountability Set (MCAS) preventive health and chronic condition management services
   - Pharmacy services
   - Primary Care Provider facility site and medical record reviews to identify patterns that may indicate the need for quality improvement and that ensure compliance with

State and Federal requirements

7. Promoting awareness and commitment in the health care community toward quality improvement in health care, safety, and service.
8. Continuously identifying opportunities for improvement in care processes, organizations or structures that can improve safety and delivery of health care to members.
9. Providing appropriate evaluation of professional services and medical decision making and to identify opportunities for professional performance improvement.
10. Reviewing concerns regarding quality-of-care issues for members that are identified from grievances, the Public Policy/Community Advisory Committee (PP/CAC), or any other internal, provider, or other community resource.
11. Identifying and meeting external federal and state regulatory requirements for licensure.
12. Continuously monitoring internal processes to improve and enhance services to members and contracting providers.
13. Performing an annual assessment and evaluation of the effectiveness of the QI Program and its activities to determine
    a. How well resources have been deployed in the previous year to improve the quality and safety of clinical care
    b. The quality of service provided to members
    c. Modifications needed to the QI Program
    d. Results of the annual evaluation are presented to the EQIHEC and Board of Directors

Kern Health Care System - Overview

I. Background

Kern Health Systems (KHS), d.b.a. Kern Family Health Care (KFHC), is the Local Initiative managing the medical and mild to moderate behavioral health care for Medi-Cal enrollees in Kern County. Specialty mental health care and substance use disorder benefits are carved out from the KHS Medi-Cal plan and covered by Kern County Behavioral Health and Recovery Services pursuant to a contract between the County and the State. The Kern County Board of Supervisors established KHS in 1993. The Board of Supervisors appoints a Board of Directors, who serve as the governing body for KHS.

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

KHS total membership in 2024 is over 405,000 members with 59% assigned to the County Hospital system and two large Federally Qualified Health Centers (FQHC).

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

Characteristics of the KHS population include:

- 46% are male and 54% are female.
- 70% of the population have English as their primary language and 29% use Spanish. The remaining 1% is a mix of other languages.
- As of 2021, Kern County ranked 51st out of 58 for residents with a high school diploma or higher and 47th out of 58 with a Bachelor's degree or higher.
- A majority of members reside in Bakersfield. However, the remaining 33.1% are in more rural areas.

Area	Rural Portions per HRSA	KHS Population	Percentage
Bakersfield	No	264,377	65.27%
Delano & North Kern	Yes	34,141	8.43%
Arvin/Lamont	Yes	26,008	6.42%
Shafter/Wasco	Yes	24,597	6.10%
California City & Southeast Kern	Yes	14,187	3.50%
Taft & Southwest Kern	Yes	10,528	2.60%
Tehachapi	Yes	6,967	1.72%
Ridgecrest & Northeast Kern	Yes	9,879	2.44%
Lake Isabella & Kern River Valley	Yes	5,385	1.33%
Lost Hills & Northwest Kern	Yes	2,771	0.68%
Frazier Park & South Kern	Yes	1,941	0.48%
Outside Service Area	N/A	4,274	1.06%

- The following is a breakdown by race and ethnicity of the KHS population:

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

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

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

Additional facts about Kern County's Health Behaviors as presented by County Health Rankings &

Roadmaps include higher rates of adult smoking, adult obesity, physical inactivity, alcohol-impaired driving deaths, sexually transmitted infections, and teen births compared to state-wide statistics. Kern County ranked better than California state averages for the food environment index (combination of % of low income and low access to a grocery store), and excessive drinking.

II. Scope:

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

In 2023, KHS developed a Health Equity Program that will integrate and coordinate with the QI Program. The Health Equity Program includes assessment of needs based on race/ethnicity, language, cultural preferences, health disparities and stakeholder engagement. Understanding health disparities is critical to identify the differences in treatment provided to members of different racial/ethnic or cultural groups that are not justified by the underlying health conditions or treatment preferences of patients. KHS will implement multiple programs to monitor, assess and improve healthcare services to reduce health disparities within its membership.

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

The scope of the QI Program includes the following elements:

1. The QI Program is designed to monitor, oversee, and implement improvements that influence the delivery, outcome, and safety of the health care of members, whether direct or indirect.
   a. KHS will not unlawfully discriminate against members based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
   b. KHS will arrange covered services in a culturally and linguistically appropriate manner. The QI Program reflects the population served and applies equally to covered medical and behavioral health services.

2. The QI Program monitors the quality and safety of covered health care administered to members through contracting providers. This includes all contracting physicians, hospitals, vision care providers, behavioral health care practitioners, pharmacists and other applicable personnel providing health care to members in inpatient, ambulatory, and home care settings. New this year is the addition of street medicine providers. Street medicine provider refers to a licensed medical provider who conducts patient visits outside of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be living.

3. The QI Program assessment activities encompass all diagnostic and therapeutic activities, and outcomes affecting members, including primary care and specialty practitioners, vision providers, behavioral health care providers, pharmaceutical services, preventive services, prenatal care, and family planning services in all applicable care settings, including emergency, inpatient, outpatient, and home health.

4. The QI Program evaluates quality of service, including the availability of practitioners, accessibility of services, coordination, and continuity of care. Member input is obtained through member participation on the Public Policy/Community Advisory Committee (PP/CAC), grievances, and member satisfaction surveys.

5. The QI Program activities are integrated internally across appropriate KHS departments. This occurs through multi-departmental representation on the EQIHEC Committee.

6. Mental health care is covered jointly by KHS and Kern County Department of Health. It is arranged and covered, in part, by Kern County Behavioral Health and Recovery Services (KBHRS) pursuant to a contract between the County and the State.

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

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

As part of KHS' commitment to ensure the rights of our members to quality health care, the following six (6) Rights to Quality Health Care have been adopted:

1. Right to Needed Care
    - Accurately diagnosed and treated.
    - Care is coordinated across all the doctors and specialists.

2. Right to Equitable Care
    - All people, regardless of their gender, race, ethnicity, geographical location, or socioeconomic status receive the good quality health care they need.
    - Developing culturally competent care; for example, by expanding medical

translation services, after-hours appointments, mobile health clinics or telehealth, etc.

3. Right to Place of Care
    - Did the patient go to the right place for care?
    - Is the patient going to the ER or Urgent Care for primary care?
    - Is the patient transitioned to the right place for care?

4. Right to Timely Care
    - Timely access to care.
    - How long did the patient have to wait to get health care appointments and telephone advice?
    - Is the patient up-to-date with their preventative care?

5. Right to Be Part of Your Care
    - Patients and their families are part of the care team and play a role in decisions.
    - Information is shared fully and in a timely manner so that patients and their family members can make informed decisions.

6. Right to Safe Care
    - Conduct continuous quality assurance and improvement.
    - Customer and provider satisfaction surveys or interviews.
    - Chart audits.
    - Site reviews.
    - Administration of medications.

Executive QI Health Equity Committee Structure and Responsibilities

I. Board of Directors (BOD)

The Kern Health System (KHS) Board of Directors (Board) has final authority and accountability for the KHS Quality Improvement Health Equity Program (QIHEP). The Board has delegated the responsibility for development and implementation of the QIHEP to the Executive Quality Improvement Health Equity

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

II. Executive Quality Improvement Health Equity Committee (EQIHEC)

The EQIHEC provides overall direction for the continuous improvement process and monitors

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

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

The QIHEC members consist of:

Community Attendees:

- Two (2) Participating Primary Care Physicians
- Two (2) Participating Specialty Physicians
- One (1) Federally Qualified Health Center (FQHC) Provider
- Two (2) CAC members
- One (1) Member of Board of Directors consumer
- One (1) Community consumer
- One (1) Pharmacy Provider
- One (1) Kern County Public Health Officer or Representative
- One (1) Home Health/Hospice Provider
- One (1) DME Provider
- One (1) Behavioral Health Provider

Internal KHS Attendees:

Chief Medical Officer
Health Equity Officer
Chief Operating Officer
Quality Improvement Medical Director
Director Quality Improvement
Director Quality Performance
Director Utilization Management
Director Population Health Management
Director Behavioral Health
Director of Pharmacy
Health Education & C&L
Director Health Equity
Manager
Provider Relations Director

The EQIHEC Committee is required to meet at least four (4) times annually and more frequently as determined. The activities of the EQIHEC and subcommittees providing information to the EQIHEC are formally documented in transcribed minutes, which summarize each agenda item, the discussion, action taken, and required follow-up. Key activities of the EQIHEC are the review and approval of the QIHE Program and Work-Plan, and QIHE quarterly and annual evaluations. The EQIHEC's findings and recommendations are reported quarterly by the CMO to the BOD.

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

Activities:

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

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

III. Quality Improvement Sub-Committees

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

IV. Utilization Management Committee (UMC)

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

Activities:

1. Establish and implement written utilization management protocols and criteria applicable to the review of medical necessity for inpatient, outpatient and ancillary services.
2. Ensure that UM decisions:
    - o Are made independent of financial incentives or obligations.
    - o Medical decisions, including those by delegated providers and rendering providers, are not unduly influenced by fiscal and administrative management.
    - o Physician compensation plans do not include incentives for denial decisions.
    - o Physician and UM decision designees are not rewarded for utilization review decisions.
3. Educate staff, contracted practitioners, and vendors on KHS utilization management policies and procedures to ensure compliance with the goals and objectives of the Utilization Management Program.
4. Review established nationally acceptable utilization benchmarks, medical literature, and outcome data, as applicable.
5. Develop and implement a monitoring system to track, compile and evaluate patterns and variations in care.
6. Continually monitor and evaluate utilization practice patterns of staff and contracted

practitioners and vendors and identify variations in care.

7. Review state regulatory oversight of LTC and CBAS facilities and develop and maintain a process to identify and address quality issues through the credentialing, recredentialing and ongoing monitoring process.
8. Develop and maintain effective relationships with linked and carved-out service providers available to members through County, State, Federal and other community-based programs to ensure optimal care coordination and service delivery.
9. Facilitate and ensure continuity of care for members within and outside of KHS network.
10. Develop and implement performance measures to assure regulatory turn-around-time frames are met.

V. Physician Advisory Committee (PAC)

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

PAC-Credentialing and Peer Review

In accordance with state law, minutes will not be submitted but rather a summary of the meeting. The minutes are confidential information protected under California Evidence Code 1157. The responsibilities of the Credentialing/Peer Review Committee are to develop, monitor, and maintain standards for the education, training, and licensure of the KHS network of Participating Practitioners and Health Delivery Organizations, and establish and maintain credentialing/re-credentialing policies and procedures that are consistent with National Committee for Quality Assurance (NCQA) standards, as well as applicable State and Federal laws and regulations. The Credentialing Committee may not base credentialing decisions on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes.

Activities:

1. Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards.
2. Promote continuous improvement in the quality of the care and service provided by the KHS Providers.
3. Investigate patient, member or practitioner complaints or concerns about the quality of clinical care or service provided and to make recommendations for corrective actions, if appropriate.
4. Provide guidance on the overall direction of the credentialing program.
5. Review at least annually the Credentialing Committee Program Description to assure that the program is comprehensive, effective in meeting the goals and standards of KHS

credentialing/ recredentialing procedures and supports the Continuous Quality Improvement process.

6. Evaluate quality concerns related to medical care and make determinations as to whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards.
7. Monitoring the reporting of Provider Preventable Conditions and make recommendations for corrective actions, if appropriate.

PAC-Medical Technologies and Clinical Criteria Sets

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

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

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

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

Appeals Reviews

The PAC will review aggregate data on member appeals and individual cases as needed. The committee is charged with evaluating and analyzing appeals data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members by recommending necessary changes and process improvements for any adverse trends identified.

VI. Population Health Management Committee (PHMC)

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

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

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

- Care Management
- Case Management
- Utilization Management
- Disease Management
- Social Services
- Quality Management

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

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

- Long Term Care (LTC) and Long Term Services and Supports (LTSS)
- Major Organ Transplants (MOT)
- Transitions of Care (TOC)
- California Children's Services (CCS)
- Enhanced Care Management (ECM)
- Community Support Services (CSS)
- Behavioral Health

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

- Provide wellness services and intervene on the highest-risk members.
- Improve clinical health outcomes.
- Promote efficient and coordinated health care utilization.
- Maintain cost-effectiveness and quality care.
- Improve access to essential medical, mental health, and social services.
- Improve access to affordable care.

- Ensure appropriate utilization of services.
- Improve coordination of care through an identified point of contact.
- Improve continuity of services for members across transitions in healthcare settings, providers, and health services.
- Improve access to preventive health services.
- Improve beneficiary health outcomes.

Activities:

1. Responsibilities of the committee include leading strategic analytics, evaluation design, clinical and economic evaluation, and optimizing programing, ensuring that PHM addresses health at all points on the continuum of care.
2. Ensures that the medical care provided meets the community standards for acceptable medical care.
3. Collaborates with behavioral health practitioners and entities to ensure appropriate utilization of behavioral health services and continuity and coordination of medical and behavioral healthcare.
4. Improve communications (exchange of information/data sharing) between primary care practitioners, specialists, behavioral health practitioners, and health delivery organizations and ancillary care providers.
5. Monitors appropriate use and monitoring of psychopharmacological medications.
6. Incorporates Population Health Management Model into policies, procedures, and workflows.
7. Improving member access to primary and specialty care, ensuring members with complex health conditions receive appropriate service.
8. Identifies and reduces barriers to needed healthcare and social services for members with complex health conditions.
9. Supports a process for members in resolving their individual barriers to physical and mental wellness.
10. Improve member health status through the delivery of wellness and disease prevention services, programs, and resources by educating and empowering members to effectively use primary and preventive health care services, modify personal health behaviors, achieve, and maintain healthier lifestyles, and follow self-care regimens and treatment therapies for existing medical conditions.
11. Ensures continuity in treatment access and follow-up for members with co-occurring medical, behavioral health, and Substance Use Disorder (SUD) conditions.
12. Promotes routine depression, anxiety, trauma-based care, and SUD screenings are completed and appropriate follow-up referrals are made for adolescent and adult members with chronic health conditions and for women during pregnancy and the postpartum period.
13. Link members to ECM, CSS, SUD Providers and other community-based programs with comprehensive and holistic approaches.

VII. Quality Improvement Health Equity Sub-Committee (HEC)

The Quality Improvement Health Equity Sub-Committee (HEC) is responsible for identification and

management of equity efforts throughout the organization including the planning, organization, and the direction, of the Health Equity Program. The HEC is charged with systematic analysis to identify root causes of health disparities impacting KHS members and collaborating across the organization, with providers, and with other community agencies to eradicate inequities for KHS members served. The HEC reviews and updates relevant health equity policies and procedures and the annual Population Needs Assessment (PNA). From this, the HEC formulates the PNA Action Plan for addressing and mitigating the disparities identified in the PNA. Community Agency Representatives are active HEC participants. The HEC shall monitor, evaluate, and take timely action to address necessary improvements in the quality and equity of care delivered by Network Providers in any setting and take appropriate action to improve upon quality improvement and health equity goals.

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

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

1. Increase the awareness of health equity and quality and implement strengthened, expanded and/or new health equity and quality activities to support providers and members ultimately reducing health inequities within KHS membership.
2. Ensure services provided to members promote equity and are free of implicit bias or discrimination.
3. Implement programs that address the causes of inequity that members and their communities experience including food insecurity, housing problems, tobacco use, and other concerns.
4. Analyze the existence of significant health care disparities in clinical areas.
5. Reduce health disparities among members by implementing targeted quality improvement programs.
6. Promote physician involvement in health equity/disparities and activities.
7. Conduct focused groups or key informant interviews with cultural or linguistic minority members to determine how to meet their needs.
8. Address social determinants of health.

VIII. Grievance Review Committee

The Grievances process addresses the receipt, handling, and disposition of Member Grievances in accordance with the Department of Health Care Services (DHCS) Contract and applicable state and federal statutes, regulations and DHCS All Plan Letters. KHS maintains written records of each Grievance as detailed in Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations. This committee is a subcommittee of the EQIHEC.

All complaints, grievances, investigations, follow-up, tracking and trending reports are submitted to the Grievance Review Committee. The Grievance Review Committee meets at a minimum four (4) times a year.

Under the direction and oversight of the Chief Operations Officer (COO) or designee, individual and aggregate data on member grievances is reviewed by the Grievance Review Committee. The COO is supported by KHS staff Medical Directors. The committee is charged with evaluating and analyzing Grievance data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members by implementing necessary changes and process improvements for any adverse trends identified.

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

1. Difficulty obtaining an appointment.
2. Customer service at the provider or practitioner office.
3. Billing issues.
4. Difficulty accessing specialists.
5. Facility Conditions.
6. Confidentiality issues.
7. Refusals of PCP to refer the member for care.
8. Cultural Issues.

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

IX. Behavioral Health Advisory Committee (BHAC)

The KHS Behavioral Health Advisory Committee (BHAC) is a subcommittee to the EQIHEC and is charged with facilitating collaborative coordination of medical and behavioral health services. The committee will support, review, and evaluate interventions to promote collaborative strategic alignment between KHS and the County Mental Health Plan (MHP) and the Drug Medi-cal Organized Delivery System (DMC-ODS). Kern Behavioral Health and Recovery Services (KBHRS) administers both the MHP and DMC-ODS, treating KHS members with the goal to maintain continuity, reduce barriers to access, linkage to appropriate services, opportunities to integrate care, and provide resources for members with mental illness and/or substance use disorder.

Activities:

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

7. Review Plan’s compliance with overseeing MOU with KBHRS.
8. Provides support to KHS management based on their regular and direct interactions with KHS Members receiving BH Services.

The BHAC is chaired by the KHS Director of Behavioral Health or designee and a credentialed and participating behavioral health provider with an M.D. or approved BH Licensure. BHAC will require two-thirds of the members to be present to establish a quorum. The committee meets at a minimum four (4) times a year.

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

X. Pharmacy and Therapeutics/Drug Utilization Review (P&T/DUR) Committee

The Pharmacy and Therapeutics/Drug Utilization Review (P&T/DUR) Committee is a subcommittee that reports to the EQIHEC. The P&T/DUR committee is comprised of KHS pharmacists and contracted providers in the community serving KHS members. The P&T/DUR is responsible for reviewing matters related to the use of medications provided by the KHS contracted provider network. The basic objectives are to specify drugs of choice and address alternatives, based on safety and efficacy; to minimize therapeutic redundancies; and to maximize cost-effectiveness pertaining to drugs administered in the outpatient settings by physicians under KHS’ division of responsibility. Medi-Cal RX retains responsibility for formulary drugs carved out to them by the DHCS.

Activities:

1. Pharmacy and formulary utilization, guidelines, and policies and procedures based on clinical evidence and DHCS contractual requirements.
2. Drug Utilization Review.
3. Review of reports to identify members and providers with potentially inappropriate/excessive utilization of medication therapy.

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

XI. Access and Availability and Delegated Vendor Oversight Committee (AADVOC)

The Access & Availability and Delegated Vendor Oversight Committee (AADVOC) is charged with monitoring member accessibility to obtain covered services within the Plan’s contracted network of providers and evaluating and overseeing any functions and responsibilities delegated to a subcontracted entity. Access & Availability includes appointment availability, geographic access, and network adequacy, monitored through provider surveys, grievance reviews, geographic mapping and analysis, and provider to member ratio reviews. Delegation reporting will include pre-

delegation evaluation, ongoing delegation oversight activities, and results of any conducted audits.

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

Activities:

1. Ensuring Network accessibility and transparency align with DHCS and DMHC requirements through established quantifiable standards for both geographic distribution and number (ratio of providers to members) of PCPs, high-volume and high impact specialists, including high volume behavioral health practitioners and specific high volume ancillary providers.
2. Ensure the performance of the annual network certification meets requirements.
3. Consistent monitoring of practitioner availability and accessibility of services.
4. Efficient collection and analysis of provider-experience data.
5. Address complex and problematic provider-related issues, grievances, and concerns timely, effectively, and appropriately.
6. Ensure provider adherence to all regulatory and legal requirements in the contracting process.
7. Ensure providers receive training and education in accordance with KHS policies and procedures.
8. Ensure KHS First Tier Entity, Downstream Entity, or Related Entity (“delegated vendor entities”) can perform the delegated functions that they are contracted to perform and that they can meet the requirements of all applicable laws and regulations.
9. Pre-delegation and annual audits, review of delegated entity reports.
10. Maintenance of an informed provider network regarding regulatory updates and program requirements.
11. Use data to drive practice improvements.
12. Design and monitor Pay-for-Performance (P4P).

XII. Quality Improvement Committee (QIC)

The QIC is a subcommittee of the EQIHEC. The committee will be chaired by the Chief Medical Officer or designee. The Committee is responsible for ensuring the development, implementation, and monitoring of the KHS QI Program.

The focus of the QIC is on clinical quality, patient safety, and patient and provider experience in four functional areas: HEDIS/Medi-Cal Managed Care Accountability Sets (MCAS), NCQA Accreditation, Quality Improvement, and Network Clinical Oversight.

Activities:

1. Review and approve the QI Program Description, the annual Work Plan, and annual Evaluation of the work plan.
2. Ensure compliance with DHCS facility site review requirements.
3. Review aggregate data of potential quality of care issues (PQIs), identify areas of improvement, and oversee implementation of improvements.
4. Oversee KHS safety program.

5. Oversee the identification of quality-of-care trends and recommend corrective action as needed.
6. Monitor evidence-based care through the HEDIS and Managed Care Accountability Set (MCAS) audit and make recommendations for areas of improvement.
7. Monitor member satisfaction by reviewing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Outcomes and address measures of dissatisfaction.

XIII. Public Policy Community Advisory Committee (PP/CAC)

The PP/CAC reports directly to the KHS BOD. The PP/CAC is comprised of a diverse membership pursuant to 22 CCR section 53876(c), comprised primarily of KHS Members, representing member and community engagement stakeholders, community advocates, and traditional and Safety-Net Providers. The goal of the PP/CAC is to establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan supported by acts performed by KHS or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public. The PP/CAC is a standing Committee within KHS and provides a mechanism for structured input from KHS members regarding how KHS operations impact the delivery of their care. Information from the PP/CAC is reported to the EQIHEC to heighten awareness and incorporate PP/CAC recommendations into quality improvement activities.

Activities:

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

XIV. Other EQIHEC Formal Informational Reporting Sources

Member Services Information:

Incorporates member experience and data-analysis to identify opportunities for improvement in member satisfaction as identified from Member Satisfaction Surveys, and Member Retention Reports.

Patient Safety:

Patient safety and promoting a supportive environment for network practitioners and other providers to improve patient health outcome and safety. Information about safety issues is received from multiple sources including, but not limited to: member and practitioner grievances, care

management and utilization management activities, adverse issues, pharmacy data such as polypharmacy, facility site reviews, continuity of care activities, and member satisfaction survey results. Many of the ongoing QI Program measurement activities, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation include safety components.

Hospital Quality and Safety
KHS tracks and trends hospital performance to reduce variation and assure consistent and standardized metrics across all contracted hospitals. Sources include: Cal Hospital Compare supplemented with data and reports from Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH), and the California Maternity Quality Care Collaborative (CMQCC). Each of these entities provides performance comparisons across hospitals along with regional and national benchmarks of quality and safety. Other sources include sentinel event reporting.

Nurse Advice Line (NAL)
Review of KHS contracted nurse advice line reports to include aggregated data sets for assessment and evaluation for the provision of triage and screening.

Data Sources
Data sources include but are not limited to: encounters/claims, pharmacy and lab data through direct, supplemental or health information exchanges, medical record review or facility site review results, and other monitoring and audit results as well as grievances, appeals, and denial overturns, HEDIS results, quality and performance reports, member and provider satisfaction survey results, network access and availability reports, utilization management metrics, annual population health assessment, and the annual QI work Plan evaluation.

Personnel

Reporting relationships, qualifications and position responsibilities are defined as follows:

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

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

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

The responsibilities of the CMO include:

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

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

III. Chief Operating Officer (COO)

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

IV. Medical Director of Quality

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

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

Under direction of the Chief Medical Officer:

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

V. Behavioral Health Provider

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

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

VI. Director of Quality Improvement

Under the direction of the KHS CMO, the Director of Quality Improvement will oversee and participate in activities related to quality improvement for the organization and membership by monitoring, assessing and improving performance in ambulatory and inpatient health care delivery or health care related services. The Director will implement the KHS Quality Management Plan and communicate with contract providers regarding required studies and participation. Related duties will include ongoing data collection, medical record reviews, report writing, and collaboration and coordination with other KHS departments, as well as outside agencies.

This position is responsible for quality improvement, health education and disease management functions for KHS. This professional will be responsible for ensuring compliance with the QI work plan, oversight of the design, implementation, analysis and dissemination of utilization and accessibility studies and member and provider satisfaction studies. The Director of QI will also be responsible for overseeing the production, analysis, and dissemination of contractually mandated reports. The Director of QI is also responsible for maintaining compliance with Medi-Cal contractual stipulations for Quality programs. Makes an effective contribution to the KHS business planning and fiscal processes. Is clear about departmental objectives and resource requirements.

The QI Director will keep the KHS quality plan "front and center", reinforcing a shared sense of purpose throughout the organization. Takes a mentoring role and strongly encourages the growth of team members. Ensures that professional development goals are incorporated into team members' annual performance objectives, and regular reviews progress towards attaining them.

Under direction of the CMO and QI Medical Director:

- Designs and implements QI programs that meet the goals of the KHS QI plan and complies with regulatory, contractual, and NCQA requirements.
- Maintains responsibility for all activities of the Quality Improvement staff including policies, procedures, and operations.
- Works in coordination with the Provider Relations Manager of Special Programs to develop grant programs.
- Maintains overall direction and supervision for all ongoing and new projects for the QI program.
- Provides leadership and support to QI staff involved in QI projects.
- Annually updates QI policies and procedures with input from the Quality Improvement Committee.
- Participates as an active member of plan committees requiring preparation, research, and follow-up as requested by the CMO.
- Oversees credentialing processes and all HEDIS related activities.
- Supervises quality of care investigations and reporting.
- Represents KHS as the QI liaison for external subcommittees, behavioral health subcontractor, QI workgroups, etc.
- Assists with interviews, selects, trains, develops and evaluates subordinate staff; provides input to Human Resources regarding disciplinary issues, as required.
- Coordinates QI activities and data collection between KHS departments and KHS contracted providers.
- Prepares the organization for review and the accreditation processes by monitoring of

external contract providers and internal processes.

- Contributes to the overall design of the Pay for Performance Incentive Program in collaboration with Provider Relations department.
- Coordinates and conducts in-depth chart analysis, data collection, and report preparation.
- Summarizes information collected for identification of patterns, trends, and individual cases requiring intensive review.
- Identifies and recommends the initiation of quality improvement studies related to multi-disciplinary quality issues and State required studies.
- Serves as staff support and resource to the Quality Improvement and Utilization Management Committee, the Physician Advisory Committee and other committees, as appropriate.
- Assists in problem identification, data analysis, conclusions, recommendation, action-plan design, follow-up and tracking.
- Implements and facilitate internal Quality Improvement studies and work groups for continuous improvement within the organization.

VII. Senior Director of Contracting and Quality Performance

Under the direction of the COO and CMO, the Senior Director of Contracting and Quality Performance will be responsible for managing the provider contracting and quality performance functions for KHS. This includes maintenance of provider agreements, process improvements, contract and quality performance management, negotiation and re-negotiation of contracts in coordination with Executive Leadership, the Senior Director of Provider Network Management, KHS attorney and staff; oversee and participate in activities related to QI for the organization and membership by monitoring, assessing and improving performance in all health care settings.

Oversees, plans, and implements new and existing healthcare QI and practice transformation initiatives, and education programs specific to the Provider Network; ensures maintenance of Provider QI programs, Pay for Performance, and MCAS in accordance with prescribed quality standards; conducts data collection, reporting and monitoring for key performance measurement activities, leads improvement in operational efficiency, financial performance, staff engagement, and health equity.

This position provides the vital role of maintaining network contracting integrity for KHS. This position will ensure that processes are in place and followed in all negotiations, contracting and payment set-up functions. This position also requires a developed understanding of practice operations, revenue cycle management, performance improvement methods, and QI operations as a whole. Also essential is the ability to direct multi-faceted projects across various settings, departments, and programs. Strong leadership and consensus-building skills are essential.

Essential Functions include:

- Developing and maintaining contracting templates which comply with regulatory and legal requirements, effectively implementing strategic initiatives which meet KHS business needs.
- Mitigating risk and liability when negotiating agreements and informing and advising appropriate KHS staff, CEO and KHS attorney of such risks.

- Developing and maintaining a work plan and timeline for completing contract development/negotiations, ensuring that contracts and amendments are implemented in a timely fashion.
- Plan, implement and manage contracting strategies to ensure development of contracted providers to support existing and future product lines.
- Oversee technical products/software related to fiscal impact reports and rate development for provider contracts.
- Oversee the negotiations for Letter of Agreements and administer the Agreements.
- Negotiate Provider contracts for the provision of all covered benefits including physicians, behavioral health, ancillaries, and hospital agreements.
- Oversight responsibility for the Contract Administration unit including contract development, processing, and maintenance of the Agreements.
- Responsible for coordinating payment with Finance Department for special funding sources such as Provider Proposition initiatives, Hospital Directed payments, and any other provider payments not included in the overall contractual payment structure.
- Responsible for validating provider eligibility of special provider funding and oversight of payouts. This includes auditing payments and creating departmental procedures to ensure compliance of such funding distributions.
- Work closely with the KHS Legal to ensure compliance with regulatory agencies, KHS Policies and Procedures and KHS legal requirements.
- Assisting network providers and their staff with practice transformation plans to shift into value-based care, improving quality and encounter data submissions.
- Identify opportunities for increased provider practice efficiency and leveraging health IT and data to deliver high-quality, culturally competent, equitable, and comprehensive primary, specialty, and ancillary health care.
- Develop practice transformation processes and tools, aimed at building practices' overall capacity for ongoing and sustainable change into high-performing, quality medical practices.
- Helps practices to identify areas of need and helps with efficiency measures to improve availability, through sharing of scorecards, delivering gaps-in-care information and risk reports, sharing of satisfaction results as applicable, and delivering other critical operational and efficiency reports.
- Assist in the contracting portion of KHS Grant process including but not limited to RFP development, grant review, grant contract development.
- Monitors and ensures that key quality activities are completed on time and accurately to present results to key departmental management.
- Leads quality improvement activities meetings and discussions with and between other departments within the organization or with and between key provider network partners.
- Evaluates project/program activities and results to identify opportunities for improvement.
- Any other duties as required ensuring the Health Plan operations are successful.
- Provide oversight of contract system configuration and provider set-up.
- Responsible for Credentialing staff and processes.
- Responsible for Facility Site Review processes.

VIII. Director of Quality Performance

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

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

Essential Functions include:

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

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

IX. Quality Managers

The Quality Manager possesses a master's degree in health or business administration or bachelor's or Associates Degree in Nursing and five (5) years of experience in the direct patient care setting or operations management, or teaching adult learners, and one (1) year of experience in health care Quality Improvement, Utilization Management, or Process Improvement, and two (2) years of management experience.

Under the direction of the Director, the Quality Manager conducts oversight and management of state and regulatory and contractual compliance for the QI program. This includes managing the HEDIS and Managed Care Accountability Set (MCAS) audit and initiatives to improve health outcomes related to those measures. They also manage quality improvement initiatives for Performance Improvement Projects (PIPs), Improvement Plans (IPs), Facility Site Reviews (FSRs), delegation audits, and other external quality reviews. The manager applies clinical knowledge and analytical skills to manage and oversee day-to-day operations of the QI team.

X. QI Program Staffing

The QI and QP Directors oversee staff consisting of the following members:

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

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

- Annual Managed Care Accountability Set (MCAS) audit and measurement results submission.

- QI Department Strategic Goals and Projects, and Special Programs (such as member incentives and engagement, DHCS-required project improvement plans, site reviews, etc.).

Senior QI Operations Analyst: The Senior QI Operations Analyst reports to the Director and has a master's degree in Business, Statistics, Mathematics, or other related field with academic demonstration of analytical skills from an accredited school or equivalent AND three (3) years working experience with a Managed Care Organization (MCO) or similar type organization. This position provides primary oversight, management and validation of data and reports submission for the annual DHCS MCAS/HEDIS audit. This includes serving as the liaison between the QI Department, vendors and internal KHS Department such as IT. They provide similar management and support for other department audits. They are responsible for providing operational department support for department processes, projects, or other assignments and provide data and reports for ongoing activities such as performance improvement projects.

Senior QI Coordinator: The Senior QI Coordinator roles report to the QI Manager. He/she is a high school graduate and is licensed/certified in CA as either a certified medical assistant (CMA) or licensed vocational nurse (LVN) with either five (5) years of experience for a CMA or two (2) years experience for a LVN in a physician's office. The Senior QI Coordinator assists in department functions related to data collection, data entry, report preparation, record maintenance, and collaboration with other departments, regulatory and contracted agencies. This position will work extensively with MCAS methodology, data collection and intervention development and implementation. The Senior QI Coordinator assists with medical record requests and record preparation for any QI activity. The role also provides administrative support for provider site review activities.

Other KHS Department Leads as needed.

Quality Program Components

I. Population Health Management (PHM)

KHS supports its PHM delivery infrastructure that ensures the needs of its entire population and the delivery of quality care and services to each member are met. Through the Population Needs Assessment (PNA) conducted annually by KHS, the members' health and social needs are identified, and quality-driven strategies are developed to assist these members to the appropriate services offered by the following:

- Care Management Program
- Enhanced Care Management (ECM)
- Complex Case Management
- Transitional Care Services

The following is a list of all PHM Programs:

1. Basic Population Health Management
    - Community Supports Services
    - Maternal Health Outcomes – Baby Steps
2. Wellness and Prevention Programs
    - Nutrition Education Program

- Diabetes Prevention Program
- Diabetes Education Program
- Asthma Education
- School Wellness Grant Program

3. Care Management Programs
    - Care Coordination (i.e., Skilled Nursing Facility Coordination)
    - Complex Case Management (CCM)
4. Special Programs
    - COPD Clinic
    - Transition of Care (TOC) Program
    - ER Navigation
    - Palliative Care Program
    - CHF Clinic
    - Comprehensive Diabetes Program
    - Potentially Preventable Admission (PPA) Program
    - Homebound Program
5. Enhanced Care Management (ECM)

Continuous Quality Assurance and Improvement

Performance metric data are collected monthly, quarterly and aggregated annually to identify and analyze opportunities for improvement of performance. Feedback obtained from the Nurse Case Managers (NCM) and from members via the satisfaction survey are analyzed, trended over time, and correlated to the quality measures and care workflows.

The PHM Program is overseen by the PHM subcommittee and reports to the EQIHEC for all its activities and outcomes of performances.

The PHM Director oversees the Population Health Program and reports to the Chief Medical Officer. There are several different staff involved to support the population health initiatives including but not limited to:

- Case Managers
- Care Coordinators
- Health Educators
- Member outreach staff

The Business Intelligence unit provides the majority of data guiding the population health program. The Quality Performance Department provides HEDIS reporting and analysis, including Gap in Care reporting. There is collaboration between all departments on initiatives and interventions that are part of the Population Health Program.

II. Health Equity Program

a. Cultural and Linguistics

b. Diversity, Equality and Inclusion

KHS gathers race/ethnicity, language, gender identity and sexual orientation data to assist in

providing culturally and linguistically appropriate services (CLAS).

Key Functional Areas

I. Member Grievances and Appeals System

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

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

KHS regularly analyzes grievance and appeals data to identify, investigate, report and act upon trends impacting health care access and delivery to the members.

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

II. Behavioral Health

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

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

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

III. Health Education

The Plan's Health Education Department conducts a field-testing process to ensure that written health education materials are understood by members and accessible for the targeted member audience. Newly developed or adapted materials provides opportunities for Plan Members and

their families to review materials prior to their release or publication. Mechanisms for field testing may include, but are not limited to:

1. Review during the PP/CAC meeting.
2. Key informant reviews with Members.
3. Focus groups with targeted members to determine relevance and effectiveness.

All field testing is overseen by a KHS health educator to monitor its appropriateness. Members or the parents/guardians of Members have the opportunity to provide input for the materials being presented including how better to engage the targeted audience. The effectiveness of the chosen mechanism is taken into consideration for future field testing.

IV. Member Services

KHS implements and maintains written policies and procedures that set forth the Member's rights and responsibilities and shall communicate its policies to its Members, Providers, and, upon request, potential members.

Members are also assured of their rights to confidentiality, right to advance directives, and rights to linguistic services.

V. Pharmacy Services

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

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

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

VI. Provider Network

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

reports to the Senior Director of Provider Network and oversees Contracting and Credentialing. The Deputy Director of Provider Network reports to the Senior Director of Provider Network and oversees Provider Relations, and Provider Grants, and Analytics and Regulatory Reporting.

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

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

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

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

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

Provider network accessibility is primarily monitored via the Provider Network Management, Quarterly Network Review. The Quarterly Network Review includes, but is not limited to an Access Grievance Review, Provider Accessibility Monitoring Survey, Geographic Accessibility Review, and Network Adequacy/Provider Counts. These reports track and monitor the Plan's regulatory compliance to standards such as: PCP to member and Physician to Member ratios, Appointment Availability, Provider Response times, Provider After-Hours availability, and In-Office wait times. The PNM Analytics Team monitors and tracks members' geographic access to PCP, Specialist, Non-Physician Mental Health, Specialty OB/GYN, and Hospital providers and confirms the geographic access is within regulatory standards. If any provider type/geographic region is not meeting regulatory standards, it is the responsibility the PNM Analytics Team to request an Alternative Access Standard and identify potential providers for recruitment/contracting

activities. The PNM Analytics Team reviews Access Grievance data to determine if any provider, group, or specialty is experiencing the same access issue on a continuous basis. The PNM Analytics Team reports all findings to PNM leadership and the EQIHEC committee.

VII. Utilization Management (Adverse Events/Sentinel Event)

Utilization Management is responsible for coordinating and conducting prospective, concurrent, and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care/continuum of care, and continued inpatient stay, as appropriate.

The QI Department reviews a sampling of hospital re-admissions that occurred within 30 days of the first hospital discharge each quarter to identify and follow-up on potential inappropriate care issues.

Any issue that warrants further investigation of potential inappropriate care is forwarded from the Utilization Management Department, Member Services Department, or any other KHS Department, to the QI Department for determination whether a PQI issue exists and follow up corrective action based on the severity level of PQI identified. These referrals may include member deaths, delay in service or treatment, or other opportunities for care improvement.

VIII. Business Intelligence (BI) Unit

Functions include:

- Establish advanced health analytics to ensure that leadership has full purview into the population to improve individual experience of care; improve the health of the population while reducing per capital cost of care for populations.
- Create, manage, and continuously improve Corporate Key Performance Indicators (KPI's)
- Reduce operational silos and proactively manage and improve overall operations.
- Provide and validate standard metrics and information around process improved to ensure that project goals, objectives, or Return on Investments (ROI) are achieved.
- Establish data governance over various systems to ensure that reliable data can be consumed for analytics and reporting.
- Manage all operational and regulatory reporting inventory for the organization.

IX. Management and Information System (MIS)

KHS utilizes information provided through the Information Technology (IT), Operations, and Provider Network Management departments.

KHS MIS has the capability to capture, edit, and utilize various data elements for both internal management use and to meet the data quality and timeliness requirements. These include DHCS' encounter data, network provider data, program data, and template data submissions and processes. MIS also has the ability to meet Population Health Management data integration requirements and is able to provide the requested data to DHCS and Centers for Medicare and Medicaid Services upon request.

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

KHS MIS supports at a minimum:

- All Medi-Cal eligibility data.
- Information on members enrolled with Kern Health Systems.
- Provider claims status and payment data.
- Health care services delivery encounter data.
- Network provider data.
- Program data.
- Template data.
- Screening and assessment data.
- Referrals including tracking of referred services to follow up with Members to ensure that services were rendered.
- Electronic health records.
- Prior auth requests and specialty referral system.
- Care Management data.
- Care Coordination data.
- Financial information.
- Social drivers of health data.
- Grievance and appeal information.

Quality Work Plan and Activities

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

- The Work Plan is developed by the Quality Improvement Department on an annual basis and is presented to the PAC, EQIHEC and Board of Directors for review and approval. Timelines and responsible parties are designated in the Work Plan.
- The Work Plan includes the objectives and scope of planned projects or activities that address the quality and safety of clinical care and the quality of service provided to members.
- After review and approval of quality study results including action plans initiated by the EQIHEC, KHS disseminates the study results to applicable providers. This can occur by specific mailings or KHS Provider bulletins to contracting providers.
- The activities in the QI Work Plan are annually evaluated for effectiveness.
- QI Work Plan responsibilities are assigned to appropriate individuals.

Components of the QI Work Plan:

Quality and Safety of Clinical Care: KHS evaluates the effect of activities implemented to improve patient safety. Safety measures are monitored by the QI Department in collaboration with other KHS departments, including:

- **Provider Network Management Department –** provider credentialing and recredentialing, using site visits to monitor safe practices and facilities.

- **Member Services Department –** by analyzing and taking actions on complaint and satisfaction data and information that relates to clinical safety.
- **UM Department –** in collaboration with the Member Services Department, by implementing systems that include follow-up to ensure care is received in a timely manner.

1. Quality of Clinical Care

a. Managed Care Accountability Set (MCAS) Measures

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

DHCS has established minimum performance levels (MPL) for several of the MCAS measures. This benchmark is the 50th percentile based on outcomes published in the latest edition of NCQA's Quality Compass report and the National HMO Average. Results submitted to DHCS for the designated MCAS measures are compared to the NCQA benchmarks to determine the Managed Care Plan's (MCP) compliance. When an MCP does not meet the 50th percentile or better for a measure, DHCS may impose financial penalties and require a corrective action plan (CAP). The following table identifies the MCAS measures KHS is held accountable to meet the 50th percentile or better for measurement year (MY) 2024. Results for the 2023 measures will be calculated and submitted in report year (RY) 2023. The MCAS Measures include:

#	**MEASURE** Total Number = 36 (10 Hybrid and 26 Administrative)	**MEASURE ACRONYM**	**MEASURE TYPE METHODOLOGY**	**HELD TO MPL?**
Behavioral Health Domain				
1	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	Administrative	Yes
2	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	Administrative	Yes
Children's Health Domain				
3	Child and Adolescent Well-Care Visits*	WCV	Administrative	Yes
4	Childhood Immunization Status: Combination 10*	CIS-10	Hybrid/Admin**	Yes
5	Developmental Screening in the First Three Years of Life	DEV	Administrative	Yesiii
6	Immunizations for Adolescents: Combination 2*	IMA-2	Hybrid/Admin**	Yes
7	Lead Screening in Children	LSC	Hybrid/Admin**	Yes

8	Topical Fluoride for Children	TFL-CH	Administrative	Yes[iii]
9	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	W30-6+	Administrative	Yes
10	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits*	W30-2+	Administrative	Yes
	Chronic Disease Management Domain			
11	Asthma Medication Ratio*	AMR	Administrative	Yes
12	Controlling High Blood Pressure*	CBP	Hybrid/Admin**	Yes
13	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	HBD	Hybrid/Admin**	Yes
	Reproductive Domain			
14	Chlamydia Screening in Women	CHL	Administrative	Yes
15	Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	Hybrid/Admin**	Yes
16	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	Hybrid/Admin**	Yes
	Cancer Prevention Domain			
17	Breast Cancer Screening*	BCS	ECDS & Admin***	Yes
18	Cervical Cancer Screening	CCS	Hybrid/Admin**	Yes
	Report only Measures to DHCS			
19	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED [ii]	Administrative	No
20	Adults' Access to Preventive/Ambulatory Health Services	AAP	Administrative	No
21	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	No
22	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	Administrative	No
23	Colorectal Cancer Screening*	COL-E	ECDS	No^^
24	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	No
25	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	Administrative	No

#	MEASURE Total Number = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
26	Depression Remission or Response for Adolescents and Adults	DRR-E	ECDS	No^^
27	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	ECDS	No^^
28	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Administrative	No
29	Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	Administrative	No
30	Follow-Up After ED Visit for Substance Use – 7 days*	FUA	Administrative	No
31	Follow-Up Care for Children Prescribed Attention- Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	No
32	Follow-Up Care for Children Prescribed Attention- Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase	ADD-Init	Administrative	No
33	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	No
34	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	Administrative	No
35	Pharmacotherapy for Opioid Use Disorder*	POD	Administrative	No^^
36	Plan All-Cause Readmissions*	PCR ii	Administrative	No
37	Postpartum Depression Screening and Follow Up*	PDS-E	ECDS	No^^
38	Prenatal Depression Screening and Follow Up*	PND-E	ECDS	No^^
39	Prenatal Immunization Status	PRS-E	ECDS	No^^
Long Term Care Report Only Measures to DHCS				
40	Number of Out-patient ED Visits per 1,000 Long Stay Resident Days*	HFS	Administrative^	No
41	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization*	SNF-HAI	Administrative^	No
42	Potentially Preventable 30-day Post-Discharge Readmission*	PPR	Administrative^	No

KHS is contractually required to meet or exceed the DHCS established Minimum Performance Level (MPL) for each required HEDIS measure. For any measure that does not meet the established MPL, or that is reported as a “No Report” (NR) due to an audit failure, an Improvement Plan (IP) is contractually required to be submitted within 60 days of being notified by DHCS of the measures for which IPs are required. Managed Care Plans are required to meet or exceed the performance levels set forth by Department Health Care Services (DHCS) as outlined in their contract. Based on KHS’ compliance level for MCAS measures for MY2022, KHS was placed in the orange tier and is completing a cause-and-effect analysis to understand the barriers of not meeting the MPLs.

b. DHCS-required Studies: Performance Improvement Projects (PIP)

KHS is mandated to participate in two (2) PIPs. These PIPs span over an approximate 36 month time frame and are each broken out into four (4) modules. Each module is submitted to HSAG/DHCS for review, input, and approval incrementally throughout the project.

The two new PIPS required by DHCS will include annual submissions for 3 years from 2023-2026. The framework for the new PIPs has been updated by DHCS to align with the CMS protocol.

Clinical PIP:

The new cycle of PIPs began in August 2023 and will run through 2026. The clinical PIP is focused on Health Equity, specific to the W30 0-15 months African American population. KHS submitted the first phase of the PIP design to HSAG in August.

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. KHS also submitted the first phase of the PIP design to HSAG in August. HSAG validated and approved the submission with minor feedback to improve the framework.

2. Safety of Clinical Care

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

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

b. Credentialing/Recredentialing

Assessment and Monitoring: To monitor that contracting providers have the capacity and capability to perform required functions, KHS has a pre-contractual and post- contractual assessment and monitoring system. Details of the activities with standards, tools and processes are found in specific policies and include:

Pre-contractual Assessment of Providers – All providers desiring to contract with KHS must, prior to contracting with KHS, complete a document that includes the following sections:

- Health Care Delivery Systems, including clinical safety, access/waiting, referral tracking, medical records, and health education.
- Credentialing information.

c. **Drug Utilization Review** – KHS performs drug utilization reviews to provide oversight of prescribed medications. DUR is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to elicit improvements and measure the results. The objectives of DUR are to improve the quality of patient care by assuring safe and effective drug use while concurrently managing the total cost of care.

d. **Clinical Practice and Preventive Health Guidelines** – Clinical Practice Guidelines are developed using current published literature, current practice standards and expert opinions. They are directed toward specific medical problems commonly found with members. The PAC reviews and approves all Clinical Practice Guidelines and/or Preventive Health Guidelines prior to presentation to EQIHEC Committee. The EQIHEC Committee is responsible for adopting and disseminating Clinical Practice Guidelines for acute, chronic, and behavioral health care services. Guidelines are reviewed every two years and updated if necessary.

3. **Quality of Service**

a. **Primary Care Physician (PCP) and Specialist Access Studies** – KHS performs physician access studies per KHS Policy 4.30, Accessibility Standards. Reporting of access compliance activities is the responsibility of the Provider Network Management Manager and is reported annually.

b. **PCP and Specialist** Appointment Availability Study KHS members must be offered appointments within the following timeframes:

Type of Appointment	Time Standard
Urgent care appointment for services that do not require prior authorization[1]	Within 48 hours of a request
Urgent appointment for services that require prior authorization	Within 96 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Non-urgent appointment with a specialist	Within 15 business days of a request
Non-urgent appointments with a physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent appointments with a non-physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of a request
Pediatric CHDP Physicals	Within 2 weeks upon request
First pre-natal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

c. **PCP After-Hours Access**

KHS contracts with an after-hours triage service to facilitate after-hours member access to care. The Director of UM reviews monthly reports for timeliness, triage response and availability of contracting providers. Results of the access studies are shared with contracting providers, EQIHEC Committee, Board of Directors and DHCS.

4. **Member Safety**

KHS continuously monitors patient safety for members and develops appropriate interventions as follows:

- **Coordination of Care Studies** – KHS performs Coordination of Care Studies to reduce the number of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days.
- **Interventions** – KHS initiates interventions appropriate to identified issues. Such interventions are based on evaluation of processes and could include distribution of safety literature to members, education of contracting providers, streamlining of processes, development of guidelines, and/or promotion of safe practices for members and providers.

KHS evaluates the effect of activities implemented to improve patient safety. Safety measures are monitored by the QI Department in collaboration with other KHS departments, including:

- **Provider Network Management Department –** provider credentialing and recredentialing, using site visits to monitor safe practices and facilities.
- **Member Services Department –** by analyzing and taking actions on complaint and satisfaction data and information that relates to clinical safety.
- **UM Department –** in collaboration with the Member Services Department, by implementing systems that include follow-up to ensure care is received in a timely manner.

The Director of Member Services presents reports regarding customer service performance and grievances monthly to the CEO, CMO and Chief Operations Officer. At least quarterly, reports are presented to the EQIHEC Committee for review and recommendations.

Member Information on QI Program Activities – A description of QI activities are available to members upon request. Members are notified of their availability through the Member Handbook. The KHS QI Program Description and Work Plan are available to contracting providers upon request.

QUALITY IMPROVEMENT PROCESS

a. **Prioritization of Identified Issues** – Action is taken on all issues identified to have a direct or indirect impact on the health and clinical safety of members. These issues are reviewed by appropriate Health Services staff, including the CMO, and prioritized according to the severity of impact, in terms of severity and urgency, to the member.

b. **Corrective Actions** – Corrective Action Plans (CAP) are designed to eliminate deficiencies,

implement appropriate actions, and enhance future outcomes when an issue is identified. CAPs are issued in accordance with *KHS Policy and Procedure 2.70-I Potential Quality of Care Issues (PQI)*. All access compliance activities are reported to the Senior Director of Provider Network who prepares an activity report and presents all information to the CEO, CMO, Chief Operations Officer, Sen, and EQIHEC Committee.

c. **Quality Indicators** – Ongoing review of indicators is performed to assess progress and determine potential problem areas. Clinical indicators are monitored and revised as necessary by the EQIHEC Committee and PAC. Clinical practice guidelines are developed by the DUR Committee and PAC based on scientific evidence. Appropriate medical practitioners are involved in review and adoption of guidelines. The PAC re-evaluates guidelines every two years with updates as needed.

KHS targets significant chronic conditions and develops educational programs for members and practitioners. Members are informed about available programs through individual letters, member newsletters and through KHS Member Services. Providers are informed of available programs through KHS provider bulletins and the KHS Provider Manual. Tracking reports and provider reports are reviewed and studies performed to assess performance. KHS assesses the quality of covered health care provided to members utilizing quality indicators developed for a series of required studies. Among these indicators are the MCAS measures developed by NCQA and CMS. MCAS reports are produced annually as well as throughout the year and have been incorporated into QI assessments and evaluations.

Quality Improvement Strategies

I. Quality Improvement Strategies

The following strategies and key action items were identified for improvement of 3 focused areas:

a. Data Accuracy, Completeness, & Timeliness,
b. QI Training & Resources for KHS staff & providers, and
c. Collaboration & Communication.

Strategies and key action items for the 3 focus areas are as follows:

- Data Accuracy, Completeness, & Timeliness
  - Strategy: Develop process for timely, complete, & accurate data to measure MCAS compliance for strategy development and outcomes analysis
  - Key Actions:
    - Implement an organizational standard data QA process
    - Evaluate options to support consistent data exchange with providers
    - Analyze audit and perform risk management and remediation on any findings to close the gaps
    - Analyze data by geographic areas and identify areas with higher gaps in care
      - Special programs with providers in remote geographic areas (geographic barriers)
      - Mobile clinics in underserved areas
      - Onsite visits to LTC facilities
    - KHS members are stratified by Race, ethnicity & other SDoH data used to target interventions & develop special programs.
    - Utilization & outcome data is stratified to identify areas of underutilization such as

low performance scores on preventive services

- Target services for CHWs, home visits, doulas etc.
- Basic Population Health Management Program supported with mobile clinics, and home visits to close gaps

- Training & Resources
  - Strategy: Develop a quality education program to enable KHS staff & providers to develop & implement effective MCAS improvement strategies
  - Key Actions:
    - Develop e-learning courses for KHS staff & providers that align with industry-standard, QI principles and methods. Courses will cover current MCAS measures
    - Identify organizational structure for the role of a Health Equity Officer, as required in the DHCS CQS. This position will be responsible for carrying out the CQS strategies in collaboration with the Quality Improvement and Population Health Management departments
    - Identify and assess members risks guiding the development of care management programs and focused strategies
    - Create strategies to engage members as “owners of their own care”. Member Engagement Program - Develop a robust member and community engagement program
    - Develop communication strategies that will focus on keeping families and communities healthy via prevention
    - Create early interventions for rising risk and patient centered chronic disease management
    - Expand on programs that focus on whole person care for high-risk populations, addressing drivers of health
    - Implementation of strategic & corporate goals to incorporate equity in internal staffing recruitment, network development/expansion and implementation of PHM programs

- Collaboration & Communication
  - Strategy: To establish a communication process that supports strategic thought partnership, transparency, & decision-making for MCAS compliance throughout all levels of the organization.
  - Key Actions:
    - Executive Leadership Team will establish a process for communication & collaboration of QI strategies & activities at all levels of the organization.
    - Plan project with CHWs in underserved areas to engage and support members to close care gaps , home visits, working with community centers where members go to meet members,
    - Street medicine – leveraging CalAIM Incentive Program (HHIP)
    - Schools with school wellness program, SBHIP (CalAIM Incentive program), use of school clinics for immunizations, screenings and possible health fairs to close gaps in care
    - Partner with Department of Public Health for early pregnancy identification and support to initiate prenatal care

* ECM sites to close gaps in care,
* Utilize specialist for diabetes management for those with HgA1c above 9,
* PCP incentive programs supporting practice transformation
* Grant funding for telehealth
* Expand transportation providers for members in more remote areas of the county by partnering with CBOs and Provider Practices

Integration of Study Outcomes with KHS Operational Policies and Procedures: KHS assesses study outcomes over time and, as a result of key quality issue identification and problem resolution, develops changes in strategic plans and operational policies and procedures. Study outcomes are assessed and changes may be incorporated into the KHS strategic plan and operational policies and procedures to address those outcomes and incorporate ongoing quality issue solutions into organizational operations.

As previously described, a Strike Team is in place to focus on initiatives that will improve KHS' MCAS scores. The strike team is made up of marketing/member engagement, business intelligence, provider network management, quality, and population health. With this diverse team, key strategies will be developed and monitored closely to identify what the most effective approach in getting members to close their gaps in care and into their primary care physicians for their preventive health services appointments.

Evaluation of KHS' Quality Program

Annual Evaluation of the KHS Quality Improvement Program

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

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

The yearly QI Program summary and Work Plan are presented to the Board of Directors for assessment of covered health care rendered to members, comments, activities proposed for the coming year, and approval of changes in the QI Program. The Board of Directors is responsible for the direction of the QI Program and actively evaluates the annual plan to determine areas for improvement. Board of Director Comments, actions and responsible parties assigned to changes are documented in the minutes. The status

of delegated follow-up activities is presented in subsequent Board meetings. A summary of QI activities and progress toward meeting QI goals is available to members and contracting providers upon request by contacting KHS Member Services.

KHS Providers

Provider Participation

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

Provider Information – KHS informs contracting providers through its Provider bulletins, letters and memorandums, distribution of updates to the Provider Policy and Procedure Manual, and training sessions.

Provider Cooperation – KHS requires that contracting providers and hospitals cooperate with QI Program studies, audits, monitoring and quality related activities. Requirements for cooperation are included in provider and hospital contract language that describe contractual agreements for access to information.

Provider and Hospital Contracts

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

Provider contracts include provisions for the following:

a. An agreement to participate in the KHS QI Program including cooperation with monitoring processes, the grievance resolution system, and evaluations necessary to determine compliance with KHS standards.
b. An agreement to provide access to facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.
c. Cooperation with the KHS QI Program including access to applicable records and information.
d. Provisions for open communication between contracting providers and members regarding their medical condition regardless of cost or benefits.

Hospital contracts include provisions for the following:

a. An agreement to participate in the KHS QI Program, including cooperation with monitoring processes, the grievance resolution system, utilization review, and evaluations necessary to determine compliance with KHS standards.
b. Development of an ongoing QI Program to address the quality of care provided by the hospital including CAPs for identified quality issues.
c. An agreement to provide access of facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.
d. Cooperation with the KHS QI Program, including access to applicable records and information.

Conflict of Interest:
All committee members are required to sign a conflict-of-interest statement. Committee members cannot vote on matters where they have an interest and must be recuse until the issue has been resolved.

Confidentiality

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

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

Information Security

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

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

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

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

External Audits/Regulatory Audits and Oversight

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

Medical Reviews and Audits by Regulatory Agencies – The KHS Director of Compliance & Regulatory Affairs, in collaboration with the CHSO and the Director of Quality Improvement manages KHS medical reviews and medical audits by regulatory agencies. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI Program. CAPs for medical matters are approved and monitored by the EQIHEC Committee.

Delegation

Delegation: KHS delegates quality improvement activities as follows:

1. In collaboration with other Kern County Health Plans – delegation for Site Reviews as described in APL 20-006, Site Reviews: Facility Site Review and Medical Record Review and the applicable MOU.
2. VSP – delegation of QI and UM processes with oversight through the EQIHEC committee.

____
KHS Board of Directors (Chair) Date

____
Chief Executive Officer Date

____
Chairman EQIHE COMMITTEE Date

Kern Health Systems

2024 Quality Improvement Program Work plan

Source	Key Performance Measure	Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Person
QUALITY PROGRAM STRUCTURE							
NCQA 1A	QI Program Description	QI Program description of committee accountability, functional areas and responsibilities, reporting relationship, resources and analytical support	2023 trilogy documents did not meet NCQA requirements	Annual approval by the QIC and the BOD	Presentation of the QI Program to BOD and QIC for review and approval.	April 15, 2024	QI Director
NCQA 1B	Annual QI Work Plan	Yearly planned objectives and activities	2023 trilogy documents did not meet NCQA requirements	Annual approval by the QIC and the BOD	Presentation of the QI Work Plan to BOD and QIC for review and approval.	April 15, 2024	QI Director
NCQA 1C	Annual QI Evaluation	Summary of completed and ongoing QI activities, trending of results and overall evaluation of effectiveness	2023 trilogy documents did not meet NCQA requirements	Annual approval by the QIC and the BOD	Presentation of the QI Evaluation to BOD and QIC for review and approval	July 31, 2024	QI Director
NCQA; DHCS	Policies and Procedures	Review of organization's policies and procedures	No issues identified	Annual approval by the QIC	Presentation of the QI Evaluation to QIC for review and approval	April 15, 2024	QI Director
NCQA 1A	Quality Improvement Health Equity Committee (QIHEC)	Quarterly meetings and maintenance of minutes	New committee establishing 2024	Conduct quarterly meetings, as required by the QM Program	Meet quorum of voting members +at every meeting	December 31, 2024	QI Director
Quality of Clinical Care							
DHCS	MCAS Measures	18 MCAS measures mandated by DHCS to meet minimum performance levels (MPLs)	KHS placed in red tier status due to overall MCAS rates. Improved from Red Tier to Orange Tier from MY2021-MY2022.	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	Q1 - April 30, 2024 Q2 - July 31, 2024 Q3 - November 30, 2024 Q 4 - January 31, 2025	QI Director
DHCS	Performance Improvement Projects (PIPs)		PIP topics are selected based on MCAS performance. Childrens Domain and BH are areas of focus				
	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.	Did not meet MPL for multiple measures in Children's Domain of Care	Use MY2023 W30 (0-15months) baseline data to develop PIP interventions and get Annual Approval by HSAG.	Interventions to be established in 2024	December 31, 2024	QI Director
	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 through provider notifications with in 7-days of the ER visits.	Did not meet MPL for FUA and FUM measures	Use MY2023 baseline data to develop interventions that includes a process for notifying PCPs of ED visits for eligible population. Annual Approval by HSAG	Interventions to be established in 2024	December 31, 2024	QI Director
DHCS	Potential Quality of care Issue (PQI)	Monitoring of PQI volume month over month.	No issues identified	Monitor if the volume is below the median value of last 12 months.	Monitor Trending Reports	by the end of every month January 31, 2024 February 29, 2024 March 31, 2024 April 30, 2024 May 31, 2024 June 30, 2021 July 31. 2024 August 31, 2024 September 30, 2024 October 31, 2024 November 30, 2024 December 31, 2024	QI Analyst
		PQI Volume by Provider and by Severity	No issues identified	Monitor Total PQI volume with severity level 2 and 3 is below 30 for rolling 12month period.	Monitor Trending Reports	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	QI Analyst
		PQI Volume by Ethnicity and by Severity	No issues identified	Monitor Total PQI volume with severity level 2 and 3 is below 30 for rolling 12month period.	Monitor Trending Reports	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	QI Analyst
NCQA QI 3	Continuity and Coordination of Medical Care - Transitions of Care:	*Collecting data, identifying improvement opportunities and measuring effectiveness*	No issues identified	Will establish baseline for NCQA requirements	Interventions to be established in 2024	December 31, 2024	QI Director
	a) Movement of Members Between Practitioners	example – consult report received by PCPs	No issues identified	Will establish baseline for NCQA requirements	Interventions to be established in 2024	December 31, 2024	FSR Nurse QI Director
	b) Movement of Members Across	example – post partum rate	No issues identified	Will establish baseline for NCQA requirements	Interventions to be established in 2024	December 31, 2024	QI MCAS Analyst

	Settings	Example – post partum rate		Will establish baseline for NCQA requirements	Interventions to be established in 2024	December 31, 2024	QI Director
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:*	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	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	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	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)	No issues identified	Increase MCAS result by 2 percentage points from previous year	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	c) Appropriate use of psychotropic medications	Examples: AMM ; ADD Analysis of pharmaceutical data for appropriateness of a psychopharmacological medication	No issues identified	Increase MCAS result by 2 percentage points from previous year	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	d) Management of coexisting medical and behavioral disorders	Example: FUH	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	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	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	b) Special needs of members with serious mental illness or serious emotional disturbance	Example: HEDIS measure Diabetes Monitoring for People with Diabetes and Schizophrenia	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
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 (MMCD) Program*	*Issues were identified in Critical Elements while conducting FSR.*	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	CSR will schedule and complete reviews timely.	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	FSR Nurse
DHCS	Physical Accessibility Review Survey (PARS)	Conduct PARS audit with FSR	No issues identified.	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	QP Senior coordinator will schedule and complete all PARS due 2024	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	FSR Nurse
DHCS	Medical Record Review	Conduct medical record review of practitioners due for facility site reviews	Previously identified issues from MRR: 1.Emergency contact not documented 2.Dental/Oral Assessment not documented 3.HIV infection screening not documented	Achieve medical record review score of 85% for each practitioner	CSR will schedule and complete reviews timely.	December 31, 2024	FSR Nurse
Kern	Drug Utilization Review	TAR PAD	None	Turnaround Time Timeliness - reviewed and returned in 1 business day TAR=24hrs PAD=5 days routine 3days=urgent	None	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Pharmacy Director
NCQA	Credentialing/Recredentialing	Credential/recredential practitioners timely	No QOC trends for provider re-credentialing in 2023 to prevent moving forward from a QI perspective	100% timely credentialing/recredentialing of practitioners	Review of trends for Grievances and PQIs, QOC look back review Q3 years	December 31, 2024	Credentialing staff
Quality of Service							
NCQA; DHCS	Grievance and Appeals	a) Timeliness of acknowledgment letters		Within 5 calendar days		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Grievance and Appeals Manager
		b) Timeliness of resolution		Within 30 calendar days		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Grievance and Appeals Manager
DHCS; NCQA	Potential Quality of Care Issues (PQI)	a) Timeliness of acknowledgment letters		Within 5 calendar days		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Grievance and Appeals Manager
		b) Timeliness of resolution		Within 30 calendar days		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Grievance and Appeals Manager
NCQA; DHCS	Access to Care - PCP	*PCP access for preventive, routine care, urgent care, and after-hours access* Urgent care – w/in 48 hrs. Routine care – 10 business days	Identified Providers that are noncompliant with appointment availability standards	80%	Provider Accessibility Monitoring Survey	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	PNM
	Access to Care - SCP	*Access to specialty care* Urgent care – w/in 48 hrs. a) Routine care – 15 business days		80%	Provider Accessibility Monitoring Survey	March 31, 2024 June 30, 2024	PNM

	Access to Care - SCP			80%	Provider Accessibility Monitoring Survey	September 30, 2024 December 31, 2024	PNM
DHCS; NCQA	Telephone access to Member Services	a) Speed of answer		≤ 30 seconds	Perform quarterly telephone access audit	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Customer Service Manager
		b) Call abandonment rate		5%		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Customer Service Manager
Members' Experience							
Kern	CAHPS survey	Adult and Child Medicaid Survey	Getting Needed Care scored lowest in the Adult Survey categories	Monitor CAHPS Results and establish baseline for Getting Care needed measure	Trending report on CAHPS results by survey questions	31-Dec-24	QI Analyst Health Education TBD
	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.	Did not meet MPL	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	by end of every month January 31, 2024 February 29, 2024 March 31, 2024 April 30, 2024 May 31, 2024 June 30, 2021 July 31. 2024 August 31, 2024 September 30, 2024 October 31, 2024 November 30, 2024 December 31, 2024	QP Director
Provider Engagement							
Kern	Provider Satisfaction Survey				Trend PSS results by survey questions	December 31, 2024	TBD - PNM
	Provider Incentive Program	Improve HBD Measure rate	KHS placed in red tier status due overall MCAS rates	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.	by end of every month January 31, 2024 February 29, 2024 March 31, 2024 April 30, 2024 May 31, 2024 June 30, 2021 July 31. 2024 August 31, 2024 September 30, 2024 October 31, 2024 November 30, 2024 December 31, 2024	QI Coordinator
	Provider education	Improve MCAS Measure Rates	Did not Meet MPL	Meet Providers Quarterly	QI coordinator meet Providers to update them on the MCAS Measure Rate performance	by end of every month January 31, 2024 February 29, 2024 March 31, 2024	PNO representative QI Coordinators

Performance Measure		**Barrier/Opportunity for Improvement**	**Previously Identified Issue**	**Intervention**	**Outcome**	**Outcome**	**Outcome**
Program Structure							
Quality of Clinical Care							
MCAS Measures:	MY 2023 MCAS Results:	Providers close to meeting MPL for MCAS Measure Compliance.	Not Meeting MPL	End of the year push through Provider outreach	Baseline data for MY2023		
AMR	<50th percentile	Monitor Measure performance month over month	Report only for MY2022. No issue	none	TBD		
BCS	<50th percentile	Monitor Measure performance month over month	Met MPL for MY2022. No issue	Measure is part of Member Engagement and Rewards Program	TBD		
CHL	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		
CCS	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		
CIS-10	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	none	TBD		
CBP	<50th percentile	Monitor Measure performance month over month	Report only for MY2022. No issue	none	TBD		
DEV	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	none	TBD		
IMA-2	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	none	TBD		
LSC	<50th percentile	Did not meet MPL	Not Meeting MPL	QI Senior Co-ordinators reached out to Top 10 provider that have less than 150 members to complete Lead Screening in Children before the 2 years of age (LSC)	% members successfully completed Lead Screening.		
FUA-30Day follow up	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	% members successfully completed follow-up visit.		
FUM-30Day follow up	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	% members successfully completed follow-up visit.		
HBD	<50th percentile	Monitor Measure performance month over month	Met MPL for MY2022. No issue	none	TBD		

PPC-Pre	<50th percentile	Monitor Measure performance month over month	Met MPL for MY2022. No issue	Measure is part of Member Engagement and Rewards Program	TBD		
PPC-Post	<50th percentile	Monitor Measure performance month over month	Met MPL for MY2022. No issue	Measure is part of Member Engagement and Rewards Program	TBD		
TFL-CH	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	none	TBD		
W30(0-15M)	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		
W30(15-30M)	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		
WCV	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		

To: KHS EQIHEC

From: Pawan Gill, Health Equity Manager

Date: 5/23/24

Re: Health Equity Transformation Steering Committee (HETSC)

Background

The Health Equity Office (HEO) was officially launched on January 3, 2023 in response to the 2024 DHCS contractual requirements and the pursuit of NCQA Accreditation. The mission of the Health Equity Office is to improve the health and well-being of our members and the communities through the delivery of trusted, high quality, cost effective and accessible healthcare to all, regardless of their zip code, race, ethnicity, preferred language, cultural preference or personal history. The HEO is responsible for developing an annual workplan which is informed by both quantitative and qualitative analysis that includes clinical and non-clinical interventions in support of equitable service delivery for our members. The work is being coordinated through the HETSC which is structured to receive valuable input from employees, members, providers and the community through the development of five Regional Access Committees (RACs), a Provider Health Equity and Learning Committee (HEAL), an internal Justice, Equity, Diversity & Inclusion (JEDI) committee and a Community Advisory Committee (CAC).

Discussion

- Updated Workplan: In January of 2024, the HEO proposed a preliminary 2024 workplan which was subsequently reviewed and approved by the EQIHEC. No substantive changes have been made to the plan in this quarter. Minor updates have been made to reflect updated titles of assigned staff. Plan will be reviewed with all stakeholders in upcoming HETSC and reported on in the next scheduled EQIHEC.
- Strategic Roadmap: Presentation of the 2024 strategic roadmap of the Health Equity Office that reflects the work being undertaken in the 4 HE domains: Employees, Providers, Members and Community.
- Listening Sessions Summary: Kern Health Systems (KHS) conducted a series of listening sessions in various regions, including Taft, Lamont, Bakersfield, and Delano, to gather qualitative feedback from members. The primary goals were to establish trust, enhance visibility, and understand the unique needs and concerns of the members in these areas. These sessions were held in January 2024, featuring an open forum format that encouraged members to share their experiences and suggestions. Each session included facilitators and translators to ensure all members could participate fully. The purpose of

this presentation is to summarize our findings. This feedback, along with other qualitative data that is being solicited through various channels including KHEP, will be addressed and incorporated into the workplan.

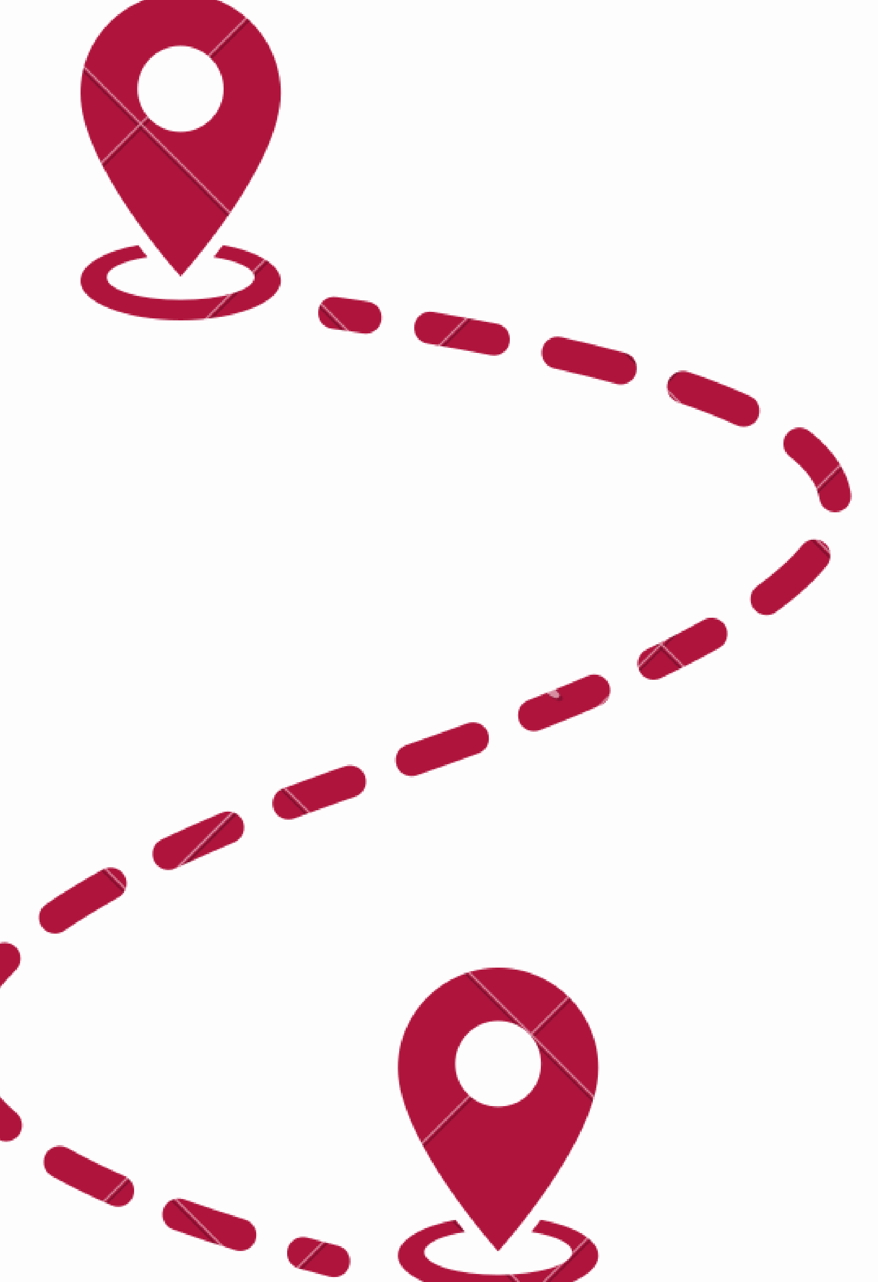
Fiscal Impact
None.

Requested Action
Workplan/Roadmap – Approve.
Summary – Receive and File.

YEARLY OBJECTIVE	GOAL	RESPONSIBLE PERSON(S)	Activities/ Interventions	Timeframe	Previously Identified Issue	HEO 2023	KHS	HEO 2024
ACCESS (PROVIDER)								
Scope of Activity: Determine member access to provider network by ensuring geographic accessibility of choice of providers via mapping of the provider network by level of care; auditing samples of Member Services notes to ensure that a choice of								
Member Needs Assessment	Conduct an annual member needs assessment. Identified gaps in the provider network will be addressed through the recommendations of the Network Adequacy Committee.	Sr. Provider Network Management	Run report to assess needs of members. Review with stakeholders. Adjust provider network as necessary.	Q1-Q2	No	3	2B &2C	2, 12, & 13
Multicultural Practices Provider Survey	Assesss provider cultural responsiveness. Additional goals and objectives with a timetable for implementation are documented in the C&L	Sr. Director of Provider Network Management	Conduct Survey Review results Adjust provider network and/ or address gaps	Q1-Q2	No	3C	2F	12 &13
Collection of Providers' Race/Ethnicity Demographic Data	Assess provider's race/ethnicity demographic profile to that of the member race/ethnicity profile	Sr. Director of Provider Network Management/HEO	Assess the needs of members. Review with stakeholders. Add to Provider Directory	09/2023 11/2023	No	3	2F	12 &13
Provider Training on Language Resources	Offer KHS contracted providers access and availability of language assistance resources	Sr. Director Member Services; Sr. Director of PNM, QI Director	Run report to assess needs of members. Review with stakeholders.	09/2023 11/2023	No	3C	2F	2
Assess KHS Provider Network Language Capabilities	Assesss provider language capabilities to that of the KHS member language needs.	Sr. Director PNM & HEO	needs of members. Review with stakeholders. Add to Provider Directory	09/2023 11/2023	No	3	2F	1, 2, &6
ACCESS (Member)								
Scope of Activity: Ensure consumer access services by reviewing the answer and abandonment rates of telephone calls to the KHS Member Services line; monitoring the provision of interpretation and translation services; and evaluating penetration rates.								
Utilization of Language Assistance Resources	Assess utilization of language assistance resources for organizational functions	Sr. Director Member Services	invoices to assess utilization of services. Review reports with stakeholders. Take corrective actions	1/15/2024 1/30/2024	No	5 &6	2D	2, 12,13
Identification of Threshold and Notification Languages	Identify threshold languages for members at 1,000 or 5% (whichever is less) and notification languages for members at 200	Sr. Director Welness & Prevenetion - Cultural and Linguistics	Run Annual Report Share with Stakeholders Update Vital Documents Process	04/2023 10/2023 10/2023	No	6	3B, 6A	2
COMPLAINTS AND GRIEVANCES								
Scope of Activity: Ensure the proper and timely handling of complaints and grievances.								
Grievances are written in clear, easy-to- understand language.	100% of grievance resolution letters are easy to understand and written in a language no greater than 6th grade.	Complaints and Grievances Manager	Run quarterly reports to assess grievance resolution letters. Review reports with stakeholders. Take corrective actions as necessary.	4/15/2023 7/15/2023 10/15/2023 1/15/2024 4/30/2023 7/30/2023 10/30/2023 1/30/2024	Yes	4	2C	
Improve tracking mechanism of grievances	Enhance current tracking mechanism to capture and easily report types of grievances (particularly discrimination related) and monitor regularly to identify trends	Complaints and Grievances Manager/HEO	Assess current report, add necessary columns and include in HESTC report					
COUNTY								
Share CLAS Progress with Stakeholders	Share CLAS progress with stakeholders, including obtaining MHC distinction	Health Equity Officer	Share with Stakeholders	Apr-22	No	5	2F	
Annual evaluation of the CLAS program	Conduct annual evaluation of the CLAS program	Health Equity Officer/Sr. Member	Share with Stakeholders Identify and address areas for improvement	04/2024 06/2024 06/2024	No		2F	12 &13
Assessment of KHS Workforce Demographics	Analyze KHS workforce demographics	Health Equity Officer	workforce activities. Review with stakeholders. Monitor workforce demographics for hiring	1/15/2024 1/30/2024	No	3A	2A	12 &13
Diversity, Equity and Inclusion (DEI) Task Force Development	Development of the KHS DEI Task Force will serve as the stepping stone to mobilize efforts around implementation of DEI practices, policies, engagement, climate pulse checks, and training opportunities.	Health Equity Officer	Solicit workforce participation for task force development Establish task force with regular occuring meeting schedule	1/15/2024 1/30/2024	No	10	2A	14
Identify Consultant for Organizational Climate Assessment	Facilitate a vendor search to identify a Diversity, Equity, and Inclusion consultant to examine workforce activities.	Health Equity Officer	Issue RFP for DEI Consultant Identify qualified respondents. Select DEI Consultant	1/15/2024 1/30/2024	No	2	2F	5

Organizational Climate Assessment	Conduct Organizational Climate Assessment	Health Equity Officer	Select DEI Consultant Develop KHS Organizational Climate Assessment Tool Facilitate Organizational	1/15/2024 1/30/2024	No	2	2A	12 &13
Diversity, Equity and Inclusion (DEI) Training	Develop organization- wide divesity, equity and inclusion training curriculum	Health Equity Officer	Select DEI Consultant Assess organizational training needs Create DEI Training Curriculum	1/15/2024 1/30/2024	No	10	2A	10
Ensure Bilingual KHS Workforce	Maintain a bilingual Member Services Department workforce that is representative of 5% of the population	CHRO Sr. Director of Member Services	Maintain Member Service Staffing Share with Stakeholders Add to Qualified	1/15/2024 1/30/2024	No	3	2F	
Bi-Lingual Staff Competency Assessment	Conduct Language Proficiency Test for all new bilingual applicants	CHRO Sr. Director of Member Services	Facilitate LPT Assessment Provide LPT assessment scores	1/15/2024 1/30/2024	No	10	2A	13
Staff Experience with Language Assistance Resources	Assess baseline of staff experience with language resources	Sr. Director of Member Services	Run Annual Report Share with Stakeholders Identify and address	10/2023 04/2024 04/2024	No	10	2A	8
QUALITY MANAGEMENT								
Scope of Activity: Demonstration of appropriate quality management strategies, as incorporated into the QM Program Description and Work Plan, and additional quality activities around specific service areas such as BHRS, BH-PH coordination, collaboration with other services								
Reduce language disparities among Asian speaking members	Reduce language disparities among Asian speaking members getting screening for breast cancer by 5 % in comparison to other groups.	Health Equity Officer Director of Quality	Run quarterly report to assess IET measures. Review reports with stakeholders. Take corrective actions as necessary.	4/15/2023 7/15/2023 10/15/2023 1/15/2024 4/30/2023 7/30/2023 10/30/2023 1/30/2024	No	6A	2F	
Reduce disparities among Hispanic Members	Improve manamgent of Diabetes by reducing A1c levels in Hispanic members by 2024. Improve the good control rate by 5 % by 2024.	Health Equity Officer Director of Quality	Run quarterly report to assess IET measures. Review reports with stakeholders. Take corrective actions as necessary.	4/15/2023 7/15/2023 10/15/2023 1/15/2024 4/30/2023 7/30/2023 10/30/2023 1/30/2024	No	6A	2F	
CONSUMER/FAMILY SATISFACTION								
Scope of Activity: Qualitative review of overall member satisfaction, via Consumer Satisfaction Team reports and the timely resolution of issues raised								
Assessment of member experience with Language Resources	Assess baseline of member experience with language resources	Sr. Director of Member Services	Run Annual Report Share with Stakeholders Identify and address areas for improvement	10/2023 04/2024 04/2024	No	4	2B & 2D	8
HEO Regional Listening Sessions	Gather qualitative data directly from members and the community regarding their experience	Health Equity Office	Assess baseline of member experience for medical access, quality and trust		No	4	2B & 2D	

2024 KHS Health Equity Strategic Roadmap



Health Equity Domains

Employees
15%

Engage and develop employees with training, culture initiatives and state-mandated DEIB programs.

Providers
15%

Provide training, programmatic support and incentives to provider network to ensure the delivery of quality care to all members

Communities
25%

Build relationships and invest in communities and Community based Organizations (CBOs)

Members
45%

Focus on member wellness, prevention, reducing health disparities and quality improvement.

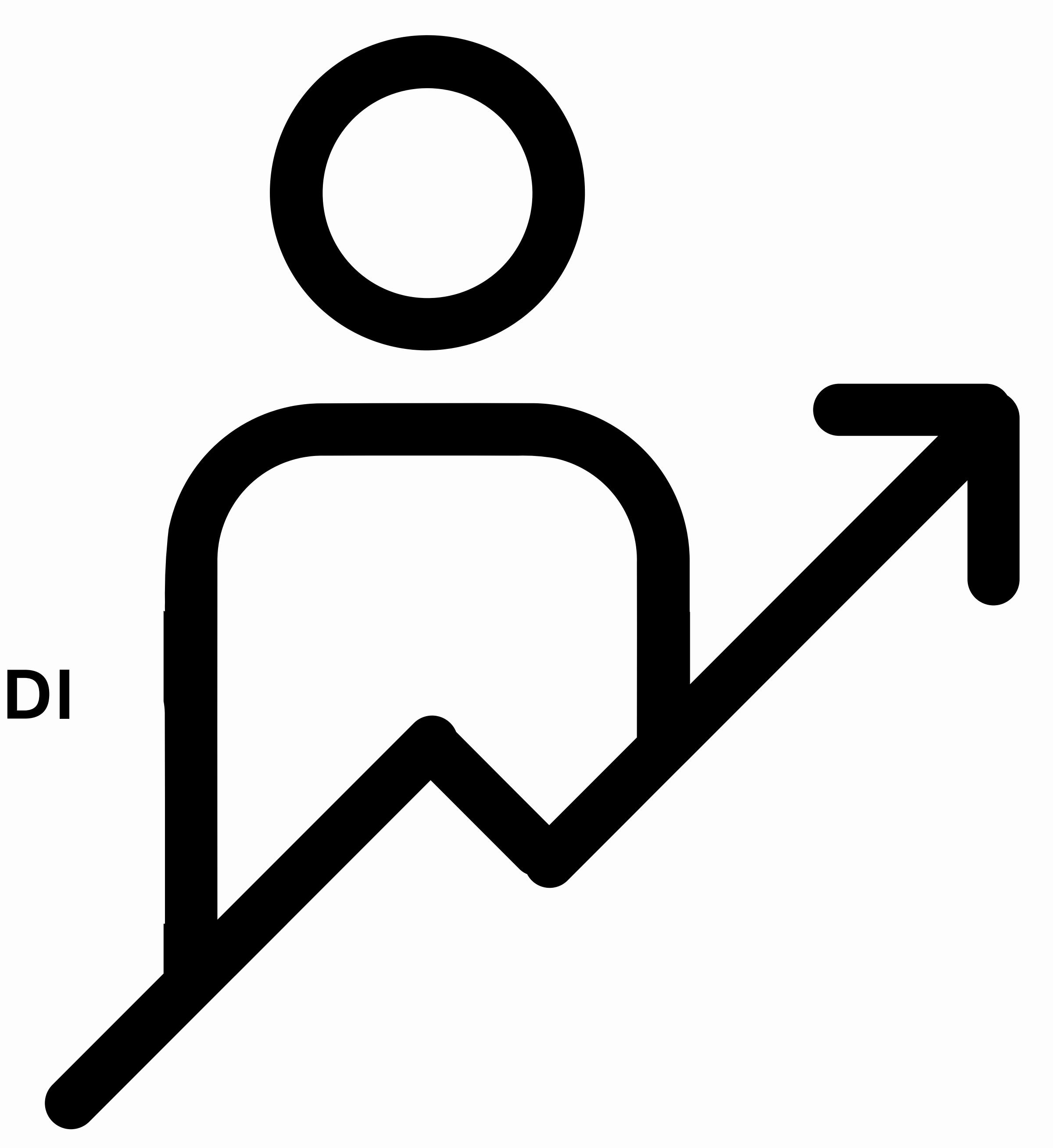
Employees Domain

Training: Mandated DEIB and Cultural Competence Training
Values Based: Expanded offerings for specific populations

Recruitment & Retention (exit surveys)

Experience: EE Survey, DEIB Survey, Career Development, JEDI

Structural/Systemic: Promotions & Succession Planning



Providers

Provider Trainings # of training
Provider Satisfaction Survey
Health Equity Programs
*5 yr EPT; 1st cohort
IHI/DCHS Child Health Equity Collaborative
Access: service expansion, extended hours, locations by region, transportation, telehealth provisions, mobile clinics, comprehensive access study
Quality/MCAS: Doula’s
HEAL engagement (# and quality of engagement)

Communities

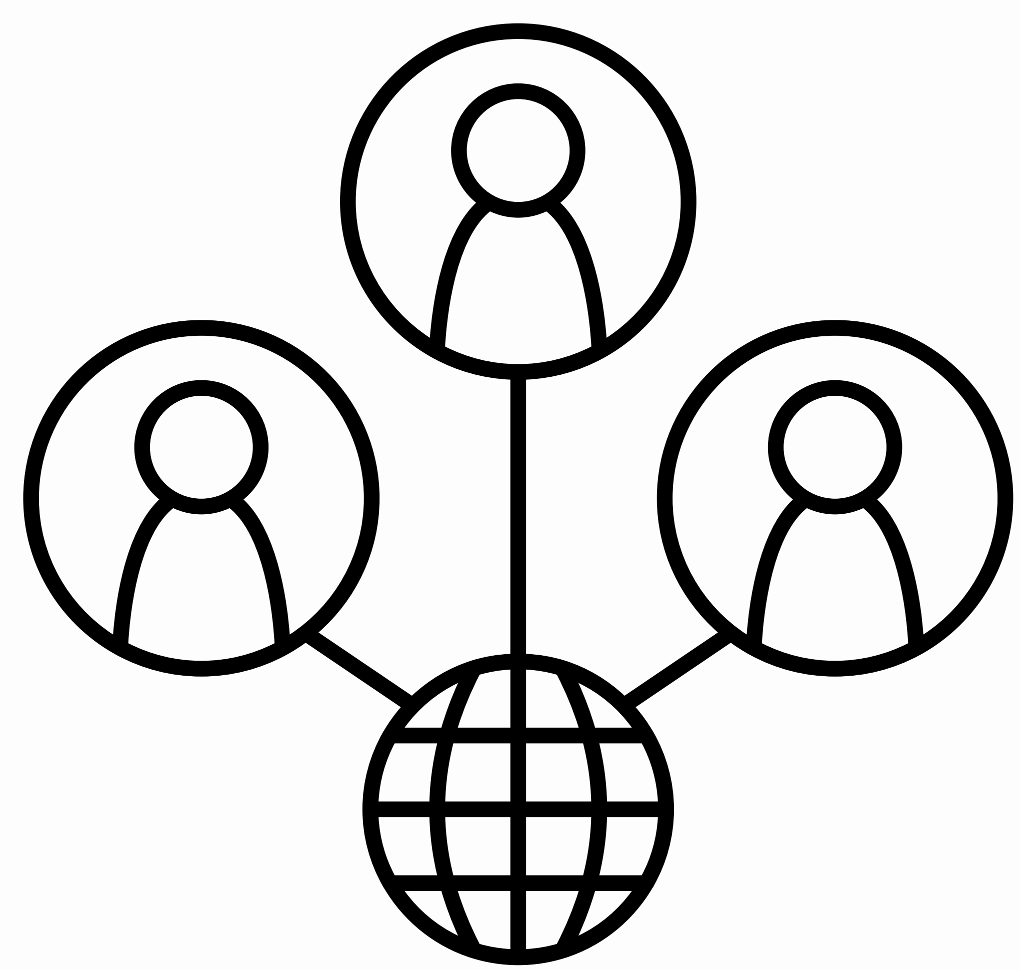
Community Investments (community grants program, organizational wide CBO contracts, level of diversity/breadth, RAC's, CAC

How to track community engagement (outreach events per region and by demographic)

Targeted interventions & outreach

Special populations programming and resources

Member portal accounts

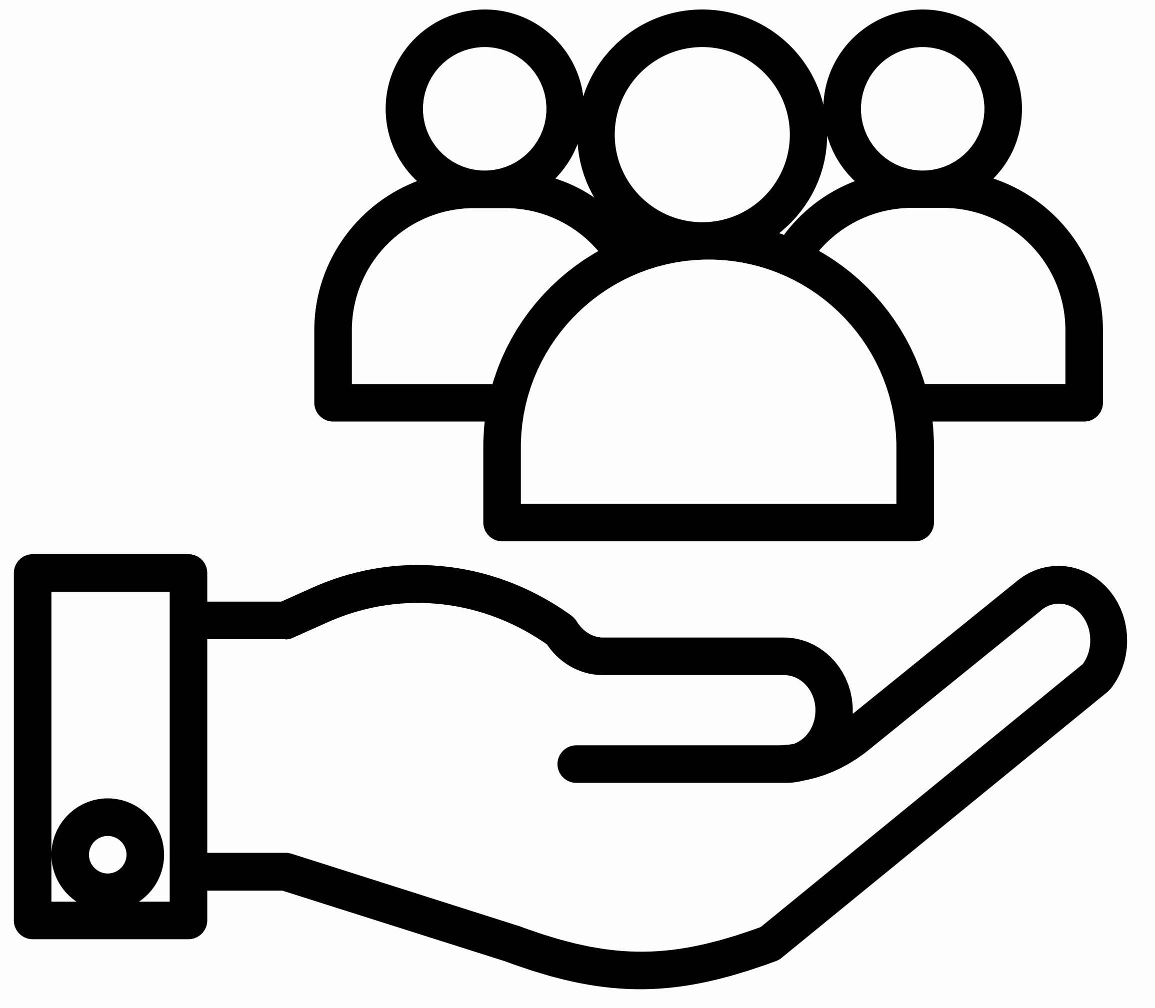


Members

Individual metrics for annual workplan
Targeted interventions & outreach
Special populations programming and resources

Member satisfaction survey
Member engagement opps: RACs, Listening sessions, Language offerings, health fairs

Member Choice
Member portal accounts



KHS Listening Sessions

Gathering community feedback in Kern County to learn about healthcare access, quality, and trust.

Listening Sessions Dates: January 22-23 and 29-30, 2024

Background

Kern Health Systems (KHS) conducted a series of listening sessions in various regions, including Taft, Lamont, Bakersfield, and Delano, to gather qualitative feedback from members. The primary goals were to establish trust, enhance visibility, and understand the unique needs and concerns of the members in these areas. These sessions were held in January 2024, featuring an open forum format that encouraged members to share their experiences and suggestions. Each session included facilitators and translators to ensure all members could participate fully.

HEO Regional Listening Sessions

Community Listening Sessions have been hosted in: Bakersfield, Lamont, Delano & Taft.

Executive Summary

Positive Feedback

Participants mentioned good experiences with specific providers and clinics like Clinica Sierra Vista and Kern Family Health Care.

Common Concerns

Participants raised issues with appointment availability, transportation, trust in medical system, and quality of healthcare services.

The feedback highlights positives but also areas for improvement in Kern County's healthcare system.

Common Challenges

Difficulty obtaining timely appointments

Participants reported challenges getting appointments within a reasonable timeframe, with waits up to 6 months

Transportation issues

Concerns were raised about lack of transportation options and difficulties getting to appointments

Lack of trust in medical system

Participants expressed distrust due to failed referrals, poor communication, and feeling overlooked

Concerns about quality of care

Issues were noted regarding medication delays, lack of comprehensive care, and need for more education

These common challenges across Kern County highlight the need for improvements in appointment availability, transportation, trust, and quality of healthcare services.

Potential Solutions

Improve appointment availability

Increase number of providers, optimize scheduling, offer extended hours

Enhance transportation services

Provide shuttle services, offer transportation vouchers, partner with rideshares

Strengthen patient education

Provide detailed info on services, referrals, healthcare process

Improve trust and communication

Enhance provider-patient communication, address referral issues

Collaborative efforts needed between providers, organizations, and authorities to address common concerns.

Participants in Kern County listening sessions expressed concerns regarding access to timely appointments, transportation for medical visits, quality of interpretation services, rushed appointments with providers, and lack of trust due to issues like poor communication from providers.

Access Concerns in Kern County

- Difficulty getting appointments

  Long wait times up to 6 months and sometimes no appointments available

- Limited after hours & weekend services

  Need more urgent care and specialist appointments outside regular hours

- Transportation challenges

  Lack of transportation options for appointments, especially for workers

- Limited provider choice

  Difficulty finding providers, especially specialists

- Communication barriers

  Need more patient education on insurance, resources, and services

Challenges Regarding Quality of Healthcare

- Prescription Delays and Referral Issues

  Concerns were expressed about delays in receiving prescriptions and issues with referrals, including a lack of communication and interpreter problems

- Provider Attitudes and Time Management

  Participants reported experiences of providers being behind schedule, rushed visits, and a lack of patience and respect from some healthcare providers

- Lack of Comprehensive Care and Communication

  Issues were raised about the lack of comprehensive care and communication between providers and patients

- Interpreter Quality and Language Barriers

  Participants highlighted challenges related to the quality of interpreters and language barriers during medical appointments

- Lack of Trust in Providers

  Some participants expressed a lack of trust in healthcare providers, citing rushed appointments and lack of prioritized care

Trust

Lack of Trust Due to Complications About Children

Some participants reported a lack of trust due to complications related to children's healthcare, including concerns about incorrect diagnosis

Communication and Follow-Up Problems

Concerns about lack of follow-up and delays in response from providers contributed to distrust

Provider Attitudes and Time Management

Issues with provider attitudes and rushed appointments led to distrust

Lack of Comprehensive Care and Patient Prioritization

Feeling providers did not address all concerns and patients were not prioritized led to distrust

Multiple issues related to provider interactions, attitudes, and communication contributed to a lack of trust in the medical system among participants.

County Breakdowns

- Bakersfield

  Difficulty getting appointments, lack of bilingual providers, transportation issues, concerns about quality of care, lack of trust in system.

- Delano

  Difficulty getting Medi-Cal, lack of specialized providers, lack of trust in system.

- Lamont

  Lack of information and guidance, poor interpretation services, lack of trust in system.

- Taft

  Transportation issues, lack of access for low-income households.

Bakersfield

Bakersfield residents face challenges getting timely medical appointments, with wait times up to 6 months in some cases. The area also lacks bilingual providers to serve the diverse population. Transportation issues make accessing care difficult, especially for those without private transportation. There are also concerns about rushed appointments and poor communication diminishing the quality of care and trust in providers.

Bakersfield: Key Themes

1. Access to Healthcare Services
- Long Wait Times for Appointments
- Transportation Barriers
- Lack of Bilingual Services

2. Quality of Care
- Insufficient Time with Providers
- Need for Better Patient Education
- Issues with Medications and Referrals

3. Trust in the Healthcare System
- Perceived Lack of Competence and Care
- Desire for Consistent Care
- Communication Issues

Delano

Difficulty obtaining Medi-Cal was frequently cited, with participants mentioning rude staff and negative experiences with DHCS. There is also a lack of specialized providers in dentistry and medicine, especially after 5pm which impacts field workers. Participants expressed distrust due to issues like improper diagnosis of children and perception of bias based on insurance status.

Delano: Key Themes

1. Access to Healthcare Services
- Difficulty in Obtaining Appointments
- Rude and Unhelpful Staff
- Slow Processing of Medi-Cal Applications

2. Quality of Care
- Inadequate Time with Providers
- Differential Treatment Based on Insurance
- Long Wait Times at Clinics

3. Trust in the Healthcare System
- Lack of Trust in Providers
- Poor Communication
- Failed Referrals and Follow-Ups

Lamont

Lamont residents expressed concerns about lack of information on available medical services and health insurance coverage. Poor quality interpretation services created communication barriers during medical appointments. Some felt providers did not take enough time with children, leading to lack of trust in the system.

1. Access to Healthcare Services
- Long Wait Times for Appointments
- Lack of After-Hours Care
- Transportation Issues

2. Quality of Care
- Rushed Appointments
- Inconsistent Care
- Interpreter Services

3. Trust in the Healthcare System
- Lack of Trust in Providers
- Poor Communication
- Referral and Follow-Up Issues

Taft

Taft residents face transportation challenges getting to medical appointments, especially those without access to a private vehicle. Low-income households also have difficulty accessing medical services due to lack of transportation options and challenges obtaining referrals.

1. **Access to Healthcare Services**
    1. Transportation Challenges
    2. Timely Referrals and Appointments
    3. Prescription and Medical Supply Issues
2. **Quality of Care**
    1. Positive Experiences with Primary Care
    2. Issues with Specialized Care and Medical Supplies
    3. Inconsistent Follow-Up Care
3. **Trust in the Healthcare System**
    1. Mixed Trust Levels
    2. Reliance on Community and Personal Advocacy
    3. Communication and Follow-Up Issues

Conclusion

The listening sessions across Bakersfield, Delano, Lamont, and Taft revealed significant insights into the challenges faced by members in accessing healthcare services, the quality of care received, and their trust in the healthcare system. These findings highlight the need for targeted interventions to improve access to services, enhance communication, build trust, and address specific health needs. By addressing these themes and developing trainings based on the learnings from the listening sessions, KHS will better serve its members by fostering a more inclusive and effective healthcare system.

Regional Advisory Committees - RACs

- Quarterly townhall style structured meetings to engage and acquire information from members & communities held in each of the 5 regions
- Topics for the meetings will be gauged by the requests of HETSC
- 2024 Themes: Access, Quality, and Trust

Provider Programs And Opportunities

- In partnership with the Bakersfield Sikh Women's Association, KHS hosted a provider and community partner training covering Intimate Partner Violence in the South Asian Community. Key focus areas included:
  - Cultural Sensitivity: insights into the cultural nuances and barriers surrounding IPV within the South Asian community.
  - Identification & Screening: effective techniques for recognizing signs of IPV and utilizing a SAV screening tool
  - Resources & Referral: exploring available resources and referral pathways to connect survivors with appropriate support services

DHCS Equity Practice Transformation - EPT Payment Program Update)

Overview of EPT Payment Program

Budget: $650 million
Timeframe: 5 years
Goal: Improve primary care for Medi-Cal recipients

- Advance equity
- Reduce COVID-19-driven care disparities
- Invest in upstream care models/partnerships to address health/wellness
- Fund practice transformation aligned with value-based payment models

Initial Cohort: 207 primary care practices that care for Medi-Cal enrollees

Directed Payment Structure: Practices receive payments for reaching specific milestones approved by CMS. Payments are allocated by DHCS and then passed to managed care plans, who then pay the providers they are partnered with in the program.

19 MCPs Across 207 Practices

Plans sponsoring 1 EPT practice

Alameda Alliance for Health
Blue Shield of California Promise Health Plan
Community Health Group Partnership Plan
Community Health Plan of Imperial Valley
Health Plan of San Mateo
Molina Healthcare of California Partner Plan

Plans sponsoring 2-10 EPT practices

San Francisco Health Plan (2)
CalViva Health (3)
CenCal Health (3)
Anthem Blue Cross Partnership Plan (4)
Santa Clara Family Health Plan (5)
Health Plan of San Joaquin (7)

Plans sponsoring 11-20 EPT practices

Inland Empire Health Plan (12)
Kern Family Health Care (12)
CalOptima (14)
Central California Alliance for Health (15)

Plans sponsoring 21+ EPT practices

Partnership Health Plan of California (27)
L.A. Care Health Plan (44)
Health Net Community Solutions Inc. (53)

Kern Health Systems (KHS) received a total of 19 applications for EPT program and 12 were selected by DHCS to participate in the program.*

- Universal Healthcare Services Inc.
- Ajitpal Tiwana
- Jasleen Tiwana
- Polyclinic Medical Center
- Pinnacle Primary Care
- Kern Rural Wellness Center (Arvin Medical Clinic)
- The Children's Clinic of Bakersfield
- Infusion and Clinical Services, Premier Valley Medical Group
- Good Samaritan Hospital
- Omni Family Health
- Kern Medical
- Adventist Health Delano

Practice with Max Potential Payment Amount.*

Practice	Max potential payment
Universal Healthcare Services Inc.	$2,250,000
Ajipal Tiwana	$600,000
Jasleen Tiwana	$375,000
Polyclinic Medical Center	$2,250,000
Pinnacle Primary Care	$1,000,000
Kern Rural Wellness Center (Arvin Medical Clinic)	$1,500,000
The Children's Clinic of Bakersfield	$375,000
Infusion and Clinical Services, Premier Valley Medical Group	$1,000,000
Good Samaritan Hospital	$375,000
Omni Family Health	$10,000,000
Kern Medical	$5,000,000
Adventist Health Delano	$1,500,000
Total:	**$26,225,000**

***Note: Potential payment award amount listed by practice, all milestones must be met to be awarded max amount.**
****The maximum amount of payments a practice may receive is based on the number of assigned Medi-Cal (inclusive of D-SNP) members under an active Medi-Cal Managed Care Plan contract at the time of application.**

Provider Health Equity and Learning * Committee -(HEAL)

Health Equity and Learning Committee - HEAL

Mission

The mission of the Provider HEAL Committee is to foster a proactive and collaborative environment among our network providers, dedicated to advancing health equity.

Membership

Open to all practices within Kern Family Health Care's network and may include healthcare providers, administrators or other designated staff

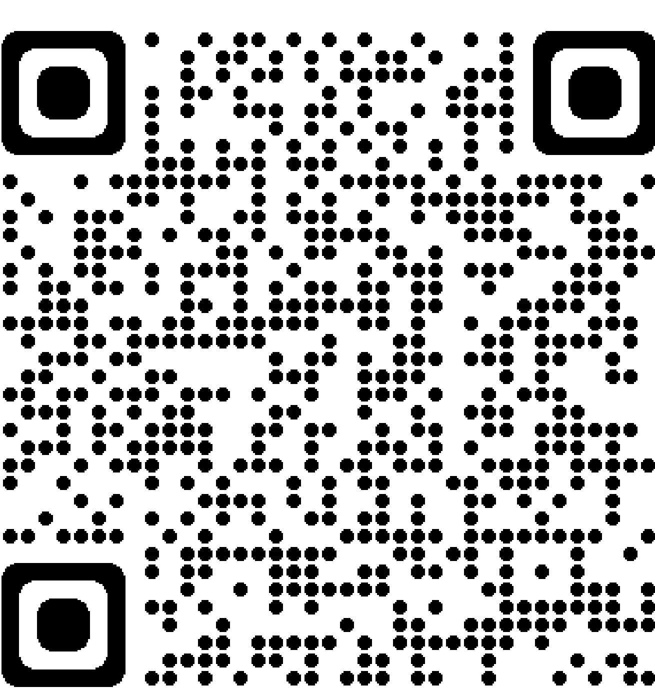
HEAL Sign Up Form

Solicit Feedback: Act as platform for providers to share challenges in the field and gather feedback to address issues related to health equity to help inform the development of KHS's training offerings and support for provider network

Resource sharing: Facilitate the exchange of resources, funding opportunities, best practices and innovative approaches to improve healthcare service delivery with health equity

Training & Development: Identify, develop and promote opportunities for training & professional development to enhance provider knowledge and skills in delivering equitable healthcare

Practice Expansion: Explore & discuss opportunities for expanding access and/or services that align with and support health equity initiatives



Confirm your interest today!

Coming soon!

Updated Discrimination Grievances & Appeals Reporting

Educational Partnerships Update

1st quarter RAC Summary

THANK YOU.!

Questions?

Kern Health Equity Partnership's

Kern County Health Equity Plan

January 2024- December 2026

Presented to Kern County Board of Supervisors on January 09, 2024

Background:

Kern County has over 900,000 residents of diverse backgrounds, life experiences, and demographics. Kern County also spans 8,000 square miles and consists of diverse geographies and communities with varied levels of access to health services.

Kern County Public Health set forth to identify challenges and barriers that Kern County residents experience to identify ways to close gaps and address community needs along with partners *Adventist Health, Anthem Blue Cross, Bakersfield American Indian Health Project, Bakersfield Memorial Hospital, Community Action Partnership of Kern, Kern Behavioral Health and Recovery Services, Kern Community College District, Kern County Network for Children, Kern County Superintendent of Schools, Kern Health Systems, United Way of Central Eastern California,* and others. In July of 2023, the Kern Health Equity Partnership was established, and the strategic planning series was organized to guide this process.

Kern County Public Health engaged over 200 community members and partners, and convened over 86 partners throughout Kern County through the 6 month-long strategic planning series. These sessions aimed to assess challenges that exist within organizations in serving families throughout Kern County to identify areas of focus listed within this 3-year plan. The goals and objectives are based upon the SMARTIE framework by which they must be Specific, Measurable, Action oriented, Relevant, Time bound, Inclusive, and Equitable. This process included listing organizations throughout the communities of Kern, organizing them into categories to identify domains, and lastly, listing challenges that exist within each domain.

The domains are:

- **Access to Care:** *Lack of Providers, Distance/Geography, and Transportation*
- **Education/Health Literacy:** Literacy Levels, Cultural, and Community Health Workers/Promotoras/Social Service Providers
- **Socio-economic Status/Poverty:** Living Wage, Economic Workforce Development, and Systemic Barriers

Over 130 potential activities were identified in this process that were grouped and refined within the goals and objectives in this plan. This work requires systemic change and partnership among all local health agencies. While some objectives may be specific to community groups and geographic areas, the goals and objectives are designed to establish a blueprint that can be replicated in communities experiencing similar needs. Thus, this plan aims to establish a framework of work that can be replicated in communities throughout all of Kern County.

Goals and Objectives:

Access to Care

Goal 1:

By December 31, 2026, the Kern Health Equity Partnership will improve the access to health care in rural communities by addressing geographical barriers and lack of providers for Kern County communities who are underserved and challenged with accessing service providers.

Objective 1: Lack of Providers

By December 31, 2024, the Kern Health Equity Partnership will conduct an initial gap analysis of providers to identify communities of California City/Mojave that do not have provider adequacy to inform the development of strategies that address lack of providers in communities with geographical barriers.

Objective 2: Distance/ Geography

By December 31, 2026, the Kern Health Equity Partnership will create telehealth infrastructure to co-locate health services in at least three (3) non-traditional care settings, such as churches, school districts, senior centers, libraries, community rooms, or veteran's halls, to better serve families experiencing geographical barriers.

Objective 3: Transportation

By March 31, 2025, the Kern Health Equity Partnership will conduct an initial gap analysis of transportation service providers that are designated to health care services and develop strategies that will strengthen transportation services that are high-capacity ADA compliant vehicles, equipped with car seat, in rural areas of Kern County communities.

Education/ Health Literacy

Goal 2:

By December 31, 2026, the Kern Health Equity Partnership will increase opportunities for health literacy by addressing literacy levels, cultural differences, and supporting community health workers, promotoras, and social service providers for the Hispanic community and all communities impacted by Social Determinants of Health.

Objective 1: Literacy Levels

By March 31, 2025, the Kern Health Equity Partnership will host sessions aimed to obtain community input for at least five (5) different geographic communities, to identify health topics that will increase education and literacy for residents impacted by Social Determinants of Health.

Objective 2: Cultural

By March 31, 2025, the Kern Health Equity Partnership will create at least two (2) paths for agencies to be trained and commit to Diversity, Equity, Inclusion and Belonging (DEIB) practices aimed to support belonging, acceptance, and build awareness of cultural diversity of the communities of Kern.

Objective 3: Community Health Workers/Promotoras/Social Service Providers

By December 31, 2026, the Kern Health Equity Partnership will create at least three (3) opportunities for in-person community conversations and trainings between health care agencies, clinical providers, community health workers, promotoras, and social service providers in Kern County aimed to understand community experiences, share universal best practices, and support service delivery.

Socio-Economic Status/ Poverty

Goal 3:

By December 31, 2026, the Kern Health Equity Partnership will contribute to the improved socio-economic status for rural communities and low-income households by conducting a gap analysis, creating pathways to employment opportunities, and advocating with legislative officials at the local and state level.

Objective 1: Living Wage

By December 31, 2026, the Kern Health Equity Partnership will partner to create at least two (2) pathways to quality jobs that address the special needs of rural communities.

Objective 2: Economic & Workforce Development

By March 31, 2025, the Kern Health Equity Partnership will create at least one (1) gap analysis and develop strategies around workforce opportunities to support rural communities.

Objective 3: Systemic Barriers

By June 30, 2025, the Kern Health Equity Partnership will advocate for equitable changes in policies and practices to prioritize resources for workforce recruitment of low-income households by engaging with at least three (3) elected and appointed officials at the local and state level.

To: KHS EQIHEC

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

Date: May 2024

Re: Quality Performance Q1 2024 Report

Background

The QP team develops a quarterly report to outline, monitor, and evaluate our ongoing departmental activities. This report also serves as an opportunity for committee members to provide input regarding our work. This report reflects activities and outcomes for the first quarter of 2024.

Discussion

See pages 2-4 of this document.

Fiscal Impact

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

Requested Action

Review and approval of the report.

Quality Performance Department
Executive Summary
1st Quarter 2024

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

8 Initial Facility Site Reviews and 4 Initial Medical Record Reviews were completed in Q1 2024. 2 Periodic FSRs and 2 periodic MRRs were also completed. 100% of Facility Site Reviews passed and 83% YTD of Medical Record Reviews passed. 1 site failed the first review, however Corrective Action Plans were completed and closed. QP also conducts mid-cycle interim reviews of facilities to monitor facility compliance. Of which, 5 were completed in Q1 2024. The QP department also conducts Physical Accessibility Review Surveys (PARS) and 4 were completed in Q1 2024.

II. Quality Improvement Projects (pages 11-12)

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

The current PIPs began in August 2023 and run through 2026. The first PIP is focused on the W30 MCAS measure, specific to Health Equity of the 0-15 months African American Population in Kern County. The second PIP is considered a non-clinical Behavioral Health PIP, specific to the FUA and FUM measures. We will be partnering with KHS' Behavioral Health Department to ensure success of this PIP. The first submission for both PIPs were approved by HSAG.

We are currently developing the second phase of the PIP, which will focus on interventions and testing. We are developing a provider notification process for ED visits related to Behavioral Health and Substance Use Disorders.

For the W30 PIP, we are leveraging activities from mobile units and the IHI/DHCS collaborative focused on well-care visits for the 0-15 months, African American babies.

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

The QP team continues with MCAS specific initiatives in support of improving all measures for current measurement year with a heavy focus on the Children's domain of care. As of March 2024, 14 of 18 measures have improved compared to last year.

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

QUALITY PERFORMANCE DEPARTMENT

QUATERLY EQIHEC COMMIITTEE REPORT

Q1 2024

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

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

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

II. Quality Improvement Projects
   A. Performance Improvement Projects (PIPs)
   B. Red Tier & Strike Team

V. Managed Care Accountability Set (MCAS) Updates

VI. Policy and Procedures

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

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

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

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

Critical Elements:

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

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

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

Scoring and Corrective Action Plans

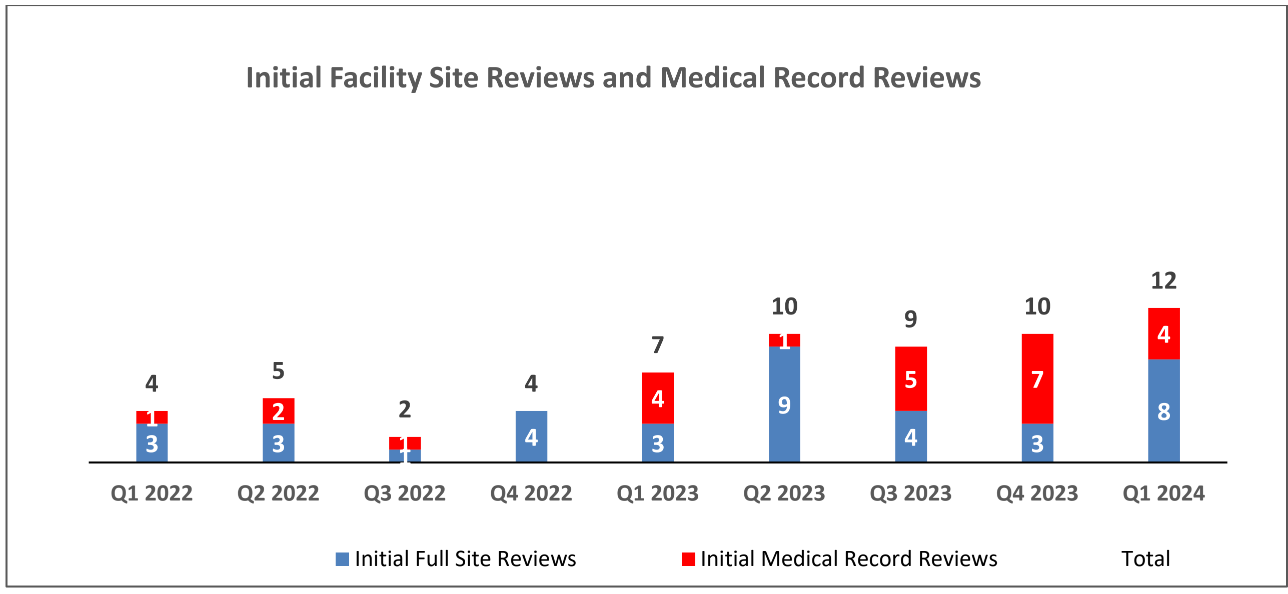
Provider sites that receive an FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are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

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

Corrective Action Plans (CAPs)

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

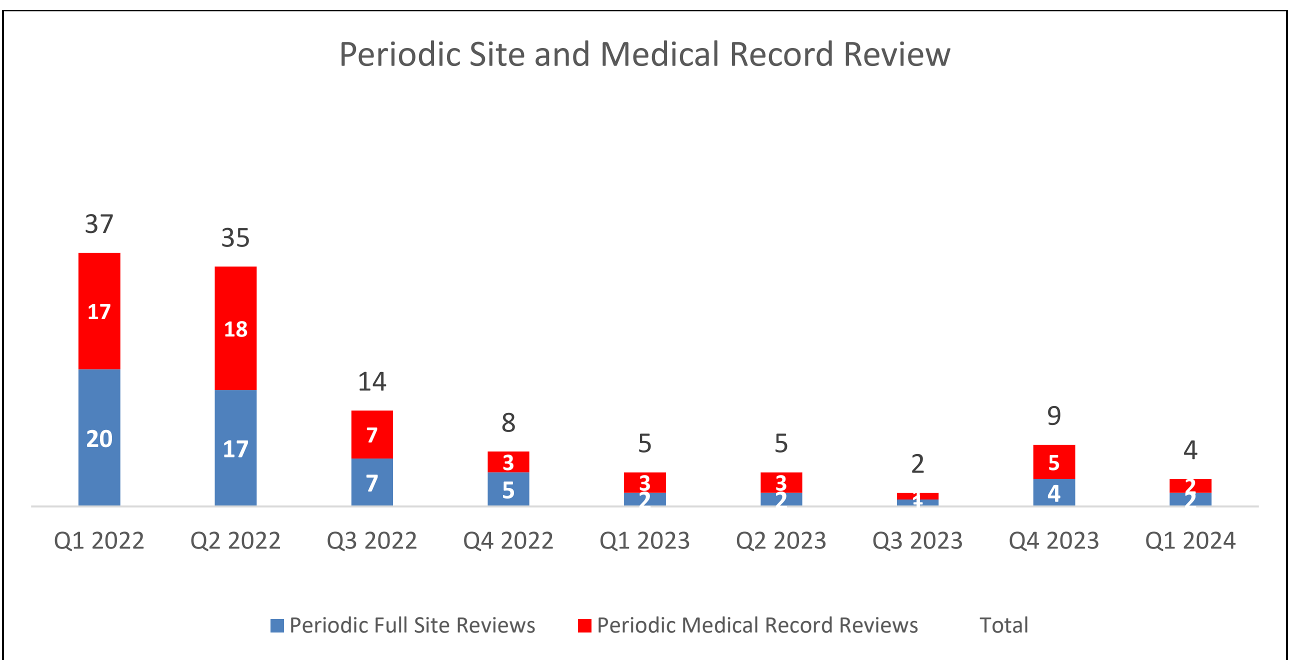
A. Initial Facility Site Review and Medical Record Review Results:



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

B. Periodic Full Site and Medical Record Reviews

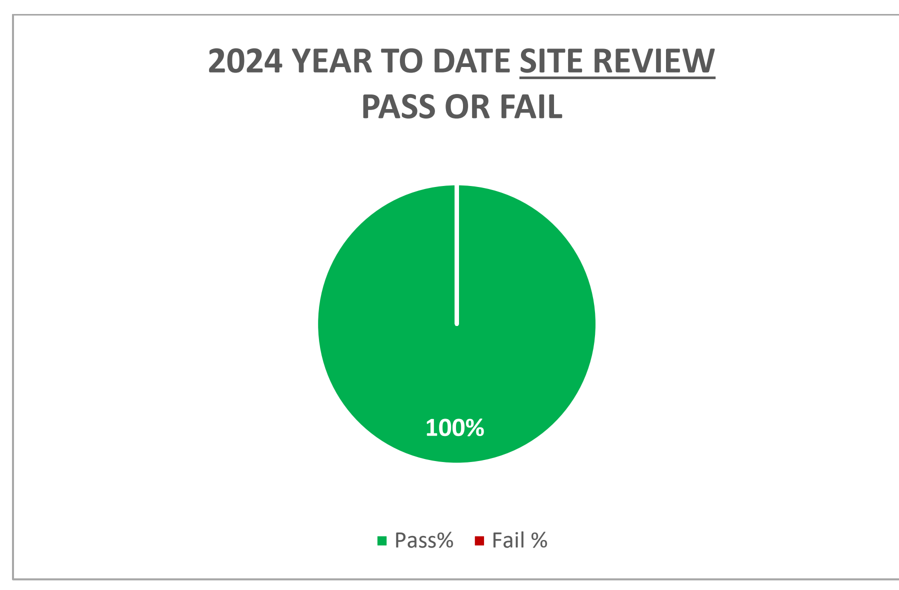
Periodic reviews are required every 3 years. The due date for Periodic FSRs is based on the last Initial or Periodic FSR that was completed. The volume of Periodic Reviews is not controlled by KHS. It is based on the frequency dictated by DHCS.



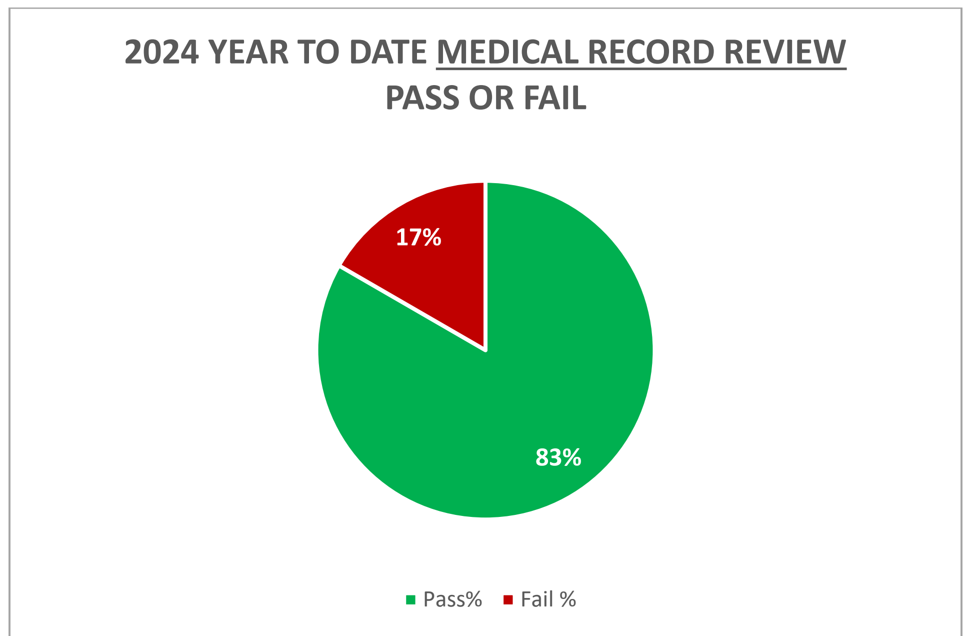
The above chart reflects the number of Periodic Full Site Reviews and Medical Record Reviews that were due and completed for each quarter.

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

Based on DHCS' standard 80% or higher is considered as passed. Scoring 80% - 89% is considered a "conditional pass" and requires a CAP only for the elements that were non-compliant. A score below 80% is considered a Fail and requires a CAP for the entire site or medical record review.



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



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

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

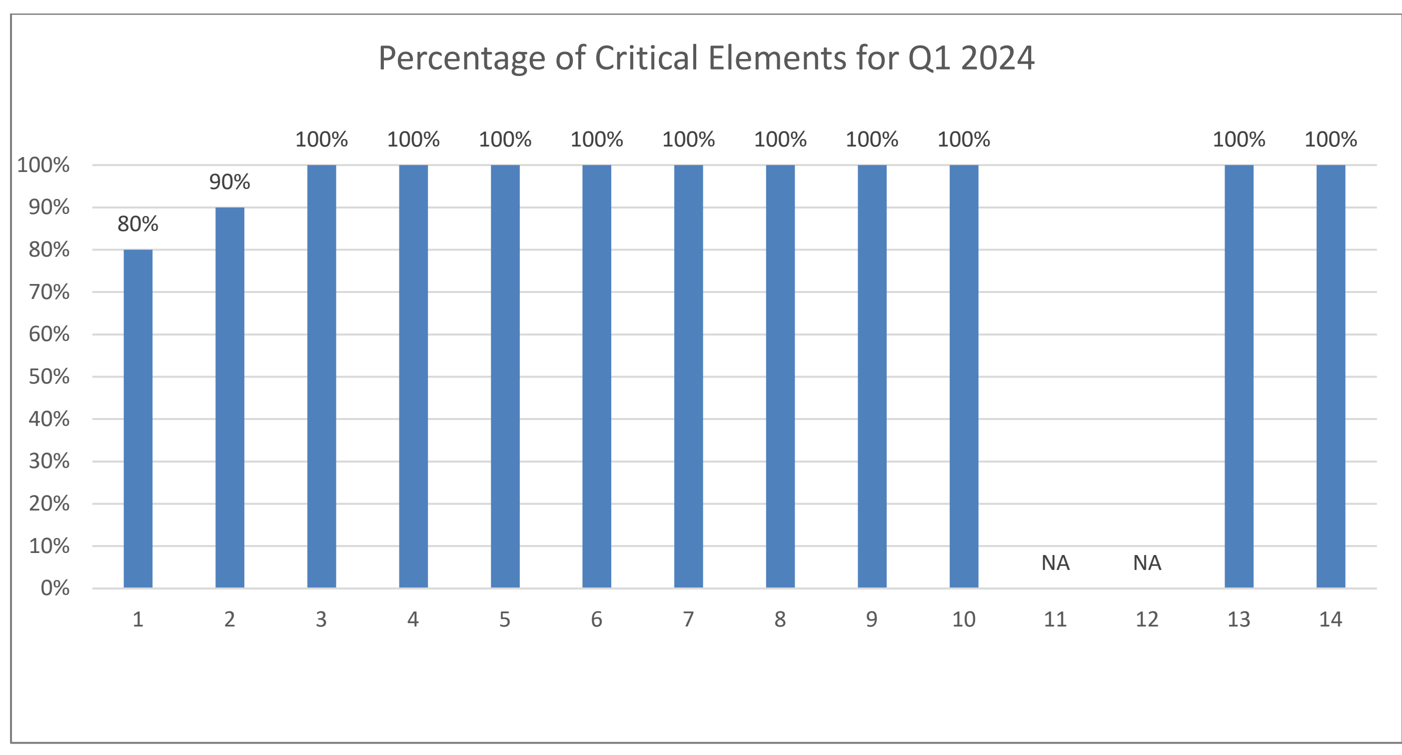
1. Calibration of Equipment not done
2. Clearly diagramed Evacuation Routes are not in visible locations.
3. Site does not utilize California Immunizations Registry (CAIR)

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

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

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

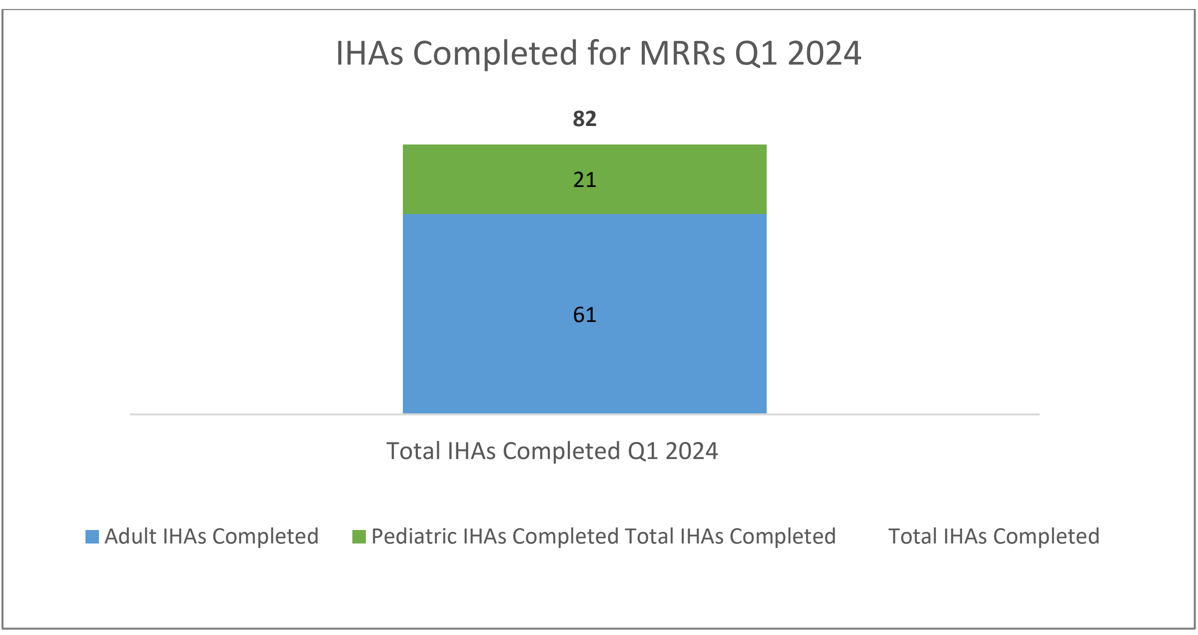
C. Critical Elements (CE) Percentage for Site Reviews:



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

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

D. IHA's percentage for MRRs:



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

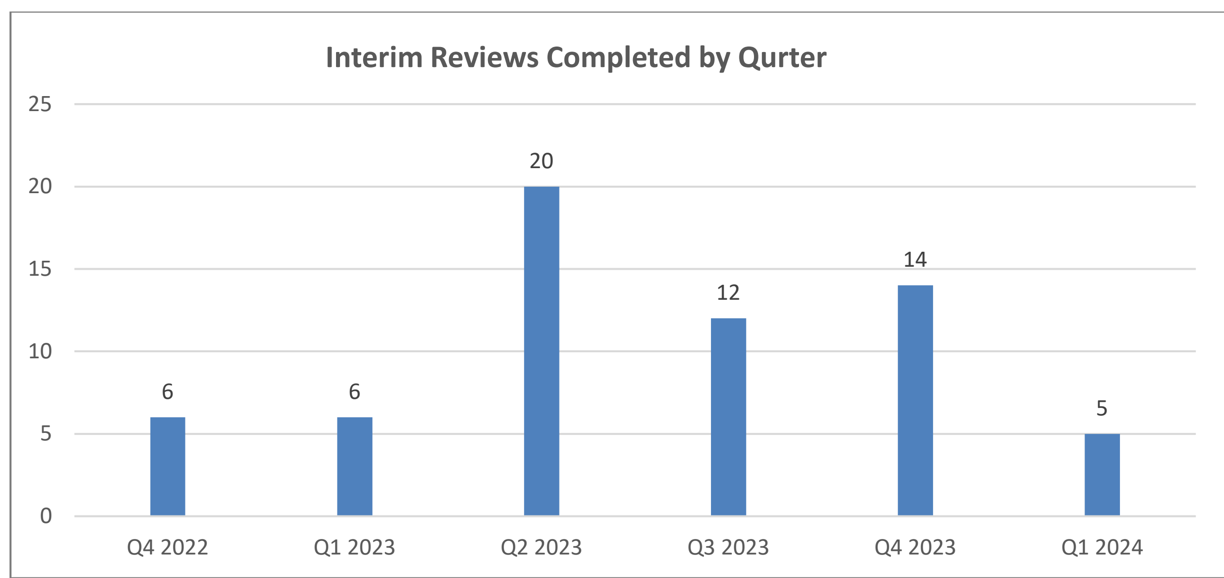
For Q1 2024, based on the medical record reviews, 82 IHA's were completed. 21 total pediatric charts and 61 adult charts. 19 out of the 21 pediatric charts were compliant and 2 were non-compliant. Out of all the 61 Adult charts, 55 adult charts were found to be compliant and 6 were non-compliant. Education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

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

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

E. Interim Reviews:

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

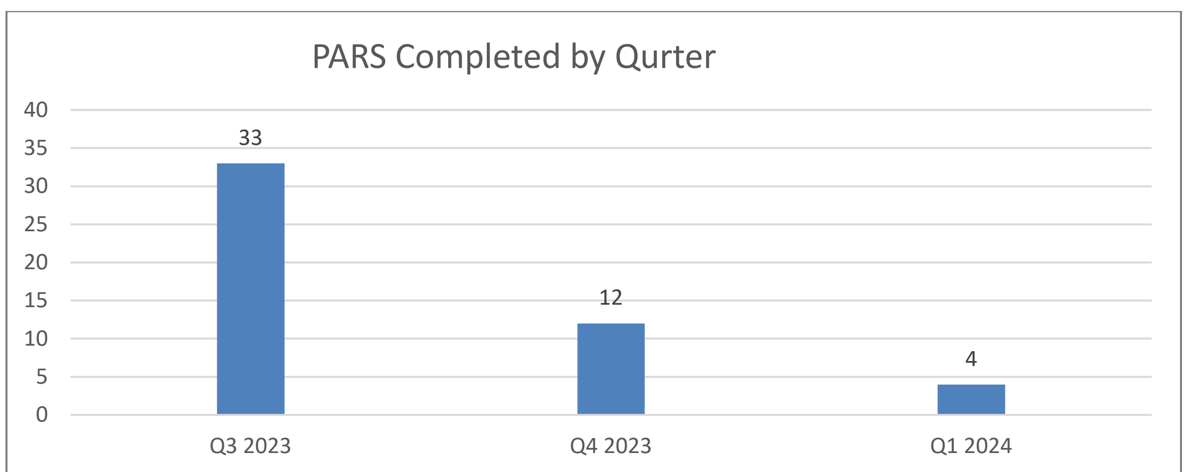


For the Q1 2024, there were 5 Interim reviews completed.

F. Focus Reviews: Focused reviews are conducted when a site fails their review as a follow up to ensure elements are maintained. The focused review consists of FSR and MRR elements and is completed within 3-6 months of the failed review. For Q1 2024, we had 4 focused MRRs completed.

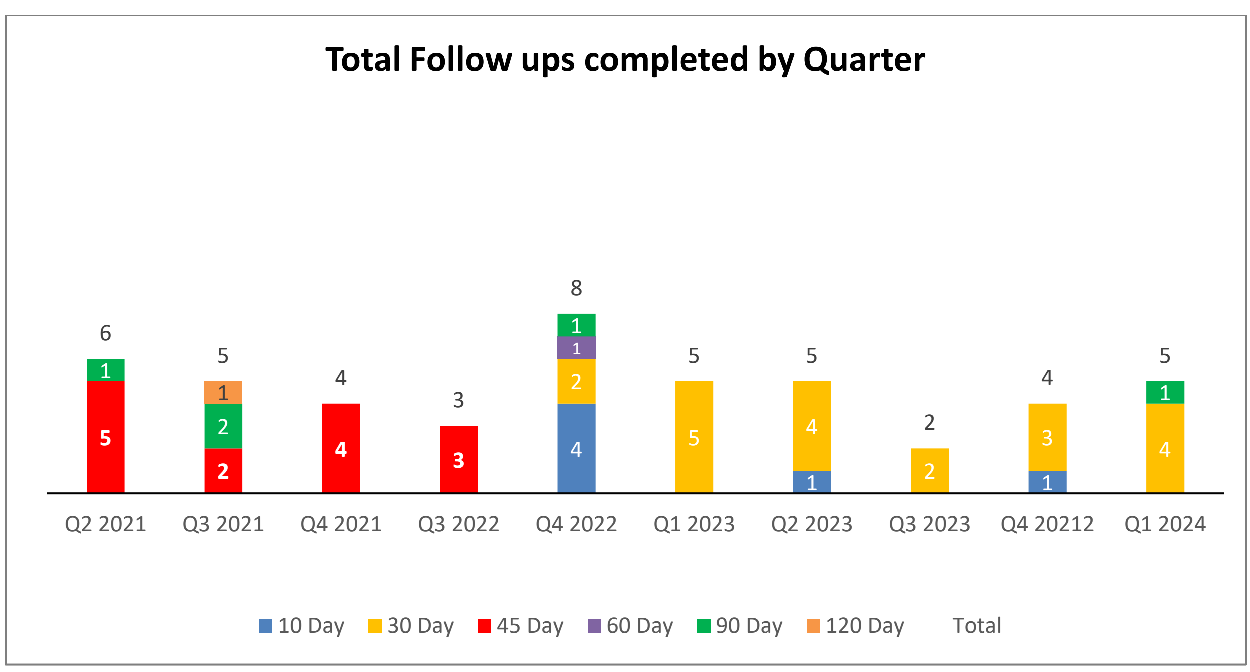
G. Physical Accessibility Review Survey (PARS):

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



For Q1 2024, 4 PARS were completed.

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



The above chart reflects the total number of follow-ups completed for each quarter. For Q1 2024, there were 4 30-day, and 1 90-Day follow-ups completed.

II. Quality Improvement Projects:

A. Performance Improvement Projects (PIPs):

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

Clinical PIP:

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

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

Non-Clinical PIP:

The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health department for support of interventions. We will be partnering with the Behavioral Health Department, UM, PHM, and any other necessary stakeholders. We are working with BI to get an updated ADT report as per the PIP requirement. Ongoing meetings are scheduled to ensure success and to remain on track with deliverables. The PIP team is planning to meet with Kern Medical to discuss on strategies for FUA/FUM measures.

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

B. MCAS Initiatives

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

Interventions to improve our performance in MCAS:

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

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

- Working with Blackhawk regarding new MERP Incentives. FUA, FUM, and HBD accounts to be setup and completed.
- Member Engagement Reward Program (MERP) Campaigns:
  - Adding FUA, FUM, and HBD text messages to the campaign list once final approval is received from Compliance.
  - Working with BI for configuration on FUA, FUM, and HBD.
  - Text Messages to members encouraging the scheduling of their appointments for gaps in care with a focus on:
    - Breast Cancer Screening
    - Blood Lead Screening
    - Initial Health Appointment
    - Chlamydia Screening
    - Cervical Cancer Screening
    - Prenatal & Postpartum Care
    - Well-Care Visits

    - Well-Baby Visits in first 30 Months of Life
  - Robocalls will be sent out to members that do not receive text messages.

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

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

Currently for MY2023:

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

MCAS MY2023 Measure Rates_As of 4/26/2023

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

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

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

Legend	
(green)	Measure Met MPL
(purple)	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.

To: KHS EQIHEC

From: Nate Scott

Date: May 23, 2024

Re: Executive Summary for 1st Quarter 2024 Grievance Summary Report

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Background

Executive Summary for the 1st 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 1st quarter, 2024, we had four thousand, sixty-two (4,062) Grievances and Appeals (G&A) received. Here are the top three grievance categories:

- Access to Care/Difficulty Accessing Specialists at 32.9% of grievances received.
- Quality of Service at 32.8% of grievances received.
- Quality of Care at 16% of grievances received.

Of the 4,062 G&A received:

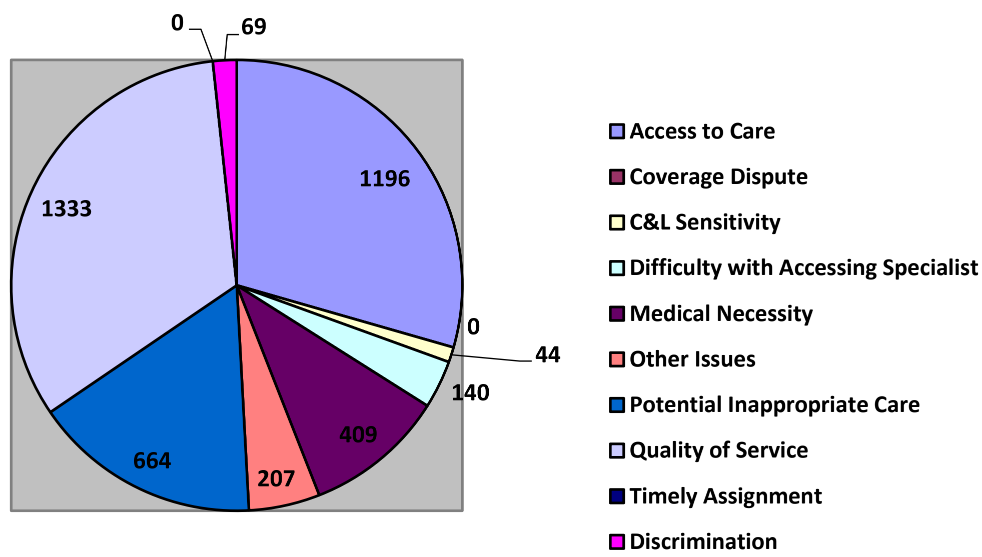
- 2,060 (50.7%) G&A were Standard Grievances and took up to 30 days to investigate and resolve.
- 2,002 (49.3%) G&A were Exempt Grievances and were resolved within one business day.
- 2,581 (63.5%) closed in Favor of the Enrollee
- 1,467 (36.1%) closed in Favor of the Plan/Provider
- 14 (.03%) are still open for review.

Requested Action

Receive and file.

1st Quarter 2024 Grievance Summary

Issue	Number	In Favor of Health Plan	In favor of Enrollee	Still under review
Access to care	1196	175	1020	1
Coverage dispute	0	0	0	0
Cultural and Linguistic Sensitivity	44	11	33	0
Difficulty with accessing specialists	140	71	66	3
Medical necessity	409	196	212	1
Other issues	207	69	137	1
Potential Inappropriate care	664	546	114	4
Quality of service	1333	332	997	4
Timely assignment to provider	0	0	0	0
Discrimination	69	67	2	0



Type of Grievances

KHS Grievances and Appeals per 1,000 members = 3.25/month

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

1st Quarter 2024 Grievance Summary

Access to Care

There were one thousand one-hundred ninety-six grievances pertaining to access to care. Three hundred fourteen were standard, and eight hundred eighty-two were exempt cases that closed within one business day. One hundred seventy-five closed in favor of the Plan. One thousand and twenty cases closed in favor of the Enrollee. There is one cases pending review. The following is a summary of these issues:

> One hundred thirty-eight members complained about the lack of available appointments with their Primary Care Provider (PCP). Twenty-six 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 twelve cases closed in favor of the Enrollee after the responses indicated the offices may not have provided appropriate access to care based on Access to Care standards. There are no cases pending review.
>
> Six hundred and three members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Sixty cases closed in favor of the Plan after the responses indicated the members were seen within the appropriate wait time for a scheduled appointment or the members were at the offices to be seen as a walk-in, which are not held to the Access to Care standards. Five hundred forty-two cases closed in favor of the Enrollee after the response indicated the member was not seen within the appropriate wait time for a scheduled appointment. There is one case pending review.
>
> Three hundred and one members complained about the telephone access availability with their Primary Care Provider (PCP). Forty-three cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate telephone access availability. Two hundred fifty-eight cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate telephone access availability. There are no cases pending review.
>
> One hundred forty-eight 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. One hundred and three cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner. There are no cases pending review.
>
> Three members complained about geographic access to provider. One case closed in favor of the Plan after it was determined the geographic access have been appropriate. Two cases closed in favor of the Enrollee after it was determined the geographic access may not have been appropriate. There are no cases pending review.
>
> Two members complained about physical access to provider. Two cases closed in favor of the Enrollee after it was determined the physical access may not have been appropriate. There are no cases pending review.
>
> One member complained about out-of-network access to provider. The case closed in favor of the Enrollee after it was determined the out-of-network access may not have been appropriate. There are no cases pending review.

1st Quarter 2024 Grievance Summary

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

There were forty-four grievances pertaining to the lack of available interpreting services to assist during their appointments Sixteen were standard cases and twenty-eight were exempt cases that closed within one business day. Eleven cases closed in favor of the Enrollee after the response from the provider indicated the member may not have been provided with the appropriate access to interpreting services. Thirty-three 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. There are no cases pending review.

Difficulty with Accessing a Specialist

There were one hundred forty grievances pertaining to Difficulty Accessing a Specialist. Ninety-eight were standard cases and forty-two were exempt cases closed within one business day. Seventy-one cases closed in favor of the Plan. Sixty-six cases closed in favor of the Enrollee. There are three cases still under review. The following is a summary of these issues:

> Twenty-four members complained about the lack of available appointments with a specialist. Twelve 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. Eleven cases closed in favor of the Enrollee after the responses indicated the offices may not have provided appropriate access to care based on Access to Care standards. There is one case still under review.
>
> Seventy members complained about the wait time to be seen for a specialist appointment. Fifteen 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. Fifty-five cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate wait time for a scheduled appointment based on the Access to Care Standards. There are no cases under review.
>
> Twenty-seven members complained about the telephone access availability with a specialist office. Twenty-seven cases closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access availability. There are no cases under review.
>
> Nineteen members complained about a provider not submitting a referral authorization request in a timely manner. Seventeen cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. There are two cases under review.

1st Quarter 2024 Grievance Summary

Medical Necessity

There were four hundred and nine appeals pertaining to Medical Necessity. One hundred and ninety-six 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, two were partially overturned. Two hundred and twelve were closed in favor of the Enrollee. There is one case under review.

Other Issues

There were two hundred and seven grievances pertaining to Other Issues that are not otherwise classified in the other categories. Eighty-eight were standard and one hundred nineteen were exempt cases that closed within one business day. Sixty-nine cases were closed in favor of the Plan after the responses indicated the appropriate services were provided. One hundred thirty-seven cases closed in favor of the Enrollee after the responses indicated the appropriate services may not have been provided. There is one standard case still under review.

Potential Inappropriate Care

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

Quality of Service

There were one thousand, three hundred and thirty-three grievances involving Quality of Service issues. Four hundred and two were standard and nine hundred and thirty-one were exempt cases closed within one business day. Three hundred thirty-two cases closed in favor of the Plan after the responses determined the members received the appropriate service from their providers. Nine hundred ninety-seven cases closed in favor of the Enrollee after the responses determined the members may not have received the appropriate services. There are four 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-nine standard grievances pertaining to Discrimination. Sixty-seven cases closed in favor of the Plan as there was no discrimination found. Two cases closed in favor of the Enrollee. There are no cases under review. All grievances related to Discrimination, are forwarded to the DHCS Office of Civil Rights upon closure.

To: KHS EQIHEC

From: Nate Scott

Date: May 23, 2024

Re: Executive Summary for 1st Quarter 2024 Operational Board Update - Grievance Report

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Background

Executive Summary for 1st Quarter 2024 Operational Board Update - Grievance Report: When compared to the previous four quarters, the following trends were identified related to the Grievances and Appeals received during the 1st Quarter, 2024.

- There was an increase in Grievances and Appeals in Quarter 1, 2024 when compared to 2023. With the significant increase in membership during the first three months of the year, the increase in Grievance and Appeal volume was expected. The impacted categories were Quality of Service, Quality of Care, and Other Issues.

KHS Standard Grievance and Appeals per 1,000 members = 3.25 per month.

Requested Action

Receive and file.

1st Quarter 2024 Operational Report

Alan Avery
Chief Operating Officer

1st Quarter 2024 Grievance Report

Category	1st Quarter 2024	Status	Issue	Q4 2023	Q3 2023	Q2 2023	Q1 2023
Access to Care	412		Appointment Availability	347	303	233	123
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	409		Questioning denial of service	423	478	420	363
Other Issues	104		Miscellaneous	39	65	55	53
Potential Inappropriate Care	664		Questioning services provided. All cases forwarded to Quality Dept.	522	644	703	758
Quality of Service	402		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	296	326	282	216
Discrimination (New Category)	69		Alleging discrimination based on the protected characteristics	40	45	64	62
Total Formal Grievances	2060			1667	1861	1757	1575
Exempt	2002		Exempt Grievances	1620	2026	1873	1606
Total Grievances (Formal & Exempt)	4062			3287	3887	3630	3181

KHS Grievances and Appeals per 1,000 members = 3.25/month

Additional Insights-Formal Grievance Detail

Issue	2024 1st Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	1196	175	0	1020	1
Coverage Dispute	0	0	0	0	0
Specialist Access	140	71	0	66	3
Medical Necessity	409	196	0	212	1
Other Issues	251	80	0	170	1
Potential Inappropriate Care	664	546	4	114	4
Quality of Service	1333	332	0	997	4
Discrimination	69	67	0	2	0
Total	4062	1467	0	2581	14

Timeliness of Decision Trending

Summary:

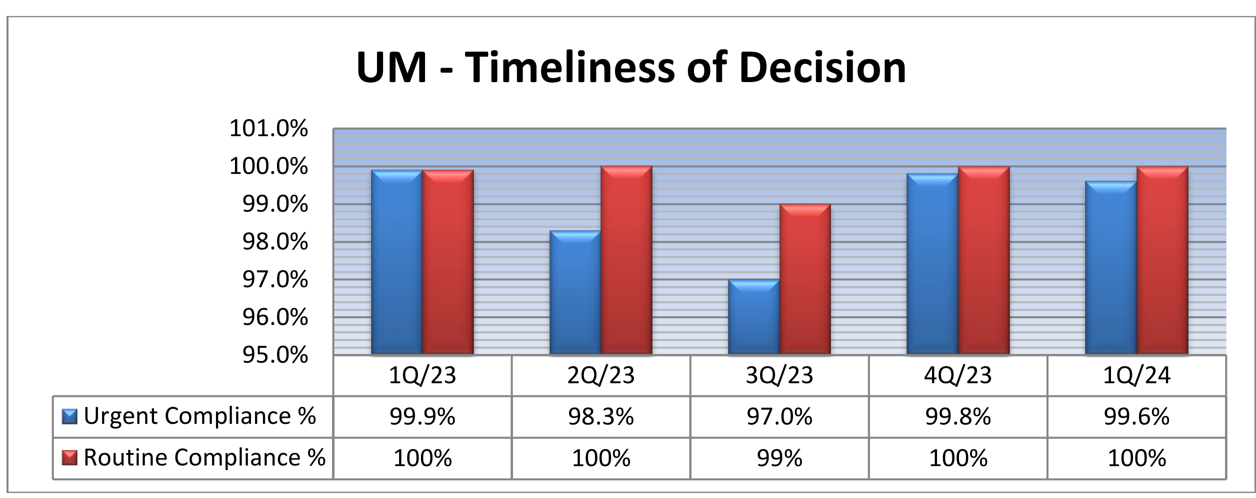
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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 91,098 referrals processed in the 1st quarter 2024 of which 8,479 referrals were reviewed for timeliness of decision. In comparison to the 4th quarter's processing time, routine referrals increased from the 4th quarter which was 99.9% and urgent referrals decreased from the 4th quarter which was 99.8% to 99.6%.



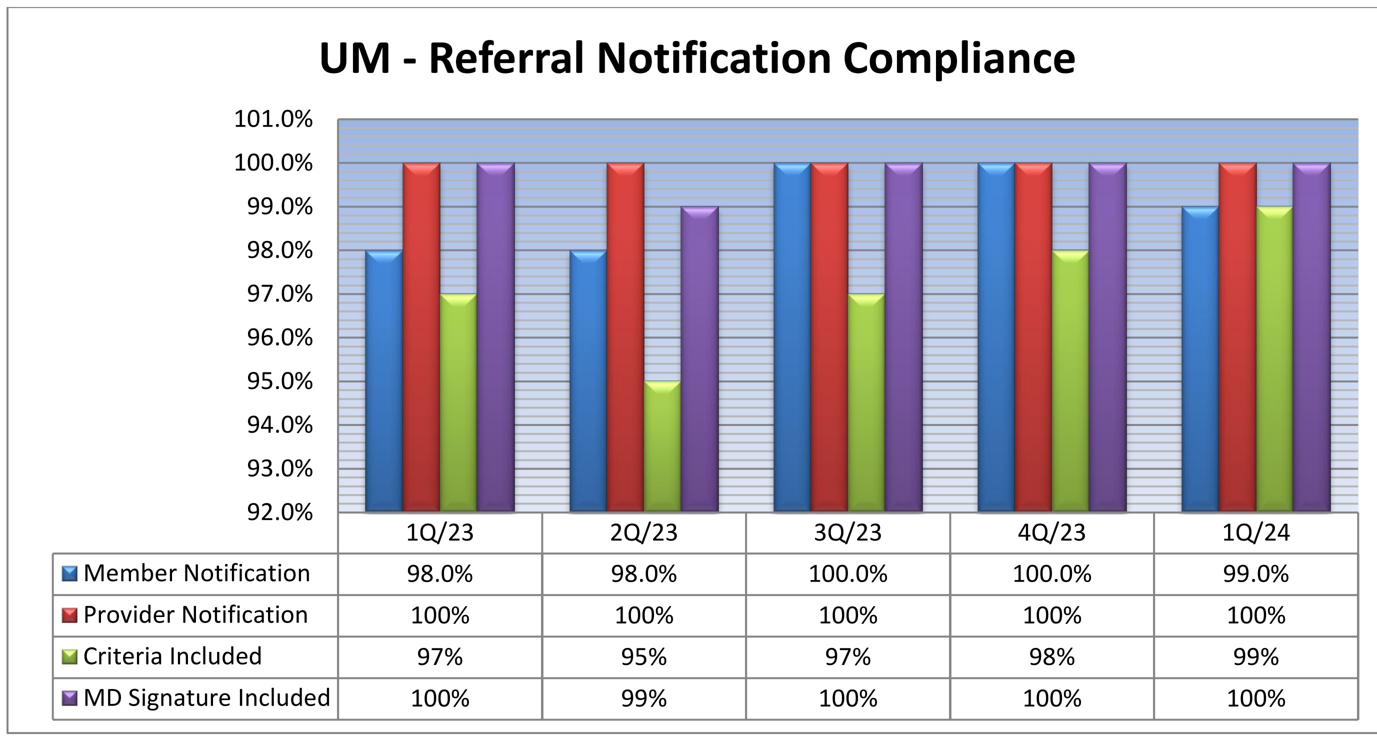
	1Q/23	2Q/23	3Q/23	4Q/23	1Q/24
Urgent Compliance %	99.9%	98.3%	97.0%	99.8%	99.6%
Routine Compliance %	100%	100%	99%	100%	100%

Referral Notification Compliance

Audit Criteria:

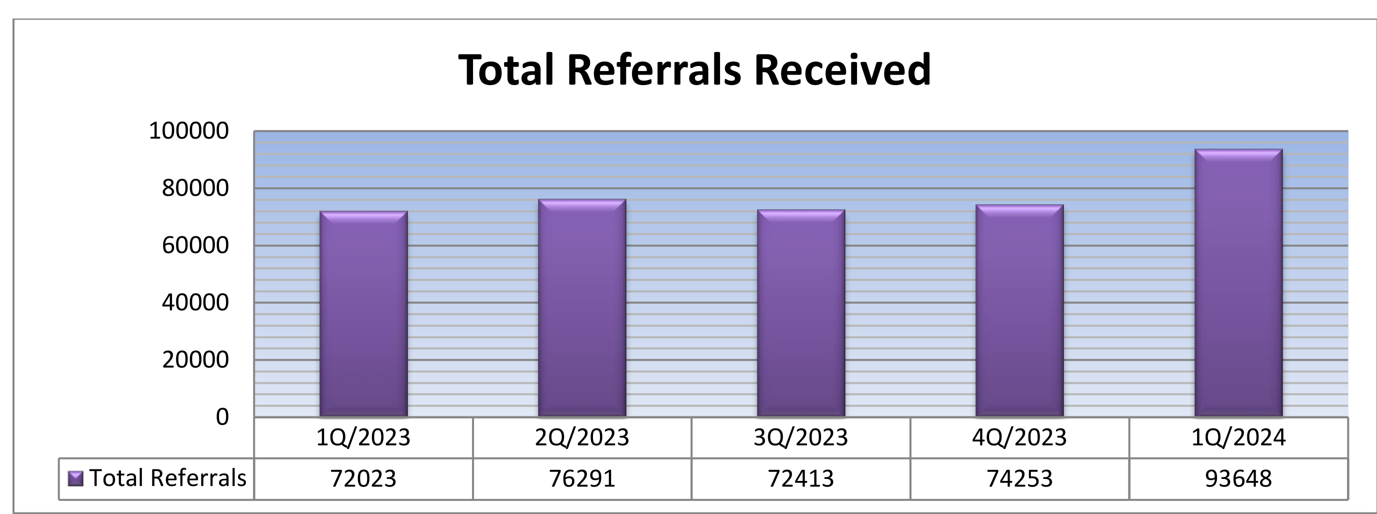
- Member Nofication: Letter of referral decision sent to member within 24 hours
- Provider Notification: Referral is faxed back to the provider with 24 hours of decision
- Criteria Included: Criteria provided to provider on denial reason
- MD Signature: MD Signature included all referrals/NOA letters upon denial

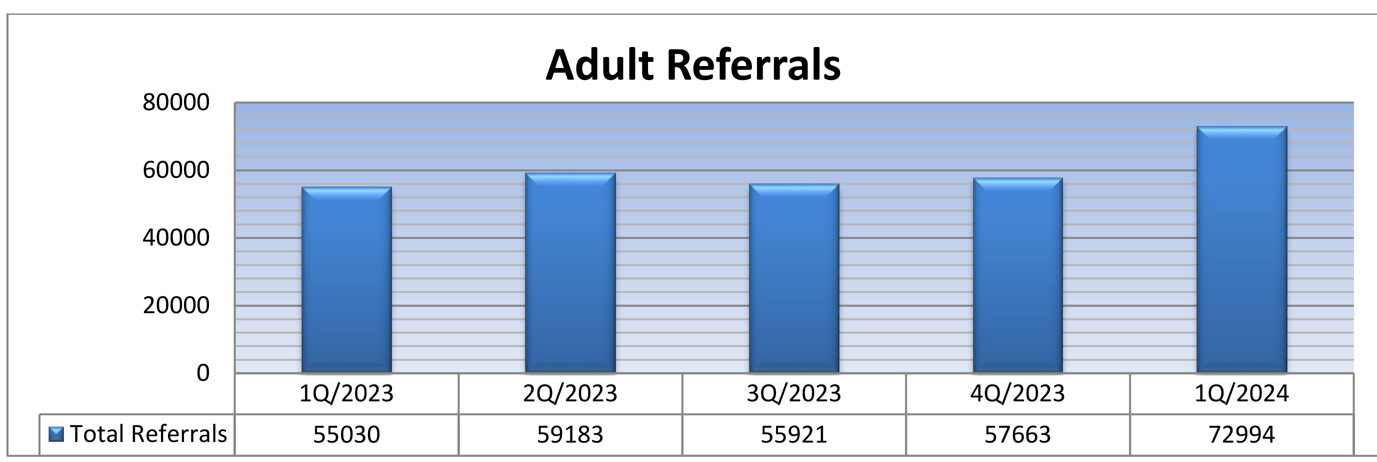
Summary: Overall compliance rate from the 1st Qtr. of 2024 is 99.5% which decreased from the 4th Qtr. which was 100%

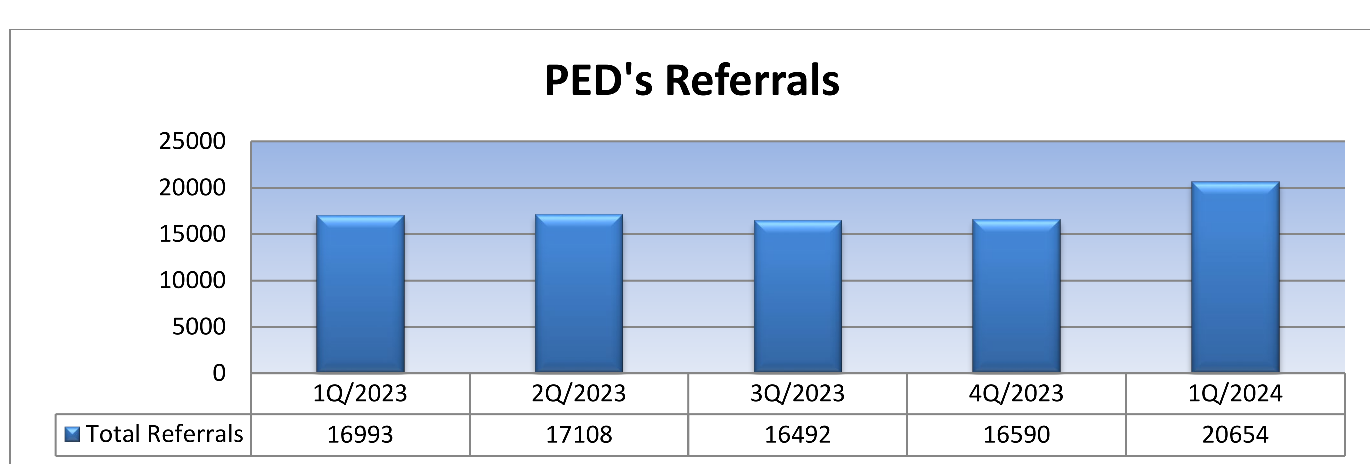


	1Q/23	2Q/23	3Q/23	4Q/23	1Q/24
Member Notification	98.0%	98.0%	100.0%	100.0%	99.0%
Provider Notification	100%	100%	100%	100%	100%
Criteria Included	97%	95%	97%	98%	99%
MD Signature Included	100%	99%	100%	100%	100%

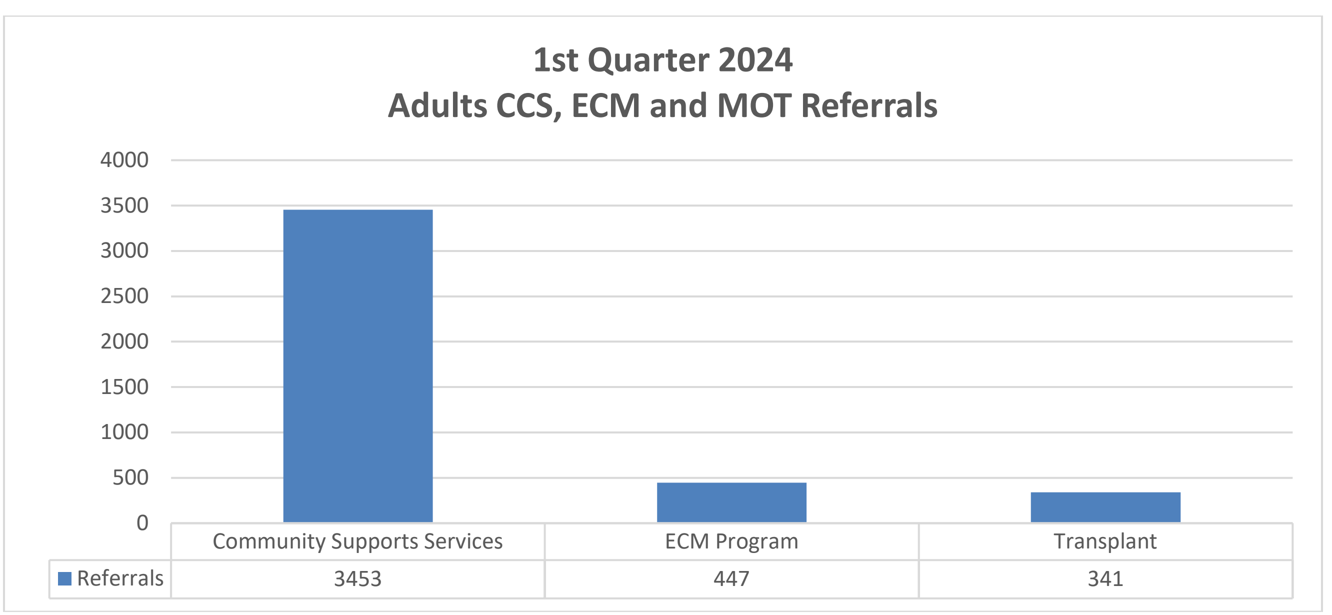
Outpatient Referral Statistics

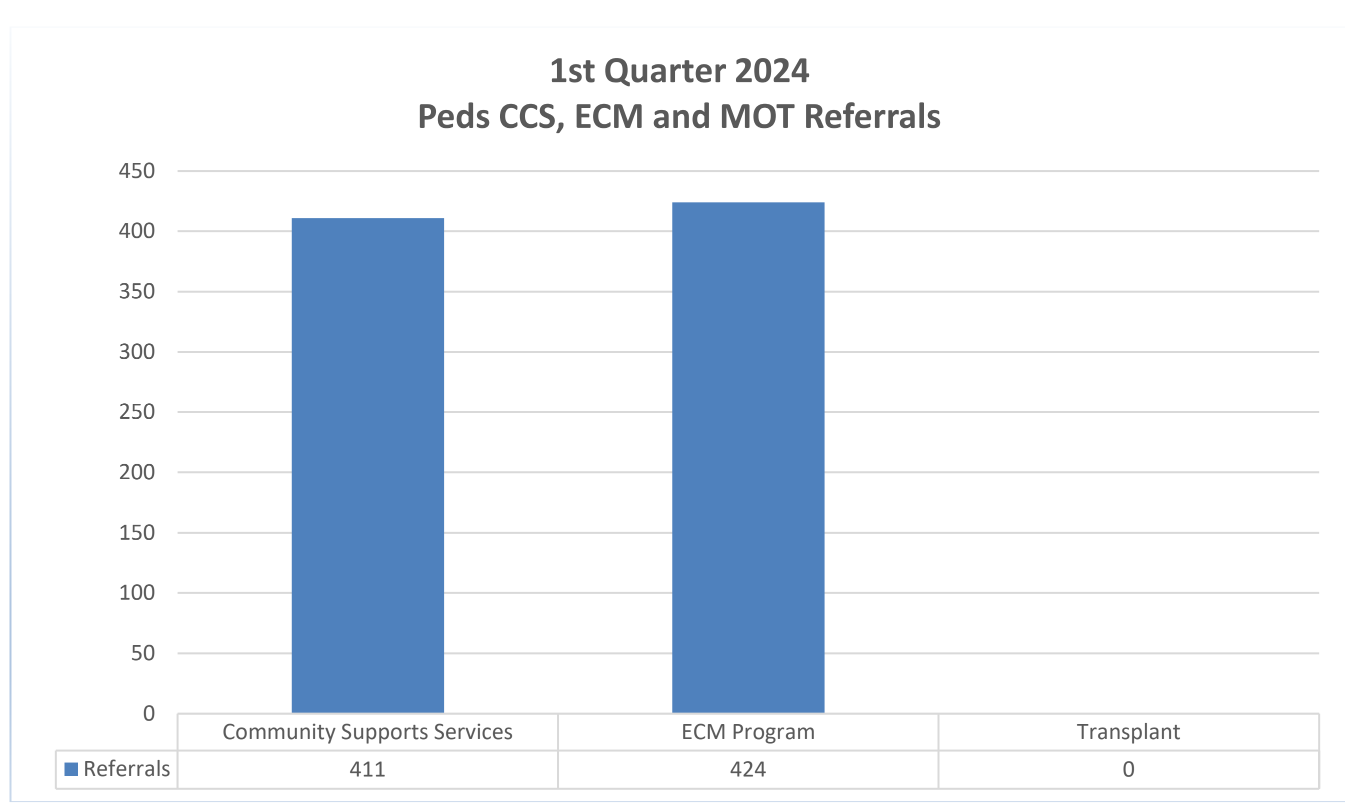






Specialty Referral Management



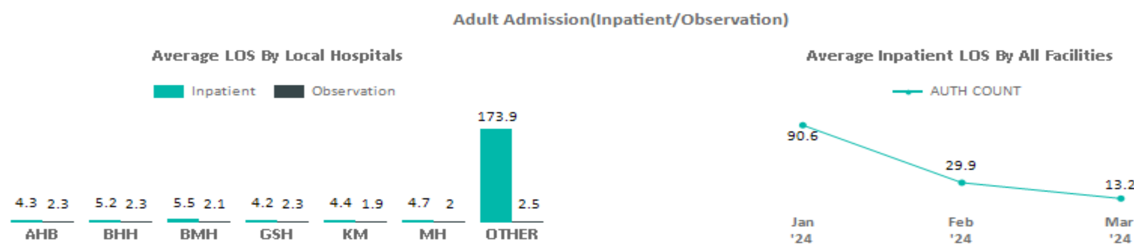


Inpatient Statistics

KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(Inpatient/Observation)

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



Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
	8	32.0	4.00
ADVENTIST HEALTH BAKERSFIELD	839	3218.0	3.84
ADVENTIST HEALTH COMMUNITY CAR	44	109.0	2.48
ADVENTIST HEALTH DELANO	107	291.0	2.72
ADVENTIST HEALTH MEDICAL CENTE	37	845.0	22.84
BAKERSFIELD HEART HOSPITAL	96	401.0	4.18
BAKERSFIELD MEMORIAL HOSPITAL	1004	4546.0	4.53
BROOKDALE RIVERWALK SNF (CA)	35	12071.0	344.89
CHILDRENS HOSPITAL OF LOS ANGE	2	16.0	8.00
DELANO DISTRICT SKILLED NURSIN	93	32014.0	344.24
GOOD SAMARITAN HOSPITAL	62	235.0	3.79
HEIGHT STREET SKILLED CARE	38	13315.0	350.39
HUMANGOOD NORCAL	7	2370.0	338.57
KECK HOSPITAL OF USC	118	781.0	6.62
KERN COUNTY HOSPITAL AUTHORITY	3	6.0	2.00
KERN COUNTY MEDICAL AUTHORITY	876	3484.0	3.98
KERN RIVER TRANSITIONAL CARE	67	22999.0	343.27
KERN VALLEY HEALTHCARE DIST RH	5	15.0	3.00
KERN VALLEY HEALTHCARE DISTRIC	56	11561.0	206.45
MALIBU BEACH HOLDINGS LLC	77	26975.0	350.32
MERCY HOSPITAL	772	3047.0	3.95
OPTIMAL HOSPICE CARE	1	210.0	210.00
PARKVIEW JULIAN, LLC	27	8356.0	309.48
RIDGECREST REGIONAL HOSPITAL	89	12195.0	137.02
SAN JOAQUIN NURSING AND REHABI	34	11707.0	344.32
SANTA MONICA UCLA MC AND ORTHO	13	70.0	5.38
SHAFTER NURSING REHAB LLC	39	13868.0	355.59
THE REHABILITATION CENTER	29	8738.0	301.31
UCLA MEDICAL CENTER	19	80.0	4.21
USC NORRIS CANCER HOSP	19	187.0	9.84
USC VERDUGO HILLS HOSPITAL	1	9.0	9.00
VALLEY CHILDRENS HOSPITAL	1	8.0	8.00
VALLEY CONVALESCENT HOSPITAL	40	12725.0	318.13
VALLEY VIEW CARE CENTER	33	11860.0	359.39
WELLSPRINGS POST ACUTE CENTER	4	397.0	99.25
WINDSOR ARVIN HEALTHCARE, LLC	46	16790.0	365.00
WINDSOR BAKERSFIELD HEALTHCARE	10	1822.0	182.20
Total	**4751**	**237353.0**	**49.96**

Non Participating Providers

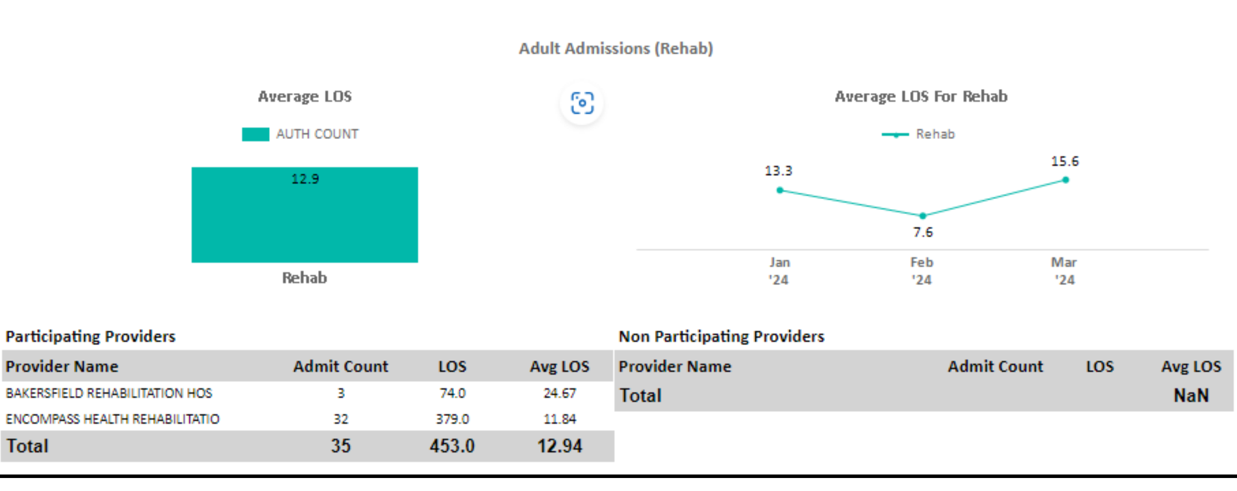
Provider Name	Admit Count	LOS	Avg LOS
ANTELOPE VALLEY HOSPITAL	38	202.0	5.32
PALMDALE REGIONAL MEDICAL CENT	21	203.0	9.67
HENRY MAYO NEWHALL	17	53.0	3.12
FRESNO COMMUNITY HOSPITAL AND	15	140.0	9.33
EXECUTIVE MEDICAL TRANSPORT LL	10	71.0	7.10
NORTHRIDGE HOSPITAL MEDICAL CE	7	49.0	7.00
RIVERSIDE COMMUNITY HOSPITAL	6	29.0	4.83
CENTENNIAL HILLS HOSPITAL MEDI	6	38.0	6.33
KND DEVELOPEMENT	6	185.0	30.83
KAWEAH DELTA MEDICAL CENTER	5	18.0	3.60
SUNRISE HOSPITAL AND MEDICAL	5	28.0	5.60
KINDRED HOSPITAL SAN GABRIEL	5	150.0	30.00
Total	**312**	**10642.0**	**34.11**

Post-Acute Statistics:

KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(SNF/Rehabilitation)

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



Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
BAKERSFIELD REHABILITATION HOS	3	74.0	24.67
ENCOMPASS HEALTH REHABILITATIO	32	379.0	11.84
Total	**35**	**453.0**	**12.94**

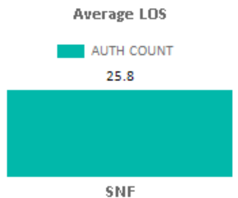
Non Participating Providers

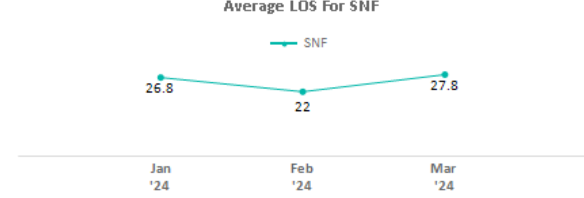
Provider Name	Admit Count	LOS	Avg LOS
Total			**NaN**

KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(SNF/Rehabilitation)

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





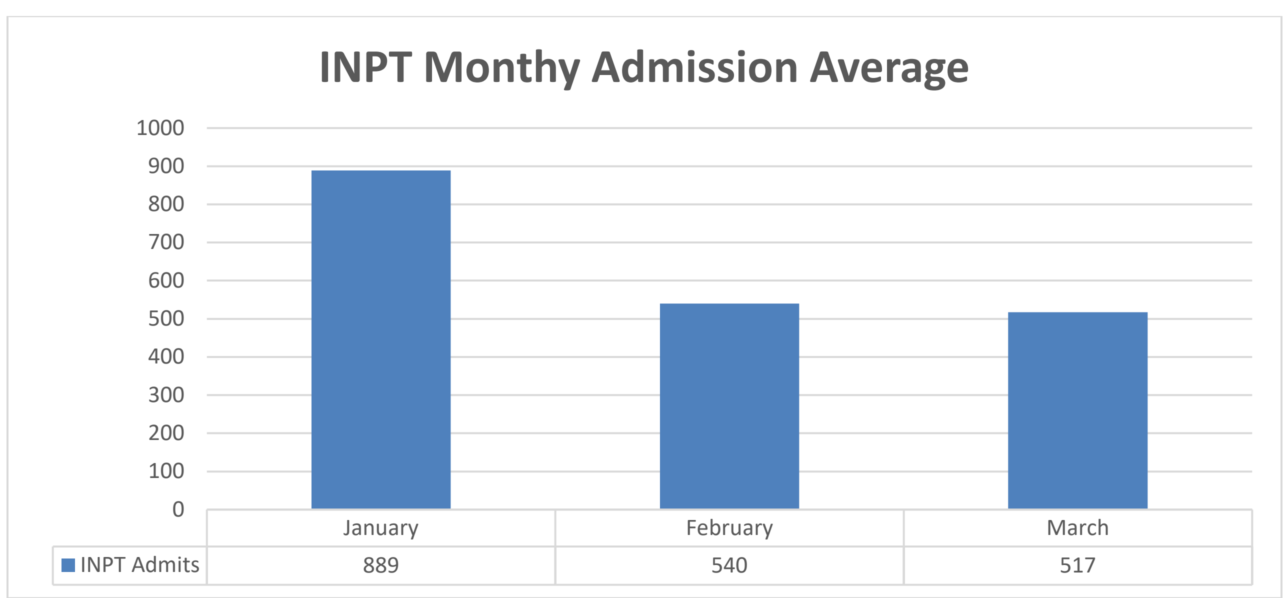
Participating Providers

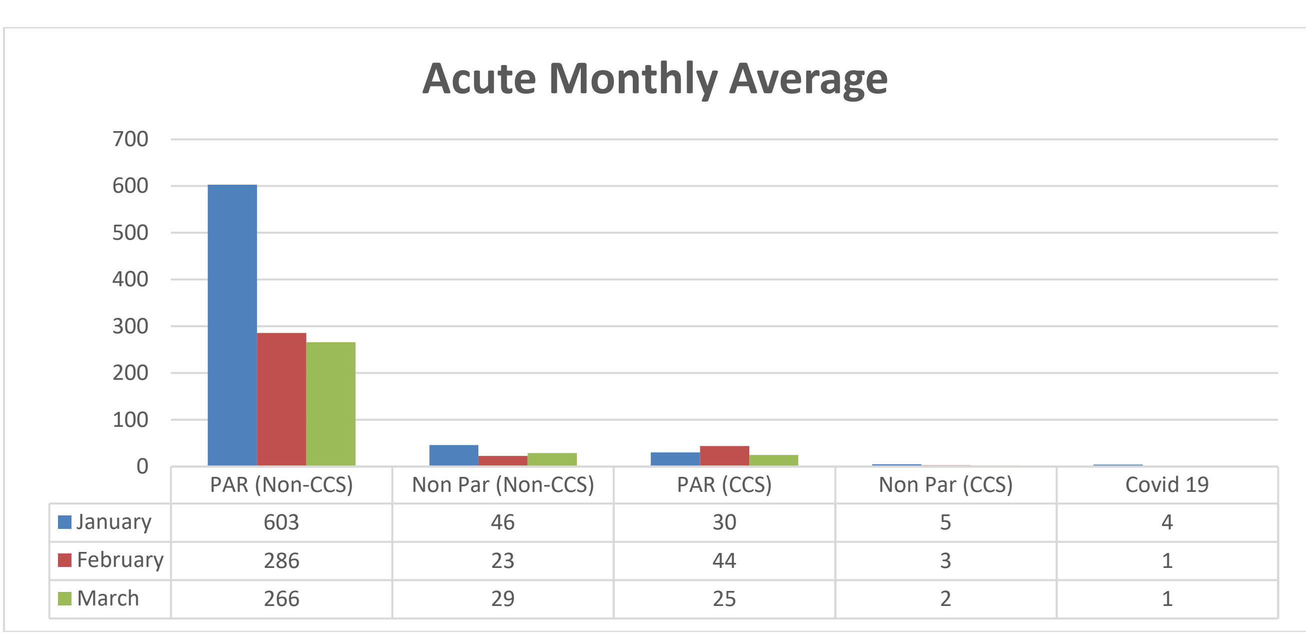
Provider Name	Admit Count	LOS	Avg LOS
ANGEL CONGREGATE LIVING, INC	3	178.0	59.33
BROOKDALE RIVERWALK SNF (CA)	13	271.0	20.85
EVERLASTING HEALTHCARE	4	53.0	13.25
HEIGHT STREET SKILLED CARE	25	501.0	20.04
HUMANGOOD NORCAL	7	125.0	17.86
MAGNIFIQUE CONGREGATE LIVING I	9	213.0	23.67
MALIBU BEACH HOLDINGS LLC	21	312.0	14.86
NAPOLI IN THE DESERT	5	245.0	49.00
OAK FENCE SENIOR LIVING, LLC	1	14.0	14.00
PARKSIDE CONGREGATE LIVING, IN	5	253.0	50.60
PARKVIEW JULIAN, LLC	25	459.0	18.36
ROSE DESERT CONGREGATE	7	264.0	37.71
SAN JOAQUIN NURSING AND REHABI	15	413.0	27.53
SAN MARINO IN THE DESERT	7	193.0	27.57
SHAFTER NURSING REHAB LLC	22	412.0	18.73
SORRENTO IN THE DESERT	13	313.0	24.08
THE REHABILITATION CENTER	36	761.0	21.14
VALLEY CONVALESCENT HOSPITAL	22	500.0	22.73
VALLEY VIEW CARE CENTER	23	1033.0	44.91
VFP HOMES	4	247.0	61.75
WELLSPRINGS POST ACUTE CENTER	7	190.0	27.14
WINDSOR ARVIN HEALTHCARE, LLC	23	606.0	26.35
WINDSOR BAKERSFIELD HEALTHCARE	18	370.0	20.56
Total	**315**	**7926.0**	**25.16**

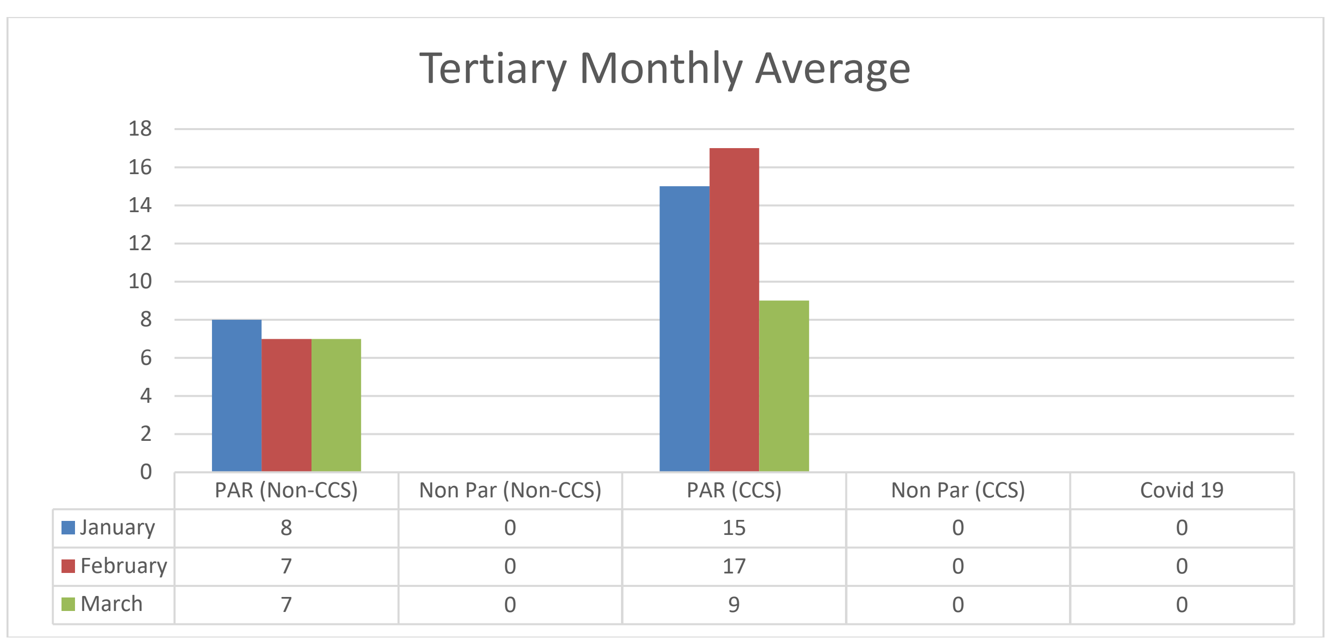
Non Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
RIO BRAVO CONGREGATE LIVING, I	8	415.0	51.88
GATEWAY HOMES TO INDEPENDENCE	3	36.0	12.00
ORCHID PLUS, INC	2	47.0	23.50
LAUREL AVENUE LLC	1	100.0	100.00
ST ELIZABETH HOMES CLHF, INC.	1	6.0	6.00
VALLEY CONVALESCENT HOSPITAL	1	6.0	6.00
PORTERVILLE CONVALESCENT, INC.	1	14.0	14.00
Total	**17**	**624.0**	**36.71**

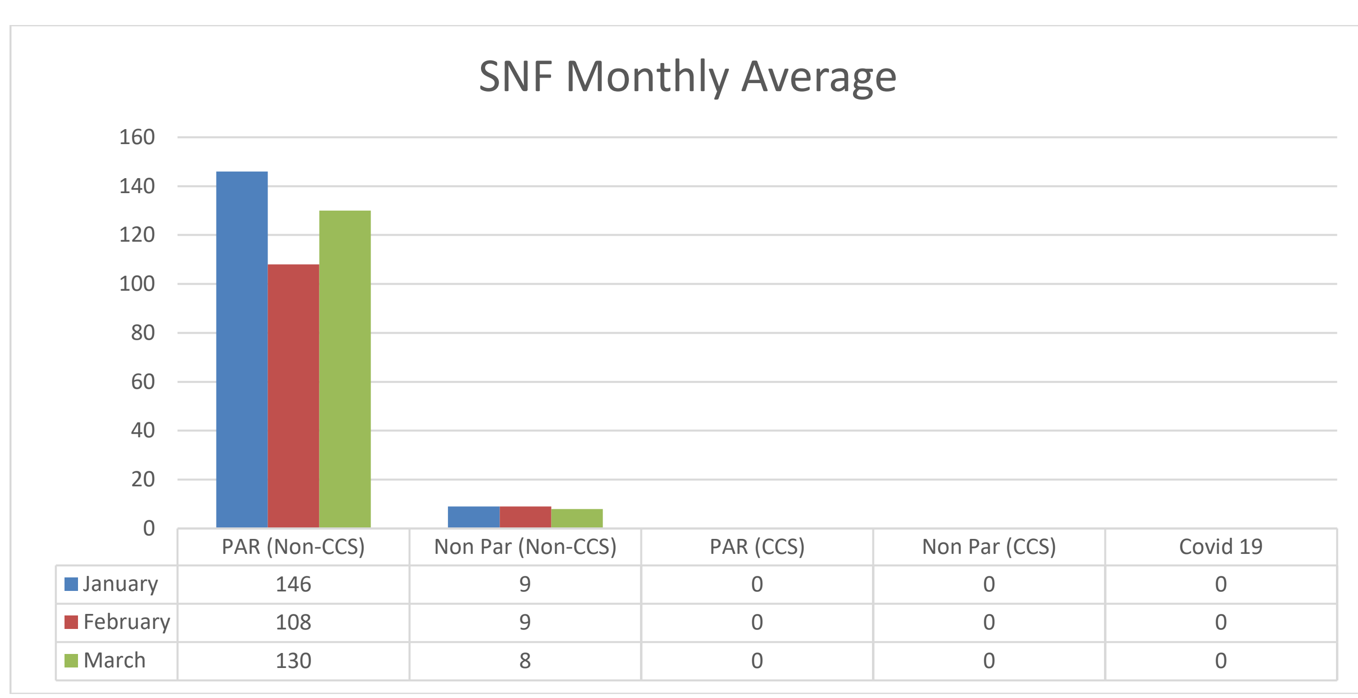
Inpatient Statistics Averages 1st Qtr. 2024



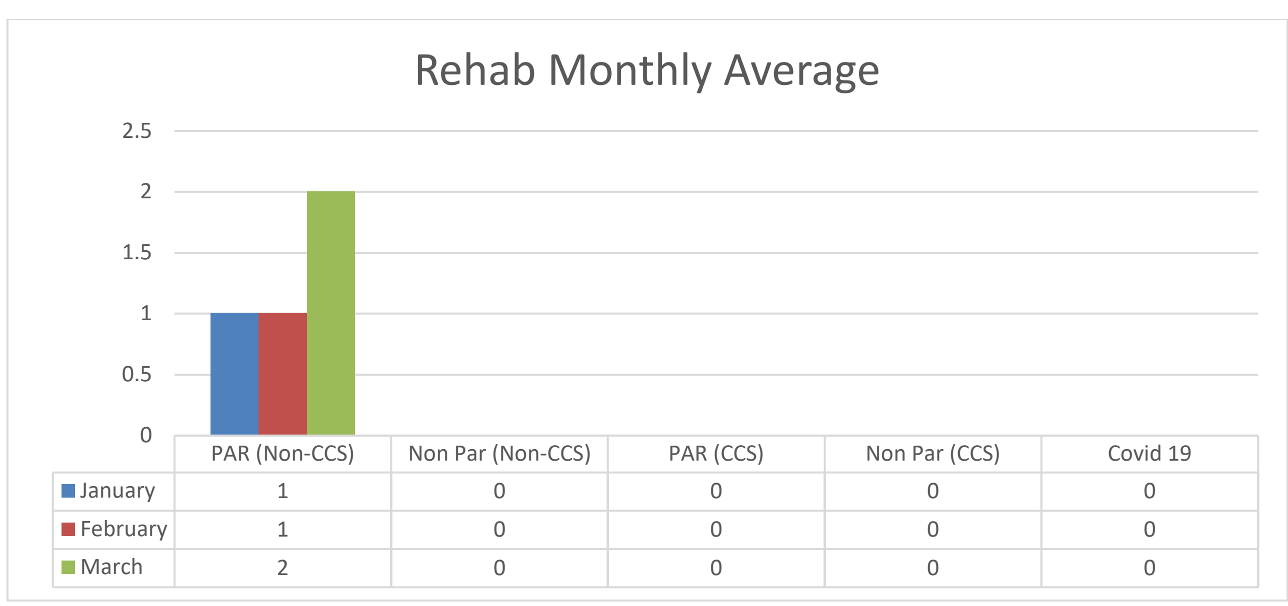




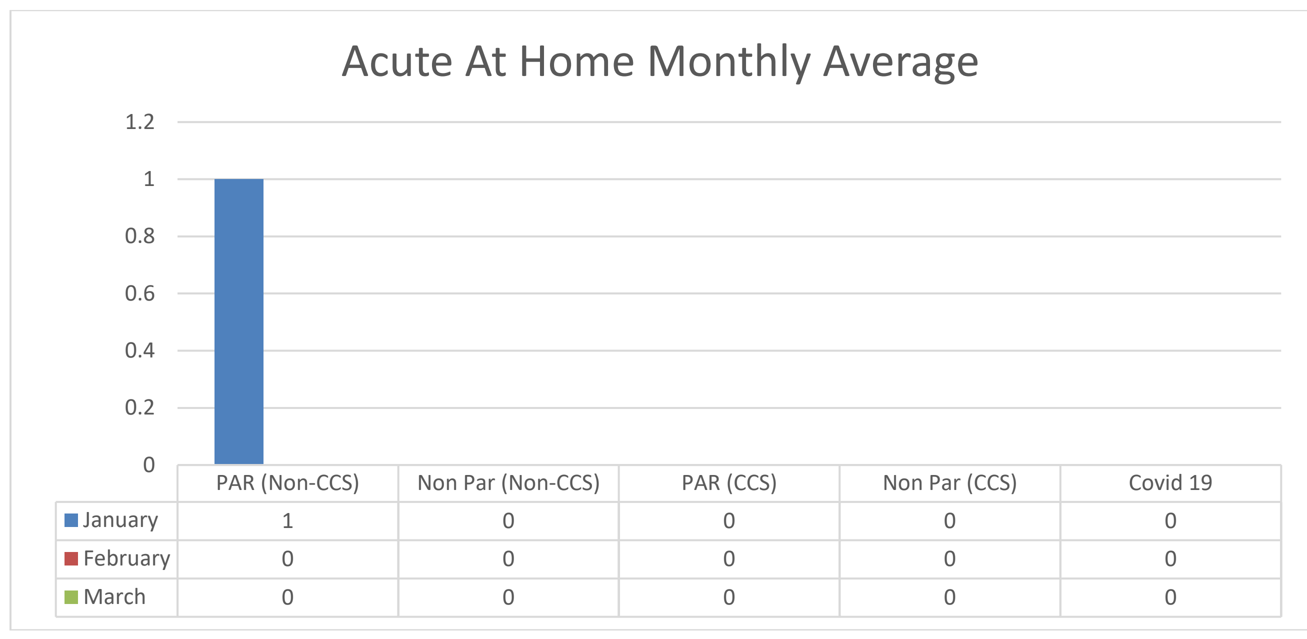
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
January	8	0	15	0	0
February	7	0	17	0	0
March	7	0	9	0	0



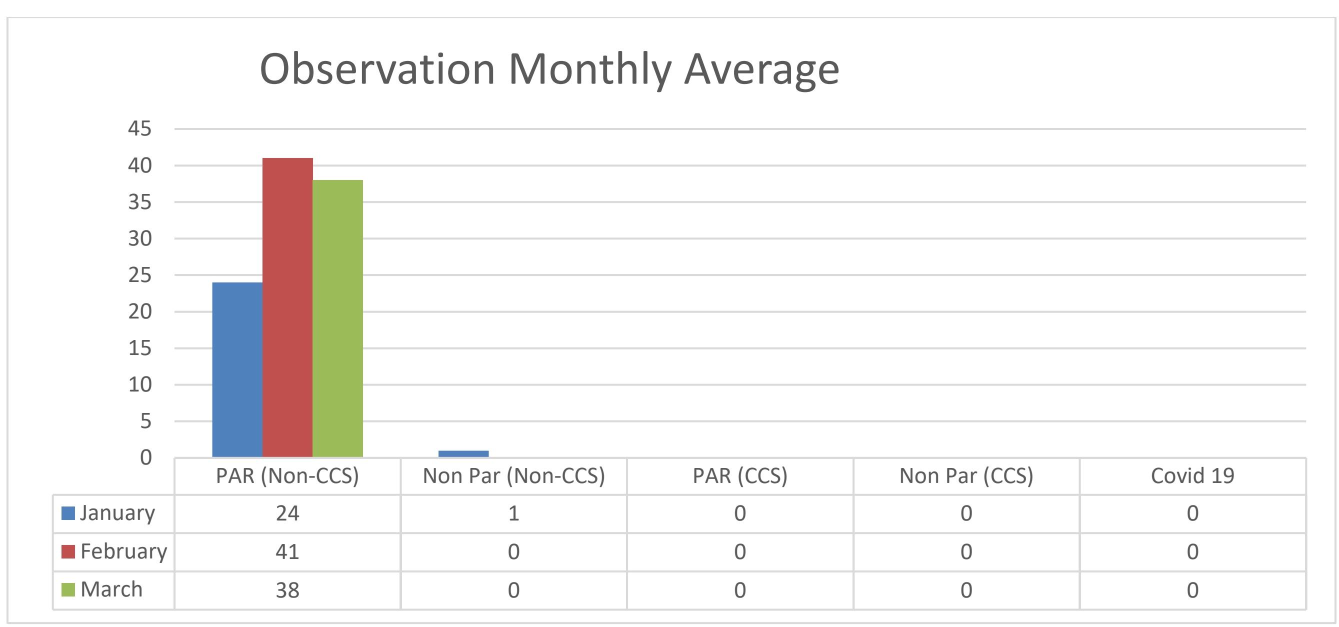
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
January	146	9	0	0	0
February	108	9	0	0	0
March	130	8	0	0	0



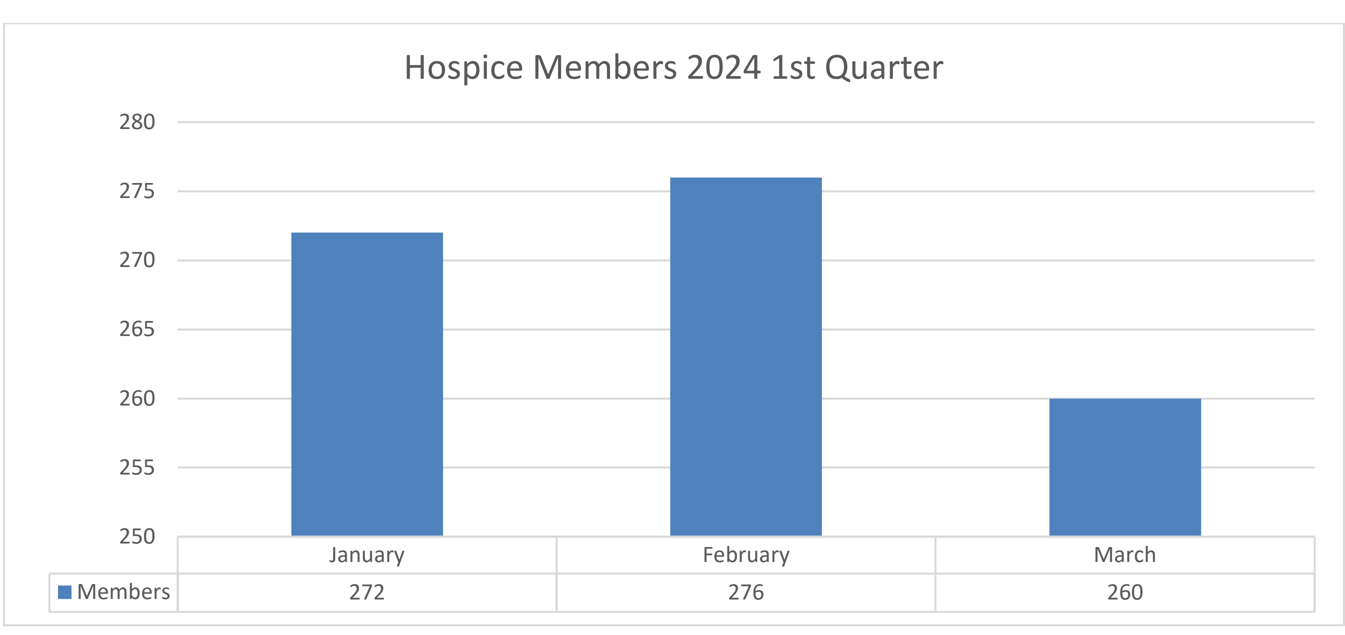
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
January	1	0	0	0	0
February	1	0	0	0	0
March	2	0	0	0	0



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
January	1	0	0	0	0
February	0	0	0	0	0
March	0	0	0	0	0



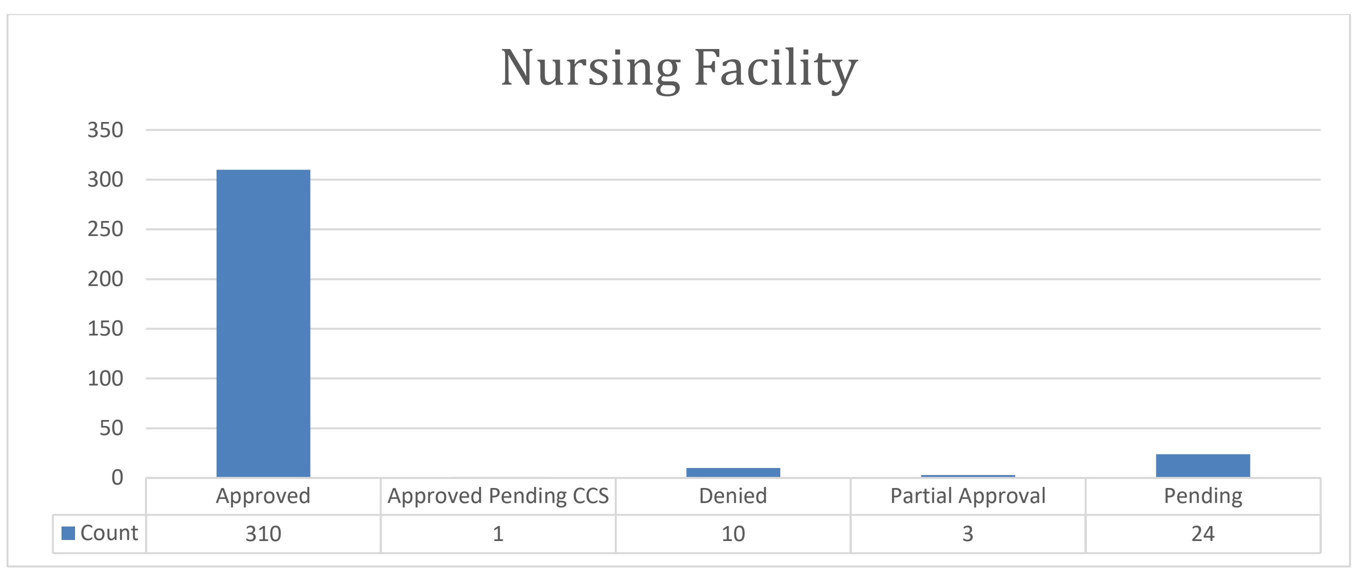
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
January	24	1	0	0	0
February	41	0	0	0	0
March	38	0	0	0	0



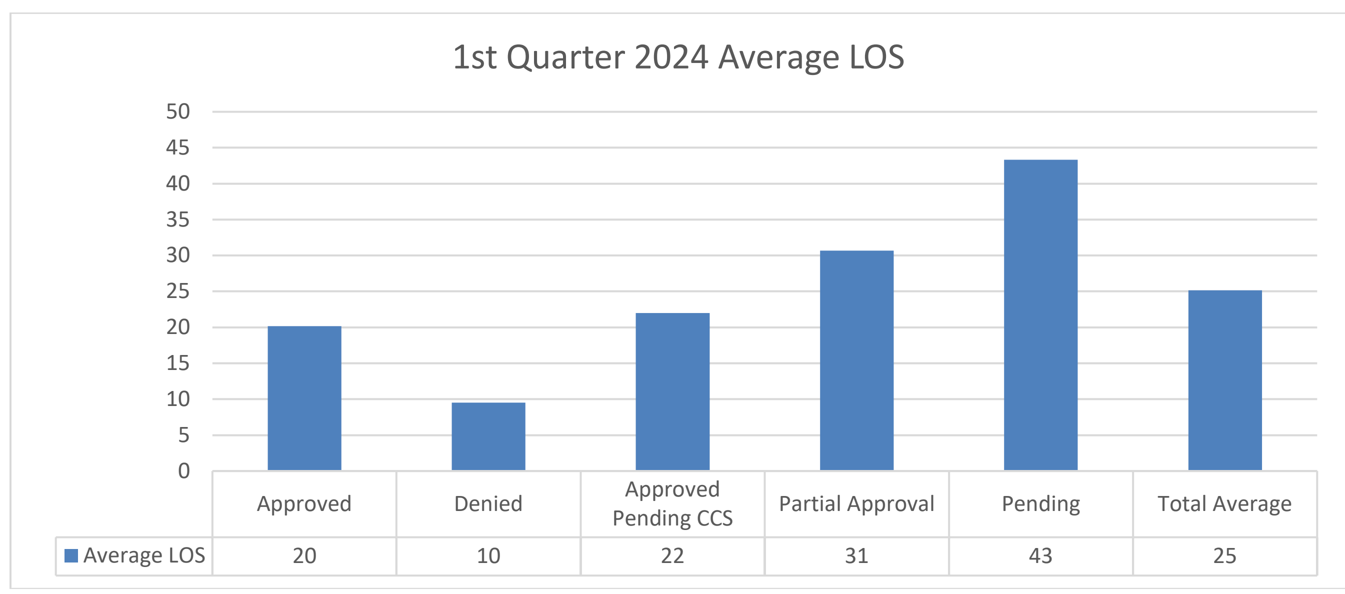
	January	February	March
Members	272	276	260

Nursing Facility Services Report

Purpose: Kern Health Systems covers medically necessary Nursing Facility Services for eligible members. KHS members requiring Nursing Facility Services are identified and placed in health care facilities, which provide the level of care most appropriate to the member's medical needs. For members requiring long-term care, monthly and quarterly reporting is completed as per Policy 3.42, Sec. 5, for nursing facility services and to identify any current trends.

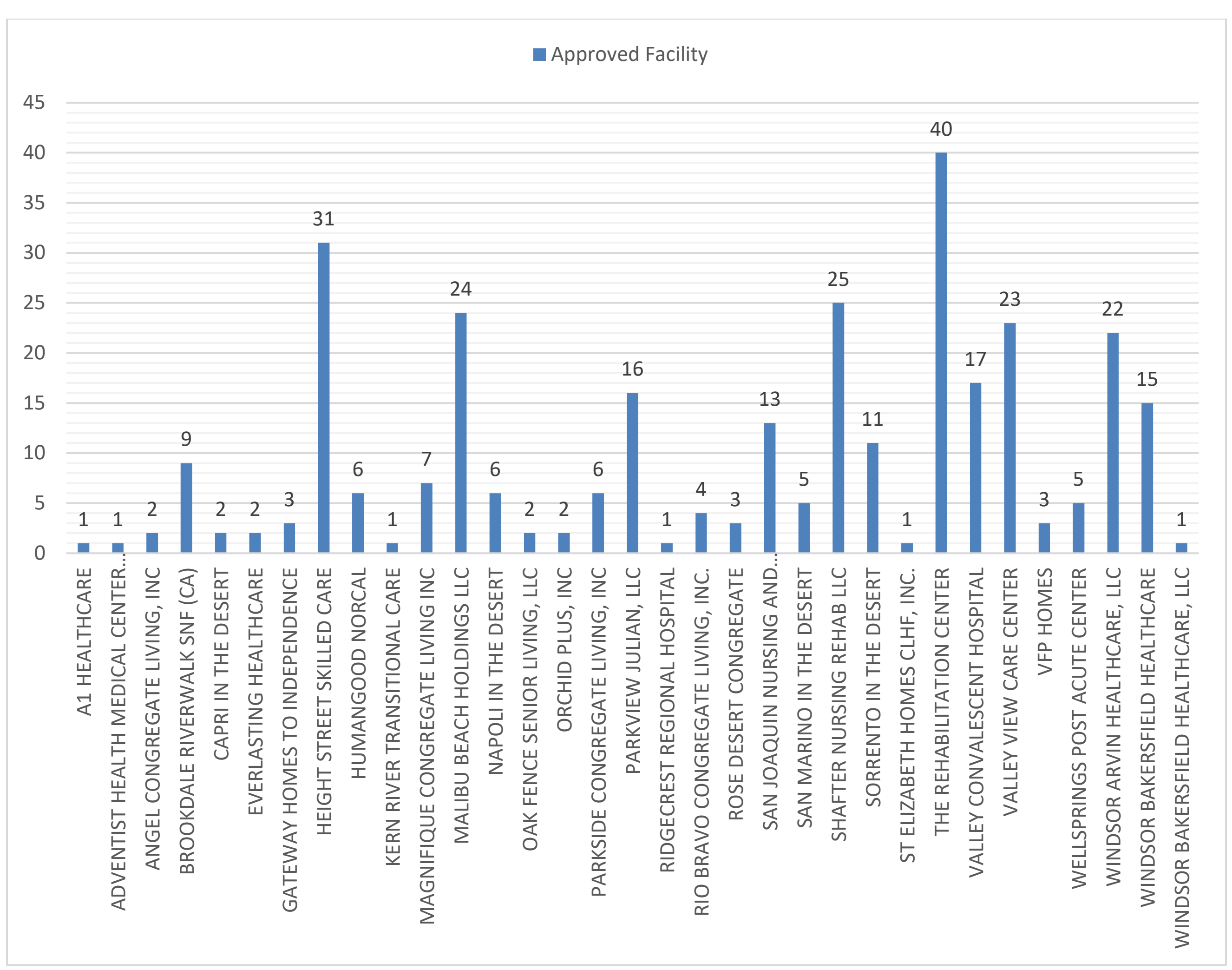


	Approved	Approved Pending CCS	Denied	Partial Approval	Pending
Count	310	1	10	3	24

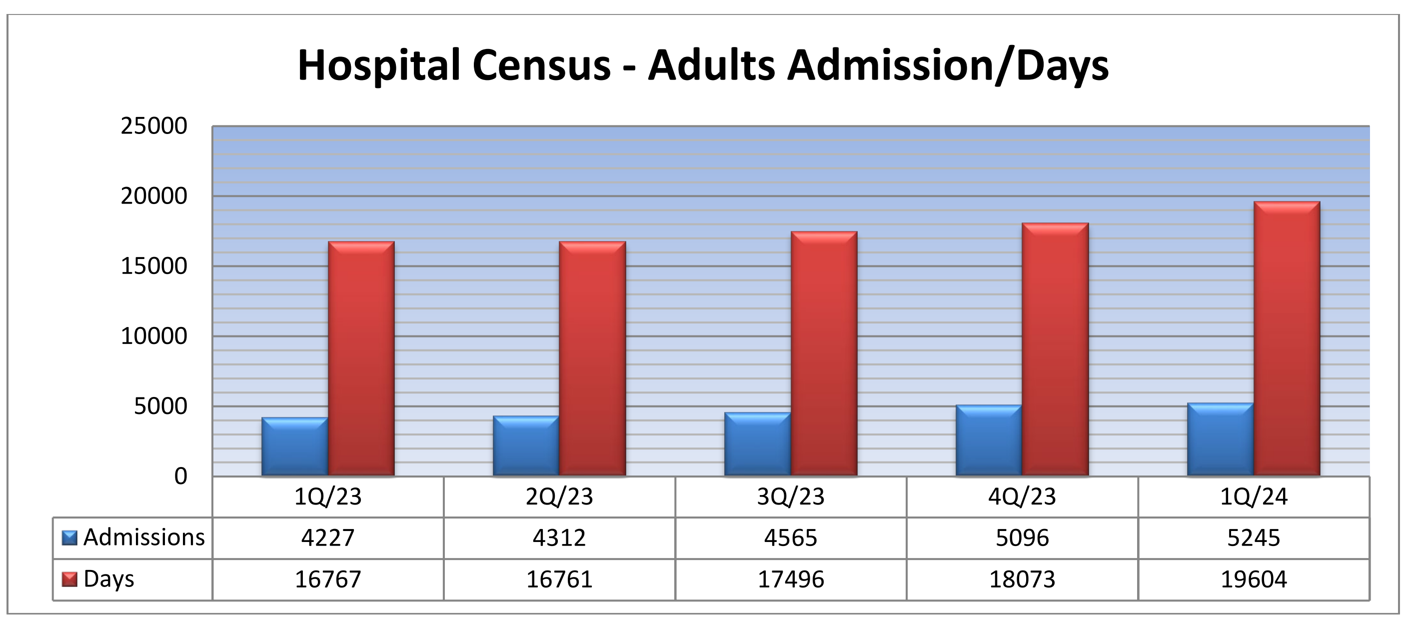


	Approved	Denied	Approved Pending CCS	Partial Approval	Pending	Total Average
Average LOS	20	10	22	31	43	25

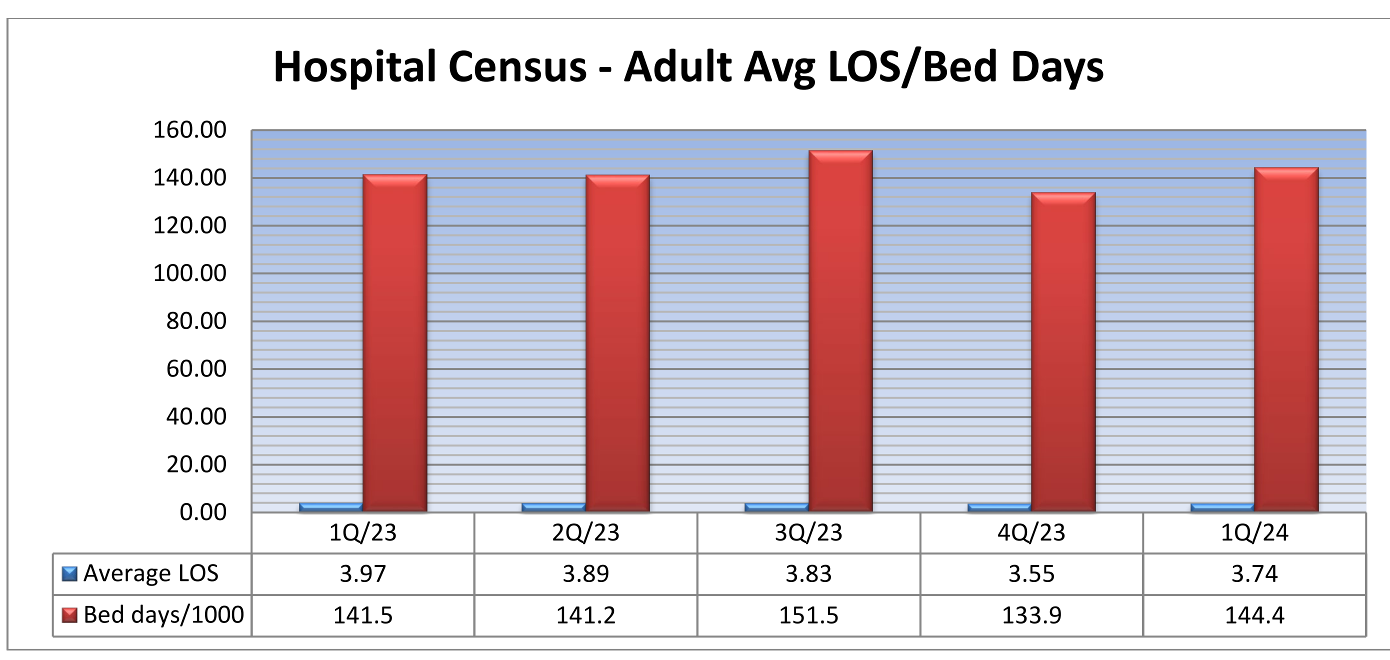
Post-Acute Nursing Facility Services Referral Volume by Location



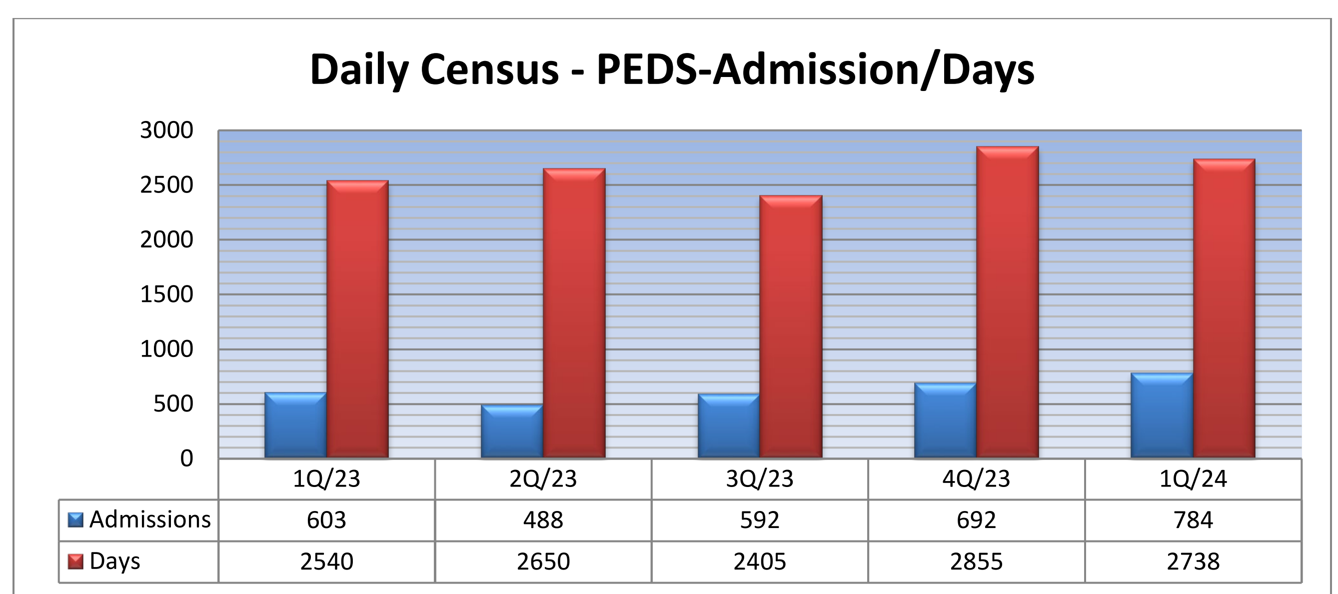
Inpatient 1st Quarter Trending



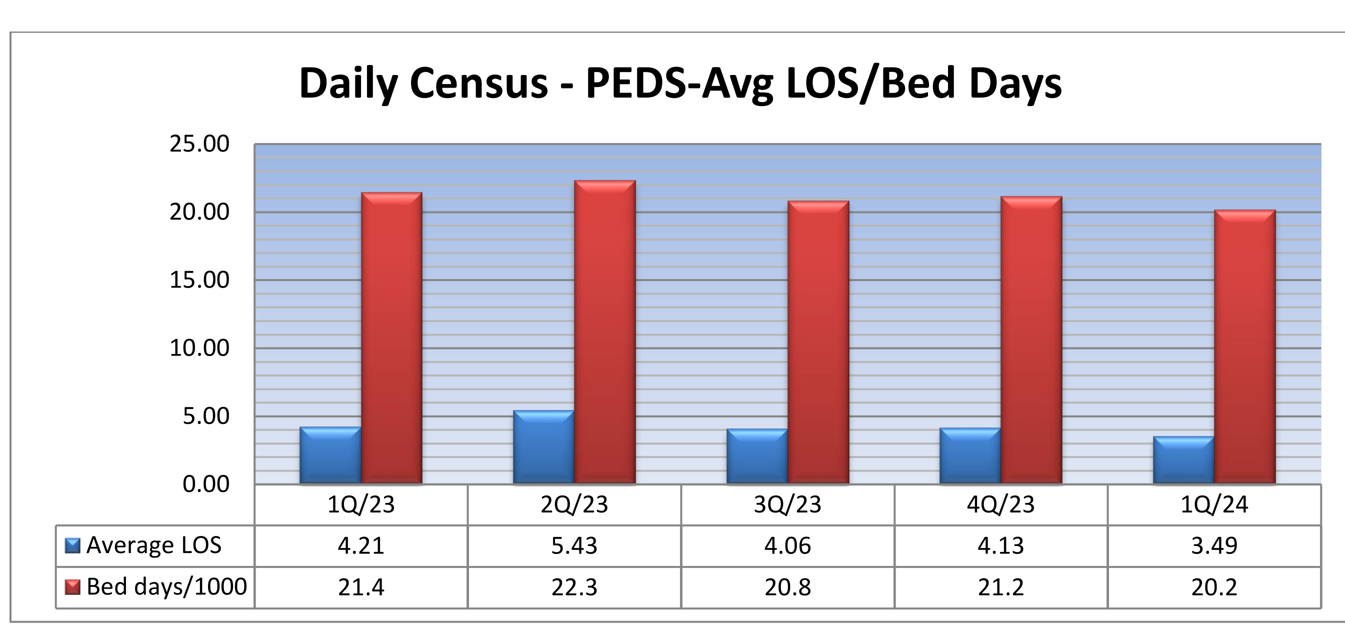
	1Q/23	2Q/23	3Q/23	4Q/23	1Q/24
Admissions	4227	4312	4565	5096	5245
Days	16767	16761	17496	18073	19604



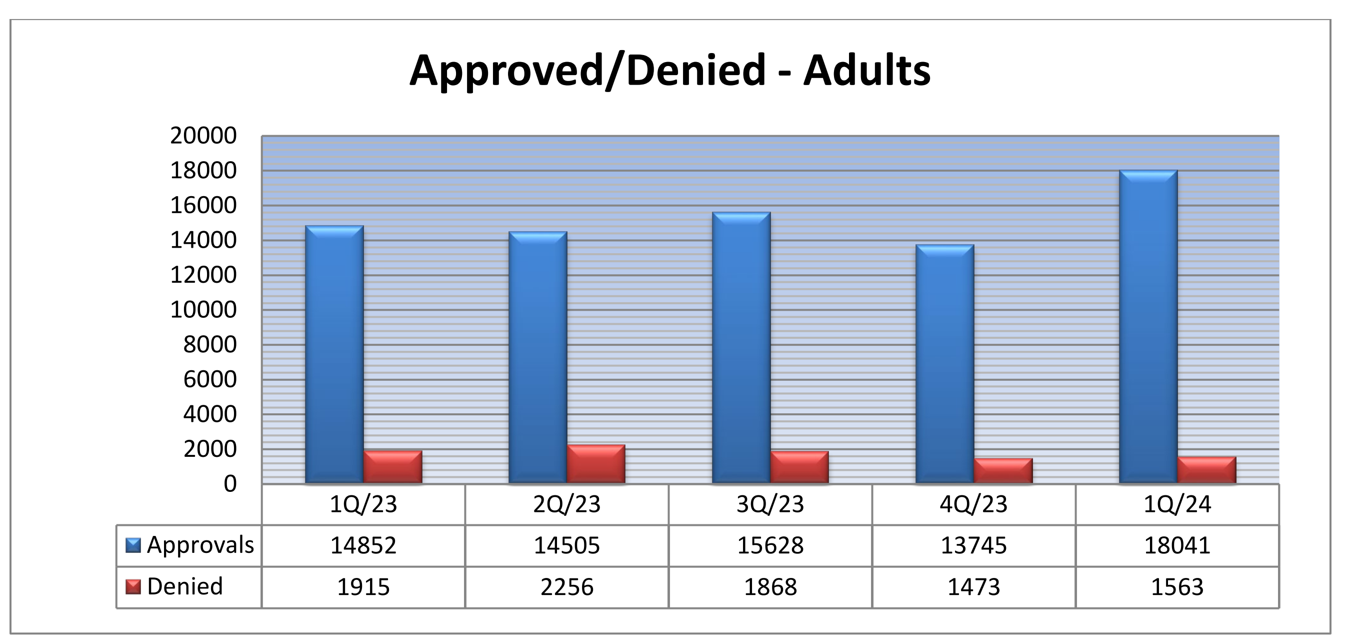
	1Q/23	2Q/23	3Q/23	4Q/23	1Q/24
Average LOS	3.97	3.89	3.83	3.55	3.74
Bed days/1000	141.5	141.2	151.5	133.9	144.4



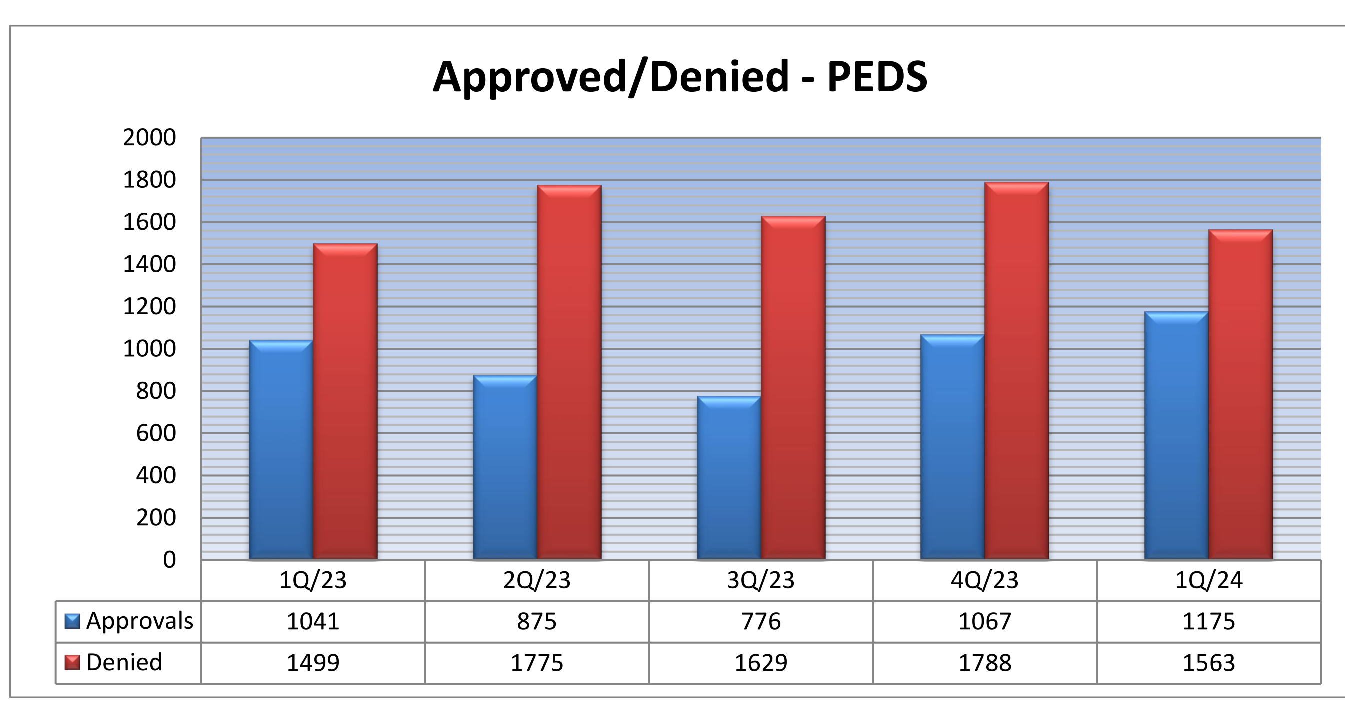
	1Q/23	2Q/23	3Q/23	4Q/23	1Q/24
Admissions	603	488	592	692	784
Days	2540	2650	2405	2855	2738



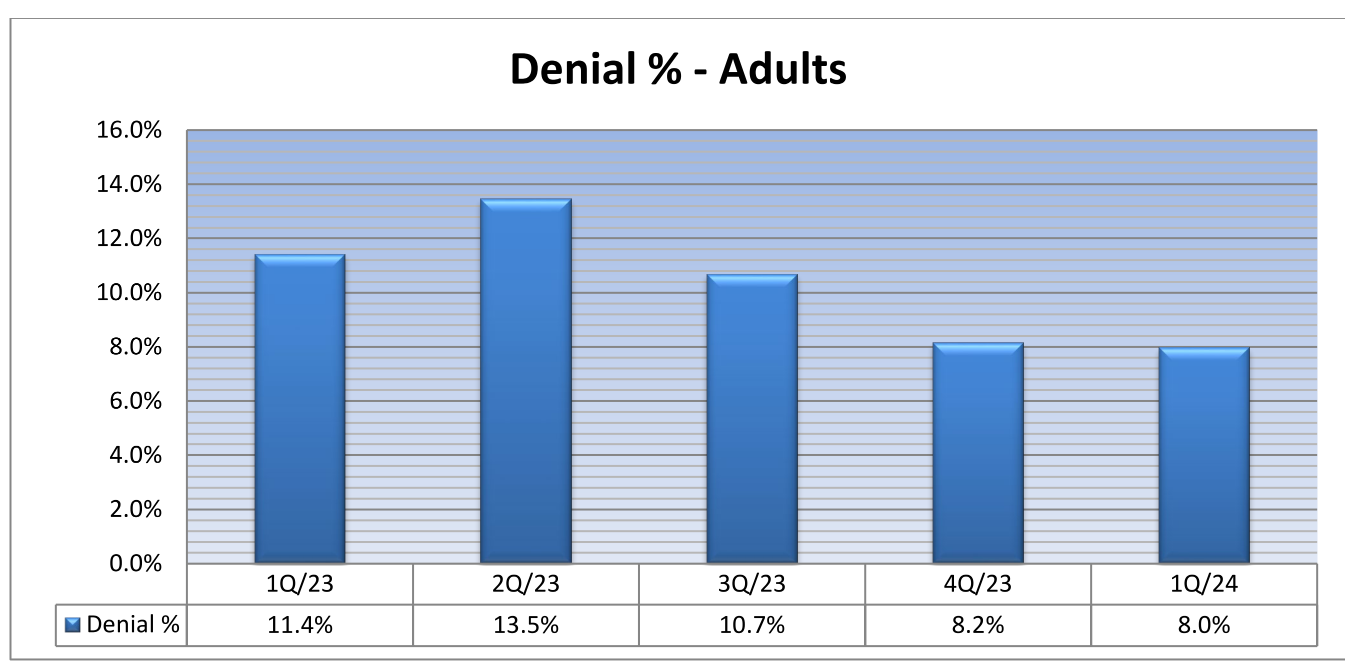
	1Q/23	2Q/23	3Q/23	4Q/23	1Q/24
Average LOS	4.21	5.43	4.06	4.13	3.49
Bed days/1000	21.4	22.3	20.8	21.2	20.2



	1Q/23	2Q/23	3Q/23	4Q/23	1Q/24
Approvals	14852	14505	15628	13745	18041
Denied	1915	2256	1868	1473	1563



	1Q/23	2Q/23	3Q/23	4Q/23	1Q/24
Approvals	1041	875	776	1067	1175
Denied	1499	1775	1629	1788	1563

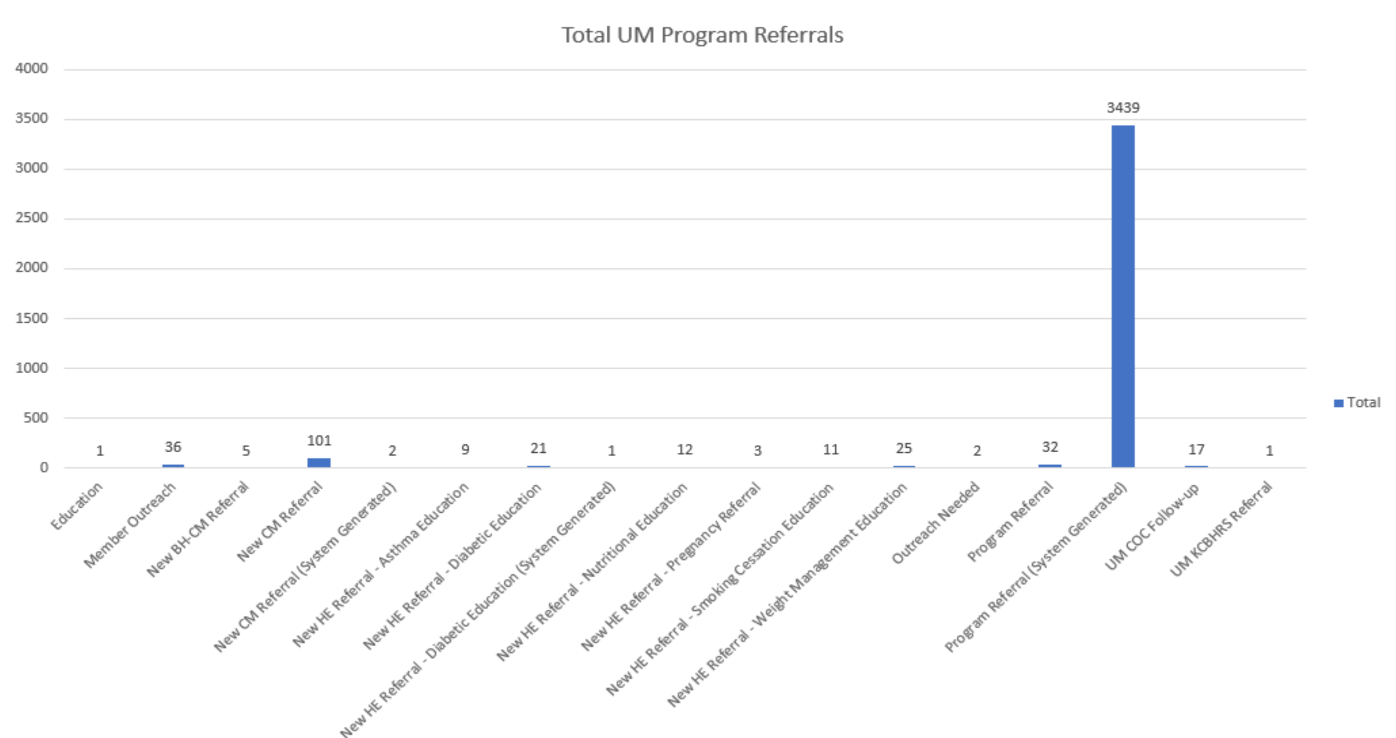


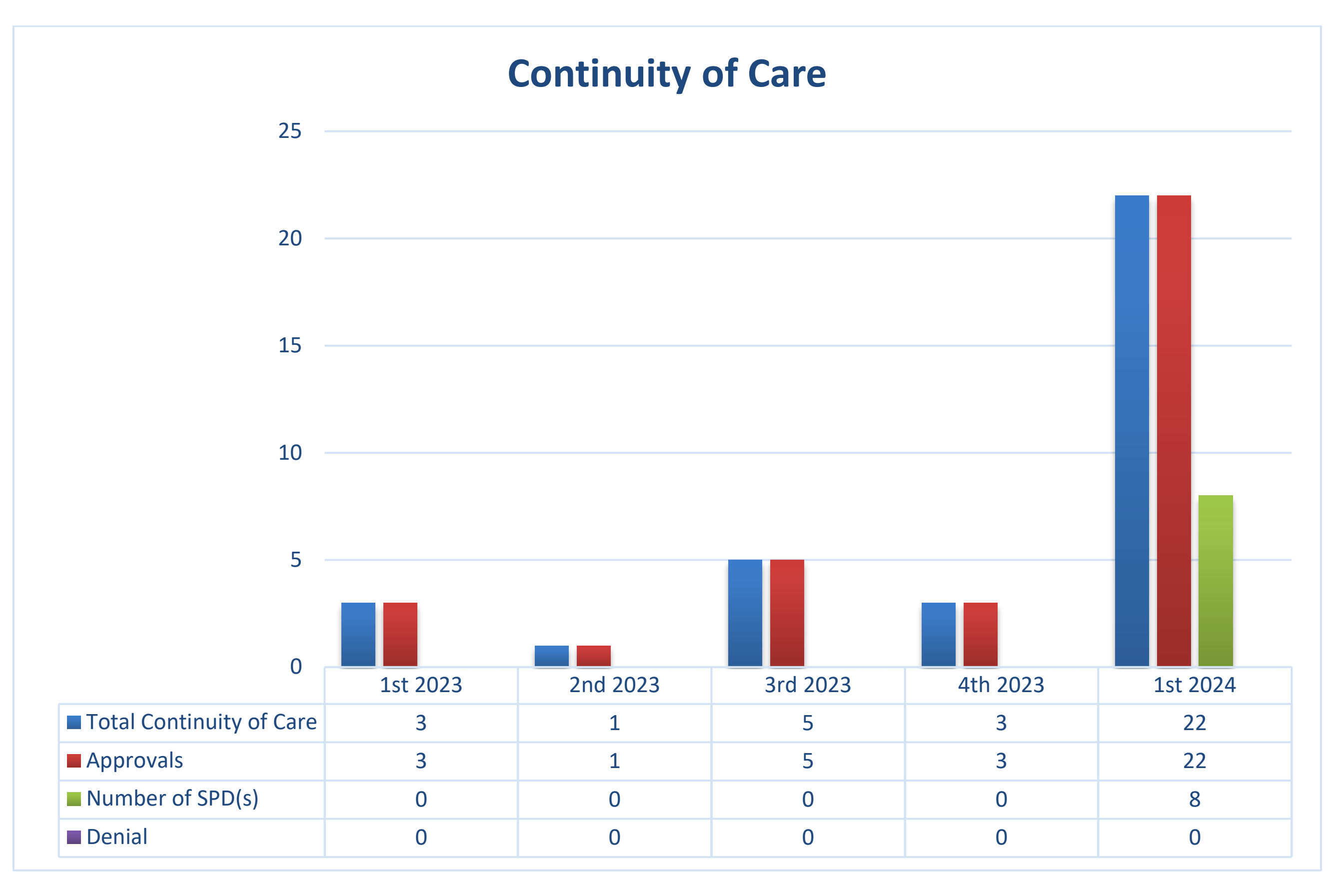
	1Q/23	2Q/23	3Q/23	4Q/23	1Q/24
Denial %	11.4%	13.5%	10.7%	8.2%	8.0%

UM Created Activities 1st Quarter 2024

Activity Type/Activity	Count
Education	**1**
Referral to Health Education	1
Member Outreach	**36**
CM Periscope Review	35
Referral to Case Management	1
New BH-CM Referral	**5**
Refer the child to their health care and/or mental health provider(s) for follow-up and evaluation of depression risk factors/triggers.	1
Referral to BH Case Management	2
Referral to Case Management	1
Referral to KCBHRS For Serious Mental Illness	1
New CM Referral	**101**
CM Periscope Review	8
Refer the member to social services for community resources and financial assistance related to their medical equipment and home modifications, such as a wheelchair ramp if indicated.	2
Referral for Case Management	9
Referral to Case Management	82
New CM Referral (System Generated)	**2**
Referral to COPD Program	1
Referral to TOC Program	1
New HE Referral - Asthma Education	**9**
Referral for Case Management	1
Referral for Health Education	1
Referral to Health Education	7
New HE Referral - Diabetic Education	**21**
Referral for Health Education	1
Referral to Health Education	20
New HE Referral - Diabetic Education (System Generated)	**1**
Referral for Health Education	1
New HE Referral - Nutritional Education	**12**
Referral for Health Education	1
Referral to Health Education	11
New HE Referral - Pregnancy Referral	**3**
Referral to Health Education	3
New HE Referral - Smoking Cessation Education	**11**
Referral for Health Education	1
Referral to Health Education	10
New HE Referral - Weight Management Education	**25**

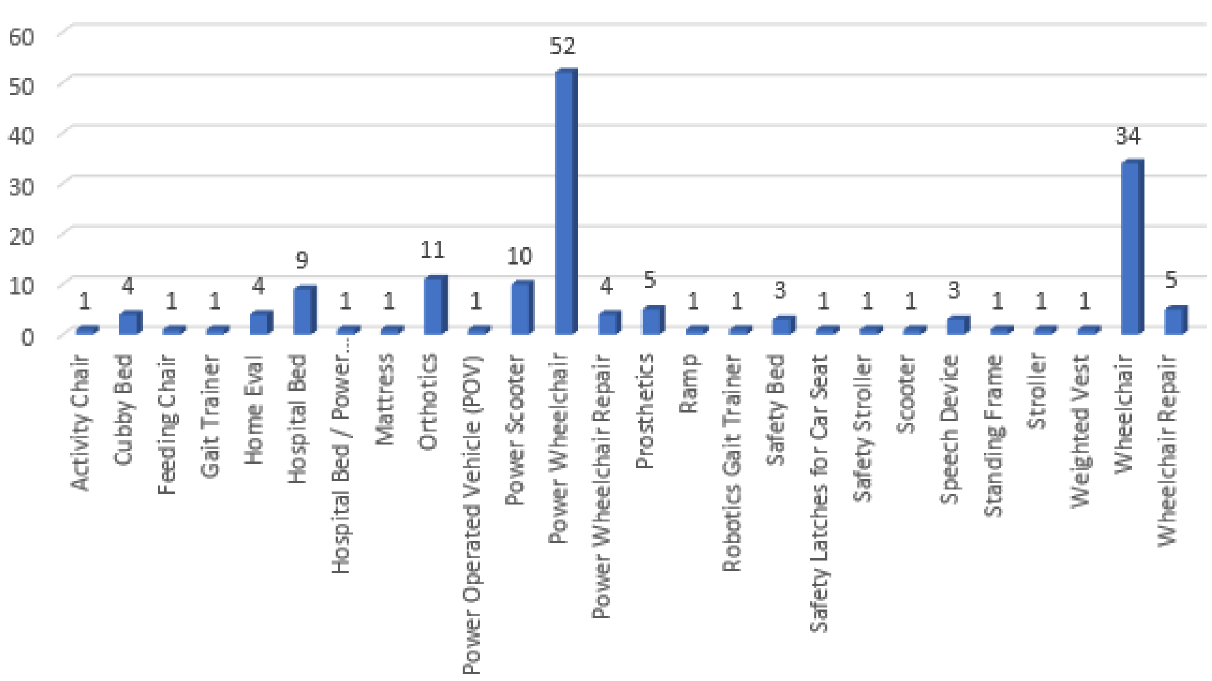
Referral to Health Education	25
Outreach Needed	**2**
Referral to Case Management	2
Program Referral	**32**
Referral for Case Management	1
Referral to Care Management Program	15
Referral to Case Management	15
Referral to CHF Program	1
Program Referral (System Generated)	**3439**
Referral to Comm Supports Asthma Remediation Program	450
Referral to Comm Supports Caregiver Respite Program	129
Referral to Comm Supports Comm NF Transition Program	2
Referral to Comm Supports Day Habilitation Program	148
Referral to Comm Supports Housing Deposits Program	75
Referral to Comm Supports Housing Navigation Services Program	663
Referral to Comm Supports Housing Sustainability Program	103
Referral to Comm Supports Personal Care Services Program	269
Referral to Comm Supports Recuperative Care Program	89
Referral to Comm Supports Short Term Post Hospitalization Program	29
Referral to Comm Supports Sobering Centers Program	164
Referral to Comm Supports Tailored Meals Program	521
Referral to ECM Program	381
Referral to LTC Program	416
UM COC Follow-up	**17**
Contact member for acknowledgment of COC request	5
Contact member for provider choice after COC Expiration	12
UM KCBHRS Referral	**1**
Referral to KCBHRS for Substance Use Treatment Services	1
Grand Total	**3718**

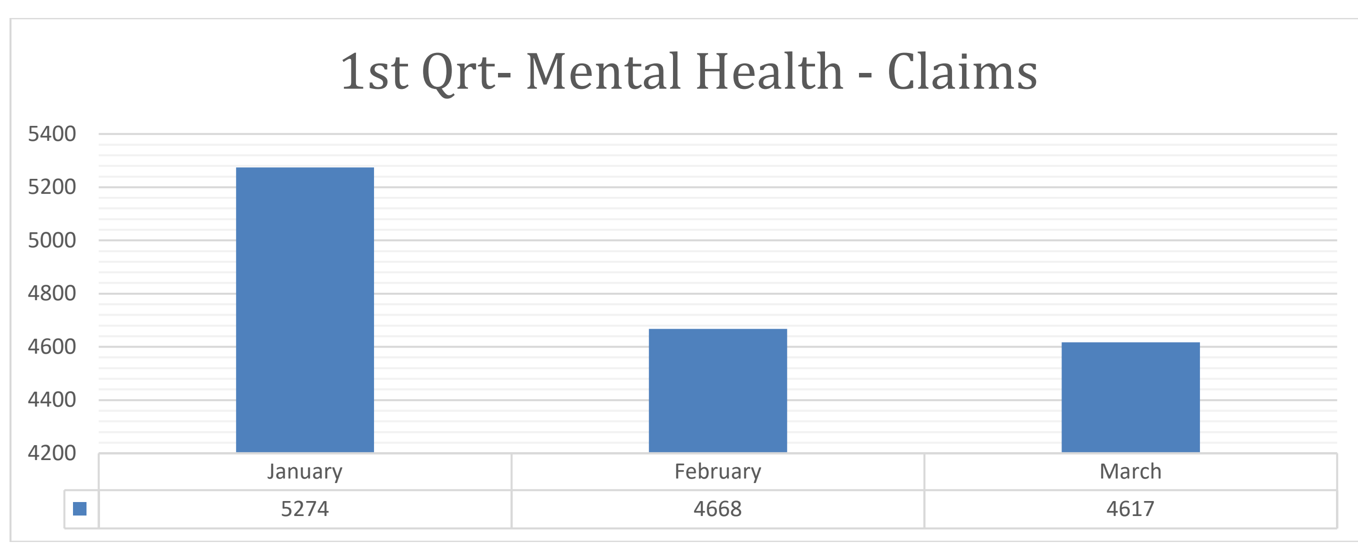




	1st 2023	2nd 2023	3rd 2023	4th 2023	1st 2024
Total Continuity of Care	3	1	5	3	22
Approvals	3	1	5	3	22
Number of SPD(s)	0	0	0	0	8
Denial	0	0	0	0	0

Periscope Group Referrals Q1 2024


60
50
40
30
20
10
0
Activity Chair 1
Cubby Bed 4
Feeding Chair 1
Gait Trainer 1
Home Eval 4
Hospital Bed 9
Hospital Bed / Power... 1
Mattress 1
Orthotics 11
Power Operated Vehicle (POV) 1
Power Scooter 10
Power Wheelchair 52
Power Wheelchair Repair 4
Prosthetics 5
Ramp 1
Robotics Gait Trainer 1
Safety Bed 3
Safety Latches for Car Seat 1
Safety Stroller 1
Scooter 1
Speech Device 3
Standing Frame 1
Stroller 1
Weighted Vest 1
Wheelchair 34
Wheelchair Repair 5


1st Qrt- Mental Health - Claims
5400
5200
5000
4800
4600
4400
4200
January 5274
February 4668
March 4617

ABA Services

UNIQUE CASES		Total
MEMBER COUNT		417

SEVERITY	Jan	Feb	Mar	Total
Approved FBA	227	190	281	698
Approved Treatment	138	112	167	417
	Jan	Feb	Mar	Total
AGE 7 OR LESS	94	85	111	290
AGE 8 OR GREATER	44	27	56	127
TOTAL	138	112	167	417
% < 7	68.12%	75.89%	66.47%	69.54%
% > 8	31.88%	24.11%	33.53%	30.46%

Initial Health Assessment (IHA) Letters to Members

Letters to the member's PCP with a count of their assigned members who still need an IHA.
These letters direct the PCP to the Provider Portal to review their list and perform outreach.
Letters are also mailed to the PCP regarding members who have open authorizations.
Open authorizations are defined as any auth that has not expired and has no claim attached to it.
The auth does not need to be fulfilled to no longer be considered open.
Letters are mailed out to each PCP at each location where they have members assigned.

January 2024

- IHA Letters Mailed – 380
- Open Authorization letters mailed – 132

February 2024

- IHA Letters Mailed – 442
- Open Authorization letters mailed – 131

March 2024

- IHA Letters Mailed – 445
- Open Authorization letters mailed – 147

Internal Auditing Results

Delayed Referrals - Quarter 1, 2024

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

Auditor:
Lynette Barca, RN UM Outpatient Clinical Trainer & Auditor

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

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

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

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

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

Audit Indicators:

1. Processing of Referral
    - Appropriately delayed for additional medical records.
    - Delay completed on a routine authorization.

- Delay completed on the fifth working day of receipt.
- Service line(s) appropriately chosen.

2. Notices to Provider and Member after referral delayed.
    - Referring Provider Notice:
        i. Copy of Notice of Adverse Determination Letter and the Referral/Prior Authorization Form within 24 hours of the date of decision.
    - Member Notice:
        i. Notice of Adverse Determination documents within 2 business days of the decision.
            1. Notice of Adverse Determination – Delay letter
            2. Your Rights Under Medi-Cal Managed Care
            3. Form to File a State Hearing

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

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

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

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

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

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

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

- Processing of Referral
  - One (1) authorization was incorrectly delayed for reasons other than obtaining additional medical records: 202401050000817.
  - All delayed authorizations were correctly done on routine requests only.
  - One (1) authorization had the service line chose as previously delayed in error by the CIC when it was not delayed: 202401180000291.
  - Three (3) authorizations were incorrectly delayed by the CIC before the 5th working day: 202401080001297, 202401170001550, 202401220001264.

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

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

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

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

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

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

February Audit Findings:

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

- Processing of Referral
    - One (1) authorization was incorrectly delayed for reasons other than obtaining additional medical records: 202402230000793.
    - All delayed authorizations were correctly done on routine requests only.
    - Two (2) authorizations were incorrectly delayed by the CIC before the 5th working day: 202402150001139, 202402230000793.

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

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

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

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

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

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

March Audit Findings:

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

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

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

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

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

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

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

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

Denied Referrals - Quarter 1, 2024

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

Auditor:
Lynette Barca, RN UM Outpatient Clinical Trainer & Auditor

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

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

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

Purpose:

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

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

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

Audit Indicators:

8. Referral Turnaround Time
    - Decision rendered within 72 hours for urgent referrals and 5 working days for routine referrals.
    - Provider notification within 24 hours of decision and member notification within 48 hours of decision.
9. Notice of Action Letter
    - Spelling/Grammar, Verbiage, and Format
    - 6th grade reading level
    - Criteria indicated and attached.
    - Recommendations indicated.
10. Medical Director / Case Manager Name and Signatures on NOA and OP Notification
11. Processing of Referral

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

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

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

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

- Five (5) referrals were found to be mailed outside of the referral turnaround time indicator due to not being set to print our being outside of TAT when completed.
- One (1) referral cited KHS policy for denial, but the policy was not attached.
- Two (2) referrals cited KHS policy for denial, but the attached policy was outdated.
- Zero (0) referrals were found within the signatures of the NOA letter.
- Two (2) referrals were found with errors in the NOA letter verbiage.
  - Citations not separated and abbreviations/errors within the letter.
- Four (4) referrals were found with processing errors.
- Eight (8) referrals were found to have above 6th grade readability on the NOA.
- Guidelines cited and attached:
  - Three (3) ECM referrals denied for medical necessity had DHCS criteria attached.

- Nine (9) referrals were denied using Medi-Cal guidelines.
- Two (2) referrals were denied using UpToDate guidelines.
- Forty-nine (49) referrals were denied using MCG guidelines.
- Five (5) referrals were denied using KHS Policies.

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

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

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

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

<u>Corrective Action Plan (CAP):</u>
1. Email reminder sent to NOA/NCIC/CIC teams:
   a. Ensure to check body of the NOA letter for 6th grade readability using the HLA Tool.
      i. Many letters were found with above 6th grade reading level.
   b. Check for any spelling or grammatical errors.
      i. Some letters had grammar errors, missing information, or had repeat words/sentences.
   c. Ensure that each criterion or policy that is cited is attached and most current.
      i. KHS policy updated 11/2023
      ii. UTD guidelines are reviewed periodically and will show the date that the guideline is current through.

d. Always verify that the correct member's notes are attached.
e. NOA letters must be mailed to the member within 48 hours of the decision.

Modified Referrals - Quarter 1, 2024

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

Report Completion Date:
May 8, 2024

Auditor:
Lynette Barca, RN UM Outpatient Clinical Trainer & Auditor

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

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

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

Policy and Procedures 3.22, Section 4.2.2 Modifications states – There may be occasions when recommendations are made to modify an authorization request in order to provide members with the most appropriate care. Recommendations to modify a request are first reviewed by the KHS Chief Medical Officer, or their designee(s).

The referrals that qualify for a modification are:

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

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

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

Audit Indicators:

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

January Audit Findings:

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

- Three (3) referrals were found to be mailed outside of the referral turnaround time indicator.
- Four (4) referrals were found with errors in the Notice of Action letter: Typos, abbreviated verbiage, and commentary errors.
- One (1) referral was found with NOA language that was above 6th grade readability.
- Ten (10) errors found within the processing of referral: With five (5) urgent auths that were modified to routine in error. One (1) auth was modified to VCH as per the CIC recommendation, but the web note asking for CHLA due to VCH access issue. One (1) auth was CCS eligible (scoliosis with Cobb angel of 30) and was modified to local provider that was not CCS paneled and doesn't see pediatrics. This should have been approved with CHLA and pended to CCS by the CIC (failed to recognize CCS eligible). One (1) referral requested KRC and notes attached from CA Spectrum stated member did not have ASD but developmental delay and referring to KRC. Codes were for FBA eval and CIC modified to par FBA provider, but should have been carved out to KRC. One (1) auth was not set to "Approved – Modified from out of network."

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

February Audit Findings:

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

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

March Audit Findings:

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

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

Corrective Action Plan (CAP):

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

NAR/ Appeal Audit

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

Report Completion Date:
May 17, 2024

Auditor:
Lynette Barca, RN UM Outpatient Clinical Trainer & Auditor

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

Appeals Nurses:
Tuddao, Gilrose, RN
Patel, Prerna, RN

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

Audit Indicators:

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

- Overall process
- Criteria used

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

- **NAR spelling, grammar, verbiage, and format:** One (1) cert 202401090000960 with minor grammatical error on the NOA.

- **6th grade readability:** Zero (0) errors found within the 6th grade readability.

- **Criteria indicated and attached:** Zero (0) errors found.

- **Recommendations indicated:** Zero (0) errors found.

- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.

- **Overall Process:** Zero (0) errors found.

- **Criteria Used:**
    - One (1) referral with Medi-Cal guidelines used.
    - Three (3) referrals with MCG guidelines used.
    - Two (2) referrals with UTD guidelines used.
    - Four (4) referrals with KHS policy used.

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

- **NAR spelling, grammar, verbiage, and format:** One (1) cert 202402170000066 with minor grammatical error found on the NOA.

- **6th grade readability:** Zero (0) errors found within the 6th grade readability.

- **Criteria indicated and attached:** Zero (0) errors found.

- **Recommendations indicated:** Zero (0) errors found.

- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.

- **Overall Process:** One (1) cert 202401230001447 with error found within the process indicator where a final document was not generated.

- **Criteria Used:**
  - One (1) referral with Medi-Cal guidelines used.
  - Five (5) referrals with MCG guidelines used.
  - Three (3) referrals with UTD guidelines used.
  - One (1) referral with KHS policy used.

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

- **NAR spelling, grammar, verbiage, and format:** Zero (0) errors found.

- **6th grade readability:** Zero (0) errors found.

- **Criteria indicated and attached:** Zero (0) errors found.

- **Recommendations indicated:** Zero (0) errors found.

- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.

- **Overall Process:** Zero (0) errors found.

- **Criteria Used:**
  - Two (2) referrals with Medi-Cal guidelines used.
  - Three (3) referrals with MCG guidelines used.
  - Zero (0) referrals with UTD guidelines used.
  - Five (5) referrals with KHS policy used.

Corrective Action Plan (CAP):
1. Medical Director Dr. Dike was emailed regarding minor error on NOA template (KSH instead of KHS)
2. Gilrose Tuddao emailed regarding KHS Policy 3.22 revision 11/2023 and will use most current policy when attaching in Jiva.
   a. KHS website Policy 3.22 has also been updated to reflect the most current policy.

NOA Audit:

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

Report Completion Date:
May 20, 2024

Auditor:
Lynette Barca, RN UM Outpatient Clinical Trainer & Auditor

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

NOA Team Members:
Camarena, Monica
Cruz, Gabriela
De Santiago, Susana
Garza, Melida
Guzman, Veronica
Proeung, Melanie (No longer with UM effective 04/20/24)
Rodriguez, Beronica
Torres, Esperanza

Purpose:
Quarterly audits of the Notice of Action (NOA) Team to ensure appropriate processing of referrals that were previously denied or modified and to monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process.

Audit Indicators:

- NOA spelling, grammar, verbiage, and format
- 6tth grade readability level
- Criteria indicated and attached.
- Recommendations indicated.
- Medical Director / Case Manager name and signatures

January Audit Findings:
Out of the **10** NOAs audited, the following is a breakdown of the findings:

- **NOA spelling, grammar, verbiage, and format:** One (1) cert 202401100000674 with minor grammatical error on the NOA which is an error from within the template regarding incorrect period placement after the treating provider.
- **6th grade readability:** Zero (0) errors found.
- **Criteria indicated and attached:** Zero (0) errors found.
- **Recommendations indicated:** Zero (0) errors found.
- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.

February Audit Findings:
Out of the **10** NOAs audited, the following is a breakdown of the findings:

- **NOA spelling, grammar, verbiage, and format:** One (1) cert 202402020001061 with minor grammatical error on the NOA which is an error from within the template regarding incorrect period placement after the treating provider.
- **6th grade readability:** Zero (0) errors found.
- **Criteria indicated and attached:** Zero (0) errors found.
- **Recommendations indicated:** Zero (0) errors found.
- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.

March Audit Findings:
Out of the **10** NOAs audited, the following is a breakdown of the findings:

- **NOA spelling, grammar, verbiage, and format:** One (1) cert 202403160000126 with minor grammatical error on the NOA which is an error from within the template regarding incorrect period placement after the treating provider. One (1) cert

202402270000345 with minor grammatical errors found with a word missing. One (1) cert 202402240000042 with the Medi-Cal and MCG criteria not separated appropriately on the NOA.

- **6th grade readability:** Zero (0) errors found within the 6th grade readability.
- **Criteria indicated and attached:** Zero (0) errors found.
- **Recommendations indicated:** Zero (0) errors found.
- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.

Corrective Action Plan (CAP):

1. Email was sent to Clarissa Cisneros (NCIC supervisor) regarding the findings and for any follow-up refresher training of the NOA Team that may be needed.

CBCC OP Auto Approval Referral Audit:

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

Report Completion Date:
May 17, 2024

Auditor:
Lynette Barca, RN UM Outpatient Clinical Trainer & Auditor

Audit Sample Size:
The greater of 10% of the total online approved and online reviewed referrals or ten (10) referrals. The audit sample will include at least 10% from each provider.

	January, February, March
Total of referrals that were approved: (online approval and online reviews)	20
Percent of audit: (greater of 10% of the total online approved or online reviewed referrals OR 10 referrals)	10 referrals

Number of referrals in audit: (includes at least 10% from each provider)	10 referrals

Purpose:
Quarterly audits of referrals that have been processed for Comprehensive Blood and Cancer Center (CBCC) providers to ensure appropriate processes were used to review and approve the provision of medically necessary covered services and monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process.

Audit Indicators:
1. Processing of Referral
    - Medical records received from provider.
    - Criteria reviewed and applied appropriately.
    - Process of referral based on KHS Policy and Procedure 3.22.

1st Quarter Audit Findings:
Out of the **10** approved referrals that were audited, the following is a breakdown of the findings:

- Seven **(7)** referrals **MET** criteria for medical necessity based on the review of clinical documentation received.

- One **(1)** referral **PARTIALLY MET** criteria for medical necessity.
    - Below is the breakdown of the findings:
        - 202402070001291 – This was a request for a CT of the head, chest, abdomen, and pelvis. Dr. Kanamori's office only submitted the cytology report and there were no clinical notes. The request did not meet MCG guidelines for the CT of the head due to no documentation of an MRI being contraindicated, not available, or results indeterminate.

- Two **(2)** referrals **DID NOT MEET** criteria for medical necessity.
    - Below is the breakdown of the findings:
        - 202402130000498 – There was no clinical documentation received from Dr. Kanamori's office to support the request.
        - 202402280001167 – There was no clinical documentation received from Dr. Shambaugh's office to support the request.

Corrective Action Plan (CAP):
1. An email was sent on May 17th, 2024, to Alex Herrera in Provider Relations regarding the audit findings. I have requested that she notify me of their office's understanding of the need to submit clinical documentation for each request that supports the request for the services.

Gold Card - OP Auto Approval Referral Audit

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

Report Completion Date:
May 14, 2024

Auditor:
Lynette Barca, RN UM Outpatient Clinical Trainer & Auditor

Audit Sample Size:
10% of the total referral from each gold card provider

	January, February, March
Total referrals approved for quarter 1	1,304
Percent of audited referrals from each provider	10%
Number of referrals in audit	133

Purpose:
Quarterly audits of referrals that have been processed for gold card provider to ensure appropriate processes were used to review and approve the provision of medically necessary covered services and monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process

Audit Indicators:

2. Processing of Referral
    - Medi-Cal criteria or other criteria applied.
    - Clinical documentation from provider
    - Process of referral based on KHS Policy and Procedure 3.22

1st Quarter Audit Findings:
Out of the **133** approved referrals that were audited, the following is a breakdown of the findings:

- One **(1)** referral **was excluded** from the audit as the notes submitted by the referring provider were for another member. This incident was reported to compliance.
- Seventy-seven **(77)** referrals **MET** criteria for medical necessity based on the review of clinical documentation received.
- Fifty-four **(55)** referrals **DID NOT MEET** criteria for medical necessity.

- Fifty-four **(54)** referrals did not have any clinical documentation uploaded to support the request.
- One **(1)** referral did not meet with the clinical documentation provided.
- Below is the breakdown of the findings:
  - Forty-eight **(48)** referrals were submitted without supporting documentation by Dr. Bui's Group which includes: Dr. Hao Bui, Dr. Tien Nguyen, Dr. Allan Capote, and Dr. Sara Honari.
    - 202401250001331
    - 202402090000286
    - 202402220000864
    - 202402230000123
    - 202402290001053
    - 202403050001312
    - 202403130000108
    - 202403130001178
    - 202403210000337
    - 202403270001814
    - 202401030001041
    - 202401090001606
    - 202401160001648
    - 202401170001466
    - 202401190001570
    - 202401230000690
    - 202401250000081
    - 202402020001211
    - 202402050001024
    - 202402080000116
    - 202402090000065
    - 202402190000231
    - 202402280000084
    - 202403190001559
    - 202403260001085
    - 202401080000061
    - 202401090000655
    - 202401170001307
    - 202401230000131
    - 202402010000942
    - 202402020000148
    - 202402050000586
    - 202402060001364
    - 202402190000812
    - 202402200000163
    - 202402230000096

- 202402260001216
- 202403050000112
- 202403180001328
- 202403260000346
- 202401020000241
- 202401040000121
- 202401260001442
- 202402090001096
- 202402220000839
- 202403010001136
- 202403150000059
- 202403190001303

▪ Five **(5)** referrals were submitted without supporting documentation by Stockdale Podiatry which includes: Dr. Brandon Hawkins, Dr. Kyle Huber, Dr. Michael Flores, Dr. Solomon Kim, and Dr. Tzu Lu Lin.
  - 202401100000610
  - 202401180001773
  - 202402230001648
  - 202403290001507
  - 202403300000087

▪ One **(1)** referral was submitted by a PCP Dr. Ajitpal Tiwana
  - 202402070000752

▪ One **(1)** referral had no documentation the member was homebound.
  - 202403290000573

Corrective Action Plan (CAP):

1. Provider Relations (PR) representative Diane Nieblas was contacted regarding lack of supporting documentation from Dr. Bui's office. She reached out to Dr. Bui's Group and reinforced to them that clinical documentation is needed on all requests so that we may audit for medical necessity. On 03/24/24 Diane emailed stating that their office understands and have confirmed that they will include clinical documentations moving forward.
2. Email sent on 05/14/2023 to Liz Sanchez in PR to remind Stockdale Podiatry to submit clinical documentation on each request.

OP Auto Approval Referral Audit

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

Report Completion Date:
May 16, 2024

Auditor:
Lynette Barca, RN UM Outpatient Clinical Trainer & Auditor

Audit Sample Size:
Thirty (30) referrals

	January, February, March
Total referrals approved for quarter 1	59,718
Percent of audited referrals	< 1%
Number of referrals in audit (15 manual approvals + 15 online approvals)	30

Purpose:
Quarterly audits of referrals that have been processed for auto-approval by the UM Staff and Online to ensure appropriate processes were used to review and approve the provision of medically necessary covered services and monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process

Audit Indicators:

3. Processing of referral
    - Medi-Cal criteria or other criteria applied.
    - Clinical documentation from provider.
    - Process of referral based on KHS Policy and Procedure 3.22.

1st Quarter Audit Findings:
Out of the **30** approved referrals that were audited, the following is a breakdown of the findings:

- Twenty-three **(23)** referrals **MET** criteria for medical necessity based on the review of clinical documentation received.
- Seven **(7)** referrals **DID NOT MEET** criteria for medical necessity.
    - Below is the breakdown of the findings:
        - 202402120000033 – This auth was a request for CPAP supplies and most codes are on the NCIC AA list; however, HCPC A4604 is not on the AA list, and this should have gone to the CIC for review. Auth was approved for 4 months, but some codes have quantities that would be allowable for 12 months per Medi-Cal guidelines and would have been over allowable for a 4-month duration. No MD notes from Super Care and only order attached)

- 202403040000917 – This was a request for a sleep study and is on the NCIC AA list if member has daytime fatigue AND a dx of HTN or BMI 30+, soring, witnessed apnea etc. Member had the daytime fatigue, but no other indications and this should have been sent to the CIC for review to determine medical necessity.
- 202402220000321 – This was a request for a CT of the soft tissue of the neck and did not meet MCG criteria as there was no ultrasound results provided by Ridhima Softa, NP's office (Pinnacle Primary Care Inc.), or any documentation that an US was nondiagnostic.
- 202402070000266 – This was a request for a cardiac monitor and did not meet MCG criteria as there was no documentation from Dr. Nasser Khan's (Comprehensive Cardiovascular) notes stating why this testing was ordered or if episodes were expected to occur less frequently than every 48 hours or that a Holter failed to ID any arrhythmia.
- 202401170000289 – This was a request for a dermatology consultation and follow-up visit, but there were no notes received from Dr. Padmaja Kankar's office (Coastal Kids).
- 202402200000888 – This was a request for a neurology consultation, but there were no clinical notes submitted by Bertha Barraza, NP's office (Good Samaritan Hospital).
- 202402220000347- This was a request for a dermatology consultation, but there was no documentation in Dr. William Bichai's notes regarding why the member was being referred to dermatology.

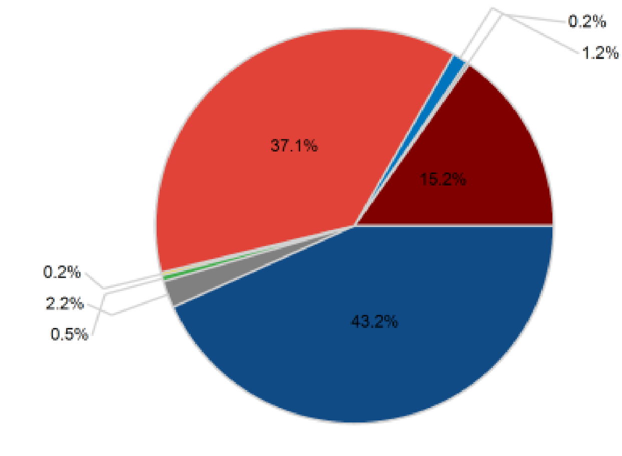
Corrective Action Plan (CAP):

3. The following emails were sent:

- **a.** Email to management on 05/15/2024 requesting HCPC A4604 that is commonly requested with CPAP supplies may be added to the NCIC AA list.
- **b.** Email sent to Clarissa Cisneros (NCIC OP supervisor) regarding findings on certs: 202402120000033, 202403290001310, 202402060001727, 202403040000917 and requested appropriate reminders to be sent out to the team.
- **c.** Emai sent to Kristie Onaindia in PNM regarding findings on certs: 202402220000321, 202402070000266, 202401170000289, 202402200000888, 202402220000347 with request for PR reps to reach out to provider's offices to:
  - **i.** Submit all clinical documentation that is needed to support medical necessity for the services requested.
  - **ii.** Ensure clinical documentation is submitted with every request.

Health Dialog Report

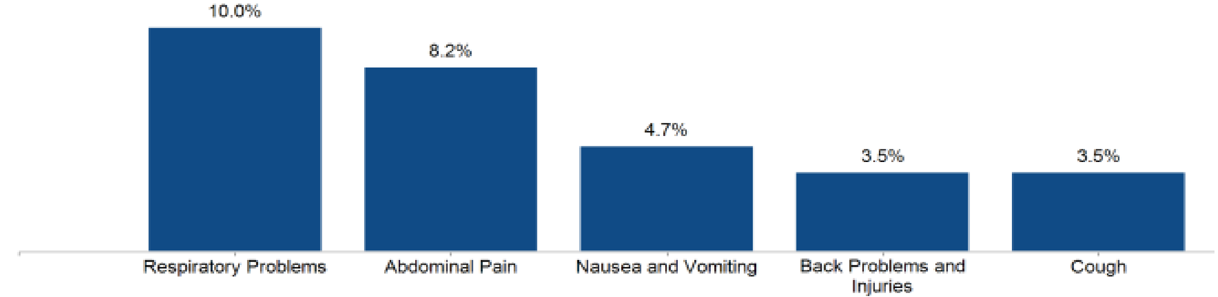
Member Inbound Call Reasons (Jan-2024)



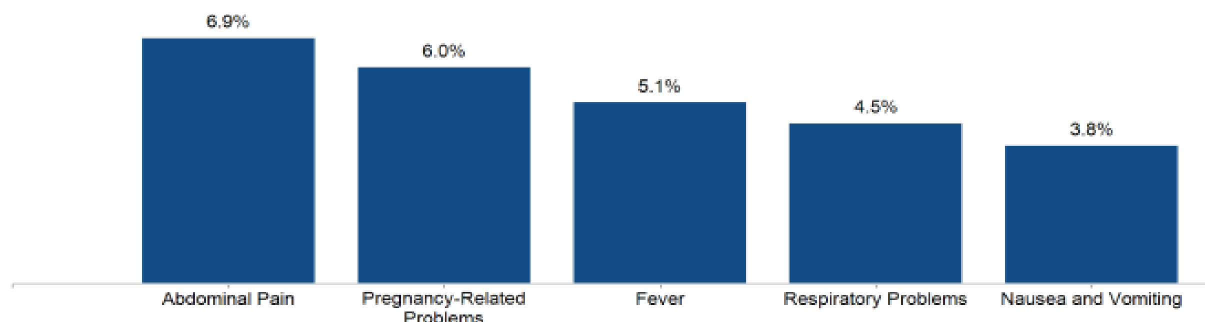
REASON	NUMBER
Symptom Check	176
Condition Support	9
Decision Support	2
Wellness Support	1
Health Plan	151
Mailing or Message Follow Up	5
Web Tools	1
Other	62

Symptom Check
Wellness Support
Web Tools
Condition Support
Health Plan
Other
Decision Support
Mailing or Message Follow Up

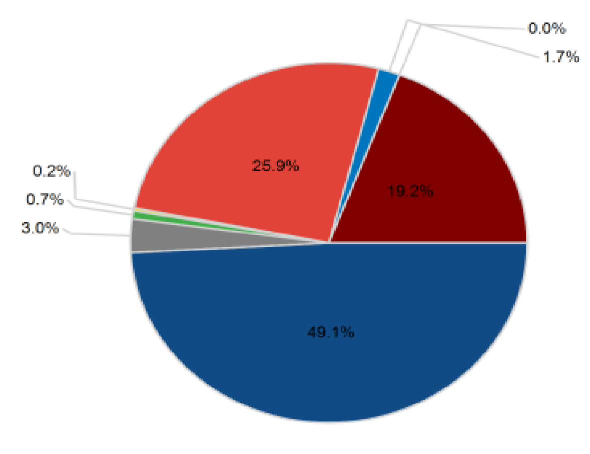
Most Frequent Symptoms - Inbound Symptom Check Calls (Jan-2024)



Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)

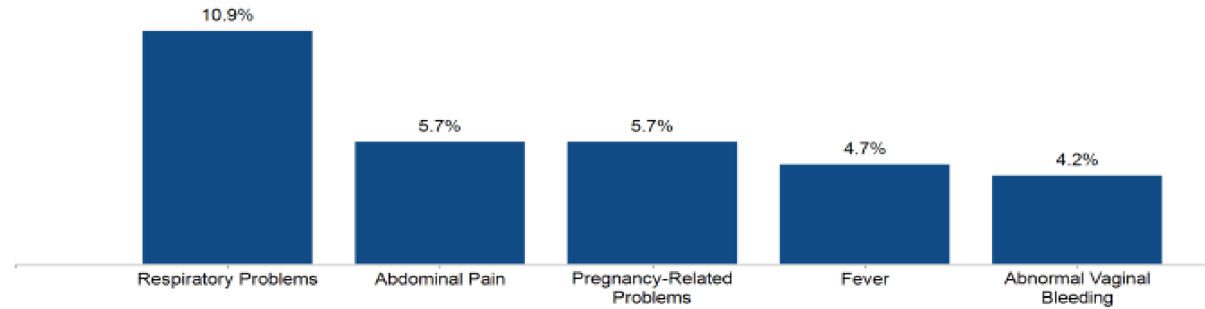


Member Inbound Call Reasons (Feb-2024)

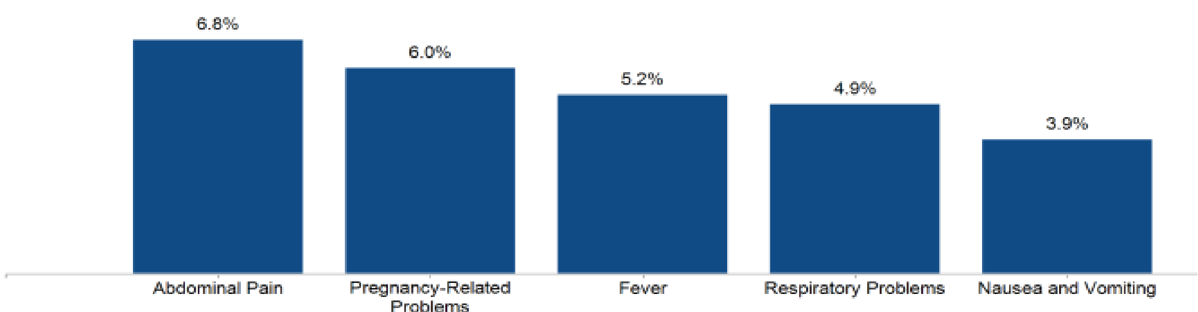


REASON	NUMBER
Symptom Check	197
Condition Support	12
Decision Support	3
Wellness Support	1
Health Plan	104
Mailing or Message Follow Up	7
Web Tools	0
Other	77

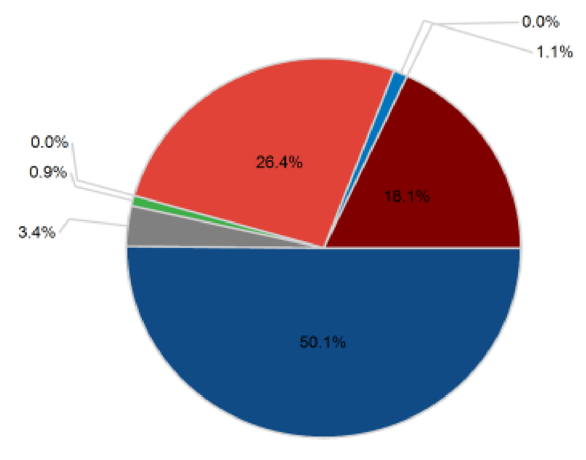
Most Frequent Symptoms - Inbound Symptom Check Calls (Feb-2024)



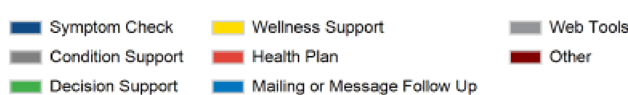
Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



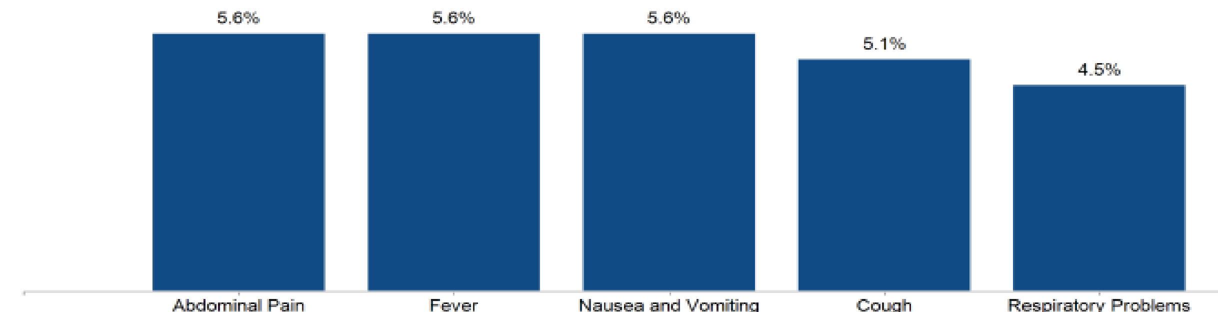
Member Inbound Call Reasons (Mar-2024)



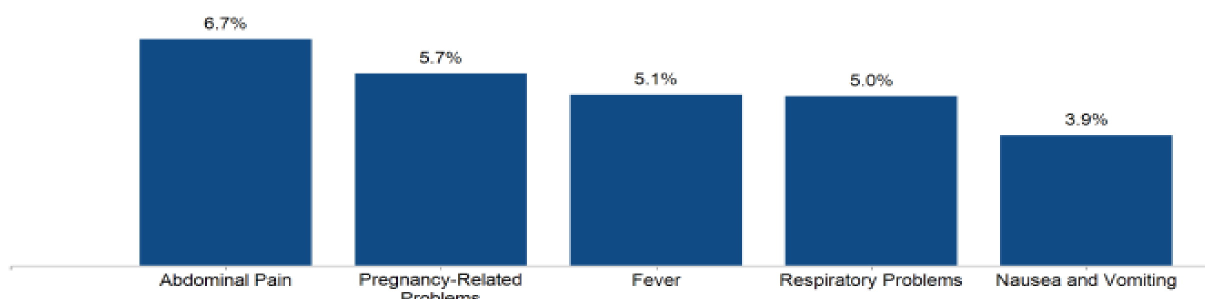
REASON	NUMBER
Symptom Check	175
Condition Support	12
Decision Support	3
Wellness Support	0
Health Plan	92
Mailing or Message Follow Up	4
Web Tools	0
Other	63



Most Frequent Symptoms - Inbound Symptom Check Calls (Mar-2024)



Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



Diabetic Exam Reminder Effectiveness Report

KERN HEALTH SYSTEMS - 12049397

April 2023 - March 2024

Reminder Year:	Reminder Month:	Reminders Sent	Received Exam Within 0-90 Days	Received Exam Within 91-180 Days	Total Exams Within 180 Days
2023	April	1,262	44	46	90
	May	697	34	33	67
	June	7,326	228	197	425
	July	6,038	189	157	346
	August	589	34	28	62
	September	1,423	64	43	107
	October	1,228	78	35	113
	November	0	0	0	0
	December	3,050	92	13	105
2024	January	939	30	0	30
	February	1,915	27	0	27
	March	1,080	6	0	6
Totals		**25,547**	**826**	**552**	**1,378**

LTM Effectiveness* : 5 %

12-Month Effectiveness (Oct 2022 - Sep 2023) : 7 %

* This figure does not include an estimate of those patients who will return within 90 or 180 days.
It solely calculates based upon the patients who have returned to date for letters sent within the last twelve months.

Medical Data Collection Summary Report

KERN HEALTH SYSTEMS - 12049397

April, 2023 through March, 2024

Overview

This report shows an aggregate view of your members who have received an eye exam during the reporting period. It also shows the number and percentage of your members that have one or more of the health conditions listed below, as reported by VSP doctors. VSP focuses on the six conditions listed below because they represent some of the most frequent and costly health conditions for which early detection and treatment can reduce or prevent vision loss as well as potentially avoid more costly treatment. VSP can work with your health plan or disease management company by providing them with patient-specific information upon request.

Summary of Findings

The left section below shows how many of your members received an eye exam during the reporting period as well as how many of them had each of the conditions listed (as reported by VSP doctors). The percentages represent the number of people with the respective conditions divided by the total number that received an eye exam. The right section below shows the estimated number of cases in your member population. We use health and demographic statistics provided by the Centers for Disease Control and the US Census. Also, because prevalence rates vary by age, we incorporate patient age data from your VSP eye exam claims for the reporting period.

The estimates for diabetes and hypertension are expected to be higher than the reported rates because approximately 30% of people with diabetes and 50% of people with hypertension are unaware of their condition and would not report it to their VSP doctor. The percentages represent the estimated number of people with the conditions divided by your total membership. Note that diabetes and hypertension are self-reported while the other conditions are reported based on the VSP doctor's findings. This report does not indicate if cases are newly diagnosed or existing.

Reported Cases

	Members	
Received Eye Exam:	29,093	
Diabetes[1]:	1,745	6.0%
Diabetic Retinopathy:	156	.5%
Glaucoma:	870	3.0%
Hypertension:	732	2.5%
High Cholesterol	298	1.0%
Macular Degeneration:	177	.6%

Estimated Number of Cases

Total Members:	409,755	
Diabetes[1]:	12,696	3.1%
Diabetic Retinopathy:	1,254	.3%
Glaucoma:	2,152	.5%
Hypertension:	53,080	13.0%
High Cholesterol	64,986	15.9%
Macular Degeneration:	850	.2%

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

To: KHS EQIHEC Committee

From: James Winfrey, Deputy Directory of Provider Network Management

Date: May 9, 2024

Re: Network Adequacy Committee, Q1 & Q2 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 1st and 2nd Quarter Network Adequacy Committee meetings, including minutes for both sessions.

Fiscal Impact

None

Requested Action

Approve and File.

Network Adequacy Committee, Q1 & Q2 2024

Executive Quality Improvement Health Equity Committee

May 9, 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

Q1 & Q2 2024 Committee Meetings

Quarter 1, 2024 Meeting – 3/29/2024

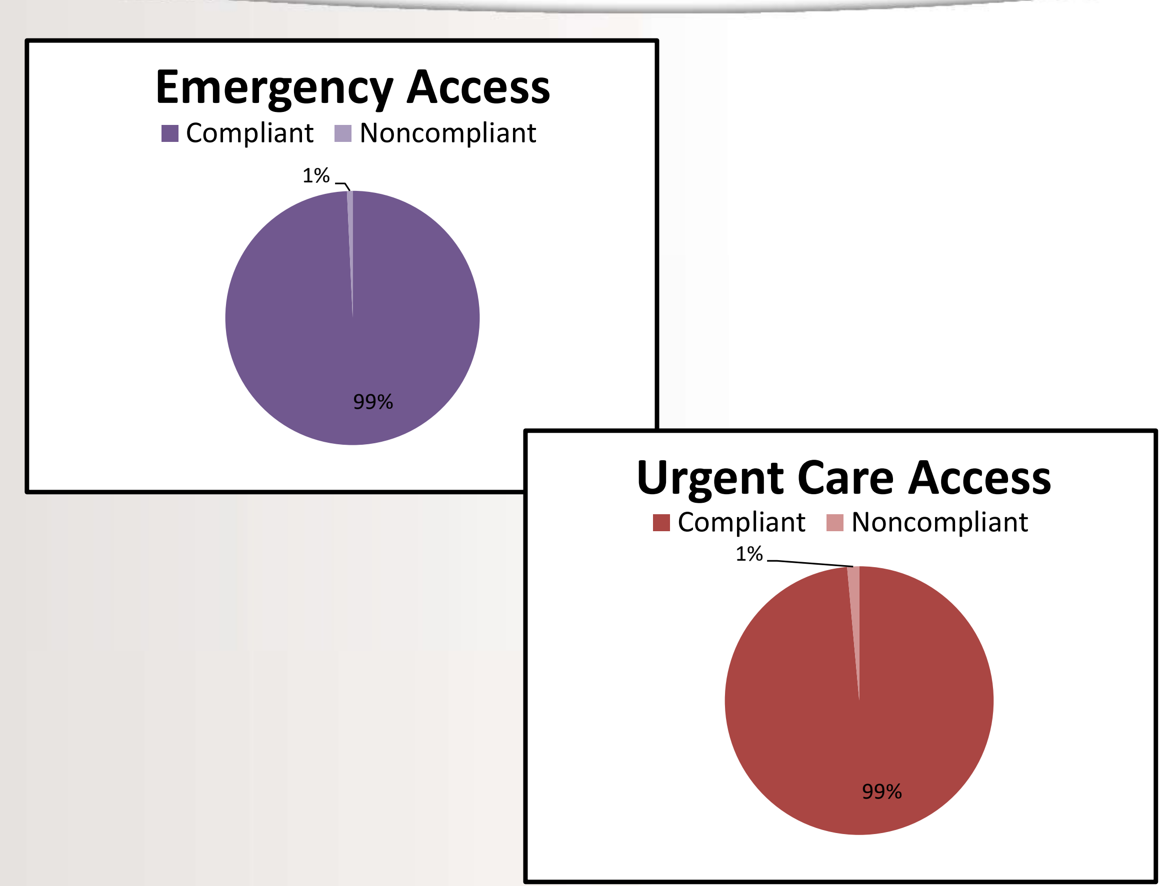
- Delegation and vendor oversight removed from committee focus
- Reviewed Quarter 4, 2023 Provider Network Management, Quarterly Network Review

Quarter 2, 2024 Meeting – 4/19/2024

- Approved updated charter
- Reviewed Quarter 1, 2024 Provider Network Management, Quarterly Network Review

After-Hours Survey Report

- During Q1 2024 **139** provider offices were contacted.
- **138** were compliant with the **Emergency Access Standards**
- **137** 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 15 primary care provider offices, 15 specialist offices, 5 non-physician mental health (NPMH) offices, 5 ancillary offices, and 5 OBGYN offices were surveyed during Q1 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.
- **Committee members requested additional monitoring/analysis that will begin Q2 2024**

Average urgent wait time	Q1 2024
Primary Care (48 Hours)	34.4 Hours
Specialist (96 Hours)	46.2 Hours

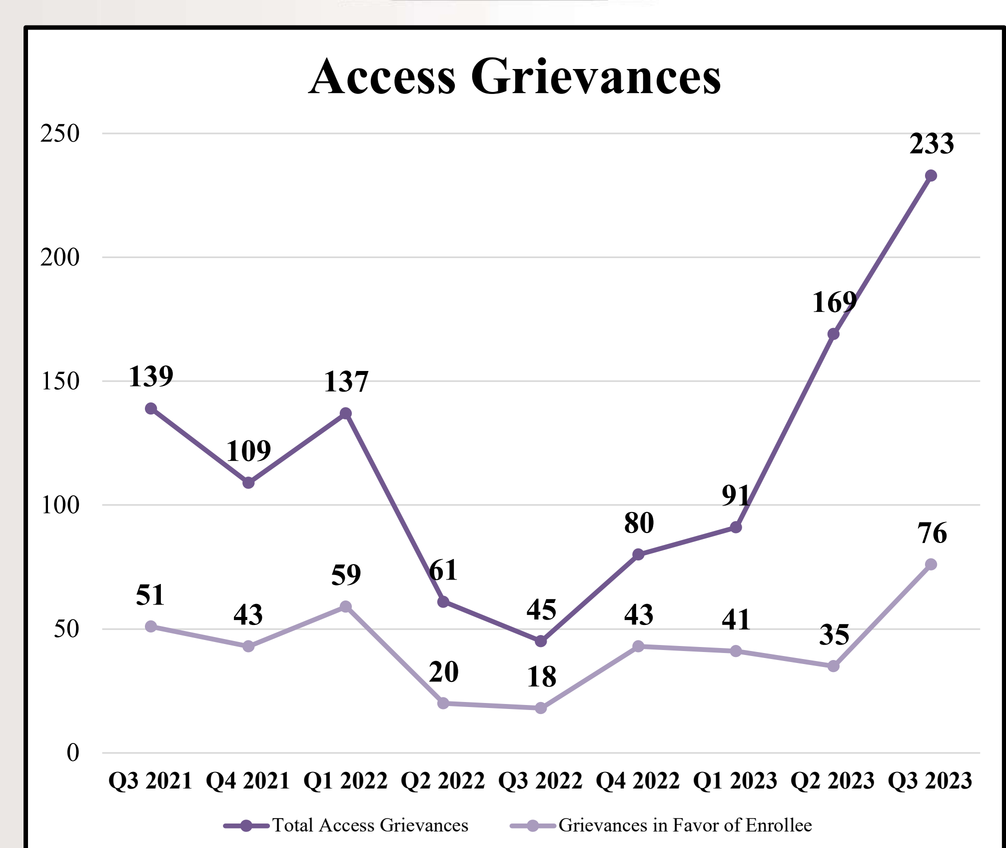
Average non-urgent wait time	Q1 2024
Primary Care (10 Days)	2.7 Days
Specialist (15 Days)	4.9 Days
NPMH (10 Days)	3.8 Days
Ancillary (15 Days)	2.4 Days
OB/GYN (Two Weeks)	8.2 Days

Access Grievance Review

- Quarterly, the Provider Network Management Department 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. After researching this trend, the Plan believes this increase was due to back-to-school appointments and redetermination outreach calls. **No other trends were identified.**

- **Committee members requested additional breakdown of access grievance data that will be incorporated into future reporting.**



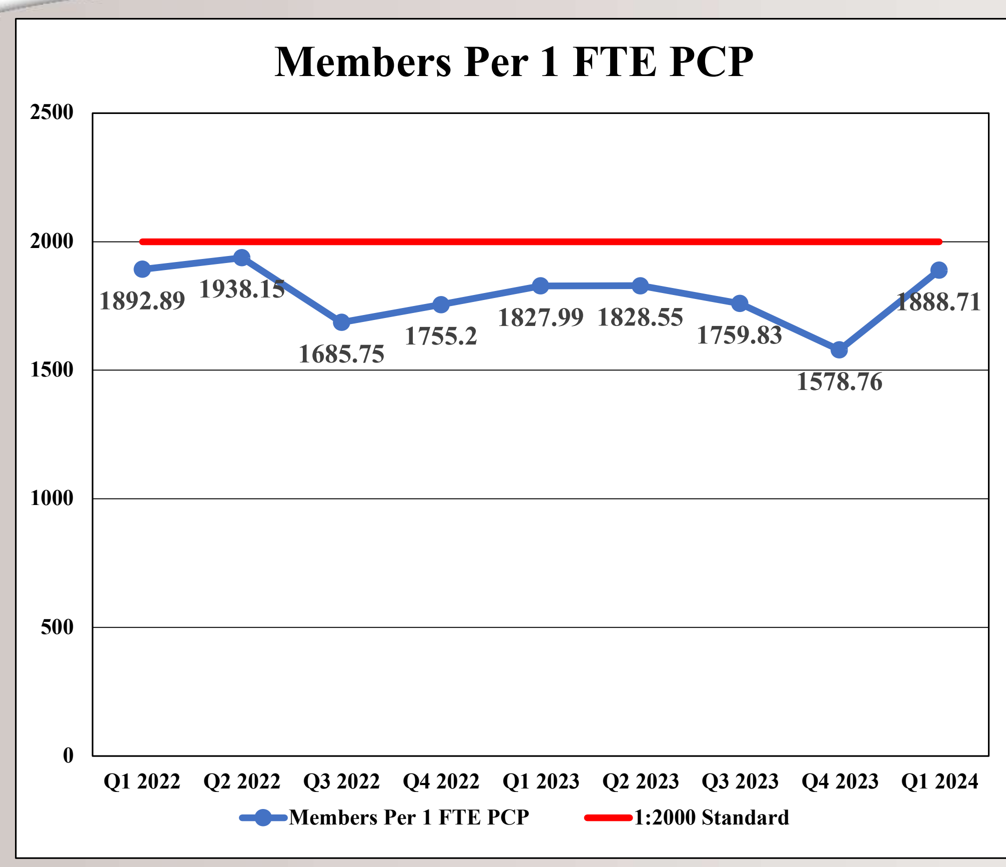
Geographic Accessibility

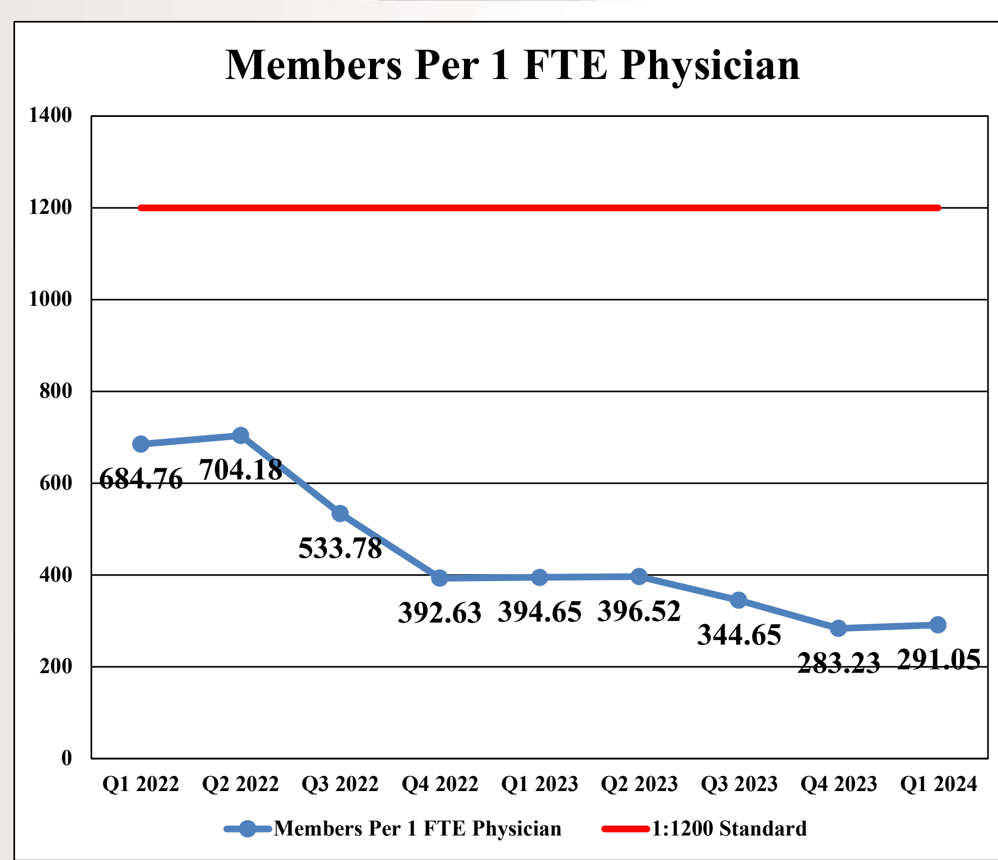
- The Provider Network Management department conducts ongoing review of our network to measure member geographic accessibility to our providers

- As of Q1 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

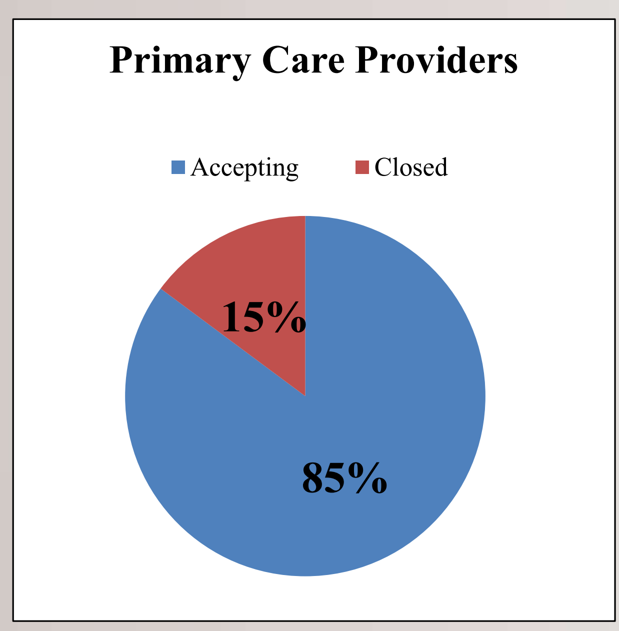
Network Adequacy

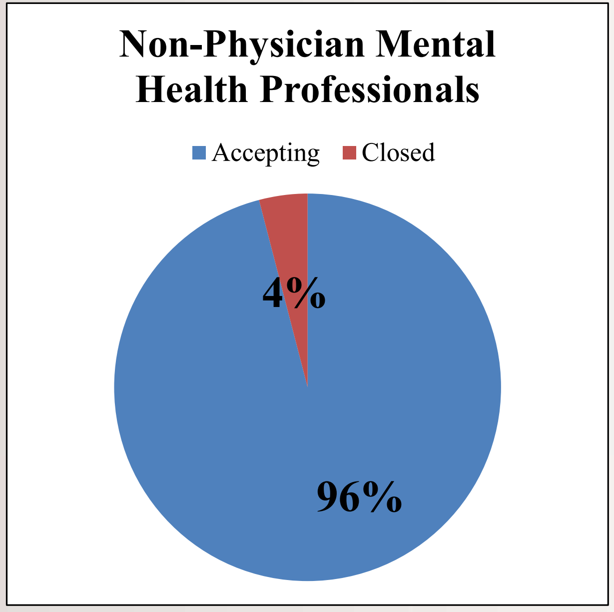


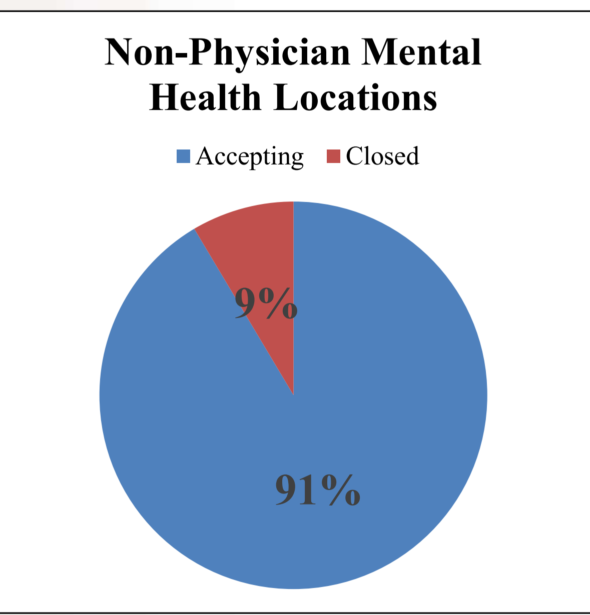


Network Adequacy & Provider Counts

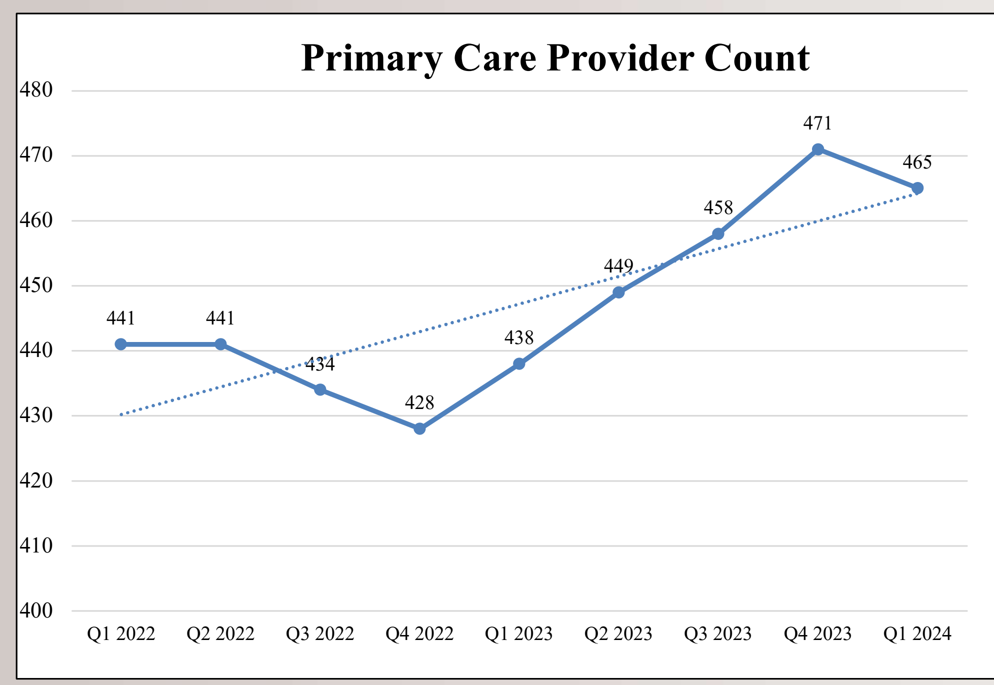
Accepting New Members

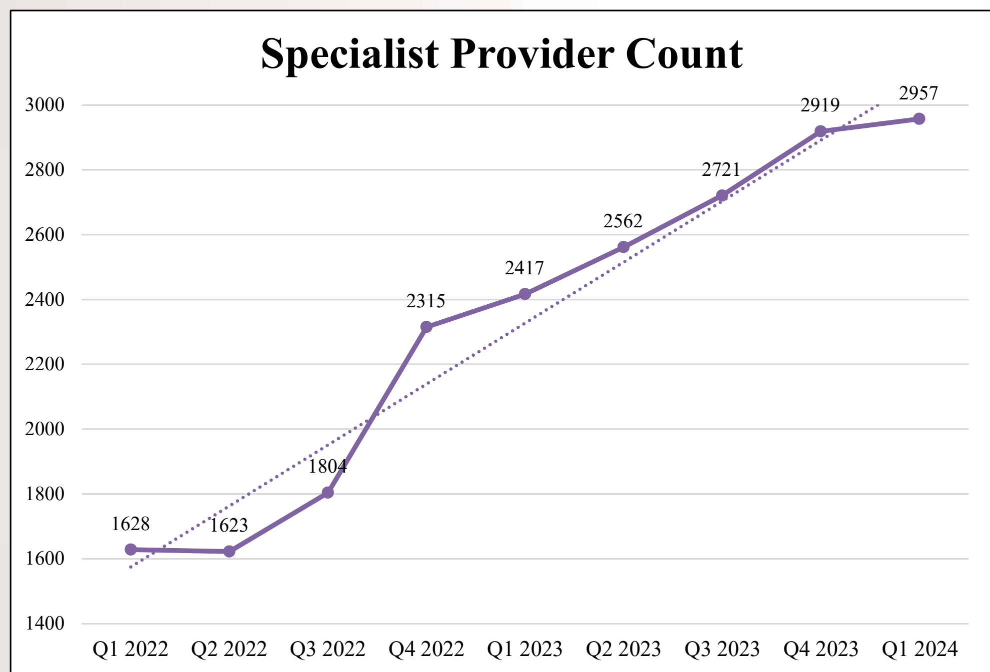






Network Adequacy & Provider Counts





Access and Availability and Delegation Vendor Oversight Committee (AADVOC)
Agenda – March 29, 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	N/A - Introductory meeting only – There are no past minutes to approve.	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*1 min*	*N/A*
OLD BUSINESS	N/A – Introductory meeting only – There is no old business to discuss.	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*N/A*	*N/A*
NEW BUSINESS	1. Welcome	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*2 min*	*N/A*
	2. Committee Charter a. Discuss inclusion of Delegation Vendor Oversight within this committee b. Cadance – Quarterly, third Friday of the first month of the quarter	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*20 min*	*Approve*
	3. Provider Network Management, Q4 2024 Quarterly Network Review	***Greg Panero, KHS, Provider Network Analyst Program Manager***	*15 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, April 19th, 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*

COMMITTEE: **Access and Availability & Delegation Vendor Oversight Committee**
DATE OF MEETING: **March 29, 2024**
CALL TO ORDER: **11:04 AM by James Winfrey, KHS - Deputy Director of Provider Network Management, Chair**

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
CALL TO ORDER	- James Winfrey called the meeting to order at 11:04 AM - Quorum/Attendance	- Committee quorum requirements met.	N/A
APPROVAL OF MINUTES	- Introductory meeting – there are no past minutes to approve.	- N/A	N/A
OLD BUSINESS	- Introductory meeting - there is no old business to present	- N/A	N/A
NEW BUSINESS	**Welcome** - James Winfrey welcomed the members of AADVOC to the introductory meeting.	☑ **CLOSED**: Informational discussion only.	*3/29/24*
	Committee Charter - James Winfrey initiated discussion of the AADVOC charter, and the appropriateness on including Delegated Vendor oversight within this committee. The Plan already has a Delegation Oversight Committee that reports to the Board through the Compliance Committee. Recommended to remove the Delegated Vendor Oversight portion of the committee.	☐**OPEN**: The committee members in attendance approved the recommendation to remove Delegation Oversight from the AADVOC. - James Winfrey to present updated committee charter at next meeting.	*Pending*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	○ Traco Matthews and Deb Murr agreed that removal would avoid duplication of work that may cause confusion		
	<u>**Committee Cadence**</u> - James Winfrey initiated discussion of the committee cadence. Due to timing of the Executive Quality Improvement Health Equity Committee (EQIHEC), recommended the following cadence for the committee: the AADVOC will take place the third Friday, of the first month, following the close of the quarter.	☑ **CLOSED**: The committee members in attendance approved the proposed cadence. - Committee members discussed proposed cadence was appropriate as it allowed for timely retrospective review of monitoring that took place the previous quarter, while allowing for reporting to each quarter's EQIHEC.	*3/29/24*
	Provider Network Management, Q4 2023 Quarterly Network Review - Greg Panero presented the Provider Network Management Q4 2023 Quarterly Network Review. ○ After Hours Survey Results: Emergency Access at 99% compliant, Urgent Care Access at 97% compliant. Reviewed trending results and discussed Plan follow up action. ▪ During discussion of after-hours survey, Traco Matthews, Greg Panero, and James Winfrey, discussed Plan/Provider target/standard. ○ 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 Q4 2023 Survey. ▪ During discussion of provider accessibility monitoring survey Traco Matthews, Melissa McGuire, Greg Panero, and James Winfrey discussed modifications to survey methodology to add the ability to review geographic equity. ○ Access Grievance Review: The Plan has 35 access grievances found in favor of the member in Q2 2023, for a total of .9 grievances for every 1,000 members. ▪ During discussion of provider accessibility	☑ **CLOSED**: The committee members in attendance approved Provider Network Management, Q4 2023 Quarterly Network Review. Recommendations that we made to improve Plan monitoring will be implemented in future Quarterly Network Reviews.	*3/29/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	monitoring survey Traco Matthews, Greg Panero, and James Winfrey discussed modifications to analysis to review access grievance geographically. Traco Matthews also questioned trends identified in graph and recommended additional narratives to address. o Geographic Accessibility & DHCS Network Certification: The Plan is in compliance with DHCS Network Standards or maintains a DHCS-approved access standard when non-compliance identified. ▪ During discussion of geographic accessibility & DHCS network certification Traco Matthews, Melisa McGuire, Greg Panero, and James Winfrey discussed annual DHCS Network Certification and alternative access standard request process. o Network Adequacy & Provider Counts: ▪ FTE PCP ratio at 1:1579. ▪ FTE Physician ratio 1:283 ▪ PCP Accepting new members: 86% ▪ NPMH accepting new members: 96% ▪ NPMH locations accepting new members: 93% ▪ PCP Count: 471 ▪ Specialist Provider Count: 2919 ▪ Mental Health Provider Count: 112 ▪ During discussion of network adequacy & provider counts Traco Matthews, Greg Panero, and James Winfrey discussed network adequacy from a health equity perspective, including understanding additional provider demographics.		
OPEN FORUM	**Open Forum** - Deb Murr initiated discussion of updated geographic access analysis methodology being utilized by the DHCS as part of their annual Network Certification. James Winfrey and Greg Panero discussed how they are aware of the changes in methodology and discussed pros and cons.	☑ **CLOSED**: Informational discussion only.	*3/29/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	- Katie Sykes raised Enhanced Specialty Access Pilot that the Plan currently participates in. James Winfrey and Amisha Pannu discussed shifting this work to PNM Department and potential future reporting as part of this committee.		
NEXT MEETING	Next meeting will be held Friday, April 19, 2024.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 11:52 AM. ***Respectfully submitted: James Winfrey; Deputy Director of Provider Network Management***	**N/A**	*N/A*

For Signature Only – AADVOC Minutes 03/29/24

The foregoing minutes were APPROVED AS PRESENTED on: 4/19/24 Date [signature] JAMES WINFREY Name

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

Network Adequacy Committee (NAC)
Agenda – April 19, 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	1. Updated Committee Charter	***James Winfrey, KHS, Deputy Director of Provider Network Management***	*5 min*	*Approve*
NEW BUSINESS	1. Provider Network Management, Q1 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, July 21st, 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
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kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

COMMITTEE: **Network Adequacy Committee**
DATE OF MEETING: **April 19, 2024**
CALL TO ORDER: **2:02 PM by James Winfrey, KHS - Deputy Director of Provider Network Management, Chair**

Members Present On-Site:	Traco Matthews, KHS - Chief Health Equity Officer Deb Murr, KHS - Chief Compliance and Fraud Prevention Officer Melissa McGuire, KHS - Senior Director of Delegation and Oversight
Members Virtual Remote:	
Members Excused (E), Absent (A)	Alan Avery, KHS - Chief Executive Officer (E) 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 Gil - Health Equity Manager (virtual)

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
CALL TO ORDER	- James Winfrey called the meeting to order at 2:02 PM - Quorum/Attendance	- Committee quorum requirements met.	N/A
APPROVAL OF MINUTES	- James Winfrey presented the Q1 2024 AADVOC meeting minutes for approval.	☑ **CLOSED**: Traco Matthews moved to approve Q1 2024 AADVOC minutes, seconded by Melissa McGuire. Motion Carried.	*4/19/24*
OLD BUSINESS	**Committee Name Change** - James Winfrey reviewed the committee's decision to remove delegation vendor oversight portion of committee, with singular focus on access, availability, and adequacy. James Winfrey informed the member of committee name change to Network Adequacy Committee. **Committee Charter** - James Winfrey reviewed and initiated discussion of the Network Adequacy Committee charter. ○ During review of the charter Deb Murr and James Winfrey discussed the possibility of CMS being	☑ **CLOSED**: Melissa McGuire moved to approve the Network Adequacy Committee name change and charter, seconded by Traco Matthews. Motion Carried.	*4/19/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	included as part of Network Adequacy in the future. ○ During review of the charter Traco Matthews noted that as part function three (3) in the charter, KHS is in the process of expanding provider demographic information and may be expected to provide monitoring and reporting in the future.		
NEW BUSINESS	Provider Network Management, Q1 2024 Quarterly Network Review - Greg Panero presented the Provider Network Management Q1 2024 Quarterly Network Review. ○ After Hours Survey Results: Emergency Access at 99% compliant, Urgent Care Access at 99% compliant. Reviewed trending results and discussed Plan follow up action. ▪ During discussion of after-hours survey, Melissa McGuire and Greg Panero discussed procedures to obtain after-hours monitoring and changes in vendor who conducts the after-hours survey. ○ 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 Q1 2024 Survey. ▪ Deb Murr and Greg Panero discussed expectations for urgent call back time. And nurse advice line usage. ○ Access Grievance Review: The Plan has 233 access grievances found in favor of the member in Q3 2023, for a total of .21 grievances for every 1,000 members. ▪ During discussion of grievances Traco Matthews, Melissa McGuire, and James Winfrey discussed possibility of reviewing year over year trends. Due to grievance process changes it can be difficult to identify true trends. Deb Murr, Traco Matthews, James Winfrey and Pawan Gill also discussed if there is a need for grievance trends to be dissected further by	☑ **CLOSED**: The committee members in attendance approved Provider Network Management, Q1 2024 Quarterly Network Review.	*4/19/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	demographic but decided not to include in this reporting at this time. ▪ Access Grievance review using Health Equity map that was requested at previous committee meeting was introduced. During the review Greg Panero noted most grievances were filed in Bakersfield/Central Kern and that is due to population density in this area. James Winfrey recommended comparing totals against population within these area. ○ Geographic Accessibility & DHCS Network Certification: The Plan is in compliance with DHCS Network Standards or maintains a DHCS-approved access standard when non-compliance identified. ▪ During discussion of geographic accessibility & DHCS network certification Traco Matthews, Melisa McGuire, Greg Panero, and James Winfrey discussed annual DHCS Network Certification and alternative access standard request process. ▪ Geographic Accessibility & DHCS Network Certification: In Q1 2024, DHCS approved 51 alternative access standard (AAS) requests that were completed in Q1 2023 for the 2022 Annual Network Certification (ANC). In Q1 2024, KHS responded to 343 AAS requests received from DHCS for ANC 2023. The increase in AAS requests was due to DHCS methodology change. James Winfrey and Greg Panero reviewed the DHCS methodology changes and the PNM procedure to complete the AAS requests. ○ Network Adequacy & Provider Counts: ▪ FTE PCP ratio at 1:1889 ▪ FTE Physician ratio 1:291 ▪ PCP Accepting new members: 85% ▪ NPMH accepting new members: 96% ▪ NPMH locations accepting new members: 91%		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	▪ PCP Count: 465 ▪ Specialist Provider Count: 2957 ▪ Mental Health Provider Count: 124 • Deb Murr and James Winfrey discussed PNM recruitment efforts for mental health providers. ○ Significant Network Change: In Q1 2024, the DMHC approved the plan's significant network change filing on February 15th 2024. The plan initiated the filing on December 9, 2021 and continued to work respond to comment letters ending on December 14, 2023. The plan will be working to submit a new significant network change beginning in Q2 2024.		
OPEN FORUM	**Open Forum** - Traco Matthews and Deb Murr discussed the importance and value they see in these committee meetings. Group again discussed updated geographic access analysis methodology being utilized by the DHCS as part of their annual Network Certification. James Winfrey and Melissa McGuire shared background and processes it took to put together access reporting. Greg Panero discussed how they are aware of the changes in methodology and discussed pros and cons. - James Winfrey shared his and Greg Panero's involvement in the Kern Health Equity Partnership Access to Care sub-committee. Goals include addressing issues with lack of providers, geographic accessibility issues, and transportation.	☑ **CLOSED**: Informational discussion only.	*4/19/24*
NEXT MEETING	Next meeting will be held Friday, July 21, 2024.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 3:00 PM. ***Respectfully submitted: James Winfrey; Deputy Director of Provider Network Management***	**N/A**	*N/A*

For Signature Only – AADVOC Minutes 04/19/24

The foregoing minutes were APPROVED AS PRESENTED on: ______________________ Date ______________________________ Name

The foregoing minutes were APPROVED WITH MODIFICATION on: ______________________ Date ______________________________ Name

To: KHS EQIHEC

From: Michelle Curioso, Director of Population Health Management

Date: 5/23/2024

Re: Population Health Management: Transitional Care Services

Background:
By January 1, 2024, KHS are required to ensure all transitional care services are complete for all transitioning members including low-risk members per DHCS requirements. Comprehensive Transitional Care Services (TCS) are a broad range of time-limited services available for all Kern Health Services (KHS) members transferring from one setting or level of care to another designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another. The goals for Transitional Care Services are to ensure that every member:

- Can transition to the least restrictive level of care that meets their needs and is aligned with their preferences in a timely manner without interruptions in care.
- Receives the support and coordination needed to have a safe and secure transition with the least burden on the member as possible.
- Continues to have the needed support and connections to services that make them successful in their new environment.

Discussion:
The purpose of the report is to provide updates on the Transitional Care Services which includes the following:

- Description/Relevance
- Activities
- Data Outcomes
- Conclusions

Fiscal Impact: None.

Requested Action: Review for approval.

Population Health Management: Transitional Care Services (TCS)

Overview

Comprehensive Transitional Care Services (TCS) are a broad range of time-limited services available for all Kern Health Services (KHS) members transferring from one setting or level of care to another designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another.
TCS necessitate strengthened requirements for members especially in need of support to manage their care and are vulnerable to experiencing adverse health events due to care team changes, inadequate health education and follow-up, changes in the level of support and care they receive, environment changes, and medication and supplies changes.

Description / Relevance

KHS is required to provide and support transitional care coordination to all members undergoing a transition, including as directed by federal and state authorities. Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to, discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities to home or community-based settings, Community Supports, post-acute care facilities, or long-term care settings.

Experiences of transitions of care, such as between the emergency department (ED) or hospital and home, leave patients vulnerable to adverse outcomes. Among many challenges, issues with medication reconciliation, inconsistent handoff processes and information transfer among providers, lack of preparation for self-care among patients, inadequate test result follow-up, and patients' social barriers to health (e.g., food, transportation, support services, housing) make the hospital or emergency department to home transition particularly fraught**.** Studies show a follow-up within 7 days upon enrollment is associated with meaningful reductions in readmissions for patient with multiple chronic conditions.

The purpose of TCS is to ensure effective transition planning across delivery systems or settings, through care coordination and other means, to minimize patient risk and ensure appropriate clinical outcomes for the member. The goals for TCS is as followed:

- Ensure that every member:
- Can transition to the least restrictive level of care that meets their needs and is aligned with their preferences in a timely manner without interruptions in care.
- Receives the support and coordination needed to have a safe and secure transition with the least burden on the member as possible.
- Continues to have the needed support and connections to services that make them successful in their new environment.

Activities

By January 1, 2024, KHS is required to ensure all transitional care services are complete for low-risk members per DHCS requirements. The PHM Department established a TCS Team comprised of nurses and certified medical assistants. Table 1 below shows the roles and responsibilities of the TCS Team.

Table 1

General MCP Requirements			
Knowing when a member is Admitted/Discharged/Transferred (A/D/T)			
Processing Prior Authorizations in a Timely Manner and when possible, prior to discharge. This includes assisting with in-network placement, if necessary.			
Identifying members that belong to the high risk and the lower risk group for transitional services			
High Risk Members Transitioning (No Change)	**Responsible Entity**	**All Other Members Transitioning (Modification)**	**Responsible Entity**
Assigning/Notifying a Single Point of Contact/Care Manager	MCP	**MCP Dedicated Team/Phone Number for Member Contact:** MCP must ensure transitioning members have a dedicated number to call to connect to a dedicated TCS team who can access discharge documents, if needed. The MCP must directly notify transitioning members of this dedicated team and how to contact them, via text messaging or other modalities.	MCP/Delegate
Discharge Risk Assessment: Coordination with the discharging facility	Care Manager	**Facility's Risk Assessment Fulfills Requirement:**. However, if the facility assesses an otherwise lower-risk member as having a high-risk transition through the Risk Assessment, MCP must consider that member in the TCS high risk pathway. MCPs must provide each facility with a dedicated way of contacting the MCP to flag up higher-risk transitions.	Discharging Facility
Discharge Planning Document Ensuring sharing with patient, PCP, and other providers, coordinated with discharging facility		**Facility's Discharge Document fulfills Requirement.** MCP must ensure facilities are sharing the discharge planning document with PCP (already a requirement on hospitals), and with the MCP TCS team, when needed (new).	Discharging Facility
Follow Up Ensuring follow-up doctor appointments/ medication reconciliation/referrals are complete		**PCP/Ambulatory Visit Fulfills Follow Up Requirements.** MCP must ensure ambulatory follow up appointment with medication reconciliation is completed within 30 days. If not completed within 30 days, MCP or delegate must ensure it is completed.	MCP/Delegate
End Services or Continue/Enroll in Longer Term Care Management/Community Supports		**End Services/Enrollment in Care Management Programs:** MCPs must continue to offer TCS support through dedicated telephonic team for at least 30 days post-discharge. In addition to accepting referrals to longer term care management at any point, MCPs must use data including any information from admission, to identify newly qualified members for outreach and enrollment into ECM/CCM and/or Community Supports.	MCP/Delegate

Upon discharge from the hospital, a TCS letter is sent to all transitioning members informing them to contact KHS for any questions or assistance. A dedicated TCS phone number is provided to the members, and hospital discharge packets are sent to the primary care physicians (PCPs). Two days prior to discharge, the discharge risk assessment is completed and also sent to the PCPs.

Furthermore, KHS ensures that all transitioning members have a care manager/single point of contact for all high-risk members. KHS has TOC Clinics to provide services to facilitate high-risk members' transitions from and among treatment facilities, including admissions and discharges. The TOC clinics are physician managed and required to provide Comprehensive transitional care services including, but are not limited to:

- Providing medication review and reconciliation;
- Assigning a care coordinator to each member;
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners;
- Collaborating, communicating, and coordinating with all members of the patient's care team;
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management;
- Planning appropriate care and/or setting post-discharge, including temporary or stable housing and social services;

- Arranging transportation for transitional care, including medical appointments, as per Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) policy and procedures; and
- Developing and facilitating the member's transition plan.

A transitioning member's encounters consist of interactions between KHS staff, physician's medical practitioner, mid-level (nurse practitioner or physician's assistant), Registered Nurse, Licensed Vocational Nurse, and Certified Medical Assistants. The duration of member participation is limited to no more than thirty (30) business days, unless otherwise specified by KHS and agreed by the TOC physician.

Data Outcomes: Transition of Care (TOC) Clinics (High Risk Members)
January 2023 – December 2023
Total 28,643 Members outreached (Golden 6,237 + PVMG 22,406)
Total 21,560 members seen at the TOC Clinics
70% of acute hospital stay discharges had follow-up ambulatory visit within 7 days post hospital discharge.

Table 2

Program Eligibility Period = Q4 2023 I Claims Expense Period = Q1 2024							
	Not Enrolled			Enrolled			
PHM Program	Members	PMPM	Member Months	Members	PMPM	Member Months	Cost Savings
TOC	988	$9,149.58	2,788	137	$7,583.97	392	$4,364,916.63

Data Outcomes: Transitional Care Services (Low Risk Members)

Low Risk Members

Table 3

	February	March	April	Total
Total # of letters mailed	456	608	529	1,593 (100%)
# of Undeliverable	0	12	8	20 (1.2%)
# of Call Backs *	4	24	16	44 (2.7%)*
HSAG Discharge Risk Assessment Completed	-	-	129	129

*# of Call Backs = Of the 44, **36** received care coordination (e.g., assisted with transportation, schedule with PCP, etc.).

High Risk Members **Table 4**

These high-risk members received care coordination from the nurse in the TCS team.

	February	March	April	Total
High Risk Members Received Care Coordination	8	30	90	128

Continuous Quality Assurance and Improvement

According to the Health Resources and Services Administration (HRSA**),** quality assurance (QA) measures compliance against certain necessary standards, typically focusing on individuals, whereas quality improvement (QI) is a continuous improvement process focused on processes and systems. As the process is still evolving, KHS will continue to measure effectiveness:

1. Ensure all members have follow-up visits within 7 days post discharge with their providers (PCPs or TOC Clinics) as required by DHCS.
2. Monitor hospital readmissions within 30 days.
3. Manage and report transitional care services KPIs in a quarterly basis as required by DHCS. KPIs to be reported to DHCS: Percentage of acute hospital stay discharges which had follow-up ambulatory visit within 7 days post hospital discharge.
4. Meet with TOC Clinics team to review performance quarterly.
5. Provide education to the PCPs on the importance of transitional care services.

Conclusions

The transition of care is critical to help patients transfer in a safe and timely manner from one level of care to another or from one type of care setting to another and improve the patients' quality of care. The TCS Team ensures that all transitioning members received TCS services throughout their transition and ensure all required care coordination and follow-up services are complete. The TOC Clinics provide services to facilitate high-risk members' transitions from and among treatment facilities, including admissions and discharges. We will monitor and track the effectiveness of the program and continue to provide updates on any progress and challenges to the EQIHEC and PHM Committees.

Transitional Care Services (TCS)

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

What is Transitional Care Services (TCS)?

- Kern Health Systems (KHS) provides Transitional Care Services (TCS) to all Patients transferring from one setting, or level of care.
- Transferring from one setting, or level of care, to another includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities to home or community-based settings, Community Supports, post-acute care facilities, or Long-term Care settings.

Goals for Transitional Care Services

Ensure that every patient:

1. Can transition to the least restrictive level of care that meets their needs and is aligned with their preferences in a timely manner without interruptions in care.

2. Receives the support and coordination needed to have a safe and secure transition with the least burden on the patient as possible.

3. Continues to have the needed support and connections to services that make them successful in their new environment.

General MCP Requirements			
Knowing when a member is Admitted/Discharged/Transferred (A/D/T)			
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Discharge Planning Document Ensuring sharing with patient, PCP, and other providers, coordinated with discharging facility		**Facility's Discharge Document fulfills Requirement.** MCP must ensure facilities are sharing the discharge planning document with PCP (already a requirement on hospitals), and with the MCP TCS team, when needed (new).	Discharging Facility
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End Services or Continue/Enroll in Longer Term Care Management/Community Supports		**End Services/Enrollment in Care Management Programs:** MCPs must continue to offer TCS support through dedicated telephonic team for at least 30 days post-discharge. In addition to accepting referrals to longer term care management at any point, MCPs must use data including any information from admission, to identify newly qualified members for outreach and enrollment into ECM/CCM and/or Community Supports.	MCP/Delegate

TOC Clinics

Jan. 2023 – Dec. 2023

Total 28,643 Members outreached (Golden 6,237 + PVMG 22,406)

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TOC	988	$9,149.58	2,788	137	$7,583.97	392	$4,364,916.63

Transitional Care Services (TCS)

Implementation Date: February 1, 2024

Low Risk Members

	February	March	April	Total
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High Risk Members

	February	March	April	Total
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THANK YOU!

To: KHS EQIHEC

From: Melinda Santiago, Director of Behavioral Health

Date: 05/02/24

Re: Behavioral Health Advisory Committee (BHAC)

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

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

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

Fiscal Impact: None.

Requested Action: Review for approval.

Behavioral Health Advisory Committee (BHAC)

Charter

Description of Committee

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

The committee will support, review, and evaluate interventions to promote collaborative strategic alignment between KHS as Managed Care Plan (MCP) and the County Behavioral Health Plan (BHP) and the Drug Medi-cal Organized Delivery System (DMC-ODS). Kern Behavioral Health and Recovery Services (KBHRS) administers both the BHP and DMC-ODS, treating KHS members with the goal to maintain continuity, reduce barriers to access, linkage to appropriate services, opportunities to integrate care, and provide resources for members with mental illness and/or substance use disorder.

Function

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

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

Composition

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

Appointed members include, at a minimum:

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

Other KHS attendees:

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

Meetings

The BHAC meets quarterly with additional meetings as necessary.

Meeting Schedule 2024

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

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

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

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

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

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

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

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

The foregoing minutes were APPROVED AS PRESENTED on: __________________________ ___________________________________

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: __________________________ ___________________________________

Date Name

Behavioral Health Advisory Committee 2024

BHAC

- **Behavioral Health Advisory Committee -**

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

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

BHAC Structure

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

BHAC Duties

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

Input Topics

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

New Year – New Process

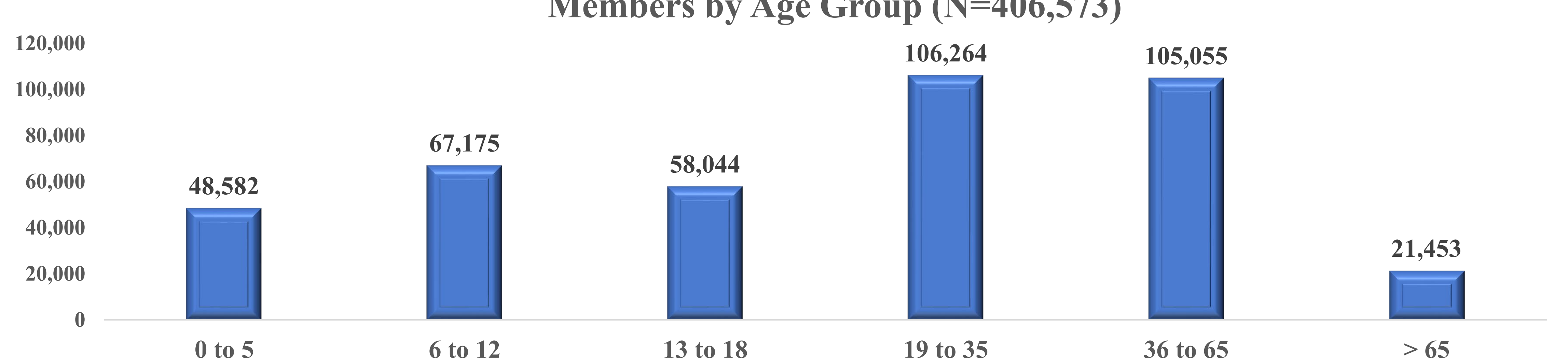
- National Committee for Quality Assurance (NCQA) Accreditation Standards
- 2 – year term begins in 2024
- Chair and Co-chair will be the KHS Chief Medical Officer and Director of Behavioral Health
- Other KHS clinical staff may attend the meeting but are neither considered part of the Committee nor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

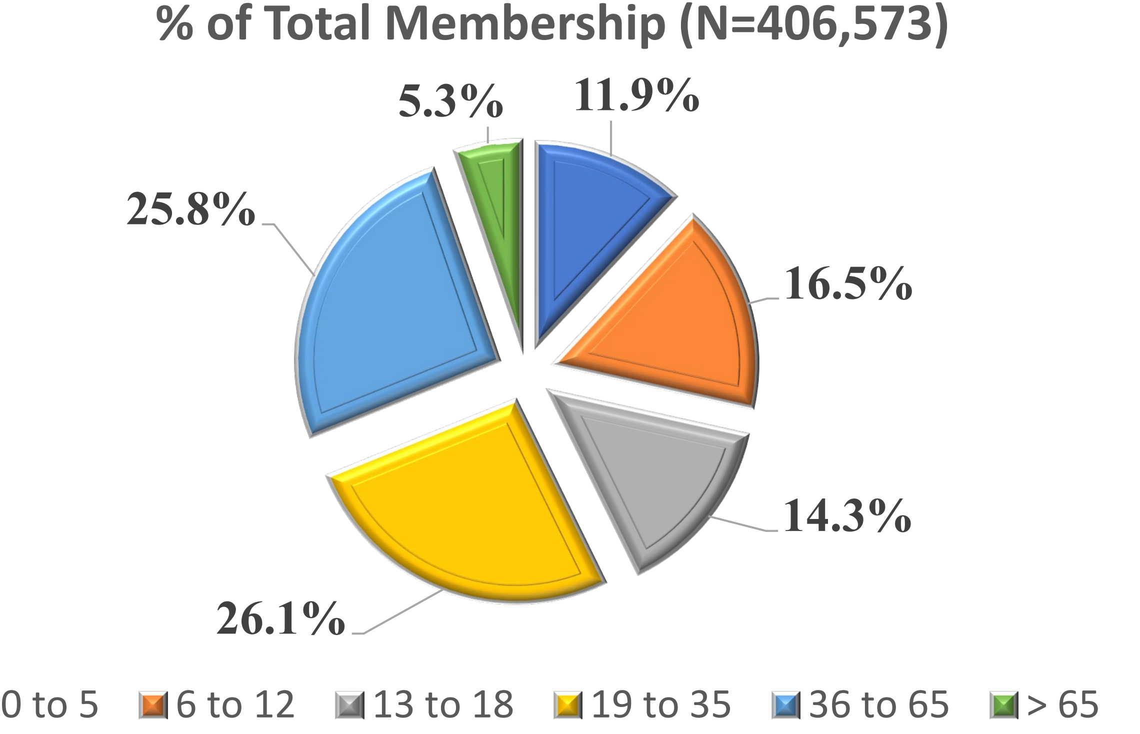
Executive Quality Improvement Health Equity Committee EQIHEC

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

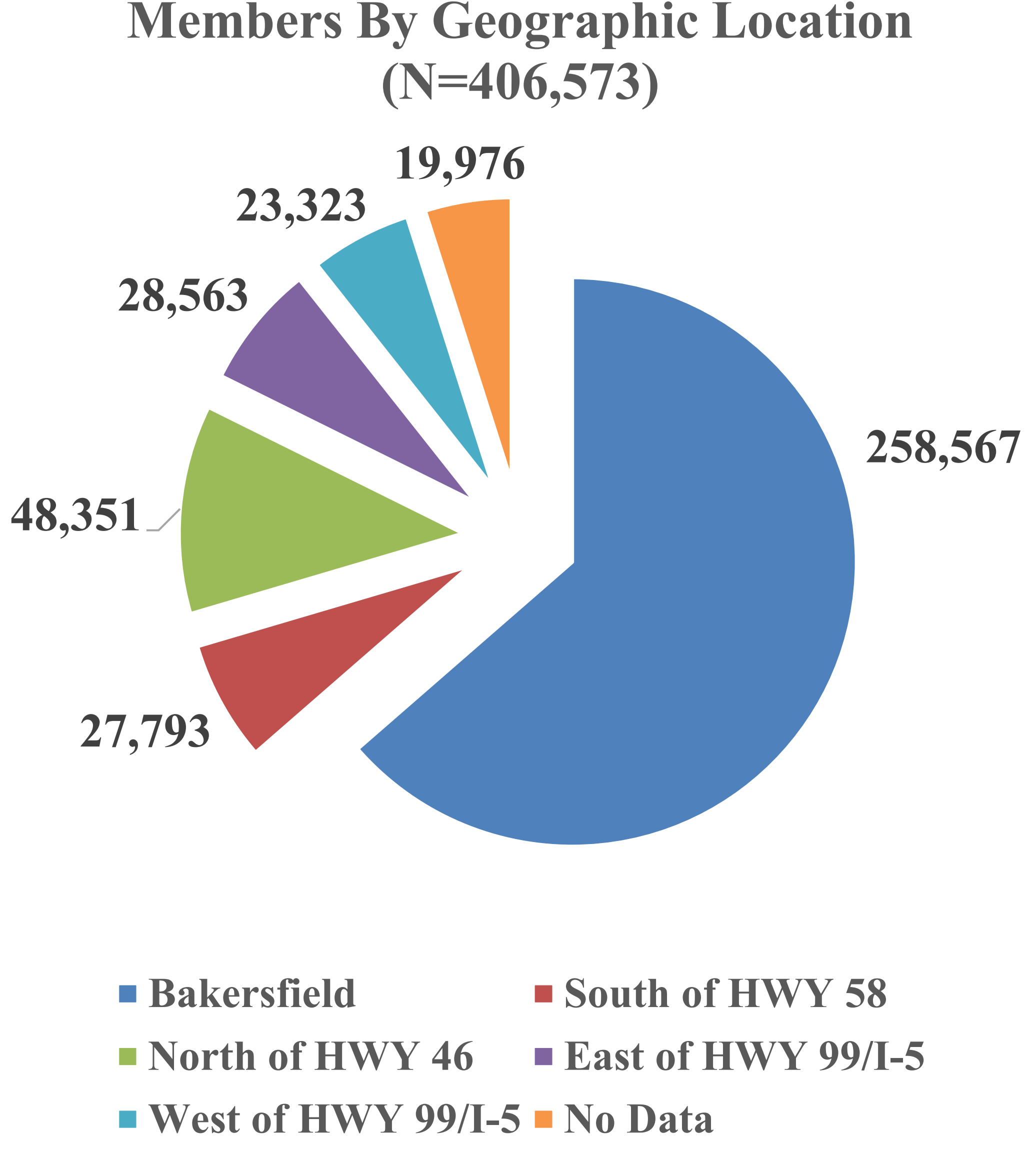
The EQIHEC consists of actively participating clinical and non-clinical providers. The physicians are voting members for clinical decision making. The EQIHEC is comprised of internal and community participants. This process promotes an interdisciplinary and inter-departmental and community approach and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

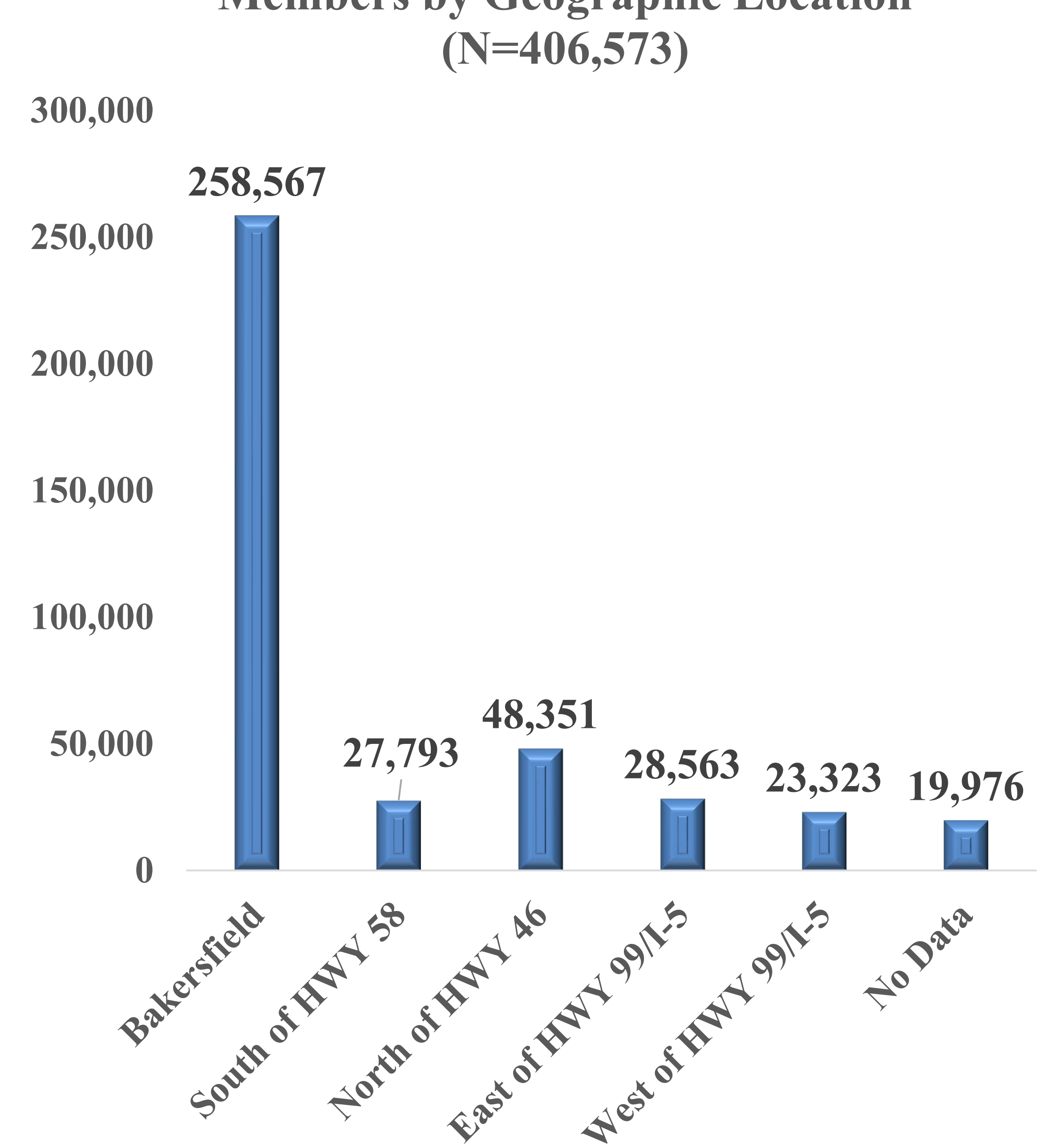
Member Demographic


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

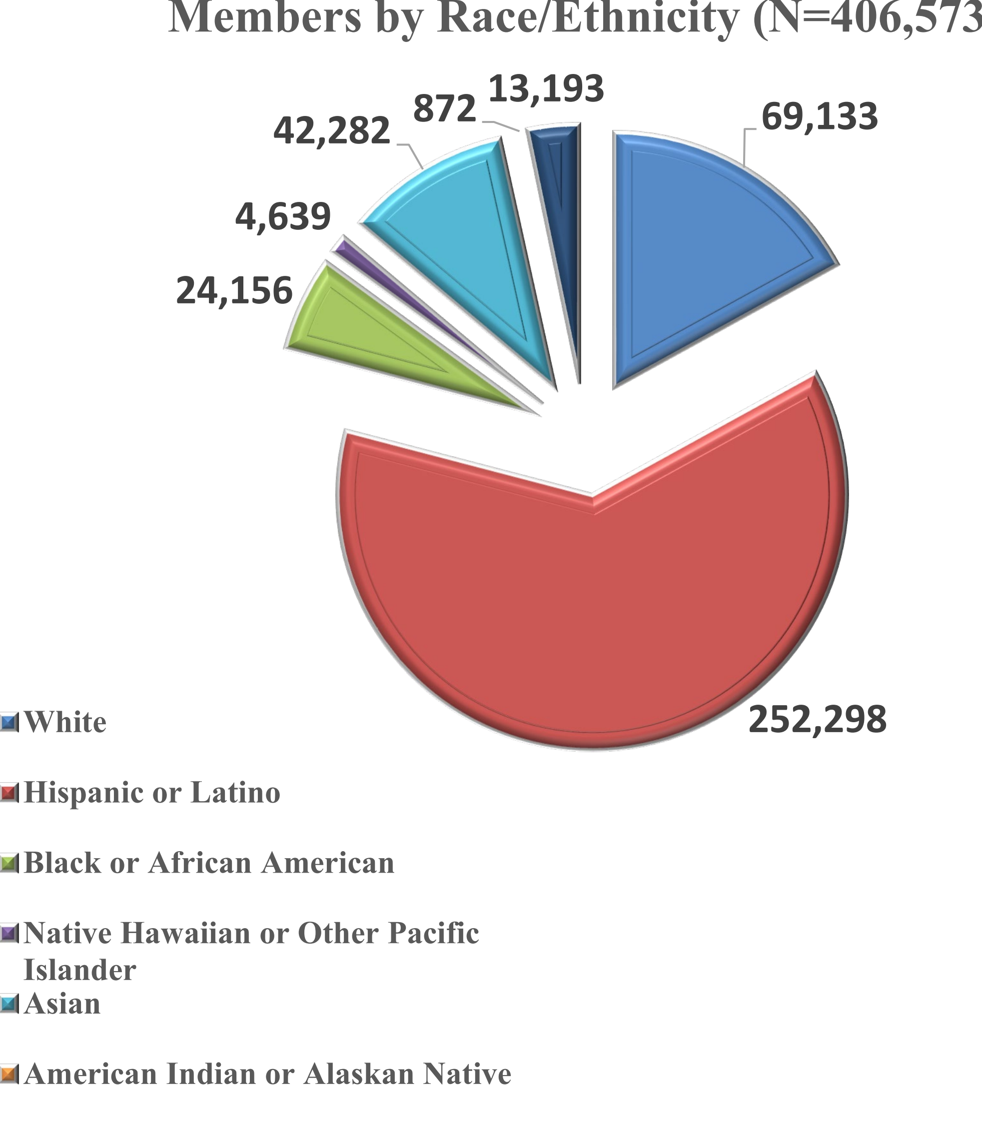

% of Total Membership (N=406,573)
5.3%
11.9%
25.8%
16.5%
14.3%
26.1%
0 to 5
6 to 12
13 to 18
19 to 35
36 to 65
> 65

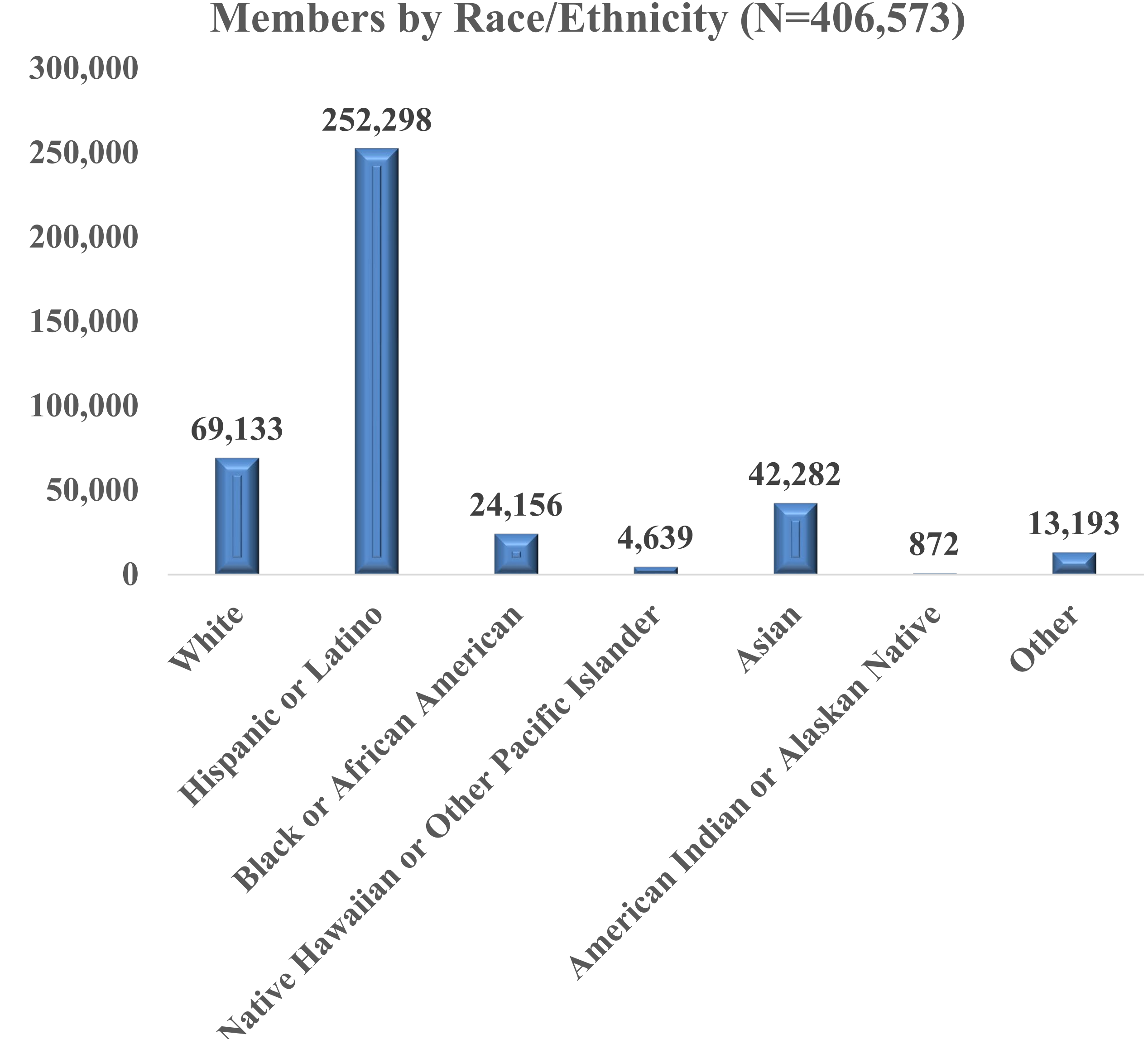
Geographic Location





Members by Race-Ethnicity





Behavioral Health Department

Highlights

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

BH Member Specific Populations

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

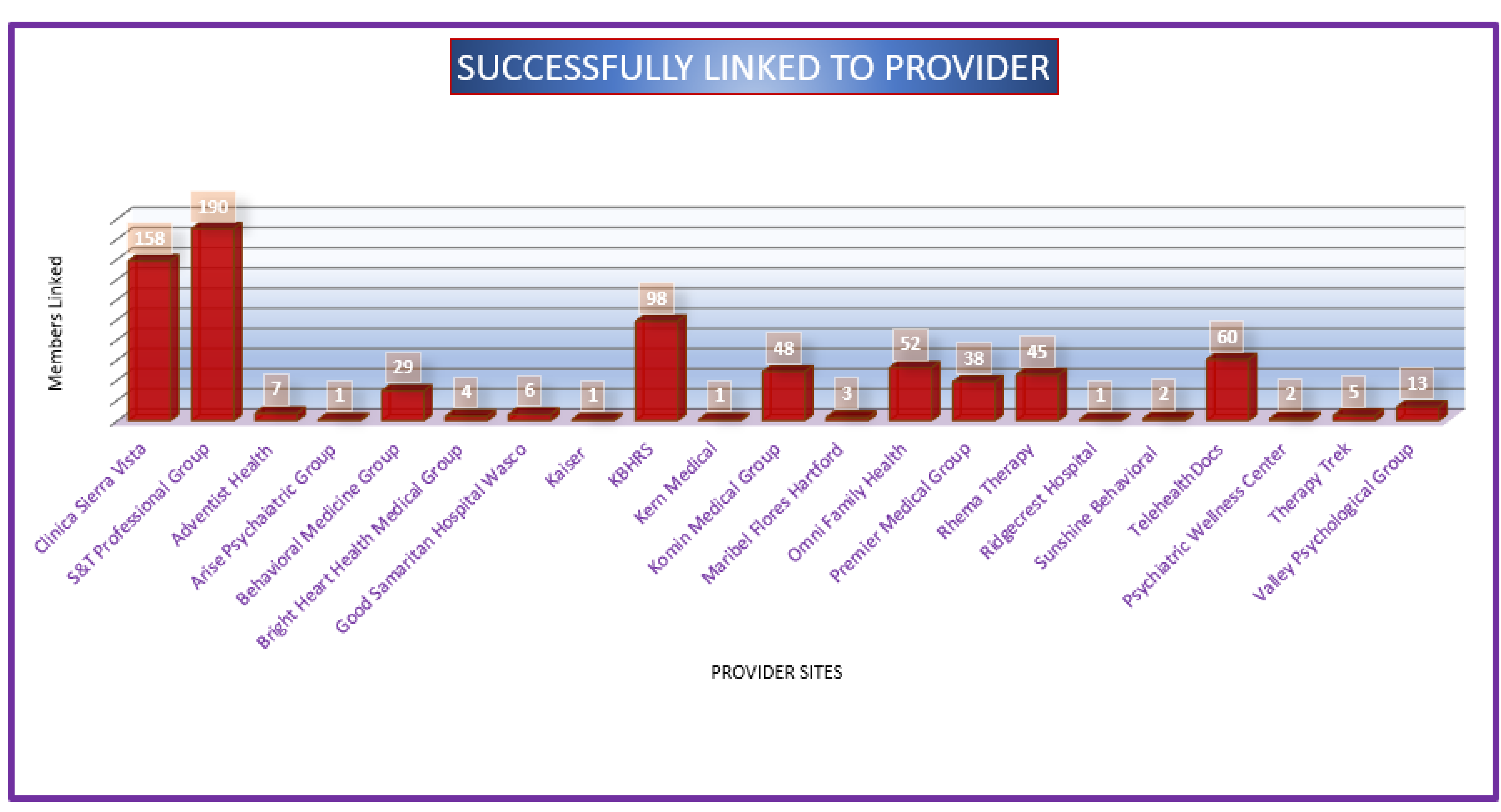
BH Member Stratification

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

Member Referrals

Referrals to BH since launching department: 1187

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



Care Coordination Overview

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

Care Management Overview

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

THANK YOU

Questions?